

Administrative Office: 805/484-6822

www.venturamedical.org

June 29, 2017

CALIFORNIA'S PHYSICIANS URGE CAUTION WITH U.S. SENATE HEALTH CARE PROPOSAL

Last week the U.S. Senate released its health care proposal, which calls for a repeal of the Affordable Care Act's insurance mandate, as well as drastic cuts to the Medicaid program. Under the bill, Medicaid expansion would be phased out over three years and federal funding for the program would be subject to a per-capita cap. While the Senate bill delays the Medicaid cuts until 2021, the long-term Medi-Cal reductions are substantial – at least \$30 billion over 10 years.

In response, CMA called on the Senate to postpone voting on this legislation and work with health care professionals to craft legislation that increases patient access to health care providers and maintains health care coverage for the more than 15 million Californians insured through Medi-Cal and Covered California.

Patients without coverage seek more expensive care in overcrowded emergency rooms, passing costs to states, counties, health care providers and taxpayers. Nationwide, physicians would be burdened with nearly \$20 billion in uncompensated care due to Medicaid cuts. These problems would be exacerbated by the reduction of subsidies currently provided to poor and middle class families, although Senate leadership made progress by reinstating income-based, geography-adjusted tax credits to help low-moderate income families afford insurance.

On Tuesday, June 27th Senate Republican leaders announced they will postpone a vote until after Congress returns from next week's July Fourth recess.

VCFMC-Accountable Care Organization (ACO) supported by VCMA to assist practices meet MIPS, MACRA and Quality Measures reporting.

DEADLINE TO ENROLL

for 2018-2019

FRIDAY, JUNE 30, 2017

Questions, or to request extension or formal agreement, contact:

marycarr@venturamedical.org

REMINDER: NEW OUT-OF-NETWORK BILLING AND PAYMENT LAW TAKES EFFECT JULY 1

On July 1, 2017, a new law (AB 72) will take effect that will change the billing practices of non-participating physicians providing covered, non-emergent care at in-network facilities including hospitals, ambulatory surgery centers and laboratories. The law, signed in 2016, was designed to reduce unexpected medical bills when patients go to an in-network facility but receive care from an out-of-network doctor.

While patients with out-of-network benefits can consent to treatment from out-of-network providers, absent a valid consent form, health plans and insurers are required to reimburse out-of-network physicians at an interim payment rate. The interim rate is the greater of 125 percent of Medicare or the plan/insurer's average contracted rate (ACR).

Under the new law, payors must submit their ACR data to insurance regulators by July 1, 2017. Both the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC) recently released implementation instructions for ACR filings under the new law.

CMA is working hard to ensure health plans and insurers do not game the system to pay artificially low reimbursement rates to physicians. CMA told regulators that in order to accurately reflect an "average" of the rates, the ACR must account for the volume of claims paid at a specific contracted rate rather than simply averaging the total volume of contracts. For example, a contract that accounts for a small volume of services should not be weighted equally as a contract that accounts for 75 percent of the services provided by that payor.

CMA argued that a failure to base ACR on claims volume would result in payors having the ability to skew the data to artificially deflate the ACR and diminish the value of contracts with large groups that treat the majority of patients. CMA also expressed concern that an ACR that is below current market rate creates a disincentive for payors to contract with physicians because they can rely on the interim payment as a de facto fee schedule.

Consistent with CMA advocacy, CDI is requiring insurers to calculate ACR based on claims volume paid at a specific contracted rate by CPT code in each geographic region, and requires that data to be submitted separately by insurance product market segment – individual, small group and large group insurance products. DMHC, however, is not requiring plans to weight their contracts based on claim volume and is instead allowing them to average the total volume of contracts.

While DMHC is not requiring plans to utilize a weighted average for their ACR calculations, plans are required to indicate when filing their ACR whether they are using a weighted average and also to submit the methodology used to calculate their ACR. Also, if plans contract at different rates by provider type and/or facility, they are required to calculate and report these ACRs separately.

CMA will be monitoring implementation of this new law very carefully. If your practice experiences a change in payor behavior regarding contract negotiations, claims payment or network adequacy concerns, or is experiencing other challenges, CMA wants to hear from you.

For more information, visit www.cmanet.org/ab-72

Questions: Reimbursement Helpline, (888) 401-5911 or economicservices@cmanet.org.

MARK YOUR CALENDAR

General Membership Dinner Meeting

Speaker: Elizabeth McNeil

CMA Federal Lobbyist

"Behind the Scenes of

National Health Care Bills"

Thursday, September 14

Spanish Hills Golf & Country Club

999 Crestview, Camarillo

RSVP: marycarr@venturamedical.org

ASSEMBLY BILL WOULD TEMPORARILY SUSPEND LAB RENEWAL FEES

The California Legislature is considering a bill (AB 658) that would temporarily suspend the state's clinical laboratory

license renewal fees for two years, 2018 and 2019.

The bill is a result of an audit that found that the California Department of Public Health (CDPH) had collected millions more in laboratory fees than it had spent operating the Laboratory Field Services (LFS) branch. The fund's current reserves exceed \$22 million. Under state law, however, CDPH cannot suspend or refund these fees.

This proposed legislation will only suspend renewal fees and would not apply to other fees like multiple site, personnel licensure, new lab or delinquency fees.

Fees would be reinstated in 2020, but going forward CDPH will only be permitted to collect enough fees to operate its LFS branch, as spelled out in the current law.

If this bill becomes law, labs in California should see significant savings over the next few years as licensing fees paid to the state are lowered after the freeze.

Did you know?

Did you know that COLA Laboratory Accreditation is a California Medical Association (CMA) member benefit?

COLA a physician-directed organization whose purpose is to promote excellence in laboratory medicine and patient care through a program of voluntary education, consultation and accreditation. This member benefit provides a 20 percent savings on COLA's Laboratory Accreditation Program.

COLA is approved by LFS under state law as well as the federal CLIA program. By enrolling, your one COLA survey every two years will meet both state and federal regulations.

[CMA members also receive free online support and a complimentary basic quality lab course and may be eligible for a discount on AAFP and ACP proficiency testing programs.](#) Call CMA Member Service for more info 800-786-4262

SIGNIFICANT IMPROVEMENTS IN 2018 MACRA RULE

CMS has issued a proposed rule that would make changes in the second year of the Quality Payment Program as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Though not perfect, the CMA is pleased that CMS has listened to physician feedback and has made changes that will significantly reduce the administrative burdens on physicians, particularly for small and rural practices.

Under the proposed rule, 2018 will be another transition year like 2017. This means that physicians who report only one quality measure in 2018 can avoid all penalties in 2020.

MACRA repealed the fatally flawed sustainable growth rate (SGR) payment system, which governed how physicians and other clinicians were paid under Part B of the Medicare program. It replaced the SGR and its fee-for-service reimbursement model with two paths: The Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

CMS estimates that under the proposed 2018 MACRA rule, 94 percent of physicians will earn either a positive or neutral payment adjustment in 2020 for the 2018 reporting year.

Major highlights:

- Allows the creation of virtual groups to assist small practices.
- Significantly expands the low-volume threshold to \$90,000 or less in Medicare Part B allowed charges OR 200 or fewer Medicare Part B patients CMS estimates that only 37 percent of clinicians who bill Medicare will be subject to MIPS with this larger exception.
- Provides automatic bonus points for small practices.
- Adds a hardship exemption from the electronic health records (EHR) category for small practices.
- Provides opportunities to achieve bonus points in the EHR category, with physicians only needing to report on Stage 2 measures instead of Stage 3.
- Provides bonus points for treating complex patients, such as dual eligibles.
- Physicians will not be scored on "resource use" (physician cost) in 2017.
- Reduces the Medicare revenue and patient threshold to qualify for APMs.

CMA will submit comments on the proposed rule and will continue to fight for improvements to the MACRA regulations to reduce administrative burdens and open up more opportunities for fair payment.

NEW OUT-OF-NETWORK BILLING AND PAYMENT LAW TAKES EFFECT CHILD HEALTH & DISABILITY PREVENTION CODE & CLAIM FORM CONVERSION EFFECTIVE JULY 1

The DHCS is currently transitioning Child Health and Disability Prevention (CHDP) program billing processes to be compliant with HIPAA standards for national health care electronic transactions and code sets.

Rather than billing on the CHDP Confidential Screening/Billing Report (PM 160) claim form, claims will be submitted using CPT codes on the CMS 1500 or UB-04 claim forms or equivalent electronic claim transactions.

The transition, effective for dates of service on or after July 1, 2017, affects claims for Medi-Cal Early and Periodic Screening, Diagnosis and Treatment, well-child health assessments and immunizations through the CHDP program. After July 1, these services will also be billed as Medi-Cal services in accordance with Medi-Cal policy, will be reimbursed per the Medi-Cal fee-for-service fee schedule and will receive payment on the standard Medi-Cal warrant. DHCS has released an updated CHDP Code Conversion Table, which is accessible on its website.

Services provided prior to July 1, 2017, should be billed on the CHDP PM 160 claim form.

CMA has received calls from physicians who report that for their practice, the transition to reimbursement based on the Medi-Cal fee-for-service schedule may result in a decrease of up to 20 percent for some services. CMA has also received questions about whether problem-focused evaluation and management visits, when billed with a preventive medicine visit, will continue to both be reimbursed as they were under the CHDP program. CMA has reached out to DHCS for clarification.

HAVE YOU RECEIVED A TERMINATION NOTICE FROM BLUE CROSS RECENTLY?

The California Medical Association (CMA) has heard from several physicians who have received unexpected termination notices from Anthem Blue Cross. The notices, which specify no cause for termination, appear directed only to physicians who refer to out-of-network ambulatory surgical centers. If you have recently received a similar termination notice from Anthem Blue Cross, CMA wants to hear from you. Please contact CMA's Reimbursement Helpline at (888) 401-5911 or economicsservices@cmanet.org.

DHCS PREPS CONTINGENCIES IN CASE OF DELAYED BUDGET APPROVAL

DHCS recently announced it will implement a contingency plan for claim

payment if the state budget is not enacted before the beginning of the 2017-2018 fiscal year on July 1. Although the state legislature passed a budget by the June 15 deadline, the Governor has not yet signed it. According to DHCS, providers should continue to submit claims for processing as normal, but payments for some programs may be delayed until the budget is signed.

Claims for the following services will be processed and adjudicated regardless of dates of service:

- Medi-Cal program
- California Children's Services (CCS) program/Medi-Cal
- Child Health and Disability Prevention (CHDP) program/Medi-Cal
- Family Planning, Access, Care and Treatment (Family PACT) Program
- Abortion

Claims submitted after June 22, 2017, for the following programs will be withheld regardless of dates of service.

- CCS-only (aid code 9D)
- CHDP services only (aid code 8Y)
- Genetically Handicapped Persons Program (GHPP) (aid code 9J)
- Optional Targeted Low Income Children's Program (OTLIPC)

Claims submitted by Every Woman Counts (EWC) will continue to be processed until contingency funding is exhausted.

CLASSIFIEDS

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

PRACTICE OPPORTUNITIES

Simi Valley- Urgent Care opening, Full-time MD, DO or PA needed ASAP. Outpatient Urgent Care Facility. There is an opening as well to assist with coverage on an ongoing basis. The clinic is open Mon-Friday 8am-8pm and Sat/Sun 9am-5pm. There are two additional Urgent Care locations; Thousand Oaks and Newbury Park, CA. No call schedule is required. Provider will see approximately 20-35 patients per shift. This would include standard urgent care procedures (suturing), Occupational Medicine and primary care as well. We have x-ray on site. The Simi Valley location has a high volume of Occupational Medicine. This Center is looking for a Full-time MD, DO or PA as soon as possible. www.medcentersimi.com

Please contact Denice @ 805-583-5555 ex 26 or email admin@medcenterofsimivalley.com

Thousand Oaks area - seeking candidates from either academic or private practice backgrounds to consider.

- Part-time or full-time; Flexible schedule
- 100% Outpatient, Privately owned
- New 6,300 square foot office facility
- Traditional Family Medicine with an Integrative Medicine approach
- Competitive financial package
- Well established in the area and poised for high growth
- Opportunity to concentrate on women's health issues both young adults to adults
- Opportunity to become vested in the profitability of the practice

drwilkes@summithealth360.com Please reply with your specialty and location of interest, and the best number to reach you along with a few dates and times you are available to speak.

Ventura - Full Time MD or DO needed for M-F 8:00 AM to 5:00 pm at WVMC. WVMC is a designated Federally Qualified Health Center (FQHC), affiliated with the Ventura County Medical Center (VCMC). If interested please contact Kristina Navarro @ 805-641-5611 or Kristina.navarro@ventura.org

OFFICE SPACE AVAILABLE

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

Oxnard - Medical office in prime location, Palms Medical Plaza. 1640 sq feet, comes fully furnished, networked, with 2 large 'procedure rooms', Newer 2 story medical building, several plumbed exam rooms, multiple work areas, in-suite restroom.

Easy access to building, with own parking lot. Large windows with green view. Newly painted. All utilities and cleaning included in rent of \$4,750. Contact (805) 479 7680

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 - Space Offered: 1-5 operatories in well maintained medical building in Westlake Village. Photos on our website at www.smilesbyaps.com. Please call (805) 279-7021

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

Looking for good Workers Comp coverage rates? MERCER is endorsed by CMA & VCMA. (800) 842-3761

MARK YOUR CALENDAR

September 14 VCMA General membership Dinner Meeting - Elizabeth McNeil, CMA Federal Lobbyist; Spanish Hills Country Club, Camarillo 6pm Exhibitor Reception, 7pm Dinner/Program RSVP: marycarr@venturamedical.org

October 25 Annual OSHA Staff Training At the Courtyard by Marriott, Oxnard. Contact the VCMA office for registration

CMA WEBINARS

Free access to both live and on-demand webinars updating you and your staff on key issues affecting physicians. Upcoming webinars include:

July 19 Tired of Government Interference? Be Part of the Solution! 12:15pm-1:15pm

July 26 Leave of Absence Laws for Health Care Employers 12:15pm-1:15pm

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

Professional Liability:



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

The MIPS Navigator™ is an online tool that makes it possible for individual clinicians or practice administrators to quickly and easily sort through the various MIPS alternatives and produce a practice specific "2017 MIPS Itinerary/Plan" for each of the 4 MIPS domains that will maximize their likely MIPS success.

1. A step-by-step guide to maximize your score.
 2. Continued access to the MIPS Navigator FAQs and list serve through 2017.
 3. The ongoing ability to update your plan.
- Regular \$69.95 for 1 year subscription, only \$49.95 through VCMA website homepage link: www.venturamedical.org click on MIPS Navigator icon link.
Endorsed by VCMA.

Homepage link: www.venturamedical.org click on MIPS Navigator icon link:

"Easy and affordable solution for your practice."
Avoid Penalties and Maximize Bonuses

The MIPS NAVIGATOR
\$49.95