

2015 Medical/Legal Summit Covers Key Points

At the 2015 Medical/Legal Summit—which was co-sponsored by the Cleveland Metropolitan Bar Association (CMBA), Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and the Academy of Medicine Education Foundation—the Honorable Michael O. Leavitt delivered the keynote address. His presentation followed opening remarks from CMBA President Bruce Hearey, and Summit Planning Committee Co-Chairmen Ray Krncevic, Associate General Counsel, University Hospitals, Law Department and AMCNO President James Coviello, MD.

Leavitt is the Founder and Chairman of Leavitt Partners, a healthcare intelligence firm that helps clients navigate the future of health care as they transition to new and better models of care. In previous roles, Leavitt served in the Cabinet of President George W. Bush (Administrator

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Keynote speaker the Honorable Michael Leavitt spends a moment with representatives from the AMCNO, the CMBA and the summit planning committee (l to r – Dr. James Coviello, Gov. Leavitt, Mr. Ray Krncevic, Ms. Lisa Barrett and Mr. Bruce Hearey).

AMCNO President Provides Testimony Addressing Proposed Physician Reimbursement Changes in the Biennial Budget Bill

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) President Dr. James Coviello testified before the Ohio House Finance Subcommittee on Health and Human Services to voice concerns about physician reimbursement changes proposed in the Executive Budget for the Medicaid program. The budget proposed by Gov. John Kasich would eliminate Medicaid's crossover payment for physician services delivered to dual-eligible (Medicare/Medicaid) patients and use the funds generated by this cut to provide for a small increase in Medicaid physician reimbursement rates for a small set of primary care codes. Additional funding for this reimbursement rate increase would come from a \$25 million cut to Medicaid's direct graduate medical education (GME) payments.

Dr. Coviello noted that from September 2013 to April 2014, Ohio's Medicaid enrollment increased by 12.3%, and, according to a recent report from The Center for Community

Solutions, Cuyahoga County had the highest percentage of newly eligible adults enrolled as a result of Medicaid expansion. As the number

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Dr. James Coviello, AMCNO President, provides testimony on physician reimbursement issues at the Statehouse.

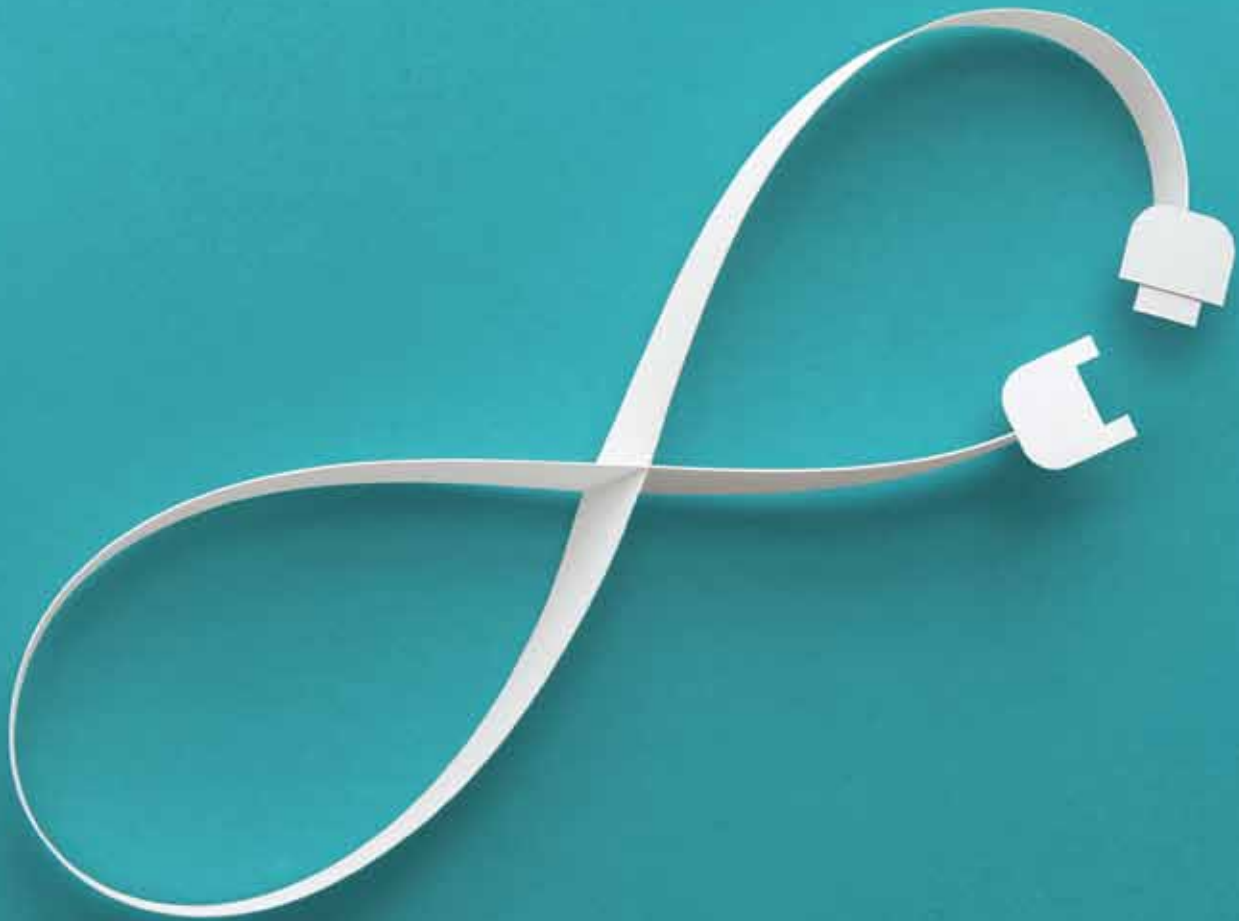
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of the Environmental Protection Agency and Secretary of Health and Human Services (HHS)) as well as a three-time elected Governor of Utah. He is a seasoned diplomat, leading U.S. delegations to more than 50 countries. He has conducted negotiations on matters related to health, the environment and trade.

In his address, Leavitt spoke about "Healthcare Reform 2.0: Navigating Uncertainty and Anticipating What's Next." The transition to a value-based payment (VBP) system is the most significant change in the U.S. healthcare system since the widespread adoption of health insurance, he said. VBP will become the norm in healthcare and we need to act now to make sure we head off a major healthcare crisis.

The transformation has already begun from fee-for-service (FFS) to VBP. The Centers for Medicare and Medicaid Services has aggressive goals: 30% of Medicare FFS payments will tie to alternative payments in 2016 and at 50% by 2018; 85% will be linked to quality.

Bundled pricing and expanded bundled payment initiatives (such as Patient-Centered Medical Homes) are seeing a lot of activity now. The full transition to a VBP system won't happen overnight, but it will happen sooner than anticipated. Factors that are driving the change are politics, health IT adoption, vertical integration, market viability, and Medicare/Medicaid.

There are two counterbalancing forces, in the economy and in society, that are also driving change. The first is compassion. In the healthcare business, people typically join the field to help others. That has been the underlying policy of the American people for the last 50 years, who want to live in a compassionate society, Leavitt said. The other force is dispassion. This is not a lack of compassion, he said, it is global economic dispassionate forces that are compelling us to do things that are uncomfortable and difficult.

Are we potentially setting ourselves up for a healthcare crisis? Yes, we are at risk of creating an access dilemma if physicians and systems don't change, and change in time, Leavitt said. "This is a balancing act, and there will be those who succeed and those who fail. There will be imperfection." However, we have no choice but to make the change. "It is driven by those economic dispassionate forces," he said. "I see people doing very hard things—mergers of practices, closures of hospitals—not because they sign up for them but because they have an economic imperative to do it. Our job is to figure out how to do this in the best way possible."

"If we want to remain a great nation, we have to accomplish this change," he said. "We have three choices: fight it and die, accept it and have a chance to survive, or lead it and prosper."



Mr. Ray Krncevic introduces the telemedicine panel (l to r – Mr. David Chmielewski, Dr. Brook Watts, Mr. Kevin McCarter and Ms. Kim Anderson).

On Saturday, following a welcome and introductions, the first plenary session on Telemedicine began. Sitting on the panel were David Chmielewski, VISN 10 Cleveland Facility Telehealth Coordinator, Dept. of Veterans Affairs (VA); Brook Watts, MD, CMIO, Louis Stokes VA Medical Center; Kevin McCarter, Director, Retail Strategy, CareSource Management Group; and Kimberly Anderson, Esq., Assistant Executive Director, State Medical Board of Ohio.

Mr. Chmielewski opened the session with "Telehealth at the Cleveland VAMC." The

VA's goal of home telehealth is to reduce emergency room visits, hospital admissions and bed days of care. The VA uses several technologies, including a clinical video version that works either from facility-to-facility or facility-to-home and allows for diagnoses to be made, care to be managed and check-ups to be performed, using real-time videoconferencing with supportive peripheral devices. All telehealth transmissions are fully encrypted, Mr. Chmielewski said.

Ms. Watts then discussed "Telehealth: What does the evidence show?" Key points for the literature focused on the effects on the practice, healthcare outcomes, patient satisfaction and provider satisfaction. The VA-specific evidence showed few randomized trials and telehealth was usually part of a complex intervention, but patients did like the technology. Using telehealth for cancer pain showed significant improvements in patients for both pain and depression. And, when telehealth was used for diabetes patients, researchers saw a significant difference in A1c outcomes at 6 months.

Mr. McCarter spoke next about creating a connection between retail and telehealth. "We're looking to improve access and increase communication, not to replace physicians," he said. "Telehealth would be an extension." Health Spot is one prototype, which he said is like a photo booth with access to care, and mobile clinics would provide telemedicine services in a self-contained environment. The plan is to place these mobile clinics in "hot spot zones" for a week or two to service a community's needs.

To close the session, Ms. Anderson defined "the practice of telemedicine" in Ohio. She also provided a detailed overview of sections of the Ohio Revised Code (ORC) and the State Medical Board of Ohio interpretative guidelines and position statements on the issue of telemedicine. Telemedicine resources can be found on the State Medical Board of Ohio website at www.med.ohio.gov as well as the AMCNO website www.amcno.org.

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The second plenary session covered Physician Extenders. The panel consisted of Sallie Debolt, Esq., General Counsel, State Medical Board of Ohio; Thomas Dilling, JD, Adjudication Coordinator/Legislative Liaison, Ohio Board of Nursing; Ed Taber, Esq., Tucker Ellis LLP (moderator); and Rajesh Chandra, MD, Division Chief, Internal Medicine and Geriatrics, UH Case Medical Center (UHCMC).



Mr. Edward Taber provides introductions for the physician extender panel (l to r – Dr. Rajesh Chandra, Ms. Sallie Debolt and Mr. Tom Dilling).

Ms. Debolt spoke first about “Physician Assistant Practice in Ohio,” and discussed certain sections of the ORC, including Section 4730.09 (A) which lists 42 services a physician assistant (PA) may provide under a standard supervisory plan approved by the Medical Board. Ms. Debolt also discussed the similarities and differences between PAs and advanced practice registered nurses (APRN). Ms. Debolt also described how the PA practice may change in the future if SB 55 passes in the current legislature. To view SB 55 go to (www.legislature.ohio.gov).

Next, Mr. Dilling talked about “Advanced Practice Nursing in Ohio.” He discussed the different types of nurses and the APRN Standard of Practice, as defined under Rule 4723.8.02 of the Ohio Administrative Code. Additional information can be found on the Board of Nursing website: <http://nursing.ohio.gov/practice.htm#advancedpractice>.

Dr. Chandra then presented “Physician Extenders Hospital Practice Models.” He gave several examples, including two University Hospital models. One is the UHCMC

hospitalist-nurse practitioner (NP) general medicine service model, which consists of seven full-time and three part-time NPs. The capacity of service is 24 patients. One team is supervised by two hospitalist physicians and they admit and manage private attending patients with supervision and the NPs have prescriptive authority. There are shared medical visits with onsite physician supervision available at all times and services are billed under the physician. The other model is the UHCMC oncology hospitalist-NP service model. It is similar to the general medicine model, but there are two teams and the remaining patients are managed directly by the hospitalists. There is potential growth and deployment with using these types of models, Dr. Chandra said, including independent billing opportunities and managing low acuity observation unit patients after day 1.

Mr. Taber closed with a discussion on “Physician Extender Liability Issues.” He stated that the number 1 reason for liability allegations is the PA or the APN fail to consult the physician. Other reasons: the PA or APN exceeded the scope of practice, the physician failed to supervise, and there was a violation of policies/procedures. Mr. Taber gave a couple of case examples before ending the session.

Following the plenary sessions, attendees were given the choice of four breakout sessions: End-of-Life Issues, Medical Marijuana, the Affordable Care Act, and Opioids and Pain Medicine.

Dale Cowan, MD, JD, UH Parma Medical Center, moderated the End-of-Life Issues session. The panel consisted of Monica Gerrek, PhD, Director of Ethic Education at MetroHealth; May Al-Abousi, MD, UH Parma Medical Center; and Kim Bixenstine, Esq., VP & Deputy General Counsel, UH. The panel discussed two difficult case problems. One involved a male patient who had a history of strokes, recurrent aspiration pneumonia and other health conditions. His clinical condition significantly worsened over a 6-month period, but he was able to express a “Do Not



Dr. Dale Cowan makes a few remarks before introducing the end-of-life panel (l to r – Dr. May Al-Abousi, Dr. Monica Gerrek and Ms. Kim Bixenstine).

Resuscitate Comfort Care Order.” His family, however, did not want to accept his wishes. Ms. Gerrek stated that a case can be referred to the ethics committee at any point. In this case, the family was ethically and legally obligated to fulfill the patient’s wishes. The panel also discussed POLST (Physician’s Orders Life Sustaining Treatment). Many states have been using this form because it’s a way to address complicated issues. The second case problem involved a baby who was born with a neurologic condition and had been in the NICU since birth. He couldn’t swallow or react to any stimuli, and he was blind and deaf. The team concurred his condition was not expected to improve. His mother wanted to have a G-tube and tracheostomy placed. The team and the mother had to discuss what was ethical and what the child’s quality of life would be. Ms. Bixenstine provided her input on the legalities involved in both case scenarios, suggesting the involvement of palliative care and a second opinion in the latter.



Dr. Jason Jerry discusses medical marijuana during one of the breakout sessions.

The Medical Marijuana breakout session was moderated by Dr. Robert Hobbs and featured several presenters: Jason Jerry, MD, Staff Physician, Cleveland Clinic Alcohol and Drug

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Mr. David Valent introduced the panel that discussed the ACA - (l to r – Ms. Patricia Decensi, Dr. Donald Ford, Dr. Michael Hughes and Mr. Tom Campanella).

Recovery Center, Assistant Professor of Medicine, Lerner College of Medicine of CWRU; Attorneys Barry Maram and Richard Hu from the law firm of Taft, Stettinius & Hollister, LLP; and Tim Cosgrove, Esq., an attorney and government relations representative with Squire, Patton Boggs, LLP. Dr. Jerry led the discussion with an overview of marijuana and medicine. He noted that although marijuana has been around for 5,000 years, we've only begun to understand the drug's pharmacology within the last 50 years.

On the topic of cannabis-related medicines, Dr. Jerry noted that rigorous research is needed regarding cannabis-derived substances, which is in its infancy. He said that the Food and Drug Administration (FDA) has a regulatory process that should be utilized, which is supported by all major medical organizations, whereas the use of state legislation to determine the availability of medications is opposed by the medical community. He stressed that medical marijuana should go through the appropriate FDA process, not through state legislatures. Messrs. Hu and Maram provided an overview of state laws, noting that 23 states and Washington, DC, and Guam allow for the use of medical marijuana. Mr. Hu stated that each state's medical cannabis laws and regulations are very distinct. Mr. Cosgrove rounded out the discussion by offering his viewpoint on the medical marijuana discussions taking place in the Ohio legislature and the possibility of this issue finding its way onto the November ballot.

In the Affordable Care Act (ACA) breakout session, David Valent, from the Cleveland

Clinic, served as the moderator. Also on the panel were Thomas Campanella, Esq., Baker Hostetler, LLP; Michael Hughes, MD, Summa Health System; Donald Ford, MD, VP of Medical Affairs, Hillcrest Hospital, Cleveland Clinic; and Patricia Decensi, Esq., Medical Mutual of Ohio. Dr. Hughes discussed Accountable Care Organizations (ACOs) as a way to reduce healthcare costs—they provide better care, not duplication of care, and they lower premiums, which gives access to more patients. Dr. Ford talked about the Medicaid expansion and how it created a dilemma that wasn't foreseen for the ACA. Ms. Decensi said that huge changes have been and are being made in how insurance is sold and priced. What hasn't changed yet, however, is that insurance companies are still paying on an fee for service basis. To obtain private insurance, 700,000 Ohio individuals logged onto the federal exchange. It was also noted that the King v. Burwell case may have far-reaching consequences once a decision is determined.

Issues related to prescribing pain medications and regulatory issues were addressed in the breakout session on Opioids and Pain



Dr. Joan Papp provided the introductions for the opioid and pain panel (l to r –Dr. Bina Mehta, Dr. Christopher Adelman and Mr. William Schmidt).

Medicine. Joan Papp, MD, FACEP, MetroHealth Medical Center, Department of Emergency Medicine, and Cuyahoga County Project DAWN Medical Director, moderated the session and introduced the panel. Dr. Bina Mehta, from the Akron General Spine and Pain Institute, led the discussion by outlining what steps should be followed once a physician decides to prescribe opiate therapy. The prescriber and patient should agree on: risks and benefits of opioid therapy supported by an opioid agreement, treatment goals, expectations for routine urine drug screenings and a follow-up plan. Dr. Mehta also described the principles for safe prescribing. In addition, she provided some red flags to look for when prescribing opioids, offered safe prescribing tips and describing what type of patients may abuse opioids. Dr. Chris Adelman, Medical Director, Rosary Hall at St. Vincent Charity Medical Center, provided an overview of the scope of the opioid epidemic both nationally and statewide and described pharmacotherapy options in opioid addiction. Mr. William Schmidt from the State Medical Board of Ohio rounded out the panel discussion by providing an in-depth overview of the regulatory perspective. Mr. Schmidt described legislation in effect, including pain clinic regulations, naloxone access, prescribing opioids to minors and the mandatory use of the OARRS system. He also provided insight into recent OARRS updates, including two that took effect in March and April of this year.

More than 200 Northern Ohio physicians and attorneys signed up to attend this event—we thank them for their attendance and for supporting our organizations. We would especially like to extend our sincere thanks to the planning committee, presenters and all of the event sponsors. The AMCNO and CMBA are already starting to plan for the 2016 Medical/Legal Summit. The planning committee will be meeting in the near future, and AMCNO members are encouraged to submit topics and suggest presenters for the Summit. Contact Elayne Biddlestone at ebiddlestone@amcnoma.org or 216-520-1000, ext. 100.

AMCNO Legislative Update

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of Medicaid enrollees increases, it is vital that policymakers make sure that our most vulnerable patients – more than 2.6 million in Ohio who are enrolled in Medicaid – can access the health care they need from physicians.

He stated that the physician members of the AMCNO strongly supported the expansion of the Medicaid program in Ohio, and when the program became a reality, physicians across Northern Ohio stepped up to ensure that access to care was available to this newly eligible Medicaid population by signing onto the Medicaid program as participating physicians. Now it is critical to ensure that physicians receive adequate reimbursement from the Medicaid program for the healthcare services they provide to Medicaid enrollees.

Numerous studies have shown that healthcare delivery systems providing high-quality, coordinated care will achieve better patient outcomes and lower overall costs. During testimony to this committee, the Office of Medicaid Director John McCarthy presented Medicaid managed care data collected from January to June 2014. This data showed encouraging trends in terms of shifting the newly enrolled Medicaid population from uncoordinated, higher-cost care to coordinated, lower-cost care. The data indicated that for the Medicaid expansion (Group 8) enrollees, there was a decrease in the inpatient per member per month (PMPM) cost percentage from 61% to 39%, while there was an increase in the medical/outpatient/pharmacy cost percentage from 39% to 60%. Such a shift in spending demonstrates a move from episodic care to coordinated care and it was encouraging to see that 65% of new enrollees received a preventive visit, the entry point for comprehensive medical care. Additionally, 60% of enrollees were ages 19-44, an age group where preventive care and chronic disease management can have the greatest impact on health outcomes. Chronic medical conditions such as asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, and depression are prevalent in the Medicaid patient population.

These are the very medical diagnoses that require consistent, longitudinal care to ensure healthier patients, leading more satisfying and productive lives.

However, maintaining Medicaid's positive momentum requires sufficient patient access to care. Through an Affordable Care Act provision, the Primary Care Rate Increase (PCRI) program paid eligible primary care providers 100% of Medicare rates for Medicaid patients in 2013 and 2014 – and studies have shown that this rate increase provided better access to care. As healthcare reform continues to present physician practices with numerous challenges in adapting to new regulatory requirements, value-based purchasing, and care coordination, physician practices often incur additional costs to succeed in this new environment. In this business model, practice sustainability requires adequate reimbursement for services rendered.

The Executive Budget proposes to increase the physician primary care reimbursement rate by \$151 million over the next biennium, raising the average Medicaid reimbursement from 59% to 64% of the Medicare reimbursement rate for a limited number of codes. However, the budget proposes to pay for this primary care increase by reducing dual-eligible payments by \$129 million and by decreasing funding for physician training. Since many primary care physicians manage Medicare/Medicaid dual-eligible patients, they will essentially receive no meaningful increase in reimbursement under the current budget proposal. In addition, reducing the funding for physician training at a time when more patients are entering the medical system seems counterproductive.

Dr. Coviello stated that as an organization representing physicians, the AMCNO knows that patient access to primary care is correlated to lower cost of care and better patient health outcomes. While any additional reimbursement is welcome, the AMCNO believes that if physicians do not receive adequate reimbursement for treating Medicaid patients, it is highly probable that physicians would leave the Medicaid program and patient access to care could be diminished. This will likely result in an increase in healthcare costs in Ohio and a reduction in

patient health outcomes. In addition, if patients are shut out of primary care offices or dropped from physician panels, they will seek care in emergency departments, resulting in higher costs and lack of care coordination.

The AMCNO has urged the legislature to restore the cuts that have been proposed in the budget for the Medicare/Medicaid dual-eligible patients and consider enhancing the payment increase that has been proposed for primary care services to Medicare parity. Doing so will not only continue, but further extend Medicaid's promising trend toward providing higher quality care to all enrolled Ohioans. Healthier citizens will lead to lower healthcare costs, ensuring a sustainable Medicaid program for years to come.

HB 64 – Biennial Budget Bill

At press time the House had passed their version of HB 64 – the Biennial Budget Bill.

The House version deleted the increases in sales, commercial activity, oil and gas severance taxes – and unfortunately also eliminated the proposed tobacco tax increase (see related story on page 8). So, instead of a major overhaul to the tax code that continues a shift away from income to consumption-based taxes, the House plan would instead provide for \$1.2 billion income tax cuts using in large part the projected growth in tax revenue to offset the expense. The overall plan spends \$775 million less in general revenue funds than the governor but more in all funds as a result of increasing the proposed hospital franchise fee from 3% to 4%. That change draws down more Medicaid matching funds from the federal government.

Other key healthcare-related changes include:

- Mandating a report of the clinical care and outcomes of the expansion population to be delivered to the General Assembly by January 1, 2017;
- Implementing of cost transparency measures;
- Requiring the administration to seek a Medicaid waiver for health savings accounts;
- Returning Medicaid eligibility determinations to the General Assembly;
- Increasing funding for drugs courts and drug addiction treatment programs;
- Maintaining the current populations covered by managed care;

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- Granting the Joint Medicaid Oversight Committee the ability to roll over unspent balances and direct JMOC to study certain Department of Health appropriation lines; and
- Raising the hospital franchise fee to 4%.
- Investing \$20.7 million in FY'16 and \$41.6 million in FY'17 to increase physician primary care codes from current levels*;

*Despite testimony and comments from organized medicine, the House version of the biennial budget bill still includes the proposed cuts to the dual-eligibles and to direct graduate medical education funding, and reduces the increase in Medicaid physician primary care rates to \$61 million with the remainder of the funds going into the General Revenue Fund.

The AMCNO will continue to work with other medical associations in an effort to do away with the proposed cuts to dual-eligibles, eliminate the proposed cuts to graduate medical education, and increase Medicaid's reimbursement for select primary care services to Medicare levels. The AMCNO will advocate for these points at the legislature as the budget debate continues and AMCNO members are encouraged to contact their legislators and do the same. The budget has to be passed no later than June 30, 2015.

AMCNO Meets with Legislators to Support Medicaid Reauthorization

The AMCNO is a member of the Northeast Ohio Health Advancement Coalition (NEOHAC), which was formerly known as NEOMEAC (Northeast Ohio Medicaid Expansion

Coalition). This group continues to be active in our region and also works with the statewide coalition to support the continuation of Medicaid coverage for the thousands of individuals who became covered under the Medicaid program following the Medicaid expansion.

Over the past few months, the AMCNO has participated in meetings with Northern Ohio legislators in an effort to educate them about the importance of continuing the Medicaid program. In addition to advocating for continuation of the program, the AMCNO is also working hard to assure that physicians are adequately reimbursed for their services.

Legislation Under Review

The AMCNO evaluates and takes a position on many of the healthcare-related bills under review by the legislature. Some of the bills supported by the AMCNO include:

HB 4 – Overdose Drugs – This bill would allow a physician to authorize an individual to furnish naloxone pursuant to the physician's protocol to a person at risk of an opioid-related overdose or to another person in a position to assist that person. The bill would also authorize a pharmacist or pharmacy intern to dispense naloxone without a prescription to a person at risk of an opioid-related overdose under the same circumstances. The bill requires that a physician's naloxone protocol be in writing and grants a physician acting in good faith who authorizes an individual to furnish naloxone is immune from criminal liability and grants the

same to a family member, friend or another person in a position to assist a person at risk. This bill provides for a standing order by a physician similar to what is allowed in other states, and the AMCNO supports this bill. The AMCNO submitted testimony in support of the bill to the House Health and Aging Committee. The bill has passed the Ohio House by a vote of 98-0. The bill is now in the Senate Health and Human Services Committee, and once again the AMCNO submitted testimony in support of the bill.

HB 14 – Powdered Alcohol – This bill would prohibit the sale of powdered or crystalline alcohol for human consumption. AMCNO position: Support.

HB 28 – Suicide Prevention – This bill would provide for suicide prevention programs at state institutions of higher education. This bill would provide colleges and universities with access to a suicide prevention program that's already available to K-12 schools. The institutions will be required to take part in a five-part program that includes crisis intervention access, mental health program access, multimedia applications, a student communication plan and more. Prevention materials will be provided free of charge. AMCNO position: Support.

SB 9 – Infant Mortality – This bill would provide for data collection on state-administered services provided in the home that are aimed at reducing infant mortality and negative birth outcomes or health disparities among women who are pregnant or capable of becoming pregnant and who belong to a racial or ethnic minority and Medicaid coverage of certain services for pregnant women, new mothers, or women who may become pregnant. AMCNO position: Support.

SB 32 – Telemedicine – This bill would require health insurers and Medicaid to provide coverage for telemedicine services. AMCNO position: Support.

SB 48 – Bicycle Helmets – This bill would require bicycle operators and passengers under 18 years of age to wear protective helmets when the bicycle is operated on a roadway and to establish the Bicycle Safety Fund to be



The AMCNO participated in a meeting with Rep. Marlene Anielski hosted by University Hospitals. Pictured with Rep. Anielski is Mr. Daniel Bucci, UH Manager of Government Relations.

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used by the Department of Public Safety to assist low-income families in the purchase of bicycle helmets. AMCNO position: Support.

SB 54 – Liquid Nicotine – This bill would ban the sale of products intended for use in electronic cigarettes that are not in child-resistant packaging. AMCNO position: Support.

SB 129 – Prior Authorizations (PA) –

This bill would:

- Ensure that PA requirements or restrictions are listed on the health insurer's website;
- Allow providers and patients to obtain PA authorizations through a web-based system;

- Ensure that a new or future PA requirement is disclosed at least 60 days prior to the new requirement being implemented;
- Guarantee that once a PA has been approved, the insurer will not retroactively deny coverage for the approved service;
- Disclose on their website statistics regarding PA approvals and denials;
- Task the Department of Insurance with developing a single form not to exceed two pages to be used by all insurers for PA requests;
- Guarantee a 48-hour turnaround on PA requests, with automatic approval in the event no decision is rendered in 48 hours, and 24-hour turnaround for more urgent requests;

- Ensure adverse decisions are made by a physician under the direction of the medical director of the health insurer or by a panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or board eligible in the same specialty as the treatment under review; and
- Ensure a streamlined appeals process in the event a prior authorization is refused without sufficient explanation.

The AMCNO strongly supports SB 129.

For additional information about the legislative activities of the AMCNO please go to our website www.amcno.org. ■

AMCNO Participates in Day at the Capitol Event to Show Support for Tobacco Tax Hike

The AMCNO was pleased to participate in the American Cancer Society Cancer Action Network Day at the Capitol Event in March. During this event, AMCNO representatives met with legislators from the Northern Ohio area to ask for support of the tobacco provisions contained in Gov. Kasich's budget (HB 64).

Legislators were provided with information showing that tobacco use remains the single largest preventable cause of disease and premature death in Ohio. Currently, Ohio has the eighth highest number of smokers in the nation, with 23.4% of adult residents identifying as smokers, compared to the national average of 17.8%.

Ohio has not raised cigarette taxes in nearly a decade. The AMCNO and other tobacco cessation advocates know that what works in tobacco use prevention and cessation is a combination of significantly increasing tobacco taxes on a regular basis, investment in tobacco prevention and cessation programs, and comprehensive smoke-free laws that cover all workplaces. Ohio has the smoke-free law thanks to the advocacy work of organizations like the AMCNO and hundreds of others in Ohio, and we have the opportunity in the next state budget to get increases in the cigarette and other tobacco taxes.

The AMCNO supports the tobacco provisions in HB 64 which would have increased the cigarette tax by \$1.00 per pack and match the other tobacco products (OT) tax to the cigarette tax. We also supported investing in tobacco use and prevention and cessation programs to help people quit and deliver both health- and cost-savings benefits to the state.

During the Advocacy Day events, the AMCNO also attended a press conference where the Campaign for Tobacco-Free Kids (a group supported by the AMCNO) released a Public Opinions Strategies poll showing that 69% of respondents said they support raising the cigarette tax, which would put the total tax at \$2.25 per pack. In addition, nearly three-quarters of the 600 Ohioans who participated in the telephone survey conducted from March 7-10 said they also support equalizing the tax on other tobacco products, like cigars, chewing tobacco and e-cigarettes. The poll also found that respondents would be 57% more likely to vote for a candidate that supported a tobacco tax increase and 24% said they were less likely to vote for a candidate if they voted against the increase. When asked to gauge the fairness of having smokers subsidize a personal income tax

decrease, 29% of survey takers said they support the idea and 67% agreed that those particular Ohioans should foot the bill for increased state healthcare costs associated with smoking and other tobacco products.

Opponents of the tax increases continue to ask lawmakers to remove the language from HB 64. Business owners and tobacco industry representatives allege that the tax increases would put Ohio out of line compared to neighboring states, which could lead to an increase in cross-border sales, lost retail jobs and a rise in black market activities. A previous effort by the Kasich Administration to raise the tobacco tax, which was strongly supported by the AMCNO, as part of the mid-biennium review budget died in committee last year. At press time, the House-revised version of HB 64 had passed and, unfortunately, the opponents of the tax increases won the day and the tobacco tax increases have been completely stripped from the House version of the budget bill.

The AMCNO will continue to advocate for the tobacco tax increase during the budget debate that will continue until the end of June. ■



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Medical Records Fact Sheet New Fees Effective January 2015

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics. Current Opinion **7.05**. Under Ohio Law (R.C. §4731.22 (B)(18)), violations of the ethical rules of the American Medical Association, the American Osteopathic Association or the American Podiatric Medical Association can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. However, Ohio Revised Code §2913.40 (D) mandates the retention of records associated with Medicaid claims for a period of at least six (6) years after reimbursement for the claim is received by the physician. For consistency, it is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires a five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §2305.113). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations. As a practical matter, all of this makes a succinct and comprehensive definition of the Ohio statute of limitations difficult. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Providing Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what Ohio law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §3701.74 obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a valid request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. These fees are adjusted annually. EFFECTIVE JANUARY 2015, the maximum fees that may be charged, are:

(1) The following maximum fee applies when the request comes from a patient or the patient's representative (a minor patient's parent or other person acting in loco parentis, a court appointed guardian of the patient, the holder of the patient's durable power of attorney for health care, an executor of the patient's estate).

- a) No records search fee is allowed;
- b) **For data recorded on paper or electronically:** \$3.07 per page for the first ten pages; \$0.64 per page for pages 11 through 50; \$0.26 per page for pages 51 and higher
For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film: \$2.10 per page
- c) Actual cost of postage may also be charged

(2) The following maximum applies when the request comes from a person or entity other than a patient or the patient's representative.

- a) A \$18.61 records search fee is allowed;
- b) **For data recorded on paper or electronically:** \$1.24 per page for the first ten pages; \$0.64 per page for pages 11 through 50; \$0.26 per page for pages 51 and higher
For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film: \$2.10 per page
- c) The actual cost of postage may also be charged

If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000. For additional information about State and Federal Requirements Concerning Disclosures of Medical Records, log on to the AMCNO website at www.amcno.org and click on the Practice Resources link.



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The Time to Prepare for a HIPAA Audit is Now

By John Mulligan, Esq., McDonald Hopkins, LLC

HIPAA audits conducted by the government are expected to begin soon

HIPAA-covered entities (such as healthcare providers and health plans) and their business associates will soon face governmental audits of their HIPAA compliance. According to some sources, covered entities and business associates may have just two weeks to respond to the auditor's request for information. As a practical matter, it will be impossible for a covered entity or business associate to bring its "HIPAA compliance house" in order within such a short period of time. Furthermore, reports have indicated that the Office for Civil Rights (OCR) of the Department of Health and Human Services might disregard documents created or modified after receiving the information request. Therefore, the time to prepare for a HIPAA audit is now.

Of course, the primary reason for the covered entity or business associate to make sure its activities are HIPAA compliant is to reduce the likelihood and consequences of a privacy or security breach. However, the fact that there will be HIPAA audits makes it clear that simply avoiding a privacy or security breach will not assure a covered entity or business associate that it will not be exposed to significant legal costs and penalties. Moreover, physicians and other healthcare providers are also subject to meaningful use audits that can expose them to recoupment of meaningful use payments if they fail to satisfy HIPAA requirements, such as risk analysis.

Required action steps

The following list of "action steps" is similar to those included in a number of our prior alerts. What is important to note is that these action steps are not simply "recommendations" that a covered entity or business associate may implement at its discretion. These first five safeguards are "requirements" under the law, and cybersecurity insurance provides important financial protection. Failure to take each of these action steps can expose the covered entity or business associate to serious legal complications.

1. Confirm that you have written policies and procedures covering the privacy and security of protected health information, and that these policies and procedures are periodically updated and reviewed. Make certain that you have breach notification policies and procedures. Document all reviews and updates. Make certain that you have policies and procedures in place with respect to the disposal or destruction of protected health information. Pay particular concern to issues associated with mobile devices. For example, are personnel allowed to take hard copies of medical records out of the office? Do personnel take mobile phones or laptops out of the office that could be used to access protected health information? This relates to the encryption recommendation discussed below.
2. Make certain that all employees or other members of your workforce have been thoroughly trained in HIPAA compliance matters and are familiar with the policies and procedures you have adopted. Be sure the training is conducted on a regular basis, is an integral part of any orientation program for new personnel, and is documented.
3. If you are a covered entity, make certain that you have identified all of your business associates and updated all of your business associate agreements. Make certain, if you are a business associate, that you have updated business associate agreements with all of your covered entities and that you have agreements in place with any downstream contractor to which you provide protected health information.
4. Perform a risk analysis of your practice or business to determine where vulnerabilities might exist. If and when issues are discovered, take prompt steps to correct them. Document the risk assessment process and the correction steps taken. Consider engaging an outside consultant to perform the risk analysis — make sure you have a business associate agreement with the consultant. Although there is a cost to such an engagement, the benefit

will often substantially outweigh the cost.

5. Consider special areas of concern. For example, do you encrypt your data? If not, why not? If your data is not encrypted, you should at least have an analysis of why you concluded that encryption was not necessary. It should be noted that cost or inconvenience may not prove to be a satisfactory excuse if your information is ever compromised, as encryption has risen to the level of an expected safeguard.
6. Obtain cyber liability insurance and make sure you fully understand the scope of coverage.

Clearly, there is time, effort, and cost associated with implementing HIPAA compliance policies and procedures. However, these are the costs of doing business in the world of healthcare in 2015. They are not discretionary. ■

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False Claims Act – 2015 Update

By *Seamus J. McMahon, Esq., Moscarino & Treu, LLP*

The United States Supreme Court has held that the False Claims Act “was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.” *United States v. Neifert-White Company*, 390 U.S. 229, 233 (1968).

On its website, the Department of Justice boasts that, since January 2009, it recovered more than \$23.9 billion through False Claims Act cases, with more than \$15.2 billion of that amount coming from cases against physicians, hospitals, and others in the healthcare industry. In its press releases advising the public of settlements with healthcare providers, the Justice Department suggests that its ongoing efforts to enforce the FCA is based on three objectives — yielding a recovery for taxpayers, deterring future conduct, and making healthcare more affordable. Whatever the reason, as healthcare providers in different settings, including those with administrative responsibilities, our member physicians need to be cognizant of the FCA, its prohibitions, and the DOJ’s ongoing enforcement efforts. The DOJ is enforcing this law now more than ever and, as reflected below, they are willing to engage the offending providers in litigation to effectuate this enforcement.

The FCA provides, in pertinent part, that:

Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government ... a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;... or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person (b) For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. 31 U.S.C. § 3729.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting

the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information can also be liable under the Act. 31 U.S.C. 3729(b). The following are several examples of settlements reached with the DOJ in the last several months as a result of their ongoing efforts of enforcement.

Medically Unnecessary Services

Federal health programs only reimburse for products and services that are medically necessary. Because all health care providers certify to Medicare that their billed services are medically necessary, billing for a medically unnecessary claim is a false certification. In April 2015, two cardiovascular disease testing laboratories agreed to resolve allegations that they violated the FCA by compensating physicians in exchange for patient referrals and billing federal health care programs for medically unnecessary testing. As alleged in the lawsuits, the labs induced physicians to refer patients to the labs for blood tests by paying them processing and handling fees per referral and by improperly waiving patient co-pays and deductibles. As a result, physicians allegedly referred patients to the labs for medically unnecessary tests, which were then billed to Medicare.

Over-billing

In March 2015, a heart monitoring company agreed to pay \$6.4 Million for alleged overbilling for Mobile Cardiac Outpatient Telemetry (MCOT) services when those services were allegedly not reasonable or medically necessary. The government alleged that the company was aware that MCOT services were not eligible for Medicare reimbursement when those services were provided to patients who had experienced only mild or moderate heart palpitations because less expensive monitors could just as effectively collect the necessary data about those patients’ conditions. The government further alleged that, despite this, the company submitted claims to Medicare for those patients containing the billing code for the more expensive MCOT services along with an inaccurate diagnostic code that misrepresented the true condition of the patients and their need for MCOT services.

Kickbacks

In March 2015, an Ohio-based hospital system agreed to pay \$10 million to settle claims that it violated the FCA by engaging in improper

financial relationships with referring physicians. The settlement involved the hospital system’s financial relationships with a number of referring physicians that allegedly violated the FCA which restricts the financial relationships that hospitals may have with doctors who refer patients to them. The violating physicians allegedly failed to provide sufficiently legitimate management services to have justified the payments that they had received over the period of time reviewed by the DOJ. The hospital-system ultimately disclosed the issues to the government by way of self-reporting.

In February 2015, an Illinois physician pleaded guilty in federal court for receiving illegal kickbacks and benefits totaling nearly \$600,000 from two pharmaceutical companies in exchange for regularly prescribing an anti-psychotic drug — clozapine — to his mostly elderly patients. The physician also agreed to pay the United States and the state of Illinois \$3.79 million to settle a parallel civil lawsuit which alleged that, by prescribing clozapine in exchange for kickbacks, he caused the submission of false claims to Medicare and Medicaid for the clozapine he prescribed for thousands of elderly and indigent patients in at least 30 Chicago-area nursing homes and other facilities. The government had alleged that the physician submitted to both Medicaid and Medicare claims for “pharmacological management” of those patients for whom he prescribed clozapine. However, he allegedly did not engage in meaningful pharmacological management because his prescribing decisions for his clozapine patients were based primarily on the kickbacks he received and not his independent medical judgment or the needs of his patients.

Inpatient vs. outpatient

In October 2014, a hospital system with facilities in California, Nevada, and Arizona agreed to settle allegations that 13 of its hospitals submitted false claims to Medicare by admitting patients who could have been treated on a less costly, outpatient basis. The DOJ specifically alleged that those hospitals billed Medicare for inpatient care for patients who underwent elective cardiovascular procedures in scheduled surgeries when the claims should have been billed as outpatient surgeries and that they billed Medicare for patients undergoing elective kyphoplasty procedures that should have been performed and billed as outpatient procedures.

“Unbundling” or upcoding

Upcoding occurs when health care providers falsely represent that patients received a more complex or expensive service than what was actually provided. In March 2014, a North Carolina hospital system agreed to pay \$1 million to settle allegations under the FCA that it made false claims by: (1) billing the government for services provided by physician

(Continued on page 15)

Comprehensive Error Rate Testing (CERT) Program

The Centers for Medicare & Medicaid Services (CMS) developed the CERT program to improve the processing and medical decision making involved with payment of Medicare claims. Under the CERT program, a random sample of claims is selected from each Medicare Contractor, and medical records are requested from the providers who submitted the claims. These records are then reviewed to determine if the claim was submitted and paid appropriately.

The fiscal year (FY) 2014 Medicare FFS program improper payment rate is 12.7%, representing \$45.8 billion in improper payments, compared to the FY 2013 improper payment rate of 10.1% or \$36.0 billion in improper payments. The table below outlines the improper payment rate and projected improper payment amount by claim type for FY 2014. The reporting period for this improper payment rate is July 1, 2012 - June 30, 2013.

SERVICE TYPE	IMPROPER PAYMENT RATE	IMPROPER PAYMENT AMOUNT (2)
Inpatient Hospitals	9.2%	\$10.4B
Durable Medical Equipment	53.1%	\$5.1B
Physician/Lab/Ambulance	12.1%	\$11.0B
Non-Inpatient Hospital Facilities	13.1%	\$19.2B
Overall	12.7%	\$45.8B

CMS utilizes two contractors for the request and review of medical records; the CERT Documentation Contractor (CDC) and the CERT Review Contractor (CRC). The CDC is responsible for requesting and obtaining the medical records for the sampled claims. The CRC is responsible for reviewing the supporting documentation for compliance with Medicare coverage, medical necessity, coding and billing rules.

Recently CGS has encountered an increase in "No Documentation Response" that has an impact on the error rate in this category. CGS would like to remind you that once you receive a request for documentation from the CERT contractor the following steps are to be taken.

The CERT Documentation information:

- Each request from the CERT Documentation Contractor is accompanied by a barcoded coversheet. This coversheet labels the documentation for the correct beneficiary and date(s) of service. It is critical that you submit a copy of this coversheet with all documentation, if that coversheet is not available be sure you write your CID number on the documentation. Lack of a correct coversheet or identification of CID number may result in denials if the CERT Documentation Contractor cannot identify the record.
- The barcoded coversheet or CID number **MUST** be included as the first page of all documentation submitted to the CERT Documentation Contractor, regardless of media used.
- When submitting records for more than one request, place the corresponding coversheet in front of **each** record.
- For any subsequent requests for additional documentation, the new, corresponding barcoded coversheet or CID number **MUST** accompany the additional documentation. The barcoded coversheets contain specific claim information, so it is important that you use a barcoded coversheet specific to the CID number associated with your current request. ■

Resources:

Comprehensive Error Rate Testing (CERT)

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html>

CGS Comprehensive Error Rate Testing (CERT) Program

<http://www.cgsmedicare.com/partb/cert/index.html>

CERT Task Force

http://www.cgsmedicare.com/partb/education/cert_task_force.html?wb48617274=B8C0C5D9

FALSE CLAIMS ACT – 2015 UPDATE

(Continued from page 14)

assistants during coronary artery bypass surgeries when the PA's were acting as surgical assistants which is not permitted under government regulations and (2) increasing billing by unbundling claims when the unbundling was not appropriate, specifically in connection with cardiac and anesthesia services. The allegations resolved by this settlement arose from a whistleblower lawsuit filed by a former employee who identified irregularities in the billing practices of the Hospital.

Although these examples may appear to be extreme, they should continue to serve as reminder that, when it comes to violating the FCA, the stakes are high, the government continues to be vigilant, and the resulting related litigation can be costly to all involved. ■



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Summary of Activity on Ohio's Return to Play Law

During the 129th General Assembly the AMCNO supported the passage of HB 143 — legislation that established requirements related to youth sports concussions. The legislation, which was signed into law by Gov. Kasich in December 2012, required the Ohio Department of Health to develop a concussion information sheet and post links to concussion training for coaches and referees on their website. Under the law, youth could only return to play if assessed by a physician or a licensed healthcare professional acting in consultation with a physician.

In the 130th General Assembly, during the full biennial budget process, chiropractors sought to be included among those who could assess and clear concussed student athletes for play. The language made it through the General Assembly but was vetoed by Gov. Kasich after the AMCNO and other medical associations voiced our concerns about the issue. Gov. Kasich said in his veto message that the item should be considered in separate legislation with input from all healthcare professionals because of the “potentially significant dangers from improperly treated concussion injuries.”

During the Mid-Biennium Review (MBR) proceedings in the 130th General Assembly the Senate added language to HB 487 which required the ODH to establish a concussion committee tasked with developing guidelines related to youth sports concussions. HB 487 raised concerns among several state and regional medical groups, including the AMCNO because it included a provision that would broaden the list of practitioners allowed to clear student athletes for play after a head injury.

Despite objections from the physician community, HB 487 was signed into law in June 2014 and specified that the Director of Health was to establish a committee regarding concussions and head injuries sustained by athletes participating in interscholastic youth sports activities. The concussion committee was tasked with developing guidelines related to youth sports concussions. The new law specified that the committee develop and publish guidelines addressing issues with regard to athletes exhibiting signs, symptoms or behaviors consistent with having sustained a concussion or head injury while participating in an interscholastic athletic event or an athletic activity organized by a youth sports organization.

The committee's guidelines were to specifically outline the diagnosis and treatment of concussions; the conditions under which an athlete may be granted clearance to return to practice or competition; and the minimum education requirements necessary to qualify a physician or licensed healthcare professional

(LHCP) to assess and clear an athlete for return to practice or competition.

The first committee meeting was held in October and the committee members completed their work in March 2015.

Committee Recommended Guidelines (as posted on the ODH website)

Diagnosis and Treatment

The Committee debated and reviewed the best practices for the diagnosis and treatment of concussion in athletes with the intent of establishing a best practice guideline for return-to-play clearance for use in organized youth athletic activities in Ohio.

RECOMMENDED GUIDELINE:

Providers will diagnose and treat concussion in athletes participating in youth sports in accordance with the most recent Consensus Statement on Concussion in Sport (currently the 4th International Conference on Concussion in Sport, held in Zurich, November 2012) or with nationally accepted standards and guidelines consistent with that statement. These “Standards of Care” will also determine the best practice for return-to-play clearance protocol.

Granting Clearance

The law required the Committee to determine which licensed health care professionals (LHCPs) meet the standards of care for independently — or in consultation — granting clearance for youth athletes to return to practice or competition.

RECOMMENDED GUIDELINE:

Based on the experience and knowledge gained through their residency and other educational requirements, Physicians (M.D. or D.O.), Diplomates in either Chiropractic Neurology or Chiropractic Sports Medicine and those Certified Chiropractic Sports Physicians who are listed on the American Chiropractic Board of Sports Physicians National Concussion Registry will be considered able to meet the recommended standards of care and able to independently clear youth athletes to

return to play. All other licensed health care professionals must work in coordination or consultation with a physician (M.D. or D.O.) as written in HB 143. The Committee also recommends that all LHCPs use the model form developed by the Committee to document written clearance as required by Ohio law — this form is available for download on the Ohio Department of Health website at www.odh.org.

Minimum Education Requirements

The Committee additionally took up the charge to determine should all or some licensed health care professionals be required to have additional continuing education in this standard of care.

RECOMMENDED GUIDELINE:

Due to the rapidly changing evidence base of concussion management in youth athletes, the Committee encourages licensed healthcare professionals in Ohio who treat concussed athletes to maintain a level of continuing education that keeps pace with this evolving issue. The Committee further Encourages licensing boards to recommend to their respective licensees a model level of continuing education that is consistent with the continuing education recommendations reflected in the most recent Consensus Statement on Concussion in Sport (currently the 4th International Conference on Concussion in Sport, held in Zurich, November 2012) or with nationally accepted standards and guidelines consistent with that statement.

Consultation and Collaboration

One issue that was debated by the Committee centered on what was meant in HB 143 of the 129th General Assembly by the term, in consultation with, and in collaboration with a physician. This issue was of particular importance in that some members felt that by having the “consultation” language included in HB 143, it already authorizes many qualified health care professionals the opportunity to clear a patient as long as a physician (M.D. or D.O.) was part of the concussion management team. Lance Himes, ODH's General Counsel, clarified the language regarding the law's use of broad terms, including: in consultation with a physician; pursuant to the referral of a physician; in collaboration with a physician; or under the supervision of a physician. Therefore the Committee has agreed to keep coordination and consultation with a physician (M.D. or D.O.) as written in HB 143. ■

Access Works: Seven Reasons Why Continued Support of Medicaid is Critical

By Kirstin Craciun, MSW, MPP, Community Outreach Director, The Center for Health Affairs

Introduction

When Medicaid expansion became a reality in Ohio — and childless adults earning up to 138 percent of the federal poverty level gained access to health insurance — Ohio healthcare advocates celebrated this hard-fought victory. For consumer advocates and healthcare providers in the Buckeye state, nothing ranks higher on their 2015 list of policy priorities than ensuring access to care continues to be available to this newly eligible Medicaid population. This Policy Snapshot explores seven reasons why continued support of Medicaid expansion is essential.

History of Medicaid Expansion in Ohio

The state of Ohio operates on a biennial budget, meaning budgeting for the state's programs and various state agencies normally runs on a two-year cycle. During the state's last round of budget negotiations, expansion of the Medicaid program in Ohio would typically have been achieved by ensuring authorizing language was included as part of the state's biennial budget that began July 1, 2013 and expires after June 30, 2015. However, despite Governor Kasich's inclusion of a Medicaid expansion provision in his proposed budget bill, lawmakers in the General Assembly removed the Medicaid expansion provision.

When Medicaid expansion through the traditional legislative process proved unsuccessful, Governor Kasich asked the little-known Controlling Board to vote on Medicaid expansion. On Oct. 21, 2013 the Controlling Board voted by a 5-to-2 majority to authorize the state to accept \$2.56 billion in federal funds to expand Medicaid to all adults earning up to 138 percent of the federal poverty level. The Controlling Board's decision allowed the state to accept federal funding starting Jan. 1, 2014 through the end of the current biennium on June 30, 2015.

Continued Access is Essential

Medicaid Provides Access to Necessary Healthcare Services

Continued access to coverage ensures that many of our most vulnerable citizens will continue to have access to a complete package of preventive and emergency healthcare services.

Already, Medicaid expansion in Ohio is helping almost half a million Ohioans access necessary healthcare services. Recent data show more than 492,000 newly eligible Ohioans have enrolled in Medicaid¹. At least 17,200 newly eligible Ohioans have accessed behavioral health benefits due to expansion.

Locally, county-level enrollment figures show the percentage of 18 to 64-year olds who have benefitted from Medicaid expansion. Across the state, the expansion population is comprised of 6.1 percent of adults ages 19 to 64². Compared to other urban counties in the state, Cuyahoga County has the highest percentage of newly eligible adults enrolled as a result of Medicaid expansion³.

Medicaid Expansion Enrollment in Northeast Ohio⁴

	COUNTY-LEVEL ENROLLMENT	18-64 YEAR OLD POPULATION BY COUNTY	PERCENT OF 18-64 YEAR OLD POPULATION ENROLLED IN MEDICAID EXPANSION
Ashtabula	3,559	60,286	5.90%
Cuyahoga	70,751	784,419	9.00%
Geauga	1,149	54,504	2.10%
Lake	6,087	140,672	4.30%
Lorain	10,551	185,027	5.70%
Medina	3,257	106,873	3.00%

Health Insurance is Essential for a Person's Well-Being

The importance of health insurance to a person's well-being has been proven in the literature. In fact, a study of three states (Arizona, Maine and New York) that have expanded their Medicaid programs to cover nondisabled adults without dependent children found that these states have shown a decrease in mortality rates compared to states that have not expanded Medicaid. The greatest mortality reductions were among adults between the ages of 35 to 64, residents of poor counties and minorities. Specifically, the study found that states that expanded their Medicaid programs prevented 2,840 deaths per 500,000 new Medicaid enrollees⁵.

State Costs are Minimal

Under the Affordable Care Act (ACA), the federal government will reimburse 100 percent of Medicaid costs for the expansion

population through 2016. After that, reimbursement drops to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019. By 2020 and for all subsequent years, the federal government will pay 90 percent of the costs of covering these individuals. These reimbursement percentages are much more generous than the reimbursement amount for the non-expansion population.

States that have not expanded Medicaid are not only missing an opportunity to provide coverage to many individuals in need of healthcare services, but they are also witnessing their state Medicaid spending increasing at almost the same rate as in expansion states. Specifically among expansion states, state spending grew 6.6 percent while spending in non-expansion states grew almost as much at 6.1 percent, despite a much smaller increase in enrollment of only 2.8 percent compared to a 12.2 percent increase in enrollment in expansion states⁶.

Medicaid is a Work-Support Program

Essential to the ability to contribute productively to society is having the ability to quickly ensure healthcare issues are addressed. Being able to get healthcare issues addressed in a timely manner requires having health insurance that offers comprehensive coverage, such as that offered by many private health insurance plans, Medicare and Medicaid.

Health insurance is not thought of or talked about as a "dependency" for those with higher income levels and it shouldn't be framed that way for people who have lower income levels. Given the importance of health insurance to a person's ability to work, Medicaid is more aptly considered a work-support program that has demonstrated its value.

The homeless population in particular demonstrates the benefits of having access to health coverage. A study of five federally qualified health centers (FQHCs) — four of which were located in Medicaid expansion states and one of which was in a non-expansion state — found that nearly all homeless individuals assisted were eligible for

(Continued on page 18)

Access Works (Continued from page 17)

Medicaid in the expansion states, while most of the homeless population remained ineligible for coverage in the non-expansion state. Providers included in the study reported that access to health coverage allowed homeless individuals to obtain surgeries and other treatments that resolved medical conditions and improved their ability to work and maintain stable housing⁷.

Medicaid Reimbursement for Newly Eligible Patients is Crucial for Hospitals

Ensuring that healthcare providers receive reimbursement from the Medicaid program for many of the healthcare services they already provide to the newly eligible population is vital. Prior to passage of the ACA, hospitals agreed to billions of dollars in funding reductions with the understanding that greater numbers of individuals who had previously been uninsured would now be insured through expansions of both private coverage and Medicaid coverage. Yet when Medicaid expansion became a state option, Ohio hospitals feared that if the state didn't expand coverage they would be at risk of serious financial consequences given that they had agreed to drastic reductions in uncompensated care funding that has historically helped cover the cost of caring for uninsured and low-income patients.

Existing Outcome Data Demonstrate a Positive Return on Investment

Polymakers, researchers, advocates and the media have been clamoring for data showing what the return on investment is for the Medicaid expansion population. MetroHealth's 11-month Care Plus demonstration project, which covered 35,976 Cuyahoga County patients in 2013 who mirror the current expansion population, provides a window into some of the positive benefits that health coverage provides to this population. According to John Corlett, president and executive director for The Center for Community Solutions, and former vice president of Government Relations and Community Affairs at the MetroHealth System, data from MetroHealth's Care Plus demonstration project showed "significant improvements in diabetes and hypertension outcomes, access to behavioral health services, pharmaceutical therapies, and dental services." Furthermore, these positive health outcomes were achieved at a cost that was 28.7 percent below projected costs⁸.

Results from the Oregon Health Insurance Experiment, in which the state used a lottery system to allow a finite number of uninsured, low-income adults to enroll in Medicaid in 2008, showed that the newly enrolled Medicaid recipients had improved self-reported health and reduced financial strain. Furthermore, the newly Medicaid-eligible population in Oregon also had increased healthcare utilization which resulted in this population of newly insured having a more consistent source of primary care. Specifically, the newly eligible Medicaid population was 65 percent more likely to have a regular doctor and 70 percent more likely to have a regular place of care compared to the control population⁹.

Updated information from Oregon continues to demonstrate the value Medicaid expansion provides in ensuring the expansion population is receiving care in the correct setting. Recent data show that the Medicaid expansion population in Oregon has *lower rates* of avoidable emergency department utilization as well as *higher rates* of care in an outpatient setting when compared to other categories of Medicaid beneficiaries in the state¹⁰.

Concerns about the "Woodwork Effect" Have Not Come to Pass

Prior to the expansion of the Medicaid program in Ohio, some lawmakers expressed concern that expanding Medicaid to a new population of individuals would create a "woodwork effect." Essentially, some lawmakers were concerned that heightened awareness about the ACA coupled with vigorous outreach efforts would lead to an unsustainable number of previously eligible yet unenrolled individuals signing up for coverage.

Since January 2014, just 177,000 previously eligible Ohioans have signed up for Medicaid coverage, accounting for far less than 1 percent (0.6%) of all Medicaid enrollees¹¹. This is fewer than the state had expected to sign up for traditional Medicaid¹².

Conclusion

Governor Kasich and his administration have indicated that there is no need for the General Assembly to reauthorize Medicaid expansion during the budget process since the Centers for Medicare and Medicaid Services (CMS) have already approved the state's plan for administering the program to the expanded population. Access to care remains a top priority for hospital advocates and the broad

coalition of advocates in Northeast Ohio and across the state. As the legislature debates the various provisions of the state budget one thing should be clear, access to care works. Ensuring access to care is protected is not only financially savvy, it is also compassionate. ■

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AMCNO Updated Community Resource Guide Now Available

As a member of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), you have access to valuable resources, one of which is the *Community Resources* list. This guide has been updated and is available on our website www.amcno.org.

The resource provides a wealth of knowledge that you can share with your patients when they need assistance within their communities. It features contact information for numerous organizations and healthcare-related groups in the Northeast Ohio region, covering services from A (adoption) to W (women's health).

Right at the top of the list are important numbers to know, including those for the Center for Health Affairs, Cleveland

Department of Public Health, Cuyahoga County Board of Health, as well as those for the Greater Cleveland Foodbank, and other healthcare related organizations.

In addition, the Cleveland chapters of national organizations are featured, such as the American Heart Association, Red Cross and United Way. Also included are resources that may not be commonly found or published in local resource listings, such as Dogs for the Deaf, Parenting Help Lines/Classes, and DNA Testing services.

Some of the AMCNO's services are also listed in the guide including the Pollen Line and Physician Referral line. ■

Senate Approves Legislation to Repeal SGR

In April on a bipartisan vote of 92 to 8, the Senate passed H.R. 2, the "Medicare Access and Chip Reauthorization Act," or MACRA. Although six amendments were considered on the floor, none reached the threshold required for passage. As a result, the Senate-passed bill was identical to the version that passed the House of Representatives by an overwhelming 392-37 margin on March 26 and President Obama has now signed the bill into law. Medicare has been processing claims for services provided in April at the rates that were effective before the 21% cut was scheduled to take effect. Under the provisions of H.R. 2, the fee schedule conversion factor will be increased by 0.5% on July 1, 2015, and by another 0.5% on Jan. 1, 2016.

Under the new bill:

- Physicians will receive a 0.5% fee increase in June and then an annual 0.5% starting on Jan. 1, 2016, through 2019. There is no increase from 2020 through 2025;
- Physicians will be encouraged to begin shifting patients into value-based payment

models — such as accountable care organizations, bundled-payment plans and medical homes — which could bring additional rate increases in 2026 and beyond;

- There is a goal of achieving interoperable electronic health record systems by the end of 2018;
- The Merit-based Incentive Payment System (MIPS) program is revised to include more incentives for improving quality of care; and
- The Children's Health Insurance Program is extended by 2 years with an additional \$7.2 billion earmarked for community health centers.

The AMCNO and medical organizations across the nation have worked tirelessly for more than 15 years to achieve this change to the SGR formula. Thank you to all of our members who contacted their Senators and Representatives regarding H.R. 2. The AMCNO will continue to send additional information about this bill in the future. ■



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