MEDICAL BOARD OF CALIFORNIA
Executive Office

Education and Wellness Committee Meeting

San Francisco Airport Marriott Waterfront
180 Old Bay Shore Hwy
Burlingame, CA 94010
(650) 692-9100

Thursday, July 30, 2015
2:30 p.m. – 3:15 p.m.

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Education and Wellness Committee (Committee) of the Medical Board of California (Board) was called to order by Chair Barbara Yaroslavsky at 2:30 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:
Barbara Yaroslavsky, Chair
Howard Krauss, M.D.
Denise Pines

Members of the Committee Not Present:
Gerrie Schipske, R.N.P., J.D.

Other Members not on the Committee Present:
Michelle Bholat, M.D.
Dev GnanaDev, M.D.
Randy Hawkins, M.D.
Sharon Levine, M.D.
Ronald Lewis, M.D.

Staff Present:
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Dennis Frankenstein, Business Services Officer
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Elizabeth Rojas, Business Services Officer
Regina Rao, Associate Governmental Program Analyst
Letitia Robinson, Research Program Specialist
Paulette Romero, Staff Services Manager II
Jennifer Simoes, Chief of Legislation

Lisa Toof, Administrative Assistant II
Kerrie Webb, Staff Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Teresa Anderson, California Alternate Performance Assessment
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Lou Galiano, Videographer, Department of Consumer Affairs
Bridget Gramme, Center for Public Interest Law
Doug Grant, Investigator, Health Quality Investigation Unit
Dr. Greenberg, Monitored Aftercare Program
Marian Hollingsworth, Consumers Union
Todd Iriyama, Investigator, Health Quality Investigation Unit
Lisa McGiffert, Consumers Union
Michelle Monserrat-Ramos, Consumers Union
James O'Donnell, Pacific Assistance Group
Andres Sciolla, M.D., University of California, Davis
Dr. Sucher, Monitored Aftercare Program
Ashby Wolfe, M.D., Chief Medical Officer, Centers for Medicare and Medicaid Services
Dr. Zemansky, Pacific Assistance Group

Agenda Item 2 Public Comment on Items Not on the Agenda

No public comments were received.

Agenda Item 3 Approval of Minutes from the January 29, 2015, Education and Wellness Committee Meeting

Dr. Krauss made a motion to approve the minutes from the January 29, 2015 meeting; s/Pines. Motion carried.

Agenda Item 4 Presentation on Updates on the Affordable Care Act and Information on Physician Compliance Programs

Dr. Wolfe, Chief Medical Officer, Centers for Medicare and Medicaid Services (CMS) Region 9, presented updates on the Affordable Care Act (ACA) and information on the physician compliance programs.

Dr. Wolfe started by explaining that she had been asked to present some information regarding the provider compliance program as authorized by the ACA and to provide some updates on some key programs within the ACA itself.

Dr. Wolfe reviewed Section 6401 of the ACA stating that it is the legalizing portion of the statute that provides details around provider compliance programs with the intent to assist physicians and other clinicians in appropriately providing information when they are billing Medicare and Medicaid or the Children's Health Insurance Program (CHIP). She continued by stating that there have been no updates since the last presentation but she would review the key elements and talk about the published guidance that is available and then review some programs that are new and deal with value based payment. She also would provide a review of a new model out this summer that may be of interest.

Dr. Wolfe continued with the provider compliance programs, saying that no new updates to the current guidance is available and that an enforcement date has not been set for these programs. The authorizing portion of the ACA is Section 6401, which specifically directs the Department of Health and Human Services (DHHS), in consultation with the Office of the Inspector General (OIG), to establish core elements for provider and supplier compliance programs within the health industry in order to participate or as a condition of enrollment in Medicare, Medicaid or the CHIP program. Physicians, their associated clinicians and providers of medical supplies, must establish a compliance program to deal with proper claims billing as well as insuring that there is a minimized risk when it comes to fraud and abuse. The OIG has been providing guidance on these types of programs since the early 90's when they began a major initiative to support health care professions in establishing compliance programs throughout the organizations and practices. The OIG has been working with the DHHS, advising providers, physicians, clinicians and other organizations to voluntarily adopt compliance plans. The OIG has issued several helpful guidelines on this issue specifically as it pertains to physicians, hospitals, nursing homes, pharmaceutical manufactures and physician group practices. Section 6401 of the ACA specifically addresses solo and small physician groups; however, the intent of the legislation is that all physician groups are in compliance. The guidance for these programs is published at the OIG's website. CMS.gov has multiple webinars, as well as guidance, as it pertains to developing a compliance program and setting one up in an office or other entity.

Dr. Wolfe continued with putting the importance of fraud and abuse in perspective, stating that recoveries from the fiscal year 2013 totaled about 4.3 billion dollars and that this was one of the major areas that the CMS concentrates on in collaboration with the rest of DHHS and the OIG. She continued explaining that the intent of compliance programs is to minimize the risk to practices as it pertains to improper billing, fraud, and abuse, and there are websites that serve as excellent resources in terms of guidance, products and other information on compliance programs. Most health professionals are aware that there are compliance programs that are recommended for clinicians but there are no enforcement dates specifically for physician programs at this time.

Dr. Wolfe stated that the intent of this legislation is for all health professionals to implement a compliance program and continued with the seven core elements for an effective compliance program which is outlined in the guidance that the OIG provides. Dr. Wolfe stated the following items are what an effective compliance program includes:

1. Written policies and procedures and standards of conduct – establishing written policies and specific detail of procedures is necessary to promote consistency and uniformity in an office or practice as it pertains to proper billing and compliance. Written policy should be composed with the guidance of either an identified compliance officer or compliance committee. Details for set up is available on the OIG's website and the CMS' website.

2. Compliance oversight of the program – identifying a compliance officer or a compliance committee who can oversee the program, as an organizational watch dog to ensure that the policies are being implemented appropriately.

3. Training and education – training the physicians and staff within the organization to be able to comply with the compliance plan and to ensure everyone is aware of expectations and standards as they are written.

4. Communication – opening the lines of communication so that there are requirements for the employees to be proactive, providing a formal process for managers to communicate compliance issues as well as results, audits or investigations and a process to allow anonymous reporting without fear of retaliation.

5. Auditing and monitoring – provides assurance that the program is effective, and ensures that it is in compliance with CMS requirements, and identifies any risks to the organization. Ideally, the system should include a way to do internal audits for internal learning, as well as external audits if they are requested by OIG or CMS.

6. Consistent discipline – written policies should be available for review from all staff and physicians and it should be a plan that provides appropriate disciplinary sanctions on those who fail to comply with any requirements.

7. Use of corrective actions – consistent and corrective actions must be conducted, examples might include repayment of over payments, and or disciplinary action against responsible employees.

Dr. Wolfe provided four elements of information about the steps that physicians should take for an effective compliance program. The OIG has a specific guide for all physician groups in all modes of practice on its website. The HEAT Team (Healthcare Fraud Prevention and Enforcement Action Team) provides compliance training for providers. She commented that keeping a plan simple and readable will allow it to be useable and setting a date every 6 -12 months to review the compliance program was a suggestion.

Dr. Wolfe continued with programs authorized by the ACA that are in the process of changing as a result of the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Physician Quality Reporting System (PQRS) and the electronic health record (EHR) incentive program also known as Meaningful Use (MU) has been in place since 2007. This year, 2015, is important because if eligible physicians or their accompanying clinicians are eligible to participate and choose not to, they will potentially face a negative payment adjustment up to seven percent of the fees they bill under the part B fee schedule in 2017. Failure to participate as an eligible professional in PQRS and MU in 2015 results in a negative payment adjustment in 2017. CMS is not authorized to waive that negative payment adjustment, it is required by statute.

Dr. Wolfe said she brought up these two programs because under the MACRA multiple changes, which will include some changes to the PQRS, MU, and the MACRA, permanently repealed the sustainable growth rate and, in its place, instituted a stable period of annual updates to the reimbursement schedule

for physicians, which took effect July 1, 2015, with a .5% annual update and will continue once a year as a .5% update to the fee schedule through 2019. In 2019, CMS is required to implement a Merit-based Incentive Payments System (MIPS) which is a combination of the PQRS, MU and the Value Modifier Program (VMP). While there are no regulations yet, Congress has asked CMS by early 2016 to provide a basic outline of how this MIPS system will work. She stated that she would follow up with the Board as the details for those regulations are written.

The Regional Innovation Network (RIN) is something that Region 9 is trying through the Center for Medicare and Medicaid Innovation (CMMI). The idea is to have CMS provide a platform for both virtual and in-person collaboration amongst physicians and other providers in the state. With Region 9 being such a large and geographically diverse area, as well as ethnically diverse, CMS thought that it would be interesting to try the CMS website as a way of providing a way for people to connect and collaborate throughout the region. The kick-off event was in May and information is on the website to sign up to join the Regional Innovation Network.

Dr. Wolfe stated that finally she wanted to bring to the Board's attention a new pay for performance model that has just been announced this summer, which could potentially become the way that CMS introduces future pilots and demonstrations. It is known as the Million Hearts Cardiovascular Disease Risk Reduction Model, and it will test the concept of pain physicians reducing long term cardiovascular risk in their high risk patient populations. The idea is to provide a payment incentive or bonus payment for prevention rather than specific processes or outcomes like reducing blood pressure or LDL cholesterol levels. So essentially the predictive algorithm, ASCBD calculator, which is approved by the American College of Cardiology (ACC) and the American Heart Association (AHA), will give beneficiaries and patients within different practices their individual risks scores and over a period of five years, practices will receive a financial incentive, and bonus payments if they are able to reduce their beneficiaries or patients risk scores. This as something that CMS has never done before and they are looking for practices to participate. CMS is hoping to have about 300,000 medicare beneficiaries and about 720 physician practices involved.

Dr. Krauss asked if the Recovery Audit Contractors (RAC), who are private firms contracted with CMS that receive a percentage of the payments taken back as compensation for their work, also receive a percentage when they discover under payments.

Dr. Wolfe stated that she did not know, but would be happy to double check the under-payment process.

Dr. Krauss said that many of his colleagues simply pay the RAC or let the RAC take the money back because their administrative costs to contest it would be greater than the amounts of money that the RAC is asking for. He continued that the letters physicians receive whenever there is an adjustment include words like "fraud" and that every overpayment is not necessarily fraud. He said that he is concerned as to whether or not that is also communicated to the physician's patients that their doctor may be suspected of committing fraud.

Dr. Wolfe stated that the RAC is not authorized to communicate with any of the patients of the practice or hospitals they are evaluating; that it is monitored very carefully by CMS policy regulations committees and divisions.

Dr. Krauss stated that from reading the newspaper that there are very egregious cases of fraud and abuse, and that he would like to think that they occur at the hands of a minority of physicians and medical providers, but in his community there is this underlining sense of fear and trepidation in dealing with the federal government and in dealing with CMS, and that he is aware of physicians who intentionally under code services in an effort to stay under the radar. He asked if CMS might change their perception.

Dr. Wolfe stated that actually the fear is of accidently up coding and therefore under coding so that they do not make that mistake. In that situation the physician is not getting paid the value for the work that they are providing and that is one of the reasons to actually develop a compliance program for the practice, because it will provide information to any external auditors, including CMS or OIG that there is a plan in place that is clearly written out and that people are proactively evaluating what they are doing. Certainly the intent is not to go after every accidental up code; the idea is to ensure that it is not a systemic process to defraud the federal government. So, having a compliance program in place, even a basic one that is structured on the guidance provided by the OIG, is actually a great way to protect a practice and to ensure that physicians are actually getting paid for the value of the work.

Dr. Krauss stated that the EHR was a help, because most of the software in the EHR lets a physician know what the proper level of coding is for the service provided. On the flip side of that there has been some EHR's that prompt for additional information and sometimes even cut and paste additional information. Dr. Krauss stated that as a Medical Board Member, it causes him to worry whether the medical record physicians review become an accurate representation of the service that was really provided on that day.

Dr. Wolfe said with respect to cutting and pasting, that it has potential to provide inaccurate information, so active documenting in real time is always the best idea.

Ms. Yaroslavsky asked if there is mandatory reporting for those individuals to report to the Medical Board.

Dr. Wolfe stated that she did believe there was, but she would check with her Legal Office of Legislation to see if there is a statue that directly addresses that issue.

Dr. Krauss said that he anticipated that ICD 10 will occur sometime in October. Physicians are worrying that this new system of coding and billing will have an adverse effect and scrutiny just because it is a new system and it is more complicated. He asked if CMS is willing to give the doctors a little more leeway as they learn how to use the system.

Dr. Wolfe stated with the MACRA there was some thought that there might be a delay in ICD 10 implementation. There was not and CMS expects the ICD 10 to be up and running by October 1, 2015. However, about 3-4 weeks ago, CMS, in conjunction with the AMA, issued additional information about the first year of ICD 10 implementation, specifically, stating that providers would not be penalized if they get the incorrect ICD 10 code as long as it is in the correct ICD 10 family of codes. There will not be any penalty provisions when using the system and there is specific information as well as a person that will be designated as the ICD 10 ombudsman who will be responsible for triaging physician issues with the implementation of ICD 10.

Agenda Item 5 Presentation on Trauma Informed Care and its Impact on Lifelong Health

Dr. Sciolla, Associate Professor of Clinical Psychiatry, Medical Director of Northgate Point Regional Support team at the University of California at Davis presented two issues; first, why Trauma Informed Care (TIC) is important and second, how to address TIC in terms of physician competence to improve health outcomes of patients with trauma.

Dr. Sciolla stated that his objective was to provide an overview of epidemiologic and neuroscience research on the prevalence of adverse and traumatic experiences across the lifespan and the mechanism underlying their association with poor health outcomes. Also, to propose measurable patient-physician communication attitudes and skills that can enhance health outcomes in patients with trauma histories.

He stated that childhood maltreatment appears to be a risk factor in the history of patients having many different psychiatric outcomes and that it is more difficult to identify a disorder to which childhood maltreatment is not linked, than to identify a disorder to which it is linked. He also stated that childhood maltreatment raises risk for a particular psychiatric disorder because maltreatment exacerbates the ability to experience any disorder at all.

Dr. Sciolla presented a chart that showed over the years how the incident of diabetes increased steadily and that even people with trauma symptoms, but no history of Post-Traumatic Stress Disorder (PTSD) have an increased risk for developing diabetes. The behavioral and health manifestations of trauma are many fold and are not encapsulated only by PTSD and not only by mental health issues, but by physical health issues, also. He stated that the main killers of people in the nation are all related to a history of trauma, especially trauma that happens early in life. There is a hallmark study, the Adverse Childhood Experiences (ACE) Study, that was conducted by Kaiser San Diego. They measured 10 childhood adverse experiences with over 17,000 patients, from zero to ten. The reality is that ACE impacts every person in California and that trauma exposure across the lifespan is prevalent in the general population and all clinical settings. Patients want to be asked about trauma and are not harmed when asked about it; for many patients, disclosure of traumatic experiences is therapeutic in itself. Many patients are unaware that their health problems are linked to ACE.

Dr. Sciolla continued saying that trauma exposure is associated with increased morbidity, premature mortality, treatment-resistant chronic conditions, health risk behaviors, and difficulty trusting healthcare systems and providers. It is also associated with increased sensitivity to power differentials and authority figures, problematic clinical encounters, difficulty engaging in preventive care, and increased physical and behavioral health and co-morbidity, including substance use disorders.

Dr. Sciolla stated that some of the challenges of TIC are that it requires excellent patient-centered communication skills; it may imply changes in certain billing and reimbursement procedures, and it works best when care is collaborative and integrated; and some of the billing practices might need to be modified. Also, the new generation of providers needs to be educated in an inter-professional setting. It also needs to be included in medical school curriculum and assessment of competency.

Opportunities of TIC are that it fits naturally with cultural competence, it is congruent with inter-professional practice, it works synergistically with ACA supported patient-centered medical homes, it takes into account social determinants of health, and it is aligned with the goal of eliminating health disparities.

Dr. Sciolla spoke about the proposed TIC for physicians and stated that board certified physicians should be able to elicit regularly, histories of exposure to traumatic experiences across the lifespan in patients and caregivers in all clinical settings, and they should be able to adjust interviewing in response to patient's demographics, e.g., sex, age, religious, practices/beliefs, race/ethnicity, socioeconomic status, and sexual orientation or gender identity. He continued with physicians should be able to respond with compassion, normalization and education to a patient's disclosure of traumatic or adverse experiences. They should identify and advocate for resources and refer patients to appropriate psychosocial services in the clinical setting and community in which they work. Also, physicians should determine their patients' strengths, life goals and values that can sustain recovery and healing from trauma and integrate the trauma and resilience information gathered in patient-centered, culturally-responsive treatment plans to enhance health outcomes.

Dr. Krauss asked Dr. Sciolla if he found similar problems with children who witnessed trauma, but are not the recipients of the trauma.

Dr. Sciolla stated that one of the main findings of this research in the neurobiology of stress is that it does not matter what the stress is. The final pathway is a stress response system, in that the system is blind to whether a patient is a recipient or witness of the trauma.

Dr. Krauss asked if in that sense should a physician inquire about the domestic situation and the neighborhood situation in terms of neighborhood violence?

Dr. Sciolla responded affirmatively, and stated one of the limitations of the original ACE study is that the study was conducted mostly in white, middle class neighborhoods with privately insured patients, and they did not consider any other determinants of health, such as community violence. Newer versions of the ACE study are considering those factors.

Ms. Pines asked if Dr. Sciolla sees ACE increasing and if he sees more incidences.

Dr. Sciolla replied that it depends on the location. The data shows that in some locales, because of concentrated poverty in urban settings, there are epidemics of violence. There are also studies that show there are transgenerational transmissions of trauma, for instance with the survivors of the Jewish Holocaust, there are some abnormalities in the stress response system that can happen in generations after, that were not exposed to the actual trauma.

Ms. Pines asked if Dr. Sciolla thought the time frame that a general physician has to see a patient (approximately 15 minutes) is enough time to help them move through that trauma.

Dr. Sciolla stated that this is a challenging question and that physicians need to approach this issue by building a therapeutic alliance, a trusting relationship first, which are the tenants of patient centered care that can lead to improvement and changes in lifestyle when you treat patients with respect and empower them.

Dr. Hawkins commented that in his own practice he has patients that are very difficult to treat and even going through all the levels of evaluation and treatment cannot seem to get there. Then sometime later, six

months, sometimes longer, he finds there is an underlying thing, maybe trauma, that has been there all along. Sometimes it seems to take time to get there.

Agenda Item 6 Future Agenda Items

No future agenda items were provided.

Agenda Item 7 Adjournment

Ms. Yaroslavsky adjourned the meeting at 3:15 p.m.

The complete webcast can be viewed at: http://www.mbc.ca.gov/About_Us/Meetings/2015/