amcno
THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

NORTHERN OHIO
PHYSICIAN

March/April 2020 | Volume 105 | No. 2

THE VOICE OF PHYSICIANS IN NORTHERN OHIO

www.amcno.org

# AMCNO Partners with the American Heart Association on the Cleveland Healthy Kids' Meals Campaign

**AMCNO/CMBA Medical Legal Summit Takes Place April 24-25 – see inside this issue for more information**

The AMCNO is pleased to announce that we have joined a broad coalition of local and regional organizations to support the Cleveland Healthy Kids' Meals Campaign—a campaign that seeks to raise awareness of sugary drink consumption, and calls for policy changes that can lead to better outcomes for kids.

The campaign is a community-based initiative that addresses the epidemic of sugary drink consumption among Cleveland's kids, and the resulting risks of chronic health issues, including diabetes and heart disease. Eighteen groups, including the AMCNO, have signed on as formal supporters of the healthy defaults drinks policy, with many others participating in awareness and engagement efforts on behalf of the campaign.

### TOP 5 THINGS TO KNOW ABOUT THE KIDS' MEALS CAMPAIGN

1. The Kids' Meals Campaign is an effort to pass a healthy default drinks policy that would ensure that kids' meals offered in Cleveland restaurants include healthier drinks as the default options (not sugary drinks).
2. The policy would affect only restaurants in the City of Cleveland, and only those restaurants that have kids' menus with beverages included.

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# Ohio Supreme Court Justice Judith French Meets with AMCNO Board of Directors

The AMCNO Board of Directors was honored to have Ohio Supreme Court (OSC) Justice Judith French attend their February meeting. Justice French spent time with the board discussing her background, her role on the court and why the OSC matters. The following includes an overview of her discussion with the board and the background information she provided during the meeting.

Justice French became a justice of the OSC in January 2013 and was elected to her first full term in 2014. For more than two decades, Justice French has dedicated her career to public service. In that time, she has served as a lawyer for a state agency, an assistant attorney general, counsel to the governor, and, finally, as a judge. In December 2012, Governor John Kasich appointed Justice French to fill a vacancy on the OSC and she became the 155th justice of the OSC on Jan. 1, 2013. In 2015, United States Supreme Court Chief Justice John Roberts appointed her to serve on the Federal Appellate Rules Committee.

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*AMCNO President Dr. Mehrun Elyaderani stands with Ohio Supreme Court Justice Judith French at a recent board meeting.*

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3. The policy doesn't restrict choice; parents could still order anything they want for their kids from the menu.
4. Healthy default drinks policies are already active in local schools and at early childcare centers.
5. Beyond the City Council policy, the Kids' Meals Campaign is working to build awareness and engage community members around the health impact of sugary drinks.

As physicians, the health of kids and families is something on all of our minds, and we all know the importance of being healthy right from the start. But we know that it's not just what you eat—drink choices matter too! This is especially true for children.

With today's busy schedules, families are eating out more than ever. Unfortunately, most restaurant kids' meals are packed with calories, salt, and saturated fat. And too often they're served with a sugary drink.

A child-sized soft drink contains a whopping 8 teaspoons of sugar. And the average American child is drinking more than 30 gallons of sugary drinks every year! THAT'S 10 TIMES THE RECOMMENDED AMOUNT!

**That's why the Academy of Medicine of Cleveland & Northern Ohio is partnering with the American Heart Association on the Cleveland Healthy Kids' Meals Campaign.** The Healthy Kids' Meals Campaign aims to make restaurant kids' meals healthier by ensuring that healthy drinks, like water and low-fat milk, are included as default options instead of sugary drinks. This policy has been effective in cities around the U.S. in helping parents make healthier choices while eating out, and it can lead to better outcomes for Cleveland kids. By offering further protections for kids, healthier restaurant kids' meals support our work as physicians and advocates for our patients.

Cleveland City Council will be considering the healthy default drinks policy in the coming weeks. The AMCNO has submitted a letter of support for this effort to City Council and will keep our members updated on this important initiative. ■

## Ohio Supreme Court Justice Judith French Meets with AMCNO Board of Directors

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Justice French stated that she understands the need for access to the judicial system and noted that in 2013 she served as a member of the OSC's Access to Justice Task Force, which recommended practical remedies to widen judicial access. Currently, she is working with the Ohio Legal Assistance Foundation and legal-aid organizations around the state to advocate for changes and programs that will ensure access to justice for all Ohioans.

Justice French also spent some time outlining for the board why the OSC matters, noting that the court impacts the life of every Ohioan and the bottom line of every Ohio business. She stated that the court resolves issues important to Ohio businesses—from independent businesses to large corporations, they decide what candidates and issues may appear on the ballot, and the court considers all criminal matters, including death penalty, violent crime and drug offenses. She also noted that the court hears cases involving tort liability, medical malpractice and damage limitations. She emphasized that filing an amicus (friend of the court) brief to the OSC can provide information and viewpoints to the OSC during their review of a case.**

She noted how the judicial election can impact these decisions and outlined how it is important to elect justices with the legal experience, integrity, and work ethic necessary to be effective – but it is just as important to elect judges with a philosophy ensuring that they will not second-guess the policy choices of elected officials charged with making the law.

Justice French stated that she has a proven record as a conservative justice—someone who stays within constitutional limitations and doesn't second-guess the policy choices made by Ohio's elected policymakers. She stated that if she is re-elected to the OSC in 2020 she plans to continue to honor the Constitution and uphold the law, not creating it or legislating from the bench. ■

**Note: The AMCNO has recently filed three amicus briefs on cases that are pending before the OSC that could have an impact on physicians and the practice of medicine. Updates on the outcome of these cases will be provided in future issues of the *Northern Ohio Physician* magazine. For information on other amicus briefs filed before the OSC by the AMCNO and the outcome of these OSC cases, please visit our website, amcno.org, and click on the link under "Recent Advocacy Work."

# Physician-Patient Relationship and Professional Liability

*By Isabelle Bibet-Kalinyak, Esq., and Arielle J. Lester, Esq.*
*December 9, 2019*

On April 17, 2019, the Minnesota Supreme Court ruled that a hospitalist could be held liable for the death of a patient he had never seen following a 10-minute consultation on the telephone with a nurse practitioner. In *Warren v. Dinter*, the Supreme Court held that a physician-patient relationship is not required in matters of medical malpractice, sending a chilling message to the medical community at large.[1] This article summarizes the facts and legal analysis of the *Warren* Court and explains how Ohio law differs with regards to professional liability as well as when vicarious liability attaches to physicians involved in a contractual relationship with a physician assistant or a nurse practitioner.

## I. The *Warren v. Dinter* Effect

a. *Warren v. Dinter* – Facts

In August 2014, Susan Warren, 54, went to Essentia Health Clinic, an outpatient clinic in Hibbing, Minnesota, with complaints of abdominal pain, fever, chills, and other symptoms. A nurse practitioner, Sherry Simon, ordered a series of tests to diagnose Warren's illness. The test results showed Warren had unusually high white blood cell levels and other abnormalities, which led Simon to believe that Warren had an infection and needed to be hospitalized. Simon prepared a letter for Warren's employer explaining that Warren would be unable to work due to illness and hospitalization.[2] She then called Fairview Range Medical Center to get Warren admitted in accordance with standard past practices. Simon's call to Fairview was assigned to one of three hospitalists on duty, Dr. Richard Dinter, and lasted about 10 minutes. Dr. Dinter and Simon disagree about what information Simon shared with Dr. Dinter during the call. Ultimately, Dr. Dinter told Simon the abnormal test results were likely due to diabetes and that Simon should focus on treating the diabetes. Dr. Dinter did not recommend Warren's hospitalization.[3]

After said telephone conversation, Simon consulted Dr. Ian Baldwin, her collaborating physician at Essentia, to try to get Warren hospitalized. Dr. Baldwin concurred that diabetes could cause an elevated white-blood cell count and did not recommend hospitalization either. Simon went back to Warren and explained that the hospitalist at Fairview did not feel hospitalization was necessary. They discussed the diabetes diagnosis, medications, and scheduled a follow-up appointment. Three days later, Warren's son found her dead in her home. The autopsy concluded Warren's cause of death was sepsis due to an untreated staph infection.[4]

b. *Warren v. Dinter* – Legal Analysis

Almost two years after Warren's death, Warren's son sued Dr. Dinter and Fairview alleging negligence, including the advisement of Simon that Warren did not need hospitalization. The complaint stated Dr. Dinter's negligence was the direct cause of Warren's death and included Fairview under the theory of *respondeat superior*, a legal doctrine in which an employer may be held responsible for the actions of its employees performed in the course of employment. Dr. Dinter and Fairview argued that Dr. Dinter owed no duty of care to Warren because Dr. Dinter only offered his thoughts to Simon as a professional courtesy. The Minnesota District Court agreed with Dr. Dinter and Fairview and concluded that Dr. Dinter had no duty of care to Warren due to lack of physician-patient relationship. Warren's son appealed the lower court's decision, arguing that as a matter of law, a physician-patient relationship is not necessary for a physician to owe a duty to a patient. The Court of Appeals affirmed the District Court's decision.[5]

The Minnesota Supreme Court accepted review of the case and reversed the lower courts' rulings. The Supreme Court analyzed whether Dr. Dinter owed Warren an ascertainable duty of care and found that the lower courts were misguided in relying on the physician-patient relationship as a requirement for medical malpractice claims. In examining whether a physician-patient relationship is a necessary element in a medical malpractice claim, the Supreme Court found that Minnesota had never actually held that such a relationship was necessary, and traditionally turned to the inquiry of whether a tort duty has been created by foreseeability of harm when there is no express physician-patient relationship.[6]

In Minnesota, a doctor owes a duty to patients and third parties regardless of the physician-patient. This century-old concept is founded on the premise that "professionals are responsible for the direct consequences of [their] negligent acts whenever [they are] placed in a position with regard to another that it is obvious that if [they do] not use due care in [their] own conduct, [they] will cause injury to that third party."[7] The Supreme Court stated that as a gatekeeper, Dr. Dinter's role was to make the medical decision on whether to admit new patients. Thus, the Supreme Court reasoned that it was foreseeable that Simon would rely on Dr. Dinter's decision not to admit Warren because her scope of practice as a nurse practitioner did not permit her to admit Warren and that Dr. Dinter's decision therefore caused Warren's death by keeping her from care in the only hospital in her locality.[8] In light of this recent ruling, Minnesota will remain in the minority of states where the physician-patient relationship is not a threshold issue.

## II. Ohio Law

Ohio is one of many states that requires a physician-patient relationship in order to file and ultimately prevail on a medical malpractice action. The Ohio Administrative Code states that "a physician-patient relationship is established when the physician provides service to a person to address medical needs, whether the service was provided by mutual consent or implied consent, or was provided without consent pursuant to a court order. Once a physician-patient relationship is established, a person remains a patient until the relationship is terminated."[9] In light of the Ohio rules and jurisprudence, the *Warren* case is not expected to affect providers practicing in the Buckeye state. However, it may arouse the subject of physicians' vicarious liability for the acts or omissions of nurse practitioners (NPs) or physician assistants (PAs) under their supervision. The following sections clarify when Ohio physicians may be held liable for a PA or an NP.

a. Physician Assistants

In Ohio, PAs are authorized to practice and prescribe drugs and therapeutics *subject to supervision and delegation* by one or more physicians licensed and practicing in the state.[10] Medical services performed by PAs are therefore considered delegated by the supervising physician and under the physician's expertise.[11] **Physicians who supervise PAs assume liability for all the acts and omissions of the PA by law.** They will therefore be unfailingly sued along with the PAs whom they supervise. Ohio law requires a written supervision agreement between physician and PA. There is no required format for such supervising agreement so long as it

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## Physician-Patient Relationship and Professional Liability

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addresses the requirements under O.R.C. § 4730.19. The supervising agreement must, among other things:

- **State that the supervising physician is legally responsible and assumes legal liability for the services provided by the PA.**
- List the responsibilities of the supervising physician and those of the PA, as well as any limitations agreed upon by both parties.
- State the circumstances under which the PA is required to refer a patient to the supervising physician.

If a physician is supervising several PAs for the same duties and scope of work, a single supervision agreement containing the signatures of the physician and all of the PAs (three PAs at most). On the other hand, if a PA has multiple supervising physicians, separate supervision agreements are required.[12] Supervision agreements can be amended at any time and have no expiration date. If a supervision agreement cannot be located, a new agreement should be created immediately. As of September 2018, supervising agreements no longer have to be filed and approved by the Ohio Medical Board. However, if a supervising physician fails to comply with the requirements of O.R.C. § 4730.19 or the supervising agreement, the Board has authority to initiate disciplinary measures and impose a civil monetary penalty of up to $5,000 against the physician.[13]

b. Nurse Practitioners

Under Ohio law, NPs are authorized to practice and prescribe drugs and therapeutics *subject to collaboration* with one or more physicians licensed and practicing in the state.[14] NPs may provide a variety of professional medical services based on their education, training, specialty certification, and the scope of practice of their collaborating physician.[15] **Unlike PAs, NPs may practice without *supervision* from a physician.** *Collaboration* with a physician, as evidenced by a "standard care arrangement" (SCA) is, however, mandatory—unlike in already over half the states where NPs may practice totally independently from physicians. The SCA must be kept on file by the NP's employer but does not have to be approved by the Ohio Board of Nursing or the State Medical Board.[16]

There is no required format for the SCA so long as it meets all the requirements set forth under Ohio law.[17] The SCA must contain certain quality assurance provisions such as, among other things:

- Review process of the SCA at least every two years.
- Process for periodic chart review of patients treated by the NP, including a review of prescriptive practices every 6 months.
- Criteria for patient referrals to the collaborating or another physician.
- Process for consultations with the collaborating physician.
- Plan for coverage in emergency situations or planned absences of the NP or the collaborating physician.
- Process for resolution of disagreements on matters of patient management.

**In contrast to the supervision of PAs, physicians who collaborate with NPs do not automatically assume vicarious liability for the acts or omissions of the NP by law.** The collaborating physician is, however, not immune from liability and may be named in any lawsuit involving an NP. Absent direct involvement with the patient, the physician is, however, unlikely to be held liable due to the absence of a physician-patient relationship. Nonetheless, any time an NP involves or consults with a collaborating physician, he or she may draw in the physician's medical judgment to make patient care decisions. Physicians must exercise caution and refrain from systematically annotating the medical records of patients seen by NPs unless the physician is consulted or directly involved with the patient. This is especially true if such documentation is only for billing purposes.

### III. Conclusion

The *Warren* case reaffirms that a physician-patient relationship is not required in malpractice cases under Minnesota law, an unforgiving posture which fortunately does not extend to Ohio and the majority of states. Ohio continues to require a physician-patient relationship at the onset of litigation. After widespread tort reform to stop physicians' exodus in many states, it would seem unlikely and unwise for the same states to embrace Minnesota's expansive legal theory of "foreseeability" in medical malpractice cases, but only time will tell. In the meanwhile, Ohio physicians can rest assured that vicarious liability does not automatically attach by collaboration with an NP and can take proactive measures to prevent the same. ■

Isabelle Bibet-Kalinyak and Arielle J. Lester are attorneys with the business law firm of McDonald Hopkins (www.McDonaldHopkins.com). Their practice focuses on health care law (transaction and compliance). For additional information about this topic, please contact Mrs. Bibet-Kalinyak at IBK@McDonaldHopkins.com.

References:

1) *Warren v. Dinter*, 926 N.W.2d 370 (Minn. 2019) at 373.
2) *Warren v. Dinter*, 926 N.W.2d 370 (Minn. 2019) at 373.
3) *Id.* at 373-74.
4) *Id.* at 374.
5) *Id.* at 375.
6) *Id.* at 375-76.
7) *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919), *Molloy II* (2004).
8) *Warren*, at 378-79.
9) O.A.C. 4731-27-02
10) O.R.C. § 4730.40
11) O.R.C. § 4730.20
12) O.R.C. § 4731.19; State Medical Board of Ohio, Frequently Asked Questions About Physician Assistant Supervision Agreements.
13) *Id.*
14) O.R.C. § 4723.481
15) O.R.C. § 4723.43(C)
16) O.R.C. § 4731.27
17) O.R.C. § 4723.431 and O.A.C. § 4723-8-04.

# AMCNO ADMINISTRATION ACTIVITIES

## Legislative Updates

### AMCNO Supports Legislation to Protect Ohioans from Discriminatory Practices

The AMCNO, patient advocacy groups and healthcare providers from around the state are asking the Ohio legislature to address discriminatory and unpredictable health plan practices that drive up out-of-pocket costs for patients' prescription medications. HB 469—bi-partisan legislation joint-sponsored by Rep. Susan Manchester and Rep. Thomas West—will address these practices and assist patients. This legislation will address the health insurance industry practice of no longer counting copay assistance toward a patient's deductible.

It is a well-known fact that when it comes to medication coverage, health plans have increasingly shifted the cost burden to patients through high deductibles or co-insurance, and through multi-tiered formularies with specialty drugs in the highest cost-sharing category.

Many drug manufacturers and health foundations help patients with assistance programs that cover additional costs patients are required to pay. These programs are very important for patients with chronic, complex conditions. Co-pay assistance programs include funding, as well as co-pay cards or coupons that patients can use to cover out-of-pocket costs.

Insurance companies are refusing to count co-pay assistance payments toward patients' deductibles. While each insurer has their own name for these policies, they are commonly referred to as "co-pay accumulator adjustments." Patients are required to pay an increasing amount of out-of-pocket money at the beginning of their plan year before the plan provides coverage. By not counting the assistance toward a patient's cost-sharing, plans target those who need help. The plans also keep the assistance payment in addition to any co-pays paid directly by the patient while in the deductible phase.

This legislation directs insurers to apply all payments made by either the patient or on the patient's behalf through an assistance program, to their cost-sharing obligation. This legislation does not interfere with the ability of a health insurance plan to save money by requiring the use of generics—the legislation specifically states that this requirement shall not apply to cost-sharing for a drug for which there is a medically generic equivalent.

Ohioans need health insurers to count all payments and not discriminate against those patients living with a chronic condition or battling a life-threatening illness, and for that reason, the AMCNO supports HB 469.

### Ohio Department of Medicaid (ODM) Launches Unified Preferred Drug List

The ODM believes that their unified preferred drug list, which took effect January 1, will bring more transparency to the ODM's prescription drug benefit. The lists came from recommendations by the ODM Pharmacy and Therapeutics Committee, and the agency continues to work with clinicians and pharmacists in the managed care plans to review the list and prior authorization guidelines. All drugs that are approved by the Food and Drug Administration (FDA) are available to Medicaid patients. The managed care plans will begin to utilize the list in the first quarter of the year and will be monitored for compliance starting April 1. ODM is also working on obtaining a contract for a single pharmacy benefit manager to handle the drug benefit for all of the managed care plans.

### AMCNO Joins Other Medical Associations to Voice Concern with Bill to Address Surprise Billing

The AMCNO joined medical associations from across the state to voice concerns with House Bill 388 and urged that this legislation not be passed without certain changes to its provisions. There are real concerns that the legislation, as currently drafted, poses a negative impact to physicians.

Physicians support efforts to remove the surprise billing burden, and we agree that patients should not be stuck in the middle of payment disputes between providers and insurance companies. And, they should not receive high-surprise medical bills after unknowingly receiving care from an out-of-network provider. Physician organizations are committed to working with the legislature and other interested parties to create a meaningful solution to this issue. We believe that any successful policy to address out-of-network or "surprise" billing must encourage contracting between the two parties. A market-based solution protects patients while providing a fair means to settle any payment dispute and encourages providers and plans to reach a settlement. A system in which insurers set the rates leaves little incentive for plans to contract with more providers, because they can opt to just continue paying significantly lower reimbursement rates for care delivery by capping in-network reimbursement rates. HB 388 would change how insurance contracting functions in a way that could only exacerbate problems for providers and patients. The AMCNO and the medical associations across the state are urging legislators to revise HB 388 to create a comprehensive and fair system for all parties involved.

Although the AMCNO has concerns with HB 388, we do support SB 198. The AMCNO and statewide medical associations support the Senate proposal (SB 198) rather than HB 388, since the Senate version prevents surprise bills and includes arbitration, but does not include cost caps in arbitration. As aforementioned, there is concern on the part of organized medicine that HB 388 will create more narrow insurance networks for patients and actually limit their ability to seek appropriate and timely care.

### State of Ohio Board of Pharmacy Addresses Mandatory e-prescribing Queries

The State of Ohio Board of Pharmacy has received questions about mandatory e-prescribing in Ohio. Under current Ohio law, there is no requirement for mandatory e-prescribing. Beginning Jan. 1, 2021, all Medicare Part D plans will require the use of e-prescribing for controlled substances prescriptions. The SUPPORT for Patients and Communities Act (HR6) requires the use of e-prescribing for controlled substances (EPCS) for schedule II-V controlled substances covered under a Medicare Part D prescription drug, or a Medicare advantage prescription drug plan starting January 2021.

As a reminder, gabapentin is not considered a controlled substance in Ohio. The Board was made aware of incorrect communications made by a third-party vendor stating that Ohio had made gabapentin a controlled substance. Although gabapentin is not a controlled substance, rule 4729:8-2-02 requires the following entities to submit the specified dispensing, personal furnishing, or wholesale sale information on all products containing gabapentin to the Ohio Automated Rx Reporting System (OARRS):

- All pharmacies located outside this state and licensed as a terminal distributor of dangerous drugs that dispense gabapentin to outpatients residing in this state.
- All pharmacies located within this state and licensed as a terminal distributor of dangerous drugs that dispense gabapentin to all outpatients.

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## Legislative Updates

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- All wholesalers licensed as a wholesale distributor of dangerous drugs that sell gabapentin at wholesale shall report those drug transactions.
- All pharmacies licensed as a terminal distributor of dangerous drugs that sell gabapentin at wholesale shall report those drug transactions.
- All prescribers, except veterinarians, located within this state that personally furnish gabapentin to outpatients, including samples.

NOTE: This requirement has been in effect since December 2016.

### SMBO Issues Reminder to All Licensees Regarding Extortion Scam

The State Medical Board of Ohio (SMBO) cautions licensees to be on alert for a scam that has resurfaced targeting Ohio physicians. Scammers have been calling and faxing prescribers stating they are being investigated by the Drug Enforcement Administration (DEA) and their license will be revoked if they do not pay a fine immediately via phone or fax. In one such incident, the scammer even faxed a fraudulent document to the physician using the SMBO logo.

Please be aware that if the SMBO is truly conducting an investigation and the investigated individual faces action against their license, they will receive an official notice of opportunity for a hearing either via certified mail or by personal service. Further, information on all suspensions of Board licenses and the payment of all Medical Board fines can be found via the official state website, eLicense.ohio.gov. If you are contacted, please report the incident to the investigation division of the SMBO by calling (614) 466-3934. Medical Board investigators have alerted their partners at the DEA of this scam and they have published information on their website, including how to notify the DEA if you are contacted by the scammers.

### SMBO Issues a Position Statement Regarding the Use of the Term "Nurse Anesthesiologist"

The SMBO has been reviewing information regarding activity in other states regarding Certified Registered Nurse Anesthetists (CRNAs) using the alternative title of "nurse anesthesiologist." It was determined by the SMBO that a policy statement should be prepared by the SMBO expressing the Board's concerns that use of the alternative title of nurse anesthesiologist could be confusing to patients, and that anesthesiologist refers to a physician specialty. At their most recent board meeting the following policy statement was adopted by the SMBO:

*Policy Statement: Use of the Title Anesthesiologist by Non-Physicians*
A non-physician should not use the term "anesthesiologist" in his or her title. The Board is aware that some Certified Registered Nurse Anesthetists ("CRNA") are using the title of nurse anesthesiologist. Use of the term "anesthesiologist" is misleading to patients who may not understand that a CRNA using the title of nurse anesthesiologist is not a physician. Patients today encounter healthcare professionals with varying levels of education and training, and it is important for healthcare professionals to use titles that clearly identify their profession and that are easily recognizable to patients. ■

# AMCNO Members Receive Complimentary Registration for Healthcare Innovation Summit

The AMCNO is pleased to once again partner with Healthcare Innovation for their annual Health IT (Information Technology) Summit.

At this year's Midwest-Cleveland Health IT Summit, which will be held April 2, 2020, at the Westin Downtown, you'll have the opportunity to hear from innovative leaders and speak with them about your own organizational issues. And, as a member of the Academy of Medicine of Cleveland & Northern Ohio, you will receive complimentary registration when you sign up using the code: AMCNOCOMP.

To register for the event, visit https://endeavor.swoogo.com/summit_series/Begin. Through this link, you can also view the agenda and featured speakers for this one-day Summit, which will include a keynote presentation by Adrienne Boissy, MD, Chief Experience Officer, with the Cleveland Clinic.

For more information, please contact Pam Durget at pdurget@hcinnovationgroup.com. ■

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THE NORTHERN OHIO PHYSICIAN (ISSN# 1935-6293) is published bi-monthly by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Periodicals postage paid at Cleveland, Ohio. POSTMASTER: Send address changes to NORTHERN OHIO PHYSICIAN, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Editorial Offices: AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131, phone (216) 520-1000. $36 per year. Circulation: 3,500.

Opinions expressed by authors are their own, and not necessarily those of the Northern Ohio Physician or The Academy of Medicine of Cleveland & Northern Ohio. Northern Ohio Physician reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.

**ADVERTISING:** Commemorative Publishing Company c/o Mr. Chris Allen, 3901 W. 224th Street, Fairview Park, OH 44126 • P: (216) 736-8601 • F: (216) 736-8602

# The SECURE Act

*By Mark O'Sickey and Phil Moshier*
*North Coast Executive Consulting*
*Affiliated with Lincoln Financial Advisors*

Congress recently passed—and the President signed into law—the SECURE Act, landmark legislation that may affect how you plan for your retirement. Many of the provisions go into effect in 2020, which means now is the time to consider how these new rules may affect your tax and retirement-planning situation. However, clients, financial advisers and tax professionals must pay close attention to the effective dates of the various provisions of the SECURE Act. For example, some of the SECURE Act's provisions became effective prior to 2020.

Here is a look at some of the more important elements of the SECURE Act that have an impact on individuals. The changes in the law might provide you and your family with tax-savings opportunities. However, not all of the changes are favorable, and there may be steps you could take to lessen their impact.

## Setting Every Community Up for Retirement Enhancement Act (SECURE Act)

**Selected key provisions affecting individuals:**

***Repeal of the maximum age for traditional IRA contributions.***
Before 2020, traditional IRA contributions were *not* allowed once the individual attained age 70½. Starting in 2020, the new rules allow an individual of any age to make contributions to an IRA, if the individual has compensation, which generally means earned income from wages or self-employment.

***Required minimum distribution age raised from 70½ to 72.***
Before 2020, retirement plan participants and IRA owners were generally required to begin taking required minimum distributions, or RMDs, from their plan or IRA by April 1 of the year following the year they reached age 70½. The age 70½ requirement was first applied in the retirement plan context in the early 1960s and, until recently, had not been adjusted to account for increases in life expectancy.

For distributions required to be made after December 31, 2019, for individuals who attain age 70½ *after* that date, the age at which individuals must begin taking distributions from their retirement plan or IRA is increased from 70½ to 72. In addition, certain individuals working past age 72 may be able to defer RMDs even further.

***Partial elimination of stretch IRAs.***
For deaths of plan participants or IRA owners occurring before 2020, beneficiaries (both spousal and nonspousal) were generally allowed to stretch out the tax-deferral advantages of the plan or IRA by taking distributions over the beneficiary's life or life expectancy (in the IRA context, this is sometimes referred to as a "stretch IRA").

However, for deaths of plan participants or IRA owners beginning in 2020 (later for some participants in collectively bargained plans and governmental plans), distributions to most nonspouse beneficiaries generally are required to be distributed *within ten years* following the plan participant's or IRA owner's death. So, for those beneficiaries, the "stretching" strategy is no longer allowed.

***Exceptions*** to the 10-year rule are allowed for distributions to (1) the surviving spouse of the plan participant or IRA owner; (2) a child of the plan participant or IRA owner who has not reached majority; (3) a chronically ill individual; (4) a disabled beneficiary; and (5) any other individual who is not more than ten years younger than the plan participant or IRA owner.

Those beneficiaries who qualify under this exception generally may take their distributions over their life expectancy (as allowed under the rules in effect for deaths occurring before 2020).

**Note: This particular provision of the SECURE Act can significantly affect your current retirement plans and planning for beneficiaries of your IRAs and certain qualified plans (e.g., IRC section 401(k)) upon your death. For individuals who died prior to 2020, the SECURE Act's impact will be more limited regarding stretch IRAs.**

**If your retirement and/or estate plan include designated beneficiaries, other than those enumerated exceptions in the paragraph above, then you need to determine whether your goals and objectives are impacted by the SECURE Act. For example, if your designated beneficiaries include adult children, a trust, etc., the SECURE Act will affect such beneficiaries' ability to accomplish a stretch IRA strategy.**

**While a stretch IRA strategy may be limited under the SECURE Act, there are other strategies that can help extend a beneficiary's recognition of income. In addition, there are methods to replenish (or replace) the benefits lost, that were available to designated beneficiaries prior to the passage of the SECURE Act.**

***Expansion of IRC section 529 education savings plans to cover registered apprenticeships and distributions to repay certain student loans.***
An IRC section 529 education savings plan (a 529 plan) is a tax-exempt program established and maintained by a state, or one or more eligible educational institutions (public or private). Any person can make nondeductible cash contributions to a 529 plan on behalf of a designated beneficiary. The earnings on the contributions accumulate tax-free. Distributions from a 529 plan are excludable up to the amount of the designated beneficiary's qualified higher education expenses.

Before 2019, qualified higher education expenses didn't include the expenses of registered apprenticeships or student loan repayments.

However, for distributions made after *December 31, 2018* (the effective date is **retroactive**), tax-free distributions from 529 plans can be used to pay for fees, books, supplies, and equipment required for the designated beneficiary's participation in an apprenticeship program. In addition, tax-free distributions (up to $10,000 per beneficiary)

*(Continued on page 8)*

# Check Your Initial 2020 MIPS Eligibility on the QPP Website

You can now use the updated CMS Quality Payment Program Participation Status Lookup Tool to check on your initial 2020 eligibility for the Merit-based Incentive Payment System (MIPS). Simply go to https://qpp.cms.gov/participation-lookup/ to begin.

Just enter your National Provider Identifier, or NPI, to find out whether you need to participate in MIPS during the 2020 performance period.

**Low Volume Threshold Requirements**
To be eligible to participate in MIPS in 2020, you must:

- Bill **more than $90,000** a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS), **AND**
- Furnish covered professional services to **more than 200** Medicare Part B beneficiaries, **AND**
- Provide **more than 200** covered professional services under the PFS.

If you **do not exceed all three of the above criteria** for the 2020 performance period, you are excluded from MIPS. However, you have the opportunity to opt-in to MIPS and receive a payment adjustment if you meet or exceed one or two, but not all, of the low-volume threshold criteria. Alternatively, you may choose to voluntarily report to MIPS and not receive a payment adjustment if you do not meet any of the low-volume threshold criteria or if you meet some, but not all, of the criteria.

**Find Out Today**
Find out whether you're eligible for MIPS today. Prepare now to earn a positive payment adjustment in 2022 for your 2020 performance.

**Note:** The 2020 Eligibility Tool Update for QPs/APMs will be updated at a later time. Additionally, the tool will be updated in late 2020 to indicate final MIPS eligibility.

**For More Information**

- Visit the https://qpp.cms.gov/mips/how-eligibility-is-determined on the Quality Payment Program website.

**Questions?**

- Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 am – 8 pm ET or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, consider calling during non-peak hours—before 10 am and after 2 pm ET.
  - Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

## The SECURE Act

*(Continued from page 7)*

are allowed to pay the principal and/or interest on a qualified education loan of the designated beneficiary, or a sibling of the designated beneficiary. Be aware that some states may not follow the federal law changes relating to 529 plans.

***Kiddie tax changes for gold star children and others.***
In 2017, Congress passed the Tax Cuts and Jobs Act (TCJA), which made changes to the so-called "kiddie tax," which is a tax on the unearned income of certain children. Before enactment of the TCJA, the net unearned income of a child was taxed at the parents' tax rates if the parents' tax rates were higher than the tax rates of the child.

Under the TCJA, for tax years beginning after December 31, 2017, the taxable income of a child attributable to net unearned income is taxed according to the brackets applicable to trusts and estates. Children to whom the kiddie tax rules apply and who have net unearned income also have a reduced exemption amount under the alternative minimum tax (AMT) rules.

There had been concern that the TCJA changes unfairly increased the tax on certain children, including those who were receiving government payments (i.e., unearned income) because they were survivors of deceased military personnel ("gold star children"), first responders, and emergency medical workers.

The new rules enacted on December 20, 2019, repeal the kiddie tax measures that were added by the TCJA. So, starting in 2020 (with the option to start *retroactively* in 2018 and/or 2019), the unearned income of children is taxed under the pre-TCJA rules, and not at trust/estate rates. Additionally, starting retroactively in 2018, the new rules also eliminate the reduced AMT exemption amount for children to whom the kiddie tax rules apply and who have net unearned income.

***Penalty-free retirement plan withdrawals for expenses related to the birth or adoption of a child.***
Generally, a distribution from a retirement plan must be included in income. Unless an exception applies (for example, distributions in case of financial hardship), a distribution before the age of 59½ is subject to a 10% early withdrawal penalty on the amount includible in income.

Starting in 2020, plan distributions (up to $5,000) that are used to pay for expenses related to the birth or adoption of a child are penalty-free. That $5,000 amount applies on an individual basis, so for a married couple, each spouse may receive a penalty-free distribution up to $5,000 for a qualified birth or adoption.

***Taxable non-tuition fellowship and stipend payments are treated as compensation for IRA purposes.***
Before 2020, stipends and non-tuition fellowship payments received by graduate and postdoctoral students were not treated as compensation for IRA contribution purposes, and so could not be used as the basis for making IRA contributions.

Starting in 2020, the new rules remove that obstacle by permitting taxable non-tuition fellowship and stipend payments to be treated as compensation for IRA contribution purposes. This change will enable these students to begin saving for retirement without delay.

These are just some of the SECURE Act's significant changes that may affect your current retirement and/or estate plans. Please contact us so we can help tailor a plan, with your other advisers, that will work best for you. ■

# AMCNO Annual Wine Tasting Raises a Glass to its Members and their Guests!

Each year, the AMCNO hosts a wine tasting to toast its members and have them gather in an inviting atmosphere where they can interact with each other while sampling various wines.

At this year's event, held in February once again at the spacious Market Avenue Wine Bar, our guests were treated to another fun evening, which featured five different Australian wines—ranging from a sauvignon blanc to a shiraz-viognier blend—and an assortment of tasty hors d'oeuvres and desserts. Wine expert Samuel Winterberger provided a detailed description of each wine before he poured it.

We would like to thank everyone who was able to attend this event—we appreciate you taking the time to spend the Sunday of your Valentine's Day weekend with us, and we hope to see you next year! ■

*Wine expert Samuel Winterberger (standing on left) describes the first wine to the attendees during the event.*

*AMCNO President Dr. Mehrun Elyaderani (left) stands with AMCNO Board Members Dr. DeAundre Dyer (center) and Dr. John Bastulli (right).*


*The residents and their guests enjoy a nice night out together.*

*AMCNO Board Members Dr. Mary Frances Haerr and Dr. John Bastulli take a pause in their conversation for a picture.*

*Mr. Winterberger pours a wine sample for Dr. Halina Podlipsky.*

*Drs. Jonathan Scharfstein, Baljit Bal, and Kristin Englund stand together as the event begins.*

*Dr. Dyer and his wife Maria (far left and far right) pose for a moment with AMCNO Past President Dr. Fred Jorgensen and his wife Sandy.*

*The Academy of Medicine of Cleveland & Northern Ohio and the Cleveland Metropolitan Bar Association Present the:*

# Medical Legal Summit

## April 24-25, 2020

Location: CMBA Conference Center
One Cleveland Center
1375 East 9th Street, Floor 2, Cleveland, OH 44114

**Friday, April 24, 2020**

### Health Care Law Update

(*No CME or UH CRME credits are available for this session*)

12:30 p.m. - 4:00 p.m.

- Medical Legal Partnerships and Holistic Care – Legal Aid Society of Cleveland
- Health Law Considerations Regarding Medspas
- Pharmacy Benefit Managers 101: The Role of PBMs in the Prescription Drug Supply Chain and Interactions with Employers, Providers and Patients

4:15 p.m. Adjourn to Medical Legal Summit

# Summit Details

## Medical Legal Summit – Friday Evening Session
## April 24, 2020

(CLE TBD, 1.5 CME*, and 1 UH CRME**)

4:15 p.m. **Welcome & Introductions**
**Mehrun Elyaderani, MD**, *AMCNO President;* **David Valent, Esq.,** *Cleveland Clinic*

4:30 p.m. - 6:00 p.m.
**Keynote Presentation**
*Kathleen Blake, MD, AMA Vice President For Healthcare Quality*

**Intelligence: Artificial or Augmented? Hope or Hype?**
*Artificial intelligence (AI) has been used in a variety of settings for more than 30 years, and yet its use in the direct care of patients is in its relative infancy. As with any new technology, physicians, patients, regulators, payers and educators are striving to keep up with the rapid pace of AI development. Four key questions: Does it work? Who will pay for it? Who's liable if it does not work? How should/will I integrate AI into my practice? The answers to these questions will determine if AI is a reason for hope, or just hype, and, whether AI will augment or replace human intelligence.*

***A networking reception follows***

## Saturday Session – April 25, 2020

(CLE TBD, 4 CME*, and 2 UH CRME**)

7:30 a.m. **Registration & Breakfast**

8:00 a.m. **Welcome & Introductions**

8:15 a.m. **Telemedicine: The Future is Now – Medical Legal Implications Examined**
*(Co-Chairs: Mehrun Elyaderani, MD, and Dave Valent, Esq.)*
***Overview***
The panel will review the advancement of telemedicine, and its impact on health care. The panel will study different use cases and the implications of telemedicine on quality improvement, patient access, cost of care, liability risks, and other considerations facing patients, providers and business professionals.

***Speakers (continued)***
**Corey Scurlock, MD, MBA,** Medical Director of the Westchester Medical Center Health Network's eHealth Center; **Matthew Faiman, MD, MBA,** Medical Director, Cleveland Clinic Express Care Online; and **Adam Davis, Esq.,** Reminger, Partner, Medical Malpractice and Health Care Attorney

9:15 a.m. **Gene Editing: Progress or Peril?**
*(Co-Chairs: Gerard Isenberg MD, and Isabelle Bibet-Kalinyak, Esq.)*
***Overview***
Gene editing has the potential to revolutionize the treatment of thousands of diseases that result from single-gene mutations but with biohacking on the rise, the gene editing movement is no longer confined to scientists. Gene editing is crossing into the mainstream with at-home DIY bio kits that enable self-experimentation. The following will be explored during this session: *NanoPOD basics, biohacking basics, and legal implications/ state laws.*

***Speakers***
**Leslie Whetstine, PhD,** Professor of Philosophy and Bioethicist at Walsh University; and **John Tilton, MD**, Associate Professor, Director of Immunobiology, CWRU School of Medicine

10:15 a.m. **Break**

10:30 a.m. **Mandatory School Vaccinations – Can and Should These be Enforced?**
*(Co-Chairs: Kristin Englund, MD, and Mr. Bradley Reed, Frantz Ward, LLP)*
***Overview***
Vaccine preventable diseases, such as measles, mumps, pertussis and influenza, are increasing dramatically in the U.S. and all over the world, often due to vaccine hesitancy, legislated exemptions and misinformation. This plenary session will offer a debate concerning school immunization requirements, patient and parental rights, physician roles and public health responsibilities.

***Speakers***
**Julie Hertzer, MD,** Pediatrician, Advanced Pediatrics; **Katharine Van Tassel, Esq.**, Visiting Professor at CWRU School of Law; and **Gwendolyn Majette, Esq.,** Associate Professor of Law, Cleveland State University

11:30 a.m. **Break**

11:45 a.m. **Danger Ahead: Risks that Lurk Within the Electronic Medical Record (EMR)**
*(Co-Chairs: Matthew Levy, MD, and Mr. Russell Horn, University Hospitals)*
***Overview***
Love it or hate it, the electronic medical record (EMR) is here to stay. Although the combination of EMRs and payment rules present opportunities to maximize reimbursement, there are also risks, that if not avoided, could result in exposure to claims for fraud and abuse. This panel will discuss the risks vs. efficiency gains from copying forward; entries made by unlicensed personnel; over-coding, up-coding and inflation of risk scores; outsourcing documentation; and who should sign-off on entries in the EMR.

***Speakers***
**Sally Streiber,** Director, Provider Compliance, University Hospitals; **Matthew Albers, Esq.**, Vorys, Sater, Seymour and Pease LLP; **Matthew Levy, MD**, St. Vincent Charity Medical Center; and **Russell Horn, Esq.,** University Hospitals

Location: **CMBA Conference Center**
**One Cleveland Center**
1375 East 9th Street, Floor 2, Cleveland, OH 44114

This summit is designed to bring together doctors, lawyers, healthcare professionals and others who work in allied professions for education, lively discussion and opportunities to socialize.

Co-sponsored by the Academy of Medicine of Cleveland & Northern Ohio, Cleveland Metropolitan Bar Association, and Academy of Medicine Education Foundation.

Co-Chairs: **Mehrun Elyaderani, MD**, *AMCNO President;* **David Valent, Esq.,** *Cleveland Clinic*

**For more information, call the AMCNO at (216) 520-1000 or CMBA at (216) 696-2404.**

# Registration

*Health Care Law Update*
***(This session is optional for physicians and takes place 12:30 - 4 pm on Friday, April 24, 2020. No CME and UH CRME available. Contact the AMCNO to sign up for it at 216-520-1000.)***

❑ $50 AMCNO Members and Non-Members

**Please note: All *attorney* registrations will be handled through the CMBA.**

**Online registration is available at www.CleMetroBar.org/CLE**

## Medical Legal Summit Only
**(Friday keynote speaker and Saturday sessions)**

❑ $85 AMCNO Members

❑ $110 Staff of Physician Members

❑ $140 Non-Members

❑ $15 Medical Students & Residents (limited seats available)

**To register online: www.amcno.org/index.php?id=1247**

**(If you have trouble with this link, visit www.amcno.org, and click on the link for the Summit under "Upcoming Events" on the home page)**

TOTAL $ _____

Name _____

Company _____

Address _____ City _____

State _____ Zip ___ Phone _____ E-mail _____

❒ I have submitted a membership application within the last 30 days.

Credit Card No. _____ Exp. Date _____

Signature _____

**PHYSICIAN REGISTRATIONS: Phone/fax or mail to: AMCNO, 6100 Oak Tree Blvd., Ste. 440, Independence, OH 44131, Phone: (216) 520-1000, FAX: (216) 520-0999. Physicians (i.e., members, staff of physician members, and non-members) may also register and pay the AMCNO online at www.amcno.org/index.php?id=1247. (If you have trouble with this link, visit www.amcno.org, and click on the link for the Summit under "Upcoming Events" on the home page.) Make checks payable to the AMCNO. CANCELLATIONS must be received in writing three business days prior to the program. Refunds will be charged a $15 administrative fee.**

**ATTORNEY REGISTRATIONS:** All attorney registrations will be handled through the CMBA. For more information, visit www.CleMetroBar.org/CLE.

Please note: Persons needing special arrangements to attend this program are asked to contact the CMBA at (216) 696-2404, at least one week prior to the program.

***The MetroHealth System is accredited by the Ohio State Medical Association to provide continuing medical education for physicians.***
***The MetroHealth System designates this educational activity for a maximum of 5.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.***

University Hospitals

***The AMCNO has obtained approval from University Hospitals (UH) for four hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program. Please note: 1 CRME credit is available for 4/24/20 (Friday) and 2 CRME credits are available for 4/25/20 (Saturday).***

***Professional Practice Gap: The U.S. healthcare system has significantly transformed over the last decade and changed the practice of medicine. Rules and regulations and other forces are continually reshaping the medical practice. They include issues related to artificial intelligence, strategies for the use of telemedicine in the practice of medicine, the use of gene editing which has the potential to change the treatment of patients, electronic medical records and how to establish proper safeguards for their use in hospitals and medical practices, and concerns about vaccine preventable diseases. This session is intended to increase knowledge of current rules and regulations and how they impact the practice of medicine.***

- ***Current medical approaches and issues concerning the use of artificial intelligence.***
- ***The risks and challenges related to the use of electronic medical records in hospitals and medical practices.***
- ***Best practices, rules and policies related to the use of vaccines and how these affect both patients and physicians.***
- ***The impact of telemedicine on the practice of medicine and the legal challenges related to its use.***
- ***The current legal and medical issues surrounding the use of gene therapy in the practice of medicine.***