

NEWS BREAK

December 23, 2009

Health Reform Update from CMA

Following is an update on changes to the Senate health care reform bill and an overview of the final House-Senate Conference Committee process. CMA is in close communication with our Democratic House leaders -- all of whom will be on the Conference Committee - Speaker Pelosi, Chairmen Waxman, Stark and Miller. Our priorities for the final health reform bill will be a meaningful expansion of health insurance coverage and access to physicians for the 6 million uninsured in California, financial assistance to help low-income families afford health care, private insurance industry reforms, a repeal of the Medicare SGR and a more stable reimbursement system going forward, a Medicaid rate increase to ensure that the newly insured will have access to a physician, the California GPCI fix, improvements to the independent Medicare Commission and protections for the quality reporting programs to ensure the data is valid and accurate.

SENATE "MANAGERS" AMENDMENTS:

A package of "managers" amendments to the Senate health reform bill, HR 3590, were adopted on Monday, December 21, 2009.

There were some important improvements to the Senate bill for physicians including:

- The 10% increase for primary care and general surgery will not be paid for by cutting payment rates for specialists. Therefore, the specialist rate reduction of 0.5% has been eliminated.
- The 5% tax on cosmetic surgery and medical procedures has been eliminated. Organized medicine was extremely concerned about this tax and the precedent it set to tax medical procedures to fund an expansion of health care services.
- The Medicare physician enrollment fee of \$350 has been eliminated. Organized medicine was extremely concerned about this fee and the precedent it set to tax physicians to pay for regulatory activities.
- The public plan option has been eliminated.
- The Comparative Effectiveness Research provision has been further clarified to ensure that the sole research focus is on clinical information and use by physicians, not coverage and payment.
- CMA medical liability protections to ensure that physicians are not exposed to new liability as a result of the quality or payment provisions in the bill.

There are several issues on which organized medicine will continue to work on in the final conference committee agreement where we were not able to make significant changes:

- **Medicare Payment Advisory Board**
The main structure of the Board remains. Organized medicine will continue to work to eliminate or seriously improve this commission. Moreover, the House health reform legislation does not include a Board and the House leaders are opposed to its enactment.
- **Senator Cantwell Value Modifier**
While the CMA amendments ensuring that geographic practice costs and socioeconomic factors (including health status) were accepted, there is more work to do in conference committee to establish protections on the methodology for quality reporting consistent with CMA policy on the CPPI-PBGH quality reporting project. Those protections address how patient care is attributed to physicians, whether there is statistically valid data, due process for physicians to receive the data and have it corrected if found to be inaccurate.
The House bill does not establish a quality/cost modifier on which to base payment but it does call for a study on the geographic variation in care.
- **Public Physician Performance Report Cards**
AMA, CMA and all of organized medicine are extremely concerned with this new provision which is being pushed aggressively by the employers and patient groups. Organized medicine is working to ensure that inaccurate information is not made public. The House bill does not include public reporting.
- **Medicare SGR Repeal**
The Senate bill fails to repeal the SGR. However, last weekend, the House, Senate and White House leaders reiterated their commitment to passing a permanent repeal of the SGR. Senator Reid and the Senate Democratic leaders announced during their press conference and on the Senate floor their commitment to resolve the issue with health care reform. The House has already repealed the SGR.
- **Medicaid Rate Increase**
The Senate bill fails to address the woefully inadequate Medicaid rates in many states. The House bill increases all E&M services in Medicaid to Medicare levels - 100% financed by the federal government. CMA remains committed to ensuring this provision is retained in the conference agreement.
- **California Medicare Physician Payment Locality Update (GPCI fix)**
The Senate bill fails to update the physician payment locality borders. The House bill provides \$300 million to California to update payments in 14 California counties while holding the rural counties harmless from cuts. CMA will fight to have the House GPCI fix included in the final conference agreement.

SENATE HR 3590: IMPORTANT COVERAGE EXPANSIONS AND INSURANCE INDUSTRY REFORMS

And most significant, the House and Senate bills both provide coverage to at least 94% of the uninsured. Moreover, the bills provide assistance to help make health insurance affordable for low-income families through tax credits and subsidies. In California, 2/3 of the uninsured are very low-income families. And finally, the bills include historic reforms on the for-profit insurance industry, including requirements to direct 85% of revenues on direct patient care and prohibitions on pre-existing conditions, recession, and premium differentials based on health status. These have been goals of the California Medical Association for two decades.

HOUSE-SENATE CONFERENCE COMMITTEE

The Senate is expected to pass HR 3590 on Christmas Eve. The House-Senate Conference Committee will convene in January. Medicine has made significant progress on the bills within the political and financial framework that we are working in Congress. We will continue to fight for our unfinished priorities in the final conference agreement, including a repeal of the Medicare SGR, a Medicaid rate increase, a California GPCI fix, and improvements to the Independent Medicare Commission and the quality reporting programs.

CMS to Hold Claims for 10 Days & Extends Participation Deadline

This past week Congress acted to avert the 21.2% Medicare physician payment cut and on December 19th, the President signed into law the Department of Defense Appropriations Bill (H.R. 3326) which will stop the cuts until March 1, 2010. Other changes reflected in the 2010 Medicare Physician Fee Schedule final rule will still take effect on January 1, 2010 and may have a slight impact on the conversion factor used for the first two months of 2010. Similar to other years, since Congress acted so late in the year to avert the cut, **the Center for Medicare and Medicaid Services (CMS) will hold claims for the first 10 business days of January (January 1 through January 15) for 2010 dates of service to allow its contractors time to update their systems and pay claims based on the updated rates.** CMS does not anticipate any cash flow problems for physicians since by law no claims are paid prior to 14 days after receipt anyway.

In addition, CMS has extended the 2010 Annual Participation Enrollment Program end date from January 31, 2010, to March 17, 2010. Physicians still have time to consider their participation options with the Medicare program. The effective date for any participation status change during this extension remains January 1, 2010, and will be in force for the entire year. Medicare contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are received or post-marked on or before March 17, 2010.

CMS announced the claims processing delay and extended participation enrollment period December 21st. Communication that was developed prior to the Congressional action therefore inaccurately suggests that payments may still be cut on January 21st. The AMA is concerned that the announcement will prove confusing to physicians and has asked CMS to update and clarify the notice.

Consultation Code Changes

The Centers for Medicare and Medicaid Services is expected to make a final decision within the next two days on whether to delay the implementation of the consultation code changes. CMA will notify physicians immediately once they get the final decision from CMS. CMA is aggressively advocating to stop the elimination of the consultation codes. If the codes are eliminated, CMA has prepared a crosswalk to the new codes for physicians to use and analyze the impact on their practice.

TODAY, from 12:30pm to 1:30pm CMA is hosting a webinar entitled "*Consultation Code Crosswalk: How to Bill Medicare in 2010.*" You should have received an e-mail reminder (if we have an e-mail address on file for you) for the webinar from MMCMS yesterday. If you miss the webinar, CMA is recording it and posting it on their website for subsequent viewing. For more information, please call MMCMS at 209-723-2976.

Also, CMS has released Transmittal #6740, a 29 page document which provides greater detail on the new policy prohibiting billing for CPT consultation codes and describes how consults should be billed to Medicare. To obtain the document, visit the CMS website or contact MMCMS at 209-723-2976 or chrisym@pacbell.net.

Significant New Laws of Interest to CA Physicians for 2010

Despite numerous vetoes from the governor, 2009 produced significant, if incremental, changes to laws affecting the practice of medicine in California. With the health system reform debate now centered in Congress, state policy makers directed much of their attention to discrete issues impacting patient access to health care, the role of allied health professionals, medical records and privacy, physician licensing and discipline, patient safety and professional liability.

Below is a summary of some of the most significant new statutes enacted in California, along with references to the most relevant ON-CALL document that discusses the topic more fully. For a more detailed summary of the new laws discussed below and for a summary of other new laws impacting the practice of medicine, see <http://www.cmanet.org/newlaws>.

ACCESS TO HEALTH CARE

Coverage for Off-Label Medications

The law requiring health plans and insurers to cover "off-label" medications was expanded to require coverage where the drug has been recognized for treatment of the condition by one of the listed compendia, if recognized by the Federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen. For more information, see CMA ON-CALL #0507, "Drug Formularies, Prescription Drug Benefit Plans, and Pharmacy Benefit Managers," and #1071, "Coverage Requirements/Pre-Existing Condition Exclusions." (AB 830)

Rescission of Individual Health Coverage Policies or Plans

This new law prohibits a health care service plan or health insurer from rescinding an individual health care service plan contract or individual health insurance policy for any reason, or from canceling, limiting, or raising the premiums of the plan contract or policy due to any omission, misrepresentation, or inaccuracy in the application form, after 24 months following the issuance of the plan contract or policy. For more information, see CMA ON-CALL #1025, "Denials of Necessary Medical Services," and #0145, "Payment Denial After Treatment Authorization or Verification of Eligibility." (AB 108)

Medi-Cal Coverage

The new law imposes various obligations on hospitals, physicians and other providers with respect to verifying a patient's Medi-Cal eligibility, billing Medi-Cal beneficiaries, and the reporting of Medi-Cal beneficiaries to consumer credit reporting agencies. (AB 1142)

Authorization for Treatment

A new law that applies to the Worker's Compensation system provides that, regardless whether an employer has established a medical provider network or entered into a contract with a health care organization, an employer that authorizes medical treatment shall not rescind or modify the authorization, for any reason, after that treatment has been provided. For more information, see CMA ON-CALL #1929, "Treating Physicians: Payment for Treatment (OMFS)." (AB 361)

PHYSICIAN LICENSING, DISCIPLINE AND OVERSIGHT

Disclosure to Medical Board

A new law requires osteopathic physicians (like those licensed by the Medical Board) to report to the Osteopathic Medical Board of California ("Board") at the time of initial licensure any specialty board certification and their practice status. The new law also allows the Board to collect information regarding osteopathic physicians' backgrounds and foreign language proficiencies. For more information, see CMA ON-CALL #0220, "Disclosure Requirements - State and Federal." (SB 620)

Medical Board Enforcement

Clarifying that licensing boards for non-physicians have no jurisdiction to investigate or discipline physicians. For more information, see CMA ON-CALL #1605, "Medical Assistants," and #0708, "MBC Enforcement Authority." (AB 1535)

Medical Board - Medical Records Requests

Existing law establishes a licensee's obligations to comply with requests or subpoenas for medical records from the Medical Board. That law was amended to apply to "certified medical records," which are defined as a copy of the patient's medical records authenticated by the licensee or health care facility. The amended law also allows for penalties of up to \$10,000 for failure to comply with a request for a patient's certified medical records, when accompanied by that patient's written authorization for release of records to the board, or for failure to comply with a court order mandating the release of records to the Board. For more information, see CMA ON-CALL #1420 "Administrator and Board Access to Peer Review Files." (AB 1070)

ALLIED HEALTH PROFESSIONALS

Nurse Practitioners

The Legislature clarified the scope of practice of a nurse practitioner (NP) to provide that standardized procedures may also be implemented that authorize a nurse practitioner to (1) order durable medical equipment, as specified; (2) certify disability after performance of a physical examination by the NP and in collaboration with a physician; and (3) approve, sign, or otherwise modify a plan treatment for individuals receiving home health services or personal care services, after consultation with the treating physician. For more information, see CMA ON-CALL #1615, "Nurses." (SB 819)

Physician Assistants

The law provides under which conditions a physician may delegate to a licensed physician assistant (PA) procedures using fluoroscopy and specifies the requirements a physician must meet to supervise a PA in performing the functions authorized by the Radiologic Technology Act. For more information on physician assistants, see CMA ON-CALL #1620, "Physician Assistants." For more information on x-rays, see CMA ON-CALL #1335, "Mammography Facilities and X-rays." (AB 356)

PROFESSIONAL LIABILITY

Elective Cosmetic Surgery

A physician may not perform elective cosmetic surgery procedure on a patient unless the patient has received, within 30 days prior to the procedure, and confirmed as up-to-date on the day of the procedure, a physical examination by, and written clearance for the procedure from, any of the practitioners listed in the statute. For more information, see CMA ON-CALL #0790, "Grounds for Medical Board Discipline," and #0202, "Surgicenters and Other Outpatient Facilities." (AB 1116)

Immunities for Psychiatric Release

The new law extends physician's immunity from civil and criminal liability to cover the detention of any person who meets specified criteria, whether or not they qualify for a 72 hour evaluation, and for the actions after release of a person who was detained up to 24 hours and who meets specified criteria. For more information, see "Mental Health: §5150 Holds/72-Hour Detention." (SB 743)

PATIENT SAFETY

Hospital Security Plans

The 2009 amendments to existing law require, after July 1, 2010, that hospitals conduct a security and safety assessment annually and that the security plan be updated annually based on the assessment. In developing this plan, the hospital must consult with members of the medical staff, as specified. (AB 1083)

MEDICAL RECORDS

Management of Medical Records

The law was clarified to require licensed clinics, among other licensed institutions (and now also home health agencies) to report instances of unlawful or unauthorized access to a patient's medical information to the Department of Public Health and to the affected patient within 5 business days of detecting it. For more information, see CMA ON-CALL #1144, "Security Breach of Health Information." (SB 337)

CMA ON-CALL is the most comprehensive health law and medical practice resource for California physicians. It is an online library that includes most of the Center for Legal Affairs' California Physician Legal Handbook (CPLH), as well as more specialized information on peer review and other topics, including information from the CMA's Center for Medical Policy and Economics. These documents are available free to members at the members-only website, www.cmanet.org/member, by calling the CMA member help center at 800.786.4262 or by contacting MMCMS at 209-723-2976 or chrisym@pacbell.net. Nonmembers can purchase CMA ON-CALL documents for \$2 per page in the CMA Bookstore, www.cmanet.org/bookstore.

Happy Holidays!!!

