Payor Issues

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At the last CMA Board of Trustees meeting at the end of April, the board members reviewed more than 700 pages of material and so the overall pace of the meeting was quite rapid. However, a couple of the items around payor issues received more intensive examination and discussion. One of these was the Governor's proposed budget and his attempt to use the Tobacco Tax Initiative monies to backfill cuts to the state's general fund contributions instead of increasing Medi-Cal reimbursement rates. With extensive lobbying from CMA including a focus on this issue at its Legislative Day, the legislature rejected the Governor's proposal, and now a substantial amount of that money is earmarked to increase access to care by increasing provider payments.

The other payor issue that received extensive attention was last year's bill on surprise billing (AB 72), which will become active in July of 2017. The problem being addressed involved billing to a patient who goes to their in-network facility but ends up getting care from an out-of-network provider without prior consent and then gets billed for those services. Two years ago AB 533 which was on this same issue was defeated, but the issue remained urgent in the eyes of the legislature who pushed CMA to work for a solution to this problem. CMA initially opposed AB 72 stating that it would interfere with physicians' ability to negotiate fair rates with health insurance plans, as a statutory default rate would incentivize the plans to drive down contracting rates and make them less willing to sign fair contracts, and this would in turn lead to increasingly narrow networks. After extensive amendments to the bill were adopted that made it much less onerous, CMA withdrew their opposition although many physicians remained opposed to the bill. The current law states the payor has to pay either their average contracted rate or 125% of the MediCare rate, whichever is higher, and that either party can engage in an independent dispute resolution process (IDRP). CMA is working on many aspects of this legislation including making sure that the average contracted rate is based on weighted averages of payments, pushing that the MediCare rate used be the noncontracted rate (which is 9.2% higher), and that network adequacy must be insured – so that plans have to continue to contract with physicians. They are working to get "baseball arbitration" for the independent reviews (where the reviewer is just given two numbers and has to pick one; this has been shown to favor the doctors in other states like New York). CMA has been going on Listening Tours and developing a Grassroots Campaign – again with the initial goals to make sure that the Average Contracted Rate is not "gamed" by the insurance companies and that they maintain network adequacy. They are listening and responding to physician concerns, but also hearing from a few physicians that the bill will have a positive impact on them. They have developed a webinar and will have an online research tool where members can submit their stories. They have a dedicated team for this issue that involves staff from multiple areas of CMA and have budgeted for a new staff person to be dedicated to it. They plan to assist members in filing for greater reimbursement through the regulators' mandatory IDRP, as well as develop a template for physicians to use to opt out. AB 72 also was discussed in the context of the year around

resolution 206-17, which asked CMA to be involved in a lawsuit against AB 72. Although CMA did not believe the lawsuit against AB 72 will be successful, an amended version of resolution 206-17 was passed that noted that CMA plans to "aggressively advocate for physicians affected by the law – using all appropriate regulatory, legislative, public relations and legal resources including unfair contracting and inadequate networks, and will develop resources for physicians to challenge any unfair practices that may result from the law, and will report to the board quarterly".

Another payor issue that CMA has on the top of their priority list is looking at retroactive Medi-Cal recoupments. Currently there is no limit of how far back the Department of Health Care Services can go to recoup funds it feels were overpaid. CMA will be pushing to limit Medi-Cal recoupments to 365-days from the date of payment. Finally, CMA will be looking at Quality Rating Programs through its newly formed CMA Quality TAC. A recent study shows that physicians and their staff can spend more than 15 hours per week dealing with quality measures that come from different payors. CMA has existing policy that payors should just have one set of quality reporting requirements and CMA will be looking to support any legislation that arises in this regard.

CMA is involved in advancing medicine in California in many different areas. It has been a privilege to serve on the Board and learn more about all their efforts. Although I can't possibly cover all the actions and activities that pass through the Board each quarter, I will continue to focus on separate areas and update you on items of interest and look forward to communicating again after its upcoming July Board meeting.