

Statement by the

**Medical Group Management
Association**

to the

Small Business Committee
United States House of Representatives

**RE: Medicare Physician Fee Cuts: Can
Small Practices Survive**

Presented by: Mona Reimers, CMPE, CPC

May 8, 2008

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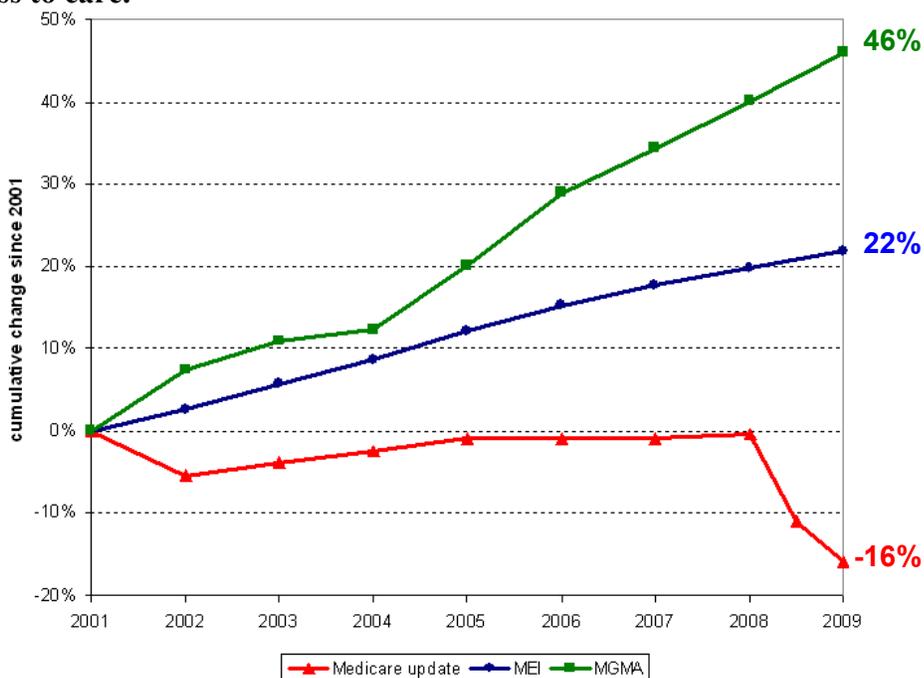
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The Medical Group Management Association (MGMA) applauds the Small Business Committee for examining the operational impact of Medicare programs on medical group practices. MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA's more than 21,500 members manage and lead 13,500 organizations, in which more than 270,000 physicians practice. MGMA's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them.

Flawed sustainable growth rate formula

Medicare payments have continually failed to keep pace with both the Medicare Economic Index (MEI) and MGMA's annual survey of practice expense costs. **MGMA urges Congress to provide physicians with an 18-month positive payment update that reflects ever-increasing practice costs and stabilize an extremely uncertain financial environment that threatens Medicare beneficiaries' access to care.**



- Medicare Economic Index is the measure of inflation used by CMS to calculate practice costs and general wage levels.
- MGMA's survey data of total operating costs per FTE physician.

Congress averted the 10.1 percent reduction in Medicare payments that physicians were scheduled to receive on Jan. 1. This stop-gap measure allowed medical groups to continue providing quality

treatment to Medicare beneficiaries. However, by only approving a short-term, six-month delay, Congress has heightened the uncertainty that physicians and Medicare patients now face.

MGMA surveyed over 1,100 medical groups nationwide in which 28,679 physicians practice. The research indicates that group practices have already taken significant steps in reaction to the tenuous reimbursement environment and the continued failure of Medicare physician payments to accurately cover the costs of delivering care. Nearly 24 percent of respondents indicated they had already begun limiting or not accepting new Medicare patients. Also, in light of the anticipated 10.6 percent cut scheduled to go into effect in July 2008, nearly half - 46 percent - of respondents said that failure to halt this cut would cause them to stop accepting and/or limit the number of Medicare beneficiaries their practices treat.

MGMA members reported they are considering changes to their practice operations as a result of the physician payment instability. More than half of responding practices are considering reducing administrative and clinical staff, with the majority reporting they would limit hiring decisions for those positions. More than two-thirds of the respondents described how they are sacrificing or postponing indefinitely their information technology and clinical equipment investments resulting from the six-month payment adjustment.

Operational burdens caused by the Medicare Advantage program

While averting the scheduled Medicare payment cut remains our primary interest, an equally important and rapidly growing concern is the administrative burdens associated with Medicare Advantage plans. As beneficiary enrollment in Medicare Advantage plans steadily increases, statutory loopholes, coupled with a lack of oversight by the Centers for Medicare & Medicaid Services (CMS), are creating serious problems for Medicare Advantage patients and the medical practices that care for them.

Recent efforts by CMS suggesting voluntary guidance have been insufficient, and as a result, MGMA believes Congress should take a strong leadership role in fixing the program. Congressional action on the following recommendations is imperative to allow medical group practices to continue to provide efficient, high-quality care to Medicare Advantage patients.

Standardization of Medicare Advantage patient identification cards

Variations in the Medicare Advantage program subject medical practices to an excessive administrative burden in identifying Medicare Advantage plan patients. This impairs efficient care and adds to the cost of treating Medicare beneficiaries. In recent research:

- More than 50 percent MGMA members expressed concern regarding their inability to identify Medicare Advantage patients;
- 90 percent of respondents indicated that patient insurance cards did not provide clear identification of insurance coverage;
- MGMA members overwhelmingly believe that a majority of Medicare Advantage patients do not understand their coverage; and
- 89 percent of respondents believe that Medicare Advantage enrollees do not understand that they are no longer traditional Medicare patients.

The last two factors contribute to widespread patient confusion.

Standardized patient identification cards for Medicare Advantage enrollees would allow physicians to more easily identify the specific type of beneficiary health coverage (such as traditional Medicare, Medicare Advantage health maintenance organizations, Medicare Advantage private fee-for-service plans). Identification card standardization already exists for traditional Medicare patients and should be extended to Medicare Advantage. By standardizing Medicare Advantage patient identification cards, physicians can correctly deliver the appropriate medical services to which patients are entitled, and patients can better understand their Medicare Advantage plan and its benefits.

Therefore, MGMA recommends that all Medicare Advantage products be mandated to adhere to a national standard for patient identification cards. The card should bear a CMS-approved Medicare Advantage logo, the Medicare Rx logo (if Part D coverage applies) and clearly state the Medicare Advantage plan sponsor, type of Medicare Advantage product, co-insurance amounts (if any) and claim submission address and phone number. Additionally, the card should prominently state “Providers: Do not bill Medicare. Submit claims directly to [name of plan].” **MGMA encourages Congress to use the Workgroup for Electronic Data Interchange (WEDI) endorsed American National Standard (INCITS 284:1997) for all Medicare patient identification cards.**

Elimination of the Medicare Advantage “deeming provision”

MGMA members also report widespread concerns associated with Medicare Advantage private fee-for-service plans. Physicians seeing Medicare Advantage private fee-for-service patients are treated as if they have a contract with the sponsoring plan. However, physicians lack the ability to review and negotiate the terms of such a contract. These plans are not required to have a provider network, but may “deem” physicians to accept the plans’ terms and conditions and be part of a network by virtue of treating the plans’ patients.

While the Medicare regulations stipulate that physicians are only deemed if they knew or were “given a reasonable opportunity to obtain information” that they are treating Medicare Advantage private fee-for service patients, plans do not pro-actively ask physicians whether they knew that certain patients were indeed enrolled in a private fee-for-service plan. The regulations state that a physician is deemed if the provider knew or should have known that an individual was enrolled in the plan and understood the terms and conditions of payment. The regulations state that this information must be provided in a manner that is designed to “effect informed agreement,” such as a patient identification card. Sixty-five percent of respondents to our research noted that they have been classified as “deemed” physicians by one or more Medicare Advantage plans. This requirement underscores the importance of the standardized Medicare Advantage patient identification card.

No other insurance product enables plans to create networks without contracts with physicians. Medicare Advantage plans should be held to the same contracting standards as the rest of the industry. The deeming provision section of the Medicare regulation is found at 42 CFR 422.216(f). **MGMA recommends that the deeming provision be eliminated in its entirety.**

Fair contracting for Medicare Advantage providers

Several private insurance companies include provisions in their provider contracts that require providers to accept all of the plan-sponsored products. Thus, a medical practice may be forced to participate in a Medicare Advantage plan by virtue of an unrelated contract signed previously by the practice. “All-products” clauses in provider-private payer contracts result in a practice being

classified as a network participant with a Medicare Advantage sponsor - without the practice's affirmative acceptance of a Medicare Advantage plan. The elimination of the all-products clauses in Medicare Advantage plans would increase transparency of the Medicare Advantage program and improve patient and physician relations.

Many fair-contracting practices have already been agreed to by several Medicare Advantage plan sponsors in relation to their commercial products in the Multi-District Litigation settlements and mandated by several states. All-products clauses typically require a provider to submit to the same terms that would have applied had he or she originally signed a separate contract to provide services for a specific insurance plan. According to MGMA members who participated in our Medicare Advantage research, 41 percent were considered part of Medicare Advantage networks through all-products clauses. Thus, all-products clauses are a significant component of Medicare Advantage provider network creation.

Several named payers in the Multi-District Litigation settlements are restricted from requiring physicians to participate in products without affirmative agreement for each product. Notably, Aetna, CIGNA, Anthem/Wellpoint and HealthNet are required to exclude all-products clauses from their contracts. Several states have passed similar prohibitions, including Alaska, District of Columbia, Colorado, Kentucky, Maryland, Minnesota, Nevada and Virginia.

MGMA recommends that Congress prohibit the establishment of Medicare Advantage networks through private-contract, all-products clauses and require affirmative acceptance of plan sponsor and products for Medicare Advantage networks.

Medicare Advantage prompt payment of providers

The Medicare statute requires Part B contractors to issue payment for 95 percent of all clean claims within 30 days after the date on which claims are received. Plans participating in Medicare Advantage should at a minimum be required to comply with CMS' payment policies regarding timely payments made to physicians. Medicare regulations, found at 42 USC 1395u(c), already require prompt payment for non-network physicians seeing Medicare Advantage private fee-for-service patients, but these logical provisions are not extended to network providers.

For example, under current law, a Medicare Advantage health maintenance organization only has to specify a prompt-pay clause, but without any minimum requirement.

MGMA therefore recommends that Congress apply the Medicare Part B timely processing requirement for all claims submitted by providers to Medicare Advantage plans as part of the plans' contracting requirements to the Medicare program.

Thank you for providing MGMA the opportunity to inform the Small Business Committee of these issues. We appreciate your attention to fixing the Medicare physician payment formula and reforming operational aspects associated with the Medicare Advantage program. Our goal is to ensure patient access to high quality medical care. If you should have any questions, please contact Robert Bennett in the Government Affairs Department at rbennett@mgma.com or 202.293.3450 ext. 1378.