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** **May 16, 2018**

ACT NOW TO AVOID COSTLY VIRTUAL CREDIT CARD FEES ON AETNA PHYSICIAN PAYMENTS

CMA has learned that Aetna will no longer allow contracted physicians to receive payment via check. According to a February 1 notice, Aetna is asking providers to choose one of two options to receive electronic payments – via electronic funds transfer (EFT) or through a virtual credit card (VCC). Providers who do not make a selection will be automatically enrolled in the VCC payment method.

Aetna reports that it began the move to electronic payments in 2009 following the Centers for Medicare and Medicaid Services' lead and in an effort to reduce costs. Aetna was initially allowing physicians to request a hardship exemption and continue to receive paper checks. However, Aetna will no longer be allowing exemptions; providers will be required to choose to receive electronic payment via EFT or VCC.

Physicians who have not yet enrolled in an electronic payment option will be receiving notices from Aetna with specified enrollment deadlines (dates will vary). Those who do not enroll and select an electronic payment method by the deadline in their notice will be automatically converted to virtual card payments.

What is a virtual credit card?

With the VCC payment method, payors send credit card payment information and instructions to physicians, who process the payments using standard credit card technology.

This method is beneficial to payors, but costly for physicians. Health plans often receive cash-back incentives from credit card companies for VCC transactions. Meanwhile, VCC payments are subject to transaction and interchange fees, which are borne by the physician practice and can run as high as 5 percent per transaction for physician practices. Physicians can avoid these interchange fees by enrolling in EFT.

While there is no requirement that payors continue to issue paper checks, physicians have the right to request electronic funds instead. HIPAA requires all health plans to offer standardized EFT using the Automated Clearinghouse (ACH) Network. Similar to direct deposit, ACH EFT allows health plan payments to be directly paid into a physician's designated bank account. *Each ACH EFT transaction carries only one fee of about $0.34, far less than the potential 5 percent fee charged to VCC transactions.* In order to receive ACH EFT, physicians should request and register for this payment method with payors.

Providers who wish to enroll in EFT can do through EnrollHub®, the Council for Affordable Quality Healthcare's (CAQH) free multi-payor EFT portal. Physicians enrolling in EFT payment will also want to sign up to receive EFT email notifications in order to be notified whenever Aetna transmits a payment. To sign up for EFT email notifications, visit NaviNet's secured website at https://connect.navinet.net/enroll.

Providers who do not use CAQH or who wish to enroll directly through Aetna can get enrollment forms from www.aetnapaperlessoffice.com . Providers with questions can visit the Aetna website at www.aetna.com/health-care-professionals.html or can contact Aetna at (888) 632-3862.

CALIFORNIA HEALTH CARE COMMUNITY CONDEMNS AB 3087

Last month the Assembly Committee on Health voted to advance Assembly Bill 3087 (Kalra), a harmful government intrusion into the health care market that would decimate California's health care system, limit access to health care providers, create state-sanctioned rationing and increase out-of-pocket costs for patients.

According to an initial estimate by the California Hospital Association (CHA), the bill would cause an estimated 175,000 hospital workers alone to lose their jobs, and force many hospitals and medical practices to close. AB 3087 would also push physicians, dentists and other clinicians into early retirement or to other states that have more viable working conditions.

A recent survey of 359 California physicians conducted by CMA found:

- 92 percent opposed AB 3087 (6 percent undecided, 2 percent in support).
- 57 percent believed AB 3087 would force them to leave California and practice elsewhere.
- 39 percent believed AB 3087 would force them into early retirement.
- Only 5.5 percent believed AB 3087 would have little to no effect on their medical practice.
- Of the 82 percent of respondents who currently serve Medi-Cal patients, 64 percent believed AB 3087 would force them to decrease the number of Medi-Cal patients they serve.

The top five concerns from the survey respondents included:

1. Ineffective policy since physicians are a small percentage of health care costs (62 percent).
2. Untested government-mandated price cap (61 percent).
3. Exacerbates California's physician shortage (58 percent).
4. Forces physicians into early retirement, out of state or out of business (59 percent).
5. Reduces patient access to care (54 percent).

A coalition of nearly three dozen health care organizations submitted a letter in opposition to AB 3087.

CMA URGES DOJ TO TAKE STEPS TO ENSURE SMOOTH TRANSITION TO CURES MANDATE

The California Department of Justice (DOJ) has certified that as of April 2, 2018, the Controlled Substance Utilization Review and Evaluation System (CURES) – California's

prescription drug monitoring database – is ready for statewide use. The certification starts a six-month implementation period for the duty to consult requirements enacted by the Legislature in SB 482 (Lara, 2016).

Effective October 2, 2018, physicians must consult CURES prior to prescribing Schedule II, III or IV controlled substances to a patient for the first time and at least once every four months thereafter if that substance remains part of the patient's treatment. Physicians must consult CURES no earlier than 24 hours or the previous business day prior to the prescribing, ordering, administering or furnishing of a controlled substance to the patient.

The California Medical Association is urging DOJ to take a number of steps to ensure a smooth implementation of the new requirement, including the development of educational materials, user outreach and assistance, and the establishment of a provider workgroup or advisory committee that ensures the clinician perspective is taken into consideration as these tools and resources are created for their use. The Medical Board of California has also released information on what physicians can do to prepare for October.

GOV. BROWN'S MAY BUDGET MAINTAINS TOBACCO TAX FUNDING FOR MEDI-CAL PROVIDER PAYMENTS

On Friday, Governor Jerry Brown released his revised budget proposal for fiscal year 2018-19. The proposal includes total General Fund expenditures of $137.6 billion, an increase of $10 billion (8.3 percent) over the current year.

The revised budget proposal continues the Administration's commitment to using the Proposition 56 tobacco tax funding to provide supplemental payments for Medi-Cal providers. However, because claims for physician payments for the designated CPT codes were lower than expected, expenditures in the current fiscal year were also lower than expected. The total dollar amount allocated for physician payments remains unchanged from the January budget at $1.3 billion, and any funds unspent in 2017-18 and 2018-19 will rollover for expenditure in 2019-20.

Governor Brown's revised budget includes $40 million for graduate medical education (GME) as required by Proposition 56. The budget proposal also includes $55 million to support psychiatric GME programs in underserved areas, which is part of a larger package of mental health proposals that the Governor is putting forward.

Beginning this week, budget subcommittees in both houses of the legislature will hold hearings to discuss these and other budget issues.

Contact: Michelle Baca, Associate Director, Government Relations, mbaca@cmanet.org.

PRESIDENT TRUMP WANTS TO STRIP $7 BILLION FROM CHILDREN'S HEALTH INSURANCE PROGRAM

President Donald Trump recently announced his intention to strip more than $15.4 billion out of the $1.3 trillion federal spending bill approved by Congress in March – of which the Children's Health Insurance Program (CHIP) stands to lose $7 billion in funding.

CHIP provides 5.6 million California children with access to comprehensive coverage, mental health services and essential preventive services, such as immunizations and developmental screenings, to prevent more serious illness and disease.

Earlier this year, Congress passed – and President Trump signed – bipartisan legislation authorizing CHIP funding for an additional decade.

The proposed cuts include $2 billion from the Child Enrollment Contingency Fund, which ensures that eligible children can continue to receive health insurance coverage by providing payments to states if they experience an unexpected surge in enrollment due to an economic recession or public health crisis.

The Trump Administration also proposes to withdraw $5 billion from the Children's Health Insurance Fund, which provides low-cost health coverage for children under age 19 whose family income is too high to qualify for Medi-Cal.

CMS 2018 MIPS ELIGIBILITY STATUS

CMS announced that physician practices /groups may now log into the CMS QPP website to check their 2018 eligibility for Medicare's Merit-based Incentive Payment System (MIPS). After groups log in, they will be able to click into a details screen to see the eligibility status of every clinician in the group (based on their National Provider Identifier or NPI) to find out whether they need to participate during the 2018 performance year for MIPS. Unfortunately, CMS will not be sending out letters to advise physicians of their eligibility status this year so checking on the QPP participation status look-up tool is the only way to determine or verify eligibility status. Eligibility rules in 2018 are different than in 2017 so status this year may be different than last. Also as is indicated in the look-up tool, exempt individual clinicians still will need to report if their group is eligible and chooses to report as a group. The look-up tool can be found at https://qpp.cms.gov/participation-lookup

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CMS RENAMES EHR INCENTIVE PROGRAMS AND ADVANCING CARE INFORMATION

CMS is renaming both the Electronic Health Record (EHR) Incentive Programs and the Merit-Based Incentive Payment System (MIPS) Advancing Care Information performance category, reflecting the increased focus on EHR interoperability and improving patient access to health information.

The EHR Incentive Programs for eligible hospitals, CAHs and Medicaid providers will be renamed as the Promoting Interoperability Programs. For MIPS-eligible clinicians, the MIPS Advancing Care Information performance category will be retitled as the Promoting Interoperability performance category.

The rebranding of these programs does not merge or combine the EHR Incentive Programs and MIPS. For more information on these programs, visit the CMS.gov webpage.

UNITEDHEALTHCARE UPDATES EMERGENCY DEPARTMENT FACILITY E/M CODING POLICY

Citing the need to address inconsistencies in coding, United Healthcare (UHC) recently altered its Emergency Department (ED) Facility Evaluation and Management (E/M) Coding Policy to include an analysis of the appropriateness of submitted high level facility E/M codes. Utilizing the Optum Emergency Department Claim (EDC) Analyzer tool, UHC will apply an algorithm to determine the UHC calculated visit level for the emergency department E/M services rendered. Facilities whose level 4 (99284, G0383) or level 5 (99285, G0384) codes (for dates of service on or after March 1) are submitted at a higher level than the UHC calculated visit level may experience downcoding of their submitted codes or denials of their claims as submitted. The EDC Analyzer will take into consideration the following factors:

- Presenting problems – as defined by the ICD-10 reason for visit diagnosis
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound)
- Patient complexity and co-morbidity – based on complicating conditions as defined by the ICD-10 principal and secondary diagnosis code

Criteria that may exclude facility claims from being subject to an adjustment or denial include:

- Patients who are admitted to inpatient, observation or have an outpatient surgery during the course of the same ED visit
- Critical care patients (99291, 99292)
- Patients less than 2 years old
- Claims with certain diagnosis that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Patients who have expired in the emergency department
- Claims from facilities whose billing of level 4 and 5 E/M codes does not disparately deviate from the EDC Analyzer.

While UHC has advised that the facility E/M coding policy will only apply to facility services and will have no impact upon physicians, CMA will continue to monitor the situation in the wake of the recently announced Health Net Non-emergent Emergency Room Services policy.

More information regarding this change can be found on the UHCProvider.com website, or providers can contact UHC at (877) 842-3210 for more information.

HEALTH NET TO DELAY MODIFIER 25 AND EMERGENCY SERVICES POLICY CHANGES UNTIL JULY 1

Health Net has advised CMA that it will delay implementation of its recently announced modifier 25 and emergency services payment policies for its Medicare and Medi-Cal lines of business until July 1, 2018, to allow time to review provider concerns over the new policies.

Health Net first notified physicians in March of the new payment policies set to go into effect on May 16, 2018. CMA, along with several specialty societies, raised significant concerns with Health Net about the proposed changes and urged that the policies be rescinded.

CMA, along with the California Podiatric Medical Association, met with Health Net representatives to request that the policies be rescinded. Health Net verbally agreed to delay implementation to review the policies and continue the dialogue with providers about their concerns. Health Net will be sending out an official notice to physicians about the implementation delay.

The policies delayed until July 1 would:

- Reduce reimbursement of evaluation and management (E/M) services when billed with modifier 25 under the following circumstances:
  - When a minor surgical procedure code is reported on the same day as an E/M code by the same physician, payment for the E/M code will be reduced by 50 percent.
  - When a preventative/wellness exam and a problem-oriented E/M are billed during the same encounter, payment for the problem-oriented E/M code will be reduced by 50 percent.
  - Reduce reimbursement for level 4 (CPT 99284) and level 5 (CPT 99285) emergency room services that are billed with what Health Net deems a non-emergent diagnosis to a level 3 (CPT 99283) contracted rate.

Health Net has advised that it will, however, proceed with the May 16 implementation of the policy to no longer recognize or reimburse for consultation codes (99241-99255). However, consultation codes billed will be crosswalked to the appropriate E/M level code for reimbursement.

CMA appreciates Health Net's willingness to delay the implementation to allow more time to review the policy changes and further dialogue with CMA and others.

MEDICARE ADVANTAGE PLANS TO SEE 3.4% PAYMENT INCREASE IN 2019

CMS recently finalized a rule increasing baseline Medicare Advantage payment rates for 2019 by an average of 3.4 percent. That is nearly double the 1.84 percent increase the agency initially proposed earlier this year.

According to CMS, the proposed payment increase is based on better use of encounter data and changes to the risk adjustment model used to pay for aged and disabled beneficiaries. Under the final rule, 75 percent of Medicare Advantage risk scores will be based on traditional fee-for-service data, and 25 percent based on encounter data (up from 15 percent in 2018). The California Medical Association believes this will reduce the Medicare Advantage plan data requests of individual physicians, which could reduce administrative burdens.

Medicare Advantage participation is at an all-time high, with approximately one-third of all Medicare beneficiaries

enrolled in a Medicare managed care plan. Enrollment has more than doubled over the past decade, and is projected to grow by 9 percent to 20.4 million in 2018.

CMS also finalized a policy to prevent Medicare beneficiaries at risk for opioid misuse or abuse from getting prescription drugs from multiple doctors or pharmacies. Beginning in 2019, CMS will allow Medicare Part D plans to restrict at-risk beneficiaries to a single prescriber or pharmacy for access to frequently abused drugs.

PRO TIP: VOTE EARLY AND STOP THE ROBOCALLS AND CAMPAIGN MAILERS

With the California primary election less than a month away, you've undoubtedly noticed an increase in robocalls and political mailers. Did you know there's a way to put a stop to this season's political calls altogether? All you have to do is vote early.

Once you send in your absentee ballot, your name will be taken off the eligible voter lists used by campaigns. The lists are updated daily, so you stop the political calls and mailers within just a few days of voting.

For more information on the candidates and propositions, see the Official Voter Information Guide.

Endorsed Candidates

The California Medical Association (CMA) has endorsed the following candidates:

Governor: Gavin Newsom

Lieutenant Governor: Eleni Kounalakis

CLASSIFIEDS

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

PRACTICE OPPORTUNITIES

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

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 required. Provider will see approximately 20-35 patients per shift. Includes urgent care procedures (suturing), Occupational Medicine and primary care. X-ray on site. The Simi Valley location has a high volume of Occupational Medicine.

www.medcentersimi.com

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
- 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.

California Correctional Health Care Services seeking 2-3 IM/FP Primary Care Physicians. Up to $327,540 annually plus $50-$60K w/On-Call - can be $380-$390K! Benefits: 4-day workweek; 10 patients per day; generous paid time off; State of CA Pension that vests in 5 years; plus 401(K) and 457 retirement options – tax defer up to $48K; Contact Danny Richardson, (916) 691-3155 or danny.richardson@cdcr.ca.gov. EOE.

OFFICE SPACE AVAILABLE

Oxnard –Ground level in professional building. Reception area, 4 exam rooms with exam tables, 1 large private office, 1 in-suite restroom and break area. New floor coverings, new furniture, computers, internet equipped and fresh paint. 1,516 sq ft, daily Sublease (1 or 2 days per week per month), $950.00/mo. (one day per week). Contact Herb Welch at (805) 682-7801, ext. 127

Thousand Oaks - 1200 SF medical office space available immediately for sublease. Located on the campus of TOSH. Soothing reception area and two examination rooms. Patient exam rooms with fantastic mountain views. Also kitchen and physician office spaces. Call 805/379-3368 for more information and appointment to see.

Thousand Oaks – FOR SALE 5000+SF Regency Medical Plaza, 1000 Newbury Rd; 6 Phys/Staff Offices, 7 Exam Rooms, 5 Testing/Imaging Rooms, Nuclear Imaging Permit, Large Reception Area, 2 Restrooms, Break room. $453 PSF Contact: Jeff Smith 805-273-5757.

Thousand Oaks - 2700 SF office with large procedure room, 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 – 148 N. Brent St. Unit 101; 1500 SF, large doctor's office, 2 exam rooms, 1 lab room, reception, waiting room and bathroom. Across from CMH $2,150 per mo includes utilities and designated parking. Contact Amy Young 310.383.5257

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

CMA MEMBER SERVICE HOT LINE

Unable to find a document on www.cmanet.org, have a legal or reimbursement issue?

Call 800-786-4262