

AMCNO Participates in Step Therapy Advocacy Day Event

The AMCNO supported a bill in 2016 that would implement major step therapy reform by establishing new requirements for step therapy protocols required by health insurers and the Medicaid program. Recently re-introduced from last session, this legislation will give doctors a transparent and standardized process to appeal step therapy requirements for patients needing a particular treatment. The bill does not ban step therapy, or the number of steps an insurer can implement, and patients may still need a prior authorization from their insurers.

Senator Peggy Lehner (R-Kettering) will lead legislation in the Ohio Senate, and Rep. Terry Johnson (R-McDermott) will lead companion legislation in the Ohio House. The legislation would provide for exceptions from step therapy protocols when it is in the best interest of patient care.

The AMCNO advocacy staff and representatives from more than 45 patient and provider groups across Ohio are working to raise awareness of the insurance industry practice known as “fail first” or “step therapy.” The Ohio Coalition to Reform Step Therapy is comprised of patient groups, physician organizations and pharmacists.



Senator Peggy Lehner provides comments on the need for step therapy legislation during a press conference at the Ohio Statehouse. (Also pictured: Sen. Charleta Tavares and Rep. Nickie Antonio.)

Step therapy protocols can be harmful to patients both financially and physically, causing an undue wait for the proper treatment and, in some cases, a worsening of a person’s medical condition. Step

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AMCNO Joins Other Associations to File an Amicus Brief on Apology Statute

Apology. One word that means two different things to two different courts. To one court, statements or conduct expressing apology made by a physician after an unanticipated medical outcome include only expressions of sympathy and do not include expressions of fault. To another court, they include expressions of fault. The differing interpretations have caused confusion among medical professionals about what they can and cannot say to a patient or the patient’s family after an unanticipated medical outcome.

But not for long. On January 17, the AMCNO joined forces with the Ohio State Medical Association (OSMA), the Ohio Hospital Association (OHA), and the Ohio Osteopathic Association (OOA) as amici curiae—or friends of the court—to make their views known to the Supreme Court of Ohio that words of apology, by that word’s own dictionary definition, include words of fault.

The confusion started back in 2011 when the

Ninth District Court of Appeals—covering Lorain, Medina, Summit, and Wayne counties—first construed Ohio’s apology statute, R.C. 2317.43, in *Davis v. Wooster Orthopaedics & Sports Medicine, Inc.*, 193 Ohio App.3d 581, 2011-Ohio-3199, 952 N.E.2d 1216 (9th Dist.). The physician in that case told the family after surgery that he had nicked an artery, that it was his “fault,” that he took “full responsibility,” and that he was sorry. The physician argued that these

statements should be excluded under Ohio’s apology statute, which protects “any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence” made by a healthcare provider to the patient or the patient’s family whenever they “relate to the discomfort, pain, suffering, injury, or death [of the patient] as the result of the unanticipated outcome of medical care” and makes them “inadmissible as evidence of an admission of liability or as evidence of an admission against interest.” While the trial court excluded the “I’m sorry” part of the physician’s statements, it did not exclude the physician’s statements of fault or liability,

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AMCNO Joins Other Associations to File an Amicus Brief on Apology Statute *(Continued from page 1)*

finding those statements not protected by the statute. On appeal to the Ninth District, the appellate court agreed and found that “admissions of fault” are not protected. In doing so, it emphasized the “sympathy” component of the statute and claimed the General Assembly’s intent was to limit the term “apology” to words of sympathy or condolence, and not include words of fault. Although the Supreme Court accepted review of the Ninth District’s decision, the case was later dismissed and the issue was never resolved by the Court.

Fast forward five years and the same issue is now before the Twelfth District Court of Appeals in *Stewart v. Vivian*, 2016-Ohio-2892, 64 N.E.3d 606 (12th Dist.). The physician in that case went to the intensive care unit to speak with the family of a psychiatric patient who was found hanging from the bathroom door of her hospital room even though she was on 15-minute checks. According to the family, the physician acknowledged that the patient said she would continue to keep trying to commit suicide. The physician, on the other hand, said he was trying to comfort the family following an unexpected outcome. The patient died a few days later. The physician sought to exclude the statements made to the family from the wrongful-death lawsuit that followed. The trial court did so, calling the statements made by the physician an “ineffective attempt at commiseration” and excludible under the apology statute. It explained that an apology can be made in the process of commiserating,

to calm a situation down, and for the purpose of “tak[ing] responsibility for your own actions” and therefore includes statements of fault. The Twelfth District agreed and, in doing so, disagreed with the decision of the Ninth District, setting up a conflict among the appellate courts.

The Supreme Court thereafter agreed to review the Twelfth District’s decision and resolve the conflict. Supporting the physician and asking the Court to uphold the Twelfth District’s decision, the AMCNO joined forces with the OSMA, OHA, and OOA, and worked together to prepare the joint amicus brief. Together we’ve asked the Court to apply well-recognized principles of statutory construction and interpret the statute broadly to find that the word “apology,” by its ordinary dictionary meaning, includes words of fault and that the statute, plain on its face, is not limited to words of sympathy. Had the General Assembly intended to limit the meaning of apology, it would have added words to the statute that are not there and cannot be added now by a court of law. We also asked the Court to consider the purpose of the apology statute—to strengthen the relationship between physicians and patients through greater openness and transparency without fear that any statements made after an unanticipated medical outcome would be used against them.

We filed our brief on January 17, at the same time as the physician we supported. The

plaintiff, as appellant, will soon file his reply brief. Once briefing is complete, the Supreme Court will set the case for oral argument. As always, we will keep you posted on this and other important cases affecting your practice. ■

Editor’s Note: *The AMCNO Medical Legal Liaison Committee tracks cases for the AMCNO Board of Directors that come before the Ohio Supreme Court and could impact or change the tort reform laws in Ohio which would greatly impact our members.*

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AMCNO Participates in Step Therapy Advocacy Day Event *(Continued from page 1)*

therapy does not take into account an individual’s medical history or other factors, but instead relies on a pre-determined prescription drug formulary or protocol.

Step therapy is a tool insurers use to limit how much they spend covering patients’ medications. Under step therapy, a patient must try one or more drugs chosen by their insurer—usually based on financial, not medical, considerations—before coverage is granted for the drug prescribed by the patient’s healthcare provider. Patients may be required to try one or more alternative prescription drugs that are of lower cost to the insurer, but may not be the best therapy for some patients.

The legislation will improve the step therapy process by:

- Requiring that an insurer’s process for

requesting a step therapy override is transparent and available to the provider and patient.

- Allowing automatic exceptions to step therapy requirements when:
 - o The required prescription drug is contraindicated or will likely cause an adverse reaction.
 - o The required prescription drug is expected to be ineffective.
 - o The patient has previously tried the required drug or a drug in the same pharmacologic class and the drug was ineffective or caused an adverse event.
 - o The required prescription drug is not in the best interest of the patient based on medical appropriateness.
 - o The patient is stable on a prescription drug for the medical condition under consideration.



Representative Nickie Antonio provides her input on the step therapy legislation.

- Ensuring that step therapy programs are based on clinical guidelines developed by independent experts.

For more information about step therapy please go to <http://www.reformsteptherapy.com/> or <https://www.prescriptionprocess.com/steptherapy>. ■

At the Dawn of Immigration Reform, Compliance Pitfalls to Avoid in Employing Foreign Nationals in Healthcare Settings

By Isabelle Bibet-Kalinyak, Esq., McDonald Hopkins LLC

Immigration reform is undoubtedly upon us. After decades of stability, immigration laws and Department of Labor regulations applicable to U.S. companies employing foreign nationals are soon to get a makeover. The Trump administration has announced sweeping reform and bolstered enforcement to better protect American workers. As the physician shortage worsens, hospitals and health systems will face unprecedented challenges to recruit and retain physician talent.

Recruiting foreign nationals has to be and has to remain part of a comprehensive strategy to build and maintain a qualified, diversified, and engaged physician workforce. Lack of familiarity with immigration law and procedures should not deter employers from tapping into the skills of International Medical Graduates (IMGs), provided organizations exercise planned cautiousness in navigating the complexities of immigration law and its interdependence with labor and employment laws at the state and federal level. In the wake of the upcoming overhaul of the immigration system, employers should assess internal compliance with the current laws and regulations. In doing so, taking into account the following key issues and best practices is paramount because they do not solely impact immigration counsel but also effectively affect health care and labor and employment attorneys alike.

- The Association of American Medical Colleges predicts that the effects of the physician shortage will be most acute in surgical specialties and rural areas. There are currently more than 6,000 primary care Health Professional Shortage Areas (HPSAs) and 4,000 mental health HPSAs. IMGs, who already represent more than 20% of first-year residents and nearly 25% of practicing physicians, are more valuable than ever in the midst of this worsening physician shortage because they are more likely to pursue a career in primary care services and seek work in rural areas than their American-born counterparts.
- IMGs depend on residency programs and U.S. employers to sponsor their temporary work visa and lawful permanent residence (LPR) status, the proverbial “green card,” in order to stay in the United States. The most two common types of visas for foreign residents are J-1 and H-1B. The latter is the most prevalent for physicians post-residency or fellowship. Employers must understand a few concepts regarding these visas before recruiting foreign nationals to ensure that these individuals will be able to stay and work in the U.S. long enough to be productive for the U.S. employer.
- A J-1 visa holder must technically return to his or her home country for two years upon completion of training and will therefore require a J-1 visa waiver. State-based J-1

visa waivers are available but they are very competitive, as each state only grants 30 waivers each year. Employers must therefore assess the likelihood of obtaining such a waiver and whether they can fulfill all the requirements before courting an otherwise very attractive candidate.

- H-1B visa holders need not return home for two years upon completion of residency or fellowship but they can only stay in H-1B status for a period of six years maximum, unless one of three narrow exceptions applies and the employer is willing to sponsor the foreign national’s green card. Employers are therefore best advised to evaluate this six-year ticking clock and the potential paths to LPR status during the early stages of the recruitment process.
- Compliance with the Department of Labor and the United States Citizenship and Immigration Services immigration regulations requires meticulous documentation, including petition-specific document retention guidelines. Employers should establish initial and periodic training for personnel involved in recruiting and hiring foreign nationals, including the proper processing of Form I-9 for employment verification eligibility¹ and non-discrimination laws based on national origin or citizenship status. For example, an employer is not allowed to ask a candidate whether he or she is a U.S. citizen or a green card holder. On the other hand, asking whether a candidate will require sponsorship for an employment visa now or in the future is permissible.
- Financial and administrative penalties for the employer can accrue exponentially, particularly since the scope of an investigation is not limited to the allegations underlying the original complaint of an aggrieved party. Fines range from \$1,000 to \$35,000 per violation and other penalties encompass debarment from approvals of any immigration petitions for at least one year, which can be catastrophic for certain employers. Thus, being flagged as a “willful violator” may hinder the employer’s recruitment efforts for years. Foreign nationals and their families may themselves face dramatic consequences, up to deportation.

- Employment agreements are an area where the interdependence between immigration law and labor and employment law is most visible and renders the literal use of template employment agreements for foreign nationals risky because the various visas and J-1 state waivers have inherent statutory restrictions. For example, under Ohio law, the employment agreement of a physician with an underlying J-1 state waiver cannot contain any non-compete terms and obligations. Thus, the compensation of a physician on an H-1B visa must at least be equal to the highest of the prevailing wages for that specialty among all the Metropolitan Statistical Areas (MSAs) in which the physician works, including all “on-call” locations and all locations where such physician rounds. As a result, employers must carefully assess the prevailing wages for all existing or potential worksite locations before extending contract offers to applicants. Non-guaranteed income, including all types of bonuses, non-guaranteed incentives, and non-monetary compensation and perks, cannot count toward the minimum base salary being compared against the prevailing wage of the applicable MSAs. Healthcare entities, including hospitals, should therefore not utilize compensation models without a guaranteed base salary equal to at least such prevailing wage and based solely on productivity (e.g., wRVUs) for foreign nationals on temporary work visas, as they do not meet the Department of Labor requirements.
- Employers may at times be tempted to use contractual terms placing the burden of immigration filing fees and legal costs on foreign nationals, either directly or indirectly through claw back provisions. As described in greater details in *Smart Business*,² this approach is prohibited for certain types of visa applications. For example, employers must bear the entire cost of all H-1B visa petitions and Program Electronic Review Management applications. Who can or should pay for immigration fees and costs should therefore be addressed on a case-by-case basis. State law may also place an additional layer of complexity on whether an employee may bear the burden of immigration fees and legal costs.

As illustrated by the above key points, healthcare executives and in-house lawyers that understand the interplay between staffing, employee retention, immigration regulations, and labor and employment laws can best further the goals of their organizations to enhance access to quality patient care. To learn

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more about immigration strategies within healthcare settings and compliance, you may contact Isabelle Bibet-Kalinyak.

Isabelle Bibet-Kalinyak is a business attorney with the law firm of McDonald Hopkins LLC (www.McDonaldHopkins.com). Her practice focuses on healthcare law (transaction and compliance) and business immigration, primarily in healthcare settings. ■

1. See "Handbook for Employers, Guidance for Completing Form I-9 (Employment Eligibility Verification Form)," available at <https://www.uscis.gov/sites/default/files/files/form/m-274.pdf>
2. Smart Business, "Why template employment contracts don't work with foreign nationals," June 1, 2015, available at <http://www.sbnonline.com/article/why-template-employment-contracts-dont-work-with-foreign-nationals/>

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For more information, contact Pam Durget at pdurget@vendomegrp.com or Lisa Van Dyne at lvan Dyne@vendomegrp.com.

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Ohio Department of Medicaid Report Shows Positive Impact of Medicaid Expansion

Under House Bill 64 of the 131st General Assembly, the Ohio Department of Medicaid (ODM) was required to provide a report that evaluated the impact of Ohio's 2014 Medicaid expansion. Released in December, the report—the Ohio Medicaid Group VIII Assessment—examined how the expansion has affected new enrollees in regard to access and utilization of healthcare, physical and mental health status, financial distress/hardship, and employment. The report is one of the nation's most comprehensive assessments of a state's Medicaid expansion.

The phrase "Group VIII" refers to the section of the Social Security Act that sets requirements for Medicaid expansion eligibility and allowed most Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) to become eligible for Medicaid, according to the ODM. Prior to Jan. 1, 2014, Medicaid eligibility for adults was limited to those with certain qualifying characteristics, such as parenthood or disability, and the income limitation for most Medicaid eligibility groups was lower than 90% of the FPL.

The assessment examined the effects of the Medicaid expansion on recipients enrolled through the Group VIII criteria. When appropriate, these enrollees were compared to those enrolled in Ohio Medicaid under pre-expansion eligibility rules (identified as "pre-expansion enrollees"). The study excluded those enrolled as dual-eligible, pregnant, living in institutions, or with less than 11 months of continual enrollment.

Numerous methods were used to collect data for the report, such as a detailed telephone survey of 7,508 Group VIII and pre-expansion enrollees, a biometric screening of 886 respondents who completed the telephone survey (including both groups of enrollees), and interviews with 10 Ohio Medicaid service providers and other key stakeholders.

Key findings

Section II of the report focuses on the Group VIII population. It includes a review of the percentage of Ohioans age 19-64 with family income at or below 138% FPL without insurance from 1998-2015.

As of May 2016, the close of the sample selection, a total of 702,000 individuals were eligible for and received Group VIII Medicaid coverage. Findings from the 2015 Ohio Medicaid Assessment Survey indicate that Medicaid expansion contributed to a large decline in the uninsured rate for low-income non-senior adults in Ohio (\leq 138% of the FPL) to the lowest rate ever recorded (14.1%).

Most Group VIII enrollees were uninsured prior to obtaining Medicaid coverage, either because they had no prior insurance at all (75.1%) or they had lost employer-based insurance (13.9%).

Most Group VIII enrollees were white (71.5%), male (55.8%), with a high school degree or less (58.1%), unmarried (83.8%), and without a child in the home (82.1%). Employment rates were similar for Group VIII and pre-expansion enrollees (43.2% versus 41.5%, respectively).

As a result of being older (51.4% were age 45 and older) and more often male than pre-expansion enrollees, Group VIII enrollees had slightly higher rates of health risk indicators, such as high blood pressure and high cholesterol, and higher rates of chronic disease diagnoses than the younger and more often female pre-expansion enrollees.

Section III of the report covers health system access and utilization. Group VIII enrollees overwhelmingly reported that access to medical care had become easier since enrolling in Medicaid, the largest gains seen among those who were previously uninsured. Findings also indicated that emergency department use, which is often a very costly form of care, decreased for Group VIII enrollees. Survey results and medical records analyses showed that Group VIII participants were better integrated into the healthcare system.

Section IV of the report covers physical health. Nearly half of Group VIII enrollees (47.7%) reported improvement in their overall health status since enrolling in Medicaid, compared to 3.5% who said their health had worsened. According to the medical records case study, the individuals studied had lower levels of high blood pressure or high cholesterol since enrolling in Medicaid.

Section V of the report covers mental health. Based on a mental health screening of survey participants, about one-third of Group VIII enrollees (31.9%) and 35.7% of pre-expansion

enrollees screened positive for depression or anxiety disorders, with these conditions limiting usual routine activities, including employment. Since enrollment in Medicaid, 44% of Group VIII enrollees reported better access to mental health services.

Also, Medicaid enrollment enabled participants to meet other basic needs. More than half of Group VIII enrollees (58.6%) reported that it was now easier to buy food, 48.1% stated that it was easier to pay their rent or mortgage, and 43.6% said it was easier to pay off other debts. The percentage of Group VIII enrollees with medical debt fell by nearly half since enrolling in Medicaid—55.8% had debt prior to enrollment, whereas 30.8% had debt at the time of the study.

Summary

Because of Medicaid expansion, almost 1 million low-income Ohioans are receiving healthcare coverage. Also of importance, many Group VIII enrollees were diagnosed with a previously unknown chronic health condition for which they are now able to seek care. Because they were able to obtain treatment for previously untreated conditions, several enrollees stated that they did not think they would be alive today if Medicaid expansion had not occurred. The medical records review findings also indicated that there was an increase in the likelihood that a Group VIII enrollee would visit his or her medical provider at least twice annually.

In addition to the reduction of unmet medical needs, Group VIII enrollees also reported substantial declines in overall stress and financial hardship. Most enrollees reported that Medicaid made it easier to seek employment or remain employed.

Generally, providers and stakeholders had a positive outlook on Medicaid expansion and reported that it had made access to and use of needed care considerably easier for their patients.

Overall, new enrollees reported being grateful for their Medicaid expansion healthcare coverage and valued having access to Ohio's healthcare system, according to the assessment. To view the full report go to www.medicaid.ohio.gov. ■

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is committed to working on issues related to healthcare under review at the Ohio legislature and in our region. Outlined below are just some of the issues we worked on at the end of 2016 and others that we will be working on in 2017. As new issues arise we will provide additional information to our members.

Health Insurance Issues/Healthcare Reform – Modernization of Medicaid

The AMCNO Board of Directors strongly supported Medicaid expansion in Ohio—and the AMCNO continues to support the modernization of Medicaid. We are part of a broad-based statewide coalition that agrees that Medicaid expansion in Ohio should remain intact, and we agree that Medicaid expansion has been good for the state of Ohio and will continue to be a driving force for positive healthcare access across the state. (In addition, a recent report on Medicaid Group VIII enrollees clearly showed that Medicaid expansion in Ohio has had a positive impact in the state of Ohio—see page 5 for more information on this report.)

It is obvious that the future of the Affordable Care Act (ACA) is uncertain. The AMCNO will continue to monitor any changes to the ACA as well as any additional federal proposed healthcare reform policies. To that end, the AMCNO Board of Directors has adopted the following healthcare reform policy statement:

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is the premier regional medical association in Northern Ohio representing more than 5,000 physicians, residents and medical students. Since 1824, the AMCNO has delivered networking opportunities, professional education and resources, political advocacy and more for physicians in our region.

The AMCNO believes that health insurance coverage and access to quality healthcare is of utmost importance. To that end, our organization and the physicians we serve recognize the need for health system reform and have long advocated for change in the healthcare delivery system. For years, the AMCNO has voiced its support for the funding of patient-centered medical homes, enhanced

access to care for all Americans, changes in health insurance company behavior, and support for prevention and wellness programs, among others. And we remain as committed as ever to improving healthcare access and health insurance coverage for the patients in our community.

The AMCNO is committed to working with Congressional leaders and other stakeholders to work toward health system reform initiatives that will:

- Allow access to affordable healthcare for all Americans and assure that individuals currently covered do not become uninsured;
- Enact meaningful medical liability reforms inclusive of alternative dispute resolution concepts;
- Provide for insurance market reforms that enhance choice of affordable coverage; including coverage for pre-existing conditions and parental coverage for young adults;
- Strengthen the individual insurance market and provide for quality improvement as well as reductions in cost;
- Enhance choice of affordable coverage and ensure that all patients are able to secure adequate coverage;
- Ensure that Medicaid, CHIP, and other safety net programs are adequately funded;
- Support reinstating Medicaid payment parity with Medicare for physician services provided under the Medicaid program;
- Support states being given the ability to develop and test different models for covering the uninsured;
- Continue to promote market-based strategies to achieve the affordability of prescription drugs and support initiatives to negotiate drug prices;
- Require healthcare decision-making by physicians and their patients, instead of by insurers or government entities;
- Provide for investments and incentives for public health and prevention and wellness initiatives;
- Provide appropriate avenues and funding for the growth of the physician workforce to meet demand.

The AMCNO believes that in order to avoid any disruption in patient care, policymakers

should lay out, in detail, what they believe should replace current healthcare policies so that stakeholders can review the new plan before it is implemented to determine if it meets the needs of the American public. As the healthcare debate continues in the future, the AMCNO will continue to strive for changes in the healthcare system that will address the AMCNO points noted above, and establish a more efficient and complete healthcare delivery system while preserving the physician-patient relationship.

Step Therapy Legislation

The AMCNO supported a bill in 2016 which would implement major step therapy reform by establishing new requirements for step therapy protocols required by health insurers and the Medicaid program. (See pages 1-2 for more information on this legislation.)

Medical Marijuana

The AMCNO continues to review the implementation and roll out of Ohio's Medical Marijuana law, and we have been keeping our members updated on any developments. It will take at least 12-24 months before the rules and regulations are complete.

The State Medical Board of Ohio (SMBO) sent a survey to physicians in Ohio to gauge their interest in providing medical marijuana to patients. Thirty percent indicated they were likely or very likely to recommend medical marijuana to their patients. Some of the questions asked included whether the physician was in independent practice or part of a hospital system. If they indicated they were part of a hospital system they were asked if they were practicing in an environment that would allow them to recommend medical marijuana to patients—or if that health system had sent out any information to guide their physicians on this issue. SMBO staff noted that based upon the perceived number of patients who may need assistance with medical marijuana prescriptions and the number of physicians who have responded that they would be willing to recommend medical marijuana to their patients there should be enough physicians in the state to handle the patient demand. For more information visit www.medicalmarijuana.ohio.gov.

State Medical Board of Ohio (SMBO)

The SMBO had considered removal of the

“one-bite” rule that allows a physician to confidentially seek treatment for substance abuse or impairment one time without being reported to the SMBO. The AMCNO and other medical associations across the state have worked together to defend the “one-bite” rule and we are working on legislation to strengthen the one-bite rule protection.

Medical Liability/Tort Reform **HB 7 – Medical Malpractice Litigation Improvements Act**

This legislation was just introduced in the 132nd General Assembly by former Ohio Supreme Court Justice Robert Cupp—who is now a legislator in the Ohio House. The AMCNO strongly supports this legislation.

This bill outlines 10 specific provisions (outlined below in an overview prepared by the OSMA) to address gaps in existing tort reform law:

1. Amendment of “Apology Statute”

The Medical Malpractice Litigation Improvements Act will clarify the apology statute to permit a broader conversation between patients and physicians when an unanticipated outcome in medical care occurs and will further open the lines of patient-physician communication in such instances.

2. Minimization of “Shotgun Lawsuits”

This legislation will reduce the undesirable practice of “shot gunning” defendants in medical malpractice cases, in which numerous defendants are initially named in a lawsuit but subsequently dismissed from the case, in medical claims, by allowing plaintiffs a period of time to name additional defendants after the initial filing of a medical claim.

3. Notice of Intent to File a Medical Claim

Currently by law a plaintiff is able to provide notice of intent to sue prior to the expiration of the statute of limitations in order to extend the deadline for filing a lawsuit. The bill deletes the potentially awkward or embarrassing personal service requirement for notice of intent to sue in current law, and will permit notice to be provided by certified mail.

4. Abrogation of the Loss of Chance Theory

“Loss of chance” is a speculative theory of tort liability created by the courts. It

effectively shifts the burden of proof as to causation for the injury to the defendant, invites the jury to indulge in speculation and conjecture, and permits a verdict based on “possibility” as opposed to the law’s traditional requirement of “probability.” The bill will revert Ohio’s law to the traditional concept of causation.

5. Insurer Reimbursement Policies Not to Establish Legal Standard of Care

The Medical Malpractice Litigation Improvements Act prohibits the use of insurer payment policies and guidelines to establish the standard of care. In lawsuits brought against healthcare professionals, the standard of care must continue to be established by a qualified medical expert who can speak to the level and type of care that a reasonably competent and skilled healthcare professional should have provided under the circumstances.

6. Nursing Home Plan of Care

This provision corrects an imprecise use of terminology in current law relative to hospitals. While “plan of care” as a term is proper as to nursing homes it is not properly applied to hospitals and other providers.

7. Maintain Confidentiality of Peer Review Records

A provision in this legislation permits peer review information to be shared with regulators such as licensing boards, or the Ohio Department of Health, but clarifies that disclosing the peer review information to a regulator does not otherwise affect the confidentiality of the information and obligates the regulator to likewise maintain its confidentiality.

8. Prohibits Introduction of “Phantom Damages” in Evidence

This bill would ensure in tort liability cases that the jury receives evidence of the amount actually paid for services, not the amount billed for those services without expectation of payment. A provision in the legislation clarifies that the measure of economic damages is the amount actually intended to be paid.

9. Mental Health Patient Discharge and Good Faith Exercise of Medical Judgment

Current Ohio law does not address what a healthcare provider should do when a patient, whose medical condition has been sufficiently treated so that the patient could be discharged, still has a mental health

condition that may threaten the safety of the patient or others. If a healthcare provider or hospital makes a decision to retain a patient in the interest of the safety of the patient or others, the provider/hospital risks having to defend a wrongful imprisonment claim.

The bill provides protection for certain providers/hospitals for:

- *Failing to discharge a patient if the provider/hospital believes in the good faith exercise of medical judgment that the patient has a mental health condition that threatens the safety of the patient or others; and*
- *Discharging a patient whom the provider/hospital believes in the good faith exercise of medical judgment does not have a mental health condition that threatens the health or safety of others.*

10. Liability Standards for Emergency Care in a Disaster

A provision in the bill provides for alternative standard of liability when a natural or man-made disaster or an epidemic overwhelms emergency care providers.

Scope of Practice

Several bills that were under review in the last General Assembly dealing with scope of practice issues are expected to resurface in 2017. Legislation that would allow Certified Registered Nurse Anesthetists (CRNAs) to select, order and administer drugs, and to direct certain other personnel to administer drugs or perform clinical support functions, will more than likely be reintroduced in the near future. In addition, we expect two other scope of practice bills to resurface in 2017—one that would authorize certain psychologists to prescribe psychotropic drugs for the treatment of drug addiction and mental illness, and another which would permit physical therapists (PTs) to evaluate, diagnose, and determine a treatment plan for a patient, as well as order tests and imaging. Under current law, a PT can assess, but not diagnose, a patient’s condition. The AMCNO, along with other medical associations from around the state, opposed these bills in the last General Assembly due to concerns about patient safety and lack of proper training and education.

(Continued on page 8)

State Legislation/Administration Update *(Continued from page 7)*

Prior Authorization Legislation – SB 129

This new law was strongly supported by the AMCNO and we were part of a broad-based coalition formed by the Ohio State Medical Association representing more than 80 provider and patient advocacy organizations who supported this legislation.

The bill applies to health insuring corporations, sickness and accident insurers, and Medicaid managed care plans (the law excludes ERISA self-insured plans or Medicare Advantage plans). The bill also prohibits an insurer from including in their provider contracts any provision that is contrary to what is contained in the bill. The main provisions that became effective in January 2017 are as follows:

- Insurers must disclose to participating providers all new prior authorization (PA) requirements at least 30 days prior to the effective date of the new requirement.
- Insurers must disclose all prior authorization rules to participating providers, including information or documentation that a provider must submit in order for the PA request to be considered complete by the insurer.
- A provision prohibiting retroactive denials when, on the date the provider renders the prior approved service the patient is eligible; the patient's condition has not changed; the provider submits an accurate claim that matches the information submitted to the provider in the approved PA request.
- A provision allowing a retrospective review of a claim where a PA was required but not obtained when the service in question meets certain requirements; such as the service is related to another service for which the PA has already been obtained and has already been performed; the service was not known to be needed at the time the original prior authorized services was performed; the need for the new service was revealed at the time the original authorized services was performed.
- Insurers must allow for a 12-month PA for medications to treat a chronic disease under certain circumstances.

There are numerous provisions of the bill that do not become effective until January 2018 including the following:

- Insurers must have a web-based system through which to receive PA requests; there must be faster turnaround time for a PA request; there must be more clarity when an insurer responds to a PA request; and there will be faster turnaround time for PA appeals.

The AMCNO will provide additional details on these provisions in our November/December 2017 issue.

Price Transparency

The AMCNO physician leadership have agreed to join a lawsuit with the Ohio Hospital Association (OHA) and other healthcare groups to stop a complex law that would demand price disclosures before medical services and procedures could be provided to patients.

The lawsuit, which was initiated by the OHA, would block a new statute that was supposed to start on Jan. 1, on the grounds that it is an impractical mandate on physicians and healthcare systems and would create a disruption in medical care for patients. This flawed law creates confusion for hospitals and physicians who could be subject to complaints for non-compliance of the law and who are concerned about delays in patient care if the law were to become effective.

In late December, Williams County Common Pleas Court Judge J.T. Stelzer issued a 30-day restraining order blocking the law from taking effect. A hearing on this matter should take place in the near future.

State Rep. Jim Butler (R-Oakwood) authored and sponsored the law, which was added at the last minute to a Bureau of Workers' Compensation budget bill in June 2015.

This was a very broad healthcare price transparency law that required all healthcare providers to provide certain price information to patients, prior to the delivery of services. Providers cannot access this information and the law will result in delays in patient care.

Since then, healthcare organizations from across the state have attempted to work with Rep. Butler and other legislators to simplify

the language to make the intent of the price transparency law reasonable and practical for healthcare providers and patients.

Unfortunately, the discussions were not successful and no agreement was reached, so this complaint was filed in order to protect providers from violating the law, being subject to private litigation, running afoul of Medicare requirements, and other types of harm.

Despite the law's requirement that regulations be passed by the Ohio Department of Medicaid to implement the law, no regulations have been created to clarify the law and assist providers in knowing how to implement the law. With no standards in place, patients will receive conflicting and confusing information from providers.

In addition, the cost for medical procedures often varies based upon a patient's health insurance coverage and the information is not always readily available, which would create delays in delivering medical assistance.

The AMCNO and healthcare associations around the state are committed to price transparency and to continuing to work with legislators to develop price transparency policies that would yield meaningful information for patients. While this lawsuit remains under review, the Governor's recent budget proposal includes a provision to strike this law so that the legislature can revisit the issue through the regular order of committee hearings. The goal is to avoid a protracted lawsuit that could slow down the state's progress in this area, and to create and open discussion that builds strong support for healthcare price and quality transparency. The AMCNO will continue to provide updates on this issue to our members.

2017-2018 Budget Proposal Overview

Governor Kasich has introduced his last two-year budget proposal, which includes tax proposals from previous budgets as well as ideas to increase the quality of health and human services. Over the next few weeks and months, additional comments and analysis of the budget proposal will emerge as groups and organizations discuss the concepts included in the budget.

STATE LEGISLATION/ADMINISTRATION UPDATE

The budget heads first to the Ohio House, where hearings began in February and will continue in both the House and the Senate until the budget is sent to the governor for his signature by the end of June.

The governor's budget plan includes many Medicaid-related proposals, including initiatives to modernize Medicaid, streamline health and human services, and improve population health. Governor Kasich wants to maintain the Medicaid expansion; however, in keeping with the Healthy Ohio proposal, the budget provides for imposing a cost-sharing requirement on expansion enrollees through an 1115 demonstration waiver—a proposal which would require some enrollees to pay into the program at a cost of \$20 per month. The budget proposal would also require more Medicaid enrollees to sign on to privately run managed care plans.

The budget includes various changes related to managed care plans. Due to the elimination of the sales tax on Medicaid managed care plans, the Ohio Department of Medicaid asked for and received approval for a replacement of the tax by broadening it to all insurance companies through a graduated franchise fee. Medicaid plans would pay \$26 to \$56 per member and non-Medicaid plans would pay \$1 to \$2 per member, generating \$615 million next year. These funds will help the state maintain the revenue they had obtained through the previous tax on managed care plans.

The budget includes several proposals to reform provider payments as well. On a provider level, there are several proposals that will affect many aspects of the delivery system. First, hospitals will see a rate cut, except for those hospitals with a high volume of Medicaid—a newly created group of providers. The budget supports performance payments for comprehensive primary care, moves nursing facility reimbursement into managed care and adopts a single preferred drug list for the Medicaid pharmacy benefit. The budget also includes a proposed state sales tax on cosmetic surgery procedures—a budget item opposed by the AMCNO.

In addition, behavioral health redesign will continue, with new dollars being allocated to

increase practitioner capacity, and there will be efforts to increase inpatient treatment for behavioral health and the developmentally disabled. There are also initiatives to draw down federal funds for social determinants of health regarding lead abatement and medically-related transportation in non-emergency situations funded by Medicaid.

The budget also proposes an expansion of pilot programs focused on improving student success through better health—which would financially reward primary care practices that focus on better student health and more will be done to report the performance of providers engaged in Ohio's pay-for-value initiative built on episodic-based payments.

In addition, the budget includes strategies to reduce infant mortality, provide care and prevention of mental health and substance use disorders, and reduce the burden and incidence of chronic disease. A proposed increase of 65 cents in the tobacco tax included in the budget, an increase which is strongly supported by the AMCNO, would have an impact on addressing each of these strategies.

The budget also calls for modernizing medical professional licensing boards in order to shield boards from potential antitrust lawsuits by creating a third-party review of certain issues through the Ohio Department of Administrative Services. The budget calls for consolidating 16 medical professional licensing boards into eight boards. This will provide for the same level of support for the same number of licensees, but achieves administrative savings. Under this proposal, physician licensing by the State Medical Board of Ohio (SMBO) will not change, but the functions and duties of the Ohio Board of Dietetics and certain functions of the Respiratory Care Board would be under the SMBO. One item of interest to physicians in the budget related to the SMBO is the proposed reduction in SMBO licensure fees for physicians—reducing the physician licensure fee from \$335 to \$305. There is also a proposal to strengthen the public health infrastructure by making the State Health Assessment available online and creating a website to post health district and hospital community health plans.

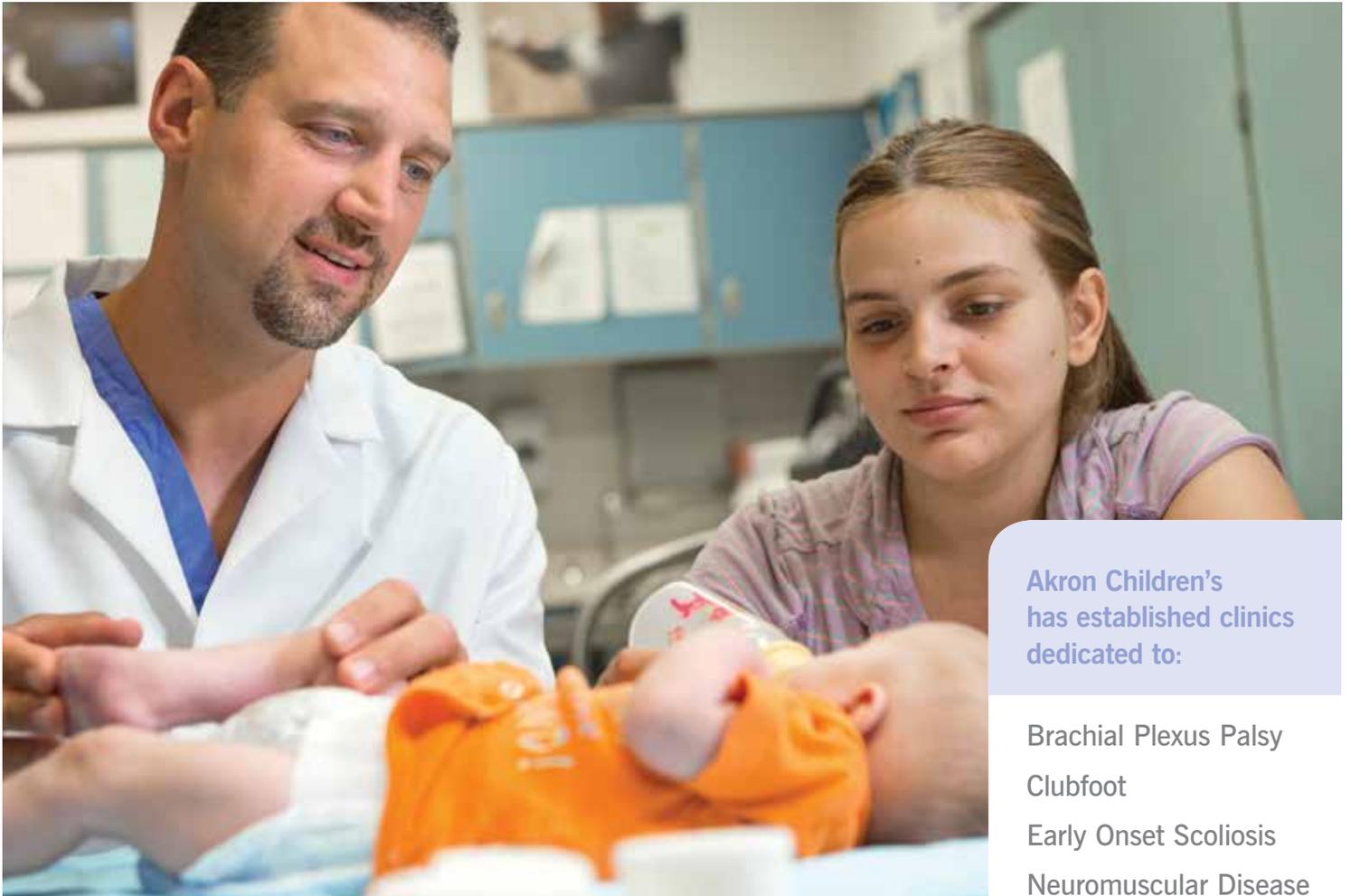
Under the Department of Mental Health and Addiction Services budget there will be funds for treatment and recovery through local ADAMHS boards, and recovery housing, prevention services in communities, and programs that help people with mental health and/or substance use disorders involved with the criminal justice system, including diversion programs and community support.

The governor's budget continues a strong investment to strengthen Ohio's fight against drug abuse through funding to address treatment, education, prevention and law enforcement. The budget will require that public colleges and universities embed drug awareness and education into their curriculum for teacher preparation programs. In addition, the budget calls for expanded access to the Ohio Automated Rx Reporting System (OARRS)—with the data to become accessible to drug courts and to coroners for drug investigations as well as to the Department of Medicaid to incentivize responsible prescribing practices. Also the length of record retention for OARRS will be extended from three to five years to provide more information on prescribing history.

There is also a provision to strengthen pharmacy board investigations by granting its investigators subpoena authority to allow the Board to obtain records to help build cases and improve investigations. Ohio will also increase the availability of naloxone by funding an additional 20 Project DAWN (Deaths Avoided With Naloxone) sites in high-risk counties. There are also provisions to authorize a county or region to establish a Drug Overdose Fatality Review Committee to allow local experts to review circumstances surrounding overdose deaths. These committees will have the authority to review data sources providing confidential information about drug overdose deaths, ranging from coroner scene investigations and medical history, including controlled prescription usage, to mental health treatment and law enforcement involvement.

The AMCNO will closely watch the debate on the budget and provide additional information to our members as the discussion continues through June. ■

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Electronic Health Records, CliniSync and the AMCNO

By Anthony E. Bacevice, Jr., MD, AMCNO Past President

Technology has been a part of medicine since the first time we used a stethoscope to listen to a patient's heart, rather than placing our ears on the chest. In more modern times, computers have become as important, if not more so, than the time-honored stethoscope. Faster, smaller and more powerful computers have become part of patient care, both in the office and at the bedside.

One of the most pervasive applications of computing technology has been the transformation of record-keeping from paper documentation to electronic documentation. With the prodding and help provided by the federal government, electronic health records (EHRs) have become parts of daily medical practice. The EHR helps to avoid the errors and vagaries associated with handwritten orders and notes. Also, a standardized format for stored data facilitates storage, retrieval and exchange of patient-specific data. "Big Data" analytics can be applied to patient populations, allowing for quality analysis of care models. Focused data analysis can be compared to evidence-based metrics to assess the quality of care delivery. Population data analysis from the EHR can improve epidemiologic analysis of health and disease trends.

One of the most important consequences of the EHR, however, is the ability to interconnect hospitals, laboratories, physicians and other providers for the purpose of exchanging data to support the care of the patient across multiple care sites and encounters. Interconnection is through the health information exchange (HIE), which provides both the hardware and software to enable communication among these entities. Wherever and whenever a patient encounters the healthcare environment, his or her information can be made available to those with a "need to know" to have all necessary information at hand for optimally efficient care delivery.

The AMCNO has been a partner in Ohio's transition to the electronic medical record as it has evolved. The Ohio Health Information Partnership (OHIP) was created to facilitate the adoption of electronic medical records in physician practices throughout Ohio. Initially, Regional Extension Centers were established to facilitate the transition to electronic medical records in physician practices, both large and small. Representing a large majority of Northeast Ohio physicians, AMCNO was involved in the local Regional Extension Center, providing advice and feedback from its physicians. As EHR connectivity evolved, OHIP

developed the HIE infrastructure under the name of CliniSync.

In 2012, OHIP invited AMCNO to provide a representative to its Clinical Advisory Council. This was an advisory group made up of representatives of the various entities that provided information to and extract information from the statewide health information exchange. The Clinical Advisory Council met by teleconference or in person six times per year for the purpose of discussing issues that were relevant as the HIE developed. With feedback from stakeholders, such as hospital systems, large physician practice systems and small physician groups represented by organizations such as AMCNO, the Clinical Advisory Council was able to provide advice to CliniSync as it developed operational policies that affect the day-to-day interaction of users of the interconnected electronic record. Issues such as patient privacy and patient consent as it applied to the HIE were instrumental in shaping how the final product was developed and deployed.

As of January 2017, CliniSync has more than 3,200 active users, including 330 healthcare organizations. At this time, 127 hospitals in Ohio are interconnected through the CliniSync HIE. AMCNO continues to be active in providing feedback from its board and its members to the Clinical Advisory Council. As innovations in EHR interconnectivity evolve, AMCNO is actively participating in policy formation and operational evaluation of Ohio's most pervasive HIE.

For more information about CliniSync and other aspects of EHRs and HIEs, please consult their website (www.clinisync.org). ■

Anthony E. Bacevice, Jr., MD, is Past-President of the AMCNO. He is Chief Medical Officer at University Hospitals Elyria Medical Center. Since 2012, he has represented AMCNO on the Clinical Advisory Council for CliniSync. He is a member of the Healthcare Information and Management Systems Society (or HIMSS), in addition to other medical societies. Dr. Bacevice will provide regular updates on the activities of the Clinical Advisory Council for AMCNO members in upcoming issues.

Register Now for the AMCNO/CMBA Medical Legal Summit: March 24-25, 2017

The 2017 Medical Legal Summit will be held March 24-25 at the Cleveland Metropolitan Bar Association (CMBA) Conference Center. This annual event is co-sponsored by the CMBA, the AMCNO, and the Academy of Medicine Education Foundation.

Keynote speaker **Gail Wilensky, PhD**, will present "Update on the Affordable Care Act and the Impact of Medicare Payment Reforms" on Friday, March 24.

Saturday, March 25, will feature three plenary sessions: "MACRA," "Addressing the Opioid Crisis in Ohio," and "Lawsuits: How to Survive, How to Avoid Them (a Medical/Legal Perspective)."

A breakout session will follow: "Medical Marijuana" or "Legal Issues in the Care of the 'Vulnerable' Patient."

This summit is intended to bring together physicians, attorneys, healthcare professionals and others who work in allied professions, for education, lively discussion and opportunities to socialize. The co-chairs of the event are **AMCNO President Dr. Robert Hobbs** and **Marlene Franklin, Esq.**, General Counsel, MetroHealth Medical Center.

Register now for the event—5.5 CME credits and 5.0 UH CRME credits are available.

See the Upcoming Events section on our website homepage, at www.amcno.org, for more information.

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Point-of-Service Collections

By Cheryl Chianello, CPCO, and Tamiya Williams, CMPE, Medic Management Group, LLC

If your practice hasn't implemented point-of-service collections, now is the time to start. Patients are choosing insurance plans that have higher copays and deductibles to decrease their monthly healthcare premiums, so practices now need to collect payment from patients instead of the insurance companies.

For your practice to remain financially healthy, it is necessary to have point-of-service collections. Getting paid for services rendered will only become more difficult unless your practice changes/updates policies on the matter. Following are recommendations for success:

1. Utilize Financial Counseling

Financial counseling should be reserved for those who have a strong understanding of health insurance and can help patients understand their financial obligation. Physicians should not request to waive copays or patient balances, because it creates a compliance concern and it will affect the practice's financial health. Physicians should direct the patient to an appointed employee who can explain the financial policy and why waiving is not an option. Remember, waiving deductibles and copays could jeopardize the contractual relationship between the practice and the insurance company. Read more at the Office of the Inspector General's website by logging on to: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>.

2. Educate Staff on the Importance of Point-of-Service Payments

Front desk staff may not be aware that patients are responsible for a higher amount of their healthcare costs. The days of the \$5 copayment are gone and have been replaced with higher copayments and deductibles—40% of the reimbursement may be coming from the patient.

Ask the billing staff to review some current explanation of benefits (EOBs) to show the comparison of insurance reimbursement to patient responsibility. You might be surprised to learn that the patient may be responsible for more of the reimbursement than the insurance company. Compare your contracted reimbursement for common E&M codes to the patient's \$40 copayment. Who is responsible for more? Are you willing to take only what the insurance reimburses? Does your front desk understand how important it is to collect from the patient?

CPT CODE	AVE INS REIMBURSEMENT EXAMPLE	PT COPAY	INS REIMBURSE
99202	\$ 75.00	\$ 40.00	\$ 35.00
99203	\$ 109.00	\$ 40.00	\$ 69.00
99212	\$ 44.00	\$ 40.00	\$ 4.00
99213	\$ 73.00	\$ 40.00	\$ 33.00
99214	\$ 108.00	\$ 40.00	\$ 68.00

3. Educate Staff on the Importance of Point-of-Service Collections

Your staff needs to understand their role in the financial success of the practice. Inform them that collecting from patients is not an option, and educate them on how to ask for payments. For example, they should never ask patients **if** they would like to pay; patients should be asked **how** they would like to pay.

Set targets for success. Most practice management software will track what should be collected versus what was collected. Identify what amount has been commonly collected and set goals, with the ultimate goal of 98-100% copayment collections and 75% balance collections.

4. Create Policies and Procedures for the Staff

Policies are the foundation of any medical practice and help with daily workflow.

Essential elements in a collection policy:

- Staff training on how to identify patient copayments and outstanding balances.
- Patients should be reminded to bring copays and outstanding balance payments when appointments are being scheduled and during appointment reminder calls.
- How to ask patients for their copayment and/or balance. Include scripts to help the front desk staff be successful and consistent.
- What to do if patients refuse to pay.

5. Write a Financial Policy for Patient Education

A strong financial policy can mean the difference between a financially strong medical practice and a practice that struggles with cash flow. Most patients will respect the practice policies.

A financial policy explains the practice's expectations:

- Copayments are expected at the time of service
- Payment options
 - Type of payments accepted (eg, cash, check, or credit card)
 - Payment plans for large balances
 - Self-pay discounts
 - Hardship discounts
- Consequences for no payment

6. Check Patient Insurance Eligibility

Real-time electronic insurance eligibility will allow you to verify patients' insurance and also give you their financial responsibility.

7. Pre-Collect for Procedures

Pre-collection should be used for non-emergent procedures or surgeries. When contacting the patient's insurance for authorization, request what the patient may owe for the procedure. Once identified, set the patient up on a payment plan or down payment. If the patient has a \$5,000 deductible, chances are they will be responsible for all or a large portion of the reimbursement to the physician.

8. Have a Strict Patient Billing Process

Studies have shown that the chance to collect the patient financial responsibility drops by 20% once the patient leaves the office, and there is a greater drop if the balance is sent to collections. With that in mind, don't send numerous statements to the patients. If the patient does not pay or reach out to your billing department after the first statement, chances are additional statements will not make a difference. Best practice recommends sending the balance to collections within 90 days. The patient will receive their EOB before the practice, so they know what they need to pay before the first statement is received. Collecting at the point of service increases your chance to collect and reduces the cost to collect. The patient statement process is costly to a practice, and, many times, the cost to collect is higher than the amount collected.

9. Track Changes

Track monthly patient payments to identify if your process is working or if the process needs review. Identify any area that is not following the developed policies and procedures and look for ways to improve.

Once staff and patients are trained on the practice's point-of-service collection expectations, it will become automatic. ■

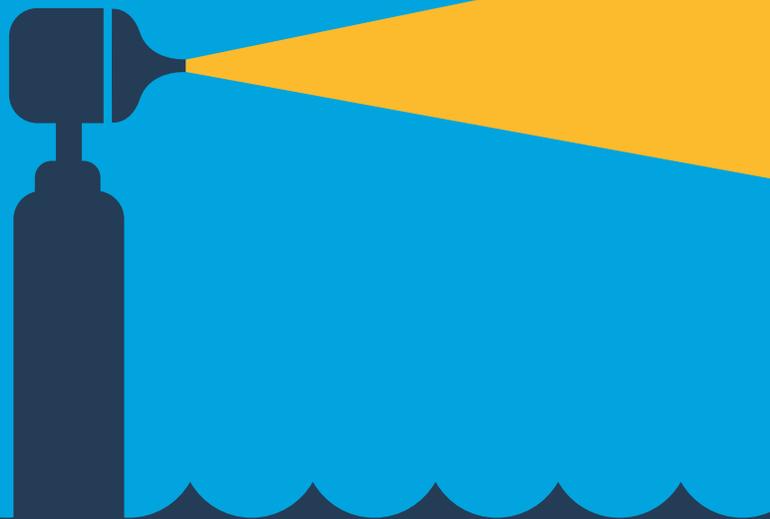
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AMCNO MEMBERSHIP ACTIVITIES

Members Gather for the Annual AMCNO Wine Tasting

The AMCNO hosted its annual Wine Tasting event on February 12 at La Cave du Vin. In the cozy atmosphere, members, residents and their guests sampled six Italian wines that were presented by a certified wine specialist. Delicious cheese plates complemented the various wines.

We'd like to thank our members for once again supporting this event, and we thank the newcomers for joining us for the evening.

You can check out more photos from the Wine Tasting on the AMCNO's Facebook and Twitter pages.

Be sure to watch for save-the-date information for next year's outing!



The event featured six Italian wines.



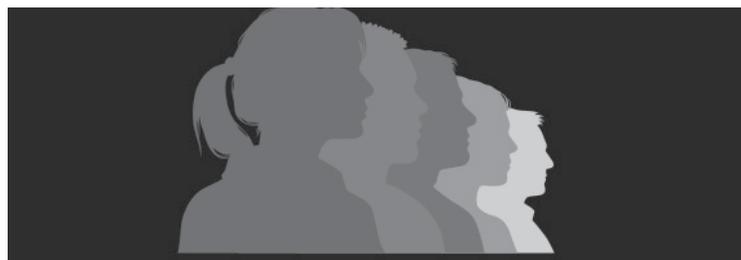
AMCNO President Dr. Robert Hobbs talks with his wife and Dr. Fred Jorgensen during the annual event.



The certified wine specialist provides highlights about each wine sampling after it's poured.



AMCNO President-elect Dr. Fred Jorgensen (center) spends a moment with his wife, AMCNO Board Member Dr. Brian Myers (far left) and his wife, and Dr. Austin Tutt (far right).



Legal Challenges in Precision Medicine

The Law-Medicine Center Conference

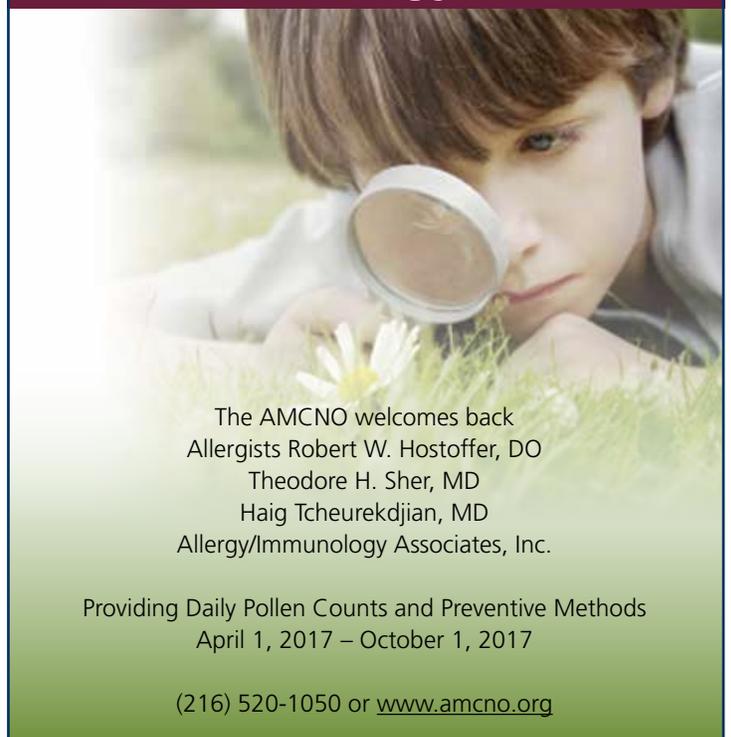
- Friday, April 7, 2017; 8:00 a.m. - 5:00 p.m.
- Glidden House Inn, Cleveland, OH

Join us for a conference discussing the emerging legal challenges of transitioning the practice of health care to the Precision Medicine Initiative model.

Register at law.case.edu/lectures



AMCNO Pollen Counts Kick Off Allergy Season



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Theodore H. Sher, MD
Haig Tcheurekdjian, MD
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The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the Academy of Medicine Education Foundation (AMEF) Present:

Solving the Third-Party Payer Puzzle

May 17, 2017

Location: AMCNO Executive Offices, Park Center Plaza I, 6100 Oak Tree Blvd., Independence, OH 44131

This is your opportunity to hear representatives from private payers, Medicare and Medicaid discuss their latest rule changes and claims submission issues that will impact your practice.

Wednesday, May 17, 2017

7:30 a.m. – 8 a.m. Registration and breakfast

8:00 a.m. Ohio Medicare/CGS

- Information regarding medical record review contractors
 - Comprehensive Error Rate Contractor (CERT)
 - Recovery Auditor (RA)
 - CGS Medical Review (MR)
- Discuss new and ongoing Medicare initiatives
- Provide CGS operational reminders
- Introduce resources and self-service technology option

9:30 a.m. Break

9:45 a.m. Ohio Medicare/CGS (continued)

10:30 a.m. Ohio Medicaid

12:30 a.m. Lunch

12:45 p.m. Medical Mutual Of Ohio

- 2017 Updates

1:15 p.m. Anthem Blue Cross Blue Shield

2017 Updates, including but not limited to:

- Provider Escalation Process
- AIM Updates
- Availability
- Ready Reference Guide/Provider Relations Contacts

1:45 p.m. Break

2:00 p.m. Medicaid Managed Care Presentations

Times are approximate and may vary based on the size of the audience, questions and number of plan presentations. The following plans have been invited to present:

- **Buckeye Health Plan** (confirmed)
- **UnitedHealthcare Community Plan of Ohio** (confirmed)
- **Paramount**
- **CareSource**

Registration Fees

AMCNO Member: \$50, AMCNO Member Staff Person: \$50

Non-member: \$100

Name: _____ Physician/Group Name: _____

Office Address: _____ City: _____ State, ZIP: _____

* Phone: _____ * Email: _____

AMEX, MasterCard and VISA accepted Account # _____ Exp. date: _____

** Phone number and email are required for registration.*

SEATING IS LIMITED; LIMIT two people per office. CUTOFF: 75 People, **REGISTRATION REQUIRED PRIOR TO DAY OF SEMINAR.

Make check payable and mail to: AMCNO, 6100 Oak Tree Blvd., #440, Independence, OH 44131 or by credit card: fax to 216.520.0999 or call 216-520-1000. For more information visit our website at <http://www.amcno.org>

**Payment also accepted day of seminar at registration.

