

CMA POLICY ON HR 3200
American's Affordable Health Choices Act of 2009

Overview

The authors' stated intent for this health reform legislation is that it "...builds on what works in today's health care system and fixes the parts that are broken. It protects current coverage – allowing individuals to keep the insurance they have if they like it – and preserves choice of doctors, hospitals and health plan." It provides "quality affordable health care for all Americans and controls health care cost *growth*."

Nearly \$400 billion in physician payment fixes

HR 3200 includes nearly \$400 billion in Medicare and Medicaid payment updates and reforms that CMA has been advocating for over a decade – rebasing the SGR, primary care increases not funded by reducing payment to specialists, a GPCI locality update, stable, cumulative updates going forward and primary care Medi-Cal rate increases to Medicare levels with prohibitions on reducing Medi-Cal specialist rates below current levels.

It is important to note that all other provider groups are receiving deep payment cuts. Medicare Advantage health plans (\$172 billion); hospitals (\$155 billion); Pharma (\$100 billion-Medicare/Medicaid), Nursing Homes \$50 billion and Home Health.

Revenue Package

Hr 3200 would impose a surcharge on the top 1.2% of earners with adjusted gross income in excess of \$350,000 (married filing a joint return) and \$280,000 (single). The surcharge would be imposed at progressive rates so that married household income in excess of \$350,000 and below \$500,000 would be subject to a surcharge of 1%, income in excess of \$500,000 and below \$1 million would be subject to a surcharge of 1.5% and incomes in excess of \$1 million would be subject to a surcharge of 5.4%. The first two rates would be increased to 2% and 3%, in the event that certain health cost savings are not achieved. The bill also contains three additional revenue provisions previously approved by the House that are not related to personal income taxes or health care.

CMA does not have specific policy on these funding sources. However, CMA Guiding Principles on Health Reform HOD 2008 state:

We recognize that public funding is necessary to fund health care. We believe that such funding should be derived from sources that are as broad-based as possible, and no larger than is necessary to fund a functioning system. Health care should not be funded by selective taxes or fees imposed on providers of care.

And

Individuals should be allowed to purchase health insurance using pre-tax dollars, as businesses currently do.

BOT Min 9-10-04:6-8

That in order to fund expanded health care access for uninsured individuals, "excess" health care coverage – or health care packages with richer than average benefits – currently provided tax-free to employees by their employers, should be subject to a new federal medical tax based on income. Specifically, federal income taxes should be

levied upon employees receiving employer-provided health benefits valued at greater than 100% of the average actuarial-valued benefit package. In addition, this same 100% threshold shall also apply to health insurance packages purchased by individuals outside of the workplace.

That, to the extent and for the period of time that a phased in tax on “excess” health benefits is insufficient to fully fund tax credits to provide catastrophic and preventative insurance for the low income uninsured (those with incomes between 200%-400% of the FPL), public federal funding should fill the gap from other revenue sources.

I. COVERAGE AND CHOICE

Health Insurance Exchange

It establishes a Health Insurance Exchange which acts as a marketplace for individuals and small employers to purchase health insurance. Enrollment in the exchange is limited to those individuals and small business employees who are currently uninsured. Over time, the Exchange will be open to all employers. States may opt to operate the Exchange under the federal rules. Private health plans and a public government-run “public plan” would compete within the Exchange. The Exchange shall enforce insurance reforms, administer benefits and affordability credits and oversee the participating health plans.

Starting in 2013, the exchange will only be open to uninsured individuals and employers with less than 10 employees. In 2014, employers with less than 20 employees may join. In 2015, the Administrator may continue to expand the exchange.

Insurance Reforms

Requires “guaranteed issue” of health insurance. Insurers are prohibited from refusing to sell coverage based on an individual’s health status.

Insurers will be prohibited from excluding coverage or treatment for pre-existing conditions.

Insurers must adhere to “community rating” which limits the plans from charging higher rates due to an individual’s health status, gender or other factors.

Health plan premiums can only be based on age, geographic region and family size.

Prohibits lifetime and annual limits on benefits.

Requires health plans to dedicate 85% of revenue to direct medical care. Plans that do not meet this requirement must provide a rebate back to enrollees.

Requires health plans to have adequate provider networks.

Implements fair marketing requirements.

Requires patient and provider grievance procedures and appeals processes, including an external medical review process.

Requires prompt payment consistent with Medicare timeline of 30 days. (CA state law is 45 days.)

Benefits

An Advisory Board, Chaired by the Surgeon General, shall make recommendations on the benefit package. There are three levels of benefit packages. The basic benefit package will include physician, hospital, prevention, mental health, dental and vision services. The Advisory Board includes physicians.

Coverage

Medicaid Expansion: Expands coverage for individuals and families with incomes below 133% of the Federal Poverty Level. This expansion is fully financed by the federal government – no state share is required until at least 2013.

Tax Credits: Establishes tax credits on a sliding scale to help low and moderate income families afford health insurance. The credits are larger for low-income families starting just above the Medicaid eligibility levels and phasing out at 400% of the Federal Poverty Level (\$43,000 for individuals; \$88,000 for a family of four). There are also caps on out-of-pocket spending.

Shared Responsibility for Coverage

Individuals will be mandated to obtain health insurance coverage.

Employers will have the option of providing health insurance coverage for their workers or contributing to a fund. Employers that choose to contribute will pay a fee based on 8% of their payroll. Employers that offer coverage must meet minimum benefit and contribution requirements.

Small Employers will be given an exemption from the employer responsibility requirement. Instead, small businesses will be given a tax credit to provide coverage for their employees through the Health Insurance Exchange.

CMA Policy:

In general, CMA policy supports the creation of a health insurance exchange, market reforms on the for-profit health plans, an individual mandate, an employer pay-or-play provision, small business tax subsidies, tax credits for low-income families and expansions of Medicaid.

Based on CMA Policy, CMA is seeking specific amendments to improve the following provisions:

1. CMA has sponsored legislation to require health plans to expend 85% of health-related revenue on direct patient care. While the existing Knox-Keene regulations

require a 15% limit on overhead and profit, the health plans have been able to get around this requirement. The language in the House bill needs to be improved to ensure plans meet this requirement consistent with CMA-sponsored legislation.

2. The House bill calls for adequate health plan networks. However, the language is vague and needs to be improved to be consistent with CMA-sponsored legislation that requires health plans to meet certain physician-patient ratios by product line in each service area and publicly report those ratios.

Guiding Principles for Health Reform HOD 2008

- *Patients should have increased access to health care and health care coverage.*
- *Every individual is ultimately responsible for obtaining and maintaining health coverage for themselves and their dependents, whether through their employer, individual coverage, or government health programs.*
- *Government programs should provide assistance to those who cannot afford premiums for health coverage, including sliding scale subsidies.*
- *All health plans and health insurers should be regulated by a single state regulatory agency.*
- *Health plans and health insurance companies shall pay rates sufficient to encourage physician participation, and completion of adequate physician networks for coverage of all care.*
- *Health insurance should be community rated, adjusting for the changing cost of providing care in different regions throughout the State.*
- *California physicians support offering patients a wide variety of health plan options to meet their individual needs, with all plans required to meet or exceed a defined minimum benefits package.*
- *Increased competition in the health insurance market is necessary, provided that all plans abide by all of California's patient and physician protection laws.*
- *Health plans and insurers should spend at least 85% of their health-related revenue on the direct provision of patient care. Health plans and insurers shall be required to disclose all performance and financial information necessary for the protection of the public interest.*
- *Portability of health coverage is necessary to allow individuals to continue their coverage, regardless of health status, at standard or community rated premium levels.*
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HOD Health Care System Reform Report B-01-04

In order for CMA to support an individual mandate for the purchase of health insurance coverage it must include the following criteria (summarized below):

- *Insurance reforms (community rating, guaranteed issue, portability, prohibition on restrictions related to pre-existing illnesses);*
- *A rational mandated benefit structure*
- *Appropriate tax incentives for employees*
- *Appropriate consumer education about options and costs*
- *A mechanism to ensure that current employer contributions are maintained.*
- *Payment assistance for low-income individuals*

In order for CMA to support an employer mandate, it must include the following requirements:

- *Elements of choice – choice of plans/insurers and delivery systems.*
- *Adequate funding – employer’s share of health care costs must be retained by the continuation of tax deductibility of the coverage or by other means.*
- *Limit on payment for lower-paid employees + premium assistance.*
- *Tax subsidies for small businesses.*
- *Insurance reform.*

HOD Health Care System Reform Report B-1-02

For those with lower incomes (e.g., less than 250% of the federal poverty level) government programs should, at the present time, be the primary sponsor and funder of care.

For those with somewhat higher incomes (e.g., between 250%-400% of the federal poverty level) federally provided refundable tax credits should be provided to cover approximately 70% of the premium cost of insurance.

CMA-Sponsored Legislation

CMA has sponsored legislation to prohibit rescissions consistent with HR 3200.

CMA policy dating to 1983 and the recent CMA-sponsored bill, AB 1455, calls for prompt payment within 30-45 days with aggressive enforcement.

CMA also sponsored the original external medical review process legislation that became law in 1998-99.

CMA supports the marketing, grievance and appeals processes in the bill which are consistent with the California Knox-Keene Act.

II. PUBLIC INSURANCE PLAN OPTION

The House bill establishes a public plan option, to be operated by HHS, that would compete with the private health plans in the newly-established Health Insurance Exchange. The public plan will only be available through the Exchange. And initially, the Exchange will be limited to those individuals and small business employees who are currently uninsured. The public plan must meet the following requirements:

- Meet the same regulatory and oversight requirements as the private health plans participating in the Exchange, including benefit packages, provider networks, consumer protections, insurance market reforms (i.e., community rating, administrative costs) and cost-sharing. (See the Health Insurance Exchange description above.)
- Financially self-sustaining through individual and small business premiums just as the private plans are. The Secretary of HHS will establish geographically-

- adjusted premium rates at a level sufficient to fully finance the costs of the health benefits provided and the plan's administrative costs.
- The government will provide \$2 billion in start-up funding and 3 months of reserves to cover IBNR claims prior to the collection of premiums to finance medical claims. All must be paid back to the Treasury.
 - Physicians participating in Medicare will be considered participating public plan physicians unless a physician opts-out of the public plan.
 - Physicians who participate in both Medicare and the public plan (including Pediatricians) will be paid the new Medicare fee schedule plus a 5% bonus payment for services provided to public plan patients.
 - **July 30 Note: New Agreement would allow delink rates from Medicare and allow competitive negotiated rates. Physician participation voluntary.**
 - In three years, the Secretary can delink the rates from the Medicare fee schedule. However, aggregate spending on provider payments must remain consistent.
 - The Secretary of HHS is also authorized to implement innovative payment mechanisms to encourage the use of medical homes, accountable care organizations, value-based purchasing, bundling of services, partial capitation, direct contracting with providers, differential payment rates and performance or utilization based payments.
 - Public plan patients will be allowed to seek treatment from physicians outside the public plan network of physicians.
 - The Medicare fraud and abuse integrity provisions apply to the public plan.

CMA/AMA Policy

AMA 2009 HOD Policy states:

AMA will support health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice and universal access for patients.

CMA Policy on a Single Payer System HOD Res 212a-06 (amended HOD Rpt B-1-04)

While the public plan as presented is not a single payer system, some health care policymakers believe that a publicly-financed plan would be less expensive and more attractive and cause a phenomenon known as "crowd-out." As private plans disappear, the public plan could become the "single payer" where the government pays all of the bills for health care. Therefore, the following CMA Policy on a single payer system is appropriate to review.

CMA policy on single payer health system reform requires the following:

That CMA will continue to consider a single payer health reform proposal, if the following criteria are in place:

- *physicians must be provided a means to ensure payment of their usual and customary charges as defined by the Gould criteria;*
- *a scientific, apolitical body must make benefit and coverage decisions*
- *pluralistic delivery system options must be retained (e.g., prepaid group practices, fee-for-service)*
- *Mechanism for addressing fraud*

- *Patients must be allowed to buy-up to purchase additional coverage outside the single plan*
- *Mechanisms to address capital investment and infrastructure building*
- *Medically appropriate copayments on a sliding scale to discourage excessive utilization;*
- *Physicians must be permitted to collectively negotiate.*

Note: The current health insurance exchange and Public Plan Option meet all of the above criteria except: #1) Usual and Customary Rates will only be allowed for patients seeking services out-of-network; However, the new July 30 agreement would allow competitive, negotiated rates. #6) It is not clear whether the rates or the mechanisms are adequate to allow investment in infrastructure. Regarding #8, physicians will only be allowed to collectively negotiate through the direct contracting provisions and the physician Accountable Care Organizations.

CMA-Sponsored Legislation/Economic Advocacy

CMA has always opposed contracts or proposals that mandate physician participation in any private or public health plan. CMA has opposed all-payer clauses in private health plan contracts, silent PPOs, and other forms of mandatory participation.

CMA Medicare Payment Reform Policy: BOT April 2009

CMA is supporting, under certain conditions, the development of medical homes, accountable care organizations and other innovative payment methodologies to improve payment to physicians who appropriately manage the care of their patients.

CMA Guiding Principles for Health Reform

- The center of the health care system must be the physician-patient relationship, and the autonomy of physicians in concert with their patients to define medically necessary care. A recommendation made by a treating physician should be presumed to be correct regardless of coverage, albeit challengeable.*
- Both public and private health plans shall reduce administrative barriers to the delivery of health care.*
- *New methods of financing and delivering health care will be encouraged if they conform to these Guiding Principles.*
- *All government-sponsored health programs and initiatives must be adequately funded and must pay rates sufficient to encourage physicians to participate and ensure access to care for patients.*
- *California physicians support offering patients a wide variety of health plan options to meet their individual needs*

2009 CONGRESSIONAL NEGOTIATIONS ON THE PUBLIC PLAN

AMA and CMA Messages:

AMA has expressed concerns with a public plan option that is administered by the federal government and modeled after Medicare. AMA has argued for reforming the private insurance market rather than establishing a competitive public plan to reign-in

the abusive behavior of the for-profit health plans. Moreover, the AMA is opposed to linking payments to the Medicare fee schedule. AMA and CMA have recommended that the payment rates be competitive with private plan rates and established through meaningful negotiations and contracts. Further, CMA and AMA strongly opposed the initial proposal that required physicians to accept patients in a public plan as a condition of Medicare participation. In response to that opposition, the mandate was removed.

Both the CMA and AMA urged the Committees to allow direct private contracting between physicians and public plan enrollees.

Because most physicians fear that a public plan will evolve to a single payer plan, we have also explored proposals that trigger private contracting and other forms of competition and choice if the public plan gains 25-30% of market share. While the Committees have been emphatic in their opposition to private contracting, they will allow patients to seek care out-of-network.

Finally, the AMA recently stated the following in their comment letter to the Tri-Committees:

“...However, we remain open to considering an alternative that would provide competition from a non-profit entity that is self-supporting, is subject to the same solvency requirements as private plans, does not receive special advantages from government subsidies, where rates are established through meaningful negotiations and contracts, and where enrollees have access to the sort of out-of-network benefits that are available in private plans...”

UPDATE: As of July 30, 2009, The House Energy Commerce Committee leaders have agreed to delink Public Plan rates from Medicare and allow physicians to negotiate competitive payment rates.

U.S. Senate Public Plan Alternative and Coops

Senator Kennedy’s HELP Committee is proposing a public plan option nearly identical to the House version. It will pay competitive, negotiated rates. However, the Senate Finance Committee is interested in establishing non-profit community coops to compete in the health insurance exchange with the private plans rather than a public plan.

CMA has long supported the physician-initiated coop in Monterey, California called the Community Health Plan of Monterey. It is a coop board comprised of local physicians, the local hospitals, community citizens and the large self-insured employers. They have over 8,000 enrollees. They offer attractive reimbursement rates to the providers (165-180%+ of Medicare) to maintain excellent access to care, aggressive utilization management to control health care costs, and have impressively slowed the rate of employer premium increases. Their administrative costs are 3%. Recently, they contracted with Aetna to provide reinsurance for catastrophic cases so they could open the coop to individuals and small businesses. They believe that such

local “public” coops could develop and compete with the private plans. However, they strongly recommend a national reinsurance pool to spread the risk and make premiums more affordable to coops. A concept that is also consistent with CMA policy.

CMA leaders have advocated for the Monterey coop model with a national reinsurance pool to the Senate Finance Committee.

Below is a Summary of the Arguments For and Against the Public Plan.

A Summary of the Arguments in Favor of the Public Plan

1. Competition: Proponents argue that the public plan will provide competition to the private health plans which will curb their abusive behavior. The mere threat of a public plan has brought the national Health Insurers of America Association (HIAA) to agree to accept all individuals regardless of their health status at an affordable rate and to not deny coverage or treatment to patients based on pre-existing conditions.

Proponents argue that the public health plan is at a severe disadvantage because it will never be able to get established in time to compete with the private plans. The public plan must start from scratch, hire staff, develop a provider network and be ready to market to individuals within a short timeframe.

The non-partisan Congressional Budget Office recently estimated that HR 3200 will cover 97% of the 37 million uninsured, legal, non-elderly population. CBO estimates that only 10-11 million people would enroll in the public plan – 4% of the population.

The non-partisan Congressional Budget Office also estimated that from 2010-2019, the number of Americans with employer provided coverage will increase from 150-162 million people. Additionally, for those Americans who purchase coverage through the Health Insurance Exchange, 2/3 (20 million people) will choose private plans.

2. Choice: Proponents argue that the public plan provides a choice to individuals who do not want to enroll in a private for-profit health plan. Moreover, the vast majority of seniors strongly support the Medicare program. CMA policy supports health plan choices. In California, many employees only have a choice of one health plan.

3. Innovation: Proponents argue that a public plan could bring about more innovation to the health care delivery system, to improve quality and to incentivize physicians.

4. Cost Controls:

Proponents argue that a Public Plan would be more affordable because administrative expenses would be lower and there would not be the need to pay shareholders. (Medicare is 1.4% compared to Wellpoint at 15-20%).

Proponents argue that a Public Plan would cost less if it paid doctors and hospitals Medicare rates. Therefore, health care reform could cover more individuals at a lower cost to the government.

Arguments Against the Public Plan

1. Funded by Taxpayers- Increasing the Federal Deficit

Opponents argue that a public plan would be partially funded by the taxpayers instead of through premiums. They argue that the Medicare program is already fiscally insolvent and federal and state governments are experiencing massive deficits. Therefore, they believe the government cannot afford the financial risk of yet another program. They also argue that any public plan must be 100% financed through premiums and be self-sustaining. However, they believe that public pressure will always force the government to supplement the premiums to continue the plan.

2. Private Plans would be Unable to Compete with the Public Plan on Cost

Because the federal government has enormous purchasing power to drive down costs, the private plans argue that they would not be able to compete on cost. Others argue that lower costs and reimbursement rates would stifle quality and drive away physicians. See the Cost Control section of “Arguments For the Public Plan” above.

3. Crowd Out

Opponents argue that a less costly public plan would compel individuals to switch from private insurance to the public plan. This phenomenon is referred to as “crowding-out” private coverage. It could also cause large employers to drop their coverage. Crowd out in the SCHIP program nationally was between 25-60%. But Proponents argue that this program is different. The Lewin Group (owned by United Health Group) published a study recently that projected a 5-10% crowd-out rate. However, the CBO has specifically refuted the Lewin Group study. See Arguments For/Competition above.

4. Single Payer System

Opponents argue that the public plan will ultimately become a monopsony because the private plans will not be able to compete for all the reasons mentioned above.

III. MEDICAID EXPANSION

As reported above in the Health Insurance Exchange Section, the bill would expand Medicaid Coverage to 133% of the Federal Poverty Level for low-income families.

In addition, at CMA’s urging the bill would increase Medicaid rates to Medicare levels for primary care. This is an important step in the right direction. This provision and the Medicaid expansion are 100% federally financed. However, states are required to meet a Maintenance of Effort requirement for all eligibility, methods and procedures in place as of June 16, 2009. That means that any rates paid on June 16, 2009 by the states cannot be cut in order to receive these additional federal funds.

CMA Policy

CMA is urging that all Medi-Cal rates be increased to Medicare levels to ensure access to care pursuant to established CMA policy developed for CMA’s state legislative

advocacy efforts, the CMA Medi-Cal lawsuits and the CMA Guiding Principles on Health Reform.

IV. MEDICARE REFORM

2010 Physician Payment Update

Medicare Economic Index

Eliminates the current SGR by wiping out the \$230 billion in future payment cuts to physicians.

2011 and beyond: Physician Payment Updates

Establishes two new conversion factors and SGR spending targets:

#1: E&M services provided by all specialists and preventive Services

Update is GDP + 2% annually/cumulative

#2: All Other Services: Update is GDP +1% annually/cumulative

Updates for the Service Categories:

These categories will work just like the current SGR spending target. However, physicians are more likely to face stable, annual, cumulative updates than cuts.

Removes the Drug Expenditures From Part B

All drugs administered in physician offices would be moved from the Part B (Physician Services) program and placed in the Part D Prescription Drug Program. Without the drug expenditures in the two new service categories, physicians are less likely to hit the expenditure targets that trigger payment cuts.

Primary Care Bonus

Starting in 2011, there is an additional 5% bonus payment for primary care specialties (for whom 50% of their billings are for certain primary care services (new and established patient office visits, primary care services, emergency department visits, consultations and home services.) There is a 10% bonus for primary care physicians practicing in health professional shortage areas. The bonus applies to internal medicine, family medicine, general internal medicine, general pediatrics, and geriatrics. It does not apply to Physician Assistants or Nurse Practitioners.

This primary care bonus is not paid for by reducing payments to specialists by 5% as proposed by the Senate Finance Committee.

CMA policy supports increases for primary care. Specific policy supports 3% annual increases for 5 years. See BOT April 2009 listed below.

BOT October 2007: That CMA add “adequate primary care physician workforce, including financial incentives to encourage primary care career choices” to CMA principles for the basis of health care reform.

Efficiency Bonus

For 2011-2013, there would be a 5% bonus payment for physician practicing in counties that are in the lowest 5th percentile of utilization based on per capita spending for Parts A and B.

CMA is requesting an amendment to clarify that the formula be cost-adjusted so that California’s high cost yet low spending regions could qualify for the bonus payment.

CMA BOT April 2009: Medicare TAC Report

REC 1: That CMA continue to support the elimination of the Medicare SGR payment formula.

REC 2: That CMA urge Congress to provide a Medicare payment update of at least 10% in 2010, which would restore physician reimbursement rates that were reduced by SGR payment cuts and inadequate cost-of-living updates.

REC 3: That CMA support a new Medicare physician payment system that allows physicians to voluntarily select a payment track based on the following five options. Tracks 1 and 3 reimburse physicians pursuant to the Medicare Fee Schedule on a fee-for-service basis.

Track #1: Medicare Economic Index (MEI) Update Plus a 3% Increase for E&M Services

(a) Automatic Medicare Economic Index Annual Update

(b) Automatic Annual 3% Payment Increase in Addition to MEI for E&M Services Annually for 5 years

Track #2: Payment for Medical Home Coordination

Track #3: Physician-Directed Organizations – Shared Savings Payments

2011 Implementation

Physicians in communities who want to move forward with establishing real or virtual Physician-Directed Organizations may obtain approval from CMS and be organized and reimbursed as follows: (a) Automatic Medicare Economic Index Update (b) Additional bonus payment for Physician-Directed Organizations that coordinate care and report on quality. Physician organizations would receive 80% of the savings achieved from reducing expenditures in Medicare Part A-Hospital services and Medicare Part B-Physician services in their Metropolitan Statistical Area (MSA) region. (c) Physician-Directed Organizations that already meet their MSA-regional spending benchmark would receive 80% of the savings achieved from spending less than the national average Medicare beneficiary expenditure. (d) Physician-Directed Organizations must be led and governed by physicians who have the sole responsibility for the medical management of their patients.

Pilot Testing

Innovative financing and delivery system reforms, such as real or virtual Physician Directed Organizations, that support physicians in the provision of high-quality cost-effective care should be further developed and tested through pilot programs. Multiple

models should be evaluated in a variety of practice settings (including large, small and solo practices), geographic areas (urban and rural), and among different specialties and patient populations. Such pilot programs should consider the elements listed in (a)-(d) above.

Track #4: *Physician Groups With Panels Appropriate to the Scope of Services Contracted for Contracting Directly with Medicare on a Risk-Basis*

Track #5: *Physicians be permitted to contract privately with Medicare patients on a per patient or per service basis for an agreed fee schedule above the Medicare fee schedule. Medicare allowed services would be paid at prevailing Medicare rates as a baseline payment for those services.*

Track #6: *Increase the Medicare Limiting Charge for Non-Participating Physicians*

REC 4: *That CMA urge the Centers for Medicare and Medicaid Services (CMS) to update the Medicare Economic Index (MEI) marketbasket to ensure it appropriately represents current physician practice expenses.*

REC 5: *That CMA work with Congress to break down the Medicare Part A-Hospital and Part B-Physician programs to fund physician payment increases.*

REC 6: *That CMA advocate for physicians who are clinically and financially integrated through the HIT requirements of H.R. 2 (2009) or the requirements of the Physician-Directed Organization Payment Track to be granted anti-trust relief to collectively negotiate contract terms with the private health plans.*

BOT April 2008: *CMA supported moving the in-office administered drugs from Part B to Part D to save \$100 billion in Part B spending.*

Establishes Accountable Care Organization Demonstration Projects.

Establishes ACO demonstration projects. Consistent with CMA policy, the ACOs must be physician-led and do not require the involvement of a hospital. It allows physicians who share HIT and report on quality to collaborate and share in 80% of the hospital savings achieved by reducing unnecessary hospitalizations. The legislation gives the Secretary broad flexibility to develop innovative ACOs at the local level. It establishes local spending targets for ACOs based on historical spending in the region. Bonuses have been estimated from 4% to 10% annually depending on the region.

CMA Policy: The provision as drafted is quite consistent with CMA policy adopted by the BOT April 2009. This is one of the payment tracks in the CMA Medicare plan. See above. CMA is asking for three additional amendments: 1) No preemption of state corporate practice bars; 2) Additional start-up costs for physicians; 3) Allow physician groups that already meet their local spending benchmark to meet a national average benchmark.

Requires the Secretary to establish Medical Home Demonstration Projects.

CMA Policy supports medical home coordination pursuant to the BOT April 2009 actions and previous BOT Actions in October 2007 as recommended by the Primary Care TAC. This is one of the payment tracks in the CMA Medicare plan (see above). , CMA is working to ensure that such projects are not burdensome for physicians to participate.

Also, the bill would allow nurse practitioners to lead a medical home “so long as...the nurse practitioner is acting consistently with State law.” State law requirements regarding physician supervision of nurse practitioners would continue to apply. However, CMA is opposing based on long-standing policy. CMA believes this would not be allowed under state law. However, CMA believes the California Nurse Practitioners would argue otherwise. CMA does not believe a NP has the training and expertise to lead a medical home and therefore, CMA is opposing this scope of practice expansion.

CMA BOT October 2007

Recommendation 3: That CMA adopt the March 2007 American Academy of Pediatrics, American Academy of Family Physicians, The American College of Physicians and American Osteopathic Association “Joint Principles of the Patient-Centered Medical Home” and refer this to the AMA for national action as follows:

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.*
- Evidence-based medicine and clinical decision-support tools guide decision making*
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.*
- Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met*
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication*
- Practices go through a voluntary recognition process by an*

appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

- Patients and families participate in quality improvement activities at the practice level.*
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.*
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:*
 - It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.*
 - It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.*
 - It should support adoption and use of health information technology for quality improvement;*
 - It should support provision of enhanced communication access such as secure e-mail and telephone consultation;*
 - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.*
 - It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).*
 - It should recognize case mix differences in the patient population being treated within the practice.*
 - It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.*
 - It should allow for additional payments for achieving measurable and continuous quality improvements.*

Recommendation 7: That CMA add “support for coordination of care and Medical Homes” to CMA’s principles for the basis of health care reform.

Recommendation 11: That CMA encourage public and private payers and medical groups in California, including Medi-Cal, to implement pilot programs to finance Medical Homes that include adequate evaluation to measure quality and cost of care.

Requires the Secretary to establish methods to allow physician groups to contract directly with Medicare on a capitated basis.

CMA policy supports per the BOT April 2009 actions. This is one of the CMA Medicare payment tracks (see above).

Physician Quality Reporting Initiative

Extends the PQRI bonuses through 2012 without penalties.

Requires timely feedback from the HHS Secretary to physicians who are participating with recommendations on how to correct any reporting inconsistencies and whether the physician will receive a bonus payment for the reporting period.

Also implements an appeals process for physicians to dispute payment amounts and errors. Requires Secretary to integrate quality reporting with the meaningful use of electronic health records.

CMA/AMA strongly support the feedback program and appeals process proposed here. CMA HOD 2008:

That CMA oppose participation in pay-for-performance programs unless they are consistent with AMA's guidelines for pay-for-performance found in AMA's June 21, 2005 Board of Trustees policy which includes: a. Improve quality, safety and effectiveness of healthcare; b. Involve physicians; c. Use sound methodology; d. Encourage participation; e. Reward achievement; f. Foster the patient/physician relationship; g. Assume administrative costs; h. Standardize across programs; i. Pay-for-Performance should be voluntary.

Quality Measurement

Establishes support for a process to identify national priorities for performance improvement and develop quality measures, including the testing and updating of measures.

AMA has requested that the Committees adopt the Stand For Quality Coalition recommendations and recognize the Physician Consortium for Performance Improvement as an entity qualified to develop physician-level performance measures. These changes were accepted.

Work GPCI Floor

Extends the work gpci floor through 2011. ***This provision does not impact California.***

California GPCI Update

Transitions all California payment localities to Metropolitan Statistical Areas (MSAs). Starting in 2011, 14 California counties will receive payment increases. The bill establishes a hold harmless to prevent physicians in other counties from receiving payment reductions for five years until 2016.

San Benito 13%+; Santa Cruz 8.6%+; Marin 7.6%+; Monterey 6.5%+; Sonoma 6.2%+; San Diego 4%+; Santa Barbara 4%+; El Dorado 2.7%+; Placer 2.7%+; Sacramento 2.7%+; Yolo 2.7%+; Riverside 0.7%+; San Bernardino 0.7%+; San Luis Obispo 0.3%+.

CMA Policy:

This is a CMA-sponsored provision except the hold harmless was reduced to five years. The 2009 CMA-sponsored bill has a permanent hold harmless.

Several years ago, the House Medicare bill included a California GPCI fix with only a three year hold harmless.

*CMA policy below calls for CMA to minimize the payment reductions.
CMA is working to extend the hold harmless provision.*

HOD Res 102-06:

MEDICARE LOCALITY REVISION

RESOLVED: *That CMA continue to seek revision of the Medicare Geographic Payment localities with counties having significantly higher practice costs (GPCIs); and be it further*

RESOLVED: *That CMA continue to advocate for additional funding for Medicare geographic payments to hold counties harmless from payment reductions.*

RESOLVED: *That CMA apply the following principles in supporting revised Medicare Geographic Payment Localities: (1) methodology for revision is applied consistently; (2) payment accuracy within the locality is improved; (3) there is a mechanism for future revision of localities that is formula driven; (4) implementation of the revision minimizes payment reduction in each payment locality; and (5) evaluation of any revision is based on accurate data gathered by CMA which shows that the revision minimizes any negative effect on access to care in California; and be it further*

RESOLVED: *That CMA continue to develop and promote other Medicare payment options to offset the impact of potential Medicare reductions; and be it further*

RESOLVED: *That CMA advocate that current Centers for Medicare and Medicaid Services reimbursement to California is inadequate to provide access to quality medical care for all Medicare and Medicaid beneficiaries in the state; and be it further*

Limited English Proficiency Reimbursement

Requires the Secretary to reduce health care disparities by studying the availability of language services and to recommend payment reforms to improve access to language services. It requires HHS to study the feasibility of on-site interpreters as well as the Medicare contracting with agencies to provide telephone and video interpreter services. Finally, it requires the Secretary to make grants to fund increased reimbursement for services provided to Limited English Proficient patients.

CMA has long-standing HOD policy supporting increased access to language services and physician payment reforms. CMA helped to develop this provision with Congressman Xavier Becerra (D-LA, CA).

CMA BOT May 2005:

RESOLVED: *That CMA reaffirm its policy with regards to providing language access to patients of limited English proficiency as:*

- *Interpreters should be made available to patients of limited English proficiency who request assistance.*
- *Physicians should not be required to pay for and then bill the Department of Health and Human Services for services that have been provided by interpreters.*
- *The State should arrange for and contract directly with interpreters for their services rather than requiring individual physicians to do so.*
- *Interpreters should bill the department directly and be directly reimbursed by the Department of Health and Human Services for their services just as other providers*

are paid by the State.

- *Physicians may need to certify that the interpretation services were provided.*

HOD Resolution 712-03

LIMITED ENGLISH PROFICIENCY AND INTERPRETER COSTS

RESOLVED: *That CMA is committed to cultural and linguistic sensitivity in the provision of medical care and believes that effective communication with patients is essential to quality care, access to care and assuring a patient's compliance with treatment plans, all of which are important to the delivery of good health care with successful outcomes; and be it further*

RESOLVED: *That CMA will continue to inform its membership via its publications and programs of the many resources currently available to assist physicians and their office staffs in addressing the cultural and language needs of their patients;*

RESOLVED: *That CMA will work with other stakeholders including, but not limited to, those involved in The California Endowment's Medical Leadership Council on Language Access, in identifying policy options that will lead to funding of interpreter services for limited English proficient patients in California;*

RESOLVED: *That CMA take a leadership role in forming an advocacy coalition for whichever interpreter funding policy is identified by CMA is most beneficial to patients and physicians, including but not limited to proposals developed in cooperation with the members of The California Endowment's Medical Leadership Council on Language Access; and be it further*

RESOLVED: *That CMA reaffirm that the cost of providing interpreter services must not be borne by physicians; and be it further*

RESOLVED: *That physicians who are unable to locate an interpreter are not to be penalized for proceeding with the provision of care for that patient; and be it further*

RESOLVED: *That CMA promptly explore legal options and press for regulatory relief so as to obtain a change in the regulation requiring payment by the physician for interpreter services in the medical office and/or clinic. Failing that, CMA should use its political influence to initiate legislation to effect relief, either by elimination of this requirement or federal/state payment for such services; and be it further*

Requires CMS to provide information to beneficiaries for end-of-life planning.

CMA-sponsored federal legislation several years ago to require CMS to provide advance directives to all Medicare beneficiaries.

Prohibits Part D Pharma plans and Medicare Advantage plans from changing the prescription drug formulary mid-year.

CMA Medicare Reform Policy adopted by the BOT April 2008.

Payment reductions to hospitals, skilled nursing facilities, home health and Part D Prescription Drug Plans.

CMA Medicare Reform Policy adopted by the BOT April 2008.

Reduces Medicare Advantage payments over time to equalize with FFS payments.

CMA Medicare Reform Policy adopted by the BOT April 2008.

Bans future physician-owned hospitals and restricts growth of current hospitals.
CMA BOT Adopted January 2005.

REC 13: That CMA oppose the extension of the present moratorium, and any prohibition on physician ownership, control, or governance of specialty hospitals.

REC 16: That CMA oppose legislation mandating that specialty hospitals provide a specified amount of “charity” and/or emergency room care.

REC 19: That CMA continue to support the “whole hospital” exception to the Stark law regarding self-referral.

REC 20: That CMA oppose any limitation on the percentage of individual physician investment in a specialty hospital other than that which is provided for under existing law.

REC 21: That CMA oppose any hospital retaliation against physicians as a result of their ownership or participation in a specialty hospital.

Increased penalties for fraud and abuse and it requires providers to adopt programs to reduce waste, fraud and abuse.

CMA and AMA have extensive policy related to fraud and abuse – program integrity provisions. In summary, CMA advocates for strong due process protections for physicians and the right not to be unnecessarily hassled by auditors and reviewers. CMA and AMA support increased funding for current programs since the current ones are underfunded and have resulted in problems for physicians.

Changes the Imaging Practice Expense formula

Increases the practice expense units for imaging services to reflect a presumed utilization rate of 75% instead of 50%. However it excludes low-tech imaging devices (i.e., ultrasound, EKGs and x-rays). Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25% to 50%.

AMA is opposed. AMA policy states “...should permit a more refined approach allowing medical specialties that represent users of the various imaging modalities to submit data to CMS to determine an appropriate assumption for utilization.

Requires the Secretary of HHS to Reduce Hospital Readmissions through payment reductions to hospitals.

AMA has called for demonstration programs to study this proposal with significant input from physician organizations on all issues, including attribution methodologies.

Requires the Secretary of HHS to develop a plan to reform payment for post-acute services, such as implementing bundled payments for physician and inpatient services.

AMA has called for demonstration programs to study this proposal.

Extension of the physician fee schedule for the mental health add-on.
CMA policy related to Mental Health Parity supports.

Requires Ambulatory Surgery Centers and Hospitals to report on infections.
CMA does not have policy.

V. ADDITIONAL MEDICAID PROVISIONS

Codifies the California State Family Planning Presumptive Eligibility Program.
CMA-sponsored provision.

Provides Public Health Clinics access to Vaccines for Children Program vaccines.
CMA-sponsored federal legislation in 1998 would have provided VFC vaccines for the SCHIP-Healthy Families program.

85% Medical Loss Ratio for Medicaid Managed Care Plans.
CMA Policy supports pursuant to CMA sponsored bills.

VI. CLINICAL PROVISIONS

Comparative Effectiveness Research

Establishes a Center to perform clinical effectiveness research to assist physicians in making appropriate medical decisions with their patients. Establishes a commission that includes a majority of physicians.

AMA Policy Statement:



Comparative Effectiveness Research

There is a consensus, driven in part by the Institute of Medicine and other prominent health stakeholders, that physicians do not have adequate information on the relative clinical benefits of various treatment and diagnostic modalities. The AMA supports efforts to establish a federal entity responsible for comparative effectiveness research consistent with AMA policy.

Following are the specific AMA principles for creating a centralized comparative effectiveness research entity.

- **Value.** Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the U.S. health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.
- **Independence.** A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.
- **Stable Funding.** The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.
- **Rigorous Scientifically Sound Methodology.** CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.
- **Transparent Process.** The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.
- **Significant Patient and Physician Oversight Role.** The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.
- **Conflicts of Interest Disclosed and Minimized.** All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

Prevention and Wellness

Requires the Secretary to develop a national prevention and wellness strategy and to expand Community Preventive Services to review existing science and recommend adoption of proven and effective preventive services. It also focuses on prevention and wellness research, including a focus on reducing health care disparities.

CMA and AMA strongly support these provisions and a focus on reducing the prevalence of chronic disease and poor health status, starting with an emphasis on obesity prevention.

Physician Payment Sunshine Provisions

Establishes a national registry that provides information on the transfer of value to physicians from manufacturers of drugs, medical devices and medical supplies. Establishes procedures for covered persons to submit corrections to incorrect data reported about them.

AMA generally supports but has asked for a series of amendments.

VII. PHYSICIAN WORKFORCE ISSUES

Graduate Medical Education

To address the need for increased residency positions, the bill authorizes the redistribution of unused GME positions with preference to hospitals that emphasize primary care training. It also increases training in non-institutional settings and establishes demonstration projects for primary care training.

CMA/AMA are seeking an amendment to increase the number of residency positions overall.

Public Health Workforce and Health Professions Training

Establishes Primary care residencies in community health centers

Public health workforce augmentation, training and loan repayment assistance.

Scholarships for students with disadvantaged backgrounds to ensure a diverse health care professional workforce.

Cultural and Linguistic Competence training for health care professionals

New grants to fund school-based health clinics

More data collection and analysis on Health Disparities

CMA and AMA have long-standing policy supporting scholarship programs, loan forgiveness and other initiatives to train more health care professionals to improve access to care. CMA/AMA also support health care disparities improvement.

BOT October 2007: Rec 4: That CMA support increased funding for primary care mentorship programs for students, physician training programs, recruitment efforts and an adequate faculty, including Title VII funding for physicians and removing restrictions on Medicare graduate medical education funding for resident time spent in ambulatory and community settings and in educational activities.

Rec 5: That CMA add “adequate primary care physician workforce, including financial incentives to encourage primary care career choices” to CMA principles for the basis of health care reform.

VIII. PRIVATE CONTRACTING

While there are provisions to allow public plan patients to seek care outside of the public plan network, there are no other allowances for private contracting.

CMA is seeking amendments that would allow private contracting in Medicare, the public plan and the private sector.

HOD402a-08

RESOLVED: That CMA support and promote appropriate solutions to the fair payment/balance billing issue for medical services which: (1) protect patients and providers from the consequences of inappropriate claims payment practices; (2) are predicated on the idea that usual and customary physician charges are reasonable; (3) ensure that non-contracted physicians are fully compensated for the fair value of their services; (4) provide for the fair, fast, and cost-effective resolution of claims payment disputes; and (5) are designed to meet the individual needs and circumstances of each specialty and practice venue

RESOLVED: That CMA continue to work with specialty societies to ensure that the house of medicine has a unified front in developing and supporting appropriate solutions to the fair payment/balance billing issue

HOD 408-07

RESOLVED: That CMA ask the AMA to devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to end the budget neutral restrictions of the current Medicare physician payment structure that interferes with patient access to care.

RESOLVED: That this national legislation be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

RESOLVED: That CMA work on state legislation that would prohibit any law or regulation from interfering with the patient-doctor relationship including any and all fiduciary relationships that are deliberate and contractual.

RESOLVED: That CMA develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician’s right to balance bill any insured patient.

IX. ANTI-TRUST REFORM

There are no provisions providing physicians with anti-trust relief.

CMA has strong policy supporting anti-trust relief for physicians. AMA and CMA have asked that Anti-trust reforms be considered an essential element of health system reform. Moreover, AMA and CMA have asked for it within the Medicare framework for the Accountable Care Organizations (ACOs). For a group of physicians to reengineer their practices to form ACOs to improve care coordination, they cannot be organized under two separate models – one for Medicare and one for private insurance. Allowing greater clinical integration of physicians would enable care coordination and quality improvements for patients that are sought in HR 3200. Physicians must be allowed to jointly contract and negotiate with both Medicare and private payers.

CMA BOT April 2009 Medicare TAC Report:

REC 6: That CMA advocate for physicians who are clinically and financially integrated through the HIT requirements of H.R. 2 (2009) or the requirements of the Physician-Directed Organization Payment Track to be granted anti-trust relief to collectively negotiate contract terms with the private health plans.

CMA HOD 501a-07

PHYSICIAN COLLECTIVE BARGAINING

RESOLVED: The CMA reaffirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform to state and federal law, including federal antitrust law, to enable physicians to negotiate more effectively with health insurers.