California Medical Association
Physicians dedicated to the health of Californians

February 25, 2010

To: President Barack Obama and the California Congressional Delegation:

While the California Medical Association appreciates and shares your resolve to provide universal access to care for the millions of uninsured Californians, implement insurance industry reforms that prohibit plans from excluding patients with preexisting conditions or rescinding coverage once a patient becomes ill, and make coverage more affordable for low-income uninsured patients, we are extremely concerned that Congress might use the budget reconciliation process to adopt the Senate health care reform bill which we oppose. We believe that a successful health care reform effort will build on what works and fix what is broken. Therefore, we cannot support a health reform bill that builds on the foundation of two broken programs – Medicare and Medicaid – unless they are fixed. The CMA urges you to strive for meaningful changes that are consistent with the following principles:

CMA Guiding Principles for Health Care Reform

- Universal access to physicians
- Affordable insurance for low-income individuals and families
- Respect for the physician-patient relationship
- Insurance industry reforms that protect patients
- Increased health plan competition and choice for patients
- Sufficient resources to deliver on the promise of improved access to health care
- Protection of MICRA, California's successful medical liability law

The CMA supports many of the compromise proposals outlined by the President this week, such as allowing families who are satisfied with their coverage to keep it, allowing the uninsured access to the same coverage that Members of Congress enjoy, making coverage more affordable for low-income families, and providing 90-100% federal financing of any Medicaid expansion. We stand ready to work with you to craft a final bill that could draw more unified support.

CMA Concerns with the Senate Health Care Reform Legislation

However, as the health care reform discussion continues, we want to reiterate our serious concerns with the Senate health care reform legislation (HR 3590). We urge these issues be addressed in any final legislation for they are the foundation to ensuring that the uninsured not only have insurance coverage but access to a doctor as well. These issues are summarized below and described in more detail in the attached addendum.

1. Protect access to care for seniors: Repeal the Medicare SGR once and for all.
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.

2. Increase access to care for Medicaid patients. Adopt the House Medicaid rate increase with

Headquarters: 1201 J Street, Suite 200, Sacramento, CA 95814-2906 • 916.444.5532

any Medicaid expansion. CMA remains extremely concerned that the legislation builds health care reform on the foundation of Medicaid where access to physicians in California is already difficult. If the Medicaid program is expanded to cover nearly 2 million of California's uninsured, resources must be provided to improve physician participation.

Physicians want to care for California's seniors and newly insured Medicaid patients. But Medicare and Medicaid will need serious reform for physicians to participate. 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 within a few years. Half of California's physicians are over the age of 50. These are significant problems that need to be addressed.

3. Update the California Medicare locality borders to improve access to care in 14 counties. Adopt the House California GPCI fix. Physicians in 14 California counties are underpaid by up to 13% annually which is negatively impacting access to doctors in these counties.

4. Eliminate the Medicare Independent Payment Advisory Board.
Without any accountability to Medicare seniors and their physicians, this Board would be allowed to make arbitrary cuts which are detrimental to patient care.

5. Test and improve physician quality reporting programs.
Based on the physician experience in California's private sector and Medicare, CMA is seriously concerned that both the House and Senate bills create numerous quality reporting programs - none of which have the capability to accurately report physician information. While the intent is for physicians to continue to develop the measures, it needs to be more explicit. There should only be one reporting program and it must continue to be tested and improved before payment is based on the results and it is disseminated to the public. Physicians must be given the data to verify its accuracy and allowed to change erroneous information.

6. Protect the right for patients to privately contract with physicians of their choice.
Patients must be given the right to privately contract with physicians in the private sector and Medicare which will improve access to physicians and not require additional federal funding.

We thank you for your efforts to expand access to care and to improve our health care system. We hope our comments are constructive in helping you develop a meaningful health care reform bill that will serve Californians well for generations to come.

Sincerely,

J. Brennan Cassidy, MD
President

Specific CMA Concerns with the Senate Health Care Reform Bill

1. **Medicare Physician Payment Formula**
   CMA Position: Support House Bill – HR 3961: Repeal of the SGR

CMA urges adoption of a plan to repeal the 40% projected cuts to the Medicare SGR physician payment formula. CMA also urges Congress to adopt a more stable, interim payment system until a long-term system can be tested and developed. CMA supports HR 3961 which passed the House as part of the health care reform effort.

2. **Medicaid Physician Rate Increase**
   CMA Position: Support House Bill – HR 3962: Medicaid E&M Rate Increase

The CMA profoundly appreciates the rate increase included in the House bill for all Medicaid Evaluation and Management (E&M) services to be reimbursed at the Medicare fee schedule. It is an important recognition of the current access to care obstacles facing Medicaid patients and a vital first step toward fixing the problem. However, it does not go far enough to address the very real doctor shortages in the Medicaid program. Resolving this issue is crucial to the success of the health care reform effort. The Senate bill does not include a Medicaid rate increase. We urge you to adopt the House provision and commit to a continued focus on this issue in the coming years.

Both the House and Senate bills expand coverage to 1.7 to 2 million uninsured Californians through the Medicaid program. Yet the California Medicaid program is seriously underfunded and half of all current California Medicaid (Medi-Cal) patients cannot find a doctor. Only one-third of California physicians accept Medicaid patients because the reimbursement rates are less than half of a physician's costs to provide the care. California's Medicaid reimbursement rates rank 47th nationally and are 50% below Medicare rates. Without an increase in the rates, the 2 million newly insured in California will immediately overwhelm the current invisible safety net of private physicians in their communities. These patients will be forced to seek delayed, more costly care in California's emergency rooms.

3. **Medicare Locality Border Update (GPCI)**
   CMA Position: Support House Bill - HR 3962

The CMA strongly supports the payment locality border update in the House bill. The Medicare locality borders have not been updated in more than 10 years. As rural counties have become urbanized, practice costs for physicians in these counties have dramatically increased. Some of the worst access problems are occurring in these counties. For instance, none of the physician groups in Santa Cruz County are accepting new Medicare patients.

GAO, MedPAC, Urban Institute, and Acumen for CMS have all recommended that the locality borders be updated. Such an update would significantly improve Medicare payment accuracy.

CMS has specifically examined the California locality problem in three different Physician Payment Rules.

The House provision would update the California Medicare localities from counties to Metropolitan Statistical Areas (MSAs). The hospitals are already organized into MSAs for Medicare payment purposes. Because California has some of the largest payment inaccuracies (physicians in 14 California counties are underpaid by up to 13% annually) and the most Medicare beneficiaries and physicians impacted by outdated localities, it makes sense to allow CMS to test locality border changes in California before initiating changes in other states. This provision does not impact any other state. Moreover, as Congress contemplates Accountable Care Organizations and other geographic payment reforms that are based on MSA regions and expenditures, it is important to test the movement of physician payment localities to MSA-based borders.

CMA has been petitioning CMS and Congress for over 10 years to make this change. It is long overdue and we appreciate your leadership to ensure Medicare pays physicians accurately. We will also continue to work with you to protect physicians in rural California from unsustainable payment reductions.

4. **Medicare Independent Payment Advisory Board (IPAB)**
   CMA Position: Oppose Senate Bill: HR 3590

The CMA is opposed to the Senate proposal that creates an independent board that is mandated to make physician payment cuts when physicians are already subject to the SGR expenditure target system, payment cuts mandated by a Medicare budget neutrality law and other potential payment reductions under the Medicare physician payment system.

It is essential for Congress to change the incentives in our health care delivery system. However, this Board would hinder future, innovative health care delivery system reforms being contemplated by Congress. The main charge of the IPAB 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 true system-wide cost savings. 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.

Further, the proposal does not take into account other factors that increase Medicare spending, including changes in coverage, benefits, new technology and medical procedures that improve care, the growth in the number of Medicare beneficiaries, patient longevity, the growing prevalence of chronic conditions, or unanticipated spending for influenza pandemics.

Moreover, all Medicare providers are not subject to the cuts. This inequitable application of payment cuts to physicians who are already subject to spending targets is seriously flawed and will drive physicians out of the program.

Finally, the CMA believes 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 and to sustain the Medicare program. Moreover, we believe in the Congressional process of public hearings where all those impacted by the program can provide public comment and exchange ideas and information.

The House bill includes important demonstration projects and other payment reforms that negate the need for an independent board. The IMAB as currently proposed is draconian, unnecessary and inequitable. We believe it will hinder future innovation. It will only drive up costs as physicians are forced to pull out of Medicare and patients obtain delayed care in costly emergency rooms. It will be detrimental to patient care.

5. **Physician Quality Reporting Programs**
   (PQRI; Value-Based Payment Modifier; Physician Performance Compare Website)
   CMA Position: Oppose Senate Bill – HR 3590
   Seek Amendments to House Bill – HR 3962

The Medicare PQRI program and the state quality reporting experiments have produced flawed, inaccurate information that has led to mischaracterization of the 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), which began as a Medicare demonstration program involving Medicare beneficiaries and the patients of three private PPO plans. Because of flaws in the program and the inability of physicians to verify their own data, Medicare agreed to destroy the Medicare patient data.

Massachusetts has extensive experience with a feedback program that has resulted in a contentious lawsuit with the Group Insurance Commission to prevent the dissemination of inaccurate information. 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 quality 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 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 Congress to only pursue these programs through demonstration projects. Inaccurate information can mislead patients and physicians without improving the quality of care or reducing costs.**

Below is a description of the problems experienced by physicians involved in feedback programs in California and other states.

1. Inaccurate Conclusions. 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. Claims Data Insufficient. Must be Supplemented with Clinical Information. 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. Attribution Methodology Flawed. 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, 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 total number of episodes must be statistically significant to be reliable.

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.

Quality reporting programs need to be vastly improved before this information can accurately be used to base payment policy and before it can be shared with the public. CMS does not have the capacity or capability to implement some of the programs in the Senate bill. Therefore, we urge Congress and CMS to continue to conduct demonstration programs. Moreover, we strongly oppose penalties on physicians who do not successfully participate.

And finally, all of the quality measures that CMS has employed to date have been developed and vetted through the AMA Consortium consensus process. The AMA consortium is composed of all of the major national specialty societies. This legislation needs to be clarified that all quality measures be developed by physicians through this process. It is essential that physicians, not government bureaucrats, develop quality measures and other tools that guide medical care. For the reasons listed above, we urge these programs be piloted and the process improved before proceeding.

6. Right for Patients to Privately Contract with Physicians
CMA Position: Support House Bill – HR 3962
Continue to Seek Amendments to Allow in Medicare

CMA urges you to continue to allow patients the fundamental right to privately contract with the physician of their choice. Abusive practices by the for-profit insurance industry have forced physicians to terminate contracts and move to private contracting arrangements with their patients. Allowing non-contracting physicians to privately contract with patients provides a patient-centered alternative for patients and it preserves physician-patient relationships.

Moreover, inadequate public funding has forced physicians out of the Medicare program. Private contracting would help maintain physician participation in Medicare without requiring additional federal funding. Many single-payer government health care systems in other countries allow patients to privately contract with physicians.