THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules

COOPERATIVE OF AMERICAN PHYSICIANS

CAP Member Talks About Healthcare Policy Choices Facing New Administration

Dr. Ted Mazer, President-Elect of the California Medical Association, Shares His Thoughts on Coverage Goals

Dr. Ted Mazer, an otolaryngologist in San Diego and president-elect of the California Medical Association, recently talked to *The San Diego Union-Tribune* about the choices facing the new administration in Washington as Congress decides whether to amend or replace the Patient Protection and Affordable Care Act (ACA).

As a practicing physician and active advocate, Dr. Mazer has a unique perspective on the potential effects federal healthcare policies may have here in California. When asked by *The San Diego Union-Tribune* what he thought the priorities should be in any reform effort, Dr. Mazer shared his views with the newspaper:

"There are some huge opportunities there. This time, instead of working in the political arena with the goal of getting something done quickly, I hope they can work to salvage what worked in the ACA, come up with a workable plan that lowers costs, maintains people's rights to access care, and provides patients with more choice than they have now."

Dr. Mazer is a member of CAP's state and federal PACs and, along with 16 of his fellow CAP physician committee members, helps educate policymakers on the issues that affect the delivery and access to care. Dr. Mazer addressed these issues in his interview regarding the nomination of Congressman Tom Price, MD, to head the U.S. Department of Health and Human Services, noting concerns expressed about the nomination by other physicians:

"I've known Tom for about 25 years, and I think he is someone who understands the system. We have to have a conversation about what works and what should we be doing to reform healthcare reform. Having a physician like Tom Price, who has been involved with the larger debate for years, sitting at the head of the HHS, can hopefully start educating the administration on how these things interplay, how medicine actually gets practiced."

While the incoming administration has still left the intended potential changes to the ACA largely unknown, the consensus among a number of different physician organizations is that the patient should remain the central focus of all reform efforts. As he expressed to CAP, Dr. Mazer is hopeful that, with the input of practicing physicians from all walks of medicine, healthcare reform this time around can move beyond the politics and focus on patients and healthcare providers, and concludes that "we cannot afford not to get it right."

Meanwhile, renewed attention in Washington is being paid to including California MICRA-like tort reform in any ACA replacement efforts.

The full article featuring Dr. Mazer's interview can be found at http://www.sandiegouniontribune.com/news/health/sd-me-ted-mazer-20161205-story.html.

January 2017

Protecting Patient Privacy and Your Practice: Free Cyber Risk Resources from CAP

By now, you are probably aware of the prevalence of cyber threats in the healthcare sector — it is hard to avoid the disheartening statistics commonly making front page news. Cyber criminals are outwitting security measures of medical entities from mammoth-sized health systems to solo practices and reaping the rewards. Consider these statistics:

- Roughly one out of every three Americans has had his or her healthcare records compromised — and most victims are completely unaware.

- Complete healthcare records can go for $60 each on the black market. Compare that with stolen Social Security numbers at $15 apiece, or credit card numbers at $1 to $3 each. Medical health records give criminals a wealth of personal information that, unlike a credit card number can last forever.

- Cyber criminals can use such records to order prescriptions, pay for expensive treatments and surgery, and even file false tax returns.

While *malicious* data breaches seem to be on everyone's radar, the independent physician is far more likely to encounter an accidental breach attributed to employee carelessness or business associate error that compromises protected health information (PHI). In fact, it is currently estimated that half of all data breaches in the United States are accidental in nature and can result in steep HIPAA penalties that could be easily prevented.

In 2016, Dr. Larry Ponemon, chairman and founder of the Ponemon Institute*, a research "think tank" dedicated to advancing privacy, data protection, and information security practices, told NBC News, "The problem is frequently not high-tech, but very low-tech." He stated, "It's getting people who work in the organization to become smarter about data protection and privacy issues — there's still a lot of carelessness and negligence."

Since its inception, CAP has strived to protect its physician members. Our comprehensive, value-added risk and practice management programs and services further that mission. To help you reduce the chance of a data breach, protect patient privacy, and remain HIPAA compliant, CAP offers you the following free benefits that you can immediately take advantage of:

The Physician's Action Guide to Cyber Risk.
This recent CAP-published practice management guide offers you tips on how to decrease the likelihood of a breach, what to do should a breach occur, how much cyber risk coverage you may need, and much more. Request your free digital copy at CAPphysicians.com/practice-management-guides#cyber-risk. For a hard copy version, contact CAP Membership Services at 800-610-6642.

CyberRisk Coverage. Every CAP member automatically receives $50,000 of protection against a potential data breach, including privacy liability, computer information security, and electronic media liability. CAP's own insurance agency can provide you with additional coverage, based on your needs, at highly competitive rates. **For a free, no-obligation quote, call CAP Physicians Insurance Agency at 800-819-0061 or email CAPAgency@CAPphysicians.com.**

CAP will soon launch a new cyber risk management website featuring webinars, tools to train employees, and much more. Additional details will be provided in next month's *CAPsules*.

HIPAA Compliance Assessment. The HIPAA Omnibus Rule requires that all medical practices now be 100 percent HIPAA compliant. Failure to comply can be costly and time-consuming. Through our trusted HIPAA compliance partner, Acentec, CAP members are entitled to a HIPAA compliance assessment free for the asking. It is a quick and easy online process that can help save you from the stress and fines of a HIPAA breach.

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For more information or to schedule your free assessment, call Vince Breck at Acentec at 949-474-7774, ext. 219, or email CAPAdvantage@CAPphysicians.com.

As a CAP member, you also have access to a variety of other free HIPAA- and cyber risk-related resources, including action guides and a recording of our "Data Breach: It Can Happen to You" webinar. Simply visit our website at CAPphysicians.com/practice-management-training-and-events. We hope you take advantage of the many valuable benefits designed to protect you and your practice.

*The Ponenmon Institute published its *Sixth Annual Benchmark Study on Privacy & Security of Healthcare Data* in May 2016. To download a free copy of this a comprehensive report on data breach in the healthcare sector, go to www.ponemon.org/library/archives/2016/05.

2017 Litigation Education Retreat Schedule

Recognizing the damaging effects a lawsuit can have on a physician's personal and professional well-being, CAP invites its members to attend its daylong Litigation Education Retreat. CAP offers the free program several times each year.

At the program, a nationally recognized expert in the field of behavioral health will provide valuable suggestions on alleviating the stress associated with being named in a lawsuit, while legal and communications experts will help physicians develop the skills that will improve their chances for a favorable outcome.

The first Litigation Education Retreat of this year takes place in Los Angeles on Saturday, April 29. CAP, a CME-accredited provider, designates this educational activity for a maximum of six AMA PRA Category 1 Credit(s)™.

CAP will also offer Litigation Education Retreats in Pleasanton on June 17 and in Orange County on October 14.

If you are interested in attending one of the retreats, please contact Andrea Crum at 800-252-7706 or at LERinfo@CAPphysicians.com.

New California Healthcare Laws for 2017

Public Policy

January 2017

As the largest industry in California with over $367 billion estimated to be spent in the state, healthcare is always an issue that generates dozens of bill proposals in any legislative cycle. The term that ended in 2016 was no exception. From negotiating passage of a managed care organization tax during a special legislative session on health to mandatory use of prescription drug databases, below are highlights of several (but not all) health-related laws effective in 2017.

- **CURES**: Authorized prescribers will be required to consult the state's Controlled Substances Utilization Review and Evaluation System (CURES) prior to prescribing a Schedule II, III, or VI drug to a patient for the first time and at least four months thereafter if the patient continues the prescription. There is a special clause in this law delaying its effectiveness until six months after the California Department of Justice certifies that updates to the CURES database provide a reliable online resource for such use.

- **Right-To-Try**: California now joins a list of other states that allow terminally ill patients to use experimental drugs that do not yet have full regulatory approval. The law authorizes, but does not require, health plans to cover investigational drugs and protects physicians from disciplinary action if they recommend their use after other treatment options have been exhausted.

- **Epinephrine Auto Injectors (EAIs)**: Businesses and public agencies in California are now defined as "authorized entities" allowed to keep epinephrine auto injectors (EAIs) on hand to help treat emergency allergic reactions. Liability and professional review protections remain in place for physicians and surgeons issuing a prescription or order for EAIs, unless their issuance of the prescription or order constitutes gross negligence or willful and malicious conduct.

- **Surprise Bills**: With the rise of narrow networks, patients experience what some call "surprise" medical bills for out-of-network services. Starting July 1, 2017, a new law will require healthcare service plan contracts or health insurance policies issued, amended, or renewed to provide the enrollee or insured the ability to pay the in-network cost if the provider's network status was not previously disclosed. The law also requires that an independent dispute resolution process be in place by September 1 of this year.

- **Premiums**: A new law will allow consumers to learn when their health insurance premium rates have been considered "unreasonable" by state officials. Currently, this notice is posted online, but the new law will require health insurers to notify individuals and small businesses in writing at least 60 days before a rate increase so that consumers can shop around for a new policy if they choose.

Case of the Month

by Gordon Ownby

Yours Is to Question Why

In handling a hospital transfer patient, a receiving specialist may have a new patient who has ongoing issues and is taking multiple medications. Discontinuing medications initiated prior to the transfer without probing the basis for the therapy carries significant risk.

A 47-year-old former mason visited the emergency department complaining of right hip pain and 10/10 pain. A drug screen tested positive for amphetamines, cannabis, opiates, and methamphetamine. CT images showed bilateral total hip arthroplasties and, on the right, a side plate and multiple fixation screws covering an old healing fracture of the proximal femur. A large lucent area indicated a possible loosening of the hardware or osteomyelitis.

The patient's temperature in the ED started out as normal but rose to 102 within five hours. This prompted the ED physician to order blood cultures and request a consult by an infectious disease specialist who initiated vancomycin and cefepime. The cultures later grew out MRSA. During that time, the patient's white blood count fluctuated between 15.4 and 8.4. At the family's request, the patient was transferred to another facility (where his hip surgery took place) following a one-day delay. The inter-facility transfer worksheet at the new facility showed "isolation: yes. Type: MRSA – blood CX" with a primary diagnosis of "aseptic versus septic right THA loosening versus acute lumbar radiculopathy."

Upon accepting the patient to the new facility's orthopedic unit (where he was placed in isolation), Dr. O, an orthopedist, documented an afebrile patient with a white count of 9.2 and 10/10 pain, aggravated by movement. Dr. O's impression was that the patient's problems were spine-related. Working with an internist, Dr. O discontinued the patient's antibiotics based on the absence of any apparent infection.

With no indication for surgery, Dr. O discharged the patient after two days.

When Dr. O saw the patient at his office for a scheduled visit six days later, the patient complained of constant 10/10 right knee pain radiating to his right hip and lower back. Dr. O suspected an acute herniated lumbar disc and sent the patient home while an MRI study was ordered. Dr. O did not record a temperature on that visit.

Three days later, the patient's wife called paramedics because of her husband's severe back pain, lethargy, and altered levels of consciousness. A toxic screening at the emergency room showed opioids and cannabis; the patient's temperature was 101.8, and his white blood count was 19.4. The ED physician intubated the patient and ordered a STAT CT. The gentleman's condition continued to deteriorate and he died 11 days later. The cause of death was attributed to "acute bacteremia... prosthetic joint sepsis."

The family's subsequent lawsuit alleged that Dr. O and the internist should have been aware of the patient's MRSA infection based on the tests performed at the initial facility and that they were negligent in discontinuing antibiotics in a patient with hepatitis B and C, cirrhosis, and morbid obesity.

Dr. O, the internist, and the family resolved the legal matter informally.

This column frequently highlights cases in which missed communications contribute to *inaction* on the part of a patient's healthcare team, leading to an injury. But sometimes a lack of communication leads to an *action* that is later questioned — such as a subsequent treater terminating a potent medication without fully exploring why the medication was initiated.

Gordon Ownby is general counsel for CAP. Questions or comments related to this article should be directed to gownby@CAPphysicians.com.

Risk Management
and
Patient Safety News

Does the Culture of Your Office Jeopardize Patient Safety?

by Kimberly Danebrock, JD, RN

It's no secret — as humans, we make errors. The problem is that in healthcare, these errors can cause patient harm, including death. In fact, the *Journal of Patient Safety* asserts that medical errors in the hospital are the third leading cause of death in the United States. In other words, it is not a matter of if your office will make such an error, but when.

One of the most important ways you can improve patient safety and reduce errors is to create a culture of safety, often referred to as "Just Culture." A culture of safety in one where everyone is treated with respect and the focus is on teamwork and communication. The ultimate goal is that staff will feel comfortable verbalizing issues related to patient safety.

Gone are the days of punitive action for a staff member who makes an error. Most medical errors are related, at least in part, to systems problems. So punishing the individual does not solve the systems problem. Today's patient safety movement focuses on having employees feel comfortable enough to report an error so that everyone can discuss it and work together to create a solution that will prevent the error from reoccurring. Although hierarchies can be important, when they prevent staff from feeling comfortable sharing matters related to patient safety, they are dangerous to our patients. Staff should not feel intimidated or afraid to share patient safety information.

Are patients in your office at risk because of any of the following?

- Staff are afraid to ask questions when something does not seem right
- Staff feel like their mistakes are held against them
- The quantity of the work done is more important than the quality of care
- Staff are using workarounds to avoid important patient safety steps
- Recurrent patient safety problems are not addressed

Or, does your office actively promote patient safety by:

- Treating everyone with respect
- Ensuring staff are comfortable questioning those with more authority
- Encouraging staff to report mistakes they make or observe without fear of judgment
- Listening to staff ideas about patient safety and how to improve office processes
- Conducting group discussions on ways to prevent errors from reoccurring

A culture of safety encourages staff, and allows them the time to double check items they are unsure about. It allows for hierarchies but does not make them so steep that staff is reluctant to share errors, potential errors, or patient safety concerns for fear of judgment or discipline. It encourages staff to voice their concerns and to work together to formulate a system or plan that improves the office systems in order to promote patient safety. In other words, a culture of safety recognizes that all humans make mistakes. And the best way to address this is by implementing a process of teamwork and improved communication that focuses on improving patient safety.

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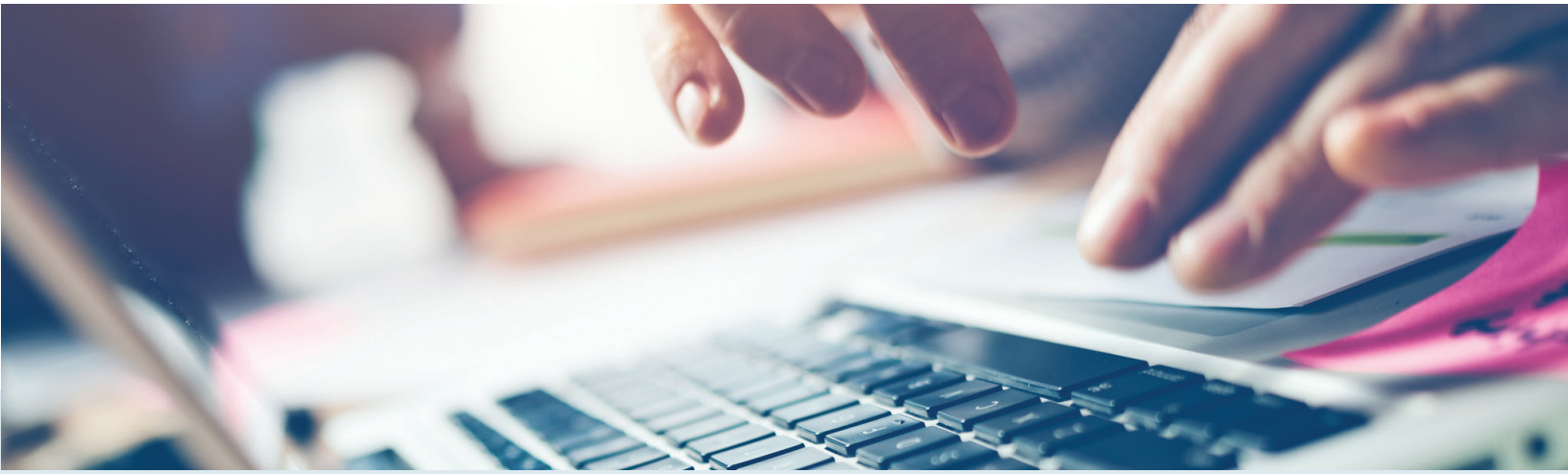
The Agency for Healthcare Research and Quality (AHRQ) has a Medical Office Survey on Patient Safety Culture available on its website or via the link at right. This survey is designed to determine whether your office has a culture of safety. In addition to the survey for medical offices, the AHRQ also has culture surveys for hospitals, ambulatory surgery centers, and nursing home facilities.

Visit http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/medical-office/index.html.

Kimberly Danebrock is a senior risk management and patient safety specialist for CAP. Questions or comments related to this article should be directed to kdanebrock@CAPphysicians.com.



CAP Physicians Insurance Agency Announces New 24/7 Online Account Access

January 2017

CAP Physicians Insurance Agency knows how busy you are with your patients and running your medical practice. With this is mind, we now offer our customers secure online access to CSR24, a leading cloud-based insurance client self-service software.

CSR24 gives you access to your insurance information for the coverages you have through CAP Agency. These services are available to you at no additional cost from a computer or mobile device 24 hours a day, seven days a week.

CSR24 gives you the ability to:

- View critical policy information
- Request policy changes online
- Report claims online with the option to upload pictures and related claims documentation
- Access your CAP Agency account executive's direct contact information
- Review and download account documents
- Obtain a certificate of insurance for your business insurance accounts
- Maintain and manage an up-to-date list of certificate holders for your business insurance accounts
- Receive documented confirmation of all activity conducted online

Access the information and service you need, when you need it, no matter where you are.

To receive access to CSR24, contact CAP Agency at 800-819-0061 or CAPAgency@CAPphysicians.com.

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Frequently Asked Questions About the Medicare Access and CHIP Reauthorization Act (MACRA)

by Miranda Franco, MA

What is the Medicare Access and CHIP Reauthorization Act (MACRA)?
MACRA is legislation passed in 2015 by Congress. MACRA eliminates the sustainable growth rate, but preserves fee-for-service payments. MACRA consolidates several quality-reporting programs into a single system, the Quality Payment Program (QPP). This system has two tracks:

1. the Merit-Based Incentive Payment System (MIPS)
2. the Advanced Alternative Payment Model (AAPM).

Under MACRA, physicians can choose to participate in either of the two tracks.

Based on their 2017 performance in MIPS or an APM, physicians will receive positive or negative Medicare payment adjustments beginning in 2019.

What track will most clinicians fall into?
Based on CMS calculations, 83 to 90 percent of eligible clinicians will fall into the MIPS track in 2017, while only 10 to 17 percent of clinicians will fall into the Advanced APM track.

How will MACRA impact my Medicare payments?
Under MACRA, all physicians will receive a 0.5 percent update to the annual conversion factor (before sequestration or adjustments due to impacts from budget neutrality factors) from 2016 through 2019. For 2020 to 2025, no update is guaranteed. Physician updates will be based on performance in either the MIPS or the APM track. Physicians will then receive that track's associated bonus or penalties.

What are the exemptions from MIPS?
For the CY 2017 performance year, there are only three exemptions from MIPS for clinicians who otherwise meet the eligibility requirements above:

- Clinicians in their first year of Medicare Part B participation
- Clinicians billing Medicare Part B up to $30,000 in allowed charges or providing care for up to 100 Part B patients in one year
- Clinicians in entities sufficiently participating in an Advanced APM

Is there any relief for solo, small, and rural practices?
The final rule, as noted above, exempts from reporting requirements for 2017 practices with $30,000 or less in Medicare Part B charges or 100 Medicare patients or fewer, or who will be in their first year of Medicare participation. The earlier version of the rule set the exemption threshold for Medicare charges at $10,000 or less and 100 or fewer patients.

Most small practices are expected to choose the MIPS track, and the final rule allows for more choices in how they report their data in 2017. They can either submit a minimum amount of information, such as an individual quality performance measure or clinical improvement activity; data covering 90 days or more and more than one quality measure or improvement activity; or a full year of data. The final rule also reduces by about half the number of required reporting measures. There are additional reduced reporting requirements for small, rural, and health professional shortage area clinicians across several of the MIPS categories.

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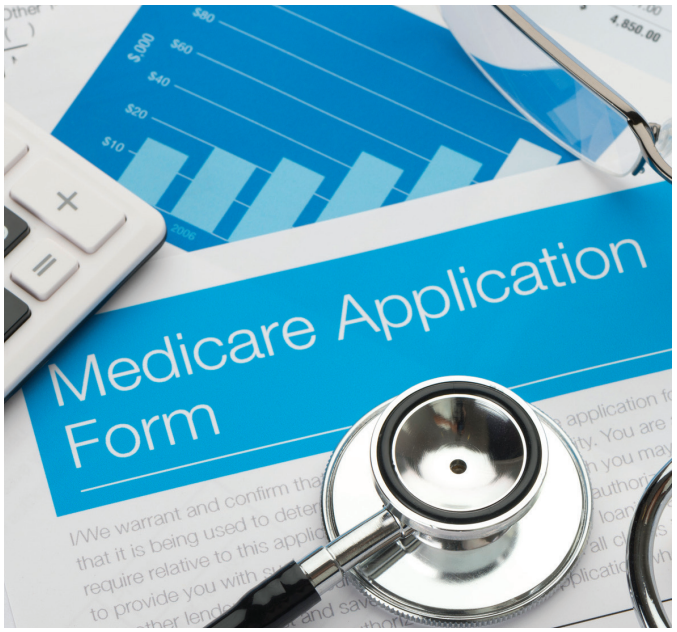
If I am in an alternative payment model (such as an ACO), do I still have to participate in MIPS?
Only APM participants who successfully participate in an advanced APM, assuming they meet the required thresholds, will be exempt from MIPS. The majority of physicians will only be eligible for MIPS. This includes many APM participants.

You must participate in MIPS if your APM does not qualify as an advanced APM. You must participate in MIPS if you cannot meet the thresholds for advanced APM participation. However, participation in an APM may help you meet some of the MIPS reporting requirements. These requirements include quality reporting and clinical practice improvement.

What if I am choosing to not participate in MIPS or an APM?
Some physicians — for example, those planning to retire in the near future — may choose not to participate in MIPS or an APM. These physicians can continue to see Medicare patients. They will receive fee-for-service-based payment for treating these patients. However, they will also experience reduction in their Medicare payments two years later. These payments will be reduced by the amount of the maximum MIPS penalty. In 2019, the maximum penalty will be four percent. It will increase to nine percent in 2021.

Is there a group reporting option for MIPS?
Yes. If a practice reports at the group level for one MIPS category, it must do so for all four categories of the program.

Should we report at the individual clinician or group practice level?
While each practice is different, there may be benefits to reporting for MIPS at the group practice level (TIN) if there are multiple eligible clinicians in the practice. There is no registration process for practices that wish to report at the group level. If you participate as a group or individual, you must do so for all categories. You cannot report at different levels for each category.



Without an EHR, is it possible to participate in MIPS?
Clinicians without an EHR can still participate in MIPS, but will not be eligible for any of the points under the Advancing Care Information (ACI) performance category. This will negatively affect the clinician's total composite score. If you do well on the quality and clinical practice improvement activity categories, you could potentially earn a score high enough to be eligible to earn a bonus.

Should those of us without EHR apply for a hardship exemption?
Yes. Under MIPS, hardship exemptions are available for MIPS-eligible clinicians who cannot comply with the advancing care information category because of a significant hardship. CMS will announce the application process at a later date.

Will MIPS performance data be made available publicly?
Yes. CMS will publish clinician and group performance on either the Physician Compare website or CMS downloadable database. CMS will allow a 30-day preview period in advance of the publication of any data on Physician Compare to allow clinicians to review and submit corrections before information is made public.

Miranda Franco is senior public affairs advisor for Holland & Knight LLP. Questions or comments related to this article should be directed to Miranda.Franco@hklaw.com.

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