California Medical Association
Physicians dedicated to the health of Californians

December 11, 2009

The Honorable Dianne Feinstein
United States Senate
331 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Feinstein:

On behalf of the California Medical Association, I want to thank you for your commitment to health care reform and expanding health insurance coverage to the millions of uninsured families in California. We are grateful for the support you have given CMA physicians and their patients. The California Medical Association remains committed to enacting meaningful health care reform that achieves universal access to care. We seek legislation that builds on what works and fixes what is broken in our health care system.

Unfortunately, HR 3590 includes many challenges for California physicians and patients that have forced us to adopt an oppose position on the bill. As physicians, we believe it is our duty to speak out on the provisions that create obstacles for patients seeking care when they become ill. Despite the fact that California physicians provide some of the best, most innovative care in the world, recent reports show that a significant number of Americans die each year because they don't have health insurance and access to a doctor. Thus, the CMA remains committed to working constructively with you to improve access to care in the Senate bill so that it solves these real problems.

Health Reform Built on the Foundations of Medicare and Medicaid

One of our greatest concerns is that the Senate builds health reform on the foundation of Medicare and Medicaid where access to physicians is already difficult. We urge you to fulfill the promise of universal coverage by ensuring that everyone also has a doctor.

Medicaid: HR 3590 would add 1.6-2 million uninsured to the state's Medi-Cal program. Half of the current Medi-Cal patients already experience difficulty finding a doctor because the reimbursement rates are 50% below Medicare rates and among the lowest in the country. Medi-Cal reimbursement rates for an office visit only cover half of a physician's costs to provide that care. Unfortunately, physicians cannot afford to take larger numbers of Medi-Cal patients and keep their doors open. Private physicians have provided 89% of the safety net primary care visits in this country (*JAMA, 2000)*.

The Kellogg Foundation recently concluded that ***"Private physicians may well be the invisible giant of the nation's health care safety net. Although the data are limited, the data that does exist suggests that while community health centers, public hospitals, health department clinics and other publicly funded safety-net organizations each play an important role, most of the health care received by the poor and uninsured is provided in doctor's offices."***

The two million newly-insured Medi-Cal patients will seek care from these already burdened invisible safety net physicians right in their communities. Yet these safety net physicians cannot absorb two million more patients. Therefore, we caution against empty promises of insurance coverage when current Medi-Cal patients don't even have a doctor to care for them. Adding more people to the program without increasing physician reimbursements will further choke California's ERs. Our ERs will be overwhelmed as the medical home for the newly insured. One-third of California's ER visits are already from Medi-Cal patients -- twice the rate of average Californians. It will prove to be a very inefficient, costly way of providing medical care. And it will increase the waiting times for all Californians who need emergency care.

Medicare: Moreover, without a repeal of the Medicare SGR physician payment formula, physicians face 40% cuts in the Medicare program over the next several years as the baby boomers come of age with multiple chronic conditions that take more time to treat. Seniors in many California communities report that physicians are not accepting new Medicare patients. The Senate bill fails to provide a long-term fix to this problem.

Physicians want to care for California's seniors and the newly insured Medi-Cal patients. But we will need serious Medicare and Medi-Cal reforms to remain in practice. The physician infrastructure has been neglected and we need to retrofit it for the coming demand. The number of California patients over the age of 65 are expected to increase by 37% over the next several years. The growth in physician demand is expected to outpace the growth in physician supply by 20% according to the University of California. Half of California's physicians are over the age of 50.

These are significant problems that disproportionately impact California and we need to constructively work together to address them.

California Medical Association's Guiding Principles for Health Care Reform

The California Medical Association is guided by a set of health care reform principles that were established by our House of Delegates and are set forth below. Our ultimate goal is to work with you to craft a House-Senate Conference agreement that meets these guiding principles.

-Provides universal access to physicians
-Ensures that insurance is affordable for low-income families
-Protects the sanctity of the physician-patient relationship
-Reforms the health insurance industry to increase competition and choice for patients
-Provides sufficient resources to deliver on the promise of improved access to health care

The Senate health care reform legislation, HR 3590, "Patient Protection and Affordable Care Act," includes many provisions that we are pleased to support, including

-Expanded Health Care Coverage for 94% of the uninsured
-Assistance for low-income families to afford coverage

-100% federal financing of the Medicaid expansion in the initial years
-Insurance industry reforms that protect patients
- A requirement that insurers dedicate 80% of revenues to direct patient care
-A Health Insurance Exchange that offers competition and a choice of doctors and plans
-Investments to improve access to primary care physicians
-Resources for surgeons practicing in rural areas
-Incentives for physicians who collaborate and coordinate quality care
-Emphasis on prevention and wellness programs

Unfortunately, HR 3590 also has many shortcomings. The following issues are of greatest concern to the CMA. HR 3590:

- Fails to repeal the Medicare physician SGR payment formula which projects 40% cuts over the next several years causing seniors to experience difficulty finding a doctor.
- Fails to establish a stable Medicare program in the future.
- Reduces payments to specialist physicians already in short supply, such as general surgeons.
- Fails to address serious shortfalls in Medicaid funding yet adds nearly 2 million Californians to the Medi-Cal program. It will completely overwhelm the invisible safety net of solo and small group private physicians.
- Fails to allow Medicare patients to privately contract with physicians of their choice.
- Establishes the Independent Medicare Advisory Board which is not accountable to physicians and patients and removes Congress' responsibility for the program. Rather than mandating reforms, the Board is required make arbitrary provider cuts that could reduce treatment options for patients.
- Establishes programs that are unproven, such as the Value Modifier, which could harm communities with large numbers of poor, minority patients already suffering from health care disparities.
- Implements individual physician reporting programs (PQRI, Value Modifier, Feedback) that have been fraught with problems in California's demonstration projects.
- Institutes quality reporting but does not assure the accuracy of the information which misleads patients and hinders physicians' ability to improve.
- In three years, would remove Medicare resources for office rents and nursing wages – costs beyond a physician's control - from California's higher practice cost areas.
- As recommended by GAO, MedPAC, Urban Institute and Acumen for CMS, it fails to update California's Medicare locality borders that would vastly improve access to doctors in California's newly urbanized communities.
- Fails to provide anti-trust relief for physicians to negotiate on a level-playing field with the powerful insurance industry to improve patient care.
- Many programs have the potential to interfere with existing physician-patient relationships and the provision of care.

Base Health Care Reform on Proven Successful Models of Care

Instead, we urge you to set a path to health care delivery system reform that is based on proven, successful models from around the country that work for patients and physicians in all modes of practice. We also urge you to test new health care models through demonstration projects before widespread implementation.

Medical Liability Protections

Regarding medical liability, we urge you to add a standard of care amendment that would protect physicians from potential liability unintentionally created in this bill related to clinical guidelines and new payment methodologies. This amendment would be consistent with the provisions in the House health reform legislation. As you know, the CMA supports ways to improve patient care through clinical research and appropriate physician payment reform. We believe these reforms will help to improve access to quality care. However, we are concerned that some of the proposed programs that influence clinical decision-making, establish value-based purchasing or provide other financial incentives could unintentionally increase the liability exposure of physicians and further escalate health care spending growth.

The clinical best practices established in the bill should be medical guidelines, not legal mandates. CMA strongly encourages the practice of evidence-based medicine. However, physicians must sometimes make decisions that deviate from guidelines based on the clinical indications for individual patients. In doing so, physicians are at increased risk of lawsuits when they deviate from federal guidelines even if based on individual patient needs. We believe that physicians must be free to make decisions that, in their clinical judgment, are in the best interest of their patients.

And finally, we urge you to continue to protect California's MICRA law which has been the most successful medical liability law in the country in keeping physician liability costs down while ensuring fair compensation for injured patients and protecting access to care.

Excise Tax on Health Plans

The CMA is concerned that the revenue provision that disproportionately taxes fully-insured health plans will place an inequitable financial burden on California employer's and individuals who are covered through fully-insured health plans. The tax, as currently constructed, would have an unfair impact on purchasers of fully-insured plans compared to self-insured plans. Only 22% of California's covered lives are in self-insured plans compared to 52% nationwide. 78% of California's covered lives are in fully insured plans compared to 48% nationwide. Therefore, California small businesses and individuals who are generally enrolled in fully-insured plans will be paying higher premiums and subsidizing others who are in self-insured arrangements. This needs to be changed so that Californians – individuals, small businesses and large employers who currently purchase coverage from fully-insured plans - do not bear a significantly disproportionate share of the $6.7 billion tax. The tax should be equitably applied to all insurers.

Tax on Cosmetic Surgical and Medical Procedures
HR 3590 imposes a 5% tax on elective cosmetic surgical and medical procedures performed by a licensed medical professional to be collected at the point of service. The CMA strongly opposes taxes on physician services to fund health care programs. We believe that additional revenues generated to help finance health system reform should come from broad-based taxes.

CMA Concurs with Detailed AMA Comments
In addition, the CMA concurs with the detailed comments submitted by the AMA to Senator Harry Reid on HR 3590. They are also attached here.

Also attached are more detailed CMA comments on the Medicare SGR, the Independent Medicare Advisory Board, individual physician quality reporting programs, geographic payment adjustments, enrollment fees, physician-owned hospitals and the allied practitioner non-discrimination clause.

Summary
We recognize that the Senate health care reform legislation presents many important opportunities to provide access to life-saving care for patients in need. It provides security to families losing their jobs in these difficult economic times. And it reins-in a for-profit insurance industry that has diverted billions of health care premiums away from patient care. Along with these significant reforms, is the opportunity to improve existing health care programs so that they better serve patients. We hope the Senate will focus on both.

We urge you to advocate for a final conference agreement that will help Californians. A conference report that is based on California systems that have managed patient care and costs in a compassionate and efficient manner. Physicians in California provide some of the best, most innovative, quality, efficient care in the world. We hope to continue these trends for generations to come.

We hope our comments are constructive in helping you improve the bill.

Sincerely,

J. Brennan Cassidy, MD
President

Additional CMA Comments on HR 3590
"Patient Protection and Affordable Care Act"

A. Independent Medicare Advisory Board
CMA Position: Oppose

The CMA is opposed to the creation of yet another Independent Medicare Advisory Board charged with making recommendations on health care delivery reform, quality measurements and payments. We believe that Congress was elected to act as stewards of the Medicare program and to protect the ability of our country's seniors to get access to care. Therefore, Congress should make decisions about the program directly and be fully accountable to the taxpayers and to the physicians and patients who participate in the program. We fear that this proposal would allow Congress to abdicate its responsibility to protect access to care. Moreover, we believe in the Congressional process of public hearings where all those impacted by the program can exchange ideas and information.

Further, it is essential for Congress to begin to change the incentives in our health care delivery system. However, the main charge of this Commission would be to implement cuts if Medicare provider spending exceeds general health care spending. Imposing arbitrary across–the-board provider payment cuts would not achieve the cost-savings Congress seeks. Automatic budget triggers have historically been unsuccessful in slowing health care spending. The Volume Performance Standard (VPS) and the SGR are the most recent examples. In fact, they have led to increased costs. We believe thoughtful health care delivery system reform that focuses on individual physicians and physician groups is the solution.

Finally, physicians are already subject to an automatic budget cut under the SGR payment formula that reduces physician payments when spending exceeds a certain level. This plan would subject physicians to two sets of cuts. Moreover, the proposal does not take into account other factors that increase Medicare spending, including changes in coverage, benefits, new technology and medical procedures, or the growth in the number of Medicare beneficiaries. The IMAB is unnecessary and would only drive up costs as physicians are forced to pull out of Medicare and patients obtain delayed care in costly emergency rooms.

B. Medicare Sustainable Growth Rate (SGR) Physician Payment Formula
CMA Position: Support an Overhaul of the Medicare SGR

On behalf of California physicians, we unanimously urge the Senate to eliminate the SGR in law this year. We are extremely disappointed that the Senate has not included a correction of one of the biggest problems in our health care system in its major health reform legislation. Physicians cannot continue to participate in such an unstable environment. We urge the Senate to eliminate the SGR and replace it with a system that updates physician payments based on the Medicare Economic Index – the index used to update all other Medicare provider payments. It is crucial to the future of the Medicare program that Congress replace the SGR with a rational physician

payment system that automatically keeps up with the cost of running a practice and is backed by a fair, stable funding formula. We believe that Congress cannot move forward with innovative health care delivery system reform until the SGR is addressed.

C. Physician Quality Reporting Programs
- Physician Quality Reporting Initiative (PQRI)
-Physician Value Modifier Program
-Expansion of the Physician Feedback Program
-Proposed Amendment Physician Performance Compare Website

CMA Position: Oppose. Continue to Pilot Test.
The Medicare PQRI program and the state quality reporting experiments have produced flawed, inaccurate information that has led to mischaracterization of the true care physicians provide to their patients. Such inaccurate information will not help physicians improve patient care or ensure the appropriate allocation of resources. It will also mislead patients. The methodology needs to be vastly improved and tested before widespread implementation and public disclosure.

Physicians in California and several other states have experienced significant problems with health insurer–physician quality reporting programs, such as the California Physician Performance Initiative (CPPI) that began as a Medicare demonstration program involving the patients of three private PPO plans as well as Medicare beneficiaries. Because of flaws in the program and the inability of physicians to verify their own data, Medicare agreed to destroy the data. However, the private health plans are still pushing to publish inaccurate physician information.

Massachusetts has extensive experience with an Episodic Grouper feedback program that has resulted in a contentious lawsuit with the Group Insurance Commission to prevent the dissemination of inaccurate information. An analysis recently presented by RAND researchers showed serious methodological issues with using episode groupers to create physician cost profiles in Massachusetts. At the urging of the Texas Medical Association, the Texas Legislature passed legislation to address serious problems experienced by physicians with health plan feedback/profiling programs. There have also been important litigation settlements in Texas and Washington. And finally, the New York experience, where health plans used inaccurate information to rank physicians, led to a landmark settlement agreement between the private health plans and Attorney General Cuomo.

The goal of such feedback programs should be to educate physicians to help them improve care. Paramount to the success of such programs is reliable, verifiable data. However, almost every state and federal feedback program to date has experienced serious problems with the accuracy of the incoming data. **Therefore, we oppose the use of this information to publicly profile and penalize individual physicians until the methodology can be significantly improved. We urge the Senate to only pursue these programs through demonstration projects.**

<u>Inaccurate information can mislead patients and physicians without improving the quality of care or reducing costs.</u>

Further, the geographic-related adjustments in the proposed feedback program must be more specific. The data must be adjusted to account for the following regional geographic differences: Number of patients living under the poverty level; patient race/ethnicity; the number of uninsured; health status; and geographic medical practice costs, including rent and wages.

Below is a description of the problems experienced by physicians involved in feedback programs in California and other states. Because of these extensive problems, we oppose the use of this information to publicly profile and penalize individual physicians until the methodology can be significantly improved.

1. <u>Inaccurate Conclusions.</u> All of these programs have produced inaccurate reports. Accurate data is critical to an evaluation of a physician's performance. Erroneous information can increase the risk of unintended consequences, mislead patients, harm a physician's reputation and increase physician distrust of the system.
2. <u>Claims Data Insufficient</u>. Based on our experience, we now understand that claims data must be supplemented with clinical information from the patient's medical record. It is crucial that it be crosschecked with the clinical information. For instance, physicians in California were penalized for not performing pap smears on women whose cervixes had been removed.
3. <u>Attribution Methodology Flawed</u>. The methodology used to attribute a patient's care to a particular physician has been found to be quite unreliable. For instance, a 30 year old, Type 1 Diabetic woman may have three doctors – a family practitioner, an endocrinologist and an OB/GYN. It is difficult to effectively and accurately attribute the care of this patient to one physician or to all three physicians.

In Massachusetts, California and Texas, physicians were scored on patients who were not theirs. Moreover, the programs incorrectly designated physician specialties. The specialty assignment is crucial because it determines the measures that will be applied to a physician. For instance, in California a general surgeon was identified as a family practice physician and received a low score for glaucoma screening. The inaccurate specialty designation resulted in erroneous metrics by which the physician was measured.

Further, in California physicians in small groups were penalized for coordinating care and reducing unnecessary or redundant tests – inconsistent with the goal of this legislation. For example, Patient Smith may have seen all three doctors in a group over the course of a year. Doctor A recommended an HbA1c test for diabetes. Patient Smith saw Doctors B and C later in the year for a cold and another condition. Yet the program penalized Doctors B and C for not also recommending the HbAlc test – although it was in the chart that Doctor A had recommended it. Physicians in this group were given low scores for not duplicating the care of their partners.

4. The Methodology Must Include Risk Adjustment. The total number of episodes must be statistically significant to be reliable and the methodology must be transparent.
5. Quality Measures Must Be Appropriate for the Physician's Specialty.
6. Patient Compliance with Recommended Treatment Must be Considered
Patient non-compliance must be taken into consideration. In many instances, patient behavior is beyond a physician's control. For instance, physicians recommend colorectal cancer screenings but many patients refuse because it is unpleasant. Some patients would prefer that an OB/GYN perform certain screens rather than their family practice physician. And other patients may not follow through with a recommended treatment plan because the procedure is not covered by their health insurance.
7. Physicians Must be Given Patient Lists Associated with Each Measure to Review and Verify the Accuracy of the Data
Some physicians were attributed patients they did not treat. Conversely, other physicians received credit for procedures they did not perform.
8. Physicians must be given the right to appeal and correct inaccuracies before any data or conclusions are published.

Finally, CMA opposes mandatory participation in quality reporting programs or the imposition of penalties on physicians who do not successfully participate. For the reasons listed above, these programs are not ready for prime time and the data inaccurately reflects the true quality of care given to patients.

D. Senator Grassley Provision to Reduce the Geographic Practice Cost Impact
CMA Position: Oppose

Current Practice Expense Adjustment Is Appropriate
Since the inception of the Medicare program, the Medicare fee schedule has appropriately included an adjustment for regional differences in practice costs, such as rents and wages. This adjustment has equalized physician payments across the country to maintain access to physicians in regions with high rents and staff wages. See the illustration below.

Payment Area	GAF	CF	Payment	Costs	Net Pay
Natl Average	1.000	$36.07	$61.31	$28.13	$33.18
San Mateo, CA	1.203	$36.07	$73.79	$40.61	$33.18
Fort Worth, TX	0.984	$36.07	$60.32	$27.14	$33.18

Oppose the Arbitrary Payment Reduction – More than 8% in Urban Areas
This provision would reduce the geographic practice expense adjustment by 25% which would arbitrarily impose more than 8% reductions in Medicare physician reimbursements in California's urban areas in three years. Please see the attached chart which shows the impact by region. Because of CMA's advocacy, the Senate Finance Committee included a hold harmless on urban areas for three years. However, in three years, this practice expense adjustment would cause physicians to leave high rent regions and disproportionately exacerbate the access to care problems in inner cities. The amendment penalizes physicians for costs beyond their control,

most notably rents and wages. Rents in our urban areas are twice as much as rent in Iowa and other rural regions. Many urban states are already experiencing difficulty retaining and recruiting physicians. California has one of the lowest primary care physician to patient ratios in the country.

More Accurate Rent and Wage Data Sources Needed

We agree that the practice expense data is not precise and we support the study to improve the accuracy of the data sources. For instance, CMS uses HUD residential rent proxy data for physician commercial office rent.

However, in March, 2006, RTI International and Urban Institute published a study, entitled, "Review of Physician Practice Expense Geographic Adjustment Data," for CMS. The researchers reviewed alternative practice expense data sources for physician office rents and wages of non-physicians employed by physician practices. They concluded that while the proxy data used for physician staff wages and physician rent was not optimal, it was accurate and consistent and changing it would not have a substantial impact on physician payment. They also stated that it may not produce more payment accuracy to justify the costs of obtaining such data.

Support for Improving Rural Practice Expense Factors

Rather than cutting the practice expense adjustment by 25% to all physicians, we believe there are more precise ways to adjust physician payments to accurately reflect unique rural practice costs. California includes rural as well as urban areas. We fully recognize the different costs associated with the region in which a physician practices. And although there is a built-in floor of 1.0 and other rural adjustments in the Medicare geographic formula, this does not account for other factors unique to rural areas, such as physician travel times. We also believe the Health Professional Shortage Area (HPSA) program could be improved to truly help access to care in rural areas. We believe other appropriate rural practice cost factors should be reviewed and added to the formula.

Moreover, the Medicare geographic physician payment locality borders have not been updated significantly since 1966 despite changing demographics and practice patterns. GAO, MedPAC, Urban Institute and Acumen for CMS have all recently recommended that the locality borders be updated to accurately reflect practice cost differentials, which would help rural physicians practicing near the border of urban communities.

Achieving Payment Accuracy

The goal of the Medicare payment system should be to accurately reimburse physicians for the services they perform and the practice costs they incur. We support the initiative to improve the data sources. We also urge the consideration of other rural cost factors. But we flatly reject the proposal to arbitrarily reduce payments in urban areas merely to improve payment in rural states. It distorts payment accuracy and with an 8% payment cut, will exacerbate access to care problems seniors are already experiencing in California.

E. Medicare/Medicaid Enrollment Fee
CMA Position: Oppose

The CMA opposes the $250 enrollment fee for physician participation in the Medicare and Medicaid programs. We understand the enrollment fee is intended to fund increased fraud and abuse oversight, but physicians are already subject to a myriad of fraud and abuse programs, including the Recovery Audit Contractor (RAC) program which is unduly burdensome for honest practitioners and costs physician practices more to comply than the savings that accrue to the federal government.

F. Ban on Physician-Owned Hospitals
CMA Position: Oppose

While the CMA supports the disclosure of physician hospital ownership and investment information, we oppose the proposal to eliminate the whole hospital exception to the Stark self-referral law for future hospitals. Physician-owned hospitals have achieved the highest quality scores in some markets and have been shown to provide more net community benefits through uncompensated care and taxes than not-for-profit hospitals as a share of total revenues. Further, a recent study by the Center for Studying Health System Change found that physician-owned hospitals do not adversely affect general hospitals' ability to care for patients. We have a number of physician owned hospitals in California and several others in the pipeline that will be harmed by this ban.

G. Health Care Provider Non-Discrimination Clause
CMA Position: Oppose

The CMA strongly objects to the provision that prohibits insurers from discriminating against any health care provider who is licensed by the state. We believe it would require insurers to expand coverage for alternative therapies which is inconsistent with the President's goals to reduce health care costs for medical treatments that are not proven effective. CMA believes it could potentially open the door for practitioners with less training and expertise, provide access to unproven therapies, which could all increase costs, reduce quality and endanger patient safety. It could also create patient confusion over greatly differing levels of education, skills and training among different types of health care professionals.

We urge clarification that this does not allow expansion of the scope of practice for non-physician allied health practitioners. We also urge a compromise that mirrors a California law requiring reasonable consideration of allied health care providers.

Health & Safety 1373.9. Plans contracting for services at alternative rates of payment; consideration of proposals for affiliation by licensed or certified professional providers; definitions; exception

(a) Except in the case of a specialized health care service plan, a health care service plan which negotiates and enters into a contract with professional providers to provide services at alternative rates of payment of the type described in Sections 10133 and 11512 of the Insurance Code, shall give reasonable consideration to timely written proposals for affiliation by licensed or certified professional providers.

(b) For the purposes of this section, the following definitions are applicable:

(1) "Reasonable consideration" means consideration in good faith of the terms of proposals for affiliation prior to the time that contracts for alternative rates of payment are entered into or renewed. A plan may specify the terms and conditions of affiliation to assure cost efficiency, qualification of providers, appropriate utilization of services, accessibility, convenience to persons who would receive the provider's services, and consistency with the plan's basic method of operation, but shall not exclude providers because of their category of license.

(2) "Professional provider" means a holder of a certificate or license under Division 2 (commencing with Section 500) of the Business and Professions Code, or any initiative act referred to therein, except for those certified or licensed pursuant to Article 3 of Chapter 5 (commencing with Section 2050) or Chapter 11 (commencing with Section 4800), who may, within the scope of their licenses, perform the services of a specific plan benefit defined in the health care service plan's contracts with its enrollees.

(c) A plan which has an affiliation with an institutional provider or with professional providers is not required by this section to give consideration to affiliation with professional providers who hold the same category of license or certificate and propose to serve a geographic area served adequately by the affiliated providers that provide their professional services as employees or agents of that institutional or professional provider, or contract with that institutional or professional provider to provide professional services.

H. Government Influence On the Provision of Care

CMA concurs with the general goals of HR 3590 to improve the quality and efficiency of medical services delivered in the United States. We believe that physicians work hard everyday to provide the highest quality care to their patients. CMA encourages the practice of evidence-based medicine.

There are several Medicare and Medicaid programs in this bill that encourage the development of quality measures and require physicians to report on those measures. We believe it is essential that physicians not government bureaucrats develop quality measures and other tools that guide medical care. We are pleased that the Centers for Medicare and Medicaid Services (CMS) will continue to rely on the AMA Consortium which is comprised of all the national specialty societies to continue to develop quality measures and guidelines. Physicians must be involved at every juncture. Therefore, we also urge you to increase physician representation on the Agency for Health Care Research and Quality project.

However, as you have recently witnessed with the public debate surrounding the recommendations for mammography, medical decisions should ultimately be made by a patient and their physician based on the individual needs of the patient and the physician's clinical judgment as to what is in a patient's best interest. This is paramount to the provision of quality care and should remain the centerpiece of health care delivery in this country.

HR 3590 also establishes a Center for Medicare and Medicaid Innovation within CMS. The purpose of the center will be to research, develop, and test innovative payment and health care delivery arrangements to improve quality. Dedicated funding is provided to test such models, particularly if there is an expansion of benefits. While CMS already has broad authority under current law to adopt such demonstration programs, CMA urges you to ensure that physicians are

involved in the development of such projects and that they are widely tested in all practice settings and regions, risk-adjusted and found to incent appropriate care before implementation. Physicians should not be incentivized to avoid high-risk, seriously ill patients.

Finally, the Independent Medicare Advisory Board has been given broad authority to “reduce excess cost growth” in the Medicare program that empowers them to mandate arbitrary payment cuts to physicians. While the bill prohibits IMAB from making decisions that ration care, we are concerned that it could not only limit access to physicians in the Medicare program but also limit patient treatment options.

I. California Medicare Payment Locality Update (GPCI)

The CMA strongly urges you to advocate for a Medicare physician payment locality border update in the final health reform legislation. As documented by GAO, MedPAC, Urban Institute and Acumen for CMS, the physician localities have not changed in more than 10 years and need to be updated. At least 14 of California’s once rural counties have become urbanized and thus, more costly to practice, as rents and wages have increased. Physicians in 14 California counties are underpaid (according to Medicare) by at least 13% per year. These counties are experiencing some of the most difficult access to care problems in the state. For instance, in Santa Cruz County no physician groups are accepting new Medicare patients.

Federal law requires Medicare to reimburse physicians based on their practice costs. Because CMS has not updated the localities, Medicare is not paying physicians accurately.

We thank you for authoring legislation this year to provide payment accuracy in California by moving the California payment localities to Metropolitan Statistical Areas (MSAs). Under the Medicare program, hospitals are organized and paid according to MSAs. Your bill also ensures that physicians in rural areas are held harmless from cuts that could occur in the border update. Physicians in rural areas cannot sustain additional payment reductions.

California can be the pilot test for the rest of the nation. We ask you to urge the Senate leadership to include your Medicare payment locality (GPCI) bill in the final health care reform legislation. Thank you.