



## AMCNO Participates in Privacy Summit

By J. Ryan Williams, J.D.

The Ohio Health Information Partnership (the "Partnership," formerly known as "OHIP") had a busy summer. The Partnership worked, and continues to work hard, to develop, revise, finalize, and implement various policies and procedures for Ohio's health information exchange ("HIE") known as CliniSync. The Partnership appears to have finalized a key policy for CliniSync — the policy concerning patient consent. This policy is critically important to the success of CliniSync and has the potential to transform the way healthcare providers share health information in Ohio. Recognizing this significance, AMCNO has monitored and remained actively involved with the Partnership concerning the patient consent policy.

Last month, the Partnership convened a privacy summit to discuss the development of the CliniSync patient consent policy, and discuss whether a need exists for legislative initiatives to clarify and update Ohio law

regarding the electronic exchange of health information. Over 30 attendees, consisting of privacy and compliance officers, in-house and outside counsel, participated in the summit. AMCNO was also present and provided useful

feedback on the health information sharing practices of physicians in Northern Ohio. Attendees of the summit were treated with an educational overview and demonstration of CliniSync. Representatives of Medicity (the vendor of CliniSync) and the Partnership fielded numerous questions from attendees regarding the infrastructure, mechanics and operation of CliniSync. Representatives also discussed the role and expectation of the participants (i.e., healthcare providers, hospitals, physicians, etc.) in establishing administrative access to CliniSync.

As a brief overview, CliniSync is the electronic infrastructure (or software) that will enable the electronic exchange of health information between healthcare providers in Ohio.

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## Ohio Providers May Face Perpetual Liability for Malpractice Claims

By Erica M. James, M.D., J.D.

How long after alleged medical malpractice occurs may a plaintiff bring a claim against his provider? In April, the Court of Appeals, Twelfth Appellate District of Ohio held that a plaintiff could bring that claim within one year of when he became aware of the alleged malpractice, regardless of how long ago the alleged malpractice occurred. In September, the Supreme Court of Ohio agreed to review that decision.

The underlying case, *Ruther v. Kaiser*, involves malpractice that allegedly occurred in the 1990s and allegedly caused a patient's death in 2009. Timothy Ruther, while a patient of Dr. Kaiser, had lab work done in 1995, 1997, and 1998 that showed significantly elevated liver enzymes. These lab results were received by Dr. Kaiser's office, but Dr. Kaiser did not notify Mr. Ruther of the abnormalities. Mr. Ruther

ceased to be a patient of Dr. Kaiser's and, in December 2008, was diagnosed with hepatitis C and liver cancer. Mr. Ruther alleged that it was around the time of his diagnoses that he became aware of his abnormal lab tests from the '90s. In May 2009 Mr. Ruther brought a claim against Dr. Kaiser and his practice. Mr. Ruther died approximately one month later, and his claim was continued by his wife.

The trial court held that Mrs. Ruther could maintain the malpractice claim, despite the alleged malpractice having occurred 10-14 years before the claim was brought, because the Ohio statute that would prevent her from doing so was unconstitutional. The Court of Appeals affirmed.

*Effect of the Medical Malpractice Statute of Repose*

The challenged statute, R.C. 2305.113, is what is referred to as a "statute of repose," a statute that provides an absolute cut-off for potential liability. R.C. 2305.113 was enacted

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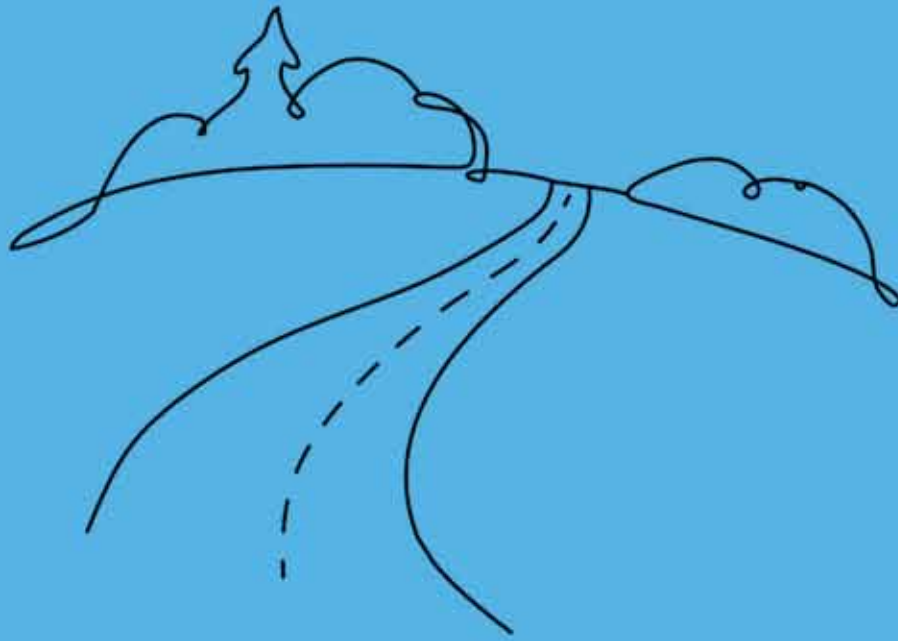
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## AMCNO Participates in Privacy Summit *(Continued from page 1)*

CliniSync is not a repository of health information. CliniSync is more akin to a records locator. Electronic health information is never transferred to CliniSync and will remain stored at the participant level. CliniSync is a portal that allows participants to access health information maintained by other participants.

To accomplish this task, CliniSync must build and maintain a community master patient index (CMPI), which is a database of demographic information on patients. CliniSync will populate and create the CMPI using the patient demographic information that participants upload into CliniSync. Populating and creating the CMPI will take time but once complete CliniSync will be capable of locating the health information of specific patients maintained by participants across the state.

From a workflow standpoint, participants will access CliniSync via a web-based portal or, depending on functionality, participants' existing EHR system.

One of the most important functions of CliniSync is its ability to track on a patient-by-patient basis whether a patient has opted in or opted out of the HIE. This is important because the Partnership introduced the revised patient consent policy for CliniSync at the summit. This revised, and final, patient consent policy is an opt-in model of consent. Simply put, a patient must affirmatively consent to the sharing of the patient's health information via CliniSync. Consequently, without a way to track and monitor the status of patient consent, CliniSync would be an unworkable system from the start.

The revised and final patient consent policy is the culmination of months of committee work and a public comment process. AMCNO and other healthcare stakeholders in Northern Ohio have been involved from the beginning providing detailed insight into the health information sharing practices in Northern Ohio and comments to the Partnership's position regarding patient consent.

Throughout the process, AMCNO focused on two main areas. First, the desire for the Partnership not to take a position regarding the necessity under Ohio law of patient consent for the sharing of health information for treatment purposes. Second, the practical workflow barriers that exist with an opt-in model and the obligation to obtain express patient consent.

The Partnership considered these two areas in great length and ultimately decided to finalize a patient consent policy that, while not exactly in

line with the requested proposal from AMCNO and others in Northern Ohio, may provide a manageable framework without too many collateral consequences. The revised policy is guided by the Partnership's interpretation of existing Ohio law regarding patient consent. The revised policy though is strictly policy based and risk management focused. The Partnership does not appear to take the position that Ohio law affirmatively requires express written consent from patients to share health information for treatment purposes.

In addition, to reduce the burdens on operational workflows, the revised policy requires only a one-time patient consent. This consent is valid indefinitely until the patient revokes it.

These aspects of the patient consent policy are critically important. By not taking a position on Ohio law, the Partnership implicitly recognizes that healthcare providers may elect not to participate in the CliniSync. While participating in CliniSync is encouraged, a healthcare provider may determine that the burden of obtaining patient consents for treatment purposes outweighs the operational efficiencies and other desires of current practice. That current practice being the permissible sharing of health information for treatment purposes among treatment providers without an express written consent from the patient.

This concept was discussed at length during the summit. Representatives from hospitals throughout the state acknowledged in some fashion that health information is shared between treatment providers without the express written authorization from the patient. In fact, several provider representatives indicated that patients oftentimes expect their treating healthcare provider to share health information with other treating providers without the need for the patient to sign an express authorization. Many representatives, specifically attorneys, argued that a contrary position from the Partnership would not only curtail workflow efficiencies with respect to health information sharing, but also put healthcare providers at significant liability risk for unauthorized disclosure of health information.

Another aspect that was discussed during the summit and is addressed by the Partnership is the desire for a robust public awareness and patient education campaign. A theme that was present with several of the attendees at the summit was that the requirement of an express patient consent furthers or strengthens

public awareness and patient education. To the extent that this theme is a major foundation for the patient consent policy, it may be a bit misguided.

There is no question that patients and the public have the right, and need, to know how their health information is being shared. But using the requirement that each patient affirmatively sign a CliniSync consent form is probably not the most effective way to educate patients and increase public awareness.

The requirement for express patient consent is more focused and serves to protect CliniSync participants from the legal liability that would flow from any unauthorized disclosure or use of a patient's health information. Given the circumstances in which most patients will be requested to sign the consent form, many patients are unlikely to acknowledge and appreciate the benefits and risk of participating in the CliniSync System. Patients that present for medical treatment are generally concerned about one thing, their medical care. Requiring patients to also comprehend the significance of their decision to participate in CliniSync at the same time is unlikely to contribute to patient education and awareness.

The Partnership has indicated that it will conduct a public awareness and education campaign. Nevertheless, the Partnership should embrace an opportunity to educate patients in ways that permit the patient to fully appreciate and acknowledge the benefits and risks of their decision to participate in CliniSync. Relying heavily on patient consent is not the best way to make the public aware of CliniSync.

Now that the revised patient consent policy appears to be final and healthcare providers will be required to obtain affirmative consents from patients before sharing health information via CliniSync, a change to the revised patient consent policy may require legislative response. Several states have addressed this issue and have taken legislative action. For example, Nevada, Tennessee and Virginia each have enacted statutes that expressly permit the electronic sharing of health information for treatment purposes. In essence, these states have statutorily declared to follow an opt-out approach to HIE implementation.

Then there is Kansas, which has passed legislation that defers to HIPAA as the standard governing the use and disclosure of health information. Accordingly, in Kansas healthcare providers are permitted to share

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## Ohio Providers May Face Perpetual Liability for Malpractice Claims

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by the legislature in 2003 as part of tort reform and prevents plaintiffs from bringing medical malpractice claims based on underlying acts that precede the claim by more than four years.

Medical malpractice claims are additionally governed by a one-year statute of limitation, which provides that medical malpractice claims must be brought within one year of the alleged malpractice. The statute of limitation may be extended, or tolled, if the plaintiff has not and could not reasonably have discovered the alleged malpractice. This "discovery rule" allows a plaintiff to bring his malpractice claim within one year of when the alleged malpractice is or reasonably should have been discovered.

When the trial and appellate courts held the medical malpractice statute of repose to be unconstitutional, they effectively held that providers can be sued for malpractice for an indefinite amount of time after the alleged malpractice, if the plaintiff discovered the alleged malpractice within one year of bringing suit.

*Why was the Medical Malpractice Statute of Repose Held to be Unconstitutional?*

The trial and appellate courts held that the medical malpractice statute of repose was unconstitutional on the grounds that it conflicted with the guarantees given to plaintiffs under the Ohio Constitution. Article I, Section 16 of the Ohio Constitution provides: "All courts shall be open, and every person, for an injury done him in his \* \* \* person \* \* \* shall have remedy by due course of law \* \* \*." The Supreme Court of

Ohio found an earlier version of the medical malpractice statute of repose to be unconstitutional because the statute denied a remedy to plaintiffs who were not able to discover that they were injured within four years, thus violating the Open Courts provision. See *Hardy v. VerMeulen* (1987), 32 Ohio St.3d 45.

In *Ruther v. Kaiser*, the trial and appellate courts compared the current version of the medical malpractice statute of repose to the earlier version found unconstitutional by the Court and did not find any significant differences between them. The trial and appellate courts concluded that the newer version of the statute also conflicted with the Open Courts provision and was also unconstitutional.

*Why do Proponents of the Medical Malpractice Statute of Repose Argue it is Constitutional?*

Dr. Kaiser and his practice, the appellants, argue that the medical malpractice statute of repose does not violate the Open Courts provision because it does not bar plaintiffs from pursuing a vested right. As noted above, when the discovery rule tolls the medical malpractice statute of limitation, the one-year statute of limitation starts to run from the time a plaintiff discovers or reasonably should have discovered the alleged malpractice. The appellants argue that the discovery of the alleged malpractice is the point of time when the plaintiff's right to sue vests, or becomes legally guaranteed. When a plaintiff fails to discover alleged malpractice within four years of the date it has occurred, that plaintiff's right to sue never vests. Thus, if the four-year medical malpractice statute of repose acts to

cut off the plaintiff's ability to sue, the statute of repose does not take away a vested right.

To support their argument, the appellants point to other statutes of repose that Ohio courts have upheld as constitutional in recent years. In 2008, the Supreme Court of Ohio held that the statutes of repose applicable to product liability claims and real property improvement were constitutional. *Groch v. General Motors Corp.*, 117 Ohio St.3d 192, 2008-Ohio-546; *McClure v. Alexander*, 2008-Ohio-1313. Relying on the Court's decision in *Groch*, the Twelfth District upheld the constitutionality of the wrongful death statute of repose in 2008. *Nickell v. Leggett and Platt, Inc.*, 2008-Ohio-5544. Appellants argue that these statutes of repose did not differ significantly from the medical malpractice statute of repose.

Appellants propose that the medical malpractice statute of repose strikes a fair balance between the rights of plaintiffs to bring suit for their harm and for defendants to be protected from stale litigation. They further point out that the legislature's adoption of the medical malpractice statute of repose is consistent with the position taken by a majority of states.

An amicus curiae expressing support for the appellate's position in this case has been filed by two state medical associations, the American Medical Association and the Ohio Alliance for Civil Justice (OACJ) – the AMCNO is a longstanding member of the OACJ and supports the appellate position in this case. ■

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health information for treatment, payment and healthcare operations purposes without any express consent from the patient. It is interesting to note also that based on the research of the Partnership, Ohio is in the clear minority of states that have elected to implement an opt-in system for HIE development.

Maybe legislative action, similar to Nevada, Tennessee and Virginia, or even Kansas, is appropriate for Ohio. Any legislative response in Ohio must affirmatively address electronic sharing of health information via CliniSync. Otherwise, policy-based positions and decisions, some of which are extremely compelling, may support and justify an opt-in system.

If legislative action is desirable, timing considerations exist that must be addressed. Right now may not be the best time to approach a legislative solution. With the revised patient consent policy, and given an opportunity for implementation and operation, participants in CliniSync may find that the legal and practical concerns are less significant than initially anticipated. Alternatively, nothing prevents the Partnership from re-evaluating the patient consent policy at a later time and deciding to change the policy in favor of an opt-out approach. This scenario would certainly exist if CliniSync experiences significant lack of participation.

Ultimately healthcare providers must embrace the concept of a state-wide, and national HIE. CliniSync appears to be a solid technical platform. The Partnership has worked, and continues to work, hard to develop policies and procedures that will contribute to the success of CliniSync. The revised patient consent policy should not stand in the way, and if it does, workable legislative solutions should be considered. ■

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## Ohio Health Information Partnership Updates

### Clinisync – The Partnership’s Statewide Health Information Exchange

The Partnership has developed an infrastructure for a statewide health information exchange. Called CliniSync, this exchange ultimately will connect hospitals, health systems, physicians and other healthcare professionals involved in a patient’s care. With patients’ permission, the exchange will allow participating organizations to access records through a secure network in virtual time. CliniSync is a secure, protected health network that is only used by personnel authorized by the partnership. Technical security protections are in place that encrypt information and provide controls to restrict unauthorized access. To share information within CliniSync, a patient must provide a one-time consent to a physician or hospital that will be captured through practice workflow or by using CliniSync’s consent form.

### What about HIPAA and privacy issues?

CliniSync’s privacy policy requires patients to provide a one-time consent to their physicians and hospitals to share information. The exchange is secure, protected and only used by authorized personnel. Practitioners who want to be connected to CliniSync will sign a participation agreement. CliniSync will also allow physicians to send and receive sensitive health information through a secure email message in order to comply with state and federal law. CliniSync will bring patient information from multiple sources together to build a complete patient medical record, known as a Longitudinal Patient Record in which a continuity of care document (CCD) could be created and shared. (For more information on the privacy issues and the consent form see page 1 of this issue). Also for more information about CliniSync go to [www.CliniSync.org](http://www.CliniSync.org)

### AMCNO asks for Input from CliniSync About HIE Ownership

Recently, the AMCNO physician leadership queried CliniSync about how they plan to protect patient and physician interests regarding the ownership and use of clinical data sent to and from the health information exchange — in particular with regard to who owns the clinical data and who can access it. Questions about this issue arose at the AMCNO when we were made aware that Aetna owns Medicity — the vendor that has been chosen to implement Ohio’s statewide HIE. The Ohio Health Information Partnership responded to the AMCNO noting that they have and will continue to address these type of concerns through several avenues. Through

their contract with Medicity the Partnership has a process to manage and protect the information flowing through the CliniSync platform. In addition, CliniSync’s partnership agreements include specific restrictions on data use and access, as well as require participants to abide by the privacy policies and procedures as approved by the Partnership board.

In their response to the AMCNO, the Partnership included the following information which provides additional background on this issue.

### The Ohio Health Information Partnership Response to Partner HIE Access Concerns

**Q. What will Aetna, as the parent company of the Partnership’s HIE vendor, Medicity, be permitted to access through CliniSync?**

The Partnership’s agreement with Medicity contractually limits Medicity’s access to the data to permitted purposes, which at this phase includes only treatment, payment for treatment, public health reporting, and as mandated by applicable laws, and does not include access by either Medicity or Aetna for unpermitted purposes. Moreover, both the Partnership and Medicity have agreed in their contract to comply with HIPAA and other applicable privacy and confidentiality laws. The Partnership serves in the role of HIPAA “Business Associate” with respect to the participating hospitals, physicians and other HIPAA “Covered Entities,” and as a result, the Partnership’s use of and protection of clinical patient information must be in compliance with HIPAA. Medicity in turn acts as a subcontractor “Business Associate” of the Partnership, and is also contractually bound to comply with HIPAA and its limitations and protections of patient information. As a result, Aetna has no right to access or use clinical data on individuals accessible through the exchange for any other purposes. Nor does Medicity have any rights to clinical patient information, except to carry out the permitted purposes of the exchange, and Medicity is directly liable to the Partnership if it improperly accesses or uses this information for purposes outside of those permitted under the Medicity contract. This language is also consistent with the other states currently in contract with Medicity to provide their HIE platform.

**Q. Are concerns about payer access addressed in the CliniSync Participant Agreements?**

The contract language in each CliniSync agreement with providers states that data accessible through CliniSync is owned by each participating provider that furnishes data about patients from their existing medical record system. CliniSync itself does not own any data or clinical patient information on individuals, nor does it store this information on its own behalf or for its own use (other than uses permitted by the participant agreement). Rather, CliniSync uses technology provided by Medicity to facilitate exchange of information on patients that is already stored in participating providers’ records systems.

**Q. Will payer access be limited to data only about their insured members?**

At a national level, the Office of the National Coordinator’s (ONC) Tiger Team, has recommended the use of Fair Information Practices (FIPS) when creating privacy and security policies. Although not expressly stated, these policies include the restriction of access by a payer is implied in the following principles:

- **Collection, Use and Disclosure Limitation** – Individually identifiable health information should be collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately.
- **Safeguards** – individually identifiable health information should be protected with reasonable administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure.

Additionally, aggregate access to protected health information is expressly prohibited in the CliniSync Policies without express consent by participating organizations (CliniSync Policy and Procedure Manual pg. 14, Section E. Permitted Use and Breach Policy: 4. Expressly Prohibited Uses)

- Neither CliniSync staff, the CliniSync vendor, nor any Participant may access or use the health information or any proprietary information of another party to compare patient volumes, practice patterns, or make any other comparison without another Participating Organization’s written approval. CliniSync shall not have access to any Participating Organization’s health information on

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CliniSync, unless expressly approved in writing by a Participating Organization and with any required patient authorizations. Other uses of health information (including but not limited to the CliniSync vendor reselling de-identified data) are expressly prohibited under this policy without prior written approval from CliniSync and any Participating Organization whose data will be involved.

Following the completion of the patient consent policies, the Privacy Committee is transitioning its efforts toward legislation to clarify and simplify exchange requirements and is beginning its analysis of administrative exchange policies.

The AMCNO will continue to work with the Partnership and Clinisync to provide information to our members as this important initiative moves forward in Ohio. ■



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## Agency for Healthcare Research and Quality Review (AHRQ)

The AMCNO Board of Directors has agreed to partner with the Agency for Healthcare Research and Quality Review (AHRQ) on their Effective Health Care (EHC) program. AHRQ is the lead federal agency within the Department of Health and Human Services (HHS) charged with health services research to improve the quality of health care, reduce its cost and broaden access to essential services. AHRQ's mission is to improve the quality, safety, efficiency and effectiveness of health care for all Americans and over 80 percent of the agency's budget is invested in grants and contracts to improve health care.

The EHC program funds patient-centered outcomes research for clinicians, consumers and policymakers and aims to improve the quality of health care and promote evidence-based decision making. The EHC research findings are utilized in summary guides, learning modules and decision aids. AHRQ's patient-centered outcomes research (PCOR) — also known as Comparative Effectiveness Research (CER) — which compares the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in "real world" settings. While not making any recommendations, AHRQ's patient-centered outcomes materials help clinicians and patients make more informed health care decisions by comparing evidence on the effectiveness, benefits, and risks of different treatment options. AHRQ is the only federal agency legislatively mandated to conduct PCOR or CER and this is done through the Effective Health Care (EHC) program.

The EHC program was initially created to impact Medicare and Medicaid programs, however, the scope has been expanded so that all clinicians and patients can benefit from the EHC research and its findings.

Hallmarks of the EHC program are:

- Provides current, unbiased evidence of clinical effectiveness of health care interventions (primarily through systemic reviews of literature and generation of new evidence through observational studies).

- Focuses on patient-centered outcomes and 14 priority conditions.
- Helps consumers, providers and other health care decision makers make informed treatment choices among alternatives.
- Does not make treatment recommendations and is stakeholder driven.

As part of the EHC effort, AHRQ is looking for organizations to partner with in its effort to help individuals make more informed decisions and to improve the quality of health care services. AHRQ's Effective Health Care Program is building a national partnership network dedicated to promoting patient-centered outcomes research in patient and professional health care communities across the United States.

AHRQ has invited the AMCNO to be a part of the important network. As a partner, the AMCNO will receive the latest updates about patient-centered outcomes research and have access to free materials. The AMCNO can obtain, disseminate and use the consumer and clinician guides, slides and other patient-centered outcomes research materials, utilize continuing education modules, and link to the EHC website and resources. The AMCNO joins numerous other medical organizations from across the country that have already partnered with AHRQ on this initiative. More information on this initiative will be available soon on the AMCNO website and in our publications. ■



In September, Dr. Joseph Eshelman, the new UnitedHealthcare Medical Director for the Northern Ohio region met with the AMCNO board of directors. Dr. Eshelman was on hand to introduce himself to the AMCNO physician leadership and to briefly discuss several UHC programs including the company's current focus on the patient centered medical home model, population statistics, optimal care plans and outcome based design programs. The AMCNO is part of the UHC Physician Advisory Committee — a group which convenes on a quarterly basis and discusses issues of importance to physicians with UHC representatives from around the state.



Dr. Evan Howe, a first year resident at Fairview Hospital attended the September board meeting with board member Dr. Fred Jorgensen.

## WISHING A HAPPY & HEALTHY HOLIDAY SEASON

*To all Members of the  
Academy of Medicine of Cleveland & Northern Ohio (AMCNO)*

*From Your AMCNO Board of Directors and Staff*



## AMCNO Legislative Update

### Redistricting Issue Heats Up

After eight momentous months in office that included the passage of a \$55 billion state operating budget, collective bargaining reform, Medicaid reform, and the transformation of the Ohio Department of Development into the public-private partnership JobsOhio; the Kasich administration and the Ohio General Assembly have now shifted gears toward drawing new lines for the Ohio statehouse and congressional districts. Every ten years after the decennial census is completed, the state apportionment board is charged with the creation of 33 new Ohio Senate districts and 99 Ohio House districts for the Ohio General Assembly in order to address population shifts and loss. The apportionment board is comprised of the Governor, Auditor, Secretary of State, and a member of the minority party and majority party of the Ohio General Assembly. As a result of the elections last year the Republicans gained a 4-1 majority on the apportionment board which has the authority to draw the newly created districts.

According to an analysis done by the Ohio Campaign for Accountable Redistricting, which includes the League of Women Voters of Ohio and Ohio Citizen Action, the map drawn up by the apportionment board would create 61 House districts that would lean toward Republican and 33 would have a Democratic tilt. The remaining 5 would have an even split. The new map was adopted on September 30th and the possibility of a court challenge was still pending at press time.

On the federal side, Ohio currently has 18 members (13 Republican and 5 Democrat) in the U.S. House of Representatives and due to population changes this must be pared down to 16. The new districts are drawn by the Ohio General Assembly, passed as a bill, and signed into law by the governor. The new maps combined the districts of Representatives Marcia Fudge of Cleveland, Dennis Kucinich of Cleveland, Marcy Kaptur of Toledo, and Betty Sutton of Akron. Rep. Kaptur and Kucinich are going to face off against each other in a primary and Rep. Sutton plans to run in a new district. The new maps were signed into law on September 26th and could be subject to referendum which could allow for the issue to get on the ballot and possibly force a new map to be drawn. The AMCNO will continue to follow this issue and provide updates to our members.

### STATE AGENCY UPDATES

#### State Medical Board Continues Discussions on Maintenance of Licensure

On September 15th the AMCNO was on hand to hear a discussion and briefing led by the State

Board with representatives from the Federation of State Medical Boards (FSMB) on their maintenance of licensure (MOL) pilot project. Maintenance of Licensure (MOL) is a system in which physicians periodically demonstrate ongoing clinical competence as a condition of licensure renewal. Last year, the State Medical Board of Ohio formally resolved to support the MOL concept and determine the necessary steps to become a pilot state for implementation. MOL involves three components to demonstrate the ongoing competency of physicians. Each of these components would in turn contain an array of items that would meet the requirement for licensure renewal. The three components are reflective self assessment, assessment of knowledge and skills, and the measurement of actual performance in practice. Mr. Whitehouse, the executive director of the state board, is a member of a small group selected by the FSMB and charged with the development of a template that state medical boards may follow to implement their own state's vision for MOL. What MOL will exactly look like in Ohio is yet to be determined and the MOL is recommended to be phased in by states incrementally over a ten-year period. It was also made clear that MOL must be implemented in a manner that is neither onerous to physicians nor deleterious to the health care workforce. Successful implementation of this plan will be defined by the degree to which it actually assists a physician's practice and avoids the need for disciplinary action by the medical board. Mr. Whitehouse did acknowledge that one of the major areas of concern for physicians has to do with whether or not MOL is a precursor to national licensure, however, this is not the intent of the MOL concept.

Members of the state board raised questions about how implementing the MOL could impact currently licensed physicians and whether or not there will be different standards due to their length of time in practice and experience. There were also concerns raised about exacerbating the physician shortage with more stringent licensure rules, and whether or not the MOL would conflict with the current American board of medical societies certifications. Other questions that still need to be answered include how a physician would be handled if he/she fell short of the MOL requirements and if retraining would address these issues. Mr. Whitehouse noted that the overarching goal of the FSMB and the MOL is to see that physicians have portability and reciprocity when addressing MOL; and their intent is to raise standards but not create threatening standards.

The AMCNO has already asked the state board to provide statistics and data that this change is warranted in Ohio noting that physicians are



*John McCarthy, Medicaid Director for the Ohio Department of Job and Family Services provides the opening comments at the Medicaid Health Home meeting.*

already beleaguered with enough rules and regulations without adding additional work to the licensure process. The AMCNO plans to continue to be involved in the MOL discussions with the state board in the future.

#### Ohio Medicaid Health Home Plans Continue at the State Level

Over the summer months, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) executive staff and physician leadership participated in a series of meetings with representatives from the Ohio Department of Health and the Ohio Department of Job and Family Services to continue discussions on the development of Ohio Medicaid Health Homes.

The Accountable Care Act 2703 provided for a state option to provide health homes for enrollees with chronic conditions. The health home concept is related to, but not the same as the medical home since the intent is to have Medicaid health homes expand on the traditional medical home model by focusing on patients with multiple chronic and complex conditions, coordinating across medical, behavioral, and long-term care, building linkages to community and social supports and recovery services, and focusing on health information technology. In addition, the health home will focus on outcomes with the intent to reduce emergency department and hospital admissions with a reduced reliance on long-term care facilities, providing for an improved experience of care and quality of care.

Medicaid health home services would be available to Medicaid consumers with two or more of the following conditions: substance abuse; asthma, diabetes; heart disease; being overweight (BMI>25); one chronic condition and at risk for a second, or a serious and persistent mental health condition. State participation in this concept is optional and timing is flexible and certain diseases as well as geographic locations can be targeted. Funding for this initiative is a federal-state match for Medicaid health home services with the state contributing 10 percent and the government contributing 90 percent of health home costs for eight quarters. For the Ohio program services would be reimbursed through a tiered per member per month payment



method with adjustments by patient severity and provider's capabilities. Over time, there must be a return on investment to sustain the program.

The program's success will be measured by tracking and reporting outcomes including avoidable admissions and readmissions, emergency room usage, care transitions, follow-ups, and screenings. The managed care plans would administer the health home services for chronic medical conditions. The program is based on the Geisinger medical home model and would include a managed care plan funded embedded nurse care manager and the use of a team of health care professionals with a single point of accountability. The managed care plans will administer the finances with a per member per month payment to the designated health home provider and included in the PMPM funding will be included for the nurse care manager. The Ohio plan will focus on outcomes, uniform measures and methodology across all health homes, and uniform data collection from practice site to evaluator.



*Dr. Ted Wymyslo, Director of Health for the Ohio Department of Health welcomes the attendees to the work group addressing the Statewide Health Improvement Plan initiative.*

The program is designed to target all Medicaid individuals with these chronic conditions — it cannot exclude dual eligible or target specific age groups. Ohio Medicaid claims encounter data preliminary findings have identified how many individuals may be eligible for this program — and of those the data has shown that of just under half of the individuals living in one of the six largest metro counties. In addition, large volume providers (providers treating 75 health home eligible or more) delivered care to 80% of health home eligibles (i.e. Cuyahoga County has 45,000 HH eligibles with 843 large volume providers). Consumer identification would be through provider referrals, and managed care plan informatics to target the consumers in a geographic region. Providers would need to complete a consumer assessment or health risk assessment for payment and a comprehensive health assessment for a care treatment plan.

In order to become a HH practice site, providers must meet quality core elements (i.e. behavioral and physical health integration, NCQA PCMH recognition, attain a nurse care manager, provide a team of health care professionals, contract with

a managed care provider, provide appropriate transitions of care, and communicate health information electronically). The program design is intended to foster and promote patient empowerment and engagement. Patient participation in the health homes program will be on an "opt-in" basis and a non-binding agreement may be utilized with the patient in order to increase patient participation in the health home and practice sites will devise strategies to retain consumers that may be resistant to change. Consumer engagement will also include a patient and family support system in order to complete the assessment and care treatment plan developed for the patient.

The next steps for this program will be to select the regions in Ohio to roll out the program. Ohio Medicaid is looking at regions with a large number of health home eligibles, as well as regions with PCMH initiatives already underway. There will also be an assessment made of the level of interest and readiness of potential health home practices in selected regions. Ohio Medicaid also plans to continue to develop program details such as working with the managed care plan administrators on the health home practice site contractual relationship, reimbursement, consumer identification, assessment, enrollment, and measurement methods.

The summer months were spent gathering stakeholder input on this project and work is underway to design the health home details with the intent to gain approval from the Centers for Medicaid and Medicare Services and rollout the program to providers in limited geographic regions by the spring of 2012 and to identify, assess and enroll consumers into the program by the summer of 2012. The AMCNO will continue to provide additional information to our members on this initiative as it becomes available.

### **The Ohio Department of Health (ODH) Statewide Improvement Plan**

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) physician leadership and executive staff are part of a statewide group working with the Ohio Department of Health to develop a Statewide Health Improvement Plan (SHIP). Stakeholders from around the state have already completed a State Health Assessment (SHA). The health assessment includes ten areas of focus organized in two sections — with the first section including data on the leading causes of death in Ohio; the prevalence of certain chronic, communicable, and infectious diseases; and the rates of different types of injuries. The second section includes potential causal factors (i.e., the risk factors most frequently experienced by Ohio residents, the degree which Ohioans are following recommendations for health screenings and other preventive care, and the social and physical environmental conditions Ohio's

residents experience that might be affecting their health).

The SHA is the first step in a two-part planning process that has been implemented to identify and address the population health needs of the residents of Ohio. Step two involves the creation of the SHIP, which will identify and prioritize the goals and objectives for improving the health of all Ohioans based on the indicators contained in the health assessment. Once the SHIP is completed it will be utilized to develop a strategic public health plan, assist local health jurisdictions with data collection, and establish quality improvement projects. The final goal of this project is to have the ODH become accredited by the Public Health Accreditation Board (PHAB).

### **LEGISLATORS AND LEGISLATION**

#### **Cleveland Legislator Joins Senate leadership**

Senator Tom Patton (R-Strongsville) was chosen by his peers to serve as Majority Floor Leader, the number three leadership post. He replaces former Senator Jimmy Stewart who resigned his seat in June to be the President of the Ohio Gas Association. Patton currently chairs the Senate Highways & Transportation Committee. He is the only Northeast Ohio Senator on the majority leadership team. Senator Patton is also the sponsor of legislation spearheaded by the AMCNO to address the issue of physician ranking by insurance companies.

#### **Grendell Appointed to Judgeship**

Senator Tim Grendell (R-Chesterland) has been appointed by Governor Kasich to fill a vacancy on the Geauga County Common Pleas Court's Juvenile/Probate Division. Grendell must run for the seat next November in order to fill out the unexpired term that ends in February 2015. He will take the bench on September 21. Grendell has served in the legislature since 2001. He currently chairs the Senate Judiciary-Criminal Justice Committee. Senate President Tom Niehaus (R- New Richmond) has said that a replacement would not be selected until after the Apportionment Board finalizes new legislative districts. Grendell is the seventh Senator to leave the legislature since the 2010 election.

#### **Legislation Under Review**

On the legislation side, the AMCNO continues to monitor and track all healthcare related bills and take a position on each one dependent upon the content of the bill or any changes that may occur in the legislation as it moves through the legislature. A number of bills have been introduced regarding scope of practice issues and The AMCNO has been closely monitoring and actively involved in the discussions that take place on these bills.

*(Continued on page 10)*

## AMCNO Legislative Update October 2011 *(Continued from page 9)*

SB 83 and HB 284 address prescriptive authority issues for advanced practice nurses. This legislation would remove some restrictions on APNs when they prescribe schedule II medications. SB 83 has passed out of the Ohio Senate and is currently in the Ohio House. Testimony continues on this legislation with the advanced practice nurses indicating that they are concerned with the site restrictions. In addition, the pharmacy association has weighed in noting that it may be difficult to determine whether a prescription was provided at a certain site. This legislation continues to be discussed and the AMCNO position on this bill remains neutral with technical assistance.

SB 228 – Certified Registered Nurse Anesthetists — this legislation would authorize certified nurse anesthetists to issue medication orders for the administration of drugs to patients during certain phases of patient care and to specify the circumstances in which such nurses may perform clinical support functions. The AMCNO has been meeting with the sponsor of the legislation and other interested parties addressing our concerns with this legislation.

HB 284 – Physician Assistants – this legislation would expand the scope of practice for physician assistants and expand their prescriptive authority under certain circumstances. The AMCNO has taken a position of neutral with technical assistance on this bill and we will be monitoring its progress in the legislature.

Among the other bills being tracked by the AMCNO is HB 143 — this bill was introduced to address the issue of how youth concussions are handled during sport events and when a young athlete may return to play after a concussion has occurred. AMCNO supports this legislation and is



*Dr. John Bastulli (r) spends a moment with Senator Burke at the CRNA legislation interested party meeting.*

monitoring its movement to ensure that if any changes are made that young athletes will be properly diagnosed, treated, and allowed to return to play only after they have been properly evaluated by a physician.

The AMCNO tracks all health care related bills moving through the Ohio legislature. AMCNO members that have questions about any of the items contained in this report may contact the AMCNO at (216) 520-1000. ■

## AMCNO Supports Legislation Introduced to Offer Assistance to Medical Legal Programs

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is thrilled to announce that the MLP for Health Act, a bill calling for a federal demonstration project for MLPs, has been introduced in the Senate by Health, Education, Labor and Pensions Committee Chairman Senator Tom Harkin (D-IA), along with Senators Patrick Leahy (D-VT) and Daniel Inouye (D-HI).

Earlier this year representatives from the AMCNO and 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. 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 the executive director of the National 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. The plan promoted by the panel and other participants was to reintroduce legislation in Congress to provide for additional funding and expansion of MLP programs.

S. 1609 is identical to the bills that were introduced in July 2010 with support from Senators Harkin, Evan Bayh (D-IN) and Kit Bond (R-MO), and Representatives Dan Maffei (NY-25) and Chris Murphy (CT-05). The legislation will help to create, strengthen and evaluate 60 MLP programs across the country.

Currently there is one MLP operating in the Northern Ohio area and through this MLP program, MetroHealth and the Legal Aid Society are able to find solutions to help patients get and stay healthy, including income supports for food insecure families, utility shut-off protections during cold winter months, and mold removal in the home of asthmatic children.

The AMCNO plans to support this legislation in order to provide for additional funding and possibly create other MLP programs in our community. The AMCNO is currently working with a communitywide stakeholder group in order to garner support for this legislation and we will continue to provide updates to our members. For a full text of the bill go to <http://thomas.loc.gov/cgi-bin/query/z?c112:s1609>: ■

Are you ready?

## WEEKLY TO-DO LIST

Version 5010

Deadline:

**JAN 1st, 2012**

ICD-10 Deadline:

**OCT 1st, 2013**

### Prepare Now for the Version 5010 and ICD-10 Transitions

The change to Version 5010 standards takes effect on January 1, 2012. The change to ICD-10 codes takes effect on October 1, 2013.

In preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards. Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013.

**Make sure your claims continue to get paid.** Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you'll have what you need to be ready. A successful transition to Version 5010 and ICD-10 will be vital to transforming our nation's health care system.

Visit [www.cms.gov/ICD10](http://www.cms.gov/ICD10) to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.



Official CMS Industry Resources for the ICD-10 Transition  
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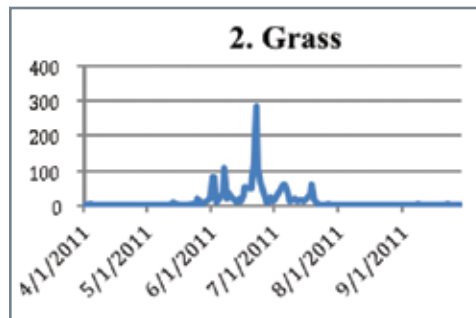
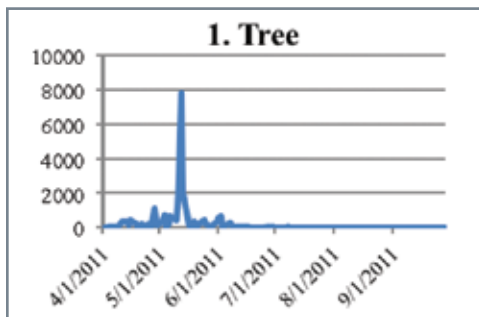


## AMCNO 2011 Pollen Line Recap

By Leah Chernin, DO & David Swender, D.O., Allergy/Immunology Associates, Inc.

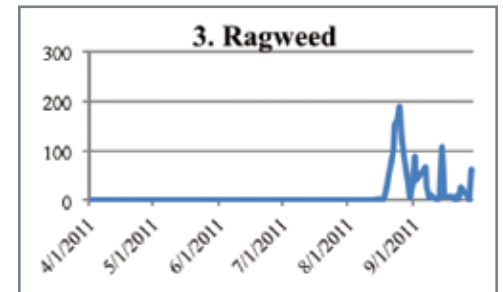
The 2011 pollen season is coming to an end. The pollen count is obtained using a Rotorod Aeorallergen device located on the roof of the University Suburban Health Center on Green Road in South Euclid. The rotor spins, sampling the air and collecting pollen. The pollen is then counted and reported to the public by Allergy/Immunology Associates Inc. every morning. The pollen count is used by local physicians to help guide the treatment plans for their patients with environmental allergies. This year's pollen count started April 1, 2011 and concluded October 1, 2011.

The 2011 pollen season started with tree pollen. The typical Ohio tree season starts in early spring and lasts through the early summer months. This year's tree season started in early April and peaked in the middle of May. The pollen count slowly declined through the end of May, with the season ending in early June. **See graph 1.**



The tree season was followed by the grass pollen season. The grass season started in mid-May and peaked at the end of June. We had intermittent spikes in the grass pollen this year. The grass counts declined through the beginning of July and ended in early August. **See graph 2.**

The ragweed season started in the middle of August, steadily increased and peaked in late August. There were intermittent spikes in the ragweed pollen counts throughout the month of September, which could be attributed to the rainy fall weather. We will expect the ragweed pollen count to decline through the beginning of October. **See graph 3.**



Mold is a year round allergen. As we enter into fall, the mold count has started to rise. We expect the mold count to increase, as it thrives in the moist fall leaves.

A sustained frost will mark the end of the 2011 pollen season. We will resume pollen counts again on April 1, 2012. The pollen count can be obtained by calling the pollen line at (216) 520-1050 or at [www.amcnoma.org](http://www.amcnoma.org). We hope for a light winter and look forward to the start of pollen season in 2012. ■

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PS Form 3526, September 2007 (Page 2 of 3)

## AMCNO Participates in Annual Community Health & Wellness Fair

Recently, Gerard Isenberg, MD, MBA, Associate Chief and Director of Clinical Services for the Division of Gastroenterology at University Hospitals Case Medical Center of Cleveland, participated in The Academy of Medicine of Cleveland & Northern Ohio's (AMCNO) Speakers Bureau event.

The event took place on Saturday, October 8, 2011, at the Warrensville Road Community Baptist Church in Maple Heights, where the church was hosting its 2nd Annual Community Health & Wellness Fair. Dr. Isenberg presented on the topic of *Colon Cancer Screening and Prevention*. The AMCNO thanks Dr. Isenberg for his time and participation. AMCNO members that are interested in participating in the AMCNO Speakers Bureau may contact the AMCNO offices at 216-520-1000, ext. 102. ■



Dr. Isenberg provides his comments on *Colon Cancer Screening and Prevention* at the Community Health and Wellness Fair.

## Medical students join the AMCNO

In September, more than 40 students, faculty, friends and family from Case Western Reserve University School of Medicine and the Cleveland Clinic Lerner College of Medicine attended this year's medical school picnic.

An annual event held this year at the Top-of-the-Hill/Carlton Commons on the CWRU campus, offered students a late summer retreat of food and outdoor fun. The AMCNO hosted a raffle awarding prizes of gift certificates to popular local eateries. During the festivities, AMCNO membership staff enrolled 32 new members.



Students and faculty line up at the grill to partake of the barbeque.

Medical school students as well as residents can enjoy the benefits of AMCNO membership at no cost throughout their training. In part, these benefits include weekly medical news updates via email, legislative representation at the state house, a listing in our physician directory and the advantage of AMCNO advocacy for the issues specific to Northeast Ohio physicians.



The winners of the AMCNO raffle prizes are all smiles at the medical student picnic.

Welcome new members! ■

## Northeast Ohio Quality Collaborative Hospitals Improve Heart, Pneumonia and Surgical Care

By Jennifer Edse, Executive Assistant, Quality Institute, the Ohio Hospital Association

The Northeast Ohio Quality Collaborative is comprised of 29 local hospitals working together to improve health care quality. Since 2007, hospitals participating in the Northeast Ohio Quality Collaborative have worked together on a shared focus of improving quality for specific medical conditions.

Through the Northeast Ohio Quality Collaborative, coordinated by the Quality Institute of the Ohio Hospital Association, hospitals are committed to learning and sharing best practices, engaging in quality improvement projects and standardizing processes that are proven to improve the quality of care for patients. By standardizing care based on best practices and evidence-based medicine, patient care in northeast Ohio is improved and lives are saved.

The Northeast Ohio Quality Collaborative meets quarterly to discuss a number of issues including current quality improvement topics and projects across the state and sharing of information and best practices being provided at each hospital. Hospital specific data on process of care, outcomes of care, patient safety data, and readmissions is shared openly amongst the organizations, a hallmark of a quality improvement project focused on collaboration, not competition. Data is also shared at a regional level throughout OHA's other quality collaboratives in the Central, Northwest, Cincinnati and Dayton areas. These twenty-nine northeast Ohio hospitals continue to demonstrate the positive results of collaboration by ensuring that patients with certain medical conditions receive all of the treatments recommended by national quality organizations at the right time.

Since they began reporting each medical condition and implementing best practices within a collaborative structure, hospitals have demonstrated a:

- 7.24% improvement in providing all recommended care to heart attack patients
- 19.55% improvement in providing all recommended care to heart failure patients;

- 17.77% improvement in providing all recommended care to pneumonia patients;
- 18.13% improvement in providing all recommended care to surgical patients.

These conditions were chosen by hospitals because they are among the most common medical conditions for which adults are admitted to the hospital. The data reflect the practice of participating hospitals in meeting the recommended process measures for each of these conditions. Process measures determine if patients are given a needed medicine, treatment or test at the right time. The measures are identified through research on recommended care of patients by the Joint Commission, the Centers for Medicare & Medicaid Services (CMS) and the National Quality Forum (NQF).

The 29 hospitals participating in the Northeast Ohio Quality Collaborative include:

Akron General Medical Center, Akron  
Akron Children's Hospital, Akron  
Aultman Hospital, Canton  
Cleveland Clinic Foundation, Cleveland  
Cleveland Clinic Hospitals:  
Euclid Hospital, Euclid  
Fairview Hospital, Cleveland  
Hillcrest Hospital, Mayfield Heights  
Lakewood Hospital, Lakewood  
Lutheran Hospital, Cleveland  
Marymount Hospital, Garfield Heights  
Medina Hospital, Medina  
South Pointe Hospital, Warrensville Heights  
MedCentral Health System, Mansfield

Mercy Medical Center, Canton  
Robinson Memorial Hospital, Ravenna  
Salem Community Hospital, Salem  
Samaritan Hospital, Ashland  
Southwest General Hospital, Middleburg Heights  
St. Vincent Charity Medical Center, Cleveland  
Summa Barberton Hospital, Barberton  
Summa Health System/Akron City and St. Thomas Hospital, Akron  
Summa Wadsworth-Rittman Hospital, Wadsworth  
Summa Western Reserve Hospital, Cuyahoga Falls  
Tripoint Medical Center, Painesville  
Union Hospital, Dover  
University Hospitals Case Medical Center, Cleveland  
University Hospitals Conneaut Medical Center, Conneaut  
University Hospitals Geneva Medical Center, Geneva  
University Hospitals Richmond Medical Center, Richmond Heights

### On the Horizon

Future plans for the collaborative center on reducing readmissions and improving transitions of care, improving hand hygiene compliance to reduce health care-associated infections and reducing preventable harm across northeast Ohio.

OHA's Quality Institute aims to drive transformational change in areas of quality and safety in Ohio hospitals and affiliated providers and together with Akron Regional Hospital Association established the Northeast Ohio Quality Collaborative.

**Editor's Note:** The AMCNO is pleased to be an active participant in the Northeast Ohio Quality Collaborative. We will continue to provide updates on their work in the coming months. ■

## GILMOUR ACADEMY

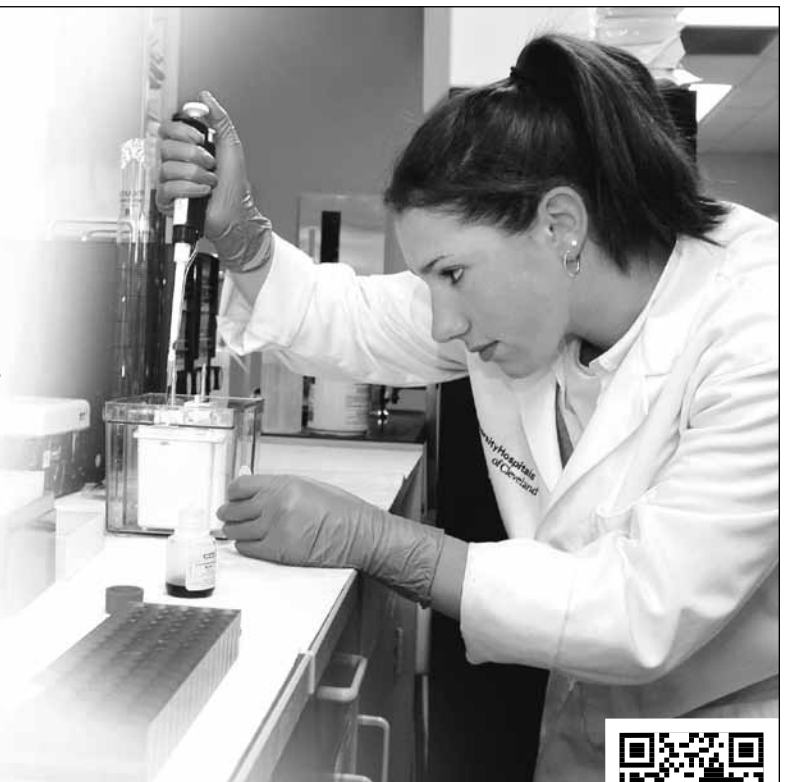
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## AMCNO Urges Action on the Medicare Payment Cut Issue

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has written to Congress and the Joint Select Committee on Deficit Reduction asking for a full repeal of the flawed Medicare Sustainable Growth Rate (SGR).

The AMCNO joins the American Medical Association (AMA) and the myriad other medical organizations from around the country in asking for the repeal of the SGR. As noted by the AMA, there is bipartisan agreement that a 30 percent cut in payments to those who care for Medicare patients would be devastating to seniors' access to health care. The SGR formula fails to keep up with the costs involved in delivering medical care to older and disabled patients and in actuality reimbursement to physicians has already gone far below what Medicare was paying for physician services in 2001. The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

The AMCNO stressed to both Congress and the committee that any serious proposal to confront the fiscal challenges facing our nation, and the Medicare program in particular, must address the massive shortfall in funding for Medicare payments for physician services. The AMCNO also pointed out that the Northern Ohio physician community provides care to a large number of Medicare beneficiaries and in order to keep serving these patients, physicians in

our community must be able to meet the expenses they incur in providing their medical care. Passing temporary patches that make future cuts steeper and escalate the costs of permanent payment reform is not the fiscally responsible course to take, nor does it support the long-term viability of important health care programs. The AMCNO stressed that it is long past time for Congress to address the flawed sustainable growth rate (SGR) formula and the time is now to repeal the SGR and adopt new payment models and move to a more stable Medicare payment system that provides security for patients and the physicians who care for them.

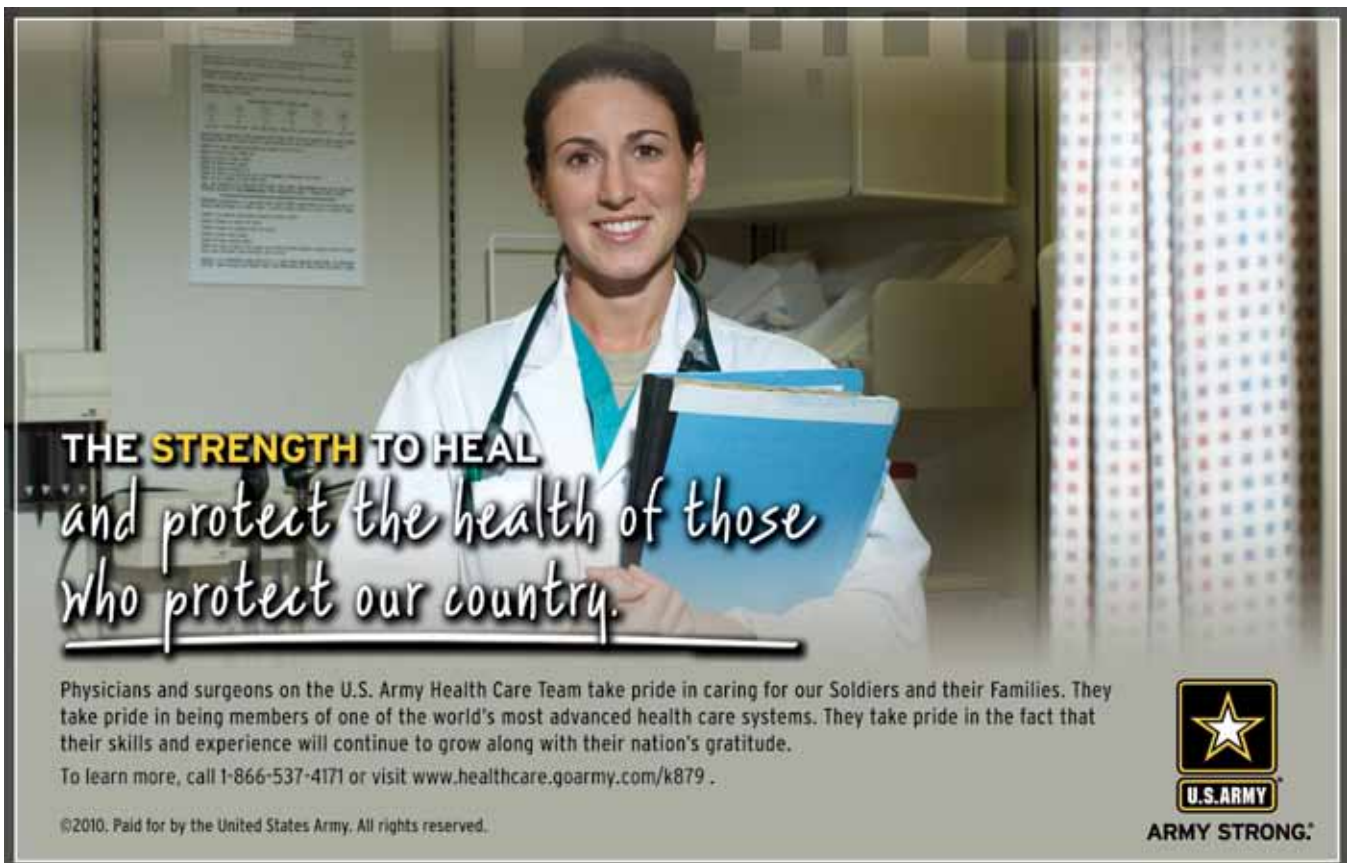
### **Time is Running Out: AMCNO Members – Contact Lawmakers now to Repeal the SGR**

As the Joint Committee on Deficit Reduction looks for ways to reduce federal government spending, AMCNO urges our members to contact your Congressional Representatives and ask them to address the flawed SGR and avoid the 29.5 percent Medicare physician payment cut scheduled for January 1, 2012. The Joint Committee has until November 23rd to develop a legislative package and Congress must vote on it by December 23rd. Contact your legislators now and request that Congress fix this flawed system ■

### **Centers for Medicare and Medicaid Services (CMS) Releases Final Accountable Care Organization (ACO) Rule**

After months of review, CMS has released the final ACO rule. The final rule reduces quality measures to 33 from the 65 originally proposed and CMS stated that this was done in an effort to reduce the administrative burden and eliminate potentially redundant measures. CMS also eliminated a potential penalty for the final year under one of two proposed accountable-care payment models. Previously, one payment proposal required ACOs to accept risk during the last year of a three-year agreement. The other model requires ACOs to accept risk for all three years.

Patients would be assigned to accountable-care groups prospectively under the final rule. An original proposal called for patients to be assigned retrospectively. All accountable care groups will share on all savings earned after qualifying by earning a minimum savings rate under the final rule. Previously, CMS proposed ACOs could share in all savings after 2%. Medicare will start its first accountable care agreements April 1, 2012. To view the final rule go to [http://www.ofr.gov/OFRUpload/OFRData/2011-27461\\_Pl.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-27461_Pl.pdf)




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## HIPAA Audits are Coming: The Time to Prepare is Now

By John T. Mulligan, J.D.

Hospitals, physician practices, and other healthcare entities have long been subject to a variety of sometimes random audits. For example, IRS audits, payer audits by Medicare or private insurance companies, state Workers' Compensation audits, federal Department of Labor audits can occur. To this list will shortly be added HIPAA audits. The United States Department of Health and Human Services (HHS) has announced that it has retained a contractor to begin doing random audits for HIPAA compliance in 2012. In June KPMG, LLP was awarded a \$9.2 million contract to administer the audits. The audits are presently scheduled to commence prior to the end of 2011, with the first audit phase scheduled to end by December 31, 2012.

In addition to random audits, HIPAA compliance audits can be triggered by a breach involving the impermissible disclosure of Protected Health Information (PHI) that compromises the security or privacy of that information and which poses a significant risk of financial, reputational or other harm to the affected individual. HHS's Office for Civil Rights (OCR) has ready access to information on breaches, due to provisions of the HITECH Act and related breach notification regulations requiring covered entities to report breaches no later than 60 days after discovery of a breach involving PHI of at least 500 individuals, and annually in the case of a breach involving fewer than 500 individuals.

During the next few years it is probably unlikely that a particular small healthcare provider will be the subject of a random audit. That being said, over time, random audits of small healthcare providers may occur, if only to "send a message" that HHS is serious about enforcing the privacy and security requirements of HIPAA. An audit is far more likely to occur in any situation in which there has been a reported breach or a complaint filed concerning a breach.

A starting point to prepare for a HIPAA audit as well as to determine how well the entity is complying with HIPAA's privacy and security requirements is to conduct a self-audit. Listed below are questions which will likely be asked by a HIPAA auditor in the context of an audit and which can be the basis for a self-audit. This list is not intended to be exhaustive. There are other items and certain healthcare entities will have special circumstances.

- Do you maintain a list of individuals and contractors with access to protected health information, and do you have a signed business associate agreement with each business associate?
- Do you have written HIPAA privacy and security policies and procedures? If so, are they followed?
- Do you have a written policy with respect to detecting, reporting, and responding to privacy or security related incidents?

- Have you conducted a risk analysis of the risks and vulnerabilities that could affect the confidentiality, integrity and availability of electronic PHI (e-PHI), as well as a physical security audit of your premises, and, if so, what were the results and what action was taken?
- What steps have you taken to encrypt protected health information?
- What policies are in place with respect to the removal from the practice site of protected health information (e.g., Do your personnel take laptops home with them? Do physicians take medical records out of the premises? What safeguards are in place?)?
- What policies do you have for establishing user access for new and existing employees? What about terminating access by former employees?
- Do you require your personnel to review and acknowledge the privacy or security policies that you have in place? How do you educate new workforce personnel?
- What sort of workforce privacy and security training do you conduct, and what documentation of that training do you have?

- Are your work stations secure? What studies have you done to determine this?
- How are you disposing of protected health information?
- Do you have up-to-date Notices of Privacy Practices (NPP)?
- Have you formally established a chain of command with regard to dealing with HIPAA or HIPAA violations, specifically to include the formal appointment of a HIPAA Privacy Officer, Security Officer, and a Contact Person? Do you have written acceptances of the appointments?
- Do these individuals have direct access to the governing body of your practice?
- Is there documentation of periodic reporting by them to the practice's governing body?
- In situations where you have had a privacy or security breach, have you documented your findings and the action that you took?
- Do you have a disciplinary action policy with respect to personnel who are the cause of breaches of privacy or security?
- Do you have a back-up plan in the event of an emergency or disaster? Have you tested it?

Taking these type of steps will not only help you deal with an audit, but can also prevent the sorts of privacy or security breaches which would be the cause of an audit in the first place.

*John T. Mulligan, Esq., is with the law firm of McDonald Hopkins, LLC and his practice is divided between the representation of general business corporations and the representations of health care providers.*

## The Academy of Medicine of Cleveland & Northern Ohio Welcomes 2012 Group Members from the Cleveland Clinic Foundation.

*Are group membership opportunities  
available at your hospital?*

Group membership provides all the benefits of the AMCNO at discounted rates. Call Linda Hale to inquire further (216) 520-1000 Ext. 101.



## AMCNO Participates in Centers for Medicare and Medicaid Services (CMS) Region V Update

Recently the AMCNO was pleased to participate in a Centers for Medicare and Medicaid Services (CMS) Region V Provider Update session. Facilitating the meeting was Dr. Derek Robinson, Chief Medical Officer for CMS Region V. Dr. Robinson mentioned that beginning in October 2012, Medicare will reward hospitals that provide high quality care for their patients through the Hospital Value-Based Purchasing (VPB) program. This program will change how Medicare pays health care providers and facilities — noting that for the first time hospitals across the country will be paid for inpatient acute care services based on quality, not just quantity of services they provide.

Dr. Robinson specifically asked the AMCNO to take note of the recent Office of the Inspector General (OIG) report to CMS regarding place-of-service coding for physician services processed by Medicare Part B contractors. The purpose of the OIG sample audit was to determine whether physicians correctly coded nonfacility place of service codes on selected Part B claims. The report found that a select sampling of physicians did not always correctly code nonfacility place of service codes on Part B claims which had resulted in overpayments. Based upon the sample results the OIG estimated that Medicare contractors nationwide overpaid physicians \$9.5 million for incorrectly coded services provided during calendar year 2009. Based upon these findings the OIG has recommended that CMS recover the overpayments and Medicare contractors have also been instructed to reopen claims associated with these type of services and enhance education to physicians regarding the importance of correctly coding the place of service.

The CGI Federal representative asked the AMCNO to continue to publicize the CGI Region B website so that physicians and their staff could stay abreast on new issues that the RAC may pursue, audit background and other key information. He also reminded the group that beginning in January 2012 there is going to be an important transition whereby the demand letters will be coming to providers from their Medicare Administrative Contractor (MAC) which in Ohio is CGS. All other correspondence such as review result letters and requests for documentation will still come through the RAC companies. Additional information on this transition will be made available to providers as the transition date gets closer. The AMCNO will also provide updates on this issue to our members.

A representative from the Ohio MAC – CGS noted that since the Part B transition from PalmettoGBA to CGS they have been working



*Dr. Derek Robinson, Chief Medical Officer for CMS Region V, provides the opening remarks at the session.*

hard to resolve overpayment and appeal issues since these have increased as part of the Affordable Care Act adjustments. CGS also reminded the group about the upcoming revalidation initiative noting that if a provider enrolled or revalidated prior to March 25, 2011 this process will have to be repeated. She cautioned that providers should wait until they receive an official notification where they are actually instructed by the MAC contractor to start the revalidation process since this process is going to be handled in phases.

The presenter from Medicare Advantage mentioned a new trend whereby Medicare Advantage plans are now receiving star ratings. CMS looks at 56 different variables to assign these star ratings to a plan. The ratings range from 5 stars for excellent performance, down to one star which denotes poor performance and would be considered unacceptable to the program. CMS is also tying reimbursement to the plans based on these ratings.

Representatives from CMS Region V plan to continue to travel around the region and meet with medical associations and other groups to discuss issues of importance to physicians and hospitals. AMCNO plans to participate in these programs and we have asked to host a session at our facility in the future. ■

## HHS Announces Bundled Payments Initiative

Physicians and hospitals will have the opportunity to collaborate and bid on providing high-quality, low-cost inpatient and post discharge care to Medicare patients under a new payment options starting in 2012. The U.S. Department of Health and Human Services (HHS) has announced a new initiative to help improve care for patients while they are in the hospital and after they are discharged. Doctors, hospitals, and other health care providers can now apply to participate in a new program known as the Bundled Payments for Care Improvement initiative. Made possible by the Affordable Care Act (ACA), it will align payments for services delivered across an episode of care rather than paying for services separately. This Centers for Medicare & Medicaid Services (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during a single hospital stay and/or recovery from that stay — known as an episode of care.

The Bundled Payments initiative is being launched by the new Center for Medicare and Medicaid Innovation, to carry out the task of finding new and better ways to provide and pay for health care to a growing population of Medicare and Medicaid beneficiaries. Under this initiative, which outlines four approaches to bundled payments, physicians and hospitals would come up with a plan and submit a bid to participate. Two of the bundled payment models focus on inpatient stays, a third involves post discharge services only, and a fourth combines inpatient and post discharge services. Providers will have flexibility to determine which episodes of care and which services will be bundled together. By giving providers the flexibility to determine which model of bundled payments works best for them, it will be easier for providers of different sizes and readiness to participate in this initiative. For more information about the various models and the initiative itself, please see the Bundled Payments for Care Improvement initiative website at: <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>. ■

## 27th Annual Mini-Internship Program Continues to Thrive

The Academy of Medicine of Cleveland & Northern Ohio was pleased to facilitate the 27th Annual Mini-Internship Program October 3 through 5, with both physician and intern participants relating the many benefits of the two-day shadowing experience. From neurology/pediatric and ENT office visits to gastroenterology/radiology procedures, orthopedic hand surgery, plastic surgery and thyroid surgery, interns experienced a "Day in the Life" of local physicians, an unparalleled look at the practice of medicine in today's healthcare arena.

The response from both community leaders and member physicians to participate in the 2011 program was impressive. The program kicked off with a brief orientation, where four interns and their respective physician(s) met, last-minute information was exchanged, and program goals were shared by Chairman Tom Abelson, M.D. The interns provided their insight on why they had asked to participate in the program. Councilwoman Mitchell mentioned she was excited to be part of this initiative because this is a distinguished field and a noble profession and she is interested in seeing how medical care is provided in the community. Ms. Roman noted she has a lot of interest in the practice of medicine and she believes the legal/medical profession has an opportunity to work together to help the community and the city. Ms. Townsend, who regularly reports in *The Plain Dealer*, said she is looking forward to getting out of the office and seeing what its like to practice as a physician and work in a hospital. Mr. Whitehead stated that healthcare represents a large employer in this city and is a leading industry in our community, so as a businessman he was looking forward to gaining insight into the practice of medicine. Following the orientation, the interns received HIPAA training from Attorney, Greg Viviani with Squire, Sanders & Dempsey LLP, which was the last item to cover before their journey began.

A debriefing dinner was held at the end of the event where enthusiastic interns and physicians exchanged comments and perspectives about their experiences. Judging from the comments made at this dinner, the Mini-Internship was a worthwhile experience for all involved. The interns saw the experience to be profoundly rewarding and eye-opening, dramatically changing their views about what it takes to practice medicine. The AMCNO expresses its sincerest appreciation to both the doctors and community members who committed their time and effort to make this very special program a true success again this year.



Councilwoman Mitchell spends a moment with several physicians attending the debrief session. (l to r Dr. Abelson, Ms. Mitchell, Dr. Ghosh and Dr. Kent.)

*"I was impressed with the teamwork and impressed with the medical staff."*

Attorney Barbara Roman, Meyers, Roman, Friedberg & Lewis/President, Cleveland Metropolitan Bar Association



Ms. Roman poses with Dr. Abelson (left) and Dr. Ghosh and Dr. Kent.

*"My experience during the internship showed me the essential value of using electronic medical health records."*

Mamie Mitchell, Representative, Cleveland City Council

*"Being able to get a different view of health care has been eye-opening. So many people would benefit from this 'behind the scenes' access."*

Angela Townsend, Medical Reporter, The Plain Dealer



The interns don their AMCNO white coats to pose for a picture with physician participants (l to r – Dr. Cheng, Dr. Abelson, Dr. Rowe, Dr. Zayat, Dr. Kent and Dr. Topalsky).

*"The chemistry among the medical team was quite impressive."*

Brad Whitehead, President, Fund for Our Economic Future



Ms. Townsend receives her certificate from Dr. Abelson (l) and Dr. Kent (r).

### 2011 Physician Participants

Tom Abelson, M.D., Chairman  
Diane Butler, M.D.  
Prabhleen Chahal, M.D.  
Jianguo Cheng, M.D.  
Robert DeBernardo, M.D.  
Christopher Furey, M.D.  
Debabrata Ghosh, M.D.  
Amanjit Gill, M.D.  
Reuben Gobezie, M.D.  
Christopher McHenry, M.D.  
David Rowe, M.D.  
Juan Sanabria, M.D.  
George Topalsky, M.D.  
Joseph Zayat, M.D.

### 2011 Program Interns

Mamie Mitchell, Representative, Cleveland City Council  
Attorney Barbara Roman, Meyers, Roman, Friedberg & Lewis/President, Cleveland Metropolitan Bar Association  
Angela Townsend, Medical Reporter, The Plain Dealer  
Brad Whitehead, President, Fund for Our Economic Future



Mr. Whitehead is all smiles posing with the physicians participating with him in the program (l to r – Dr. Abelson, Dr. McHenry, Dr. Butler, Mr. Whitehead, Dr. Cheng, and Dr. Kent).





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