

The Road to “Meaningful Use” EHR Stimulus Payments

By Amy S. Leopard, Walter & Haverfield LLP

On July 28, 2010, the Centers for Medicare and Medicaid Services (CMS) published a final rule regarding what constitutes the “meaningful use” of electronic health records (EHRs) (the “Meaningful Use Rule”) for physicians interested in qualifying for EHR incentive payments from Medicare and Medicaid under the the American Recovery and Reinvestment Act of 2009 (ARRA).¹ The Meaningful Use Rule addresses many of the issues and recommendations from providers and associations on the proposed rule, including comments submitted by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO).²

At the same time, the HHS Office of the National Coordinator (ONC) for Health Information Technology issued a related final rule on the standards EHR vendors must meet in order to have their EHR technology certified for use by physicians to qualify for the EHR incentive payments (the “Certified EHR Technology Rule”). Now,

providers and their vendors have a fairly clear picture of what it will take to earn the EHR ARRA stimulus dollars.

Background on the Meaningful Use Rule
Congress established the ARRA EHR incentive program to incentivize providers to use EHR to improve healthcare delivery,

quality, efficiency and patient safety in a transformative way. Under this program, CMS will make EHR incentive payments to eligible professionals and hospitals who qualify for extra Medicare and Medicaid payments by (1) demonstrating use of a certified EHR technology in a meaningful manner, including e-prescribing for physicians; (2) connecting the certified EHR technology to exchange health information electronically to improve quality and care coordination; and (3) submitting clinical quality and other measures selected by HHS.

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AMCNO Meets with Region V the Centers for Medicare and Medicaid Services (CMS) Medical Director

One day prior to the release of the final meaningful use rules, AMCNO physician leadership met with Dr. Derek Robinson at the AMCNO offices. Dr. Robinson is the new Medical Director for the Centers for Medicare and Medicaid Services (CMS) in Region V. Region V encompasses Ohio, Michigan, Indiana, Minnesota, Illinois, and Wisconsin.

In addition to discussing the AMCNO comments on the meaningful use rules, the AMCNO outlined several other concerns — the most prevalent of which was the issue of the ongoing Medicare payment problem and the lack of action on the part of Congress to scrap the SGR formula. Every year there are delays and changes in the debate in Congress but there has been no permanent solution to

the problem. The AMCNO representatives also noted that with all the new rules coming forward from CMS and the Office of the National Coordinator dealing with e-prescribing, meaningful use, as well as the need to install an electronic health record and track quality items through the Physician Quality Reporting Initiative (PQRI) initiative the

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Dr. Robinson, Region V Medical Director (center) poses with AMCNO physician leadership – left to right Dr. James Sechler, Dr. Laura David, Dr. Robinson, Dr. Ronald Savrin and Dr. George Topalsky.

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CMS established a three-stage, graduated approach to meaningful use. Each biennial stage will include criteria that become more stringent over time. The stages contemplate an evolution from initially just capturing and using health information in a structured format to tracking clinical conditions and using health IT for order entry, result reporting and improving quality at the point of care, and finally to interoperability among EHR technologies with clinical decision support.

The final rule covers the first two (2) years of the incentive program, which begins as early as 2011 under Medicare. CMS will propose the next two stages of criteria for meaningful use through future rulemaking. For the first payment year only, physicians may demonstrate meaningful use of certified EHR technology over any continuous 90-day period within a calendar year - allowing physicians using certified EHR technology in a meaningful manner as late as October 1, 2011 to qualify for incentive payment for 2011. After the first year, however, physicians must demonstrate meaningful use for the entire calendar year.

Medicare EHR Incentive Program

As originally set forth in ARRA and the proposed rule, Medicare EHR incentive payments for eligible professionals will be 75% of Medicare fee-for-service allowable charges up to an annual cap for up to five years beginning in calendar year 2010. (See Medicare Incentives Table pg. 6.) Eligible professionals can receive up to a total of \$44,000 over a five-year consecutive period, including \$18,000 in the first year for early adopters qualifying by calendar year 2012. Eligible professionals must begin by 2014 and the last payment year is 2016. Eligible professionals furnishing more than 50% of their Medicare covered services in a health professional shortage area (HPSA) earn an additional 10%. Eligible professionals who do not establish meaningful use by 2015 will face reductions in their Medicare fee schedule.

Medicare carriers will pay physicians demonstrating meaningful use in a single lump sum payment during each annual reporting period. The payments will be made to the physician or to a single employer under a valid Medicare reassignment. Physicians cannot allocate payments among multiple entities. Most health systems and group practices will want to review their employment and professional contractor agreements and determine who is entitled to receive the payments. CMS makes clear that the purpose of the Medicare EHR incentive payments is not

to be a reimbursement or cost pass through of software costs to encourage purchasing and adopting EHR technology, but to be an incentive to actually use the EHR technology in a manner that supports the HITECH health policy priorities.

Medicaid EHR Incentive Program

Medicaid payments will be made through the states and states must prepare a health information technology plan to receive the CMS match for their EHR incentive programs. The Medicaid incentive program will allow eligible professionals and hospitals to qualify for initial payments before achieving meaningful use. Eligible professionals who adopt, implement, or upgrade their certified EHR technology in the first payment year are still eligible for Medicaid payments during the first participation year only and do not have to meet the meaningful use objectives and associated measures of the Stage 1 criteria until the second participation year.

CMS defines this as requiring eligible professionals to at least (1) acquire, purchase or secure access to certified EHR technology, (2) install or begin utilization of certified EHR technology capable of meeting meaningful use requirements, or (3) upgrade from existing technology to certified EHR technology or add new functionality to meet the definition of certified EHR technology at the practice site, including staffing, maintenance, and training.

The Medicaid EHR incentive program pays eligible professionals up to \$63,750 over a 6-year period for most physicians. (See Medicaid Incentives Table pg. 6.) The maximum Medicaid incentive payment is \$21,250 in the first payment year and \$8,500 annually in five subsequent years, with pediatricians in the 20-29% Medicaid patient volume corridor receiving one-third less. There is no HPSA bonus. Physicians must enter the Medicaid EHR incentive program by 2016 to receive full Medicaid incentive payments available through 2021.

Consistent with the proposed rule, CMS allows that the Medicaid payment amount for any particular professional to be reduced for EHR technology or support service payments received from outside sources other than state or local governments. This reduction can be up to \$29,000 in the first year or \$10,610 in subsequent years. However, technology provided through an employer-employee relationship, vendor discounts, and in-kind contributions do not need to be backed out.

Multiple Programs

Unlike hospitals that may obtain both Medicare and Medicaid incentives, physicians must choose between the Medicare and Medicaid EHR incentive program. However, a one-time switch between programs can be made before 2015. Choosing between the two programs requires an analysis of the different payment amounts, years and whether the physician has received any cash support payments (e.g., hospital EHR donations).

In the final rule, CMS allows eligible professionals to also participate in the Medicare Physician Quality Reporting Initiative (PQRI) and the Medicare EHR Demonstration while participating in the Medicare EHR Incentive Program. However if an eligible professional participates in the Medicare e-prescribing incentive program, they cannot participate in the Medicare EHR Incentive program in the same year, but could choose to participate in the Medicaid EHR Incentive Program. HHS is required under the recent health reform legislation to develop a plan to integrate the EHR incentive programs and PQRI by January 1, 2012.

Eligibility and the Hospital-based Exclusion

The strongest recommendation from the AMCNO was that CMS should ensure the broadest possible physician participation allowed by statute. Medicare and Medicaid are separate and distinct programs with differing eligibility requirements, but physicians could qualify under either EHR incentive program. Under the Medicare program, the professionals eligible for the incentives are doctors of medicine or osteopathy, dental surgery and medicine, podiatrists, optometrists, and chiropractors participating in Medicare. Physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who practice predominantly in a federally qualified health center (FQHC) or rural health clinic (RHC) if it is led by PAs are all eligible for the Medicaid EHR program by meeting certain patient volume criteria. The Medicaid EHR program volume requirements are 30% of Medicaid patient encounters, with an allowance for pediatricians having at least 20% of Medicaid patient encounters to qualify at a reduced level, and a special formula allowing professionals who practice predominantly in FQHC and RHCs to meet the 30% threshold by serving needy individuals, such as patients covered by CHIP, sliding scale, and free care.

Hospital-based eligible professionals are not eligible for Medicare or Medicaid incentive

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payments. Unfortunately the ARRA definition was ambiguous and subject to a broad interpretation. CMS originally proposed to exclude all professionals furnishing 90% or more of their professional services in a hospital inpatient, outpatient or emergency department using place of service codes on the professional claim form to calculate eligibility. AMCNO was very concerned about the expansive definition of hospital-based physicians in the proposed rule and argued that CMS should interpret the statute considering the goals of ARRA to promote EHR adoption. The AMCNO argued that CMS should interpret the statute considering the goals of ARRA to promote EHR adoption and provided CMS with several alternatives consistent with the statute. In conjunction with area academic medical centers and integrated health systems, AMCNO estimated that this proposal would have a devastating effect on the number of local physicians eligible to participate.

AMCNO recommended that CMS eliminate the hospital outpatient department place of service code 22 from the exclusion criteria. On April 15, 2010, President Obama signed the Continuing Extension Act of 2010 to amend the statutory definition of hospital-based EPs. After reviewing public comments and the amendment, CMS revised the definition accordingly. Under the final Meaningful Use Rule, if more than 90% of an eligible professional's services on claim forms are provided in the Inpatient Hospital place of service code 21 or Emergency Department place of service code 23, the professional will not qualify for incentive payments. CMS estimates that the revised definition would exclude only 14% of Medicare eligible professionals, down from 27% in the proposed rule. This revised definition excludes many hospitalists and traditional hospital-based eligible professionals, but allows many primary care physicians and others practicing in a hospital outpatient department setting.

Realistic Objectives and Measures

AMCNO expressed concern in its comments over the breadth and depth of the objectives and measures required under the proposed rule and suggested that CMS scale back the measures to eliminate the "all or nothing" approach to qualification. In particular, the AMCNO expressed concern that requiring physicians to directly enter 80% of their orders for ancillaries, obtaining 50% of all lab results in the EHR, and requiring e-prescribing for 75% of permissible prescriptions were too high.

In a welcome relief, CMS lowered the thresholds for most objectives and provided for a core set of objectives and a menu (optional) set of criteria from which to choose. Beginning in Stage 1, eligible professionals must demonstrate that they meet a core set of 15 objectives, and a menu set allowing the professional to choose 5 out of 10 other measures. In Stage 2, all Stage 1 objectives will be core. (See page 6 for information on these objectives).

CMS also lowered the thresholds for many of the objectives it retained. For example, using computerized physician order entry (CPOE) for at least 80% of all ambulatory EHR orders was lowered to 30% of patients that have medication orders, with at least one medication ordered through CPOE. Eligible professionals will need to transmit more than 40% of all permissible prescriptions electronically. Professionals must implement at least one clinical decision support rule relevant to their specialty or high clinical priority and be able to track compliance with that rule, down from the 5 decision support rules initially proposed.

While lowering thresholds, CMS held the line on requiring health information to be recorded as structured data. The requirement to maintain an active problem list for at least 80% of unique patients must be recorded as structured data, and eligible professionals must still maintain at least 80% of all active medications and medication allergies as structured data.

Quality Measures

The AMCNO commented that the initial list of quality measures should be scaled back to a realistic level with only a few straightforward, achievable measures clearly identified for each specialty. Those measures should be evidence-based measures having full endorsement by the respective medical specialty societies **and** at the level of maturity where implementation specifications have already been developed. In the final rule, CMS limited the Stage 1 measures to those that are already in existence and not under development, but stated that they will seek to align the quality measures for Stage 2 with other quality measures development and reporting related to health care reform and other CMS quality measures programs.

Administrative Burdens

The AMCNO commented that CMS should streamline the administrative burden on physicians for easier creation of the compliance documentation, especially considering the technical criteria and the potential for manual

calculations. In 2011, eligible professionals must submit aggregate clinical quality measure numerator, denominator, and exclusion data to CMS or the States by attestation, and CMS now estimates about 9 1/2 hours for Eligible Professionals to attest and report objectives and quality measures during the first year. Despite commentator concerns that CMS compliance burden estimates were far too low, CMS says it believes that EHR technology will help reduce the burden as it evolves to calculate the clinical quality measures required for meaningful use incentives. State Medicaid programs will have some flexibility on how they approach provider compliance documentation, although CMS will review the state attestation and provider reporting mechanisms before they are implemented.

The EHR Technology Rule

What is most important is that the EHR technology not only meet the certification criteria, but actually be certified. ARRA requires providers to use EHR technology certified by ONC. The Certified EHR Technology Rule adopted by ONC provides certification standards and a pathway for EHR vendors to have their technology certified, either as a complete EHR or as one or more EHR modules.

Vendors are now gearing up to ensure that their software has the capabilities required or can work with other certified modules to allow providers to meet the minimum standards for an EHR, including the standards for demographics, history and problem list, clinical decision support, physician order entry, quality measures, and exchanging information. Eligible professionals should be working with their vendors to confirm that the vendor can and will pursue certification of the technology under the initial standards and is committed to ramping up over the three stages.

The AMCNO plans to continue to provide our members with educational materials and updates on this issue in the coming months.

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¹ This article updates "The Proposed Pathway for Achieving 'Meaningful Use' and EHR Stimulus Payments," *Northern Ohio Physician* (March/April 2010).

² The AMCNO comments on the January 2010 proposed rule are posted on the website. ■

The Ohio Health Information Partnership (OHIP) to Assist Physicians with Electronic Health Record Selection and Meaningful Use Incentives

Do you have an electronic health record (EHR) system? If you do, will you be able to collect \$44,000 or \$63,750 from Medicare or Medicaid with your system? If you aren't sure or need help setting up an EHR system, the Ohio Health Information Partnership (OHIP) is here to help.

The Ohio Health Information Partnership (OHIP) is a non-profit entity, funded through a combination of state and federal grants, to assist physicians and other providers with implementation and adoption of health information technology (HIT) throughout Ohio.

OHIP's Mission

OHIP was created as a result of two grant awards created from the American Recovery and Reinvestment Act (ARRA) legislation that was enacted in 2009. OHIP's mission is to improve the quality and value of health care by allowing authorized providers to have access to a patient's health information regardless of the care setting. The overall goal of OHIP is to improve health care quality, outcomes and experience for the citizens of Ohio.

OHIP is committed to assisting 6,000 physicians adopt and "meaningfully use" an EHR by 2012. Nationally, the goal is to have 100,000 physicians adopt an EHR within the next few years. By the end of the decade, the U.S. Department of Health and Human Services would like to have at least 75% of all physicians adopt an EHR.

Statewide Health Information Exchange

One of OHIP's two grant awards was funding to build a statewide health information exchange (HIE) for Ohio. The purposes of the grant and subsequent HIE are to accelerate the electronic exchange of health information among health care providers, hospitals, labs, pharmacies and other groups and to ensure that the exchange conforms to all established privacy and security requirements.

Qualifying for Federal Incentives

OHIP's other grant award provided funding to create a Regional Extension Center (REC) that would be responsible for assisting Ohio providers with the purchase, adoption and implementation of electronic health records (EHRs). This grant allows OHIP to provide subsidized services that will offer practice workflow redesign and implementation assistance to make the selection of an EHR system easier for health care providers. OHIP also plans to promote greater EHR adoption by:

1. Providing physicians and other providers with access to free or low cost experienced consultants who will work with individual

practices to provide assistance throughout the selection, adoption, implementation, and use of an EHR. OHIP will work through seven Regional Partners who have a wide range of EHR expertise to make the EHR adoption process easier and quicker.

2. Vetting EHR vendors to identify those that are best able to meet practice needs and negotiating discounts with those vendors.
3. Helping providers meet "meaningful use" standards. Meeting these standards, which were recently defined by the Office of the National Coordinator, is necessary in order to qualify for financial incentives through Medicare and Medicaid.

In addition, OHIP will be identifying sources of low interest loans for providers who wish to purchase an EHR.

OHIP: Providing Services through its Seven Regional Partners

To assure that health care providers in Ohio have access to easily reachable, hands-on help in selecting, implementing, and achieving "meaningful use" OHIP has contracted with seven Regional Partners which act as the technical assistance arm for adoption of EHRs. The Regional Partners in conjunction with OHIP will work with health care providers in their individual regions, offering individual practices an array of consulting services, including education, outreach, and technical assistance. Also included will be discounted certified EHR offerings and a health IT loan program.

- Provide the educational tools that practices need to understand the maximum benefits available in implementing an EHR system.
- Assist in defining practice-specific technical and functional requirements.
- Assist in the selection and acquisition of a certified EHR system.
- Provide information regarding the low-cost loans available through OHIP to enable practices to purchase the equipment they need.
- Serve as liaison between practices and EHR vendors regarding the technical assistance they need to "go live."
- Help practices meet federally-mandated "meaningful use" requirements. NOTE: If/when it is documented these standards

are met, the practice could then qualify for the Medicare/Medicaid financial incentives for adoption of an EHR that are being made available through the American Recovery and Reinvestment Act of 2009.

Qualification Requirements and Cost for Regional Partner Services

The cost of the Regional Partner services is subsidized for primary care providers (PCP): MDs or DOs who are family physicians, general internists, pediatricians or obstetrician/gynecologists (board certification not required) and who practice in individual or group settings of fewer than ten physicians.

Other qualifying primary care providers are nurse practitioners, nurse midwives, and physician assistants with prescriptive privileges. Priority is also given to PCPs who provide primary care services in the following settings: (1) public or critical access hospitals; (2) Federally Qualified Health Centers (FQHCs); (3) rural health clinics; and (4) other settings for predominantly uninsured, underinsured, or medically underserved populations. Direct technical assistance will be capped at the ten-provider level for groups with more than ten physicians/providers.

Qualifying for Federal Financial Incentives

As part of the overall effort to increase the adoption rate of EHR, the Centers for Medicare and Medicaid Services is offering financial incentives to Eligible Professionals (EPs) for attaining meaningful use.

The term "meaningful use" describes a set of objectives that providers must meet to demonstrate that they are using their certified EHR software in a meaningful way. Providers must be able to demonstrate "meaningful use" in order to qualify for federal financial incentives. The measures that are used to gauge meaningful use are meant to improve health care quality, efficiency, and patient safety.

There are five goals of Meaningful Use:

1. Improve quality, safety, efficiency, and reduce health disparities.
2. Engage patients and families.
3. Ensure adequate privacy and security protections for personal health information.

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ELECTRONIC HEALTH RECORDS

The Ohio Health Information Partnership (OHIP)

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4. Improve population and public health.

Are you eligible? How do you qualify? What are the timelines and deadlines? How do you register? For answers to these questions and the specifics about the program go to www.ohiponline.org or email info@ohiponline.org or contact one of the regional extension centers in the Northern Ohio region listed below:

REGIONAL CONTACTS:

Case Western Reserve University,
Joseph Peter, joseph.peter@case.edu
(216) 368-5756 (For counties: Ashtabula, Cuyahoga, Geauga, Lake, and Lorain)

Akron Regional Health Foundation,
Marianne Lorini, mlorini@arha.org
(330) 873-1500 (For counties: Ashland, Carroll, Harrison, Holmes, Medina, Portage, Richland, Stark, Summit, Tuscarawas, and Wayne.) ■

Medicare Incentives

Calendar Year	First Calendar Year in which EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015-subsequent years
2011	\$18,000	-----	-----	-----	-----
2012	\$12,000	\$18,000	-----	-----	-----
2013	\$8,000	\$12,000	\$15,000	-----	-----
2014	\$4,000	\$8,000	\$12,000	\$12,000	-----
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	-----	\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

Medicaid Incentives

Calendar Year	2011	2012	2013	2014	2015	2016
2011	\$21,250	-----	-----	-----	-----	-----
2012	\$8,500	\$21,250	-----	-----	-----	-----
2013	\$8,500	\$8,500	\$21,250	-----	-----	-----
2014	\$8,500	\$8,500	\$8,500	\$21,250	-----	-----
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-----
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-----	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-----	-----	\$8,500	\$8,500	\$8,500	\$8,500
2019	-----	-----	-----	\$8,500	\$8,500	\$8,500
2020	-----	-----	-----	-----	\$8,500	\$8,500
2021	-----	-----	-----	-----	-----	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

WHAT PHYSICIANS NEED TO DO

For the first round of Medicare and Medicaid EMR bonuses in 2011-12, physicians must meet 15 core objectives and at least five of 10 "menu set" items. Each objective has a measure to determine if an EMR was used to perform the function for an appropriate number of opportunities:

Core set (must meet all)

- Record patient demographics
- Record vital signs/chart changes
- Maintain current and active diagnoses
- Maintain active medication list
- Maintain active allergy list
- Record adult smoking status
- Provide patient clinical summaries
- Provide electronic health information copy on demand
- Generate and transmit prescriptions electronically
- Use computerized physician order entry for drug orders
- Implement drug-drug/drug-allergy interaction checks
- Be capable of electronic clinical information exchange
- Implement one clinical decision support rule
- Protect patient data privacy and security
- Report clinical quality measures to CMS or states

Menu set (can defer up to five for 2011-12)

- Implement drug formulary checks
- Incorporate clinical lab test results
- Generate patient lists by condition
- Identify patient-specific education resources
- Perform medication reconciliation between care settings
- Provide summary of care for transferred patients
- Submit electronic immunization data to registries
- Submit electronic epidemiology data to public health agencies
- Send care reminders to patients
- Provide timely patient electronic access to health information

Source: Centers for Medicare & Medicaid Services

http://www.cms.gov/EHRIncentivePrograms/Downloads/NPRM_vs_FR_Table_Comparison_Final.pdf

http://www.cms.gov/EHRIncentivePrograms/Downloads/EHR_Incentive_Program_Agency_Training_v8-20.pdf

This article in the *New England Journal of Medicine* provides another table outlining the menu sets.

"The 'Meaningful Use' Regulation for Electronic Health Records," *New England Journal of Medicine*, July 13 (healthcarereform.nejm.org/?p=3732)

Medicaid Conducts a Learning Session on the Medicaid Provider Incentive Payment Program (MPIP)

In August, the AMCNO staff was pleased to participate in a strategic learning session conducted by the Ohio Department of Job and Family Services (ODJFS), Office of Ohio Health Plans concerning the State Medicaid Health Information Technology Plan, and the Medicaid Provider Incentive Payment Program (MPIP) at Case Western Reserve School of Medicine (CWRU). The MPIP program offers \$63,750 over six years to eligible professionals who adopt and meaningfully use certified electronic health records (EHRs). It can also apply to professionals who upgrade their existing EHR capabilities. Hospitals are also eligible to participate in the MPIP program.

State Medicaid executive leadership provided an overview of Ohio Medicaid's goals regarding health information technology and participants provided their input on the incentive program. Participants discussed the adoption of EHRs, the history of meaningful use, and the hurdles providers will face to meet Stage 1 meaningful use criteria.

As noted in the meaningful use article on page one in this issue, eligible professionals (EPs) for Medicaid include physicians (pediatricians have special eligibility and payment rules), nurse practitioners, certified nurse midwives, dentists and physician assistants (PA) who

lead a federally qualified health center or rural health clinic that is directed by a PA. Patient volume must be at 30% with the exception of pediatricians (20%). Medicaid is different than Medicare in that — EPs may adopt and implement in 2011 and be up and running by 2012 in order to qualify. The meaningful use definition will be common with Medicare, however, under Medicaid states can choose to adopt more rigorous definitions. An example of this might be reporting of public health measures through a registry. The last year an EP may initiate the Medicaid program is 2016 with the final payment in 2021, and there are no penalties or payment adjustments in this program.

ODJFS representatives have been traveling around the state of Ohio trying to gather information from providers, consumers and others regarding the roll out of this plan. In order for Ohio Medicaid to receive the federal money for this program CMS had to approve their plan to work with stakeholders to define Ohio's current state of HIT and EHR, where Ohio plans to be in five years with regard to HIT and EHR, and a road map for getting to the vision and the basis of the MPIP program — i.e., their State Medicaid Health Information Plan (SMHP) and Ohio's I-APD (implementation of the plan). Ohio Medicaid representatives are working to define these parameters with the intent to develop and submit the SMHP to CMS by November and then develop and submit the I-APD to CMS upon approval of the SMHP. The planned implementation of MPIP is the Spring of 2011. ODJFS cannot start building incentive payment software until after their plan has been approved by CMS. ■



Over the summer months, the AMCNO assisted the CWRU-REC in setting up informational sessions in order to garner information from physicians about their use of electronic health records and in order to provide background on the purpose of the REC. Participants requested additional information and written materials on the program. The AMCNO is working with the Ohio Health Information Partnership (OHIP) as a member of the OHIP communications committee as well as with the CWRU-REC on this initiative and we will continue to provide educational materials to our members and other physicians in the region.

HITECH Temporary Certification Program for EHR Technology

The Office of the National Coordinator for Health Information Technology (ONC) released a final rule outlining certification for electronic health record (EHR) technology in June. The Health Information Technology for Economic and Clinical Health (HITECH) legislation directs ONC to support meaningful use of "certified" EHR technology through the adoption of standards and implementation specifications.

The final rule outlines how organizations can become ONC-Authorized Testing and Certification Bodies (ONC-ATCBs) This will ensure that certain types of EHR technology (complete EHRs and/or EHR modules such as e-prescribing software) are compliant with the standards, implementation specifications and certifications criteria adopted by the government and that the technology meets the definition of "certified EHR technology." In order to qualify for incentive payments, medical groups must implement EHR technology that has been certified by an ONC-ATCB.

Although the Certification Commission for Health Information Technology (CCHIT) has been certifying EHR software since 2006, previous CCHIT certification is not sufficient to qualify for the incentives. Multiple organizations are expected to apply for ONC-ATCB status, including CCHIT.

Physicians engaged in selecting EHR software are urged to review the qualifications of all ONC-ATCBs. For more information on the above HIT initiatives go to:

ONC EHR incentive program website: <http://healthit.hhs.gov>
ONC Temporary Certification Program: <http://healthit.hhs.gov/tempcert>
Medicare and Medicaid EHR incentive programs: cms.gov/EHRincentivePrograms/

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AMCNO Legislative Update

By Messrs Mike Caputo and Mike Wise, AMCNO Lobbyists

Physician Ranking Legislation Update

The number one legislative priority of the AMCNO continues to be the physician ranking Bills. The purpose of this legislation is to provide the patient with accurate information when selecting a physician. The Bills would prevent the health insurance company from ranking physician solely based on specific criteria such as cost efficiency. Instead, the legislation will establish standards for the physician designations. It stresses that health plans must use risk-adjusted data, base grades, and ratings at least in part on nationally recognized quality of care measures. The legislation also allows physicians the right to review and appeal their ratings prior to the ratings being released to the public.

The AMCNO worked with Representative Boyd and Senator Patton to introduce legislation in both the Ohio House and Ohio Senate. HB 122, sponsored by Representative Boyd was introduced April 2, 2009 and passed the full House on February 3, 2010 by a vote of 97-1! Before passage, a Substitute Bill was negotiated by the AMCNO that included changes to give the Ohio Department of Insurance rulemaking authority, extend timelines and appeals, extend the scope of the bill to third party administrators, and have the Ohio Department of Insurance approve the appointment of the independent ratings examiner.

Senator Patton introduced the Senate version of the Bill on April 7, 2009. Both Bills are now pending in the Senate Insurance Committee that is chaired by Senator Buehrer. The process in the Senate has been slowed due to the active opposition of the Ohio Association of Health Plans (OAHP). OAHP voiced its concerns about HB 122 and SB 98 on March 9, 2010 in testimony before the Senate Insurance Committee. This testimony focused on allowing the Health Plans to work out their systems without state legislation. Here is an excerpt from that testimony:

“As you know, consumer engagement in their healthcare decisions is critical at a time when health care costs are spiraling and the quality of health care outcomes documented are varying dramatically across the country. Additionally, more employers, government entities and other

groups are pushing for the development of information systems that provide interactive tools that among other things help consumers’ research costs and quality outcomes. In response, health plans across the country have begun to provide information to their enrollees to help them make informed decisions to optimize their health. As a result of these varying “designation” systems and recognizing a need for establishing national guidelines for public reporting of performance, a group of leading consumer, labor and employer organizations formed the Consumer-Purchaser Disclosure Project. This group developed The Patient Charter which is endorsed by AARP, AFL-CIO, The Leapfrog Group, and others. The charter provides criteria for physician performance measurement, reporting and tiering programs. The benefit of the work of this group is to achieve consistencies in how the programs are developed and operated, and to avoid varying differences that often occur with passage of state by state legislation. Therefore, we encourage you and your colleagues to consider allowing the Patient Charter to continue to operate unfettered by state legislation.”

This “no legislation” position of the Health Plans is not acceptable to the Academy. Therefore, the Academy is negotiating with the Senate on changes to our legislation that improve on the status quo without overly compromising on the core principals of the legislation. These negotiations will intensify through the balance of September. If a compromise can be reached, there is still time in this General Assembly to pass this legislation. The legislators will be returning to Columbus after the November elections and will stay into mid-December. If legislation is not completed by December, it will have to be re introduced next year and pass through the full legislative process.

State Election Update

There are many unknowns facing state government beginning January of 2011. For instance, no one knows who will be living in the Governor’s mansion. Additionally, no one can say with certainty which political party will control the Ohio House of Representatives. What is known, however, is that the next Governor, Speaker of the

House and the rest of Ohio’s elected leadership will face a budget crisis unlike anything previously contemplated.

Over the last several years, Ohio’s budget officials have applied a number of tactics to balance our state budget, a constitutional requirement. Transfers of funds from one account to another, the depletion of the state’s Budget Stabilization Fund, also referred to as our “Rainy Day Fund,” and the massive utilization of federal funds for ongoing operational purposes have enabled the state to ensure a balanced budget without significant tax increases.

Unfortunately, very few of these measures provide an ongoing source of revenue for the state. Consequently, Ohio is facing a structural budget deficit far more dire than anything that has been managed for quite some time. Specifically, the Ohio Legislative Service Commission has determined that approximately \$8.4 billion of funds currently being used to balance our existing state budget will not be available for the next biennium. Said another way, roughly 17 percent of the state’s operations have no funding source that has been identified in order to continue.

Adding even greater challenges to Ohio’s budget efforts over the next biennium are the continued decline of sales and income tax receipts — Ohio’s two main sources of revenue, and the continued growth of the state’s Medicaid rolls.

For these reasons, the discussion of what to do with the Fiscal Years 2012-2013 budget has already taken center stage at our state capital, and it will remain there until June 30, 2011, when the budget must be signed by the Governor, whomever that may be.

That is what we know. What is unknown is how our state’s elected leadership will rectify this situation. Naturally, not knowing the results of this coming November’s elections — when all of Ohio’s statewide constitutional offices, every Ohio House of Representatives seat and half of the Ohio Senate seats are up for election — make a prediction very difficult, there are only truly a few ways for Ohio’s budget to remain in balance; significantly increase revenue i.e. raise taxes and fees, significantly reduce funding i.e. cut virtually all discretionary programs or do both.

(Continued on page 10)

LEGISLATIVE ACTIVITIES

(Continued from page 9)

Because of the fall elections, no one wants to offer specifics on how they are going to fix the budget (voters don't elect people who promise to gut programs and/or raise taxes), but this will likely change November 3rd, the day AFTER the election.

That being said, each candidate for Governor has slightly tipped his hand. Congressman Kasich has vowed not to raise taxes. While one can argue that what is said in a campaign may not mean much after that candidate is elected, reducing the tax burden in this state has been such a central theme of Congressman Kasich's campaign that it seems unlikely such a reversal would occur.

Conversely, budget guidance offered by Governor Strickland's Office of Budget and

Management may suggest, one could argue, that part of his plan to balance the next budget, will in fact depend on raising revenue via tax and fee increases. Specifically, his budget office has asked each state agency to submit budget requests under two scenarios; a zero percent reduction in funding from the current biennium and a ten percent reduction for the current biennium. Neither scenario reduces enough spending to offset the structural deficit faced by the state, which suggests that Governor Strickland may be leaning toward a hybrid approach of reducing cost and increasing revenue to balance the budget.

Whichever candidate wins in November, and whatever budget balancing option is ultimately embraced, the effect on the medical service provider industry may be significant. Services currently exempt from the state sales tax may no longer be.

Medical equipment currently exempt from the state sales tax may no longer be. Reimbursement rates under the state's Medicaid program may be substantially reduced. Medical procedures covered under Medicaid may no longer be. These are just a few of the potential outcomes of this budget debate that could affect the membership of the AMCNO.

It is not too early to begin reaching out to our elected officials, in an effort to protect our interests as medical service providers. Our advocacy team is already working toward this end. Much work lies ahead though, and the stronger our voice in Columbus the more we can ensure continued care of your patients. If you would like to become more involved with our Government Affairs efforts, please contact the AMCNO. ■



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AMCNO LEGISLATIVE ACTIVITIES

NOMPAC: Working on Behalf of Northern Ohio's Physicians A message from the AMCNO Legislative Committee

Election Day is right around the corner – and again physicians are faced with myriad issues. Whether you agree or not, many health care issues and medical care options are decided by the legislature and government entities.

There are two choices – either get engaged or leave it to the legislators and government to set the agenda. The AMCNO believes physicians should get engaged in the process. We realize that most physicians do not want to drive down to Columbus and talk to legislators about health care issues. And for the most part most physicians do not want to interact with government entities. If you are one of those physicians, there is another way you can help set the agenda.

Encourage your colleagues to join the AMCNO – the organization is geared to

address legislative issues as well as providing avenues to share your viewpoints and perspectives along with your patients' concerns. For those physicians who have chosen to be active within the Academy of Medicine of Cleveland & Northern Ohio, we need your support and voice.

AMCNO members should become acquainted with an important organization connected to the AMCNO: NOMPAC, the Northern Ohio Medical Political Action Committee. NOMPAC was established to provide a mechanism for the AMCNO members to use the "PAC" model in

support of legislators who support your perspectives and your patients' perspectives during the election process.

Without NOMPAC's voice, patients and physicians in Northeast Ohio would find themselves less represented at crucial times when decisions are made that significantly impact both. It is well understood that a strong NOMPAC requires significant revenues to have an impact during important election campaigns. We must support candidates who have been supportive of issues important to patients and physicians. A NOMPAC mailing will be arriving in your office soon – please take the time to read the information and consider a donation to NOMPAC.

Ohio Supreme Court Candidates Meet with AMCNO Physicians

Over the summer months, the AMCNO through our political action committee – NOMPAC, endorsed the campaigns of Ohio Supreme Court Justices Maureen O'Connor and Judith Lanzinger. We believe that in order to maintain a court that will interpret the law and not rewrite it we need to elect Justice Maureen O'Connor to Chief Justice for the Court and retain Justice Judith Lanzinger on the Ohio Supreme Court. These individuals are dedicated to further establish and preserve the principles of judicial fairness.

Both justices attended a fundraiser at the home of the AMCNO Vice President of Legislative Affairs, Dr. John Bastulli in August. NOMPAC also supported the event. The session was well attended by both physicians and attorneys alike. Both justices provided comments to the attendees. Visit the NOMPAC web site for background and information on the candidates www.nompac.com



Justice Maureen O'Connor (left) spends a moment with Ms. Amy Leopard from the law firm of Walter and Haverfield, LLP.



Justice Lanzinger greets Dr. William Seitz, Jr., past president of the AMCNO.



Justices O'Connor and Lanzinger pose with the AMCNO Vice President of Legislative Affairs and the host of the fundraiser, Dr. John Bastulli and AMCNO officers. Left to right – Dr. Anthony Bacevice, Jr., AMCNO Immediate Past President, Dr. Laura David, AMCNO President, Justice O'Connor, Justice Lanzinger and Dr. John Bastulli.

AMCNO Voting Guide for Members Available Soon!

The Academy of Medicine Cleveland & Northern Ohio Legislative Committee, in concert with our lobbyists and Medical Legal Liaison Committee, is currently updating a voting guide for the upcoming election on Tuesday, Nov. 2, 2010. As always, a summary of issues and candidates will be provided and will be made available exclusively to our physician membership.

The guide will contain:

- District Information – District Number, Description, Map, and Partisan Index
- Background Information on the Democrat and Republican Candidates from our area as well as the candidates running in the statewide races, including their education and previous elected experience.
- Information on Common Pleas, Appellate and Supreme Court judicial candidates.
- Candidate responses to questions from the AMCNO Legislative Committee on issues affecting the practice of medicine in Northern Ohio.

Look for the AMCNO 2010 Voter's Guide in your mail soon! For information on any legislative issues the AMCNO takes positions on, contact Elayne Biddlestone at 216.520.1000.

NORTHERN OHIO PHYSICIAN

THE ACADEMY OF MEDICINE
OF CLEVELAND & NORTHERN OHIO

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AMCNO responds to 2011 CMS Proposed Medicare Physician Fee Schedule – Physician payment and GPCI calculation at issue

On behalf of our membership, the AMCNO submitted comments to the Centers for Medicare and Medicaid Services (CMS) in response to the Proposed 2011 changes to payment policies and rates under the Medicare Physician Fee Schedule (proposed rule CMS-1503-P). Our comments focused on the issue of the flawed sustainable growth rate (SGR) formula currently utilized by CMS to calculate physician payments under Medicare as well as items contained in the proposed rule relative to the geographic practice cost indices (GPCI) utilized by Medicare in Ohio.

The AMCNO noted that in addition to the approximate 23 percent Medicare physician payment cut scheduled to occur December 1, 2010, the proposed regulation includes provisions that would reduce 2011 Medicare payments by approximately 6.1 percent as a result of the sustainable growth rate formula (SGR). 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 AMCNO realizes that ultimately the administration and Congress will have to act in order to replace the SGR, however, CMS and its' administrators have the ability to review comments from physicians, physician organizations and other healthcare providers regarding the proposed payment and policy changes and try to find ways to improve physician payment without adding to overall Medicare costs.

Geographic Practice Cost Indices (GPCI) Locality

The AMCNO has many concerns regarding the usage of geographic practice cost indices (GPCIs) and we have provided our detailed comments to CMS in previous correspondence. To recap, it is our belief that

the boundaries of the payment localities do not accurately address variations in physicians' costs and in particular the AMCNO strongly believes that Medicare's geographic payment adjustment formula does not accurately reflect practice costs in Northern Ohio. As noted previously by the AMCNO, the state of Ohio is designated as a statewide locality. This is problematic for our physician members practicing in Northern Ohio because CMS has not revised the geographic boundaries of the physician payment localities since the 1997 revision. Also, since that year, CMS has indicated that the only mechanism the agency has set forth to modify the payment localities is for the state medical associations to petition for change by demonstrating that the change has the overwhelming support of the physician community. This mechanism for change in the payment localities seems biased since the state medical association does not represent all of the physicians in the state of Ohio. While the proposed rule does make a number of changes to the GPCIs in response to the Patient Protection and Affordable Care Act (PPACA), including a requirement that the Department of Health and Human Services (HHS) analyze current methods of establishing practice expense GPCIs and evaluate data that fairly and reliably establishes distinctions

in the costs of operating a medical practice in different localities; it does not make changes to the payment localities in Ohio.

The AMCNO is aware that CMS commissioned Acumen to conduct a study of alternative options for reconfiguring payment localities on a nationwide basis. We noted that the options provided in the Acumen report are once again outlined in the proposed rule, (CMS 1503-P), and of these the AMCNO would favor either Option 2 or Option 3. Option 2 would remove higher cost counties from their existing locality structure and each would be placed in their own locality, while Option 3 removes higher cost metropolitan service areas (MSAs) from the "rest of the State" locality. We believe that either of these proposed options would result in a fairer methodology for the physicians located in Northern Ohio. The proposed rule indicates that Acumen is conducting a more in-depth analysis of the dollar impacts that would result from the application of Option 3; however, as part of our comments the AMCNO encouraged CMS to require that Acumen conduct a similar analysis for Option 2 to ascertain the dollar impact of this option as well.

As the regional organization representing physicians in Northern Ohio the AMCNO continues to advocate for a change in the payment localities utilized in Ohio. Any questions regarding this issue may be forward to E. Biddlestone at the AMCNO at (216) 520-1000, ext. 100. ■

AMCNO Meets with Region V the Centers for Medicare and Medicaid Services (CMS) Medical Director

(Continued from page 1)

practice of medicine has become inundated with compliance issues. It can be a daunting task for physicians to comply with all of the new regulations. Dr. Robinson noted that CMS believes that all of these concepts will enhance the health care system and provide physicians with the ability to have access to patient records and avoid duplication. Medicare and Medicaid are the largest payers in the country and there is a real need to leverage these concepts and move this forward.

CMS is looking to align incentives and

determine what is safest and best for the patient — therefore, quality of care issues and distribution of payments are always points of discussion and review. The top priority right now for CMS is dealing with electronic health records and providing information on the meaningful use rules. CMS is working closely with the state regional extension centers (RECs) to get a sense of the level of preparation and outreach needed to make this work for physicians. The broader goal is not necessarily about the incentives but to move the healthcare

community into an electronic system.

With regard to the PQRI program CMS is looking for physician input and feedback on how that program is working and to offer assistance to physicians so that they can comply with the PQRI reporting. CMS believes that if all of these pieces are implemented it will create a better health care system. Dr. Robinson expressed a willingness to continue to meet with the AMCNO and the physicians in this community to discuss issues of importance to the practice of medicine. ■

UnitedHealthcare (UHC) Presents NowClinic Online Care Concept to the AMCNO Board of Directors

In June, members of the AMCNO Board of Directors were pleased to welcome Dr. Giesele Greene, former Northern Ohio medical director for UHC to the AMCNO board meeting. Dr. Greene, along with other UHC representatives provided an overview of the NowClinic concept. NowClinic is a service that provides real-time access to physicians through a computer with Internet access or by phone. OptumHealth and American Well have joined forces to create this nationwide service that offers patients the ability to access licensed physicians and clinicians 24/7. With NowClinic physicians can ask questions, discuss symptoms, review the patient's online record and medical history, if provided, and even write electronic prescriptions. The technology brings healthcare services online with live interaction between patients and available network physicians. All that is needed is a computer and access to the Internet to get together with patients. The concept is open to all physicians that are licensed to practice in the state of Ohio and physicians will be paid for their services.

One of the requirements is that any physician practicing in the NowClinic must be credentialed by the UHC network — and this is different than providing services for UHC — therefore it is possible for licensed Ohio physicians to be “credentialed” by UHC to provide these services even if they are not providing UHC services. Physicians can also set some parameters. For example, they can indicate that they only want to see established patients or only scheduled patients in this environment. These parameters can be reset by the physician as well.

Once a physician has reviewed an incoming patient request the physician can then determine if they want to connect with the patient — and they will then move into the “encounter” space. If the physician and patient are web camera enabled they can talk face to face or they can utilize a chat space. Anything that goes into the chat space becomes part of the permanent electronic health record. If the parties choose to connect via phone, phone numbers are kept confidential — and if there are any long distance calls no charge is made to either party. The program includes automated documentation and record keeping capabilities. Patients are prompted to send the encounter to their primary care physician if the encounter is with another provider. There is also a provision to prescribe medications powered by SureScripts, however, controlled substances cannot be prescribed in this environment.

Physicians will use their own professional and medical knowledge to determine whether an in-person visit is the best care management for the individual patient. If a physician determines at the outset of the NowClinic conversation that an in-person visit is required, the physician will notify the consumer, and in that event the fee will be waived. OptumHealth does not provide physicians with legal or business advice relating to how the service, consultation or delivery of health care is conducted.

The payment methodology for this service will be done through a credit card and will not be processed through UHC since no insurer covers this type of service, including UHC. The patient is charged for 10 minutes of time at a rate of \$45. A payment of \$25 goes to the doctor (this may be \$30 if the service is on a holiday or a weekend) and the rest of the payment is utilized for credit card and other fees — including medical malpractice coverage. The doctors participating in this environment do not have to worry about

the payment issues since the system moves the money into the physician account. The only expense for the physician is 10 minutes of their time, a telephone and access to the Internet. The medical malpractice coverage is provided by Lexington Insurance. The policy is independent of any other malpractice insurance policies and physicians enrolled in Optumhealth NowClinic are automatically covered by the insurance policy.

The AMCNO board commented to the UHC representatives that as this program rolls out there should be continued discussion about insurers paying physicians directly if they choose to take calls after hours or consult with their patients over the phone. UHC representatives noted that one of the reasons for doing this at this time is that many doctors do not take calls after hours and in fact their service or answering machine directs their patients to call 911 or go to the emergency room rather than leave a message since the doctor will not be taking calls. UHC believes that this concept will offset the costs and usage of emergency rooms and urgent care centers.

NowClinic online care launched in Texas in December 2009, and there are plans to launch this concept in Ohio in the near future. For more information go to www.MDnowclinic.com ■

2011 MEMBERSHIP DUES REMINDER

Support for The Academy of Medicine Cleveland & Northern Ohio (AMCNO) benefits all physicians in our region. Our focus continues to be steadfast on the issues that matter to you, your patients, and effect the way you practice medicine in Northern Ohio. Call the AMCNO's Membership Coordinator at 216-520-1000 and renew your commitment to organized medicine today!

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
is pleased to present:

Solving the Third Party Payor Puzzle 2010

Wednesday, November 17, 2010

Registration: 7:30 a.m. – 8:00 a.m.
Seminar: 8:00 a.m. – 4:00 p.m.



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AMCNO COMMUNITY ACTIVITIES

AMCNO Pollen Line Update

Robert W. Hostoffer, D.O., Theodore H. Sher, M.D. and Haig Tcheurekdjian, M.D., of the *Allergy/Immunology Associates Inc.* and their staff have been working hard over the summer to provide the daily pollen counts along with preventative methods to help allergy sufferers cope with the sniffing and sneezing brought on by the season.

In late June the AMCNO and Dr. Hostoffer and his two new fellows participated in another training session necessary to provide the service for the AMCNO. The AMCNO Pollen Line provides pollen counts Monday through Friday with reports recorded by 8 a.m. The doctors' report is updated daily, available via a telephone recording and at www.amcnoma.org.

The Pollen Line has been in existence for more than 48 years. The counts are used by local news stations, *The Plain Dealer* and many Northern Ohio residents who suffer from allergies and hay fever.

The public can call the free hotline at (216) 520-1050 or check out the AMCNO website to get a report on the density of the allergens, probable effects on those who are sensitive to such agents, and what precautions to take.

The AMCNO extends our sincere thanks to **Allergy/Immunology Associates, Inc.** for providing the daily pollen counts and for taking the time out of their practice to take the pollen count training necessary to provide the service for the AMCNO. ■



AMCNO provides training on the pollen counts (pictured left to right) Nicole Tierney, trainer, Dr. Hostoffer and two fellows, Drs. Swender and Wise.



The AMCNO pollen trainer illustrates how to utilize the pollen counting equipment.

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The AMCNO Board Adopts Health Insurer Code of Conduct Principles

The American Medical Association (AMA) Health Insurer Code of Conduct Principles. The AMA is calling on all U.S. health insurance companies to adopt consistent corporate practices that will bring transparency and accountability to the multibillion-dollar health insurance industry. The AMA has sent letters to the nation's eight largest health insurers seeking their pledge to comply with the National Health Insurer Code of Conduct Principles.

The code sets forth 10 principles that govern both the business and clinical aspects of health plans. By following these principles, health insurers can help create a more efficient, patient-centered health system. The code advocates for:

- Prohibition of cancellation or rescissions of policies because of mistakes on an application, or because a policyholder got sick or injured, or because insurer employees or contractors get bonuses for rescissions;
- Clear and transparent access to medical care, meaning benefits that are available to enrollees on a timely and geographically accessible basis at the preferred, in-network rate, and easily accessible physician directories that mark

those doctors who are out-of-network or only available on a tiered plan;

- Fair and transparent pricing and accounting of health insurance premiums, with most of the money spent on care;
- Respectful relations by plans with their enrollees, physicians and other partners, including fair contracting, protection of patients' medical information and "appropriate deference" to the physician's skill and judgment;
- Clear information on benefit restrictions to the patient and the physician, with benefits based on clinically appropriate medical guidelines;
- Medically necessary care defined by what a prudent physician would provide in a certain situation, rather than a definition for the economic benefit of the health plan;

- Elimination of complexity and confusion from health plan processes and communications;
- Physician profiling systems that use relevant data to focus on quality of care, not on reducing the cost of care;
- Health insurers to conduct their business with the highest levels of corporate citizenship, including complying with the letter of all laws affecting clinical and business operations;
- Health insurers to pay claims accurately and on time, and to provide explanations of how each claim was handled, as well as providing fee schedules, claim edits and pay policies that are disclosed and easily available.

At their June meeting the AMCNO approved the AMCNO endorsement of the AMA Health Insurer Code of Conduct Principles and agreed to list the AMCNO as a supporter of these principles on the AMA web site. The AMCNO plans to utilize this Code in future discussions with health insurers and the Ohio Department of Insurance. ■

Roth IRA Conversion..... Is it Right for You?

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

Roth IRAs can play an important role in retirement and legacy planning as they allow for tax-free growth and withdrawals that are not subject to required minimum distributions during the account owner's lifetime. If you have questions and wonder whether or not a conversion is right for you, we can help. Take advantage of the AMCNO member discount for a complimentary Roth conversion consultation.

Sagemark Consulting also offers comprehensive financial planning to help you with your goals in:

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MEMBERSHIP ACTIVITIES

Residents Join the AMCNO

The Academy of Medicine Cleveland & Northern Ohio (AMCNO) welcomed new residents this summer from the Cleveland Clinic Foundation, Fairview Hospital, Huron Hospital, MetroHealth Medical Center, South Pointe, St. John Westshore, St. Vincent Charity Hospital and University Hospitals.

In all, more than 350 new physicians joined the AMCNO as resident members. Membership entitles these new physicians to many benefits including receiving weekly updates on all manner of health care related news as well as legislative and regulatory updates under review by the Ohio General Assembly and the United States Congress, legislative representation at the state house by AMCNO lobbyists, listing in the membership directory, seminars, publications and opportunities to serve on AMCNO committees and more.



Edwin Jackson, M.D., a 2009 Academy of Medicine Education Foundation (AMEF) scholarship recipient spends a moment with Meghan Drayton, M.D., at the CCF residency orientation.

Welcome to all new resident members!

Do you know of a resident or medical student interested in free AMCNO membership? Direct them to apply online at www.amcnoma.org

Click on BECOME A MEMBER. ■



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DATE/TIME	TITLE	FEE	LOCATION
Sept 7-Oct 14 T & TH	Medical Terminology (36 hours)	\$325	CCW
Sept 13-Oct 20 M & W	Medical Terminology (36 hours)	\$325	CCE
Sept 15 9:00 am-3:30 pm	ICD-9 Fundamentals and More! (6 CEU)	\$199	CCE
Sept 18-Nov 14 Saturday mornings	Accelerated AAPC Professional Medical Coding Curriculum (36 hours)	\$950	CCE
Sept 27-Oct 20 M & W 9:00 am-12:00 pm	Fundamentals of Billing Reimbursement (24 hours)	\$325	UTC
Sept 28 M & W 9:00 am-12:30 pm	Confident Communication with Physicians about Coding Issues (3.5 CEU)	\$159	IFHC
Oct 4-Nov 10 9:00 am-12:00 pm	M & W Medical Terminology (36 hours)	\$325	UTC
Oct 6 9:00 am-3:30 pm	CPT Coding Fundamentals and More! (6 CEU)	\$199	CCE
Oct 12-Nov 4 M & W 9:00 am-12:00 pm	Fundamentals of Billing Reimbursement (24 hours)	\$325	UTC
Oct 12-Nov 4 T & T 6:00 pm-9:00 pm	Fundamentals of Billing Reimbursement (24 hours)	\$325	CCE
Oct 20 8:00 am-12:30 pm	ICD-10 Preparation Fundamentals of Structure plus Anatomy, Physiology & Terminology Review (4.5 CEU)	\$135	CCE
Oct 27 8:30 am-12:30 pm	The Ins and Outs of Surgery Coding (4 CEU)	\$169	CCE
Nov 3 8:30 am-12:30 pm	Chart Auditing Workshop and Compliance Update (4 CEU)	\$169	CCW
Nov 10 8:30 am-11:30 am	Modifier Clinic: Reduce Audit Risks and Ensure Accurate Reimbursement (3 CEU)	\$159	IFHC
Dec 9 8:30-11:30 am	ICD-9 and CPT Coding Updates for 2011 (3 CEU)	\$159	CCE

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Locations

Corporate College East 4400 Richmond Rd. Warrensville Hts, OH 44128	Corporate College West 25425 Center Ridge Rd. Westlake, OH 44145	Independence Family Health Center Crown Centre II 5001 Rockside Rd. Conference Rm B Independence, OH 44131	Unified Technologies Center 2415 Woodland Ave. Cleveland, OH 44115
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ANNUAL FOUNDATION FUNDRAISER

2010 AMEF Golf Outing

Golfers enjoyed the Kirtland Country Club on August 9, 2010 at the Academy of Medicine Education Foundation's (AMEF) seventh Marissa Rose Biddlestone Memorial golf outing. Foursomes competed in a shotgun start tournament that raised more than \$38,000 for AMEF. The funds will be utilized for medical student scholarships, annual CME seminars and the *Healthlines* radio program. The 2010 AMEF scholarship recipients were invited to join the group for dinner: Shamima Ahmed, NEOUCOM, Timothy Anderson, CWRU, Alexandria Howard NEOUCOM, Andrew Ibrahim CWRU, Craig Jarrett CCF Lerner, and Priya Malik, CCF Lerner.

1st Place Team

Sagemark Consulting, Jim Doan, Bill Hogsett, Jim Hrivnak, Phil Moshier

2nd Place Team

The Endoscopy Center at Bainbridge, Bruce Cameron, MD; Kevin Geraci, MD; Mike Koehler, MD; Greg Lincoln

3rd Place Team

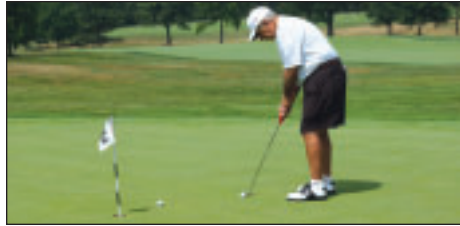
Medical Mutual, Richard Below, MD; Chris Harris, Paul Mancino, Ken Sauer

Prizes were also awarded for the following:

Closest to the pin: Tom Maloney, Tom Turner, Joe Orosz, and John Bastulli, Jr.

Longest drive: Dan McLaughlin, Bill Lynch

Longest putt holed: Mark Fusco



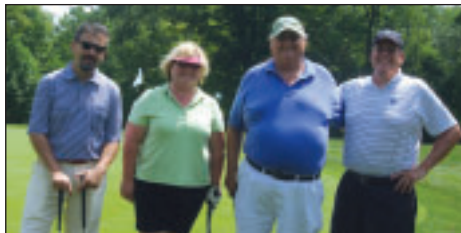
Practicing for the perfect putt.



Warming up on the driving range prior to the shotgun start.



Dr. Bello's foursome tees off "old school".



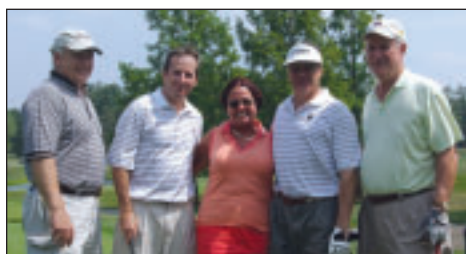
Members of the foursome from Walter and Haverfield LLP pose on the green.



Dr. William Seitz, Jr., and his group smile for the camera.



Members of the Cleveland Clinic Regional Hospitals Administration pose with the AMCNO EVP/CEO, Elayne Biddlestone.



The foursome from the Endoscopy Center at Bainbridge spend a moment with Ms. Biddlestone.



Picking a winning ticket at the raffle that followed a day of golf.



Members of the Hoyt Murray foursome (Mr. Murray sponsored AMEF at Kirtland this year) pose with the hole-in-one prize car (no one drove off with the prize this year).



Dr. Laura David, AMCNO president, greets the crowd with Dr. John Bastulli, AMEF Chairman.

A special thank you goes to all the event, hole and hole-in-one sponsors who helped make the day successful.

2010 Hole-In-One Sponsors

Victor M. Bello, MD

Classic Mini of Mentor

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Get your clubs ready for next year's event on August 8, 2011 at Canterbury Golf Club.



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