

Medical Malpractice Issues for Physicians and Attorneys Regional Associations Work Together to Create a Successful Program

In April, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), the Academy of Medicine Education Foundation (AMEF) and the Cleveland Metropolitan Bar Association (CMBA) were pleased to co-sponsor a seminar entitled "Medical Malpractice Issues for Physicians and Attorneys." The event was well-attended with both physicians and attorneys participating in the session. The AMCNO would like to thank the members of our Medical Legal Liaison Committee and in particular committee member Mr. George Moscarino for developing this seminar concept and for reaching out to the CMBA to partner with the AMCNO on this session. Presenters included James J. McMonagle, Esq., from Vorys, Sater, Seymour and Pease, LLP, John A. Lancione, Esq., from Lancione & Lancione, P.L.L., Kim F. Bixenstine, Esq., Vice President and Deputy General Counsel, University Hospitals of Cleveland, and Matthew J. Donnelly, Esq., Director of Litigation, The Cleveland Clinic Foundation.



A capacity crowd of physicians and attorneys were on hand to learn more about medical malpractice issues at the AMCNO/CMBA co-sponsored seminar.

Dr. Laura David, AMCNO President began the session with a welcome from the AMCNO and a special thanks to the CMBA for beginning a new relationship with the AMCNO. She stated that there are various issues where the medical and legal

communities can work in partnership highlighting the various medical legal initiatives currently under review by the AMCNO including specialty courts and our work with the medical legal partnership. She noted that the AMCNO has traditionally had

an educational course each spring dealing with medical legal topics, and we are pleased to start a new format this year with both physicians and lawyers represented in the audience. Mr. Michael Ungar, the

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AMCNO Participates in National Medical Legal Partnership Advocacy Day and Briefing on Capitol Hill

On March 23, 2011, medical-legal partnership (MLP) teams from around the country met with members of Congress and staff on Capitol Hill to educate them about MLP and its positive impact on vulnerable populations across the country. The response was overwhelmingly positive. Members and their staff were eager to support the work of local partnerships and the MLP Network, a testament to the important and valuable services MLPs provide.

The AMCNO was pleased to participate in the MLP Advocacy Day and we were honored to participate in a briefing to Congressional representatives. Participants in the briefing included **Dr. John Bastulli**, AMCNO Vice President of Legislative Affairs,

Mr. Thomas Susman, Esq., Director, Government Affairs Office for the American Bar Association (ABA) and Ms. Ellen Lawton, Esq., Executive Director of the National

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Dr. Bastulli (left) spends a moment after the Congressional briefing with Ms. Ellen Lawton and Mr. Thomas Susman

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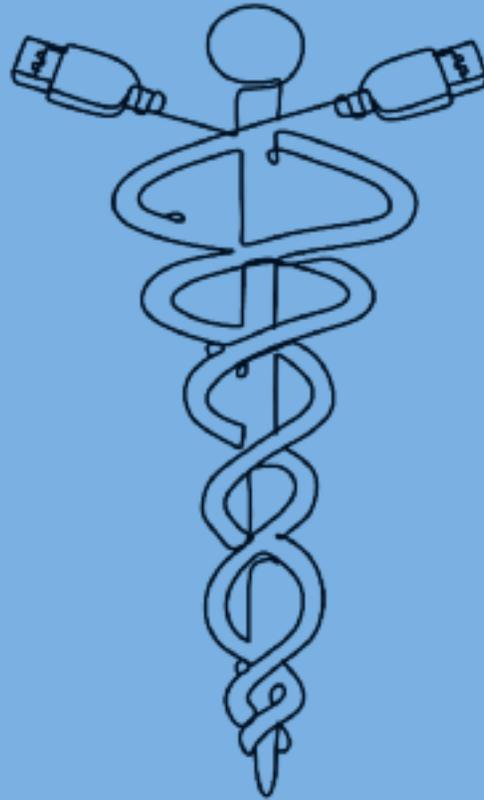
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Medical Malpractice Issues for Physicians and Attorneys

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President of the CMBA also welcomed the group and echoed Dr. David's comments noting that he hopes that this event marks the beginning of what will be a renewed bond between the AMCNO and the CMBA.

Mr. McMonagle was asked to provide commentary on some of the common themes in medical malpractice cases. He stated that one of the most common things that can come up in a trial is the issue of appropriate charting. He cautioned the physicians in the audience that under no circumstances should they be in a situation where they are found to have altered or changed a medical chart. The chart should be complete without last-minute changes – late entries are absolutely frowned upon. He stated that physicians should always be cognizant of the fact that the electronic chart gives a road map as to what happened, when it happened, and who was there. He also noted that it is very important that physicians spend some time with their lawyers prior to a deposition because the lawyer will understand how these charts are going to be used. Remember – when a plaintiff's lawyer is asking you a question, they are not doing it to give you some benefit – so you must have the appropriate period of time to prepare for the deposition. And, if you are to be videotaped remember to look professional and look at the camera, not the person asking the questions. He cautioned the doctors in the audience that if you do end up in court don't forget a jury is sitting there. Remember it is not between you and the attorney – it is between you and the seated jury. Don't ever get to the point of forgetting who the audience is – because at the end of the day the audience is the jury so understand that you have to explain things to them and have a relationship with them.

Mr. Lancione was asked to provide his observations from the plaintiff's bar point of view. A major focus of his presentation covered the insurance claims filing data released by the Ohio Department of Insurance (ODI). He stated that since the enactment of tort reform and the affidavit of merit laws in Ohio the number of medical malpractice claims reported by ODI has gone down. He stated that in reality plaintiff attorneys spend over half their time not suing doctors. Instead, a good deal of their time is spent looking at cases and telling people that their claim has no merit. He stated that it is also important to remember



The presenters pose for the camera following the session: (left to right) Mr. George Moscarino, Mr. John Lancione, Ms. Kim Bixenstine, Mr. Matthew Donnelly and Mr. Jim McMonagle.

that in Ohio lawyers cannot sue doctors anymore without an affidavit of merit from another doctor. He stated that plaintiff lawyers do take this very seriously and they do feel that they all have a commitment to the bar, the court and to the medical profession, and they do not make decisions lightly. He also noted that there are ways that physicians could avoid getting sued. For example, there are proven studies from other states which show that if hospitals and doctors can answer questions forthrightly, they are open and honest about their mistakes, and they show they are taking steps to fix problems, that they are much more likely to avoid being named as part of a medical malpractice suit.

Ms. Bixenstine and Mr. Donnelly were asked by the moderator, Mr. Moscarino, to respond to questions related to current trends in medical malpractice litigation from the hospital in-house counsel perspective.

Ms. Bixenstine stated that there has been increased regulatory action against pharmaceutical companies, device manufacturers and the health care industry. She stated that if a physician is serving as an expert or a speaker for pharmaceutical companies or device manufacturers they should be sure that they are writing their own speeches and that what they are saying on behalf of that pharmaceutical company is representative of their views. Also make sure you are scrupulously following the conflict of interest policies of universities, hospitals and employers. She commented on the ODI data noting that with respect to malpractice trends in Ohio, the number of claims closed in 2009 went up 8 percent over 2008 so there has been an uptick in the number of claims. Also, the average indemnity payment in 2009 was up 27 percent over 2008. She also noted that Northeast Ohio generated half of the claims and had the highest indemnity payments in the state.



(left to right) Mr. Michael Ungar, CMBA president, Mr. George Moscarino and Mr. Jim McMonagle listen to the presentations at the medical legal event.

Mr. Donnelly noted that he is seeing more cases pre-suit since it is expensive for the plaintiff attorneys to hire experts, and if there is agreement on resolving a matter early it is helpful. Ms. Bixenstine agreed noting that last year at least 72 percent of their claims were settled pre-suit without litigation.

In response to a question on what physicians can do to keep out of court, Mr. Donnelly noted that good communications is one of the best ways to avoid a malpractice claim. He stated that it is important to take the time to establish a good patient/physician relationship since it is much easier to spend time on the front end than years of litigation on the back end. Also, he recommended that physicians communicate expectations clearly. In the documentation be sure to clearly lay out a treatment plan, and explain your decision-making process. Ms. Bixenstine also noted that attending physicians need to remember that it is important to read a discharge summary that a resident has dictated. If your name is on it you are responsible for the contents and it does not get you out of liability if it says "dictated, but not read," so she encouraged physicians in the audience to carefully review the discharge summaries and correct them in a timely way.

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She also noted that physicians should have a follow-up process in their office or practice to report test results since there have been cases where there has been a missed diagnosis because of a failure to follow up on test results.

Mr. Moscarino asked for their views on getting affidavits of merit on time and their thoughts on whether the courts enforce these. Ms. Bixenstine stated that generally the judges will give the plaintiff's counsel time to get the affidavit of merit within 60-90 days, but after that time if the affidavit of merit is not filed the case will be dismissed. So the affidavit of merit can provide some deterrent for filing frivolous cases.

In response to a question on how to best work with an outside attorney and defend a case Ms. Bixenstine noted that as soon as there is an adverse incident where there is an unexpected negative outcome or if a physician realizes that a mistake has been made they should immediately call their risk manager or law department. They can help you figure out how to deal with it and how to disclose the error or apologize. It can be helpful to try to resolve a case pre-suit. She also cautioned to never change or alter the records. Mr. Donnelly agreed and noted that physicians have to ask for advice and realize that in this situation they are not the expert anymore. Your whole life you have been the expert and in charge, but you are in foreign territory now. Trust your lawyer to know what they are doing – they have been there before, they are the experts now so work with them. It is also necessary to go through the records, review the depositions, pay attention and put the time in to talk to your lawyer. Also he cautioned physicians in the audience not to engage in communications about the event in the hallway with other people because these conversations are not privileged.

Both attorneys were asked to provide insight into the importance of the deposition. Mr. Donnelly stated that the deposition is more important than the trial because most cases do not go to trial. The deposition is usually the first time the plaintiff's lawyer gets a chance to size up the physician. The deposition makes the initial impression. You want the plaintiff's lawyer coming away from that deposition thinking about whether or not they should move forward with the case. Ms. Bixenstine echoed these comments and stressed the importance of looking professional during the deposition.

Both attorneys commented that social media and electronic communications are dramatically changing litigation because there is so much publicly available. Physicians need to recognize that if they are involved in litigation or called as a witness in a case it is more than likely the plaintiff's lawyer will have searched for information on you, so physicians need to be very sensitive to these issues and also remember that anything that could be embarrassing or used against you in litigation should never be posted on the internet. In addition, emails have changed the way physicians interact with their patients and physicians need to be very clear with their patients whether they will communicate with them via email and under what circumstances. Physicians need to be mindful of the fact that if you use email you may create a physician/patient relationship even if you have not physically examined the patient. So if a patient emails you and you give medical advice by email arguably the patient/physician relationship has been established. That could then lead to a claim for medical negligence if some adverse outcome occurs as a result of that



Mr. David Watson, Executive Director of the CMBA, (left) and Mr. Edward Taber, co-chairman of the AMCNO Medical Legal Liaison Committee share comments during the event.

communication. It can also lead to patient dissatisfaction if a response to an email is not friendly, if it is deemed not responsive, or if it is a response from your staff. Also physicians were reminded that if you put it in an email, on Facebook or up on a blog, you may see it again in a courtroom.

The AMCNO, AMEF and the CMBA wish to thank all of the presenters for their participation in this session and the AMCNO looks forward to working with the CMBA in the coming year on other medical legal initiatives. ■

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Center for Medical-Legal Partnerships. There was a great turnout that included staff from Congressional offices, the ABA, the AMCNO staff and various government agencies.

Dr. Bastulli noted that the AMCNO became involved with the medical legal partnership in our region through the work of our Medical Legal Liaison committee. This committee is comprised of doctors and lawyers from across the Northern Ohio region. The Medical Legal Liaison committee has utilized its resources and volunteer efforts through many of the major Cleveland law firms who work for physicians to accomplish the AMCNO mission. The goal of the Medical Legal Liaison Committee is not just to help doctors work with attorneys - more importantly, the goal is to help doctors help their patients and that is why the MLP program is very important to them. Through the committee they plan to help the MLP program in order to allow physicians to better help their patients. Going forward, the Medical Legal Liaison committee plans to utilize their resources through the major Cleveland law firms that are involved with the AMCNO with the MLP effort.

He further commented that underscoring the Medical-Legal partnership is an understanding that human health is not solely dependent on pathology or medical treatment. Instead, human health can be affected by social factors and unmet legal needs. Physicians typically do not have the time to navigate the bureaucratic complexities that can unintentionally hinder low-income or vulnerable patients' ability to receive benefits from public programs like Medicaid. But because physicians are in a unique position to identify environmental issues affecting patient health, MLPs frequently can then enable lawyers to intervene on behalf of patients before an unmet legal or environmental need reaches crisis levels.

He noted that unmet social and legal needs can have a significant impact on patient health, as well as medical conditions. MLPs are designed to identify and resolve these unmet legal and social needs by joining attorneys with other members of the patient's treatment team. MLPs have been established as an effective means of improving patient health by addressing unmet needs that physicians practicing without legal collaboration typically would not be able to address. This is where the legal profession plays a major role as

advocates. That is one of the reasons the medical legal partnership is so important. Because the MLPs have limited resources, they are always looking at ways to get more resources in both people and dollars - expanding their volunteer pool, and expanding their partnerships. The more the MLP can work through partnerships to take care of their client community the more they can impact their clients. He noted that in order for these types of programs to grow and flourish we will need adequate funding and therefore the AMCNO strongly advocates on behalf of legislation that would provide us with that funding.

Mr. Susman from the ABA noted that one of the beauties of lawyers and doctors working together is that a lawyer can get involved in the earlier stages and get things done to help the patient. For example, lawyers help patients with issues such as income support for food if a child is hospitalized for malnutrition, or they can provide for utility shut off protection when frostbite is the result of the absence of heat. They can also address asbestos in a facility when a patient is brought in having chronic problems due to their environment. These kinds of things obviously are happening around the corner in every city. He stated that this kind of relationship between doctors and lawyers can do something to address not only the health care situation after the fact but also by preventing it from occurring again.

Ms. Lawton noted they are starting to see a change in the standard of care from hospitals and health centers that serve the populations that have strong support from groups like the AMCNO and national groups like the American Hospital Association and the American Medical Association. She stated that there is a lot of work left to do - noting that shifting the training and priorities is going to take time, leadership and resources. All of the panelists agreed that there is a real need to provide additional funds and help programs such as the MLP. There is a plan on the part of the national MLP to reintroduce legislation in Congress to provide for additional funding for MLP programs and the AMCNO plans to continue to work on the national and regional level in an effort to expand the MLP concept in our area. Once the legislation is introduced at the federal level the AMCNO will reconvene stakeholders in our region to continue the discussions in our region on this important concept. ■



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AMCNO Legislative Update

Overview of the Ohio Budget

The Kasich administration released its much-anticipated two-year budget package, March 15, cutting some \$2.3 billion from various line items. The proposed budget is about \$5 billion more than the last budget proposed by former Governor Strickland and approved by the 128th General Assembly. The budget includes many different reforms including public employee pension reform, public employee collective bargaining reform, K-12 education reform, and transformation of higher education in Ohio, incentivizing governmental entities to use shared services like cooperative purchasing, privatizing state assets, Medicaid reform, and criminal sentencing reform. Modernizing or reforming Medicaid is priority number one.

Medicaid funding is being increased by 28.3 percent to partially offset the loss of federal stimulus funding. However, the increase is deceiving, since a 45% increase would be needed to keep Medicaid funding at the current level. Medicaid spending currently accounts for 30% of the State's entire budget and 4% of Ohio's total economy. And about 4% of the Medicaid population (Aged, Blind and Disabled) account for almost 51% of the total spending.

The proposed budget doesn't make any reductions in Medicaid eligibility and avoids cuts in optional services, but according to Greg Moody, of the Office of Health Transformation, (OHT) the goal is to put more emphasis on outcome-based medicine that rewards quality rather than quantity of services. He said efforts to "transform Medicaid" will reduce over-all spending by about \$1.4 billion over the biennium and include:

- Improving care coordination to achieve better health and cost savings by promoting health homes, providing accountable care for children, and supporting Ohio's care coordination planning grant application to the Centers for Medicare and Medicaid Services (CMS);
- Integrating behavioral and physical health care services by elevating behavioral health financing to the state, managing behavioral health service utilization, and consolidating the Residential State Supplement program; and

- Rebalancing long-term care to enable seniors and the disabled to live in preferred settings by creating a unified long-term care budget, creating a single waiver, avoiding high cost institutional placements, linking nursing home payments to patient-center outcomes, consolidating programs for people with developmental disabilities, and reforming nursing facility payments.

The budget will affect physicians by ending hospital and physician payments for patients who must be readmitted due to hospital acquired infections. It will also restore the pharmacy benefit "carve out" to managed care but require a more standardized set of prior authorization criteria across the plans. Hospitals will also be required to pay a franchise fee. OHT estimates the \$371 million in franchise fee payments will result in a net gain of \$554 million for hospitals and \$434 million in general revenue funds for the state over the biennium.

Gov. Strickland's last budget constituted a tax (or fee) of \$718 million on hospitals, and mandated that the franchise fee to be in place for two years. It imposed an annual assessment on hospitals based on their total facility costs. It set the first annual assessment at 1.27% of a hospital's total facility costs and the second and subsequent annual assessments at 1.37%. The revenue from the franchise fee was then returned to hospitals through a draw down from an enhanced FMAP that was disbursed based on the amount of Medicaid patients treated by the hospital. As noted above, the new executive budget HB 153, extends this franchise fee.

The Ohio Hospital Association (OHA) describes the payment process for the new franchise fee as follows: Ohio hospitals pay a \$900 million franchise fee that draws down \$1.6 billion in federal matching funds; \$1.2 billion of these funds are available to the state to fund non-hospital portions of the Medicaid budget; and \$1.3 billion of these funds are used to pay hospitals for services provided to Medicaid patients and to pay hospitals through UPL formulas and other mechanisms.

In addition the budget calls for:

- Enrolling 37,544 children with disabilities into Medicaid managed care plans, while beginning the development of Pediatric Accountable Care Organizations to address their long-term medical conditions.
- Moving financial responsibility for community behavioral health from local boards to the state.
- Requiring Medicaid managed care plans to reimburse hospitals at lower fee-for-service rates if they will not contract with an MCO plan. Eliminating the Children's Buy-In Program, which provides insurance subsidies for families with uninsurable children between 300% and 500% of the federal poverty level.
- Combining PASSPORT, Ohio Home Care, Ohio Home Care/Transitions Aging Carve-out, Choices, and Assisted Living into a single waiver program for individuals with physical disabilities and seniors.
- Linking nursing home payments to patient-centered outcomes by modifying the quality incentive payment.
- Adjust nursing home facility rate reimbursements and make other changes to shift to more home and community-based services.

Recently, Mr. Greg Moody who is the head of Gov. Kasich's new Office of Health Transformation (OHT) which will coordinate and oversee health priorities and health related entitlement programs, appeared before the Ohio House Finance and Appropriations Committee to discuss the budget bill. Mr. Moody told the committee members that the group's directives are to align Medicaid policy priorities across agencies. Medicaid spending is about \$20 billion of the state's \$55 billion budget. Mr. Moody explained that Gov. Kasich's policy priorities are focused on better health outcomes for the 2.2 million Ohioans on the Medicaid program and on achieving a better value for the state's taxpayers. Among the priorities is the Affordable Care Act (ACA) focus on medical homes, which could improve care and reduce costs by avoiding emergency room use, moving consumers away from hospitals to a lower cost site to receive their primary care, and avoiding hospital admissions with earlier treatment. ACA provisions will also involve returning the control of prescription drugs to managed care organizations with the state still able to get the supplemental rebates while the

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exchanges will provide another avenue for coverage for some citizens.

Care coordination is another priority that will involve looking at coordinating services to the state's dual eligible individuals who receive services covered by both Medicare and Medicaid. Care coordination also sees a new, evolving role for children's hospitals, with the budget proposing Pediatric Accountable Care Organizations (ACOs).

The state is going to receive less in federal matching funds and is forced to make reductions. In Mr. Moody's testimony he explained where some of the reductions will be made that make up for \$1.4 billion in Medicaid cuts:

- Per member per month rate for hospitals down 1.8 percent
- Outpatient hospital rate will be down 4.5 percent with the per member per month rate down 6.7 percent
- Managed care plans will see a 1 percent reduction in administrative/trend changes
- The base rate for community-based nursing services will see a 4.9 percent decrease while the base rate for aide services will go down 2.5 percent

Other Budget Items

The Ohio Department of Insurance budget eliminates funding for the Health Care Coverage and Quality Council, but includes funds for implementing many aspects of the federal Patient Protection and Affordable Care Act, including overseeing Ohio's high-risk pool, reviewing insurance policy form and rate filings for compliance with applicable state and federal law, and coordinating with the federal government.

The department is also preparing for the health insurance market reforms to take effect in 2014, including planning for implementation of a health insurance exchange in Ohio. The department has received two federal grants to meet its regulatory obligations under federal law: a health insurance exchange planning grant and a premium rate review grant.

At a recent visit to Cleveland, Medicaid Director Mr. John McCarthy provided a detailed overview of the Medicaid budget noting that the health transformation priorities are to improve care coordination, integrate behavioral/physical health care, rebalance long-term care, modernize reimbursement and balance the budget. He noted that the vision for better care

coordination is to create a person-centered care management approach – not a provider, program or payer approach. Services are to be integrated for all physical, behavioral, long-term care and social needs. Services are to be provided in the setting of choice with a system that is easy to navigate for consumers and providers. The intention is to transition seamlessly among settings as needs change and to link payment to person-centered performance outcomes. In order to improve care coordination, Mr. McCarthy noted that there will be a need to create a single point of care coordination, as well as to promote health homes and accountable care for children.

Currently, the Ohio Department of Health (ODH) has an annual budget of over \$770 million. Seventy-two percent comes from federal funding, 12.7 percent from state general revenue funds (GRF) and the rest from permits and fees. The ODH has created a web site to provide accurate and up to date information about the budget at www.odh.ohio.gov/budget.

The leadership of the Ohio House is hoping to have HB 153 passed out of the chamber by the second week of May. The bill will then move over to the Ohio Senate. The executive budget must be enacted by July 1st.

Other Legislation Under Review in the Ohio Legislature

As always, the AMCNO is tracking all health care-related bills as they are introduced and move through the Ohio legislature. The AMCNO has taken a position of support on the following legislation:

HB 93 – Prescription Drugs – this bill would establish and modify the prevention of prescription drug abuse, development of information programs by the State Medical Board, and Medicaid coverage of prescription drugs.

SB 31 – Cancer Treatment – this bill requires certain insurers that provide coverage for cancer chemotherapy treatment to provide coverage for certain prescribed, orally administered anticancer medication on a basis no less favorable than intravenously administered or injected cancer medications that are covered under the policy.

SB 77 – Bicycle Helmets – this bill would require bicycle operators and passengers under 18 years of age to wear protective helmets when the bicycle is operated on a

roadway and to establish the Bicycle Safety Fund to be used by the Department of Public Safety to assist low-income families in the purchase of bicycle helmets.

SB 129 – Medical Immunity – this bill would grant qualified civil immunity to a physician, physician assistant, dentist or optometrist who provides emergency medical, dental or optometric services, first-aid treatment or other emergency professional care in compliance with the federal Emergency Medical Treatment and Active Labor Act or as a result of a disaster and to a certified nurse-midwife, certified nurse practitioner, clinical nurse specialist or registered nurse who provides emergency services, first-aid treatment or other emergency professional care as a result of a disaster and to provide that these provisions do not apply to wrongful death actions.

For more information on AMCNO legislative activities or items covered in this article, please contact the AMCNO executive offices at 216-520-1000. ■

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The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Spearheads Legislation to Address Physician Ratings in Ohio

After several months of working with AMCNO leadership and lobbyists, Senator Tom Patton (R-24) has introduced SB 121 – legislation meant to address the issue of physician ratings by insurance companies in Ohio.

The purpose of this legislation is to provide patients with accurate information when selecting a physician. This legislation would prevent health insurance companies from ranking physicians based solely on specific criteria to persuade a consumer to choose one physician over another. The legislation would modify the usage of physician rating (also referred to as physician ranking and physician designation) by medical insurance companies and public health plans.

The intention of the legislation is to apply a system of quality standards if and when a medical insurance company or public health plan uses a system of physician rating. The legislation will also notify a physician when they are being rated and allow for a process of appeal if the physician does not agree with the rating. This legislation will provide a system of fairness to the physician community. If

passed, Ohio will be on the forefront of implementing important new policy that promotes accurate, safe and effective health care transparency for everyone.

The issue of physician ranking has been hotly debated for several years. In recent years, there has been an increase of physician ranking across the country. Insurers have supported obtaining data in order to tier and quantify cost effective care, and consumers have wanted data to compare quality of doctors. The crux of the debate is balancing the rights of physicians to have accurate and relevant reporting of their practice with the desire of health insurers and consumers to have access to information about their treating physician.

In the past, there has been a lack of scrutiny that has enabled health insurers to unfairly evaluate a physician's individual work by using

an insufficient number of patient cases, questionable quality measurements and poor risk adjustment systems.

The AMCNO is of the opinion that doctor rankings can be confusing and could be used to steer patients to the least-expensive health care providers, rather than being based on quality. It is important that the insurance companies are truly reviewing quality issues versus cost and claims data, and the data must be accurate with the ability of physicians to appeal their data.

In the 128th General Assembly legislation was introduced by Rep. Barbara Boyd (HB 122) and Senator Patton (SB 98). HB 122 passed out of the House with a 97-1 vote and had two hearings in the Senate Insurance, Commerce and Labor Committee. The AMCNO was very active in this debate and was instrumental in getting this legislation to move through the Ohio House in the last General Assembly. The AMCNO also worked with other interested parties and stakeholders including the state medical association to craft changes to the legislation – changes which are reflected in this latest piece of legislation – SB 121.

The AMCNO plans to work diligently to achieve the passage of SB 121 in this General Assembly and we will keep our members apprised of when the bill will be up for testimony and discussion in the coming months. ■

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AMCNO Physician Leadership Meets with State Agency Administrators

Recently AMCNO physician leaders, staff and our lobbyist met with Dr. Ted Wymyslo, the Director of the Ohio Department of Health (ODH), Mr. Michael Farley, Assistant Director for Legislative Affairs for the Ohio Department of Insurance (ODI), and Mr. John McCarthy, Medicaid Director for the Ohio Department of Job and Family Services (ODJFS).

The purpose of these meetings was to meet with the new administrators from these statewide groups to provide background on the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) as well as to discuss the activities of our organization. The AMCNO leadership noted that our membership is comprised of physicians from all over the Northern Ohio region and our organization represents physicians and physician's interests, no matter what their employment status or practice environment. We also noted our efforts in the legislative arena, specifically on legislation related to tort reform issues and physician ranking, as well as discussing the importance of the AMCNO community efforts and public health initiatives. The AMCNO physician leaders also expressed a strong interest in working with these statewide organizations on health care initiatives and legislative matters as well as asking for the opportunity to have an AMCNO participant on statewide task forces or work groups as they develop to review health care related



Representatives of the Ohio Department of Insurance meet with the AMCNO lobbyist and Drs. Bastulli and David to discuss the physician ranking legislation.

matters or issues that could impact the patient/physician relationship. As a result, ODH representatives asked for the assistance of the AMCNO on their work with the patient-centered medical home initiative, the medical reserve corps and public health issues. The ODI plans to work with the AMCNO on the physician ranking legislation and insurance matters and they also asked to learn more about the AMCNO involvement on developing a pilot in Northern Ohio for a special court to review medical liability cases. The ODJFS staff was



Dr. Laura David, AMCNO president and Dr. John Bastulli AMCNO VP of Legislative Affairs spend a moment with Dr. Ted Wymyslo, Director of the Ohio Dept. of Health.



Drs. David and Bastulli take a moment to pose with the Director of Medicaid, Mr. John McCarthy.

receptive to including the AMCNO in future discussions regarding Medicaid reimbursement issues as well. The AMCNO plans to remain in close contact with the leadership from these and other state agencies in an effort to keep the AMCNO and the physicians in our region involved in budget discussions and other health care related matters at the state level. ■

AMCNO Physician Leadership Meets with the New County Executive – Mr. Ed Fitzgerald

Drs. David and Bastulli joined AMCNO staff E. Biddlestone and AMCNO lobbyist C. Patton in a meeting with the new county executive, Ed Fitzgerald, to discuss health care related issues of importance to the AMCNO.

Mr. Fitzgerald was provided with an overview of the mission and vision of the AMCNO along with background information on AMCNO activities. Mr. Fitzgerald also learned firsthand from the AMCNO President, Dr. Laura David, about the myriad public health programs that the AMCNO participates in across the region. Drs. David and Bastulli impressed upon Mr. Fitzgerald the importance of working with the AMCNO due to our status as a regional medical association representing physicians and their patients. The AMCNO physician leaders also expressed a strong interest in working with the county on health care

initiatives as well as participating on county task forces or work groups that are developed to review health care related matters or issues.

Mr. Fitzgerald was very impressed with the work of the AMCNO and he expressed an interest in working with the AMCNO physician leadership on health care related issues of importance to the county and the citizens in the community. As a result, the county staff has been in discussions with the AMCNO staff and physician leadership to discuss working with the AMCNO and the physicians in the community on initiatives



The new county executive Mr. Ed Fitzgerald took time out of his busy schedule to talk with AMCNO representatives (left to right) Dr. Bastulli, Mr. Fitzgerald, Dr. David and AMCNO lobbyist Mr. Connor Patton.

that could improve the health of the citizens in Cuyahoga County. The AMCNO is continuing these discussions and we plan to remain in close contact with the leadership from the county executive's office to maintain a strong working relationship with the county and keep the AMCNO and the physicians in our region involved in health care initiatives developed by the county. ■

AMCNO Participates in Investing in Tobacco Free Youth Advocacy Day

Recently the AMCNO was pleased to be a participant in the Investing in Tobacco Free Youth Advocacy Day at the Ohio Statehouse. Joining the AMCNO were more than 150 anti-tobacco volunteers including medical students from the Ohio State University. The day began with an issue briefing prior to the participants meeting with their legislators from their respective districts.

The Advocacy Day participants notified legislators that Ohio's laws governing tobacco have not kept up with the rapidly changing tobacco products market. Participants in the event were asked to press legislators to consider increasing the cigarette tax and equalizing the "other tobacco products" (OTP) tax in order to fund tobacco prevention and cessation programs across the state. Legislators were informed that the use of non-cigarette forms of tobacco is rising, especially among youth since these products are cheaper due to the low OTP tax rate. Equalizing the OTP tax to the current cigarette rate would generate \$50 million annually. Other concepts mentioned to legislators were reclassifying filtered little cigars as cigarettes which would raise the tax on these products, the elimination of tobacco tax credits which are discounts for cigarette

tax stamps and the discount for timely payment of the other tobacco products' excise tax – unnecessary perks for tobacco companies that could provide the state with almost \$3 million over the biennium. Instituting high-tech tax stamps in Ohio could also help since high-tech tax stamps are difficult to counterfeit and reduce cigarette tax evasion, increase government revenue and stop illegal cigarette sales at below-market prices. This funding should be used to continue tobacco prevention and cessation programs. In a recent poll, 74.9% of Ohioans supported taxing all tobacco products at the same rate and using the new funding for tobacco programs. Participants in the Lobby Day reminded their legislators that through sustained state investments in tobacco prevention, Ohio can save Medicaid dollars by roughly \$16 million for direct healthcare



Medical students from the Ohio State University were on hand at the Advocacy Day to talk to legislators about tobacco related health issues.

costs and over \$27 million in workplace productivity losses.

In the meeting with area legislators, it became clear to the AMCNO that adding new taxes or raising taxes would probably not be an option at this time, however, legislators seemed open to further discussion on instituting high-tech tax stamps, reclassifying little cigars as cigarettes and eliminating tobacco tax credits. The AMCNO plans to remain actively engaged in these efforts to make changes in the Ohio law in order to fund tobacco prevention and cessation programs in our community and across the state. ■

AMCNO Meets with the New Chief Justice Maureen O'Connor

Representatives from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Medical Legal Liaison Committee recently met with Ohio Chief Justice Maureen O'Connor to discuss alternatives and improvements to the current tort reform system. Our representatives informed the Justice that this issue has been at the forefront for the AMCNO as 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.

The AMCNO provided background to the Justice on meetings that have taken place over the last few years between the AMCNO, the late Chief Justice Thomas Moyer, Judge Fuerst and representatives of the bar association on the issue of special medical courts and the use of specially trained judges for medical liability cases. The AMCNO also provided information on recent discussions between the AMCNO and representatives from the court in the Southern District of New York regarding their specialty court concept.

The AMCNO representatives explained that the program in New York started as a judge-directed negotiation program working with one large hospital chain in the New York City area. The program was directed to

expediting adjudication and early resolution of medical liability cases - to reduce administration/litigation costs. The judge that spearheaded the concept is a medically trained judge and the program worked as follows: any medical liability case filed in the New York City area against an institution or doctor at the hospital network would be automatically assigned to the specially trained judge to handle for all pretrial activities. The judge would schedule an early pretrial and take a hard look at the case with counsel, discussing all facts very early on, rather than just setting further dates at the first pretrial. There would be a push for an early settlement in many cases, or for dismissal in weak cases, and the judge would limit the discovery in most cases to just the

key depositions. The judge's program was able to substantially shorten litigation time and reportedly save the hospital network an estimated \$50 million dollars per year.

This program served as an example for a grant application to the federal government. The grant was won, and this is now allowing an expanded version of the judge's program to now encompass five major health systems in the New York City area. The grant also covers medical training for more judges and also includes a patient safety-quality assurance component. Harvard Medical School is tracking data on this New York City program, and expects to publish a study in the next few years measuring the outcome of the program.

The AMCNO asked for the Justice's input on initiatives that could improve or streamline outcomes for all parties in medical liability cases. The Chief Justice suggested that it might be beneficial to visit the court in New York City to see firsthand how this system operates and adjudicates cases. She also suggested that the AMCNO reach out to the bar association and the plaintiff's bar to see if we could garner interest in this concept. It would be important to have both the medical and legal community involved in these discussions going forward. The AMCNO is currently involved in discussions to set up a task force to discuss this concept further. ■



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The Importance of Being Early

Patients and Physicians Benefit from Early Detection of Alzheimer's Disease

By Dr. Matthew Wayne

An increasing number of Americans are being diagnosed with Alzheimer's disease and other related dementias. The diagnosis can be devastating to patients and their families. While a cure for the disease remains elusive, our understanding of the disease has advanced and there are good reasons to maintain hope. There are a number of pharmaceutical therapies that have shown promise in attempting to slow the advancement of the disease and there are a number of brain health initiatives that may also be of benefit in helping to slow the progression of the disease.

These circumstances serve to emphasize the importance of early detection of the disease. But timely detection of memory loss or cognitive impairment offers many benefits for people with dementia, their families and physicians beyond just taking a pill.

An early diagnosis of Alzheimer's disease benefits physicians in that it triggers a search for potentially treatable or reversible disorders. In many cases, memory loss or mild cognitive impairment can be the result of maladies other than Alzheimer's disease that can be medically treated. Other health problems such as depression, thyroid problems, dehydration, malnutrition, infections and medication problems can mimic the symptoms of Alzheimer's disease. Therefore, a physician assessing a patient with memory loss and/or mild cognitive impairment can troubleshoot these other potential causes before arriving at a diagnosis of Alzheimer's disease. It is not uncommon for a patient or their loved ones to avoid diagnosing the problem for a fear of an Alzheimer's diagnosis. The fact is that many of these families may be living in fear unnecessarily and a relatively simple course of medical attention might successfully address symptoms.

An early diagnosis also allows the physician, the patient and their family to address a number of personal issues that might cause the patient avoidable harm. Issues of personal safety, personal hygiene and nutrition come into play with a person suffering from memory loss or cognitive impairment. Properly addressing those issues and implementing a regimen to avoid the obvious pitfalls will go a long way in preventing unnecessary hardship whether or not the patient is ultimately diagnosed with the disease. Other financial and professional issues can likewise be avoided with an early diagnosis.

An early diagnosis will also offer a physician some important guidance on the treatment of other concurrent health problems and will help them address comprehension and compliance challenges faced by a person with dementia.

The patient can also benefit greatly from an early diagnosis. Having their symptoms looked at and addressed can positively impact the individual by ensuring greater understanding and awareness of what is happening to him or her. An early diagnosis provides an opportunity to take medications to address some of the cognitive changes and opens the door for the patient and family to take advantage of appropriate programs and services that are available in their community.

The diagnosis will also provide the patient and family with a framework for understanding and adapting to cognitive and behavioral changes and may reduce the tendency to blame or be impatient with the diagnosed individual.

It is also important to identify the condition at a time when the patient can still participate in medical, legal and financial decisions and make proxy plans. An early diagnosis will encourage the exploration of options for job accommodations, early retirement or disability for individuals with younger-onset Alzheimer's before reduced performance jeopardizes employment and financial security. Early diagnosis gives the person with Alzheimer's and their family more time to arm themselves with knowledge about this type of dementia and the best way to live with the disease. In these circumstances, knowledge is power.

The most common early symptom of Alzheimer's disease is difficulty remembering newly learned information

because Alzheimer's changes typically begin in the part of the brain that affects learning. As Alzheimer's advances through the brain it leads to increasingly severe symptoms, including disorientation, mood and behavior changes; deepening confusion about events, time and place; unfounded suspicions about family, friends and professional caregivers; more serious memory loss and behavior changes; and difficulty speaking, swallowing and walking.

There have been recent advancements in Alzheimer's diagnostic research that have produced some promising evidence that PET scans or the presence of certain biomarkers may be able to predict Alzheimer's disease. These developments are exciting to say the least but further study is needed prior to routine diagnostic use. Therefore, physicians typically make a clinical subjective diagnosis based on patient and family testimony as well as testing the patient's memory and other cognitive skills. Basic laboratory testing as well as a CT or MRI scan may be helpful in eliminating other causes of memory problems.

Last year, The Alzheimer's Association issued some simple guidelines on the 10 warning signs of Alzheimer's disease which are listed below. Anyone experiencing one or more of these signs should consult with a doctor sooner rather than later. The earlier a patient gets a diagnosis, the better their chances are for seeking treatment and planning for the future.

10 Warning Signs of Alzheimer's disease

1. Memory loss that disrupts everyday life

One of the most common signs of Alzheimer's is memory loss, especially forgetting recently learned information. Others include forgetting important dates or events; asking for the same information over and over; relying on memory aides (e.g., reminder notes or electronic devices) or family members for things they used to handle on their own.

What's a typical age-related change? Sometimes forgetting names or appointments, but remembering them later.

(Continued on page 14)

The Importance of Being Early

(Continued from page 13)

2. Challenges in planning or solving problems

Some people may experience changes in their ability to develop and follow a plan or work with numbers. They may have trouble following a familiar recipe or keeping track of monthly bills. They may have difficulty concentrating and take much longer to do things than they did before.

What's a typical age-related change? Making occasional errors when balancing a checkbook.

3. Difficulty completing familiar tasks at home, at work or at leisure

People with Alzheimer's often find it hard to complete daily tasks. Sometimes, people may have trouble driving to a familiar location, managing a budget at work or remembering the rules of a favorite game.

What's a typical age-related change? Occasionally needing help to use the settings on a microwave or to record a television show.

4. Confusion with time place

People with Alzheimer's can lose track of dates, seasons and the passage of time. They may have trouble understanding something if it is not happening immediately. Sometimes they may forget where they are or how they got there.

What's a typical age-related change? Getting confused about the day of the week but figuring it out later.

5. Trouble understanding visual images and spatial relationships

For some people, having vision problems is a sign of Alzheimer's. They may have difficulty reading, judging distance and determining color or contrast. In terms of perception, they may pass a mirror and think someone else is in the room. They may not realize they are the person in the mirror.

What's a typical age-related change? Vision changes related to cataracts.

6. New problems with words in speaking or in writing

People with Alzheimer's may have trouble following or joining a

conversation. They may stop in the middle of a conversation and have no idea how to continue or they may repeat themselves. They may struggle with vocabulary, have problems finding the right word or call things by the wrong name (e.g., calling a "watch" a "hand-clock").

What's a typical age-related change? Sometimes having trouble finding the right word.

7. Misplacing things and losing the ability to retrace steps

A person with Alzheimer's disease may put things in unusual places. They may lose things and be unable to go back over their steps to find them again. Sometimes, they may accuse others of stealing. This may occur more frequently over time.

What's a typical age-related change? Misplacing things from time to time, such as a pair of glasses or the remote control.

8. Decreased or poor judgment

People with Alzheimer's may experience changes in judgment or decision-making. For example, they may use poor judgment when dealing with money, giving large amounts to telemarketers. They may pay less attention to grooming or keeping themselves clean.

What's a typical age-related change? Making a bad decision once in a while.

9. Withdrawal from work or social activities

A person with Alzheimer's may start to remove themselves from hobbies, social activities, work projects or sports. They may have trouble keeping up with a favorite sports team or remembering how to complete a favorite hobby. They may also avoid being social because of the changes they have experienced.

What's a typical age-related change? Sometimes feeling weary of work, family and social obligations.

10. Changes in mood or personality

The mood and personalities of people with Alzheimer's can change. They can become confused, suspicious, depressed, fearful or anxious. They may be easily upset at home, at work, with friends or in places where they

are out of their comfort zone.

What's a typical age-related change? Developing very specific ways of doing things and becoming irritable when a routine is disrupted.

The Alzheimer's Association 24/7 Helpline provides reliable information and support to all those who need assistance. Call toll-free anytime day or night at **1.800.272.3900**.

Dr. Matthew Wayne is currently the medical director for Geriatric Medicine at University Hospitals Richmond Medical Center and an assistant professor of medicine at University Hospitals Case Medical Center in Cleveland, Ohio. Dr. Wayne is also Chair of the Professional Advisory Board of the Alzheimer's Association Cleveland Area Chapter. Dr. Wayne is also a valued member of the AMCNO and he recently appeared on the AMCNO Healthlines radio program to discuss this same topic. To listen to Dr. Wayne's Healthlines program go to our web site at www.amcno.org and go to the Healthlines link.

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. Cindy Penton at the AMCNO offices at (216) 520-1000, ext. 102. ■

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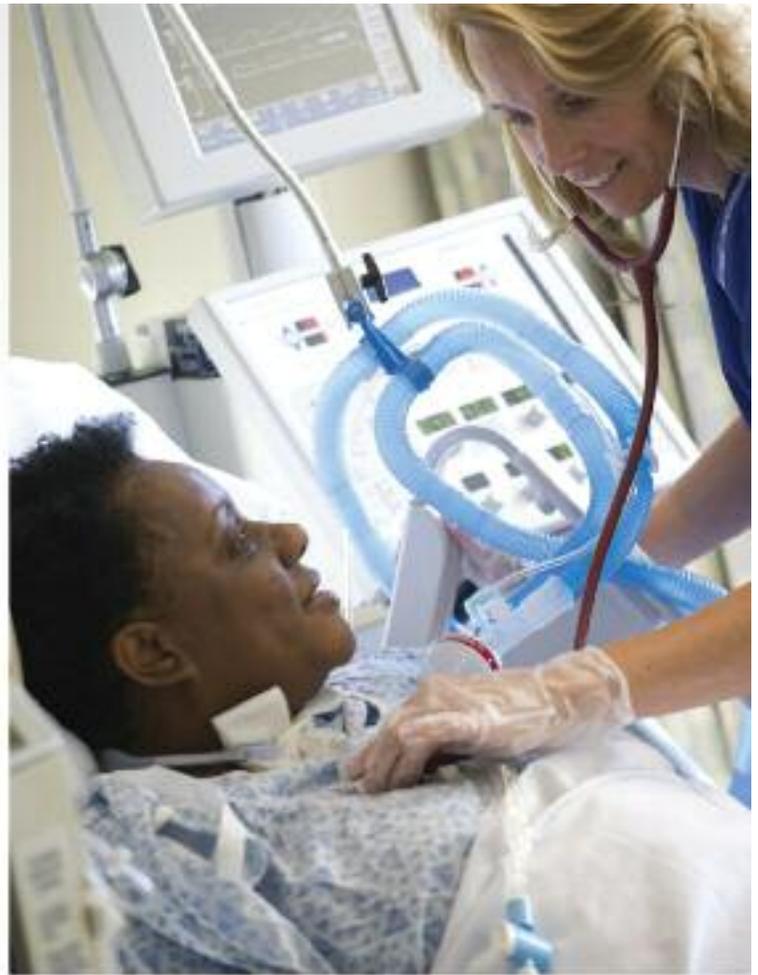
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The Ohio Health Information Partnership (OHIP) Position on Patient Consent Under Review

By J. Ryan Williams, Esq., Walter and Haverfield, LLP

AMCNO Overview of our Response to the OHIP Privacy Consent Policy

Recently, the Ohio Health Information Partnership (OHIP) requested public comments on their Research and Recommendations for Patient Consent Policies for OHIP's health information exchange. After detailed discussions and a thorough legal review of OHIP's consent policy by various parties, a detailed comment letter was sent to OHIP on behalf of the AMCNO, Aultman Health Foundation, Care Alliance Health Center, Cleveland Clinic, EMH Health Care System, Sisters of Charity Health System/St. Vincent Charity Medical center and Mercy Medical Center, Southwest General Health Center, Summa Health System, and University Hospitals.

The parties decided to write and submit a combined letter, as opposed to each organization writing and submitting separate letters, to streamline the comment process. We found that many of the organizations shared similar comments and viewpoints. We all recognized that these issues are complex, and that it is difficult to craft a solution that can be consistently applied on a statewide basis which provides a reasonable level of protection to both patients whose information is exchanged through the HIE, and to provider participants in the HIE. In addition, Ohio law regarding the consent issues raised in the Recommendations is not perfectly clear. The following article provides an overview of this issue. At press time, OHIP had not yet posted their response to the issues raised by the AMCNO and the other healthcare organizations. The AMCNO will provide an overview of OHIP's response when it becomes available.

There is no doubt that health information technology (HIT) is changing the way physicians practice medicine. The federal government, state governments, commercial payors, other healthcare providers, and more importantly patients, are demanding that physicians embrace and use HIT. This is especially true in the areas of electronic health records (EHR) and health information exchanges (HIE).

Implementing and using EHR software and electronically exchanging health information via HIE present many different issues for physicians. EHR and HIE are inextricably tied together for many reasons, but for physicians one reason is by far the most important – to receive incentive payments for the meaningful use of EHR software, physicians are required to electronically exchange health information with other healthcare providers in various patient care delivery settings. To do this requires a functional and interoperable HIE infrastructure.

The Ohio Health Information Partnership (OHIP) is the organization heading the development and implementation of the statewide HIE infrastructure. OHIP has developed a comprehensive HIE framework and selected a HIE vendor. From all accounts, OHIP intends to implement the statewide HIE (for various core functions initially) sometime in the second half

of 2011. As part of OHIP's work in developing the statewide HIE, OHIP recently published its recommendations on the issue of patient consent. These recommendations, and the ramifications that would follow, have raised some questions.

I. HIE and OHIP

The notion of electronically exchanging EHRs and other health information among physicians and other healthcare providers is not a new development. In April 2004, President Bush established what has become known as the Office of the National Coordinator for Health Information Technology, which at that time was delegated the task to develop a nationwide HIE infrastructure for the exchange and dissemination of EHRs for all Americans. President Obama continued the federal government's push to incentivize EHR use and the development of a nationwide HIE in January, 2009, just months after being elected, when he promised that all Americans would have an EHR capable of being electronically exchanged throughout the country by 2014. At the same time, states and other local stakeholders began to explore and develop statewide and regional HIEs. For instance, local stakeholders in northeast Ohio, including the AMCNO, came together in a collaborative effort

known as Northeastern Ohio Regional Health Information Organization for the purpose of implementing a secure, confidential, patient-controlled environment for a HIE in northeast Ohio.

The federal government's push to encourage EHR adoption and the development and use of a nationwide HIE infrastructure led to the passage of the HITECH Act in early 2009. The HITECH Act authorizes millions of dollars to be paid to healthcare providers to help encourage and facilitate the use of EHR software. The HITECH Act also provided millions of dollars in the form of grants to states to help fund the creation and implementation of statewide HIEs.

To date, OHIP has been awarded almost \$15 million in federal grant money to facilitate the development and implementation of a statewide HIE. According to OHIP, a true statewide HIE will permit the exchange of health information across diverse patient care delivery systems throughout Ohio. In the words of President Obama and as reiterated by OHIP, statewide HIE will support clinicians in making cost effective, fact-based decisions that reduce medical errors, decrease redundant tests and improve care coordination with the help of timely and standardized data aggregation. OHIP has a vision for the statewide HIE that will make the exchange of health records sustainable, secure and allow for physicians and other healthcare professionals to have patient authorized access to health information.

II. OHIP's Opt-In Framework

OHIP recently proclaimed that one of the most important elements in developing and implementing a statewide HIE is patient consent. In February, OHIP published its recommendations for addressing patient consent issues in connection with the statewide HIE. OHIP recommended that the statewide HIE operate under an opt-in framework for patient consent.

This opt-in framework requires that patients provide express written consent to participate in the statewide HIE. In other words, patients would need to sign specific consent forms before their health information is transmitted, shared, used or accessed via the statewide HIE. OHIP's recommendation of the opt-in framework is based on OHIP's view of Ohio patient consent laws. According to OHIP, Ohio patient consent laws require that patients provide express consent before healthcare providers are permitted to share, use or access health information for treatment purposes of the patient. OHIP's position on patient consent requirements, especially in

the situations involving the use or disclosure of health information for treatment, has caused significant concern in the healthcare provider community. While the legal justification for OHIP's position on patient consent is justifiable in some instances, but not without equally applicable and pervasive counter views, OHIP's position may have a more significant affect – physicians may elect not to participate in the statewide HIE.

III. Consequences of OHIP's Opt-In Framework

An opt-in framework for Ohio's statewide HIE may create operational and administrative barriers for physicians attempting to participate in the HIE. For the majority of physicians that routinely disclose health information to other medical providers involved in the care of a particular patient, a requirement that an express authorization must be obtained would require the physician to re-design critical workflow aspects of his or her practice. Physicians would need to implement policies and procedures to ensure that all necessary authorizations are obtained and would need to monitor policies and procedures to ensure effectiveness. Physicians would also need to consistently verify and re-verify that all necessary consents have been obtained before sharing information. This verification and re-verification would need to occur each time the physician would like to share information with other treatment providers. For many physicians, the expense (in both time and money) associated with redesigning critical workflows would be significant enough to deter use of the HIE.

The impact of an opt-in framework on critical workflows is most apparent considering current practice in Northern Ohio. Most physicians in Northern Ohio do not distinguish between health information exchanged in an electronic format, versus medical information exchanged through a paper-based or oral format. If specific patient consent for provider-to-provider transfers of medical information in the context of the HIE is required, consistency could require the same for all other movements of health information between providers, whether by paper, telephone communication, oral communication or otherwise. Many physicians in Northern Ohio are not, on a uniform basis, currently operating in such a manner. For example, when a primary care physician refers a patient to a specialist physician for a consultation, the primary care physician may not obtain a separate patient consent to share the patient's medical information with the specialist for review.

In addition, physicians would need to allocate office time with patients to inform them of the aspects of the authorization and the benefits of the HIE. While not significant on a patient-by-patient basis, the aggregate amount of time educating all of the physician's patients could be significant. This time would largely be uncompensated to the physician. These additional responsibilities and requirements may cause physicians to make practical decisions to forego using the HIE in favor of other more traditional methods to disclose health information.

An opt-in framework may also hamper patients' access to timely and appropriate healthcare. In an optimum situation, physicians would access the HIE for each patient prior to providing services. The opt-in framework would create a presumption that a particular patient had refused to sign the authorization if the physician was unable to locate the patient's information via the HIE. This presumption would apply categorically across the board to all treatment disclosures. Consequently, the physician would not receive, and would certainly be hesitant in asking for, all appropriate health information from any of the patient's current or former healthcare providers.

The reservations with an opt-in framework also relate to certain risk management matters. An opt-in framework sets a standard of care for all treatment uses and disclosures, not just those uses and disclosures made through the HIE. No logical basis exists to distinguish uses and disclosures through the HIE from other non-HIE disclosures for treatment purposes. This could certainly lead to physicians concluding that they need an express authorization to discuss treatment histories and medical conditions with other physicians via the telephone.

The use of express authorizations for treatment disclosures has always been viewed by physicians as a risk management tool. Many physicians have, from a risk management standpoint, decided to implement practices that require express authorizations for treatment disclosures. These risk management practices are designed to virtually eliminate any risk or liability exposure associated with disclosing health information for treatment purposes. OHIP's opt-in framework, however, makes these risk management practices look more like standard protocol, or even worse, absolute legal mandates.

Another example of potential problems with an opt-in framework is the HIPAA

requirement that physicians are not permitted to condition care on a patient's refusal to sign an authorization. This would not necessarily affect care that physicians personally provide, since physicians can certainly assure their patients that all care personally provided by the physician will be unaffected and uninterrupted. The problem lies with assuring the patient that continued, follow-up, or subsequent care provided by other healthcare professionals will be unaffected by the patient's decision to refuse signing the authorization. The failure to sign the authorization would in all instances prevent the physician from sharing health information with other providers for treatment purposes. Physicians could not be assured that their patients will receive continued, uninterrupted, and adequate care without the ability to share medical information with other treatment providers.

The opt-in framework may ultimately result in patients providing express opt-in authorizations that are not supported fully by informed consent. When authorization is required for the use and disclosure of medical information, the hallmark component of a valid authorization is that it is provided by the patient with informed consent. The physician-patient relationship is supported by a high degree of trust on the part of the patient in the physician's knowledge, care and recommendations. Because of this high level of trust, patients rarely question the recommendations of their physicians. This is especially true for recommendations and requests that the patient may view as more administrative than healthcare related. A physician's request for an authorization to disclose health information would fall into this category. As a result, patients would likely sign the authorization without fully appreciating the significance of the authorization.

To date, OHIP has performed a wonderful job in developing a functional and interoperable statewide HIE. However, OHIP's opt-in framework for patient consent could be an issue for many healthcare providers, not just physicians. The overall goal of the statewide HIE is to facilitate the electronic exchange of health information, however, if physicians and other health care providers have difficulties with the opt-in framework it could be a deterrent to their participation in the HIE.

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Physicians Must E-prescribe by June 30, 2011 or be Subject to Medicare Penalties

In November, the Centers for Medicare & Medicaid Services (CMS) announced that beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program. The payment adjustment in 2012, with regard to all of the eligible professionals' Part B-covered professional services, will result in the eligible professional or group practice receiving 99% of the Physician Fee Schedule (PFS) amount that would otherwise apply to such services.

For purposes of determining which eligible professionals or group practices are subject to the payment adjustment in 2012, CMS will analyze claims data from January 1, 2011- June 30, 2011 to determine if the eligible professional has submitted at least 10 electronic prescriptions during the first six months of calendar year 2011. Group practices reporting as a GPRO I or GPRO II in 2011 must report all of their required electronic prescribing events in the first six months of 2011 to avoid the payment adjustment in 2012. Even practices that plan to adopt EHR systems between July and December, 2011 will be subject to Medicare payment reductions in 2012 if the eligible professional has not

submitted 10 claims coded for e-prescribing between January and June, 2011.

Coding for E-prescribing or for exemptions from e-prescribing:

- **G8553** - At least one prescription created during the encounter was generated and transmitted electronically using a qualified EHR system. Note: If more than one prescription is generated for a patient during the same visit, then this would count as only ONE instance of e-prescribing.
- **G8642** - The eligible professional practices in a rural area without sufficient high speed Internet access and requests a

hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.

- **G8643** - The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act
- **G8644** - The eligible professional does not have prescribing privileges

The Ohio Board of Pharmacy Approved E-prescribing Modules

If your practice does not have a full EHR system capable of generating an e-prescription, you may still meet the Medicare e-prescribing requirements by utilizing a stand-alone e-prescribing module. The following is a list of the e-prescribing modular systems that are approved by the Ohio Board of Pharmacy:

- Allscripts eRx, also known as Allscripts ePrescribe (This product used to be free; unclear of the current status)
- NewCrop
- OnCallData
- MicroMD
- Cyber Access (This product used to be free; unclear of the current status) ■

Constitution & Bylaws Change

In accordance with Article VIII the Board of Directors voted in March 2011 to make amendments to the Academy of Medicine of Cleveland & Northern Ohio Constitution and Bylaws. In accordance with Article IX Amendments Section 1, of the AMCNO Bylaws, these proposed amendments are being published to the membership 30 days prior to the final board vote.

Constitution and Bylaws of the Academy of Medicine of Cleveland & Northern Ohio

Article III Membership

Proposed change in eligibility status:

Section 1. Eligibility. Any legally qualified and reputable Doctor of Medicine or Doctor of Osteopathy licensed to practice medicine in the State of Ohio, hereinafter referred to as a "Physician," or an individual who has given notable service to medicine or who has been long active in the interests of the AMCNO, ~~or a healthcare provider that becomes a corporate/group member of the AMCNO through a hospital medical staff group membership,~~ shall be eligible for membership in the AMCNO subject to any further provisions by this Constitution and Bylaws and

to such rules and regulations as may be adopted by the Board of Directors. Members of the AMCNO shall abide by the principles of Medical Ethics of the American Medical Association and the Constitution and Bylaws of the AMCNO.

BYLAWS

Article I Membership

Proposed change in voting membership status: Active limited member status would be changed under this bylaws amendment

(3) Active Limited Members: Active limited members shall be physicians who: (a) are full-time employees of any government agency and who receive no significant compensation from the private practice of medicine; (b) are engaged in full-time scientific research in connection with an accredited institution of learning and receive no significant compensation from the private practice of medicine; (c) are engaged in post-graduate training in an institution approved for such training by the accreditation council for graduate medical education, and who provide no direct patient care; ~~or (d) a podiatrist, dentist or psychologist that is included in a~~

~~corporate/group membership category of the AMCNO that has been approved for corporate/group membership by the AMCNO Board of Directors.~~ Active limited members shall have the right to vote, hold office and all other privileges of membership.

(B) Non-Voting Membership. Non-voting members may be honorary, non-resident, allied, medical student, or associate, AND physician-in-training, as follows:

(3) Allied Membership; Qualifications: An Allied Member shall be one of the following: (A) A physician who resides or is employed in Northern Ohio who may or may not be licensed in Ohio and who is not actively practicing medicine; or, upon invitation, a person holding a Ph.D. degree or its equivalent working in the field allied to medicine, (B) a full-time teacher of medicine of the arts and sciences allied to medicine who is not a holder of a degree of Doctor of Medicine or Bachelor of Medicine, (C) a Doctor of Medicine not fully licensed to practice medicine in Ohio who is engaged in Ohio in research, public health, or administrative medicine; or (D) a podiatrist or ~~dentist that is not part of a corporate/group membership category of the AMCNO.~~ These individuals are eligible to become members of the AMCNO upon application and approval by the Membership Committee of the AMCNO.

AMCNO Participates in Provider Outreach and Education (POE) Advisory Group Meeting

PalmettoGBA and CIGNA Government Services Provide Updates

At a recent POE meeting, the AMCNO was provided with an update on the Jurisdiction 15 transition to CIGNA Government Services (CGS). By way of background, CIGNA Government Services (CGS) is currently a wholly owned subsidiary of CIGNA Corporation with over 40 years experience as a Medicare contractor. Beginning on May 1, 2011, CGS will be acquired by Blue Cross/Blue Shield of South Carolina. CGS is currently evaluating a name change – with the hope of retaining the “CGS” acronym. BC/BS of SC also works with PalmettoGBA and it is possible that some items may be handled by them going forward, however, it is important to note that CGS will be taking over all aspects of the Medicare Administrative Contractor (MAC) Part B function for Jurisdiction 15.

The transition to CGS from PalmettoGBA will occur on June 18, 2011. The AMCNO has learned that as a result of the sale of CIGNA Government Services (CGS) to BlueCross BlueShield of South Carolina, there have been changes to their Jurisdiction 15 (J15) Ohio Part B EDI Strategy. While CGS will assume support for the Ohio Part B EDI submitters, they have elected to sub-contract with Palmetto GBA to continue to support the Ohio Part B EDI workload on the current EDI Gateway, GPNET. What this means for the Ohio Part B provider community is that there will be no change in connectivity or transmission of EDI transactions for the J15 A/B MAC. Physicians should continue to send claims and receive remittances to and from the same front-end system they are currently using. CGS will assume responsibility for the EDI Help Desk support at a later date. In the interim, please continue to contact the EDI Technical Support Team for technical assistance at 1-866-308-5438.

In order to prepare for the remainder of the transition J15 providers may wish to reference the CMS MLN Matters article "Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC)", available from the following CMS Web page: www.cms.gov/MLN/MattersArticles/downloads/SE1017.pdf. Knowing what to expect will minimize disruption in your Medicare business. Most provider action items will take place within the 90 day window leading up to cutover: EFT Re-enrollment – 90 days prior to cutover; EDI Preparations – 45 - 60 days prior to cutover; and LCD publication – 45 days prior to cutover.

EFT RE-enrollment - Ohio Part B providers who are currently enrolled with Palmetto GBA to receive their Medicare payments electronically must submit a new CMS-588 EFT Authorization Agreement to CIGNA Government Services immediately upon receipt of notification. Request letters for Ohio Part B providers were mailed the week of March 7, 2011 for CMS-588 – your timely completion of the EFT agreement will ensure

continued receipt of electronic Medicare payments following the completed transition of claims processing and payment operations to CGS. Once CGS processes your EFT application, they will send out a confirmation letter and it will remain on file with CGS until they begin processing claims. This will not disrupt the payments processed by the current contractor.

EFT re-enrollment for a group - If you are part of group of physicians who reassign their individual benefits to the group itself, then it is only necessary to complete one EFT re-enrollment at the group level. There is no need to submit additional EFT applications for each member of the group. In these instances, your EFT application should be completed for the “Pay-to” PTAN. You will only receive one confirmation letter from CGS to indicate that the group’s EFT re-enrollment was completed.

CMS-588 EFT Authorization Agreement: www.cms.gov/cmsforms/downloads/CMS588.pdf

J15 EFT resources available on the J15 EFT Homepage: www.cignagovernmentservices.com/j15/eft.html and an EFT Web-based tutorial: <https://www.cignagovernmentservices.com/captivate/J15588/CMS588Form.htm>

Electronic data exchange – EDI submitters who have completed an EDI enrollment form with Palmetto GBA do not need to re-enroll or complete a new application with CGS.

Payer ID update – Physicians will need to change their Contractor/ Payer ID for submitting electronic claims to CGS at cutover. The new Contractor/ Payer ID for OH Part B is **15202**. Physicians and/or your clearinghouse or vendor should use this Contractor/ Payer ID for submission of electronic claims to CGS after June 18, 2011.

CGS is subcontracting with Palmetto GBA to provide 5010 EDI translation services for Ohio Part B claims starting at cutover on June 18,

2011 and continuing through September 30, 2011. During this time period, Palmetto GBA will be supporting 5010 testing, translation, and CEM integration to include second level help desk support. CGS expects to start 5010 translation during the month of September. EDI resources J15 EDI Homepage: www.cignagovernmentservices.com/j15/edi.html

Local coverage determinations (LCDs) - CGS has worked closely with Palmetto GBA to identify and consolidate current LCDs. These “Future Effective Documents” are available from their Website at: www.cignagovernmentservices.com/j15/LCDs.html. Remember, effective dates for CGS’ Ohio Part B LCDs is June 18, 2011. Until that time, continue to follow the policies and guidelines in place with Palmetto GBA.

LCD Crosswalk - In an effort to assist physicians in understanding the key differences between LCDs currently being followed and those that CGS will use after June 18, 2011, CGS has developed an LCD crosswalk. It is available here: www.cignagovernmentservices.com/j15/LCDCrossWalk.xls

Contacting CIGNA Government Services - as of this printing, mailing addresses for the submission of paper claims, provider enrollment applications, refund checks, appeals, and others were not available and will be updated with the transition. Those details are currently being finalized and will be made available in the near future. Please remember that until notified by CGS, you should continue to direct your requests and inquiries to Palmetto GBA for timely completion.

However, the CGS J15 help desk is now available. The toll-free implementation help desk is for physicians with specific questions related to the transition. Telephone number: **1.877.819.7109**, Hours of Operation: **8:30 am - 4:30 pm CT, Monday – Friday**. J15 inquiries – see email form www.cignagovernmentservices.com/J15Questions.html. **Stay connected - Web site** www.cignagovernmentservices.com/J15

J15 list serve – the CGS ListServ is the fastest and easiest way CGS can communicate news and information related to J15 transition activities. New Customers may register at: www.cignagovernmentservices.com/medicare_dynamic/ls/001.asp. **NOTE:** If you are already receiving email updates from your current contractor, your email address has likely been added to the CGS J15 ListServ database.

J15 news page - This page will feature news items directly from CMS and CGS regarding the J15 transition: www.cignagovernmentservices.com/j15/News.html ■



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