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Industry, Business & Labor Committee
ND Legislative Council
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Chairman Keiser and Committee Members, I'm Bruce Levi and I serve the North Dakota Medical Association as executive director. NDMA is the professional membership organization for North Dakota physicians, residents and medical students. On behalf of NDMA I appreciate the opportunity to provide information regarding federal health care reform legislation and the impact of federal proposals on the state of North Dakota.

Previous Testimony

NDMA has testified before this committee on several occasions. A summary of previous testimony is attached as **Appendix A**.

Sustainable Growth Rate: *The Status of the "Doc Fix"*

In previous meetings of the committee, NDMA has provided information on the so called "doc fix." We were requested to provide an update for this meeting.

On June 24, the U.S. House passed an amended version of H.R. 3962, called the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," by a vote of 417 to 1. The Senate had previously passed this legislation on June 18, and the President signed the bill into law on June 25. The bill provides a 2.2 percent Medicare physician payment update for six months, from June 1 through November 30, 2010, in lieu of the current 21 percent cut. CMS agreed to retroactively adjust any June claims that had already been paid using the reduced payment schedule, since the 21 percent cut did take effect for a short time after the previous June 1 deadline was missed. On December 1, we will face another payment cut of 23 percent.

Every U.S. state medical society including NDMA and more than 35 specialty societies signed a statement on June 16 urging Congress to deal permanently with Medicare's sustainable growth rate (SGR) formula. The statement is attached as **Appendix B**.

The federal Balanced Budget Act of 1997 enacted Medicare's sustainable growth rate formula (SGR). The formula calculates an annual target for Medicare spending on physician services based in part on changes in the gross domestic product. If actual spending exceeds the target, Medicare is supposed to make up the difference by lowering physician reimbursement the following year, despite the reality of rising practice expenses. For almost a decade, the SGR formula has triggered a pay cut and every year Congress has postponed it, except once. However, the difference between actual and targeted spending accumulates year to year, making each cut bigger than the last. Even while cuts have been largely averted, the largest payment increase in any year has been 1.5%. Many years have seen a 0% to 0.5% increase. With health care costs exceeding the rate of inflation, the SGR has resulted in a sharp decline in payments for physician services for Medicare-related care.

Congress could have permanently solved the problem five years ago at an estimated 10-year cost of $49 billion, according to the AMA. The price tag now, according to a recent score from the Congressional Budget Office, would be $276 billion over 10 years. If not fixed, the cost of a full overhaul would top the $500 billion mark within the next five years.

The impact of the SGR is far-reaching. In previous years and earlier this year, where cuts have been actually allowed to take affect for short periods of time, physicians in some parts of the country responded by cutting appointments to new Medicare patients. Some practices even closed temporarily because of concern they could not cover the operating costs of their practice.

Congress' inaction on permanently solving this issue is certainly now tied to concern for increasing government financial debt which certainly must be balanced with the premise that allowing Medicare cuts to occur will create a crisis, leaving a large section of American seniors with a lack of health care coverage and access to physician care. As a result, the myriad patchwork fixes continue, with no plans in sight for overhauling the system.

PPACA: New Payment and Delivery Reform Models

We will also comment on new payment and delivery reform models in the health system reform legislation and urge the Committee to consider the potential impacts of these initiatives in North Dakota. As noted in previous meetings, while these strategic initiatives test almost every approach

that leading healthcare experts have suggested, it is unknown at this time how these initiatives will develop and to what extent North Dakota physicians and hospitals will participate in them. While NDMA will advocate for amendments and modifications to the *Patient Protection and Affordable Care Act* (PPACA) regarding those provisions that are inconsistent with NDMA policy, the Association will make efforts to assist physicians in evaluating opportunities to participate in demonstration programs and other opportunities under the new health system reform law.

The PPACA includes a range of pilots and demonstrations designed to test changes to the way health care is organized and reimbursed – with the goals of improving health outcomes and controlling costs. This approach takes into account that people not only need insurance coverage; they need access to physicians and other medical professionals who can provide them with high quality and affordable care. Health care will not be affordable without significant changes to the delivery system [Connecticut Health Care Reform Advisory Board, *Final Report to Governor Rell and the General Assembly* June 30, 2010, p. 3].

With respect to payment reforms, the opportunities and challenges have been described as follows:

> There is a growing recognition that the structure of current healthcare payment systems frequently impedes efforts to improve the quality of health care and control health care costs. Fee-for-service payment systems can financially penalize physicians for keeping people healthy, for reducing errors and complications, and for avoiding unnecessary care, and they can restrict physicians' flexibility to design and deliver care for their patients in the most efficient and effective manner.
>
> This has led to a variety of different proposals for change to payment systems. Each of these proposals has advantages and disadvantages, and each could have very different impacts on physicians and other healthcare providers. Harold D. Miller, *Pathways for Physician Success Under Healthcare Payment and Delivery Reforms*, AMA (2010).

The PPACA provides an array of tools for state government and providers to implement voluntary pilots and demonstrations that could spur significant delivery system innovation – through linking service delivery reform and payment reform. This is in an effort to improve care coordination and

quality while reducing the rate of spending growth. These models include bundled payments, accountable care organizations (ACOs or shared savings programs) and the medical home. The law also establishes a new Center for Innovation to test other care models, and it gives the secretary of Health and Human Services (HHS) the authority to expand the scope and duration of the new models, including the authority to expand them nationwide.

Participation in all of these demonstrations is voluntary for Medicare providers. NDMA anticipates and is already observing physician practices and our health systems begin evaluating their capacity to participate in these programs. Under these models, physicians will have to work collaboratively with other practices and/or with other providers, such as hospitals, and they may need to invest in tools and systems that are required to coordinate care and measure performance.

There may be distinct advantages to practices that are able to participate in these demonstrations. While these projects generally do not begin until at least 2012, NDMA is encouraging interested physicians to begin evaluating their ability to participate now, since organizing a practice to join in these demonstrations may require long-term planning. Even for those who do not want to participate in these particular projects, it is important to recognize their goal to test and refine these new models as potential federal payment and delivery reforms in the future. Presently, we are simply trying to ensure that physicians become familiar with the underlying concepts and overall approaches.

The following are among the many approaches envisioned under health care reform:

Center for Innovation

The PPACA establishes the Center for Medicare and Medicaid Innovation (CMI) within the federal Centers for Medicare and Medicaid Services (CMS) to test payment and delivery models that improve quality and slow cost growth (Sec. 3021). By January 1, 2011, the HHS secretary is required to establish a CMS Center for Innovation to test care models that improve quality and slow the rate of growth in Medicare costs. The secretary must publicly make an evaluation of each model, including an assessment of the quality of care provided. The secretary may limit model testing to certain geographic areas, and model designs do not initially have to ensure budget neutrality. The secretary also has discretion to develop any model that meets certain requirements, although the law

suggests a number of specific models that may be tested. The center would have broad authority to select the programs best suited to its objectives, including these:

-Promoting broad payment and practice reforms in primary care, including patient-centered medical home models for high-need individuals and medical homes that address women's unique health care needs;

-Using geriatric assessments and comprehensive care plans to coordinate care for patients with multiple chronic conditions who are unable to perform daily living activities or who have cognitive impairments;

-Supporting care coordination for chronically ill individuals at high-risk of hospitalization through a health information technology-enabled provider network;

-Establishing community-based health teams to support small-practice medical homes by assisting primary care providers in chronic care management, including patient self-management activities;

-Assisting individuals in making informed health care decisions by compensating physicians and other providers for using patient decision-support tools to improve understanding of medical treatment options.

Payment Bundling

"Bundling" payments refers to paying a single fee for an entire episode of treatment (e.g. for hospital readmissions or for care for chronic conditions). The PPACA creates a National Pilot Program on Payment Bundling (Sec. 3023). By January 1, 2013, the HHS secretary is required to establish a Medicare pilot program for integrated care. This will include episodes of care involving a hospitalization to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care. Payment will be made to the entity that is participating in the pilot program.

Accountable Care Organizations (ACOs)

An accountable care organization is a concept that would allow a provider-led organization to take greater accountability for the overall cost as well as the quality of healthcare delivered to patients. There is no one structure for an ACO; in fact, an ACO is centered more around an outcome rather than a structure or process – reducing or controlling the costs of health care for a population of individuals while maintaining, or improving, the quality of that care.

Multiple forms of ACOs are possible, including large integrated delivery systems, physician-hospital organizations, multi-specialty practice groups with or without hospital ownership, independent practice associations, and virtual independent networks of physician practices. The PPACA created a Medicare Shared Savings Program (Sec. 3022). By January 1, 2012, the HHS secretary is required to establish certain Medicare ACO shared savings programs for various providers. These providers include groups of physicians, networks of individual practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, and any other provider groups that the secretary determines is appropriate. To qualify, an ACO must agree to be accountable for the quality, cost and overall care for the Medicare fee-for-service beneficiaries assigned to it. An ACO must have at least 5,000 assigned Medicare beneficiaries and have in place, among other things, the following: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments will continue to be made to physicians and other ACO participants under the usual Medicare payment structure (e.g., the Medicare fee schedule). Additionally, ACOs would share among their provider participants a portion of any savings achieved in excess of a threshold benchmark. ACOs must agree to participate in the demonstration for at least three years.

Care Coordination Including Patient Centered Medical Homes

This is an approach to making comprehensive primary care available through a physician-led team of individuals who collectively take responsibility for providing ongoing, coordinated, and integrated care to patients. The medical home model puts emphasis on medical management rewarding quality, patient-centered care. The PPACA created a program of Community Health Team Support for Patient-Centered Medical Homes (Sec. 3502). The HHS secretary is required to provide grants or

enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including obstetrics and gynecology practices) within their local hospital service areas, and to provide payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Independence at Home Demonstration Program

The PPACA created the Independence at Home Demonstration Program (Sec. 3024). By January 1, 2012, the HHS secretary is required to establish an independent at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target.

Mr. Chairman, thank you for the opportunity to provide information on the impacts of federal health care reform. NDMA will continue to work with the committee and the ND Legislative Assembly to provide whatever information you need in assessing the impacts of the legislation in North Dakota.

Previous NDMA Testimony Before the Industry, Business & Labor Committee

At your meeting on April 28, NDMA addressed NDMA testimony focused specifically on a number of topics, perhaps most notably the issue: *who will take care of the newly insured?* We suggested that part of the solution for North Dakota in addressing projected physician shortages is to expand our state's capacity to "home grow" doctors and talked to you generally about such a plan proposed by the UND School of Medicine & Health Sciences advisory council. We also expressed the need to focus on physician recruitment and retention strategies to ensure good access to care for North Dakota patients. The need for these strategies existed before the enactment of federal health reform legislation, and is likely now an even greater need after reform. At that meeting we also provided materials on physician compensation as requested.

At your meeting of March 18, NDMA addressed the impact of what has become known as the "Frontier States" amendment which was included in the U.S. Senate bill (HR 3590), and the extent to which the proposal impacts the long-standing need to address the unfair geographic disparity in Medicare payments for North Dakota hospitals and physicians.

At your meeting of November 3, 2009, we provided you with a resolution adopted by the NDMA in September 2009 expressing general physician views and principles on both the need for Medicare payment reform and the prospect of national health system reform. That resolution urged the North Dakota Congressional Delegation as part of health system reform to pursue multiple avenues for Medicare physician and hospital payment reform that address the current unfair geographic disparity to North Dakota and address other needed payment reforms to ensure the future sustainability of North Dakota's health care system.

At your meeting of August 6, 2009, NDMA provided you with the joint NDMA/ND Hospital Association principles and recommendations for Medicare payment reform made in conjunction with an 18-month study conducted with our ND Congressional Delegation. We also at that time provided you with our position statement from July 2009 in opposition to HR 3200, the original (tri-committee) health reform bill introduced in the U.S. House of Representatives.

On August 6, NDMA also shared physician concerns regarding several commercial insurance issues, which is the subject of your original study. We shared with you the results of the study by the consulting firm Milliman requested by NDMA, the six major health systems in North Dakota and BCBSND, which prepared a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. <u>That study showed that BCBSND pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region.</u>

NDMA also shared with you our support of the efforts of the Insurance Commissioner in using the rate filing procedure this past year to require BCBSND to change its provider contracts to prohibit unilateral payment withholds and reductions at any time. For many years, NDMA has advocated for fair contracts. We also shared our experience in requesting introduction this past session of SB 2397, which was not enacted, which would have established fair contracting standards for insurance companies.

Statement of the State and Specialty Medical Societies on the Medicare Physician Payment Crisis

Failure by Congress to fulfill its responsibilities is undermining patient care in America. Three times this year, Congress has missed a deadline for dealing with Medicare's sustainable growth rate (SGR) formula, raising the specter of a 21 percent payment cut for physician services. The disruption and uncertainty for patients and physicians has made Medicare an unreliable program.

If Congress does not act this week, Medicare physician payments will be cut 21 percent. These cuts will also extend to the TRICARE program which serves military families, as well as some Medicaid programs, workers compensation programs and private insurance plans. The ripple effect of the 21 percent Medicare cut will be devastating to physician practices.

Congressional mismanagement of the Medicare program will force more physicians to stop accepting new Medicare and TRICARE patients; lay-off staff; and defer investment in new medical equipment, health information technology, and other innovations that improve patient care.

Patients and physicians should not become collateral damage in a Congressional stalemate on budgetary matters. We expect our elected officials to resolve the budget issues without punishing physicians, seniors and military families.

Past actions by Congress created the current budgetary challenge. Further, since 2003, Congress has compounded this problem by employing budget gimmicks that defer immediate cuts by stipulating deeper cuts in future years.

Democrats and Republicans agree that the flawed Medicare formula that is responsible for pending cuts should be repealed. The annual SGR battle diverts attention from more productive delivery and payment reform initiatives. We must move to a payment system that fosters innovation and rewards physician efforts to lower the rate of growth in Medicare spending across the existing silos in the program.

Medicare must adequately cover the cost of care and close an existing 20 percent gap as measured by the government's own conservative measure of annual increases in medical practice costs.

We must also allow seniors who wish to contract directly for their care with a physician of their choice to do so without foregoing the Medicare benefits for which they paid during their working years. Medicare benefits were earned by and belong to Medicare beneficiaries. They must be allowed to assign these benefits as they see fit.

Playing brinksmanship with the health care of seniors and military families is inexcusable and represents a dereliction of duty. We urge Congress to honor its obligation to provide access to quality care to America's seniors and military families by taking action to fix the Medicare physician formula problem now!

American Academy of Dermatology
American Academy of Facial Plastic & Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice & Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology

American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine & Rehabilitation
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association of Clinical Endocrinologist
American Association of Clinical Urologist
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Public Health Physicians
American College of Cardiology
American College of Emergency Physicians
America College of Gastroenterology
American College of Obstetricians & Gynecologists
American College of Occupational & Environmental Medicine
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Institute of Ultrasound in Medicine
American Medical Association
American Orthopaedic Foot & Ankle Society
American Society for Clinical Pathology
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Addiction Medicine
American Society of Cataract & Refractive Surgery
American Society of Cytopathology
American Society of Ophthalmic Plastic & Reconstructive Surgery
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
North American Spine Society
Renal Physicians Association
Society of American Gastrointestinal Endoscopic Surgeons
Society of Nuclear Medicine

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
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North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
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