THE CALIFORNIA MEDICAL ASSOCIATION
THE TEXAS MEDICAL ASSOCIATION

September 21, 2009

The Honorable Max Baucus
Chairman
Senate Finance Committee
U.S. Senate
219 Senate Dirksen Building
Washington, D.C. 20510

Dear Chairman Baucus:

On behalf of the undersigned state physician organizations, we want to thank you for your commitment to health system reform and achieving universal coverage for the uninsured. We believe the status quo is no longer viable and stand ready to work with you to pass such legislation. We are writing to comment on several provisions in "America's Healthy Future Act of 2009," that are of great concern to physicians in our states, including the expansion of flawed feedback programs and Senator Cantwell's amendment to create a value index without any study of its true impact on high cost regions with high numbers of poor, minority patients. Our concerns are based on physician experience with these programs in our states. We are also opposed to the creation of the Independent Medicare Commission and continue to urge you to adopt a long-term fix to the Medicare SGR payment formula this year.

Our organizations appreciate some of the positive aspects of the bill, such as the administrative simplicity initiatives and the recognition that we need to restore access to primary care by providing a Medicare 10% bonus payment. However, the combination mandated cuts through the Medicare feedback program, the value index, the specialist payment reduction, the Independent Commission's mandated cuts and a projected 25% SGR cut in 2011 will devastate Medicare physician participation in our states where access to doctors is already a significant problem. Our states are facing serious future physician shortages. Instead, we urge the Committee 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. Congress must fulfill the promise of increased coverage by ensuring that all patients have a doctor.

Regarding medical liability, we urge you to add amendments that would protect physicians from potential liability unintentionally created in this legislation related to clinical guidelines and new payment methodologies.

We recognize and appreciate the difficulties you face in the Senate. We thank you for keeping health care reform on the front burner. It is crucial that the Senate be able to conference a bill with the House. To that end, we hope our comments are constructive in helping you improve the bill.

A. Physician Value-Based Purchasing
Expansion of the Physician Feedback Program

State Medical Association Position: Oppose. Continue to Pilot Test.
The State experiments have produced flawed, inaccurate information that cannot be verified by physicians. Such inaccurate information will not help physicians improve patient care or ensure the appropriate allocation of resources. The methodology needs to be vastly improved.

Physicians in each of our states have experienced significant problems with health insurer–physician quality reporting programs, such as the California Physician Performance Initiative (CPPI) that has been operating under a Medicare demonstration program. It involves the patients of three private health plan 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 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 only through demonstration projects. Inaccurate information can mislead patients and physicians without improving the quality of care or reducing the cost of care.**

Further, the geographic-related adjustments in your 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 our 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. Inaccurate Conclusions. All of these programs have produced inaccurate reports which is critical to an evaluation of a physician's performance. Inaccurate 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. 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 Texas were been penalized for not performing pap smears on women whose cervixes had been removed.
3. Attribution Methodology Flawed. The methodology used in each of our programs to attribute a patient's care to a particular physician has been found to be quite inaccurate.
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 that one patient across these three physicians.

In Massachusetts, California and Texas, scores of physicians were evaluated on patients who were not theirs or were assigned the incorrect specialty. The specialty designation is crucial. 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 your 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. And 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 and Cost Outlier logic. 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.

B. Independent Medicare Commission
State Medical Association Position: Oppose

Our organizations are opposed to the creation of yet another Independent Medicare Commission 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. We believe that 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 hearings where all those impacted by the program can exchange ideas and information.

Further, we believe it is essential that Congress 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 the Consumer Price Index (CPI). Imposing 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 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. It is draconian and 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.

C. Overhaul of the Medicare Sustainable Growth Rate (SGR)
State Medical Association Position: Support an Overhaul of the Medicare SGR

On behalf of the physicians in our states, 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.

D. Medicare/Medicaid Enrollment Fee
State Medical Association Position: Oppose

Our organizations are strongly opposed to a $350 enrollment fee for physician participation in the Medicare and Medicaid programs. We believe it is yet another barrier to participation in Medicare and Medicaid where reimbursement already fails to keep pace with practice costs. We understand the enrollment fee is intended to fund increased fraud and abuse activities, but physicians are already subject to a myriad of fraud and abuse programs, including the Recovery Audit Contractor (RAC) program which cost physician practices more to comply than the savings that accrue to the federal government.

E. Medical Liability Protection
State Medical Association Position: Adopt amendments to preclude the expansion of liability exposure for physicians related to the establishment of new clinical guidelines and payment methodologies.

Our organizations are concerned that some of the clinical guidelines and payment policies in America's Healthy Future Act would unintentionally increase the liability exposure of physicians and further escalate health care spending. The clinical best practices established in the bill should be medical guidelines, not legal ones. While we encourage the practice of evidence-based medicine, physicians must be free to make decisions that in their clinical judgment are in the best interest of their patients.

The specific sections of concern include,
- Title III, Subtitle A, Part I
Physician Value Based Purchasing, commencing pg 78
Physician Feedback Program; Physician Quality Reporting Initiative
- Title III, Subtitle A, Part II
National Strategy to Improve Health Care Quality, commencing pg 85
CMS Innovation Center, commencing pg 90
- Title III, Subtitle F
Patient Centered Outcomes Research, commencing pg 15

1. Best practices regulations, directives or guidelines dealing with clinical medicine decisions or health care delivery processes may conflict with the prevailing medical standard of care and should not be admissible in a medical liability action. Our recommended amendment provides that a physician's compliance or non-compliance with such practice guidelines does not

constitute a breach of the medical standard of care and are not admissible in a medical liability action.

2. Government performance-based value purchasing decisions should not create a presumption of negligence. Our proposed amendments specify that performance-based value purchasing determinations shall not constitute a determination that the medical practitioner has or has not met the standard of care and are not admissible in a medical liability action.

3. Innovative payment policies and government financial incentives paid to physicians serve the goals of the program and should not be intended for other purposes. In certain circumstances, government incentives may conflict with the medical standard of care. Our proposed amendments provide that a physician's treatment decisions that follow or deviate shall not constitute a breach of the standard of care or be admissible in a medical liability action.

We believe these are clarifying amendments that would help physicians avoid unintended legal repercussions. These amendments would allow physicians to achieve the best possible outcomes for their patients and curb associated health care costs.

Thank you for your consideration of these issues. We are seriously concerned about the general direction of the Medicare reforms contained in America's Healthy Future Act of 2009. We respectfully urge you to consider reforms that are based on delivery systems in our states that have managed patient care and costs in a compassionate and efficient manner. We look forward to continue working with you.

Sincerely,

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California Medical Association

William H. Fleming III, MD, President
Texas Medical Association