



Meet the Board's Nominees for MPT Board of Trustees

Ballot and Proxy Also Include CAP Board Nominees and Other Important Proposals

Through a variety of approaches, the physicians nominated by the Mutual Protection Trust Board of Trustees to represent the membership share a core value in their desire to serve: Enhancing patient care by keeping medical liability protection costs low.

"Serving on the Board of Trustees is actually an opportunity to serve fellow physician members," says Stewart Shanfield, MD, an Orange County orthopedic surgeon who has served for 10 years on the Cooperative of American Physicians Board of Directors. "As your trustee, I will work to maintain MPT as a powerful voice in medicine, protect its resources, and provide support to our excellent physicians."

Phillip Unger, MD, a radiologist in Fullerton and a current member of the MPT Board, expanded on what motivates leaders at MPT. "I want to do everything I can to ensure that MPT's founding goals are achieved and maintained – providing the highest quality medical liability protection at the lowest possible cost."



Stewart Shanfield, MD

Charles Steinmann, MD

Lisa Thomsen, MD

Phillip Unger, MD

Bruce Weimer, MD

Lisa Thomsen, MD, a family practitioner in Glendora and a CAP director since 2011, says her daily medical practice experience will be an asset to MPT: "I believe in CAP and MPT and the strong work the enterprise performs in supporting and providing resources to our members. I look forward to bringing my full-time active clinical perspective to the MPT Board of Trustees as we navigate the ever-challenging medical landscape."

Glendora neurologist Bruce Weimer, MD, points to his experience at CAP as a foundation for a new role governing MPT. "As vice chair of the CAP Board of Directors and as chair of the CAP Nominating and Governance Committee, I've had the privilege of participating in CAP's growth to its now nearly 12,000 members. As an MPT trustee, I will carry that experience forward as MPT provides cost-effective medical malpractice coverage to California's best physicians."

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Another current MPT trustee, Newport anesthesiologist Charles Steinmann, MD, says his leadership and finance experience enables him to promote important MPT goals. "I am passionate about CAP and MPT. Having served as the chair of the CAP and MPT Finance Committee for many years and currently as chair of the MPT Board of Trustees, I am well qualified to protect our physicians through keeping MPT competitive, protecting our financial integrity, and grooming future leaders."

In addition to the election for the five-member MPT Board of Trustees, the CAP Board of Directors also has nominated candidates to serve on the seven-member CAP Board. Those candidates are Sheilah Clayton, MD, a general surgeon in Pasadena; Béla S. Kenessey, MD, a family practice physician in Danville; Wayne Kleinman, MD, an anesthesiologist in Tarzana; Gregory Lizer, MD, a pediatrician in La Cañada-Flintridge; Amir Moradi,

MD, a plastic surgeon in Vista; Graham Purcell, MD, an orthopedic surgeon in Santa Monica; and Paul Rocky Weber, MD, an obstetrician-gynecologist in Long Beach.

In making their nominations, both boards benefited from an evaluation process overseen by the respective CAP and MPT Nominating and Governance Committees. The ballot and proxy package also includes several governance and coverage proposals for membership approval.

The 2017 CAP ballot and MPT proxy materials were mailed to the membership in late May. Members who have not yet submitted their votes may return the ballot and proxy pages by mail or by fax at 213-576-8574. Members also may vote online by going to www.CAPphysicians.com. If you need another ballot, please contact Membership Services at 800-610-6642. ↩

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MACRA May Hold Some Familiar Features for Members

Since its passage with bipartisan support in 2015, the regulatory impact of the Medicare Access and CHIP Reauthorization Act (MACRA) is far-ranging. From repealing the Sustainable Growth Rate (SGR) formula that determined Medicare reimbursement rates to mandating new programs that establish new paths to pay physicians caring for Medicare Part B beneficiaries, MACRA's reach is ambitious. All programs are administered by the Centers for Medicare and Medicaid Services (CMS).

Aside from the current political climate, potential legislative changes to the delivery models, and patient access to healthcare, the general consensus now is that MACRA is here to stay and with its corresponding rules on payment for value, physicians increasingly will be paid based on the outcomes of their care. Though these programs may be new, in reality, what has happened is more of a consolidation of previous programs physicians and healthcare systems had already been participating in.

In its simplest form, the new rules take the previous value-based payment programs and put them in what is now called the QPP – Quality Payment Program. The QPP creates two new reimbursement structures: the Merit-based Incentive Payments System (MIPS) and additional options for Alternative Payment Models (APMs). Upon a closer look of the QPP, specifically at MIPS, physicians will recognize systems and features they may have already been using, such as the Physician Quality Reporting System (PQRS), Meaningful Use (MU), Value Modifier (VM), and the Electronic Health Record (EHR) incentive programs — all are present to some degree in the MIPS version.

For the majority of solo and small practice physicians, it mostly will be the case that if eligible, they will need to comply with MIPS reporting requirements. And, if so, much of what MIPS outlines physicians and their practices have already been engaging in to some degree. So in many respects, what MACRA attempts to accomplish may quite likely already be present in your practice.

Public Policy

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As a reminder, the reporting period for payment adjustment in 2019 began on January 1, 2017, and several options became available to provide physicians with the flexibility to “pick their pace” for the reporting program they wished to participate under this year. A very important date to keep in mind is October 2, 2017, as this marks the last day to complete a 90-day reporting cycle in 2017 to track and submit MIPS data to CMS.

Participating providers will receive positive, negative, or neutral adjustments to the base rate of their Medicare Part B payment that will increase each year starting in 2019 with +4 percent to -4 percent; 2020 with +5 percent to -5 percent; 2021 with +7 percent to -7 percent; and ending in 2022, when it will be capped at +9 percent to -9 percent. Each reporting physician or group will be scored based on the performance measures outlined in MIPS. For maximum success in attaining the highest score, each practice should select the best variables to measure to help reach a maximum score in each category.

A major topic of discussion during the formation of these rules was the question of providing support specifically to solo and small practice physicians. Toward this end, earlier this year CMS awarded \$20 million to 11 organizations across the country for the first year of a five-year project. These community-based organizations will be tasked with providing on-the-ground training and education about the QPP.

Among those organizations, the Health Services Advisory Group (HSAG) was selected and awarded a grant by CMS to provide assistance to California physicians. With multiple tools such as an online library, a live help line, printed materials, webinars, and one-on-one assistance, physicians participating in MIPS will find help with identifying the quality measures best tailored and most point-effective for each individual practice — all free of charge. Finding a new path leading to the ultimate destination of maximum reimbursement will be a multi-pronged group effort.



For more details on available resources, CMS also has created a QPP-specific web page where physicians can begin their path by confirming their MIPS eligibility and, if eligible, contacting HSAG for assistance with compliance.

CMS: <https://qpp.cms.gov/>

HSAG: <https://www.hsag.com/en/medicare-providers/quality-payment-program/> ➔

Are You at Risk for an Employment Practices Lawsuit?

If you have staff, the answer is “you betcha”



Did you know that as a business owner, you are significantly more likely to be sued by an employee than by a patient or other outsider?

In fact, within the past 20 years, employee lawsuits have risen roughly 400 percent, with wrongful termination suits jumping more than 260 percent. In California alone, 5,870 Equal Employment Opportunity Commission (EEOC) charges were filed for in 2016, comprising 6.4 percent of all of the charges in the United States. While an employer may be sued by a staff member for one of many reasons, the top four suits are:

1. Harassment
2. Discrimination
3. Unlawful Termination
4. Violation of the Americans with Disabilities Act (ADA)

The financial damage of employee lawsuits can be dramatic, whether or not there is merit: **The cost of settling out of court averages \$75,000, and the average jury award hits \$217,000.** Minimally, you could be out of pocket thousands of dollars to simply respond to an EEOC claim. And it's not just large corporations that are being hit. Roughly 41.5 percent of employee lawsuits are brought against private companies with fewer than 100 employees.

EPLI: Not Just a Nicety, but a Necessity

Many employers believe that their liability or workers' compensation insurance covers employment-related lawsuits, but unless you have an Employment Practices Liability Insurance (EPLI) policy in place, your business is at risk. EPLI provides a practice of any size with cost-effective coverage to help protect it against employee claims alleging sexual harassment, discrimination, wrongful termination, breach of employment contract, negligent evaluation, failure to employ or promote, and deprivation of career opportunity.

The cost of EPLI insurance is a fraction of what you will pay if you end up on the losing side in a lawsuit. EPLI premiums will vary depending on a number of factors:

- The number of employees
- The amount of coverage purchased
- Whether your company has anti-discrimination and anti-harassment human resources policies in place
- Whether your company has had any EEOC complaints or lawsuits filed against it in the past

The good news is as a CAP physician member, you already have a \$50,000* defense-only benefit provided by your Employment Practices Plan. As you can see from the above examples, this benefit would help, but probably not cover all claim costs. CAP Physicians Insurance Agency, Inc. (CAP Agency) offers our physician members highly competitive rates for EPLI coverage — provided by an A+-rated carrier.

You owe it to yourself and your practice to get a quote. We at the CAP Agency stand ready to help you protect your practice. Contact us at 800-819-0061 or email us at CAPAgency@CAPphysicians.com for more information.

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Case of the Month

by Gordon Ownby



Court Backs MICRA on Future Medical Expenses – and the ACA

In a case that had garnered interest across the country, a California appellate court has held that a defendant in a medical professional liability trial may introduce evidence of future health insurance benefits available to the injured plaintiff.

The national interest derives from the fact that the future insurance benefits in question involve those available via the Patient Protection and Affordable Care Act (ACA).

In a birth injury case alleging medical malpractice – *Cuevas v. Contra Costa County* – the plaintiff’s attorney put on the stand an expert to testify on the young plaintiff’s life care plan. That expert used a national database that reflects the average charges billed for the kind of medical services the plaintiff will need over the course of his life.

Defendant County of Contra Costa’s life care plan expert also testified on expected costs of the plaintiff’s medical care, based on her own investigation into the cost of medical services.

The trial court judge, however, denied the County’s request to introduce evidence on future medical benefits available to the plaintiff under an insurance policy under the ACA. The judge’s denial was based not only on his interpretation of California’s Medical Injury Compensation Reform Act (MICRA), but also on the viability of the ACA itself:

“I believe there is no reasonable certainty that that benefit will be in place”

The County argued unsuccessfully to the trial court judge that introducing such evidence of reduced costs to the plaintiff “would assist the jury in evaluating the reasonable value of plaintiff’s future medical care.” The jury found for the plaintiff and awarded \$100 million for future medical, hospital, surgical, and rehabilitation expenses. The present cash value of that award is \$9.6 million.

On appeal, the County did not challenge the finding on medical liability, but argued that under California’s MICRA, it should have been permitted to introduce evidence of “any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the U.S. Social Security Act, any state or federal income disability or workers’ compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services.”

In opposition, plaintiff’s attorneys argued that MICRA’s permitting evidence of “any amount payable” applied only to past payments, not payments for future medical expenses.

In granting the defendant County a new trial, the Northern California-based First District Court of Appeal found that allowing such evidence “with respect to future medical benefits as well as past benefits is consistent with the legislative purpose (of MICRA) of reducing malpractice insurance costs.”

As to the continued availability of insurance to cover the plaintiff’s injuries under the ACA, the Court of Appeal cited evidence proffered by the County’s expert that the ACA is reasonably certain to continue well into the future and that plaintiff will be able to acquire comprehensive health insurance notwithstanding his disability.

“Defendant presented evidence sufficient to support the continued viability of the ACA, as well as its application to plaintiff’s circumstances. Accordingly, we conclude that the trial court’s decision to exclude evidence of future insurance benefits that might be available under the ACA on the basis that the ACA is unlikely to continue was an abuse of discretion.” ⚡

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Risk Management and Patient Safety News



Telehealth: The Doctor Will See You Now What You Need to Know to Get Started

by Ann Whitehead, RN, JD

Telehealth is the use of telecommunications to facilitate healthcare delivery. As such, telehealth is seen as a tool to augment, and not replace, the clinical practice, judgment, and expertise of a healthcare provider. This article enumerates some of the important issues associated with the adoption of telehealth in a medical practice.

Definition

In 2011, AB 415 changed the definition of telemedicine (now referred to as telehealth). The new definition is codified in California Business & Professions Code § 2290.5 and defines telehealth as: “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.”

Physician-Patient Relationship

Providers who wish to employ telehealth as a tool in their practice are required to establish a physician-patient relationship. The minimum requirement is to do so through a face-to-face examination if a face-to-face encounter would otherwise be required in the provision of the same service not delivered by telehealth. Specifically, the Medical Board of California provides that a face-to-face encounter could occur in person or virtually through audio/video technology. Once this relationship is established, all usual communication standards, follow-up requirements, and documentation principles apply.

Standards of Care

Physicians practicing telehealth are held to the same standard of care as with face-to-face office encounters. While California statutes do not create different standards of care for telehealth, there are some professional organizations that set forth specific unique risks.

Consent

Healthcare providers also retain the responsibility to obtain the patient’s informed consent prior to initiating telehealth. California law requires that prior to delivery of healthcare via telehealth, the provider must:

- Inform the patient about the use of telehealth;
- Obtain oral or written consent from patient for this use; and
- Document the consent

A sample Telehealth Consent Form can be accessed from the CAP website at <https://www.CAPphysicians.com/risk-management/tools-and-resources#all-practice-forms>.

Documentation

The California Legislature has expressed its intent that all medical information transmitted during the delivery of healthcare via telemedicine become part of the patient’s medical record. In addition, the consent must be documented in the patient’s medical record.

Prescribing via Telehealth

Under state law, a physician may not prescribe medications via telehealth or the Internet without an “appropriate prior examination.” The question of what is an appropriate telehealth prior examination is not well defined in California law. Unofficially, the Medical

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Board of California provides that an appropriate prior examination may be conducted through telehealth if the technology is sufficient to provide the same information to the physician if the exam had been performed face-to-face. Physicians are advised to document thoroughly the telehealth-appropriate prior exam in the medical record.

HIPAA and Confidentiality

Health Insurance Portability and Accountability Act (HIPAA) guidelines on telemedicine make it clear that all ePHI should be protected by utilizing a secure messaging solution. The use of Skype and email should not be used for communicating ePHI at a distance. The issues related to HIPAA and secure messaging will be discussed at a later date.

Licensure

Professional licensure portability and practice standards for providers using telehealth are some of the biggest challenges for healthcare providers considering telehealth adoption. As of January 2016, 12 states have passed legislation to adopt an Interstate Licensure option. California, however, has not. Therefore, California physicians seeking to provide care to patients in other states should understand that such action is against current Medical Board of California regulations and may result in sanctions.

Reimbursement

Under state law, health insurers and managed care plans are prohibited from excluding coverage for telehealth services. Individual health plan contracts dictate reimbursement and coverage for these encounters. Since there is no concrete statement that telehealth includes telephone, email, or other remote technology, healthcare providers should research and document why it is medically appropriate in a specific case to provide a healthcare service via these modalities. Additionally, it must be noted that special regulations and requirements limit reimbursement for telehealth for Medicare recipients. Pressure within Congress to expand Medicare coverage of telehealth and remote monitoring services is approaching critical mass. There will be more to come on this issue.

Telehealth ventures often implicate other California and federal regulations and laws beyond medical



malpractice protection. This article is not intended to be a complete resource, and CAP encourages members to contact Risk Management for further information related to reducing telehealth medical malpractice liability. For other questions or for legal advice related to regulatory and legal issues, CAP recommends consulting a personal attorney.

Website Resources

The following websites provide additional telehealth resources for physicians:

- California Telehealth Resource Center, www.caltrc.org/
- California Telehealth Network, www.caltelehealth.org
- Medical Board of California: Practicing Medicine Through Telehealth Technology, www.mbc.ca.gov/Licensees/Telehealth.aspx
- American Telemedicine Association, www.americantelemed.org
- Center for Telehealth and E-Health Law, www.ctel.org/
- Federation of State Medical Boards, www.fsmb.org/ ➔

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The Successful Physician

by Carole A. Lambert, MPA, RN

Advancing Care Information: Required Measures

Last month, we looked at Improvement Activities (IA), one of the three performance categories in the Merit-based Incentive Payment System (MIPS), part of Medicare's Quality Payment Program (QPP). We asked: What steps have you taken in your practice to increase access and improve quality, contain costs, and create a positive environment for your patients, your staff and you? Our approach was to take credit for what we do best.

This month, we are looking at Advancing Care Information (ACI) and the required measures in this performance category. Below are the required measures and some key questions regarding electronic documentation of patient care. The answers can be of great help in understanding how your practice is doing in Advancing Care Information, supporting improved patient engagement, and connectivity.

How safe is your electronic health record system? The greatest threat to cyber security is an organization's employees. So how are you and your staff doing with protecting passwords and controlling access? Working with your vendor to regularly monitor and review system use will alert you to in-house as well as external threats. E-Prescribing can be a boon, increasing speed, reducing paperwork, and eliminating handwriting challenges. But it has not eliminated the need for the same attention to precision and accuracy that writing prescriptions by hand requires. As we noted last time, the Prescription Drug Monitoring Program in your state -- C.U.R.E.S. in California -- is an invaluable safety net in protecting patients and physicians from inappropriate prescribing of controlled substances.

How are you responding to the wide variation in the willingness or comfort of patients to use electronic communications with you and your office? The variation is not always due to age or previous unfamiliarity with personal devices. Improving patient access is one of the Quadruple Aims. For each practice and each physician, the structure and function of electronic access by patients will be tailored to that practice's culture. Appropriate safeguards, informed consent, and shared expectations

regarding the type of information that can be shared must be in place.

Closing the communication loop on referrals is a continuing challenge. When a patient is referred from one physician to another, what information goes with or is sent on behalf of the patient? When the patient returns, what information comes with her? Meeting this challenge is a key element in achieving an effective transition of care between practitioners. What process for follow-up and follow-through do you have in your practice? How consistently is your process implemented? Is this coordination of care reflected in (a) improved patient understanding of the plan of care; (b) improved adherence to the plan; and (3) an improved outcome?

The information below regarding reporting Advancing Care Information data is taken from the Quality Payment Program web site at <https://qpp.cms.gov/measures/aci>. In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.

- Option 1: Advancing Care Information Objectives and Measures
- Option 2: 2017 Advancing Care Information Transition Objectives and Measures

You can report the Advancing Care Information Objectives and Measures:

- If you have technology certified to the 2015 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions that support these measures.

You can report the 2017 Advancing Care Information Transition Objectives and Measures:

- If you have technology certified to the 2015 Edition; or
- If you have technology certified to the 2014 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions.

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Required Measure	Advancing Care Information Objectives and Measures	2017 Advancing Care Information Transition Objectives and Measures
Security Risk Analysis	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.
e-Prescribing	At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.	At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.
Provide Patient Access	For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's certified EHR technology.	At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician's discretion to withhold certain information.
Send a Summary of Care Request/Receive a Summary of Care; in 2017 Health Information Exchange	<p>For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers his or her patient to another setting of care or healthcare provider: (1) creates a summary of care record using certified EHR technology; and (2) electronically exchanges the summary of care record.</p> <p>For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document.</p>	The MIPS eligible clinician that transitions or refers their patient to another setting of care or healthcare clinician: (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving healthcare clinician for at least one transition of care or referral.

We hope you find this information helpful as you pick your pace for the first year of MIPS and chart your course to success. 

Sources: Advancing Care Information. <https://qpp.cms.gov/measures/aci>. Accessed June 1, 2017.
Bradley, C., Medicare Quality Payment Program 2017 and Beyond. CAMGMA, April 28, 2017.

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Legal guidance for individual matters should be obtained from a retained attorney.*

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