



**CMA FEDERAL ISSUES SUMMARY  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
February 2012**

**1. CMA Urges the Administration to Continue to Push for the Medicare SGR Repeal It Reduces the Deficit and Protects Patients**

Physicians face yet another devastating 27.4% Medicare payment cut on March 1, 2012. CMA urges Congress and the Administration to stop the cuts and repeal the SGR.

**2. CMA is Developing Innovative Alternatives to the Medicare Payment System Based on Successful California Models to Submit to CMMI**

The CMA is working to develop a series of alternative payment and delivery models to pilot test through the CMS Innovation Center (CMMI). These pilots are based on successful California models and can be implemented both by large medical groups and small-practice, independent physicians working together. The pilot ideas are listed below and can work under a variety of payment models, such as shared-savings, various forms of capitation and fee-for-service.

**CMA urges CMS to broaden the CMMI pilot categories beyond ACOs and bundling programs and allow a variety of innovations to be tested, such as**

- Clinical Variation Reduction and Quality Program facilitated by a California County Medical Society for Independent Physicians in the community - reviewed and accredited by the CMA Institute for Medical Quality (IMQ). It would apply a shared savings payment model for participating physicians.
- Medicare and Medicaid Patient-Centered Medical Home Expansion for Primary Care and Certain Specialties where physicians become the primary treating physician.
- Physician Peer Comparison Education and Shared Savings Program where physicians are compared to their specialty peers in their geographic region and rewarded for meeting certain utilization, quality, hospital admission and other standards set by physicians.
- A Palliative Care Medical Home Project that coordinates care teams of physicians and other institutional and non-institutional providers, including hospice and home health, to work with patients and their families to meet their wishes and provide palliative end-of-life care in the most respectful way in the most appropriate setting.
- Accountable Care Organization Transition Model that gives solo/small group independent physicians more time and upfront resources to create physician-led, patient-centered organizations that coordinate care and improve the overall quality of care.
- Pilots to Improve Physician Supply and Access to Care in Rural Areas, such as an expansion of the J-1 VISA Foreign Physician Program and telemedicine programs, reform of the Health Professional Shortage Area payment system so that physicians in nearby communities will be incented to care for rural patients.

**3. Medicare Physician Geographic Payment Locality Update**

**A. 2012 CMA-Proposed Bipartisan Legislation: Farr/Bilbray/Feinstein**

CMA is urging the “Middle Class Tax Reform” Conference Committee to include a BUDGET NEUTRAL update of the California Medicare physician payment regions to Metropolitan Statistical Areas (MSAs) as recently recommended by the Institute of Medicine (IOM). Medicare organizes and pays hospitals according to MSA regions. While the hospital regions are continuously updated so that reimbursement accurately reflects local costs to deliver care, the physician regions have not been updated in 15 years. Therefore, some of California’s urban counties - San Diego and Sacramento - are still designated as rural. This has caused some California physicians to be paid up to 14% per year below what Medicare says they should be paid but for their incorrect regional designation. California has the largest discrepancies in terms of dollars in the nation. Because the plan redistributes payments, it would hold the California rural physicians harmless from cuts with administrative savings achieved through the formation of a Medicaid managed care program in Alameda County, California. There is no impact on the federal budget or any other state. This is a California-only budget neutral solution. See attached for more detail.

**B. CMS Physician Payment Rule for 2013**

CMS has indicated that it is considering a proposal to move physician payment localities from a county-based system to a Metropolitan Statistical Area (MSA) system as recommended by GAO, Acumen for CMS and most recently, the Institute of Medicine (IOM). For the past several years, CMS requested public comments on such proposals but has never taken action.

If CMS moves forward with such a proposal, CMA recommends the following:

- A. CMS should not use an iterative methodology. CMS should move directly to the MSA system. Because of the nature of the iterative methodology, large counties with a high volume of RVUs, can never move to an MSA, thereby defeating the purpose of the transition. CMA would be happy to provide a demonstration of this method.
- B. Because locality changes require a redistribution of payments within a state, CMA urges CMS to mitigate the negative impact on physician payment in rural areas. While the current localities are outdated and do not pay physicians accurately, rural physicians cannot sustain large payment cuts and maintain access to care. It has been 15 years since CMS updated the physician payment localities. There should be a transition phase for the rural localities.

**4. Medicare/Palmetto Physician Audits: California Physicians Inappropriately Downcoded and Denied Payment**

**CMA is concerned that the excessive number of audits will negatively impact physician practices and drive them out of the Medicare program.**

Palmetto, the California Contractor, began conducting additional audits of physicians in the Fall of 2011. Since the audits began, CMA has received a high volume of complaints from physicians across the state regarding Palmetto's voluminous requests for medical records and the threatening tone of the letters. Moreover, no educational information or explanation was provided to physicians about their billing practices.

Recent CMA Survey results show that nearly 70% of audited physicians disagree with the downcoding and plan to appeal. Survey respondents received an average of 24 requests for medical records and nearly half experienced downcoding of 1-2 levels. More than half of the physician respondents said that 22% of their total claims submitted were downcoded. The audits have been primarily targeted at primary care physicians, cardiologists and dermatologists who report major office disruptions and costs in terms of staff and physician time spent complying with the audit requests and addressing payment delays.

**CMA sent a letter to CMS in December 2011 requesting that the inappropriate audits and downcoding of physician practices stop. We ask that the audits be targeted at the true outliers. The volume of audits should be limited to a number sufficient to identify the problem. CMA also urges CMS and Palmetto to vastly improve its educational materials. See the Attached CMA Medicare Audit Survey document attached.**

**5. CMA Requests that CMS delay implementation of ICD-10**

CMA asks CMS to delay implementation of the ICD-10 coding system because physicians are facing an onslaught of regulatory mandates and reporting requirements in an unstable payment environment which will ultimately drive physicians out of the Medicare program. Adopting ICD-10 is a massive administrative and financial undertaking. AMA has estimated the cost to physician practices ranges from \$83,000 to more than \$2.7 million depending on the size of the practice. Physicians are already facing penalties if they do not successfully participate in multiple Medicare programs, including e-prescribing, meaningful use of Health IT and quality reporting. CMA believes that CMS has the discretionary authority to halt or at least delay implementation beyond the October 2013 deadline.

**6. CMMI Pioneer ACO Program Issues**

Recently, six Pioneer ACOs were approved in California. CMA has received numerous complaints from physicians who were not aware that they were included in the Heritage California Pioneer ACOs. Moreover, the patients are extremely confused about the new ACO and are concerned that their information was shared with other entities without their permission or their physician's knowledge. Many physicians and patients are concerned that there were serious HIPAA violations. To assist physicians and patients, CMA prepared the attached FAQ document regarding the Heritage California ACO.

**CMA recommends that CMMI :**

1. Obtain written documentation from each Pioneer ACO that the physicians listed on the application have agreed to participate in the ACO.
2. For future ACOs and other pilot programs, CMMI should obtain documentation that each physician listed on the application has affirmatively agreed to participate in the organization and the pilot.
3. Require ACOs to provide more educational information to their contracting physicians and their patients.
4. Require that the name of the patient's primary treating physician be included on any letters from the ACO to the patient.

**7. CMA Supports the First California CO-OP Application to HHS**

**The Pacific Cooperative for Health (PCH)**, a non-profit entity sponsored by the Inland Empire Foundation for Medical Care in cooperation with the Riverside County Medical Association and the San Bernardino County Medical Society recently applied to be the first Consumer Operated and Oriented Plan (CO-OP) in California's Health Insurance Exchange under the ACA. CMA believes PCH will provide consumers with a unique insurance choice devoted to the best interests of patients. Moreover, it will be important for California, one of the first states to implement an Exchange under the ACA, to include a CO-OP option for patients.

**8. CMA thanks CMS for stopping the proposed Medi-Cal Copayments.**

The State of California proposed to dramatically increase copayment to Medi-Cal patients (\$5 office visit; \$50 ER visit; \$100/day/inpatient capped at \$200). CMS just rejected these higher copayments. CMA believes the copayments would have created barriers to necessary care and medications.

**9. CMA Stops CMS & the State of California From Causing Irreparable Harm to Medi-Cal Patients**

Last year, the State of California enacted a 10% Medi-Cal (Medicaid) provider payment cut negatively impacting physicians, hospitals, Medi-Cal managed care plans and their patients. The Obama Administration unjustifiably approved these cuts. However, in response to a CMA lawsuit, a federal judge recently issued an injunction to stop the rate cuts because it would cause irreparable harm to Medi-Cal patients seeking care.

Medi-Cal rates rank 47<sup>th</sup> in the nation and are 50% less than Medicare. Because the rates are so low only half of California physicians can afford to participate and thus, 56% of Medi-Cal patients report they can't find a physician. These cuts will harm access to care, increase costs by forcing patients to seek care in ERs and hospitals when they can't find a doctor and severely hinder the implementation of health care reform as 3 million uninsured enroll in Medi-Cal.

In violation of federal law, Medi-Cal patients do not have equal access to physicians that private patients have in California. This has been demonstrated through several patient surveys and the physician workforce research conducted by Kevin Grumbach, MD and Andy Bindman, MD of the University of California-San Francisco.

**10. Health Care Reform Improvements**

CMA continues to support efforts to expand affordable health care coverage to California's 7 million uninsured; expand access to primary care physicians; and to stop insurance industry abuses, such as denying coverage for pre-existing conditions, rescinding coverage when a patient becomes ill or spending less than 85% of revenues on patient care. We are working with the state to implement the Health Insurance Exchange.

**While the ACA provided coverage to the uninsured, it unfortunately did not ensure that everyone would have a physician.**

HEALTH REFORM WILL NOT BE A SUCCESS IN CALIFORNIA UNLESS THE MEDI-CAL PROGRAM IS FIXED AND PROVIDER REIMBURSEMENT RATES IMPROVED.

In 2014, when 3 million uninsured Californians enroll in Medi-Cal there will not be enough doctors in the program.

**CMA Urges CMS to Implement the Medicaid Primary Care Increase on January 1, 2013 and to help educate physicians about this payment update.**

**CMA Urges CMS to work with providers and states to reform State Medicaid programs and to assist in the proliferation of the Medicaid health homes for the chronically ill authorized under Section 2703 of the ACA with 90% federal matching funds.**