THE QUARTERLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

2023 CAP Board of Directors and MPT Board of Trustees Elections

Your Vote Matters

For more than 40 years, members of the Cooperative of American Physicians, Inc. (CAP) have benefited from trusted medical professional liability coverage offered through the Mutual Protection Trust (MPT). They have also relied on the organization's governing physician leaders to safeguard the future of the enterprise and effectively meet the individual needs of its members and their practices.

This year, elections for the CAP Board of Directors and for the MPT Board of Trustees will be held on July 19, 2023, in conjunction with the Annual Meeting of Members. The CAP ballot, MPT proxy, and additional voting information will be mailed to all CAP members of record later in May. It is critically important that all members vote without delay.

Meet the Nominees

We invite you to learn more about the seven physician members who have been nominated by the CAP and MPT Boards to serve the membership. Upon election, this diverse pool of candidates will have the privilege of serving you and maintaining a legacy of trust, security, and strength on behalf of nearly 13,000 CAP members.

Name: **Sheilah M. Clayton, MD, FACS**
Medical School: **Case Western Reserve University School of Medicine**
Practice Location: **Pasadena, CA**
Specialty: **General Surgery**
Years in Practice: **33 years**
CAP Member Since: **1990**

CAP and its members continue to thrive amidst a multitude of unprecedented and ever-evolving challenges that test our resilience as physicians. I credit CAP's and MPT's leadership and the excellence of the membership for facing this adversity head on with flexibility and perseverance. Our membership count is the highest in CAP's history, and the services we provide to support physicians are second to none. I stand by my ongoing commitment to the organization and to our members to ensure our continued growth through the delivery of affordable medical malpractice coverage and services that support successful medical practices and safe patient care.

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Name: **Steve Kasper, MD**
Medical School: **Keck School of Medicine of USC**
Practice Location: **Glendale, CA**
Specialty: **Family Medicine**
Years in Practice: **32 years**
CAP Member Since: **1994**

As a longtime CAP member, I have appreciated and relied upon the services CAP provides specifically to help physicians like me remain independent in their practices. In addition to secure medical malpractice coverage, CAP offers essential solutions that address many of the administrative challenges all physicians face so we have more time to spend with our patients. Only an organization that operates for doctors by doctors can understand these challenges and confront them accordingly. If elected to the Boards, I would draw on my own experiences as an independent physician to best represent the needs of our members, their practices, and their patients, all while working with my colleagues to protect the ongoing strength and growth of the organization.

Name: **Wayne M. Kleinman, MD**
Medical School: **Virginia Commonwealth University School of Medicine**
Practice Location: **Tarzana, CA**
Specialty: **Anesthesiology**
Years in Practice: **34 years**
CAP Member Since: **1992**

With more than 20 years of experience serving as a CAP and MPT leader, I am inspired and proud to be a part of the organization's unprecedented growth. CAP is now serving nearly 13,000 physicians and counting. Our position in the market as a leading medical malpractice coverage provider is only getting stronger as more California physicians trust the medical malpractice coverage offered through MPT. As a member of the CAP Board of Directors and MPT Board of Trustees, it is my primary duty to safeguard the long-term stability of the organization, and ensure our members are protected with quality coverage and a growing suite of valuable benefits to support their practices.

Name: **John Kowalczyk, DO, FACOS**
Medical School: **Midwestern University Chicago College of Osteopathic Medicine**
Practice Location: **Los Angeles, CA**
Specialty: **Urology**
Years in Practice: **28 years**
CAP Member Since: **2005**

It has been an honor and distinct pleasure to serve on CAP's Board of Directors and MPT's Board of Trustees. I am pleased to have the opportunity to work alongside my colleagues to ensure the future health and strength of the organization so that members continue to receive the highest degree of medical malpractice coverage. Upon joining CAP in 2005, I found tremendous value in the many resources offered to help independent physicians in their practices. Combined with excellent medical professional liability coverage delivered by MPT, CAP's valuable benefits and services alleviate many of our burdens which allows us to spend more time with our patients. In serving as a CAP and MPT leader, I will proudly support our members to help them meet their needs and goals and maintain viable practices, ultimately for the benefit of our patients.

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Name: **Meagan Moore, MD**
Medical School: **The Warren Alpert Medical School of Brown University**
Practice Location: **Fountain Valley, CA**
Specialty: **Obstetrics and Gynecology**
Years in Practice: **22 years**
CAP Member Since: **2001**

I've been a member of CAP for more than 20 years, have participated on several committees, and have observed the critical role of the Boards in the disciplined oversight of the organization's resources and assets. I truly believe in CAP's and MPT's leadership to effectively advocate for and protect its members. I would gladly uphold this long-standing commitment and mission to ensure that our members have financially secure coverage, essential support when experiencing a claim, and the resources needed for productive practices. My experiences with CAP have had a positive impact on my busy medical practice and I would welcome the opportunity and privilege to serve my fellow members in this same spirit as a CAP and MPT leader.

Name: **Stewart L. Shanfield, MD**
Medical School: **University of Texas Health Science Center at San Antonio**
Practice Location: **Fullerton, CA**
Specialty: **Orthopedic Surgery**
Years in Practice: **37 years**
CAP Member Since: **1998**

More than 40 years ago, CAP was founded to provide a way for California physicians to have stable and affordable medical professional liability coverage, while keeping their practices open to treat patients. CAP's mission resonates today more than ever as new challenges continue to threaten a physician's ability to remain independent and successful. As chair and president of CAP and chair of MPT, it has been my primary goal to maintain the powerful voice of our organization in the medical community and ensure the best coverage and support for our esteemed members. I know that together we can and will continue to prevail over healthcare-related obstacles and formulate solutions that make us stronger for our patients and communities.

Name: **Lisa L. Thomsen, MD, FAAFP**
Medical School: **University of California, San Francisco School of Medicine**
Practice Location: **Glendora, CA**
Specialty: **Family Medicine**
Years in Practice: **33 years**
CAP Member Since: **2003**

As CAP's membership grows, so do the opportunities to ensure that our members are well-equipped to manage the pressures associated with running a medical practice. CAP is at the forefront of these challenges and continues to provide solutions to help independent practices remain viable. As a CAP leader, it is my responsibility to identify resources that address our individual and collective pain points and leverage my voice to promote the value of membership. It's an exciting time for CAP and its members as we continue to make strides to grow the organization through collaboration, flexibility, and determination. I remain a committed advocate for my fellow physicians and their patients.

Case of the Month

What's at Risk When Communicating With a Deaf Patient

By Deborah Kichler, RN, MSHCA

Effective physician-patient communication is an integral part of the clinical practice and serves as the cornerstone of physician-patient relationships. The critical importance of the information a physician is relaying to their patients must be communicated in a manner so the patient understands their health condition and is able to make an informed decision about their medical treatment plan. Equally important is the patient's ability to communicate medically relevant information to the provider. A lack of effective communication and understanding can result in delayed or inadequate treatment, possible harm, and even death.

Communication with deaf or hearing-impaired patients requires additional considerations to ensure that effective communication is provided. When necessary, a qualified interpreter or interpretation service must be provided to the patient.

In 2018, the Eleventh Circuit Court heard an appeal of a Florida case, Crane v. Lifemark Hospital, involving a deaf person's right to an interpreter.[1] Mr. Crane, a profoundly deaf individual who communicates using American Sign Language (ASL) filed a lawsuit against a hospital for failure to provide a sign language interpreter to effectively communicate during an involuntary commitment evaluation. Mr. Crane appealed the district court's order granting the defendant hospital's motion for summary judgment. The issue on appeal was whether Mr. Crane was afforded an equal opportunity, through an appropriate auxiliary aid, to effectively communicate medically relevant information during his involuntary commitment evaluation.

Mr. Crane suffered from chronic depressive and anxiety disorders. In July 2011, police responded to a call that Mr. Crane was suicidal and transported him to Palmetto General Hospital where he was treated for alcohol intoxication. Mr. Crane reported that while at the hospital, he repeatedly requested a sign language interpreter but was not provided with one. The following day, Mr. Crane was evaluated by a psychiatrist for possible involuntary commitment for psychiatric care. The psychiatrist communicated with Mr. Crane through written notes and limited sign language skills. Although the psychiatrist determined that Mr. Crane was not a threat to himself or others, he remained in the hospital for two more days. It was not until his day of discharge that an ASL interpreter was provided to assist the psychiatrist in communication with Mr. Crane.

Mr. Crane subsequently filed a lawsuit alleging the hospital violated the Americans with Disabilities Act of 1990 (ADA)[2] by failing to provide a qualified sign language interpreter or other appropriate form of assistance to a deaf patient. The ADA prohibits discrimination on the basis of disability in employment, public accommodations, state and local governmental services, public transportation, and telecommunications.[3] Under the ADA, the definition

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of discrimination includes: "(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, services, facility, privilege, advantage or accommodation being offered or would result in undue burden." Title II of the ADA covers medical services and facilities run by government bodies, including public hospitals, clinics, and medical offices because they are public entities.[4] A deaf patient has the right to actively participate in their care just as a hearing person. That includes both receiving medical information from physicians and/or staff and providing medically relevant information to the physician and/or hospital staff provider.

In the Crane case, the defendants contended they provided Mr. Crane with sufficient auxiliary aids, i.e., written notes and basic sign language services, for effective communication. However, Mr. Crane asserted that he was not afforded the opportunity to sufficiently communicate with the physicians and staff. In an affidavit he declared "I was never able to thoroughly express my feelings [about] the traumas I have experienced in my life . . . during any of the doctor's evaluations and daily interactions with the Hospital's nurses. For example [,] besides writing down that I was depressed, I was never provided the opportunity during my hospitalization to go into detail [] ...about why I was depressed." The appellate court opined that "At a bare minimum, this provides evidence that Crane could not understand and suffered a real hindrance due to his disability to provide material medical information with his health care provider." The appellate court reversed the district court's order granting summary judgment and remanded the case for further proceedings.

Next month, CAP's risk management and patient safety team will share valuable strategies for communicating with and managing patients with hearing disabilities to help physicians and their staff remain compliant and provide effective medical treatment.

[1]Crane v. Lifemark Hosps., Inc., 898 F.3d 1130 (11th Cir 2018). https://casetext.com/case/crane-v-lifemark-hosps-inc
[2]42 U.S.C. § 12110 et seq.
[3]California Medical Association Health Law Library. The California Physician's Legal Handbook, Document #6002, Disabled Patients: Health Care Services, February 2022, p. 1
[4]28 C.F.R. § 35 and § 36.

Telemedicine Alert: End of the Public Health Emergency Prompts Proposed Rules by the DEA

By Dona Constantine, RN, BS and Gabriela Villanueva

Consistent with the Biden Administration's timeline to end the COVID-19 national and public health emergencies on May 11, 2023, the U.S. Department of Health and Human Services (HHS) informed states to expect the Public Health Emergency (PHE) and certain associated flexibilities to end on the same date. The announcement prompted the need to address temporary policy changes that were put in place during the PHE and that are set to expire with it.

One major policy change impacts the flexibility to prescribe certain controlled substances via telehealth.

Previously, if a public health emergency was declared, federal law would allow for an exception to the requirement that a patient be seen in person before prescribing a controlled substance via telehealth. With the PHE coming to an end, many are concerned that patients will lose access to needed medications.

On February 24, 2023, the U.S. Drug Enforcement Administration (DEA) released two proposed rules to reinstate the requirements that:

• A patient sees a doctor in person before being prescribed certain Schedule II controlled substances like Adderall and OxyContin.

• Providers be able to prescribe a 30-day supply for buprenorphine and non-narcotic Schedule III-V drugs, such as Xanax and Ambien, without an in-person visit if the telemedicine encounter is for a legitimate medical purpose. Anything beyond a 30-day supply will require an in-person visit.

If a patient had already been receiving prescriptions by telemedicine during the PHE, the DEA will defer the in-person exam requirement for an additional grace period of 180 days. Notably, the grace period does not appear to be applicable to buprenorphine.

Since the DEA only provided a 30-day public comment period starting from March 1, 2023, a final rule is expected in time for the new regulation to go into effect when the PHE ends.

What Physicians Need to Know to Prepare for New Telehealth Rules:

Medical practices are well accustomed to responding and adapting to regulatory changes. Physicians should be aware of the DEA's long-awaited proposed rules related to telehealth.

Anne Milgram, DEA Administrator, stated "...DEA is committed to the expansion of telemedicine with guardrails that prevent the online overprescribing of controlled medications that can cause harm."[1]

The proposed rules do not affect:

• Telemedicine consultations that do not involve the prescribing of controlled medications.

• Telemedicine consultations by a medical practitioner who has previously conducted an in-person medical examination of a patient.

• Telemedicine consultations and prescriptions by a medical practitioner to whom a patient has been referred, as long as the referring medical practitioner has previously conducted an in-person medical examination of the patient.

The following are other key provisions in the proposed rules

• Practitioners would have to keep records of all qualifying telemedicine referrals, and such records would need to be kept at the registered location that is listed on the prescriber's certificate of registration.

• All subsequent prescriptions via telehealth (which includes audio-only in some circumstances) would have to follow at least one in-person visit between the patient and a DEA registered practitioner.

• Prescriptions stemming from telemedicine encounters could be only for the purpose of maintenance or detoxification.

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Xavier Becerra, Secretary of HHS, has made it known that "[i]mproved access to mental health and substance use disorder services through expanded telemedicine flexibilities will save lives. We still have millions of Americans, particularly those living in rural communities who face difficulties accessing a doctor or health care provider in-person…"[1]

Although the federal proposed rules are intended to mitigate the potential abrupt end to telehealth prescribing of controlled substances, state law also governs remote prescribing and should not be overlooked when evaluating telemedicine requirements. State law could potentially provide an opening for less restrictive prescribing during an ongoing opioid crisis.

To learn more about how the proposed rules may affect you and your patients, please visit:
www.CAPphysicians.com/DEA1

To learn how the proposed rules may affect certain prescriptions, please visit:
www.CAPphysicians.com/DEA2

Additional information can be found here:
https://www.dea.gov/press-releases/2023/02/24/dea-announces-proposed-rules-permanent-telemedicine-flexibilities

Gabriela Villanueva is CAP's Government and External Affairs Analyst.

Dona Constantine is a CAP Senior Risk Management & Patient Safety Specialist.

Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com or DConstantine@CAPphysicians.com.

[1]Drug Enforcement Administration (2023, February 24) *DEA Announces Proposed Rules for Permanent Telemedicine Flexibilities* [Press release]. https://www.dea.gov/press-releases/2023/02/24/dea-announces-proposed-rules-permanent-telemedicine-flexibilities

by Andie Tena

What's Next for Telemedicine?

At the start of the COVID-19 pandemic, the federal government recognized that many healthcare providers and patients were not equipped to use telehealth technology, and that certain rules and regulations would hinder the rapid expansion of telehealth services. As a result, the Centers for Medicare and Medicaid Services (CMS) issued several waivers that temporarily relaxed regulations and expanded access to telehealth services. Some of the key waivers included:

- Allowing providers to deliver telehealth services across state lines without obtaining additional state licenses.
- Allowing providers to use telephones, FaceTime, and other communication platforms to deliver telehealth services.
- Allowing providers to bill for telehealth services at the same rate as in-person visits.

These waivers allowed healthcare providers to quickly adopt telehealth services and allowed patients to access medical care without having to leave their homes. As a result, telehealth usage exploded during the pandemic. Since then, many patients and providers have come to rely on these services.

Some providers and patients are concerned that once the waivers expire, they will no longer be able to access telehealth services. There is also concern that the expiration of the waivers will lead to a decrease in reimbursement rates for telehealth services, which may make it financially unfeasible for some providers to continue offering telehealth services. As of the writing of this article, Medicare payment parity will continue until December 31, 2023.

To address these concerns, some lawmakers are proposing legislation to make the telehealth waivers permanent. For example, the Protecting Access to Post-COVID-19 Telehealth Act (**https://www.congress.gov/bill/117th-congress/house-bill/366**) would remove many of the restrictions on telehealth services and make many of the temporary waivers permanent. The legislation has gained support from both Republicans and Democrats, and many healthcare organizations have also voiced their support for the bill.

There are also concerns about the long-term impact of telehealth on the healthcare industry. Some providers worry that telehealth services may lead to a decrease in the quality of care, as it may be more difficult to diagnose and treat certain conditions remotely. Others worry that the rapid expansion of telehealth services may lead to a decrease in in-person visits, which could negatively impact the revenue of many healthcare providers.

Despite these concerns, it seems likely that telehealth will continue to play a vital role in the healthcare industry. Whether the telehealth waivers will be made permanent

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or not remains to be seen, but the pandemic has shown that telehealth services can be an effective way to provide medical care to patients, particularly those in rural or underserved areas. As the healthcare industry continues to evolve, telehealth is likely to become an increasingly useful tool for providers and patients alike.

As we move forward as a healthcare community, it is important to understand which waivers will continue and which will expire at the end of the PHE, not only telehealth waivers, but all waivers. The below graphic provided by the Medical Group Management Association (MGMA) highlights the Medicare flexibilities that will continue through the end of 2024, and which flexibilities will terminate at the end of the PHE on May 11, 2023.

TOPIC	FLEXIBILITY	EXPIRATION DATE
MEDICARE TELEHEALTH	Originating site and geographic restrictions	151 days after declared end of the COVID-19 PHE
	Qualifying providers eligible to furnish telehealth	
	Coverage of audio-only services	
	Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) furnishing telehealth	
	Behavioral and mental health in-person requirements	
	Waived HIPAA penalties for technology used to furnish telehealth	Expiration of PHE
	State licensure requirements to furnish telehealth in other states	State specific; some currently expired, others tied to expiration of PHE

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COVID-19 TESTING	Medicare beneficiary waived for at home COVID-19 tests, testing-related services, and certain treatments	Expiration of PHE
	Group health plans and individual health plans required to cover COVID-19 testing and related services without cost-sharing	
FQHCs and RHCs	Certain staffing requirements related to nurse practitioners, physician assistants, or certified nurse-misdwife availability at an RHC	Expiration of PHE
	Temporary expansion waiver	
PRESCRIBING CONTROLLED SUBSTANCES	Waived Ryan Haight Act's in-person exam requirement for the prescription of controlled substances	Expiration of the PHE - waiting for DEA to publish rule
STARK LAW	Temporarily exempt from sanctions for certain arrangements that are "solely related" to COVID-19 purposes	Expiration of PHE

It is important to note that the graphic highlights the waiver flexibilities by **Medicare only**. For more information, visit: **https://www.cms.gov/coronavirus-waivers.** Commercial payors may have already implemented their own guidelines and it will be important to check with the individual payors that are contracted.

As of the writing of this article, the mentioned flexibilities and their end or continuation dates are accurate but there may be continued updates as the end of the PHE fast approaches.

For more information or additional questions, please contact Andie Tena, Assistant Vice President, Practice Management Services at CAP, 213-473-8630 or ATena@CAPphysicians.com.

Andie Tena is Assistant Vice President, Practice Management Services, at CAP. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

Choosing the Right Insurance for Yourself and Your Practice

Among the many worries keeping you up at night, protecting your business and personal assets from financial risks shouldn't be one of them. To help you choose the right mix of insurance coverages to meet your individual and practice needs, you can get a free copy of *The Physician's Guide to Choosing the Right Insurance*.

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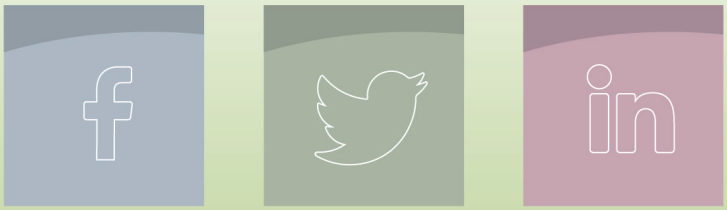

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**Must be currently working in healthcare at least 17.5 hours per week/per calendar quarter and not currently disabled or at time coverage becomes effective. Limited time pre-existing condition exclusion may apply; $200,000 annual income required to qualify for $10,000 monthly benefit otherwise benefit will be based on 60% maximum.

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