CMA CONGRESSIONAL PRIORITIES
February 2016

Fix a DOE Regulation that Excludes California Physicians from Student Loan Forgiveness
CMA urges California Members to cosign the bipartisan California Delegation letter to the Secretary of Education. In 2007, Congress passed the Public Service Student Loan Forgiveness Program that allowed physicians treating patients in non-profit facilities to qualify. However, the Department of Education narrowly interpreted the law to require physicians to be directly employed to obtain loan forgiveness. Because California state law (called the bar on the corporate practice of medicine) prohibits the direct employment of physicians (except for federal clinics and public hospitals), this regulation could exclude thousands of California physicians. There are 15,000 California physicians who have obtained their licenses since 2007 and many of them are providing care in one of California’s 269 private, non-profit hospitals. This rule will have a chilling effect on access to care in California. Physicians will choose to practice in other states where their loans can be forgiven. To cosign, please contact Molly Lowe with Congressman Calvert or Angela Ebiner with Congresswoman Lofgren.

Oversee Medicare Payment Reform (MACRA) Implementation
CMA worked closely with Congress to successfully repeal the flawed Medicare SGR formula and establish new payment pathways. The new payment system offers the potential to bring positive changes to how we pay for and deliver health care to seniors. Those changes, rolled out through the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models, also offer the potential for overly complex, counterproductive regulations that far outweigh any improvements. CMA urges Congress to oversee the regulatory implementation to ensure the reporting programs are truly simplified and that the alternative payment model track allows multiple, realistic pathways for physician-led innovations.

Reform Medicare’s Electronic Health Record Program - “Meaningful Use” (MU)
Congress should urgently adopt the following reforms to fix the Meaningful Use program. Nearly 90% of California physicians have adopted EHRs, yet only 22% met the unrealistic Meaningful Use Stage 2 requirements in 2014. The program has become extremely burdensome and is not facilitating the exchange of information or improving patient care.

- Eliminate the All-or-Nothing approach – Provide Proportional credit for the quality measures and electronic standards that physicians achieve. Physicians that meet less than 100% of the requirements are heavily penalized.
- Enforce Interoperability with vendor testing to ensure the exchange of information. Physicians with EHRs are still forced to FAX information.
- Expand the Hardship Exemptions for physicians experiencing EHR vendor problems and cyber attacks, and physicians close to retirement who cannot make the investment in HIT, yet are needed to maintain access to care in California.
- Delay Meaningful Use Stage 3 until physicians can meet the Stage 2 standards.
Adopt a California Palliative Care Medical Home Model as a Medicare Pilot

*CMA supports the expansion of a California palliative care medical home model that improves care to patients with serious illnesses near the end of life.* It uses a multi-disciplinary team of providers to provide advanced care planning and a continuum of coordinated care to help patients avoid unnecessary hospitalizations and burdensome care transitions. It improves the quality of life for patients and their caregivers. Families who participate in the medical home are extremely pleased with the care and it uses Medicare resources more efficiently. It is a proven model that should be implemented in the Medicare program.

Prescription Drug Abuse: Reauthorize & Increase Funding of Monitoring Systems & Treatment

*Place programs under state and federal health care agencies.*

*CMA urges Congress to reauthorize and increase funding for NASPERS, the national prescription drug monitoring database that tracks opioid prescriptions.* Prescription drug diversion, abuse, overdose and death have reached epidemic levels across the U.S. Prescription drug monitoring programs (PDMPs) can help to curb the problem if they are fully operational. However, the PDMP database in California (CURES) and many other state databases have been severely underfunded and thus, there have been significant technological problems that have created barriers for physician users. To ensure the appropriate administration of PDMP programs by experienced health care professionals, they should be housed in state and federal health care agencies, not law enforcement agencies. Finally, CMA supports expanding coverage and access to appropriate treatments. H.R. 1725 NASPERS Reauthorization passed the House in 2015.

Curb the Rising Costs of Prescription Drugs - Protect Patient Access to Care

*CMA urges Congress to give Medicare the authority to negotiate drug prices with pharmaceutical manufacturers and drug plans to help curb the rising cost of prescription drugs.* All other Medicare providers are subject to fee schedules. It will ensure that patients have access to affordable, life-saving therapies.

Reform Medicare RAC Audits

*CMA urges Congress to support new Committee legislation being written to reform the RACs.* Medicare pays Recovery Audit Contractors (RACs) like bounty hunters to find potential overpayments made to physicians. Nearly half of all audit findings are overturned by an Administrative Law Judge when a physician appeals. This demonstrates that the program badly needs reform. CMA urges Congress to adopt the following reforms:

- Prohibit RACs from recouping physician payments until the appeals process is final.
- Make RACs more accountable for improving extrapolation formulas, employing reviewers trained in the same medical specialty, and impose penalties for inaccurate findings.
- Provide incentives for RACs to educate physicians as to any incorrect billing practices to avoid future billing errors.
Implementation of the California Medicare Physician Geographic Payment Locality Reform

In 2014, Congress adopted an overhaul of California’s Medicare physician payment localities that will start in 2017. Congress enacted this change because CMS had not updated California’s Medicare localities since 1997 and most California Medicare payments were inaccurate. Counties that were once rural had become more urbanized with higher costs to operate a medical practice. Yet Medicare failed to update the payment regions. For instance, San Diego, the sixth largest city in the U.S., was designated as rural by Medicare. According to Medicare’s own county geographic adjustment factors, physicians in fourteen California counties were inaccurately underpaid up to 14%, for a total loss of $50 million in Medicare payments annually. It was negatively impacting access to care.

Under the new law, all California localities will move to the OMB annually-defined Metropolitan Statistical Areas (MSAs) – just as the hospitals are organized under Medicare. As recommended by the Institute of Medicine (IOM), the Medicare hospital and physician payment regions will be aligned. The payment updates will be phased-in over six years with a floor to protect California’s rural physicians.

CMA presents to CMS the attached white paper and implementation model to provide background on the problem in California, the legislative intent, and step-by-step recommendations for calculating the geographic adjustment factors for the new MSA localities. CMA looks forward to working with CMS on the implementation of this important California reform.

MACRA Implementation

CMA is eager to work with CMS on the multi-faceted implementation of MACRA. We urge CMS to consider the following recommendations for the new payment systems.

A. MIPS (PQRS, Meaningful Use, Value Modifier and Clinical Activities)
   - Simplify and reform the burdensome reporting programs.
   - Provide proportional credit to physicians for measures that are met.
   - Measures should be relevant to each specialty and within a physician’s control.
   - Hardship Exemptions should be expanded to include physicians experiencing vendor problems and cyber attacks, and physicians close to retirement.
   - Enforce Interoperability.
   - Move the initial reporting year from 2017 to 2018.
B. Alternative Payment Models (APMs)

- Provide multiple, realistic pathways for physician-led models. Otherwise, only highly capitalized hospital systems will participate which increases overall costs.
- The National Specialty Societies are aggressively engaged in developing APMs.
- State Medical Societies are supporting both specialty-centric and multi-specialty models.
- CMS should release Total Cost of Care Data (Attributable to Individual Patients) to help APMs manage their costs.
- All payments should be Risk-Adjusted and recognize diverse patient populations.
- APMs should receive credit for reducing costs to the overall Medicare program, particularly for reduced ER visits and hospitalizations.
- Based on the ACO experience, Shared-Savings APMs should receive a larger percentage of any shared savings.
- To incent the innovators, expenditure benchmarks should be based on the national average rather than the APMs historical spending. Otherwise, the innovators will be discouraged from participating.
- Downside Financial Risk is currently measured by CMS in terms of organizations being at risk for the total cost of care for a patient population. CMS’ definition of more than nominal financial risk should include the following factors:
  - Financial risk should include the APM’s start-up costs and administrative costs, such as establishing care coordination, utilization management and chronic disease management programs, data analysis, hiring a medical director and care managers, HIT costs, and registry or treatment guideline development costs. California medical groups estimate that start-up and administration costs consume ~ $8 pm/pm.
  - Physicians should only be accountable for the costs they can influence.
  - CMS should institute additional financial protections for APMs, such as excluding high cost cases over $100,000.

C. California Palliative Care Medical Home Model as an APM or Other Pilot

CMA supports the expansion of a California palliative care medical home model developed by Dr. Sharon Tapper that improves care to patients with serious illnesses near the end of life. It uses a multi-disciplinary team of providers to provide advanced care planning and a continuum of coordinated care to help patients avoid unnecessary hospitalizations and burdensome care transitions. It also improves the quality of life for patients and their caregivers. Families who participate in the medical home are extremely pleased with the care and it uses Medicare resources more efficiently, reducing unnecessary hospitalizations by 68% for an~$2,000 pm/pm savings. It is a proven model that should be implemented in the Medicare program. See the more detailed program description attached.