THE BULLETIN

Ohio Chapter, American College of Radiology, Inc.

President's Message

Yogesh P. Patel, MD, FACR

It is my honor and pleasure to have the opportunity to serve as the president of the OSRS for coming year. This is my first address since assuming the chapter presidency at the ACR annual meeting in Washington, DC, this past May. Briefly, I would like to introduce myself to the members of the society, particularly those who are not actively involved in our organization.

I have been fortunate to be in private practice with Consulting Radiologists Corporation (CRC) in the Toledo area for the last eighteen years. I have been involved with radiology in various capacities and locations including education, academic, and private practice for more than thirty years. These various opportunities have truly been a lifelong learning experience. I have also been involved with advocacy for our profession as a member of the ACR and our state chapter. Serving on the executive committee of the OSRS in different roles for the past decade helped me confront the many challenges facing radiology today. I too have learned from the other members of the executive committee and leaders from the ACR. It has been a very rewarding journey.

As many of you are aware, the recent development in Toledo, where a private practice group (CRC) was displaced by an MBA-run radiology outfit (Imaging Advantage, IA), has been a focal point of discussion, both statewide and nationally. This was well publicized in the society Bulletin and discussions at the ACR annual meeting. In spite of losing MHP business, the CRC is still thriving while IA still cannot meet the expectations for the community. It has been apparent that quality of patient care is suffering as a result of this change. Talented radiologists were forcefully displaced and changed their livelihood, as well as job losses for the local region. As a local group was replaced by an outside firm, money consequently flowed out of the community rather than staying within the community. Ultimately the local community is the biggest loser in multiple areas.

Overall, this incident is shedding light and opening discussions on the future of radiology. What this event showed is that there are significant threats to the traditional private practice model of radiology. First and foremost, like IA, many Wall Street firms and teleradiology providers will compete more directly with traditional groups. Recently, NightHawk Radiology Services openly changed their “rules of engagement” with hospitals. Also, Virtual Radiologic announced their intention to go private (currently they are a publicly-traded entity). This will cloak many of their intentions. In addition, many large radiology groups are not immune. They also practice predatory tactics and displace smaller, traditional groups. These kinds of large groups have a big footprint, both nationally and in Ohio.

Continued Page 2

Finally, with the recent passage of the health care reform legislation, the landscape of radiology and medicine, in general, will change significantly. Cost cutting measures, particularly from high-cost services such as medical imaging, is noticeable to elected members. Congress has not been able to pass good legislation regarding self-referral, which is a continuous threat to radiology.

I believe an IA-style business model will re-emerge, but with modifications. That will be a threat to the private practice model. I hope we all can learn from past experience and work together, and help local groups rather than displacing them, to protect everyone's well-being.

The 87th ACR Annual Meeting and Chapter Leadership Conference in Washington DC in May was very successful. Eighteen delegates from OSRS and eleven residents and fellows from Ohio attended the conference. OSRS delegates introduced an emergency resolution regarding conflict of interest disclosure and predatory practices, due to the nationally recognized event in Toledo. For the first time in the 87 year history of the ACR, a conflict of interest disclosure passed unanimously. Essentially, ACR leaders and those running for leadership positions, must disclose any and all ties with companies that consult with hospitals or provide radiology services. These disclosures will be listed in the ACR election manual and meeting materials. The predatory practice-related resolution did not pass, in spite of significant support of the spirit of the resolution from all ACR councilors. They could not come to an agreement on the specific wording of the resolution.

A wide range of topics were discussed at the meeting, including economics, government relations, self-referral, physician payment, relationships between hospitals and radiologists in open-microphone sessions etc. During the last day of the meeting, more than 400 radiologists went to Capitol Hill to educate and advocate for medicine, in general, and radiology, in particular. This year's focal points were self-referral issue, a permanent sustainable growth rate (SGR) fix, and expansion of existing radiation quality and safety mandates. Members of Congress and their staff were receptive, in spite of the recent tumult of the health care legislation and mid-term elections.

I would like to thank Dr. Michael Seider, who conducted the Snow Belt caucus (consisting of delegates from many states) during the ACR annual meeting.

The Ohio residents and fellows who attended the ACR conference had a wonderful experience. Many are excited, and plan on being on actively involved in the organizations and recruit more members-in-training. They created a residents and fellows section on the OSRS website. I hope members-in-training will take advantage of this resource and I hope to see more of them at our local, state, and national meetings.

In conclusion, it is important to voice your opinions and concerns and be involved with OSRS and ACR, whether through monetary means or through your time. Working together, we'll make a difference.

Where is Healthcare Taking Us?

Michael J. Seider, MD, PhD, FACR
Immediate Past-President

I love to give my opinion on matters that I have no control over. As I am writing this column, Congress (or specifically the Democrats of Congress) is writing my future. Since I have no crystal ball as to what they are going to create, I will just sit and speculate how it will impact my practice, our state and national society and medicine in general. Of course, with millions of words being written every hour on the subject, this will only add to the noise but it may make me feel better to write about it.

Continued Page 3

In regards to my practice, I have been railing about self-referral and its impact on my practice over the past 5 years. I have gotten up in national meetings of my society (ASTRO) and tried to convince the people who run the organization what was happening at the grass roots level and how it was going to affect everyone as time went on. But, as with most things in life, if it doesn't have a direct impact on "you", then the problem tends to get minimized. This is what happened. And now, five years later, the hammer is hitting all practices, both private and academic and the powers that be don't like it.

Self-referral in radiation oncology is now a number one issue, just as it has been an issue for the radiologists during this time period. So, with the politicians writing the new law, is self-referral going to remain or go away? As far as I can tell, it is not going to change.

The new mantra for management is going to be "cost controls". This is defined as paying less for services and pretending that you really are just making the payments "fair". There are a lot of ways to do this. For radiation therapy, you simply increase the utilization time of a treatment machine from 50% to 90% and voila, you save lots of money on machine costs. Do treatment machines run all the time with patients underneath getting therapy? Nah, but why let reality interfere with a great mechanism for reducing payments.

In my opinion, self-referral will be dealt with by reducing payments so much that it will not be worth it for anyone to own their own machines. So who will own them? Large multi-practice organizations that employ physicians and can spread the cost of therapy over the entire huge practice. These clinics (but not solo practices) may even get a bonus from the government for running all the therapy and diagnostic equipment units just to make sure that individuals do not go out and start their own treatment centers. This will be good for the Mayo Clinics of the world, but it will be bad for me. What really bugs me is that with one small change in a Medicare rule, all of the above would be unnecessary. The House of Medicine (aka the AMA) does not agree and therefore, we all will suffer.

How does the impending legislation affect our state and national society? This may be simple or complex, depending upon how much the government has control over the payment system. If a public option appears, then we will have a one-payer system within the decade. It will be vitally important that radiology and radiation oncology have a large, strong society if that scenario plays out. Why? We will have to fight for every reimbursement penny that the government doles out, and we will be fighting with every other specialty society out there, as well as every other interest group that thinks they have a say in the management of medicine.

Without a powerful local, state and national organization, we will be left out of the discussions and will suffer for it. So it behooves us to bulk up now and start convincing the non-believers that it is time to join up. This includes our academic brethren who until this time thought that they were above the fray. I have a message for my academic colleagues. When you are in the middle of the Coliseum, the lions do not care if you are Christian or Pagan. To them, you're just red meat. We need to actively recruit Residents and Fellows and we have to hone our message, which is: "They are out to get us". Apathy will guarantee us a place in the sand box, but not at the table.

Nationally, we need to decide how we are going to deal with the rest of the house of medicine. Are we always going to be able to own our own equipment? Should other specialties be able to read images? A better question may be: Should other specialties be able to read imaging and get paid for it? Should other specialties be able to own treatment equipment? I think that nationally we need to get our heads together and answer these questions. Will Urologists want to own an IMRT machine if they lose money on every patient they treat? If we continue on our present course, this is where we will be in a few years. We have already seen it in outpatient PET scanning and MRIs. I think that Medicine has played into the hands of the

Continued Page 4

powers that be by being fractious and divided. It needs to stop, but I always did believe in the tooth fairy.

As the immediate past-president of this organization, I will still try and make an impression on the people I lead. I am committed to increasing the head count of the state society and I am looking for members to be ambassadors for this goal. It means talking to non-members and enduring the usual statements such as: "What has the OSRS ever done for me?" or I belong to OSRS and I don't need to spend any more money on anyone else." We all know that there are physicians who are never going to join. We don't want to spend time with these people. We need to get to the undecideds that may join if given a compelling reason. I cannot think of a more compelling reason than what is happening in Washington DC right now.

Who says Healthcare Isn't Fun??

Michael J. Seider, MD, PhD, FACR
Immediate Past-President

I suspect that everyone is expecting another article on health care reform. I am not going to beat that puppy any longer. I am going to take up a lesser-known issue that has transpired over the past 12 months and that will have a significant impact on the practice of radiology and radiation for the long term. The issue I would like to address is the one of supervision.

Technically, Medicare's physician supervision requirements are provided in the following link: (From ASTRO.org 1/09 White Paper)
(http://www.astro.org/PublicPolicy/WhitePapersAndOtherDocuments/documents/suprqmnts.pdf)

In essence, this paper broke down where Medicare expected physicians to be when doing diagnostic and therapeutic procedures both inside and outside the hospital. This set of rulings has been further clarified in 2010. This is a summary from a health care bulletin sent out by a Columbus, Ohio law firm (one time use exception).

CMS' Further Clarifications of Current Rule. In the Proposed FY 2010 Outpatient Prospective Payment System (OPPS) regulations CMS issued on July 1, CMS further "clarified" that "immediately available" has always meant that the physician may need to provide medical consultation and deal with emergencies and should be available in a timely manner. In addition, CMS' comments suggest that the physician providing the supervision must be qualified to actually perform the service because that physician may be expected to step in and take over performance of the procedure and even change the procedure of course of treatment if necessary. This means that although the physician need not necessarily be the same specialty or in the same department as the supervised service, the physician must have privileges at the hospital to perform that service. This change may significantly impact arrangements hospitals currently have in place.

In addition, CMS commented that although they have not expressly defined "immediately available." They view it to mean "without interval of time," thereby excluding physicians who are "performing another procedure or service that he or she could not interrupt" or who are "far away" from the location where the outpatient services are furnished. Accordingly, physicians who are busy doing other procedures, working in an ER, or located at some distance from the procedure to be supervised may not be eligible to serve as supervising physicians.
(http://www.bricker.com/publications/articles/1501.pdf)

So what does this mean to radiologists and radiation oncologists who provide imaging services and treatment at hospitals and outpatient centers? If we look closely at the ruling, this means that an interventionalist who

Continued Page 5

is doing a renal biopsy cannot supervise a patient undergoing an MRI at the same time since he or she is busy doing a procedure, which would prevent them from stepping in, and taking care of a problem if it arose in the MRI suite. It would also mean that if the radiologist were called off campus to go to a tumor board or any other meeting during the day that all procedures would have to stop until he or she returned to the department. Now one may say that this is not a big deal in the large hospital setting since most groups have large numbers of physicians and one can cross cover for the other. But let's look at this from another perspective.

What happens at night when there is only one covering physician who is busy doing a procedure on an emergency when another patient needs a CT scan in the ER? Technically the attending MD is busy doing another procedure and cannot attend the CT scan (remember that the rule says you must be able to "step in a take over the performance of the procedure"). Furthermore, how many Radiologists can run an MRI or CT scanner? For that matter, how many radiation oncologists can run a linear accelerator? (As an aside, where I trained, Cobalt-60 was still a large part of the practice and residents were required to know how to run one and set a patient up for treatment). The simple fact is that using the new interpretation of Medicare rules, the CT scan in the ER would be illegal and technically the physician would not be able to bill for it (fraud). The same applies for radiation oncologists. I cannot bill for a patient's treatment if I am not on site ready to "take over the treatment if something should occur". If I try to argue that my techs can treat the patient without difficulty without me, then Medicare will simply say "why are we paying you when you are not even around". (This does not take into account that my butt is on the line for everything that happens to that patient, but that is another story for another column.)

So what are the consequences of the supervision rules? The first and most obvious is that Medicare recipients are going to find that their choices for where they can receive treatment are going to be impacted greatly. Many rural hospitals use only one or two radiologists and if there is no direct supervision available, then the Medicare patient is going to remain untested or treated. Patients will have to be transferred to sites, which have the capability to provide constant supervision. Second, practices are going to be at risk for RAC audits if they try and circumvent the rules, and the fines for these audits are daunting indeed. Third, where is the manpower going to come from to provide the supervision demanded by HHS? Finally, how are you going to pay for the increase in the manpower? If HHS thinks that Radiologists and Radiation Oncologists are going to have their reimbursement cut 25-50% and remain in the field, then we will all be living in a new age of medicine.

The final laugh in this entire discussion is that supervision isn't just for the Radiologist and Radiation Oncologist. It applies to all areas of medicine. Those renal dialysis centers will need nephrologists on site at all times, cardiologists will need to be available when stress tests are being run. Physiatrists will have to be around for every PT treatment done…you get the picture. We will have to revamp the entire medical system. Maybe this was the point of the process. Medical costs are going up and we need to pare them back. You don't want to ration treatment to your patients directly. So, you do it indirectly by limiting the availability of treatments because there are no physicians able to provide service all the time. This puts the entire onus on us, and lets Medicare off scot free. And who says health care isn't fun??

As a OSRS member make a statement and encourage non-members that you know to get involved and join The ACR and the Ohio State Radiological Society. We need all radiologists to become members to stay strong. Remind members to pay their dues for 2010-2011.

Congratulations to Five Ohio Physician Members Inducted as Fellows at the 2010 ACR Annual Meeting and Leadership Conference

The ACR is a national non-profit association serving more than 34,000 radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists with programs focusing on the practice of radiology and the delivery of comprehensive health care services.

One of the highest honors the ACR can bestow on a radiologist, radiation oncologist or medical physicist is recognition as a fellow of the American College of Radiology. ACR Fellows demonstrate a history of service to the College, organized radiology, teaching, or research. Approximately 10 percent of ACR members achieve this distinction.

The induction took place at a formal convocation ceremony during the recent 87th ACR Annual Meeting and Chapter Leadership conference May 15 – 19, 2010, in Washington, D.C.

William D. Murphy, MD, FACR, of Canton, Ohio has been inducted as a Fellow in the American College of Radiology (ACR). Dr. Murphy is Chairman of the Department of Radiology at Mercy Medical Center located in Canton, Ohio and Clinical Associate Professor of Radiology at Northeastern Ohio Universities College of Medicine, located in Rootstown, Ohio. He is a member of the ACR, the Ohio State Medical association and the Stark County Medical Society. Dr. Murphy earned his medical degree from the Medical College of Ohio in 1985.

Daniel A. Finelli, MD, FACR, of Solon, Ohio has been inducted as a Fellow in the American College of Radiology (ACR). Dr. Finelli is Chairman of the Department of Radiology at Summa Health System, located in Akron, Ohio. He is a member of the ACR, Ohio State Radiological Society, the Radiological Society of North America, and the American Society of Neuroradiology. Dr. Finelli earned his medical degree from Cast Western Reserve University School of Medicine in 1985.

Stephen R. Thomas, Ph.D, FACR, of Cincinnati, OH, has been inducted as a Fellow in the American College of Radiology. Dr. Thomas is a Professor of Radiology at the University of Cincinnati. He is a member of the ACR and the American Association of Physicists in Medicine, in which he served as President in 1997. Dr. Thomas earned his PhD from Purdue University School of Science/Department of Physics in 1973, He currently serves as Associate Executive Director for Radiologic Physics for the American Board of Radiology (ABR).

Mary C. Mahoney, MD, FACR, of Cincinnati, OH, has been inducted as a Fellow in the American College of Radiology. Dr. Mahoney is a Professor of Radiology and Director of Breast Imaging at the University of Cincinnati. She is a member of the ACR, Radiological Society of North America, American Roentgen Ray Society, and the Society of Breast Imaging. Dr. Mahoney earned her medical degree from the University of Cincinnati Medical Center in 1983.

Jannette Collins, MD, FACR, of Cincinnati, OH has been inducted as a Fellow in the American College of Radiology. Dr. Collins is Professor and Ben Felson Chairman of Radiology at the University of Cincinnati Medical Center and the University of Cincinnati University Hospital. She is a member of the ACR; serves as chairman of the MOC Committee for the American Roentgen Ray Society; services a chairman of the Education Refresher Course Track

Continued Page 7

for the Radiological Society of North America, is past president of the Association of University Radiologists; is immediate past president of the Society of Thoracic Radiologists; and serves as chair of the Thoracic Writing Committee for the American Board of Radiology certifying exam. Dr. Collins earned her medical degree from the University of Toledo, College of Medicine in 1989.

Follow-Up Radiologist Dr. Trager Running for Congress

Many of you attending the ACR's Annual Meeting last month got an opportunity to meet with or at least hear from radiologist congressional candidate Dr. Marc Trager.

For those wondering, Dr. Trager is both an ACRA member and supporter of RADPAC and, if elected, would be a strong voice in Congress to promote radiology's agenda of quality patient care.

As Dr. Trager described in his talks, he has a very good chance to win the Republican primary for the Wisconsin 8th congressional district seat. The primary is scheduled for September 14. The only obstacle Dr. Trager will face is raising enough money to win the primary and then turn around 7 weeks later to take on incumbent Congressman Steve Kagen.

In the first quarter of 2010, Dr. Trager raised more than $100,000 which was the most money of any of the candidates in the primary. This feat led the National Republican Congressional Committee to put Dr. Trager "On the Radar" status for their Young Guns program. In addition to meeting with many radiologists during the ACR's AMCLC, Dr. Trager also had political meetings with Congressman Kevin McCarthy, Congressman Pete Session, Congressman Greg Walden and Congressman Lynn Westmoreland. Dr. Trager also met with Congressman Michael Burgess, M.D. (a retired OBGYN from Dallas, TX). Congressman Burgess has officially endorsed Dr. Trager's candidacy.

Dr. Trager is very appreciative to have received nearly $10,000 in contributions to his campaign from radiologists during/since the ACR's AMCLC.

If you would like to get involved or learn more about Dr. Trager's campaign, you can visit his website at: https://www.tragerforcongress.com/

If you would like to help support Ohio Radiology as a player in the Ohio Political arena, mail your check today to:

ORSPAC
c/o Billie Fiori, Treasurer
41 South High Street #2600
Columbus OH 43215

Note: Contributions to PAC organizations are not tax deductible, and should be made by personal check.

2010 Annual Meeting Highlights

2010 Silver Medal Certificate Awarded

The OSRS has conferred its highest honor to Dr. Fredrich H. Dengel. Dr. Dengel was presented the 2010 Silver Medal Award at the Fellowship Dinner held in Washington, DC on May 17. Dr. Dengel's practice is in Lorain and he is a past president of the OSRS. This award was given in appreciation for his invaluable leadership and service to the Society.

Silver Certificate Award winner
Fredrich H. Dengel, MD, FACR

Newly Elected OSRS Officers for 2010-2011

President
Yogesh P. Patel, MD, FACR

Secretary
Linda Reilman, MD,

Treasurer
Yogesh P. Patel, MD, FACR

Immediate Past-President
Michael J. Seider, MD, PhD, FACR

Dr. and Mrs. Daniel Finelli at Fellowship Dinner in Washington D.C.

Minutes from March 28, 2010 Council Meeting

Fellowship Committee Report

Stanley B. Ignatow, MD, FACR
Fellowship Chairman

Five Ohio radiologists became fellows at the 2010 ACR meeting in Washington. One Ohio radiologist will become a fellow at the 2011 ACR meeting.

There are no fellowship applications to consider at this time for 2011.

May 1, 2010 was the deadline for submission to the ACR for fellowship consideration for 2011.

Councilors and alternate councilors need to identify candidates for ACR fellowship in their regions, and encourage them to apply.

Congratulations to Five Ohio Fellowship Inductees

Stephen R. Thomas, MD, PhD, FACR, inducted as as ACR Fellow at the Fellowship Dinner in Washington D.C.

OSRS Delegates on Capital Hill

Continued Page 9

Treasurer Report

Yogesh P. Patel, MD, FACR

The Treasurer's report was distributed to the council at the March 28, 2010 Executive Council Meeting.

The following accounting was given to council. Current Bank Balance as of 1/25/2010 $150,415.84

Resident & Fellow Representative Report

Resident Ramblings: The Redesigned ABR Certification Process

C. Matthew Hawkins, MD
University of Cincinnati Diagnostic Radiology

It is widely known that this year's incoming first year radiology residents (class of 2014) will embark on an altered course toward certification. Rather than a traditional oral board examination at the end of residency, a core examination with clinical content and radiology physics will be administered at the end of the R3 year with the official certification test then taken 15 months following the completion of residency. The purported intent of the redesigned format is to increase subspecialization within our field, effectively numbering the days of the general radiologist.

Suspiciously, there seem to be significant trickle-down benefits for academia -- the most obvious being that fourth year residents will no longer need extensive preparatory time for oral boards, thus rendering them productive contributors within departments facing an exponentially growing clinical workload. Additionally, the new format will theoretically increase the number of fellows since certification will be pending for at least 15 months following residency. A conspiracy theorist might conjecture that keeping these valuable minds and able bodies within academic departments during the fourth year and fellowship is the real motivation for changing the current certification format. But regardless of the intent and despite all cynicism, increasing subspecialization is unarguably necessary for our profession to remain valuable.

I surmise that we're already seeing a dramatic increase in subspecialization, though. Anecdotally, all but one resident in the past two graduating classes from my institution have pursued fellowship training. All of the residents in my class are planning on fellowships, as well. The birth of large subspecialized radiology groups and multi-specialty practices have redefined the skills necessary to provide the value-laden service that patients and referring clinicians demand. And current residents are responding accordingly.

Increased subspecialization within radiology will be realized, but restructuring of the certification process is unlikely to be the cause. Regardless, the redesigned certification will assuredly be hailed a success rather than humbly declared a beneficiary of prosperous timing.

Most discussion pertaining to the new certification process addresses potential revisions of the residency curriculum and how to best utilize the newly available fourth year. How will the call responsibilities of residency be redistributed? Should fourth year residents take electives that align with their intended fellowship, or should they diversify the breadth of their education? These topics have been discussed, debated and dissected ad nauseam. While there will be some early turbulence, I'm confident that residency programs of all sizes will uniquely adapt to the new format.

But when should residents/fellows apply for jobs? What job market will exist for a "board-eligible" radiologist? If private insurers require board-certified radiologist interpretations in order to receive payment, will it be feasible for groups to hire "non-certified" liabilities? What if a new hire fails boards? Will there be

Continued Page 10

a contingency plan? Will groups be hesitant to hire someone until after certification? A new partner-track radiologist will certainly "cost" the group more up front since, in addition to being inefficient, significant time preparing for the certification exam will be needed. So, will the young "board-eligible" certification-hopeful be unpaid for three months between fellowship and certification while studying for the exam?

These questions have garnered little attention in a public forum. Nearly all other medical specialties have a similar certification process, so a suitable model for job application and hiring amidst delayed certification must exist, right? We should not be fooled by the dangerous enlightenment of assumption. The bottom line is that the changes in the ABR certification process are going to affect private groups, as well as academic departments.

The progressive groups will, by definition, develop strategies with payers, partnership buy-ins and contract clauses that prospectively address these potential quandaries.

But, if lacking forethought, a poorly-devised knee-jerk reactionary response to these predictable circumstances could dull attractiveness for potential applicants and ultimately deteriorate the competitive edge of a group in the local market.

Let us not heed the procrastinator's creed. Foresight, thoughtful discussion and preparation within both private practice and academic sectors can lead to a seamless transition for the class of 2014.

Membership Report

Linda Reilman, MD, Chairman

From Oct 23, 2009 to March 23, 2010

NEW MEMBERS

Matthew G Aagesen, MD, Toledo
Irfan Ahmad, MD, Columbus
Amna Ali Ajam, MD, Dublin
Amy D Argus, MD, Cincinnati
Joe E Assaad, MD, Cleveland
Mayukh Babu, MD, Westlake
Stephen Edward Barnes, MD, Batavia
Maria del Pilar Bayona Molano, MD, Cleveland
Mohamed Elgabavy, MD, Cleveland
Carl N Fetko, MD, Cleveland
Jeffrey Forquer, MD, Sylvania
Matthew Fox, MD, Cincinnati
Jason Griffith, DO, Salem
Glen T Hansen, MD, University Heights
Stephen F Hatem, MD, Cleveland
Thomas E Heffernan, MD, Cincinnati
Darlene M Holden, MD, Cleveland
Steve Huang, MD, Cleveland
Neville Irani, MD, Mason
Paul G Johnson, MS, Avon
Baljendra S Kapoor, MB, BS, Cleveland
Shannon L Kauffman, MD, Dayton
James M Kennen, DO, Lakewood
Hee Kyung Kim, MD, Cincinnati
Nina Louise Klein, MD, Cleveland
Joshua Q Knowlton, MD, Cincinnati
Edward R Koehl, MD, Hudson
Monica Koplas, MD, Cleveland
Michael C Kreeger, MD, Cincinnati
David Edwin Kuhlman, MD, Cincinnati
Philip Dewayne Lanham, MD, Greenville
David B Larson, MD, MBA, Cincinnati
Charles T Lau, MD, Broadview Heights
Lee-Ming Liou, MD, Chicago
Eva L Lizer, MD, Cincinnati
Mitchell Machtay, MD, Cleveland

Continued Page 11

Amit H Majmudar, MD, Cleveland
Theresa M March, DO, New Albany
Holly Nelson Marshall, MD, Akron
Kaushal B Mehta, MD, Canton
Resham R Mendi, MD, Cincinnati
Matthew J Moore, MD, Cincinnati
Andrew H Myers, MD, Cleveland
Arpit Nagar, MD, Columbus
Matthew D Orth, MD, Estacada
Jason E Payne, MD, Columbus
Theodore K Payne, MD, Dayton
Ramya M Pham, MD, Solon
David Pratt, MD, Cincinnati
Parshan S Ramsingh, MD, Cincinnati
Brenton Dean Reading, MD, Cincinnati
Matthew Robbins, MD, Cleveland
David Ira Rosenblum, DO, Akron
Steven Ross, MD, Cincinnati
Tina Ruchalski, MD, Cleveland
Yuji Seo, MD, Cleveland
Matthew J Sfiligoj, MD, Lorain
Zarine K Shah, MD, Columbus
Aakash Deep Singh, MD, Dayton
Andrew D Smith, MD, University Heights
Shane Wesley Smith, MD, Dayton
Kevin Stephans, MD, Cleveland
Roland Talanow, MD, Cleveland
Rahul D Tendulkar, MD, Cleveland
Kyle M Tharp, MD, Springboro
Neil P Vachhani, MD, Cleveland
Anthony J Ventimiglia, MD, Akron
Matthew Mansfield Wagner, MD, Dublin
Suraj S Waikhom, MD, Columbus
Michael Allan Walsh, MD, Toledo
Mark Warren, DO, Dayton
Syed Furqan H Zaidi, MD, Canton
Steven Roger Zieber, MD, Bellevue

TRANSFERRED OUT OF STATE

Nakiisa Monique Rogers, MD, Indiana
Leann Eggers Linam, MD, Arkansas
Rashmi T. Nair, MD, Florida
Brad W. Cushnyr, MD, New Mexico
Amy Liebeskind, MD, New York State

FROM OUT OF STATE

Jorge Cepeda, MD, Tiffin
David W. Spriggs, MD, Massillon
Harvey J. West, MD, Beachwood

DECEASED

Roland G Wintzinger, MD, Cincinnati

Ohio Legislative Updates

Victor Goodman, Benesch, Friedlander Coplan & Aronoff, LLP

The General Assembly is engaged in preliminary discussions with regard to potential ways to close the budget deficit for the next biennium. The Governor's Office of Budget and Management has only projected about a $4 billion shortfall. Legislative budget staff has noted, however, that the current budget contains approximately $4 billion in "one-time money," mostly federal "stimulus" funds. There is no assurance, indeed, no indication whatsoever, that these funds will be available for the next budget cycle, meaning that the legislature will have to raise revenue and/or make cuts totaling $8 billion.

Below are some of the issues being discussed, in no particular order:

1. Further delay the last remaining year of the income tax cut scheduled as part of the CAT tax reform. The General Assembly used this delay to help balance the current budget, and it will probably be considered again.

2. Eliminate tax exemptions and credits. This option has the potential of raising a great deal of revenue but that it would be very difficult to achieve because each exemption/credit has its own constituency and proponents in the legislature. Elimination of these exemptions/credits will also likely be considered a "tax increase," which many legislators will reject out of hand.

Continued Page 12

The Ohio State Radiological Society
4342 Parkway Centre Drive
Grove City, Ohio 43123

877/991-0038 Phone
877/991-0038 Fax
www.osrs.org

3. Eliminate the automatic indexing of tax rates and personal exemption amounts. This would not raise a great deal of revenue, but will raise some revenue and may help alleviate future revenue shortfalls. It may be more acceptable than eliminating exemptions/credits because some legislators may not consider it a "tax increase."

4. Stop increasing the portion of property tax paid by the state. Again, this may be viewed as a tax increase.

5. Increases in fees/user fees and possible implementation of new user fees. This may be one of the more acceptable options because some legislators believe that those using state services should pay for them. Others, however, still view these fees as taxes.

6. Renew hospital/nursing home/ICF-MR taxes ("franchise fees") that are now contained in temporary law.

7. Cuts in spending:

a. Medicaid cuts. This may not be a good solution because it saves the state less than $.40 on each dollar of cuts because of the share paid by the federal government. Because of federal healthcare/stimulus legislation, the federal share in the current budget is even higher with a $.27/$.73 state/federal split. All of this means that the state would essentially have to gut the program to achieve the level of cuts required to balance the budget.

b. Prisons/Youth detention cuts. Also difficult to do because of all of the mandatory sentencing laws. When the General Assembly requires offenders to be sentenced to prison, the state has to pay people to watch them. Prisons are already understaffed based upon recommendations issued following the Lucasville riots. One possible reform is reducing the number of non-violent offenders sentenced to prison and making more of the them eligible for home detention/electronic monitoring. There is a cost for these as well, but some savings could potentially be achieved.

c. State employment. Total state payroll is nowhere close to $8 billion, meaning the state could lay off every single state employee and still not balance the budget. Nevertheless, one significant potential cut would be to forestall the increases contained in the third year of the state employee collective bargaining agreement in which the state agreed to restore all of the cuts previously made to help balance the last budget. The third year of the CBA will be the first year of the next budget.

d. That leaves cuts to higher education, primary and secondary education, and funding to local government. Because of the constraints set forth above, these are likely to be the most significant cuts. Each of these areas has a strong constituency that will make significant cuts difficult, but the lack of viable alternatives may make them necessary.

Discussions of proposals to raise revenue and cut spending will continue for some time as state decision-makers engage in difficult negotiations over the next biennial budget. One thing is now clear, however: no party with an interest in the state budget is likely to emerge unscathed.