California Medical Association
Physicians dedicated to the health of Californians

August 30, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule; 76 *Fed. Reg.* 42,772 (July 19, 2011); CMS-1524-P.

Dear Dr. Berwick:

The California Medical Association (CMA) appreciates the opportunity to comment on the proposed Medicare Physician Payment Rule for 2012. We strongly concur with the comprehensive comments submitted by the American Medical Association (AMA), specifically the comments urging CMS to
1) coordinate the Medicare Physician Quality Reporting System (PQRS) with the Medicare-Medicaid Electronic Health Record (EHR) Incentive Program. A system certified for PQRS should be certified for the EHR Incentive Program;
2) move back the timeline for the Electronic-Prescribing program penalties and provide more exemption categories;
3) provide more detailed guidance to physicians and beneficiaries about the new preventive services covered by the Annual Wellness Visit; and
4) significantly modify the time-frame and structure for implementing the Value-Based Payment Modifier – the new payment methodology authorized in the health reform legislation;

Overall, the CMA is extremely concerned that CMS is imposing Congressionally-mandated penalties and payment policies, such as the e-prescribing program and the value-based payment modifier on performance prior to the effective dates in the law.

The CMA's comments are focused on issues unique to California, such as the major changes to the Geographic Practice Cost Index and our extensive experience with physician quality reporting programs that should inform an improved implementation of the Value-Based Payment Modifier and the confidential physician feedback reports. Overall, we applaud CMS' continued commitment to adjust physician payments based on the differences in geographic practice costs. The detailed CMA comments are set forth below.

Finally, we fully understand that CMS is mandated by law to implement the 29% Medicare Sustainable Growth Rate (SGR) payment formula reductions unless Congress takes action before January 1, 2012. As noted in the payment rule, we also appreciate the Administration's commitment to eliminating the SGR. CMA is working with Congress to stop the 29% cut and repeal the SGR. However, we believe it is imperative that CMS work with us and Congress to

reverse the SGR. We are providing detailed comments below about the impact a 29% SGR cut would have on California physicians, their senior patients and military families, and the entire California economy.

The CMA's principle recommendations are as follows:

Medicare SGR

- **CMS should provide leadership and work with Congress to Stop the 29% Medicare SGR Physician Rate Cut and Repeal the SGR.**

Geographic Practice Cost Index Proposals

Overall, CMA supports the general direction of the CMS-proposed Geographic Practice Cost Indices changes for 2012. We applaud CMS for adjusting physician payment based on the substantial geographic differences in practice costs across the state of California and the rest of the country.

- **CMA urges CMS to provide an impact table separately showing the impact of the different CMS-proposed revisions as well as the GPCI-related provisions that are expiring in the law to the geographic practice cost indices (GPCIs) for 2012 by county and physician payment locality.**

- **CMA urges CMS to continue to use the Department of Housing and Urban Development (HUD) rent data as the proxy for physician office rent for 2012 – until the American Community Survey (ACS) is more populated and statistically valid.**

- **CMA's analysis shows that the ACS rent data is consistently less than the HUD data. CMA urges CMS to provide a cross-walk between the two data sources to determine whether the rent changes are due to the change in data source or market conditions.**

- **CMA applauds CMS' proposal to geographically adjust non-physician employee compensation and increase the weight of non-physician employee wages in the calculation of the practice expense. We support the addition of a Purchased Service component to the Practice Expense GPCI. We also support the proposed weighting. We believe this new category accurately reflects the variable professional and non professional labor costs that we commented on last year. We believe the Bureau of Labor Statistics (BLS) data source is appropriate, as well as the recognition of the new categories of professions that physicians employ – such as HIT professionals. We also concur that non-physician employee wages are consuming a larger share of physician practice expenses, particularly in California.**

- **CMA does not oppose using the 2006-based MEI weight for fixed capital and utilities as the weight for the office rent category in the PE GPCI. As we commented last year, the cost of utilities is included in the housing data used for the rent index. As long as this data source is used as a proxy for office rent, accurate weighting should include both fixed capital and utilities.**

- **Finally, the Institute of Medicine recently recommended that CMS address access to care problems through alternative payment mechanisms, not the GPCI. CMA concurs and applauds CMS for maintaining accurate payments by geographically adjusting practice expenses.**

Physician Payment Locality Issues

- **CMA urges CMS to adopt the Institute of Medicine's recent recommendation to the Secretary to move the physician payment localities to Metropolitan Statistical Area (MSA) regions consistent with the hospital wage index regions. We also ask CMS to phase-in the change to mitigate any negative impact on physicians practicing in rural areas. CMA will continue to work with Congress to develop a hold harmless for rural physicians.**

Medicare Economic Index

- **The CMA is extremely disappointed that CMS has not yet convened the MEI technical panel. This is an important endeavor that will help to ensure physician payments are up-to-date and accurate. The MEI has an enormous impact on the Geographic Practice Cost Index which is being changed once again without a comprehensive review and update of the MEI.**

Confidential Feedback Reports

- **If coming up with an attribution method that creates credible feedback reports for *all* physicians treating Medicare patients proves to be impossible, as it has been in California's Medicare pilot programs and the private sector, CMS should inform Congress that this is the case and recommend modifications in the Patient Protection and Affordable Care Act's (ACA) value-based modifier requirements.**

- **The CMA strongly supports CMS' proposal to investigate the possibility of segregating physicians by specialty and the conditions they treat and risk and cost-adjusting the data, consistent with some of the California programs. We would like to work with CMS to develop an improved physician specialty and sub-specialty list that could be applied consistently across many Medicare programs, including the value-based payment modifier, Physician Compare, and the Medicare Provider Enrollment, Chain and Ownership System (PECOS).**

- **If ongoing efforts produce reliable Medicare-specific groupers for at least a limited set of conditions, CMS should adopt them in lieu of the per capita data as soon as possible.**

- **CMA supports the detailed comments submitted by the AMA.**

Value-Based Payment Modifier

- **CMA strongly opposes the public disclosure of individual physician quality information unless the current attribution methodology, risk-adjustment methodology and reporting mechanisms are vastly improved. The data must be accurate and statistically valid. And finally, protections need to be in place to allow physicians to review the report before it is published, appeal the report and have it corrected if found to be inaccurate. See the attached information about the Medicare/Private Sector California Physician Performance Initiative (CPPI) experience.**

- **CMA also opposes the use of this information to penalize individual physicians until the methodology can be significantly improved. Inaccurate information can mislead patients and physicians without improving the quality of care or reducing costs.**

- **Any value-based payments based on geographic spending benchmarks must be adjusted for differences in geographic practice expenses and the socioeconomic status of the patients. CMS is required by the ACA to make geographic-related cost and health status adjustments to the value modifier. Those adjustments need to include all of the Medicare GPCI-related practice expense adjustments, particularly rent and wages, and the following specific socioeconomic factors: the number of patients living under the poverty level; patient race/ethnicity; insurance status of the patients and health status.**

- **To maintain access to care for traditionally underserved patients in underserved areas of California, it is essential that CMS adjust payments as described above. Moreover, it is vital that patients with serious, chronic conditions have appropriate access to physicians and that physicians are not disincented from treating these patients.**

- **CMA urges CMS to explore risk adjustment methodologies beyond the Medicare Advantage HCC system. However, at a minimum the MA HCC system should be applied to the value modifier.**

- **CMA strenuously opposes CMS' plan to truncate an already inadequate preparation period by basing 2015 payment adjustments on performance in calendar year 2013.**

- **Finally, CMA recommends that CMS inform Congress that many of the requirements under the Value Modifier have never been accurately accomplished in Medicare pilot programs or the private sector and recommend modifications in the Patient Protection and Affordable Care Act's (ACA) to the value-based modifier payment methodology.**

Physician Quality Reporting System

- **CMS should allow physicians to provide feedback on the format and content of interim feedback reports in the Physician Quality Reporting System (PQRS) once CMS has developed the prototype for these reports.**

- **The CMA urges CMS to immediately rectify the separate certification requirements for PQRS and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program.**

- **We urge CMS to identify measure clusters up-front and not leave physicians guessing as to the specific requirements for successful participation in the PQRS.**

- **We urge CMS to ensure that all measures in measures groups are also reportable as individual measures.**

- **At least for the first year a measure is proposed, it should be reportable via claims-based reporting AND registry-based reporting. It is critical to offer the claims and registry option at least for the first year a measure is in the program, in case no registries adopt a certain measure.**

- **CMA supports the detailed comments submitted by the AMA.**

Electronic Prescribing

- **In order to better align the e-prescribing incentive program with the e-prescribing penalty program, we urge CMS to only require the reporting of at least 10, rather than 25, G8553 codes for electronic prescriptions per year for the 2012 and 2013 e-prescribing incentive programs.**

- **We support CMS' decision to make a reporting option available for group practices, and allowing physicians a choice to submit e-prescribing data through Medicare Part B claims or a qualified registry or EHR product.**

- **We strongly oppose CMS' proposal to require reporting on e-prescribing activity the year before the penalty program begins. We previously have called on CMS to take such steps as establishing a new reporting period in 2012 and to refrain from applying the penalty until 2013. We also urge CMS to establish an additional reporting period in 2013 to avoid 2013 penalties and in 2014 to avoid penalties in 2014.**

- **We strongly recommend that CMS add more exemption categories so that more physicians facing hardship will be eligible for an exemption from e-prescribing penalties in 2013 and 2014.**

- **We also recommend that CMS provide feedback reports to physicians and establish a process to allow physicians to appeal decisions.**

- **CMS should take appropriate measures to ensure the accuracy of the list of successful e-prescribers and eligible professionals (EPs) participating in the EHR incentive program and to provide the appropriate disclaimers for the Physician Compare website listing.**

- **CMA urges CMS to allow physicians to e-prescribe on days when the patient is not in the office. Prescribing is often done after results of tests are made available, and many prescriptions are refills. This would also allow those physicians who prescribe during post operative periods to get credit for e-prescribing.**

- **CMA repeatedly receives inquiries from physicians who only treat Skilled Nursing Facility/nursing home patients. While they may prescribe, it is the SNF/NF that fills the prescription. This may fall under the "federal regulation" exemption, but physicians may not know that the SNF is responsible under their enrollment for filling prescriptions. This should be clarified.**

- **CMA supports the detailed comments submitted by the AMA.**

Annual Wellness Visit

- **The CMA urges CMS to ensure Medicare coverage for a physical exam as part of the Annual Wellness Visit (AWV).**

- **The CMA urges CMS to issue clear guidance to beneficiaries and their physicians on what is and is not covered in the "free" preventive service visit that is part of the AWV.**

- **CMA continues to receive numerous calls from physicians requesting clarification. The AWV is extremely confusing and has serious fraud and abuse implications for physicians. Therefore, we urge CMS to provide clarification. The CMA On-Call document attempting to provide guidance is attached for your information. It was formulated based on the inquiries we receive from physicians and may be a resource to CMS in developing a guidance.**

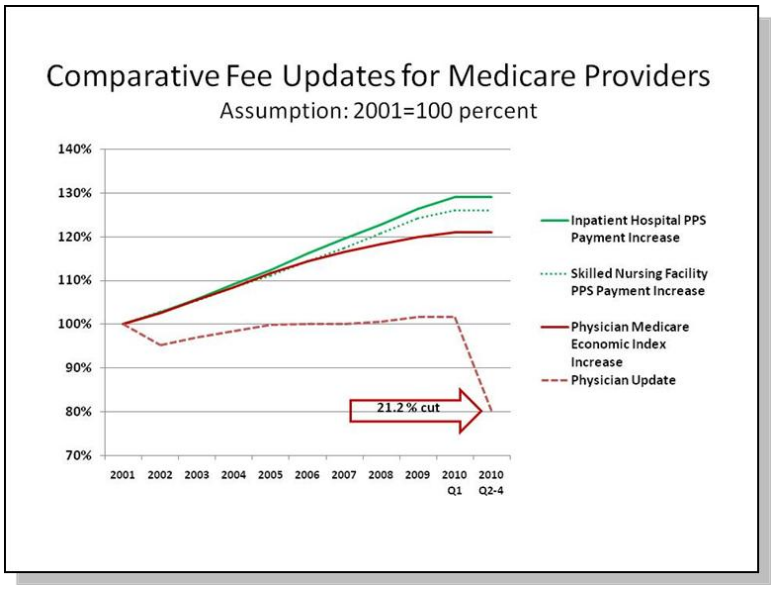
- **CMA supports the detailed comments submitted by the AMA.**

DETAILED CMA COMMENTS ON THESE ISSUES ARE SET FORTH BELOW:

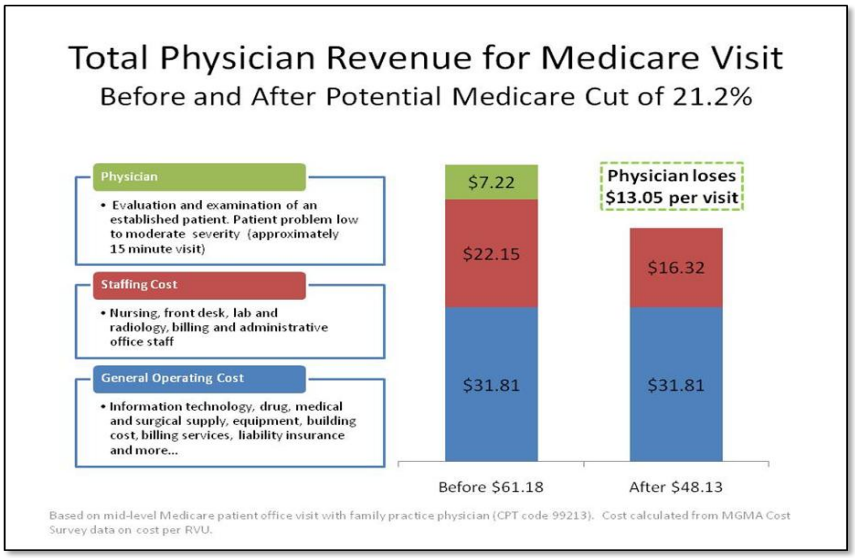
I. MEDICARE SGR

CMA urges CMS to exert its leadership and work with Congress to Stop the 29% Medicare SGR physician payment cut as well as repeal the SGR payment formula once and for all.

Impact of the Medicare SGR Payment Formula on California Physicians: The graph below shows California Medicare physician payments lag 20% behind the Medicare Economic Index – a conservative index of what it costs to provide care. While all other Medicare providers (health plans, hospitals, nursing homes) were given cost-of-living increases over the past decade, physician rates did not keep pace with the rising costs to operate a medical practice. Moreover, California private health plan rates track Medicare rates so the impact of the SGR on California physicians is devastating. The SGR is not a sustainable payment system for physicians.



The second graph illustrates that physician practices are working under thin financial margins. Medicare reimbursement rates barely cover the cost to provide care. Under the current Medicare fee schedule a physician only makes $7.22 for an established patient office visit after overhead costs and expenses are covered. If the 29% SGR cut occurs, physicians will lose money on each Medicare patient and be forced to pull out of the Medicare program or close their doors altogether.



Results of a 2010 Statewide Physician Survey
Last year, a CMA-County Medical Society Medicare survey showed that if the Medicare SGR formula is not fixed:
- 72% of California physicians will REDUCE the number of NEW Medicare patients in their practice or STOP accepting NEW Medicare patients altogether.

- 55% of California physicians will REDUCE the number of EXISTING Medicare patients in their practice or STOP seeing ALL EXISTING Medicare patients

Negative Impact on the California Economy If Physician Practices Forced To Close
If physicians are forced to cut-back or close their doors, not only will patient care be negatively impacted but the California economy as well. Physician practices are important employers in their communities. A recent report, "The Economic Impact of Office-Based Physicians in California," prepared by the Lewin Group, shows that office-based physicians are a critical component of the health care system, fundamentally assuring the health of the communities in which they practice. Moreover, physicians also play a vital role in the state and local economies by creating jobs, purchasing goods and services and supporting state and community public programs through tax revenues they create and the charity care they provide. The report shows, "…how strong physician practices not only ensure the health and well being of communities but also critically support local economies and enable jobs, growth and prosperity." If physician practices are forced to close, the entire California economy will suffer.

<u>In 2009, California office-based physicians</u>
-Created a total of $137.9 billion in revenue
-Supported 458,397 jobs.
-On average, each physician supported 5.8 jobs
-Contributed $106.3 billion in wages and benefits for employees
-On average, each physician supported $1,355,894 in total wages and benefits
-Supported $7,215.5 million in local and state tax revenues

Table 2: Total Output, Jobs, Wages & Benefits, and Tax Revenue Supported by the Office-based Physician Industry in California, by MSA, 2009

MSA Name	Number of Physicians	Output ($ in millions)	Jobs	Wages & Benefits ($ in millions)	State & Local Tax Revenue ($ in millions)
Bakersfield, CA	997	$1,000	5,318	$884	$44
Chico, CA	411	$509	2,288	$408	$25
El Centro, CA	140	$115	731	$84	$5
Fresno, CA	1,424	$1,435	7,646	$1,259	$63
Hanford-Corcoran, CA	132	$124	698	$111	$5
Los Angeles-Long Beach-Santa Ana, CA	28,829	$47,355	165,717	$35,109	$2,444
Madera, CA	182	$153	949	$110	$6
Merced, CA	239	$241	1,280	$221	$11
Modesto, CA	871	$989	4,784	$917	$48
Napa, CA	321	$365	1,744	$366	$17
Oxnard-Thousand Oaks-Ventura, CA	1,477	$1,645	7,975	$1,126	$82
Redding, CA	384	$441	2,116	$340	$20
Riverside-San Bernardino-Ontario, CA	5,382	$5,362	28,912	$3,792	$258
Sacramento-Arden-Arcade-Roseville, CA	4,732	$6,126	26,787	$4,325	$339
Salinas, CA	694	$669	3,688	$482	$31
San Diego-Carlsbad-San Marcos, CA	7,152	$9,233	40,204	$5,913	$495
San Francisco-Oakland-Fremont, CA	12,818	$19,345	71,768	$20,007	$983
San Jose-Sunnyvale-Santa Clara, CA	5,340	$5,886	28,728	$5,368	$294
San Luis Obispo-Paso Robles, CA	596	$685	3,279	$608	$34
Santa Barbara-Santa Maria-Goleta, CA	946	$1,123	5,210	$1,349	$55
Santa Cruz-Watsonville, CA	552	$583	2,985	$486	$29
Santa Rosa-Petaluma, CA	1,090	$1,235	5,946	$880	$61
Stockton, CA	961	$1,027	5,224	$685	$51
Vallejo-Fairfield, CA	878	$881	4,679	$551	$44
Visalia-Porterville, CA	447	$397	2,354	$285	$17
Yuba City, CA	232	$259	1,271	$213	$12

California Physician Shortages

There are real physician shortages in California. Failing to address the Medicare physician payment formula will compound these shortages. California's primary care physician-to-patient ratios are among the lowest in the nation. California physicians are dramatically aging. More than half of California physicians are over the age of 55 and California is not training or attracting enough new physicians to meet the demands. Prior to the passage of the health care reform legislation, the University of California projected that the growth in physician demand would outpace physician supply by 20%. As five million Californians gain coverage under health care reform and the baby-boomers become eligible for Medicare, the demand for physicians will

swell. Without Medicare payment reform to keep existing physicians in practice and attract new students to medicine, finding a doctor in California will become extremely difficult.

The CMA urges CMS to aggressively work with Congress and the CMA to rebuild the Medicare and Medicaid programs. Physicians are the foundation and the front-line of the Medicare program. We need a reasonable physician payment system to protect access to care for California's seniors, TriCare military families, Medicaid patients, and the disabled.

Medicare Private Contracting

To that end, CMA is supporting HR 1700 (Price, R-GA), My Medicare, My Choice, which allows Medicare seniors to privately contract with the physician of their choice. We would urge CMS to consider implementing a pilot program that allows private contracting. It would help to maintain access to doctors for California's seniors without imposing an additional burden on the federal budget.

II. GEOGRAPHIC PRACTICE COST INDEX PROPOSALS

Overall, CMA supports the general direction of the CMS Geographic Practice Cost Indices changes for 2012. We applaud CMS for adjusting physician payment based on the substantial geographic differences in physician practice costs across the state of California and the rest of the country. CMA provided extensive comments on these issues for the 2011 proposed payment rule – see attached.

In the 2012 proposed rule, CMS is proposing to revise the Sixth GPCI Update by:

- Reweighting the work, practice expense and professional liability insurance GPCIs to correspond to new Medicare Economic Index (MEI) weights adopted in 2011;
- Replacing apartment rental data from the Department of Housing and Urban Development (HUD) with the 2006-2008 American Community Survey (ACS);
- Reducing the weight assigned to office rent from 12.209 percent to 10.223 percent;
- Revising the occupations used in calculating the employee wage component of the practice expense GPCI; and
- Increasing the weight assigned to non-physician employee wages from 8.7% to 19.2%;
- Developing a purchased services index for which the portion deemed by CMS to be labor-related is adjusted in the GPCI.

In the CMS 2011 proposed Medicare physician payment rule, CMS proposed to reduce the portion of the practice expense GPCI subject to geographic adjustment to 58%, which inappropriately reduced Medicare payment in California. Based on the comments received from the CMA and other large states, CMS decided not to implement the proposed changes. In the 2012 proposed rule, CMS has again proposed to use the new MEI weights in the practice expense GPCI, but has also proposed to geographically adjust more of the "office expense" and part of "other expenses" with the result that 72% of the proposed 2012 practice expense GPCI is subject to geographic adjustment. In 2010, 71% of the practice expense GPCI was subject to geographic adjustment.

The AMA Physician Practice Information Survey (PPIS) shows that practice costs have increased and now consume a greater proportion of physician revenue. Therefore, it is appropriate that practice costs apply to a greater proportion of overall payment.

- **CMA urges CMS to provide an impact table separately showing the impact of the different CMS-proposed revisions as well as the expiring provisions in the law to the geographic practice cost indices (GPCIs) for 2012 by county and physician payment locality.**

Many of the changes to the geographic practice cost index are provisions in the law that have expired, such as the work gpci floor and the 50% practice expense adjustment – as well as CMS proposed changes. CMA recommends that CMS develop a table that shows the impact of each of these changes separately by county and physician payment locality. Otherwise, it is difficult to understand whether payment changes are due to fluctuations in rent or labor costs or expiring provisions of law.

- **CMA urges CMS to continue to use the Department of Housing and Urban Development (HUD) rent data as the proxy for physician office rent for 2012.**

While CMA believes the ultimate transition to the American Community Survey may be appropriate (given the lack of alternative commercial rent data sources), we question CMS' proposal to move from the HUD rent data to the American Community Survey (ACS) rent data in 2012. The Institute of Medicine (IOM), in their recent report on the geographic payment issues did NOT recommend immediate adoption of the ACS as the rental data source because it was not as populated and therefore, statistically valid. The IOM concluded that the current basis for determining rent expense from HUD is imperfect but preferable to the current data sources.

Further, the ACS rent data appears to be inaccurate in some geographic regions. For instance, rent in the Santa Clara area reportedly increased by 7% yet it was essentially unchanged in neighboring counties, such as San Francisco, San Mateo and Santa Cruz – areas with similar market conditions and characteristics. We found similar discrepancies in other states. For example, urban commercial rent surveys place Manhattan as one of the highest rent areas in the country per square foot. Yet this proposal would reduce Manhattan's rent index by nearly 20%, placing it relative to Miami, Florida and less than Teton, Wyoming!

- **CMA's analysis shows that the ACS rent data is consistently less than the HUD data. CMA urges CMS to provide a cross-walk between the two data sources so we can determine whether the change in rent was due to a change in the data source or a true market change.**
  The CMA analysis also shows physician payments being reduced from -1.3% in Los Angeles to +0.3 in Santa Clara for an average -1% reduction in California. The CMS-provided analysis shows slightly larger reductions. Based on our analysis, we believe that most of this negative impact is due to the reduction in rent. However, we fear that it is not based on reductions in rent but on incomplete ACS rental data.

- **CMA applauds CMS' proposal to geographically adjust non-physician employee compensation and increase the weight of non-physician employee wages in the calculation of the practice expense. We support the addition of a Purchased Service component to the Practice Expense GPCI. We also support the proposed weighting. We believe this new category accurately reflects the variable professional and non professional labor costs that we commented on last year. We believe the Bureau of Labor Statistics (BLS) data source is appropriate, as well as the recognition of the new categories of professions that physicians employ – such as HIT professionals. We also concur that non-physician employee wages are consuming a larger share of physician practice expenses, particularly in California.**

- **CMA does not oppose using the 2006-based MEI weight for fixed capital and utilities as the weight for the office rent category in the PE GPCI. As we commented last year, the cost of utilities is included in the housing data used for the rent index. As long as this data source is used as a proxy for office rent, accurate weighting should include both fixed capital and utilities.**

- **Finally, the IOM recommended that CMS address access to care problems through supplemental payment policies but not through the GPCIs. CMA concurs and applauds CMS for maintaining accurate payments by geographically adjusting practice expenses. We look forward to working with CMS and Congress to address access to care problems in underserved areas through different mechanisms.**

- **<u>Physician Geographic Payment Locality Issues</u>**

CMA urges CMS to adopt the Institute of Medicine's recent recommendation to the Secretary to move the physician payment localities to Metropolitan Statistical Area (MSA) regions consistent with the hospital wage index regions and to phase-in the change to mitigate any negative impact on physicians practicing in rural areas. CMA will continue to work with Congress to develop a hold harmless for the rural physicians.

The CMA is extremely disappointed that CMS has once again decided not to address the long-standing payment inaccuracies in the Physician Payment Areas. The Institute of Medicine recently criticized CMS for not updating the physician payment localities and strongly recommended that the 89 physician payment regions be modified consistent with CMA policy to Metropolitan Statistical Areas (MSAs) in-line with the hospital wage index regions. The GAO, MedPAC, Urban Institute and others have also recommended that the localities be updated to improve payment accuracy. Physicians in 14 California counties are underpaid by up to 13% annually according to Medicare's own cost data because they are misclassified. For instance, two high-cost urban regions of California - Sacramento and San Diego - are still designated as rural areas and therefore, their rent and employee practice expenses are not appropriately reimbursed as it is for physicians practicing in other regions. CMS has engaged in paying dramatically inaccurate payments and we urge CMS to adopt a transition plan to update the localities. This transition plan must take into account the

negative impact on physicians practicing in rural areas and work to mitigate the reductions in these regions.

CMA has been petitioning CMS and Congress since 2001 to make these changes. We urge CMS to make this a priority in 2012 pursuant to the recent IOM recommendations to the Secretary.

III. VALUE-BASED PAYMENT MODIFIER

Section 3007 of the ACA requires the Secretary to apply a new budget-neutral quality and cost modifier to physician payment through the Medicare fee schedule starting in 2015 and 2017. Physicians who spend less than the national average per Medicare beneficiary and successfully report on quality measures shall receive a higher level of reimbursement and those physicians who spend more than the national average per Medicare beneficiary and do not successfully report on quality measures shall receive a lower level of reimbursement. **While the CMA amendments to ensure the Value Modifier payments are risk and cost adjusted were adopted by Congress, the CMA strongly opposed the value modifier and asked for it to be pilot-tested before contemplating implementation for the following reasons:**

Quality Reporting Inaccuracy – the California Experience

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 disclosure to the public.

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 and not make it public. However, the private health plans are still pushing to publish inaccurate physician information. **Please see the attached CMA letters outlining the problems with the CPPI program in California.**

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.

CMA strongly opposes the public disclosure of individual physician quality information unless the current attribution methodology, risk-adjustment methodology and reporting mechanisms are vastly improved. The data must be accurate and statistically valid. And finally, protections need to be in place to allow physicians to review the report before it is published, appeal the report and have it corrected if found to be inaccurate.

We also oppose the use of this information to penalize individual physicians until the methodology can be significantly improved. Inaccurate information can mislead patients and physicians without improving the quality of care or reducing costs.

Geographic Variation in Spending Related to the Value Modifier

Any value-based payments based on geographic spending benchmarks must be adjusted for differences in geographic practice expenses and the socioeconomic status of the patients. The Value Modifier proposal was originally based on the incomplete Dartmouth Atlas research that shows wide variation in Medicare spending across the country. California expenditures were at or above the national average. However, the Dartmouth research has been widely criticized for not adequately taking into account geographic practice cost differences and the socioeconomic and health status of the patients. During the health care reform debate, the Institute of Medicine was charged by HHS to study geographic variation in Medicare spending. Recently, the IOM released a dataset that risk-adjusted Medicare spending according to the Medicare Advantage HCC Risk adjustment methodology. The IOM also adjusted Medicare spending data based on the geographic differences in physician practice costs (i.e., rent, non-physician wages). The IOM dataset shows that when Medicare spending is cost and risk-adjusted, California physicians are extremely efficient and spend 80-90% of the national average. **Therefore, it is crucial that CMS appropriately take these variables into account when implementing the Value Modifier as the statute requires.**

For instance, physician office rent costs are more than two times higher in California than the Midwest rural states. HUD rental data shows that rent in San Mateo, California is $1,658 and San Diego, California is $1,418 compared to rent in the rural Midwest states – Marshfield, Wisconsin $586 and Des Moines, Iowa $579.

A team of UCLA researchers recently demonstrated the socioeconomic differences between patients in Los Angeles and Minnesota and the impact on health care spending.

	LA County/Inner City LA	Minnesota
Average Income	$24,000	$37,373
Below FPL:	38% /56%	11.6%
Black/Latino:	57% /80%	9%
Uninsured:	24% /41%	8.8%

Geographic regions with high numbers of low-income, ethnically and racially diverse patients who have been uninsured are more likely to have higher health care costs because these patients have experienced barriers to care and once they reach Medicare age are more likely to have multiple chronic conditions that are more difficult and costly to treat.

CMS is required by the ACA to make geographic-related cost and health status adjustments to the value modifier. Those adjustments need to include all of the Medicare GPCI-related practice expense adjustments, particularly rent and wages, and the following specific socioeconomic factors: the number of patients living under the poverty level; patient race/ethnicity; insurance status of the patients and their health status.

To maintain access to care for traditionally underserved patients in underserved areas of California, it is essential that CMS adjust payments as described above. Moreover, it is vital that patients with serious, chronic conditions have appropriate access to physicians and that physicians are not disincented from treating these patients.

Performance Period for the Value Modifier

As previously noted, the ACA requires CMS to implement a budget neutral value-based payment modifier for some physicians by January 1, 2015, and for all physicians by January 1, 2017. The agency is required to publish no later than January 1, 2012, the quality and cost measures, implementation dates, and initial performance period to be used in the modifier and to begin implementing the modifier "through the physician rulemaking process during 2013." In this proposed rule, CMS announces its intention to use calendar 2013 as the performance year on which payment bonuses and penalties will be applied in 2015 even though many aspects of the modifier, including the attribution methodology, comparison groups, and affected physicians, have not yet been determined and are not likely to be finalized until November 2013.

The CMA and AMA are well aware that this provision of the ACA asks CMS to work through a myriad of unresolved methodological issues and implement what may ultimately prove to be an unworkable proposal within an unrealistic time frame. We believe that the effort outlined in the rule to test different methodologies, feedback report formats, and measures is both necessary and extensive and will require considerable time to complete. According to the proposed rule, for example, the agency ***"could"*** begin testing the new Medicare episode grouper "on a limited basis" in 2012 or 2013 with additional work to follow over the next three or four years. It also is looking for ways to make reports and measures more applicable to specialty physicians and to introduce more outcome measures into the process. As laid out in the rule, other specific work still to be done includes:

- Investigation of alternative attribution methods that would expand the number and types of physicians who could be evaluated.
- Development and/or testing of various types of quality measures, including both self-reported and claims-based measures that are more outcome oriented and might focus on preventable hospitalizations, avoidable emergency room use, care coordination, and complications.
- Incorporation of feedback reports and value-based modifiers into CMS' information technology systems.

- Evaluation of other cost measures, such as one tied to the Medicare Severity. Diagnosis Related Groups (MSDRGs) now used to pay hospitals.
- Combining cost and quality data into a composite value-based modifier.
- Determination of whether the modifier will be applied to individual physicians, groups of physicians, or regions of the country and whether comparisons will be made on a regional or national basis.
- Deciding how to make the modifier "systems-based," as required by the ACA.
- Evaluation of and potential improvements in risk adjustment tools.

CMA strenuously opposes CMS' plan to truncate an already inadequate preparation period by basing 2015 payment adjustments on performance in calendar year 2013. In effect, CMS is proposing to cut or increase payments to some as-yet-unidentified physicians based on comparisons to a still-to-be-determined peer group using cost and quality measures, risk adjusters, and patient attribution methods that also have not been finalized. As has been the case with other payment penalties imposed by Congress, CMS is essentially pushing up deadlines for participation by a full year due largely to its own data processing limitations. We are sympathetic to the problem, but do not agree that there is no other solution.

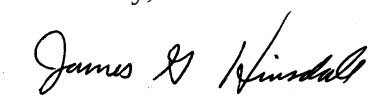
In the ACA, Congress gave the Secretary of the Department of Health and Human Services (HHS) the authority to "specify an initial performance period for application of the payment modifier" which it was to "begin implementing…through the rulemaking process during 2013." In the rule, CMS says that it will in fact begin implementing the modifier "through the rulemaking process during 2013 for the physician fee schedule effective in 2014." The agency then proposes to base the 2015 payment adjustment on how physicians performed in 2013, rather than a later time period because some claims are not processed until the year following the year when the service was rendered. Therefore, the rule asserts, CMS must use an initial performance period that covers the calendar year two years in advance of the year when payments will be adjusted.

Using 2013 as an initial performance period is much too soon, and is not required by law. In fact, nothing in the law requires that the initial performance period be based on a calendar year or that it cover an entire 12 months. We see no reason for rushing the process and adjusting physicians' Medicare payments for how they performed during a time when they didn't even know what the rules would be. This kind of logic may drive physicians, especially those in solo practices or small groups, out of medicine, creating access problems for Medicare beneficiaries and defeating the ACA's promise of coverage for the uninsured.

Finally, CMA recommends that CMS 1) inform Congress that many of the requirements under the Value Modifier have never been accurately accomplished and therefore, 2) recommend modifications in the Patient Protection and Affordable Care Act's (ACA) to the value-based modifier payment methodology.

We thank you for the opportunity to provide comments on the proposed 2012 Medicare physician fee schedule. The CMA contact is Elizabeth McNeil, Vice President, Federal Government Relations, emcneil@cmanet.org.

Sincerely,



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