STATEMENT

of the

American Medical Association

to the

Practicing Physicians Advisory Council

Re: Update on the Physician Fee Schedule
Beneficiary Access
Funding for Provider Education
Medicaid Access Provision
Health Insurance Portability and Accountability Act

September 23-24, 2002

The AMA urges the Practicing Physicians Advisory Council to recommend that CMS —

PHYSICIAN FEE SCHEDULE UPDATE

- Exercise its authority to remove drugs from the SGR pool, rather than attempt to finance their cost through reduced payments to physicians;

- As it calculates the 2003 SGR, and revises the SGR for 2001 and 2002, CMS should evaluate, as required by the law and regulation component of the SGR, the impact on utilization and spending resulting from all regulatory changes, including national coverage decisions, issued during the last several years;

- For purposes of calculating the SGR, correct errors in CMS estimates of U.S. gross domestic product (GDP) growth and enrollment changes in 1998 and 1999, which have shortchanged funding for physicians' services by $20 billion to date;

FUNDING FOR PROVIDER EDUCATION

- Recognize Congress' and the GAO's strong message on the importance of physician education and training by making funding for provider education a higher priority; such funding should be provided on an ongoing basis and should not be used for other Medicare purposes;

- Further, we urge the Council to strongly recommend to CMS that adequate and reliable funding for provider education; and

- And HHS provide comprehensive educational opportunities to physicians and other providers on HIPAA and similar law and related regulations.

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (the Council) concerning the physician fee schedule update and beneficiary access, funding for provider education, Medicaid access and the Health Insurance Portability and Accountability Act (HIPAA).

PHYSICIAN FEE SCHEDULE UPDATE

As we have discussed with the Council at several previous meetings, effective January 1 of this year, Medicare payments for all services provided by physicians and numerous other health care professionals were cut by 5.4 percent. This is the largest payment cut since the Medicare physician fee schedule was developed more than a decade ago, and is the fourth cut over the last eleven years. As we reported to the Council at its March meeting, without intervening action by the Administration and Congress, this payment cut will be severely compounded over four years and total cuts from 2002 through 2005 are expected to be more than 17 percent, and this number will increase when you medical inflation is added.

These cuts, which are coming at time when physicians' practice expenses, particularly medical liability insurance costs, are skyrocketing, will seriously add to the already significant pressures on physicians to discontinue or limit the provision of services to Medicare patients.

BENEFICIARY ACCESS

Numerous news reports across the country have already documented growing access problems resulting from Medicare cuts. In addition, recent data from multiple studies, including beneficiary representatives, indicate that Medicare payment cuts reduce beneficiaries' access to service. Rural communities are particularly at risk.

According to a survey conducted by the AMA shortly after the 5.4 percent Medicare cut was implemented on January 1, 2002, some 24 percent of physicians either had placed limits on the number of Medicare patients they treat or planned to institute limits this year. The survey also found that, if there is an additional large Medicare cut in 2003, two out of five, or 42 percent, of responding physicians would not sign or renew a Medicare participation agreement. In a similar vein, a survey by the American Academy of Family Physicians found that nearly 22 percent of family physicians are no longer taking new Medicare patients, a significant increase from the same survey conducted a year earlier.

Surveys from two nonpartisan policy organizations also suggest that physician willingness to treat Medicare patients is declining. One by the Center for Studying Health Systems Change concluded that the number of physicians accepting all new Medicare patients declined from 74.6 percent in 1997 to 71.1 percent in 2001 — a year before the cuts even took effect. The other, done for the Medicare Payment Advisory

Commission, found, based on preliminary data, a more percipitous slip — specifically that between 1999 and 2002, the percentage of physicians accepting all new Medicare patients dropped from 76 percent to 69 percent.

Beneficiary groups confirm that problems existed even before 2002 and have worsened since then. Specifically, a 30-state survey by the Medicare Rights Center found that Medicare beneficiaries in more than half of these states are already having trouble finding a physician who accepts new Medicare patients. In six of these states and two additional ones, access problems worsened after the 2002 cuts took effect.

It is imperative that CMS support immediate enactment of legislation to stop Medicare payment cuts and keep the Medicare program strong for America's seniors.

CMS AUTHORITY FOR ADDRESSING
PHYSICIAN PAYMENT UPDATE PROBLEMS

The magnitude of the Medicare physician payment cuts predicted by CMS over the next several years makes the cost of legislative changes to the physician payment update formula a major fiscal challenge. Given current federal budget constraints, it is difficult for Congress alone to address on a long-term basis the cuts facing physicians and the resulting access problems for Medicare patients.

In CMS' proposed physician payment rule, issued in June, CMS announced that it plans to change the methodology for adjusting productivity in the Medicare Economic Index (MEI) by using economy-wide multi-factor productivity instead of the current labor productivity adjuster. We appreciate and wholeheartedly agree with CMS' proposal. As we previously advocated, we believe that the current labor-only productivity adjustment in the MEI overstates productivity gains in the physician services industry. As a result, the MEI has been understating increases in the cost of practicing medicine. Use of a multi-factor productivity adjuster will produce a more equitable and realistic adjustment that better reflects actual changes in practice costs.

As we have discussed with the Council at prior meetings, however, CMS has the administrative authority to make other substantial changes to the current payment system, which could significantly reduce the cost of a legislative fix, and, in tandem with action by Congress, could alleviate the payment update problems.

Inclusion of Drugs in the SGR

As we have previously discussed with CMS and the Council, the costs of prescription drugs should not be included in the sustainable growth rate (SGR). Physician administration of a drug is clearly a physician service that by statute must be included in the pool. Drugs themselves, however, are not physician services. Based on a legal opinion from former HCFA General Counsel Terry Coleman, which we discussed

at the last Council meeting, we believe that CMS not only can, but must, remove drugs from the SGR pool.

It is our understanding that the Administration does not question that it, at least, has the authority to take drugs out of the pool but, rather, is concerned that doing so would lead to an explosion in Medicare drug expenditures. This ignores the obvious — drug expenditures have already exploded. The SGR had no discernible impact on either the price or volume of drugs covered by Medicare and provided by physicians. In fact, between 1996 and 2000, drug spending per Medicare enrollee increased by nearly 125 percent, or, about six times as fast as spending for physician services. This is hardly surprising given the pharmaceutical advances that were taking place during this time frame.

Much of the increase in drug spending can be traced to government policies that encourage the rapid development of new drugs and cancer therapies. These policies simultaneously urge Americans to be tested and seek early treatment for cancer and other diseases. For example, appropriations for the National Cancer Institute (NCI) increased by more than 35 percent between 1997 and 2000, the Food and Drug Administration (FDA) drug approval process was streamlined, and Congress expanded Medicare to include new screening benefits for breast, cervical, colorectal and prostate cancer. Secretary Thompson has actively promoted these new benefits, as did his predecessor.

These are laudable policies that have improved the lives of millions of Medicare beneficiaries. Further, the Administration apparently intends to continue these policies, as evidenced by a draft HHS strategic plan that proposes to "accelerate private sector development of new drugs, biologic therapies and medical technology." **To continue including drugs in the SGR, however, is at odds with the goals of HHS' strategic plan. In effect, physicians will be punished with lower payments if they provide the very new drugs and therapies that the strategic plan wants manufacturers to produce.**

We have seen no evidence that the increased use of Medicare-covered drugs stems from the provision of unnecessary drugs, and we do not condone the use of drugs where there is no therapeutic value. It is has been shown time and again that physicians are very responsive when they are provided with credible data, and the specialties that provide the bulk of Medicare-covered drugs are committed to working with the Administration to design education programs, guidelines or other approaches to address any areas where there is demonstrable overuse of particular drugs. (See attached letter.)

Our own analysis suggests that drug use has grown not because of misuse, but because of innovations in the treatment of cancer and arthritis along with improvements in pain management and modifications in clinical practice. Between 1996 and 2000, some 40 new drugs were introduced. Eight of the 15 most frequently used drugs in 2000 (J9202, J9265, J2430, J9310, J9170, J1260, J7320, J1745) were either brought to market or received FDA approval for expanded uses between 1996 and 2000. Off-label therapies

expanded use of a ninth (J9045) and three (Q0136, J1441, J2405) saw expanded use because they counteract side effects of new combined cancer therapies.

Notably, the use of epoetin (Q0136, Q9925-Q9935) — previously used primarily to counteract anemia in end stage kidney disease patients — rose dramatically as its use was extended to patients with chronic kidney disease, cancer and other conditions where anemia is common or is a by-product of treatment. Expenditures for immune globulin increased, though at a much slower rate, as the drug's effectiveness and low rate of side-effects made it the standard treatment for patients with auto-immune disorders of the nervous system.

Increased incidence of lung cancer and enhanced efforts to promote screening for breast and prostate cancer also contributed to the expansion of Medicare expenditures for a number of drugs (J9217, J9202, J9265, J9045, J9170). During the five-year time frame in question, expenditures for chemotherapy drugs increased by 81 percent. This new spending extended the lives of many Medicare beneficiaries and contributed to declining cancer mortality rates (which fell by about 1 percent a year between 1993 and 1999).

Moreover, quality of life was also improved for many of these patients due to increased use of epoetin and other drugs to counter side-effects of chemotherapy. Growing evidence that pain associated with cancer and other conditions is frequently under-treated along with enhanced abilities to control pain led to the evolution of pain management as a specialty during this period. Drugs associated with this development include new injections, such as hylan (J7320), infliximab (J1745), and sodium hyaluronate (J7315), as well as drugs such as botox (J0585), where a number of new uses were discovered during the time frame in question.

There is no end in sight. As the HHS plan anticipates, a number of new products, including several additional promising arthritis and cancer drugs, are in the pipe line. Many current drugs — such as rituximab, which is the subject of more than 200 planned or ongoing clinical trials — are likely to be found effective in additional conditions. Moreover, most of the more prevalent cancers are found primarily among the aged and cancer incidence in the U.S. is predicted to double over the next 50 years. (*The Annual Report to the Nation on the Status of Cancer, 1973-1999, Featuring Implications of Age and Aging on the U.S. Cancer Burden*, 94 Cancer 10, at 2766-2792 (May 15, 2002)).

We understand that CMS actuaries believe that Medicare expenditures for drugs will continue to grow more rapidly than spending on physician services. Moreover, this assumption apparently is a significant contributor to the negative updates that the actuaries have projected in the future. **The AMA firmly believes that continued reductions in physician payments will jeopardize Medicare patients' continued access to medical care, and we strongly urge the Council to recommend that CMS exercise its authority to remove drugs from the SGR pool, rather than attempt to finance their cost through reduced payments to physicians.**

Unfunded Mandates

The AMA continues to oppose use of a spending target in determining annual updates to Medicare payments for physicians' services. Nevertheless, since CMS is required by law to use a target — the SGR — in updating physician payments each year, we urge CMS to use correct data when calculating the SGR

Changes in Medicare Spending on Physicians' Services Due to Laws and Regulations

We urge the Council to recommend that CMS take into account various proposed regulatory changes, as required by law, when calculating the SGR for 2003. Further, in the final physician payment rule, when revising the SGR for 2001 and 2002 to reflect recent data, CMS is required by law to recognize the effects of numerous regulations that were not taken into account in previous estimates of the SGR for these years. We urge the Council to recommend that CMS recognize the effects of these regulations.

Under the SGR system for annually updating Medicare payments to physicians, CMS is required by law to calculate the impact of changes in laws and regulations on spending for physicians' services. As we have commented in the past, CMS, in calculating the SGR, has continually understated increased utilization and related Medicare spending increases that result from regulatory changes. Omission of the impact of these regulatory changes, when calculating the SGR, violates the law.

Further, any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as a Program Memorandum or a national Medicare coverage policy decision, constitute a regulatory change as contemplated by the SGR law. CMS' authority to make any regulatory change is derived from law — whether it is a law specifically authorizing Medicare coverage of a new service or a law that provides the Secretary of the Department of Health and Human Services (HHS) with general rulemaking authority. Thus, any new coverage initiative is a direct implementation, by regulation, of a law. This is exactly what the SGR requires be taken into account —increases in spending due to "changes in law and regulations."

When CMS fails to take into account the impact of regulatory changes for purposes of the SGR, physicians are forced to finance the cost of new benefits and other program changes. Not only is this in violation of the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services. It is not as if CMS' regulatory coverage decisions have a negligible impact on utilization of and spending on physicians' services. Rather, HHS and CMS actively promote utilization of newly-covered Medicare services through press releases and other public announcements. For example, the Secretary of HHS recently released a new report highlighting the importance of medical innovation and new technology, especially new drugs, in helping seniors live longer and healthier lives. Further, another HHS release regarding Medicare coverage of sacral nerve treatment for urinary incontinence stated, "[u]rinary

incontinence affects approximately 13 million adults in the United States, with nearly half of nursing home residents having some degree of incontinence. It is twice as prevalent in women as it is in men, and costs more than $15 billion per year, including both direct treatment of the disease and nursing home costs." The Secretary made a similar announcement when Medicare expanded its coverage of lymphadema pumps, stating, "[i]t's important to make effective technologies available to Medicare beneficiaries when it helps them the most. This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily." While we support Medicare beneficiary access to these important services, physicians and other practitioners should not have to finance the costs resulting from the attendant increased utilization.

Accordingly, we urge the Council to recommend that as CMS calculates the 2003 SGR, and revises the SGR for 2001 and 2002, CMS should evaluate, as required by the law and regulation component of the SGR, the impact on utilization and spending resulting from all national coverage decisions issued during the last several years. Numerous recent national coverage decisions, many of which impact utilization of and spending on physicians' services, are listed in Attachment A.

In addition, there are certain provisions in CMS' proposed physician payment rule that likely will increase utilization, and thus these regulatory initiatives, if finalized, must be taken into account for purposes of calculating the SGR for 2003. For example, as part of CMS' proposed process for annually adding or deleting services to the list of telehealth services covered by Medicare (as discussed below), CMS is proposing to add psychiatric diagnostic interview examinations (HCPCS code 90801) to the list of Medicare telehealth services. While we wholeheartedly support this expansion of telehealth services, an increase in utilization will likely be the result, and this regulatory change must be taken into account for purposes of the 2003 SGR.

CMS also has implemented other expansions in coverage of certain Medicare services that have not been taken into account for purposes of the SGR. For example, Medicare covers the routine costs of care for patients enrolled in clinical trials, but CMS does not consider increased utilization or spending due to coverage of these services. Likewise, CMS recently directed Medicare carriers to use new criteria for determining whether a particular drug is "not usually self-administered" and therefore not covered by Medicare. CMS stated that these new criteria are expected to "moderately expand the drugs available for some beneficiaries."

Accordingly, we urge that the foregoing regulatory changes be taken into account, as required by law, for purposes of calculating the SGR.

SGR Projection Errors

In calculating the SGR, CMS estimates of U.S. gross domestic product (GDP) growth and enrollment changes in 1998 and 1999 have shortchanged funding for physicians' services by $20 billion to date, and we again urge the Council to reiterate its recommendation that CMS correct these errors.

Specifically, CMS projected only 1.1 percent growth in real per capita GDP for fiscal year 1998, whereas actual growth was closer to 2.8 percent, according to federal government estimates. Further, CMS projected that Medicare+Choice enrollment would rise by 29 percent in 1999, even though many HMOs were abandoning Medicare. In fact, as accurate data later showed, managed care enrollment increased only 11 percent in 1999, a difference of about 1 million beneficiaries. This means that when CMS determined the fee-for-service spending target for 1999, it did not include in the costs of treating about 1 million beneficiaries. Nevertheless, these patients were and have continued to be treated, and since the SGR is a cumulative system, each year since 1999, the costs of treating these 1 million patients have been and will continue to be included in actual Medicare program expenditures, but not in the SGR target. Clearly, this disparity should be remedied as soon as possible.

LEGISLATIVE ACTION ON PAYMENT UPDATE

In June, the House passed H.R. 4954, for which the AMA has expressed its support. It contains physician payment update provisions that would (i) provide a 2 percent update in 2003, and (ii) make changes to the physician payment update formula for 2004 and 2005 that would result in positive updates in those years. The House bill would avert the immediate Medicare beneficiary access crisis by delaying the pending cuts and providing positive updates in 2003-2005.

Further, the House bill contains another important provision that would implement a permanent change in a key factor of the update system from annual GDP growth to 10-year average GDP growth. This change will help moderate the volatility in payment updates that has been caused by year-to-year fluctuations in GDP.

Following passage of the House-passed legislation, CMS announced that, due to newer data and a policy change, its estimate of medical practice cost inflation for 2003 has increased from 1.6 percent to 3 percent. The revised estimate of practice cost inflation for 2003 represents a considerably more realistic estimate of recent cost increases, including the skyrocketing costs of medical liability insurance. This increase must be reflected in the payment update for 2003.

The Senate urgently needs to pass legislation similar to the House bill to avert a serious crisis for Medicare patients. We urge the Council to recommend that CMS support Senate legislation that would build and improve upon the House bill, H.R. 4954. Specifically, the Senate legislation, as its first priority, should (i) provide a 2003 payment update of 3 percent to cover CMS-documented increases in practice costs, and (ii) provide for positive updates for 2004 and 2005, as does the House bill, and increase these updates in accordance with administrative policy changes announced after House passage of H.R. 4954. As a second priority, the Senate legislation should begin to address the longer-term structural reforms in the update system that will be necessary after 2005. Finally, the Senate also needs to clearly

acknowledge, as have sponsors of the House bill, that any proposal that does not eliminate the possibility of future cuts is a temporary solution that will require additional action within a few years.

The AMA along with about 80 medical specialty societies and other organizations representing physicians and other health professionals have jointly sent a letter to the Senate requesting that legislation with the aforementioned goals and priorities be passed immediately.

Physicians and other professionals affected by the Medicare payment cuts are the cornerstone of the healthcare system and, without them, other providers such as hospitals and nursing homes could not continue to operate. Having suffered a 5.4 percent cut in payment levels this year as fees for 2002 were rolled back below their 2001 levels, these practitioners have already had to make difficult decisions that have led to access problems for some Medicare beneficiaries, as discussed above. Yet under current law, payments will be cut by an additional 12 percent from 2003-2005, forcing more physicians and health professionals to take steps that cannot help but exacerbate the current access problems. Indeed, evidence shows that Medicare patients' access to care will continue to decline significantly unless legislation is enacted immediately, and by no later than November 1 of this year.

On November 1, CMS will publish the 2003 Medicare physician payment schedule and physicians will need to decide whether or not to sign or continue a Medicare participation agreement for 2003. When asked if they would continue to sign Medicare participation agreements if there were additional payment cuts, 42 percent of physicians responding to an AMA survey said they would not. Legislation to remedy the physician payment and Medicare patient access problem must be signed into law by November 1.

Accordingly, we urge the Council to recommend that CMS actively support passage and enactment of such legislation.

<u>AMA POLICY ON MEDICARE UPDATE AND GEOGRAPHIC PRACTICE COST INDICES</u>

The AMA's House of Delegates (HOD) adopted policy in June that directs the AMA to make fixing the payment update problem its first legislative Medicare payment priority. **This policy is based on the fact that the Medicare payment update fix "is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact."**

In addition, the HOD directed that the AMA seek enactment of legislation to reduce unjustified geographic disparities in Medicare payment rates. Specifically, the HOD adopted policy to direct the AMA to:

- Seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any

unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas;

- Advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option; and

- Work to eliminate the unfairness inherent in the current wide geographic disparity in physician Medicare reimbursement.

FUNDING FOR PROVIDER EDUCATION

As we have discussed with the Council in the past, it is critical that CMS make it a priority to allocate substantially more funding for provider education, and we urge PPAC to recommend that CMS allocate such funding immediately.

The myriad of rules and regulations governing the Medicare program, changes to local medical review policies, local interpretations of Medicare policies, HIPAA rules and requirements, and other federal mandates/requirements, such as the Office of Civil Rights limited English proficiency (LEP) requirements, leave physicians uncertain about how to file claims accurately and be in compliance with related federal rules and requirements. We have been concerned for some time about the woefully inadequate funding for physician education and training about these requirements. The relatively small amount of funding provided in the federal budget for provider education and training by Medicare contractors is insufficient to properly prepare physicians, as well as all other providers, for the regulatory requirements with which they must comply. Indeed, CMS' budget request for provider education and training for fiscal year 2002 year was only $41.5 million for physicians and hospitals and other health care providers combined. This amount is not adequate to appropriately conduct provider and education training.

Last December, however, the House of Representatives unanimously passed regulatory reform legislation that would (i) increase funding for provider education and training by $50 million over fiscal years 2003 and 2004, and (ii) provide an additional $7 million during fiscal years 2003 and 2004 in funding for an ombudsman to iron out unclear and inconsistent CMS rules and regulations. Further, in recent General Accounting Office (GAO) reports examining the impact of provider education and the interaction between physicians and carriers, the GAO emphasized the importance of provider education for minimizing claim errors.

We urge the Council to recommend that CMS recognize Congress' and the GAO's strong message on the importance of physician education and training by making funding for provider education a higher priority.

CMS cannot continue to view physician education funding as a low priority. As we discussed with the Council at its last meeting, CMS recently sent a revised Notice of

Budget Approval (NOBA) to its contractors indicating that it was reducing funding for physician education and training by 11+% to fund "HIPAA activities." This comes at a time when physicians and other health care providers will be needing significantly more funding for provider education and training for activities, including HIPAA. Yet, the agency is using those dollars for other so-called funding priorities.

We believe this cut in provider education funding is already having a noticeable adverse impact. For example, CMS' Standards for Electronic Transactions final rule, which adopted initial standards for transactions and code sets, was published August 17, 2000, with a compliance date of October 16, 2002, or 2003, if an extension form was submitted by physicians to HHS by no later than October 15 of this year. Despite strong efforts by the AMA to make physicians aware of the need to file an extension form, we are very discouraged by the low number of forms that have been filed thus far. If additional funding were available for provider education, the number of extension forms filed likely would greatly increase.

We also note that funding should be directed toward coordinating provider education on HIPAA. Various divisions within HHS are responsible for implementation of different parts of the HIPAA law. Instead of offering comprehensive provider education programs wherein each of these divisions would make their respective HIPAA presentations, physicians and other providers have been responsible for seeking out and attending numerous educational programs offered on HIPAA by each of the different divisions within HHS responsible for implementing certain sections of the law. When the federal government enacts a law and issues implementing regulations, such as the privacy law and related rules, physicians and other providers should be able to obtain answers about implementation from a single, comprehensive government source. They should not have to attend seminars on a piecemeal basis and then be responsible for putting all of the individual pieces together. **Accordingly, we urge the Council to recommend that HHS provide comprehensive educational opportunities to physicians and other providers on HIPAA and similar law and related regulations.**

Further, we urge the Council to strongly recommend to CMS that adequate and reliable funding for provider education be provided on an ongoing basis and that such funding should not be used for other Medicare purposes.

MEDICAID ACCESS

The AMA is concerned about disturbing trends in state Medicaid programs that indicate the possible development of an even greater access crisis for this vulnerable patient population. A recent study by the Urban Institute examined trends in state Medicaid programs and how states have responded to both federal constraints and state flexibility over the past few years. The study found that states may have increased pressure in the coming months as current systems reach their capacity and new fiscal challenges arise.

The study discussed a number of pressures on states' budgets that could adversely impact state Medicaid programs. Most states are now facing serious budget deficits due to a slowed national economy that has reduced state revenues and caused increased state spending. Moreover, state Medicaid programs are experiencing substantial spending increases due to a number of factors, including medical inflation, increased costs of prescription drugs, expansion of community-based long-term care and increased enrollment.

Prescription drug costs, in particular, increased an average of 18.1 percent per year from 1997 to 2000, compared with 7.7 percent for all Medicaid spending, and these growth rates are expected to continue, especially since the aged and disabled populations, which are heavy users of prescription drugs, are growing as a share of Medicaid beneficiaries. In a survey of state Medicaid programs, 48 states identified prescription drugs as a major cause of Medicaid spending growth in 2001.

These pressures on state budgets could cause states to cut Medicaid budgets, curb eligibility and benefits. Indeed, Florida has reduced Medicaid eligibility in response to budget problems. Further, many states have held physician fees at well below Medicare and private market rates. **We are very concerned that, in response to budget crises, states will implement further cuts to provider payments across-the-board. Indeed, a recent survey by the Kaiser Family Foundation found that 17 state Medicaid programs planned to reduce payments to physicians as a response to their fiscal crisis. These cuts likely will result in providers dropping out of the program, which, compounded by the additional factors discussed above, will seriously jeopardize access to Medicaid services.**

We appreciate the opportunity to provide our views to the Council on these critical matters, and are happy to work with the Council and CMS to achieve the all of the foregoing recommendations.