Fax Facts

VENTURA COUNTY MEDICAL ASSOCIATION and CALIFORNIA MEDICAL ASSOCIATION

"Advocates for patients, physicians and quality medical care"

Up-to-the-minute legislative and organizational events & issues

Administrative Office: 805/484-6822 **www.venturamedical.org** **November 18, 2016**

CALIFORNIA VOTERS MADE HEALTH CARE A PRIORITY

Election Night 2016 was one for the history books. Once again, the California Medical Association took on tough fights and prevailed.

We won all of our statewide ballot measure endorsements, including three local initiatives in the Bay area.

Together, we voted to:

• Invest in Medi-Cal. (Yes on Prop. 56, 55 and 52)

• Save lives, reduce smoking rates and prevent thousands of children from starting in the first place. (Yes on Prop. 56)

• Triple the funding for California's anti-smoking programs. (Yes on Prop. 56)

• Provide more essential services like medical check-ups, immunizations, prescriptions and dental/vision care for 13 million low-income Californians, including seven million children. (Yes on Prop. 52)

• Prevent an increase in state prescription drug costs, as well as preserve patient access to medications. (No on Prop. 61)

• Protect public health and clarify the role of physicians in controlling and regulating the adult use of cannabis. (Yes on Prop. 64)

• Reduce sugar intake to prevent diabetes and obesity. (Yes on Measures V (San Francisco), HH (Oakland) and O1 (Albany)

• Break down barriers and removed outdated bilingual education mandates to better reflect California's diverse society. (Yes on Prop. 58)

• Ensure critical infrastructure projects – including hospitals and medical facilities – aren't subject to delays or loss of local control. (No on Prop. 53)

• Strengthen California's ability to prevent gun violence. (Yes on Prop. 63)

Voters made healthcare a priority

In the coming months, we'll work to ensure the new revenue reaches the communities most in need of access to health care and improved services.

Voters sent a clear signal that they are willing to support investments in public health and that they are tired of Sacramento chronically underfunding health care. CMA's alignment with voters further demonstrates our strength and ability to fight for physicians throughout the state and in all modes of practice.

And on the national front – there are more questions than answers, but one thing is clear: we could be facing a major shake-up.

How will the next Congress and Trump's administration handle the Affordable Care Act? Rising drug prices? Health and Human Services secretary? Medicaid expansion? Mega-mergers?

Regardless of what comes next, CMA will continue to keep California's physicians in the driver's seat on health care policy. And we're working ahead to 2018 to ensure the next Governor reflects our values, including the protection of MICRA and investments in public health.

BY THE NUMBERS

$3 billion

per year in new federal matching funds for Medi-Cal to serve elderly and low-income Californians. (Yes on Prop. 52)

UP TO

$2 billion

per year to improve access to health care services, including Medi-Cal, for low-income children and their families. (Yes on Prop. 55)

UP TO

$1.7 billion

(plus $1 billion in federal matching funds) for Medi-Cal. (Yes on Prop. 56)

SAVE

$1.5 billion

in costs for children's health coverage by FY 2019-20. (Yes on Prop. 52)

$20 million

per year for public schools to enhance smoking cessation programs. (Yes on Prop. 56

Happy Thanksgiving!

VCMA and CMA offices are closed Thursday, November 24th and Friday, November 25th.

STATE'S HIGH COURT RULES HEALTH PLANS CANNOT NEGLIGENTLY DELEGATE PAYMENT RESPONSIBILITY

The California Supreme Court ruled ON Monday that health plans cannot absolve themselves of the responsibility to pay claims for emergency care by noncontracted providers by negligently delegating that responsibility to a risk-bearing organization that it knows—or should have known—to be financially insolvent.

CMA filed an amicus brief in this case, Centinela Freeman Emergency Medical Assocs. v. Health Net et al., on behalf of a broad coalition of out-of-network health care providers who were left unpaid for emergency medical care when La Vida Independent Practice Association (IPA) went bankrupt in 2010. The IPA, a risk-bearing organization (RBO) that provided health care coverage to hundreds of thousands of patients in Southern California, was contracted by HealthNet and six other health plans to pay insurance claims to providers.

Existing law insulates health plans from payment responsibility for medical claims once they enter into a delegation arrangement with an RBO.

Notwithstanding such law, the providers in Centinela sought reimbursement from the health plans on the theory that they negligently delegated to La Vida, because they continued to send patients to the IPA when they knew or should have known of its financial distress and impending insolvency.

CMA's amicus briefs urged a fair and just interpretation of provisions within the Knox-Keene Act that permit health plans

to delegate payment responsibility to risk-bearing organizations.

CMA recognizes the viability of the delegation model and accepts that, generally, health plans are absolved of liability after they delegate to an RBO. When health plans delegate negligently, however, CMA believes they must be held accountable for their own misconduct—and the California Supreme Court agrees.

Contact: CMA Center for Legal Affairs, (800) 786-4262 or legalinfo@cmanet.org.

VCFMC-ACO Update

Thursday, December 8

6:30pm-8pm

Including

MIPS Navigator Tool Demonstration

ALL PHYSICIANS INVITED

Agoura Hills Event Center
29900 Ladyface Court, Agoura Hills

In coordination with Choice Health Associates

NEW ONLINE MEDI-CAL PROVIDER ENROLLMENT PORTAL TO LAUNCH FRIDAY

The California Department of Health Care Services (DHCS) is ready to launch its new online Medi-Cal provider enrollment portal. The system, called the Provider Application and Validation for Enrollment (PAVE), will transform provider enrollment from a manual paper-based process to a web-based portal that providers can use to complete and submit their applications and verifications and to report changes. The new portal will go live this Friday, November 18, 2016.

Initially, PAVE will be available for most physician and allied providers who enroll to serve fee-for-service beneficiaries directly through the DHCS Provider Enrollment Division. However, DHCS plans to expand PAVE access to Medi-Cal providers who enroll through other divisions and departments until all Medi-Cal enrollment activities are directed through the PAVE system. PAVE will eventually replace the paper application process, although paper applications will still be accepted for an undetermined transition period.

The new system should significantly improve the provider enrollment experience by minimizing errors in the application process and significantly reducing the time required to process provider enrollments.

This initial release of PAVE will allow providers to check application status online and use electronic signatures for all provider types. PAVE will also allow providers to quickly revalidate their information in accordance with the Affordable Care Act.

CMA has been involved in stakeholder meetings and beta testing of the new system over the past two years. Recent demos of the system seem very promising, with a much more intuitive interface and streamlined process.

DHCS will also be hosting a second series of webinars that will cover individual and group billing applications, affiliating with rendering providers, the "send" and "share" features, and secure messaging within PAVE. Based on your feedback, additional topics will be covered in future training sessions. Stay tuned for more information on these and future PAVE webinars.

For more details on PAVE, visit the DHCS website.

Contact: CMA reimbursement help line, (888) 501-4911 or economicservices@cmanet.org.

CMA TO HOST WEBINAR ON CALIFORNIA WORKERS' COMPENSATION REFORMS

In 2017, California physicians will again see new reforms instituted as part of several recently enacted laws aimed at increasing the transparency and accountability within the workers' compensation system. Three recently signed bills (SB 1160, SB 1175 and AB 2503) will bring significant changes to the areas of utilization review, lien filing and bill submission.

SB 1160 will reduce utilization review in the first 30 days following a work-related injury. It also institutes expedited timelines for medication treatment and requests for payment, and adds new lien restrictions to the law that will affect both existing and future liens.

SB 1175 creates a 12-month timely filing limitation period within the workers' compensation system to submit a medical bill for treatment rendered to an injured worker or for bills submitted for medical-legal expenses.

AB 2503 requires a physician providing treatment to an injured worker to send any request for authorization for medical treatment, with supporting documentation, to the claims administrator.

CMA hosted a webinar on November 16, 2016, that presented an in-depth overview of these new laws. The webinar also discussed important implementation dates that will directly impact the processes through which physicians treat injured workers and are paid for their services. The information covered will help to ensure both compliance with the new laws and the ability to take advantage of improvements to the system.

This webinar is free to watch On-Demand to CMA members and their staff only. To register, click here or visit www.cmanet.org/events for more information.

2017 MEDICARE FEE SCHEDULE INCLUDES $140 MILLION IN ADDITIONAL FUNDING FOR PRIMARY CARE

CMS released the final 2017 Medicare physician fee schedule. The fee schedule transforms how Medicare pays for primary care through a new focus on care management and behavioral health, which is expected to result in an additional $140 million in payments next year for physicians providing these services.

DON'T FORGET: LAST DAY TO CHANGE YOUR MEDICARE PARTICIPATION STATUS FOR 2017 IS DECEMBER 31

As always, physicians have three choices regarding Medicare: Be a participating provider; be a non-participating provider; or opt out of Medicare entirely. Details on each of the three participations options are as follows:

- **A participating physician** must accept Medicare-allowed charges as payment in full for all Medicare patients.
- **A non-participating provider** can make assignment decisions on a case-by-case basis and bill patients for more than the Medicare allowance for unassigned claims. Non-participating physician fees are 95 percent of participating physician fees. If you choose not to accept assignment, you can charge the patient 9.25 percent more than the amounts allowed in the participating physician fee schedule (which equates to 15 percent of the non-participating fees).
- **Physicians who opt out of Medicare** are bound only by their private contracts

with their patients. Medicare's limiting charges do not apply to these contracts, but Medicare does specify that these contracts contain certain terms. When a physician enters into a private contract with a Medicare beneficiary, both the physician and patient agree not to bill Medicare for services provided under the contract.

Physicians who want to change their participation status for 2017 must send a letter to Noridian, California's Medicare contractor, postmarked by December 31, 2016.

The California Medical Association (CMA) also has information on physicians' Medicare participation options in CMA On-Call document #7209, "Medicare Participation (and Nonparticipation) Options." On-Call documents are free to members in CMA's online resource library at www.cmanet.org/cma-on-call. Nonmembers can purchase On-Call documents for $2 per page.

Physicians can also visit CMA's MACRA resource center at www.cmanet.org/macra to better understand the payment reforms and access resources to help with the transition. The center is a one-stop-shop with tools, checklists and information from CMA, the Centers for Medicare and Medicaid Services, the American Medical Association and national specialty society clinical data registries.

Contact: Cheryl Bradley, (213) 226-0338 or cbradley@cmanet.org.

CLASSIFIEDS

Free listings for VCMA members. Submit ad info to: marycarr@venturamedical.org

PRACTICE OPPORTUNITIES

Simi Valley- MD or DO needed ASAP 1-2 days per week 12 hour shifts at Med Center, possible 1 weekend per month. Please contact Denice @ 805-583-5555 ex 26 or email admin@medcenterofsimivalley.com

Camarillo - Office with two to three exam rooms to share. Part time or full time. Affordable and flexible. Please contact (805)383-2929.

Simi Valley – full time FP MD needed at the Med Center. Hours are Monday 8am-8pm, alternating Tuesdays 8am -8pm, Fridays 8am -8pm and every other weekend 9am-5pm. Call Denice (805)583-5555 ex 23, or send resume: admin@medcenterofsimivalley.com

Thousand Oaks - Sublease up to 4 days per week; 7 exam rooms in prof. bldg. Please call Lynn at (805)482-8989

Thousand Oaks - 2700 SF office with large procedure room and recovery area, and 4 exam rooms. Available Mondays and Tuesdays 8 AM to 12 noon; Wednesdays 2 to 6 PM. More info, visit www.AGImedical.com

Ventura – For Lease: 500 sq.ft. Beautiful medical office on Brent St. (805)258-2059 ext.2447 for info.

Westlake Village – Remodeled, medical office for sublease. Available up to four days a week. (818)438-5997 Brisbeee@aol.com

CMA WEBINARS

www.cmanet.org to pre-register

November 30 MACRA Implementation: A Review of CMS Final Rule 12:15pm-1:15pm

December 7: MACRA: The Final Rule and How to Get Ready 12:15pm-1:15pm

Past Webinars can be viewed On-Demand for FREE in the CMA Resource Library.

Online CME: new online CME platform from CMA's Institute for Medical Quality (IMQ) provides access to AMA PRA Category 1 Credit™. Easy tracking of course participation and credit. Discounts for CMA members. Catalog and register for courses at http://imq.inreachce.com.

FOR SALE

Established Medical Practice for sale – Contact Brian Tamura, Md at 805-983-0897

OB/GYN Equipment - Colposcope, microscope, cryo gun, surgical and colposcopy instruments, speculum lights (Welsh Allen), chart racks, exam table, stools, office chairs, waiting room chairs, 10 station business phone system, endometrial samplers, ultrasound, leep system. Call (805) 535 4422

Closing Practice Sale - Family practice medical equipment for sale. Equipment includes exam tables, chart files, MidMark M9 UltraClave, AT-2 plus Schiller/WelchAllyn ECG recorder, printers and other equipment associated with family practice medicine. Call for pricing (805) 525-5518.

Pediatric Practice Equipment - Vaccine 4.3 cubic ft. refrigerator-freezer combo; paid $1499, only used 4 months. (Best offer)
WelchAllyn Rectal thermometer. $100
2 different sizes pediatric Aneroid Sphygmomanometers; $30 ea. or $50 both.
SECA newborn scale $70
X-acto paper trimmer $40
Email: spa.pinzonarellano@gmail.com

MEMBER BENEFITS HI-LIGHTS

MERCER Insurance Programs
NEW Workers Comp Preferred plan, members receive 5% discount off premium. Many members' savings equal to VCMA/CMA annual dues. Disability, Life, Health & Business Overhead plans available, too. Call a Mercer Client Advisor at (800) 842-3761 or cmacounty.insurance.service@mercer.com

Resume Service: Call 484-6822 or email julie@venturamedical.org to request resumes to fill practice personnel positions. FREE to members.

MARK YOUR CALENDAR

December 8 VCFMC-ACO Update and MIPS Navigator Tool 6:30pm-8pm
All Physicians Invited; No fee
Agoura Hills Event Center
29900 Ladyface Court, Agoura Hills

January 18-25 Professionalism in the Office 9am-10:30am; $75 per person

Professional Liability:

THE DOCTORS COMPANY

has been endorsed by VCMA for the past 15 years. For quote or questions contact: MLawrence@thedoctors.com

Call or Click 2-1-1 Ventura County www.211ventura.org

The new 2-1-1 website creates a simple, user-friendly way to navigate the vast array of services available through the 2-1-1 Ventura County resource database. The site is mobile-friendly and includes 2-1-1 public reports and FAQs, in addition to a section for service providers. Now residents can dial 211 or access online www.211ventura.org.

MIPS Update

Executive Director's Note:

Although Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) penalties will not kick in until 2019, there are two more years of penalties that will be applied based on 2015-2017 performance—tied to the meaningful use, Physician Quality Reporting System and Value-Based Modifier reporting programs. This will also decrease the limiting charge amounts that nonparticipating physicians can bill to patients for unassigned claims.

QVH Systems is the consulting firm engaged to develop and provide procedures, policies and IT Analytics for the VCFMC-ACO (established by VCMA). They provided the following article, and will be presenting a demonstration of their MIPS Navigation Tool (will be provided no charge to VCFMC-ACO participants). *It will be available for purchase for a nominal fee to all other physicians.*

ALL PHYSICIANS INVITED:
MIPS Navigator (tool) Demonstration
Thursday, December 8
6:30 – 8PM
Agoura Hills Event Center
29900 Ladyface Court
Agoura Hills, CA

MIPS - What it means to your practice: *Does every cloud have a silver lining?*

There were many reasons to celebrate in April last year. Organized Medicine had finally put a stake through the heart of the SGR after more than a decade of trying! Physician payments under Medicare would no longer be subject to the ups and downs of the nation's economy and the annual battle to avert phony cuts to the Physician Fee Schedule were a thing of the past.

The SGR was replaced with a new way to adjust physician payments, the Quality Payment Program which, to use the government's own words, "is part of an overarching Administration strategy to transform how health care is delivered in America, … intended to continue to move Medicare away from a primarily volume-based FFS payment system for physicians and other professionals." So what does this grand "strategy" mean to you and what do you need to do about it? To answer this, you need to understand MIPS and APMs. MIPS (Merit Based Incentive Program) is a complex method to evaluate clinicians who bill Medicare based on their aggregate performance in 4 Categories: quality measures (Quality), practice reengineering (Improvement Activities), meaningful use of Health IT (Advancing Care Information) and cost to Medicare (Cost).

MIPS is the Value-Based Modifier on steroids and will result in each clinician receiving their own individualized payment adjustment, up or down, to the Physician Fee Schedule.

The rules that govern MIPS are profoundly complex. The variables affecting each clinician under MIPS are extensive, for example: specialty, practice size, type of clinicians in the practice, urban or rural, patient-facing or not, participation in APMs, reporting as group or individual, reporting method, the various measures available for the clinicians in the practice.

The list goes on and on. Each one of these variables interacts with the others to produce a mind-numbing set of possibilities that will change the MIPS rules for each practice. For example, how much each of the 4 Categories contributes to the aggregate score or whether any weight, at all, is given to a particular Category.

You need to know how the rules apply to your unique practice and what various measures and activities you will likely perform best on to optimize your MIPS score to achieve the highest possible payment adjustment.

APMs (Alternative Payment Models) such as MSSP ACOs, Episode Payment Models and Patient Centered Medical Homes, in general, offer opportunities for some participating physicians to avoid MIPS entirely.

Most physicians involved in an APM, will have opportunities for additional revenue streams and different, perhaps better, scoring rules under MIPS.

The final rule governing MIPS was published November 4th, 2016 in an 824-page document. The major buzz generated by the release was that CMS has made major modifications to the implementation schedule for MIPS and a significant decrease in the number of physicians subject to MIPS.

The rule as proposed in May of 2016 would have fully implemented all of the elements of MIPS with the performance year starting on January 1, 2017 and adjusting Medicare payments in 2019. The Final Rule provides physicians with three basic options for performance year 2017, which CMS has called a transition year:

1. Report nothing for 2017 and receive a negative 4% payment adjustment in 2019 for all Medicare services they provide.

2. Report one Quality measure or one Improvement Activity, or do the

4-5 requirements to obtain the "Base Score" in Advancing Care Information and get a neutral adjustment for 2019.

3. Report successfully one or more measures or activities in one or more of the 3 Categories that require reporting for at least a 90 consecutive day period in 2017 to be eligible for a positive payment adjustment in 2019.

Here is where careful scrutiny of the options will reveal a silver lining.

CMS estimates that in 2019, physicians choosing option 1 will contribute (in Part B payment cuts) $200 million to the pool of money available for positive updates for those reporting physicians who are eligible for positive updates. MIPS has an additional pool of money, $500 million yearly for the first 6 yrs., that will go to physicians who demonstrate "exceptional" performance under MIPS.

The bar for Option 2 above is set extremely low. It would take almost no effort to successfully report and avoid a penalty. It is likely that many, many physicians will choose this option. In so doing, the number of practices competing for a positive update will be much lower than when MIPS is fully implemented.

A practice that chooses Option 3 will achieve a positive update in 2019 and will have a significant opportunity to earn an exceptional performance bonus for the update. CMS has set the bar for this additional payment at 70 points.

Practices should report their performance in all 3 MIPS Categories for at least 90 consecutive days, both to earn the highest possible update and to gather the information on the practice strengths and weakness so as to be better positioned to perform well in 2018 and beyond when MIPS is fully implemented. Starting in 2019, the only way to receive a fee schedule adjustment, above the statutorily set 0.5% that ends that year, will be to perform very well under MIPS or be qualified participants in an Advanced

APM. Moreover, by the time MIPS is fully implemented, likely in the 2019 performance year, the maximum potential penalty will be 7%, and all clinicians scoring below the mean or median will receive some level of payment cut.

For more information, please contact:

Michael Sexton MD
QVH Systems, LLC
msexton@qvhsystems.com
415-595-3586