PRACTICE ROUNDTABLE MEETING

AGENDA

December 5, 2013 – 8:30am-10:30am
Oregon Medical Education Foundation Event Center

For those attending by telephone: Dial 1-888-387-8686, Room Number 226-1554#

Topics

1. Call to Order: Gwen Dayton, JD

2. The Use of MAs in Practice - Michelle O’Neill, CNA

3. Choosing Wisely Grant Update – Cassie Dictus, OMA

4. Administrative Rules Update: (1) Patient Choice Notice Requirements; (2) Medicaid Fee-for-Service Claims Submittal Timeline; (3) Vaccine Rules – Gwen

5. 2014 Legislative Preview – Gwen

6. CoverOR: (1) Update – Gwen; (2) Managing the Grace Period - Gwen & Discussion; (3) Health Insurance Exchange Discussion - Group

7. Whatever else is on your mind

ADJOURNMENT

2014 Practice Roundtable Dates
January 16 * April 17 * July 17 * November 13

Join Us for HPSP: Here and Now Dinner
Monday December 9, 2013, 5:00 - 8:00 pm
Jointly Hosted by the OMA and OMB
$40 Registration fee includes a buffet dinner
Register at http://www.theoma.org/node/4309
Medical Assistants are not regulated in Oregon.

Medical Assistants are considered unlicensed healthcare personnel in Oregon. The Oregon Medical Board has issued a statement of philosophy regarding the establishing expectations and limitations for medical assistants in a medical office that was adopted October 2012. Highlights include:

- The physician is responsible for ensuring that the medical assistant is qualified and competent to perform any delegated services.
- Unlicensed healthcare personnel must be adequately supervised by a licensed physician. Example: Verify the correct medication and dosage prior to administration of a medication by a medical assistant and being physically present in the facility when services are performed by a medical assistant.

**Risk Management FAQ’s:**

- Can a Medical Assistant start an IV in Oregon?
  There is nothing in the law that prohibits a Medical Assistant from starting an IV with proper training and supervision by a physician. If a practice determines after careful consideration that they want to train a Medical Assistant to start IVs the following should be considered:
    - Under what circumstance would it be appropriate for a Medical Assistant to start an IV?
    - Will there be direct supervision available by a physician?
    - Will quality indicators be in place to monitor outcomes?
    - How often would this practice occur in order to ensure competency?

  Training should be competency based with ongoing evaluation of performance.

- Can a Medical Assistant independently evaluate wound healing when removing sutures?
  No, a Medical Assistant could be trained to remove sutures however a Medical Assistant could not assess the healing of the wound. Medical Assistants are not trained to do assessments which is beyond their scope of practice.

- Can a Medical Assistant independently administer fluids through an IV?
  No, administration of fluids through an IV would require the ability of the Medical Assistant to assess how the fluids are affecting the patient. The Medical Assistant could collect data regarding the patient and report it to a licensed staff member but could not independently administer fluids and evaluate the patient’s response.

**CMS Certification Requirement**

- Credentialed medical assistant can enter orders into CPOE for meaningful use
Use of Unlicensed Healthcare Personnel

With ever-increasing demands on the time and resources of physicians, the role of unregulated healthcare personnel is expanding. As a result, high quality patient care depends on the contributions of a wide variety of personnel, including medical assistants. When establishing expectations and limitations for medical assistants in a medical office, the OMB advises that patient safety should be the primary factor.

The physician is responsible for ensuring that the medical assistant is qualified and competent to perform any delegated services. It is the within the physician's judgment to determine that the medical assistant's education, training and experience is sufficient to ensure competence in performing the service at the appropriate standard of care. Performance of delegated services is held to the same standard of care applied to the supervising physician, and the physician is ultimately accountable for the actions of his or her supervised personnel.

Unlicensed healthcare personnel must be adequately supervised by a licensed physician. Examples of supervision include verifying the correct medication and dosage prior to administration of medicine by a medical assistant and being physically present in the facility when services are performed by a medical assistant.

The physician may not allow any unlicensed healthcare personnel to practice medicine as defined by the Oregon Medical Practice Act. Unlicensed healthcare personnel may not provide independent medical judgment. Therefore, medical assistants should not provide assessments, interpretations, or diagnoses and should not perform invasive procedures.

Physicians should exercise caution when employing a person who has education and training as a healthcare professional but is working as an unlicensed medical assistant. In this situation, it may be tempting for the physician to delegate (or the medical assistant to perform) duties beyond the scope of unlicensed healthcare personnel.

Medical assistants and other unlicensed healthcare personnel must maintain patient confidentiality to the same standards required of physicians. Medical assistants must be clearly identified by title when performing duties. This can be accomplished through wearing a name tag with the designation of "medical assistant" and clearly introducing oneself as a "medical assistant" in oral communications with patients and other professionals.

In order to fulfill its mission to protect the health, safety and wellbeing of Oregonians, the OMB asks physicians to follow these guidelines and to be mindful of patient safety when delegating services to other healthcare personnel.

-Olsopted October 2012

Oregon Medical Board
Women’s Healthcare Associates, LLC

Standards and Scope of Practice for

Medical Assistants: Unlicensed Healthcare Personnel

Purpose of Standards and Scope of Practice:

- To establish acceptable levels of safe practice for Medical Assistants (MA)
- To serve as a guide to evaluate safe and effective care provided by MAs and a guide to determine when their practice is below the expected standard of care
- To provide a framework for evaluation of continued competency of MA work

An MA is an unlicensed person who assists in the medical practice under the supervision of a physician and performs delegated procedures commensurate with the MA’s education and training. An MA does not diagnose, interpret, design or modify established treatment programs or perform any function that would violate any statute applicable to the practice of medicine.

MAs are not licensed and certification is not required in Oregon. However, Women’s Healthcare Associates, LLC (WHA) requires all MAs to be certified.

With ever-increasing demands on the time and resources of physicians, the role of unregulated healthcare personnel is expanding. As a result, high quality patient care depends on the contributions of a wide variety of personnel, including MAs. When establishing expectations and limitations for MAs in a medical office, the OMB advises that patient safety should be the primary factor.

The Oregon Medical Board Statement of Philosophy for Unlicensed Healthcare Personnel:

The physician is responsible for ensuring that the medical assistant is qualified and competent to perform any delegated services. It is the within the physician’s judgment to determine that the medical assistant’s education, training and experience is sufficient to ensure competence in performing the service at the appropriate standard of care. Performance of delegated services is held to the same standard of care applied to the supervising physician, and the physician is ultimately accountable for the actions of his or her supervised personnel.

Unlicensed healthcare personnel must be adequately supervised by a licensed physician. Examples of supervision include verifying the correct medication and dosage prior to administration of medicine by a medical assistant and being physically present in the facility when services are performed by a medical assistant.

The physician may not allow any unlicensed healthcare personnel to practice medicine as defined by the Oregon Medical Practice Act. Unlicensed healthcare personnel may not provide independent medical judgment. Therefore, medical assistants should not provide assessments, interpretations, or diagnoses and should not perform invasive procedures.
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Medical assistants and other unlicensed healthcare personnel must maintain patient confidentiality to the same standards required of physicians. Medical assistants must be clearly identified by title when performing duties. This can be accomplished through wearing a name tag with the designation of “medical assistant” and clearly introducing oneself as a “medical assistant” in oral communications with patients and other professionals.

In order to fulfill its mission to protect the health, safety and wellbeing of Oregonians, the OMB asks physicians to follow these guidelines and to be mindful of patient safety when delegating services to other healthcare personnel.

-Adopted by the Oregon Medical Board October 2012

Scope of Practice Standards for Medical Assistants:

MAs employed by WHA may perform the following duties. Specific roles and responsibilities are outlined in the WHA job description.

- MAs must work under the direct supervision of a provider when performing clinical duties
- Perform administrative and/or clinical tasks to support the work of providers and other health professionals
- Measure patients’ vital signs
- Prepare and administer medications and injections
- Instruct patients about medications and special diets
- Authorize drug refills and transmit prescriptions to a pharmacy as directed
- Obtains and reviews patient history and other clinically relevant information, e.g. medical/surgical history, family history, medications, allergies, smoking status, last menstrual period, etc.
- Record patient information in electronic medical records (EMR)
- Collect and/or prepare specimens of bodily fluids and tissues for laboratory testing
- Perform basic laboratory tests on the premises
- Explain treatment procedures to patients
- Prepare patients for examinations and procedures
- Assist during diagnostic examinations and procedures
- Prepare, handle and sterilize medical instruments
- Remove sutures and change dressings as directed
- Health coaching as directed
- Member of a Maternal Health Home team
• Facilitate communication between the patient and other healthcare professionals
• Develop shared action plans
• Prepare and administer oral and parenteral medications as ordered by provider
• Respond to emergencies as per protocol and procedure
• Understand and follow protocols of infection control
• Follow medico legal guidelines and requirements
• Maintain highest level of professionalism
• Has the ability to communicate effectively to patients, guests, and the healthcare team
• Administer basic first aid
• Prepare paperwork on the providers’ behalf, including prior authorizations, FMLA, and disability forms
• Notify patient of signed results via phone, secure email or letter as directed

Chief Medical Officer

Chief Executive Officer

Director of Operations
ORDER FORM (item descriptions below)

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<th>Information</th>
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<td>Your Name and name of clinic/ practice:</td>
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<td>Medical Specialty:</td>
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### Order

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<th>Item</th>
<th>Interested? (please indicate with an x)</th>
<th>Additional Information (when applicable please provide additional information, such as what quantity you would be interested in ordering and if you would like OMA assistance printing)</th>
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<tbody>
<tr>
<td>#1: Consulting Appointment</td>
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<td>#2: Presentation for your clinic</td>
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<td>#3: Clinician Pocket Card</td>
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<td>#4: “5 Questions to Ask Your Doctor…” Poster</td>
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<td>#5: Patient Wallet Card</td>
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<td>#6: Pre-drafted emails or newsletter pieces for distribution</td>
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<td>#7: Patient Pamphlets</td>
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Below is a list and descriptions of our most common services and materials. Please note that this is not a comprehensive list.

This form can be returned to Cassie Dictus (Cassandra@theoma.org).
**Item #1: Consulting Appointment**

This appointment may be helpful to talk through available resources and help design package for your needs. This should take no more than 30 minutes and can be done in your office or on the phone.

**Item #2: Presentation for your clinic**

We are happy to come to you to give a presentation about Choosing Wisely and answer any questions they may have. Overview information can take between 10-25 minutes depending on the amount of time you would like. It is helpful to also have at least 10 minutes for questions.

**Item #3: Clinician Pocket Card**

This is a 4 x 6 inch card tailored specifically to our Physician and PA requests. It provides concise but specific advice on how to have the difficult but important conversations with patients before ordering tests, treatments, or procedures.

**Item #4: Poster- “5 Questions to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure”**

This poster is a patient-centered material created by the American Board of Internal Medicine Foundation and Consumer Reports Health. This poster is customizable - you are welcome to add your own logo in the upper right hand box or use the OMA’s logo. It can be printed in a variety of sizes.

Example below:
5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1. Do I really need this test or procedure? Medical tests help you and your doctor or other health care provider decide how to treat a problem. And medical procedures help to actually treat it.

2. What are the risks? Will there be side effects? What are the chances of getting results that aren’t accurate? Could that lead to more testing or another procedure?

3. Are there simpler, safer options? Sometimes all you need to do is make lifestyle changes, such as eating healthier foods or exercising more.

4. What happens if I don’t do anything? Ask if your condition might get worse — or better — if you don’t have the test or procedure right away.

5. How much does it cost? Ask if there are less-expensive tests, treatments or procedures, what your insurance may cover, and about generic drugs instead of brand-name drugs.

Use the 5 questions to talk to your doctor about which tests, treatments, and procedures you need — and which you don’t need.

Some medical tests, treatments, and procedures provide little benefit. And in some cases, they may even cause harm.

Talk to your doctor to make sure you end up with the right amount of care — not too much and not too little.

http://consumerhealthchoices.org/campaigns/choosing-wisely/
**Item #5: Patient Wallet Card**

This wallet card is a patient-centered material created by the American Board of Internal Medicine Foundation and Consumer Reports Health. It features more succinct versions of the same questions as the poster (item #2) as well as some of the most common tests and procedures the Choosing Wisely campaign has identified. If we have enough interest we will get these printed as nice laminated cards for you to hand out to your patients.

![Patient Wallet Card Image]

**Item #6: Pre-drafted emails or newsletter pieces for distribution**

We can send you drafted newsletter pieces that or zipped files with prepared emails and Choosing Wisely materials geared towards health care professionals or patients. Topics will vary depending on your needs but could include general Choosing Wisely information and specific clinical information. Mosaic Medical has started this approach as a way to deliver bite-size pieces of information on regular basis with great success.

Example Email:

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Dear Providers,

Below is the last set of 5 Choosing Wisely recommendations from the American Academy of Family Physicians:

Attached:
1. Complete list of 15 recommendations for AAFP
2. Patient-centered pamphlets: (Spanish also available at [http://consumerhealthchoices.org/oma/#patients](http://consumerhealthchoices.org/oma/#patients))
   - Related to AAFP recommendation #2, “Treating sinusitis; Don’t rush to antibiotics”
   - Related to AAFP recommendation #3, “Bone-density tests: When you need them—and when you don’t”

....
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Item #7: Patient Pamphlets

Consumer Reports Health created these patient-centered one-page, two-sided pamphlets. Each pamphlet was created using one or more specialty specific recommendation. These pamphlets turn highly technical clinical information into language and material that is easy for patients to understand. They are in “Plain English” (devoid of medical jargon) and often Spanish! The number keeps growing but at last count, there are over 50 pamphlet topics. We are happy to help you identify the topics that might relate best to your practice. You are then welcome to print these yourself, or if needed, we can provide printing assistance.

Example pamphlet below:
Millions of people each year are prescribed antibiotics for sinusitis, a frequent complication of the common cold, hay fever, and other respiratory allergies. In fact, 15 to 21 percent of all antibiotic prescriptions for adults in outpatient care are for treating sinusitis. Unfortunately, most of those people probably don’t need the drugs. Here’s why.

The drugs usually don’t help
Sinusitis can be uncomfortable. People with the condition usually have congestion combined with yellow, green, or gray nasal discharge plus pain or pressure around the eyes, cheeks, forehead, or teeth that worsens when they bend over. But sinus infections almost always stem from a viral infection, not a bacterial one—and antibiotics don’t work against viruses. Even when bacteria are responsible, the infections usually clear up on their own in a week or so. And antibiotics don’t help ease allergies, either.

They can pose risks
About one in four people who take antibiotics have side effects, including stomach problems, dizziness, or rashes. Those problems clear up soon after stopping the drugs, but in rare cases antibiotics can cause severe allergic reactions. Overuse of antibiotics also encourages the growth of bacteria that can’t be controlled easily with drugs. That makes you more vulnerable to antibiotic-resistant infections and undermines the benefits of antibiotics for others.
They’re usually a waste of money
Antibiotics often aren’t very expensive, but any money spent on unnecessary drugs is money down the drain. And since patients often request prescriptions and doctors often comply, the total cost to the health-care system is substantial—at least $31 million a year.

So when are antibiotics necessary?
Only when symptoms last longer than a week, start to improve but then worsen again, or are very severe. Worrisome symptoms that can warrant immediate antibiotic treatment include a fever over 101.5° F, extreme pain and tenderness around your sinuses, or signs of a skin infection, such as a hot, red rash that spreads quickly. When you do need antibiotics, the best choice in many cases is generic amoxicillin, which typically costs about $4 and is just as effective as more expensive brand-name antibiotics, such as Augmentin. Note that while some doctors recommend CT scans when they suspect sinusitis, they’re necessary only if you have frequent or chronic sinusitis or you’re considering sinus surgery.

Consumer Reports’ Advice
How should you treat sinusitis?
Most people recover from sinusitis caused by colds in about a week, but several self-help steps may bring some relief sooner:

• **Rest.** That’s especially important in the first few days when your body needs to channel its energy into fighting the virus. It also helps to elevate your head when lying down to ease postnasal drip.

• **Drink.** Warm fluids can help thin nasal secretions and loosen phlegm.

• **Boost humidity.** Warm, moist air from a bath, shower, or kettle can loosen phlegm and soothe the throat.

• **Gargle.** Use half a teaspoon of salt dissolved in a glass of warm water.

• **Rinse your nose.** Saltwater sprays or nasal irrigation kits might help you feel better.

• **Use over-the-counter remedies cautiously.** Nasal drops or sprays containing oxymetazoline (Afrin, NeoSypnephrine Nighttime, and generic) can cause rebound congestion if used for longer than three days. If stuffiness hasn’t eased by then, ask your pharmacist for pseudoephedrine pills (Sudafed and generic), which are available without a prescription but kept “behind the counter.” But check with your doctor first, since they can cause serious side effects. It’s best to skip antihistamines since they don’t ease cold symptoms very much and can cause intolerable side effects.
In September, DMAP proposed rules to change the timely filing limit for claims submitted by providers directly to DMAP’s Medicaid Management Information System (MMIS). Please refer to the posted notice at [http://www.dhs.state.or.us/policy/healthplan/rules/notices/nprm-120-101713.pdf](http://www.dhs.state.or.us/policy/healthplan/rules/notices/nprm-120-101713.pdf) for full text of the proposed changes (including exceptions).

Specifically proposed changes to

**OAR 410-120-1300 Timely Submission of Claims**

(1) All claims for services must be submitted within 4 months of the date of service. The date of service for an inpatient hospital stay is considered the date of discharge.

(2) A claim that was submitted within 4 months of the date of service, but that was denied [or processed payment incorrectly], may be [adjusted or] resubmitted within 6 months of the date of service. ...

OMA spoke to OHA’s Rhonda Busek regarding our concerns as well as concerns shared by practice managers and followed up with public comment by the October 17th deadline (attached).

Last week, OMA received official notification (below) that this change had been delayed.

**Subject: OAR 410-120-1300 delayed**

Thank you for submitting comments to the rule filing for OAR 410-120-1300. This is to inform you that due to the types of comments received, the complexity of the issues and timelines needed to make our MMIS system changes this rule filing has been delayed until further notice. At this time I do not have a target date to re-file this rule as a lot depends upon our MMIS system. When we have a better idea of when the system could make the changes, the process would follow our usual rule making process. The standard rule process is as follows:

1) invite stakeholders to become a Rule Advisory Committee (RAC) member to help draft the specified rule;
2) schedule and hold a RAC meeting;
3) File the rule through the secretary of state;
4) Hold the rule hearing;
5) Implement the rule as filed.

Thank you for your continued support of the Oregon health Plan.
Timely Submission of Claims

(1) All claims for services must be submitted within 442 months of the date of service. The date of service for an inpatient hospital stay is considered the date of discharge.

(2) A claim that was submitted within 442 months of the date of service, but that was denied, may be resubmitted within 648 months of the date of service. These claims must be submitted to the Division of Medical Assistance Programs (Division) at the address listed in the provider contacts document. The provider must present documentation acceptable to the Division verifying the claim was originally submitted within 442 months of the date of service, unless otherwise stated in individual provider rules. Acceptable documentation is:

(a) A remittance advice from the Division that shows the claim was submitted before the claim was four years old;

(b) A copy of a billing record or ledger showing dates of submission to the Division.

(3) Exceptions to the 442-month requirement that may be submitted to the Division are as follows:

(a) Pregnancy;

(b) Medicare is the primary payer;

(c) When the Division or the client's branch office has made an error that caused the provider not to be able to bill within 442 months of the date of service. The Division must confirm the error;

(db) When a court or an Administrative Law Judge has ordered the Division to make payment;

(ee) When the Authority determines a client is retroactively eligible for Division medical coverage and more than 442 months have passed between the date of service and the determination of the client's eligibility.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Ms. Peters,

Thank you for the opportunity to comment on proposed rules related to timely filing of claims through the Medicaid Management Information System.

The Oregon Medical Association (OMA) is concerned that proposed rule OAR 410-120-1300 does not provide sufficient time for medical practices to submit claims to DMAP for Medicaid fee for service patients. Moving from a 12 month opportunity to submit a claim to only 4 months is significant and will present practical compliance difficulties. For example, eligibility determinations can take more than 4 months and it does not appear that practices can submit the claims they have been holding longer than 4 months pending eligibility determination. Or, sometimes a practice does not determine the correct payer until after the time period for submittal of the claim has passed.

We recognize that this 4 month period is aligned with the existing CCO rule allowing only 4 months to submit a claim, and that the CCO rule supports DMAP’s reporting requirements to CMS. The same difficulties practices will have with submitting claims for fee for service patients, however, apply to CCO claims as well. Accordingly, the OMA suggests the following:

• Examine the exceptions to timely filing that currently exist in both the fee for service and CCO rules; Consider: whether DMAP can include additional exceptions that accommodate the practical challenges practices face in complying with the short filing requirement while still allowing DMAP to adhere to its CMS reporting requirements.
• Consider whether the 4 month period could be extended at all. Is there any flexibility in this time period?
• Delay implementation of the rules to allow these issues to be considered.

We appreciate consideration of these suggestions. Imposing barriers in rule to physicians accepting Medicaid patients pushes the state in the wrong direction, particularly in light of the Medicaid expansion coming in 2014. The OMA is glad to participate in any continuing conversations around these rules and effective Medicaid implementation generally.

Best Regards,

Gwen Dayton, JD
General Counsel, VP Health Policy
333-050-0010
Definitions Used in the Immunization Rules
As used in OAR 333-050-0010 through 333-050-0140:

(19) ―Nonmedical Exemption‖ means a document, on a form prescribed by the Public Health Division, signed by the parent stating that the parent is declining one or more immunizations on behalf of the child, and including documentation of completion of the vaccine educational module or a signature from a health care practitioner verifying discussion of risks and benefits of immunization.

(31) ―Vaccine Educational Module‖ means a resource approved by the Public Health Division to fulfill the requirement of receiving information about the risks and benefits of immunization in order to claim a nonmedical exemption.

333-050-0040
Statements (Records) Required

(12) Evidence of nonmedical exemption must include documentation that the parent has completed a vaccine educational module approved by the Public Health Division or signature from a health discussed with the parent. Information provided must be consistent with information published by the Centers for Disease Control and Prevention, including epidemiology, the prevention of disease through use of vaccination, and the safety and efficacy of vaccines.

(a) The Public Health Division will make available to parents a no-cost internet based vaccine educational module.

(A) Criteria for the vaccine educational module must include:
(i) Information consistent with information published by the Centers for Disease Control and Prevention;
(ii) Information about the benefits and risks of each vaccine for which a parent is claiming a nonmedical exemption;
(iii) Information about the epidemiology, prevention of disease through use of vaccination, and the safety and efficacy of vaccines; and

(B) A person who wishes to have a vaccine educational module approved by the Oregon Health Authority shall submit the module to the medical director of the Public Health Division, Immunization Program. For approval, the vaccine educational module must contain the substantive content of the internet based vaccine educational module made available by the Public Health Division. The medical director must review the module to determine if it meets the criteria in these rules including the requirement that a vaccine educational module present
information that is consistent with information published by the Centers for Disease Control and Prevention. Approval or disapproval shall be made in writing. If the module is disapproved the medical director must explain the reasons for disapproval.

(C) An official certification receipt to provide documentation of completion of the vaccine educational module must be in a form approved by the Public Health Division, Immunization Program.

(b) A health care practitioner may discuss with the parent the risks and benefits of immunization and provide documentation for the parent to claim a nonmedical exemption.

(A) The information provided by the health care provider must contain the substantive content of Internet based vaccine educational module made available by the Public Health Division. The content may be adjusted to meet individual parents’ concerns.

(B) The health care practitioner will provide documentation to parents on a form prescribed by the Public Health Division that the practitioner has provided vaccine information to the parent.

(c) Parents claiming a nonmedical exemption must provide documentation of completion of a vaccine educational module or a signed document from a health care practitioner to the administrator.

(13) The evidence of nonmedical exemption required by section (12) of this rule is effective March 1, 2014.

(a) This applies to new enterers initially attending on or after March 1, 2014, and children currently enrolled for whom parents submit additional exemption information on or after March 1, 2014.

(b) Records for children enrolled prior to March 1, 2014, with a religious exemption on file at school signed prior to March 1, 2014, will not need to be resubmitted unless updates are made to the exemption. These records will be grandfathered in as nonmedical exemptions.

(c) The evidence of nonmedical exemption from a health care practitioner or the viewing of the educational module must have occurred within 12 months of the parent signing of the nonmedical exemption.

(142) When a child reaches the age of medical consent in Oregon, 15 years of age, the child may sign his or her own Certificate of Immunization Status and complete the process for obtaining a nonmedical exemption,
Affordable Care Act Exchange Plans
Questions and Answers for Texas Physicians

Where can I find a fee schedule for the exchange plans?

There is not necessarily a different fee schedule for the exchange product. And there is no single fee schedule as with Medicare. The health plans insurance companies offer on the exchange are state commercial insurance products. Many, if not all, of the exchange plans may use contracts currently in force and their associated fee schedules. You should contact the health plans you contract with to determine which of your contracts may be used for patients on the exchange.

Exchange plans are state-regulated insurance products marketed on the federal exchange (also known as the “marketplace”). This means state insurance laws apply. The Texas prompt pay law requires an insurance company to include a provision in physician contracts that states:

1. The physician may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures;
2. The insurer or the insurer’s agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the insurer receives the request; and
3. The contract may be terminated by the physician on or before the 30th day after the date the physician receives information requested without penalty or discrimination in participation in other health care products or plans. (Emphasis added.)

TMA suggests you contact the health plan if you are not certain a patient is on an exchange plan.

How will I know which of my patients are on an exchange plan?

At this time, there is no requirement for health plans to identify which of your patients are on an exchange plan. Some companies may choose to identify those plans. For example, patients that Blue Cross and Blue Shield of Texas cover in an exchange plan will present insurance identification cards marked with either “BCA” (Blue Choice PPO Network) or “BAV” (Blue Advantage HMO Network). Aetna will identify its exchange product on the patient identification card with “QHP.” Humana HMO identification cards will be marked with “HMOx,” as shown below.

1. Texas Insurance Code §1301.136
What do I do about the 90-day grace period? I’m worried I won’t be paid by the insurance company if the patient has not paid the premium.

The Affordable Care Act gives patients who receive a federal subsidy in health insurance exchange plans three months to pay their premiums. For the first 30 days of patients’ coverage, the insurers are required to pay claims under the federal regulations and accept the government advance tax credit as payment of the premium. However, for the last 60 days of the grace period, there is no such mandate. If the insured person does not pay his or her premiums within the grace period, the law does not require the insurer to cover any services the physician provided during months two and three.

Insurers in the last two months (of the three-month grace period) may pend or pay for services provided to their insured persons (physicians’ patients). The Texas prompt pay law may even require payment for some portion of the last two months of the grace period. If an insurer pays in the last two months, then, if the insured person (patient) does not pay past-due premiums, the insurer may recover from the physician any payments made to the practice. The patient must then pay for all past services out of his or her own funds.

Will physicians have to refund payments to an insurer if a patient who bought coverage from that insurer in the Affordable Care Act marketplace doesn’t pay his or her premiums?

Yes, possibly. Here is what the government said in the March 27, 2012, Federal Register, when adopting the regulation:

We note that QHP [qualified health plan] issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws, but the option to pend claims exists. If the individual settles all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate.

If not, the claims for the second and third months could be denied. The grace period under this final rule represents an extended time for enrollees to catch up on premium payments before coverage is terminated. (Emphasis added.)

Here are examples the government provided to explain its regulation.

Assumptions for a monthly premium:

- Premium: $500
- Advance premium tax credit share of premium: $450
- Enrollee share of premium: $50
- First month of grace period: March
- Patient pays enrollee share of premium for January and February coverage.

Example No. 1: Patient misses $50 payment due Feb. 28 for March coverage. Patient realizes mistake and pays $100 on March 31 for March and April coverage, satisfying all obligations for premium payments through the end of March.
• Insurer adjudicates claims for March consistent with normal practices (that is, for nongrace periods).
• Patient will have full coverage for March and April.

**Example No. 2:** Patient misses $50 payment due Feb. 28 for March coverage and misses $50 payment due March 31 for April coverage. Patient pays $150 on April 30 for March, April, and May coverage.
• Insurer adjudicates claims for March.
• Coverage continues for April and May (second and third months of the grace period), but:
  • Insurer notifies physician of the potential for a denied claim.
  • Issuer pends claims for services performed in April and May until patient pays outstanding premiums.

**Example No. 3:** Patient misses $50 payment due Feb. 28 for March coverage, misses $50 payment due March 31 for April coverage, and misses $50 payment due April 30 for May coverage.
• Coverage is terminated retroactively to March 31.
• **Insurer can deny claims for services rendered during April and May.** Physician could then seek payment directly from the patient for any services provided during that time.

As you can see, coverage is available for the first 30 days of the grace period, and the insurer may not recoup. Termination of coverage begins on the 31st day. After that time (day 31 forward), the insurer can retroactively terminate coverage and recoup payments to the physician.

Remember that state law applies to exchange plans. Texas prompt pay law says insurers must pay you within 30 days following receipt of a clean claim. Thus, you may receive some payments within the grace period. For insurance companies, Texas prompt pay law permits recovery of overpayments and audits with the ability to recover paid amounts (up to 180 days after payment). A retroactive termination may cause an overpayment or audit recovery by the insurance company.

**Will physicians know if an insured patient is delinquent in paying the premium?**

Practices will be able to discover which patients are in the nonpayment grace period. Federal regulation requires insurers to give notice to treating physicians of individuals who are in the grace period. Different insurers will meet the obligation in different ways. Some may tell physicians when the medical office calls to verify coverage. Practices often call insurers the day before scheduled visits of current patients to verify whether the patient still has the insurance coverage on file with the practice. Other offices may verify coverage when the patient checks in. At verification of coverage is when physicians likely will be notified. Some insurers will provide this information electronically.

**Can I withhold services from or directly bill for services for a patient who has not paid the premium? Can I refuse to see any exchange plan patients?**

The obligations to withhold from collections and accept certain people as patients generally stem from the contract between the insurer and physician. The grace period regulation is a limitation on cancellation of insurance coverage. It is not a regulation of physician business practices generally. Absent an agreement, there is no limitation on how a physician interacts with his or her patients as it may regard collections. Also, if you have no contract in place, you are free to choose the patients you serve, except in emergencies.

This is in line with American Medical Association ethics opinions, which state:

**Opinion 9.06 — Free Choice**

Free choice of physicians is the right of every individual. One may select and change at will one’s physicians, or one may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are
prerequisites of ethical practice and optimal patient care.

In choosing to subscribe to a health maintenance or service organization or in choosing or accepting treatment in a particular hospital, the patient is thereby accepting limitations upon free choice of medical services.

The need of an individual for emergency treatment in cases of accident or sudden illness may, as a practical matter, preclude free choice of a physician, particularly where there is loss of consciousness.

Although the concept of free choice assures that an individual can generally choose a physician, likewise a physician may decline to accept that individual as a patient. In selecting the physician of choice, the patient may sometimes be obliged to pay for medical services which might otherwise be paid by a third party. (VI)

If you have a contract with an insurer to provide services to those covered under the insurance plan, you may not withhold services from or directly bill the patient during the grace period. In addition to the federal regulation that anticipates patients will be treated as fully covered until the grace period expires, many insurance company contracts have nondiscrimination clauses that prevent the withholding of services.

Here is an example of a nondiscrimination clause:

Physician and Insurance Company agree that Enrollees expect physicians listed in the Company's directories to accept new patients. Physician shall provide services to Enrollees on the same basis as other patients. Physician shall accept Insurance Company Enrollees as patients.

This example imposes an obligation that affects duties under the patient-physician relationship. In regard to the grace period, it is possible to interpret the phrase to accept patients “on the same basis as other patients” as meaning that care cannot be withheld when the patient is considered covered by the insurer. Indeed, the example above expressly permits the insurer to list the physician as accepting new patients.

The last sentence of the example gives the physician no flexibility in accepting patients. He or she must accept all enrollees as patients, even if the patients are in exchange plans or if the physician previously terminated the relationships. Thus, a professional relationship that was terminated because of a patient's unwillingness to follow medical advice could be created once again. The contract also should be examined for any stated patient minimums, and the physician should ensure that his or her practice has the ability to handle the caseload.

Still other provisions in contracts regulate when a physician may collect payment from patients. Some insurers prohibit collection of patient responsibility until the insurer has processed the claim and sent out the explanation of benefits. Physicians should review contracts and the physician manuals to determine the collection parameters to which the practice has agreed to be bound. Close scrutiny of the physician’s obligations is a must.

**If I receive notice that patients are within the grace period, may I pay their premiums so they have coverage while I provide services?**

That may be a risky practice and can’t necessarily be recommended. The Centers for Medicare & Medicaid Services (CMS) posted an addendum to its frequently asked questions regarding the Affordable Care Act on this very question. CMS states:

The Department of Health and Human Services (HHS) has broad authority to regulate the Federal and State Marketplaces (e.g., section 1321[a] of the Affordable Care Act). It has been suggested that hospitals, other health care providers, and other commercial entities may be considering supporting premium payments and cost sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. HHS has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces. HHS discourages this practice and encourages issuers to reject such third party payments. HHS intends to monitor this practice and to take appropriate action, if necessary.
So, the federal government is instructing insurers to refuse these payments, and warning physicians and providers that the act of paying the patient responsibility could elicit regulatory scrutiny. TMA also has an ethics opinion on the topic. That opinion holds that paying the premium is an ethical practice only if the physician does not directly or indirectly receive a benefit. The opinion states:

**PAYING FOR INSURANCE PREMIUMS.** It is ethical for a physician to pay a patient's insurance premiums provided the physician does not receive a direct or indirect benefit. Thus, a physician should not charge or bill the patient or his insurance company for the physician's services to that patient. Such payments should only be made in compliance with state and federal law and where true hardship exists.

**If I am contracted with an insurer, does that mean I am participating in that insurer’s Affordable Care Act exchange plans?**

Not necessarily. Just because a physician may have a contract with an insurer does not mean that physician is included in the network of plans that insurer offers.

In Texas, 12 insurers are offering plans on the federal insurance exchange, or marketplace. The federal insurance exchange is composed of state-regulated insurance products offered by insurers. These are commercial insurance products, and your contract with insurers will dictate participation in insurers' networks. Typically physicians agree to participate in insurer networks through a contract provision known as an “all products clause.”

Here is a typical example of an “all products clause”:

Medical practice agrees to participate in the plans and other health products as described in this Agreement. Company reserves the right to introduce, modify, and designate medical practice's participation in plans and products during the term of the Agreement.

Note that the physician has agreed to participate in all plans as designated by the insurance company. Just as important, note that the company has not agreed to designate the physician as participating in all plans. Thus, depending on your contract, you may not be able to reliably answer patient questions about your participation in federal insurance exchange networks without further research. A physician must ask the insurer whether he or she is in the plans offered on the exchange. Another method of verification is to go to the insurer websites and search for the physician through the carrier’s “provider finder” tools. Patients also can perform this search. Some insurers have created special exchange networks and invited only a limited number of physicians into those networks. Other insurers may tier or offer exclusive access based on their ratings systems, essentially creating an exclusive “high performers” tier out of its normal network. There is no prohibition of these methods of designation or exclusion.

**Careful review of contract terms and fee schedules is a must in this new environment.**

**Which insurance companies are offering exchange products in Texas?**

- Blue Cross and Blue Shield of Texas
- FirstCare Health Plans
- Humana Health Plans of Texas
- Humana Insurance Company
- Aetna
- Cigna Health and Life Insurance Company
- Scott & White Health Plan
- Sendero Health Plans
- Ambetter from Superior Health Plan
- Community First
- Community Health Choice
- Molina Health Plan