Physicians Dedicated to the Health of North Dakota

NORTH DAKOTA MEDICAL ASSOCIATION

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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 represent the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota physicians, residents and medical students. On behalf of NDMA I appreciate the opportunity to again provide information regarding the process of national health system reform.

North Dakota physicians through NDMA and other physician organizations have been working to determine the potential impact of legislative proposals on North Dakota patients and our North Dakota health care system. While many of the provisions being discussed provide opportunities for improvement in our health care system, including innovative delivery system reforms, initiatives to strengthen our health care workforce, and preventing disease and improving the public's health, other provisions remain problematic or ambiguous, particularly in their potential financial impact on our state.

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

NDMA later in September adopted a resolution expressing physician views on both the need for Medicare payment reform and the prospect of national health system reform [Attachment 1]. The American Medical Association has also adopted seven essential elements of health system reform:

- Health insurance coverage for all Americans
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions
- Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- Investments and incentives for quality improvement, prevention and wellness initiatives
- Repeal of the Medicare physician payment formula that would trigger steep cuts and threaten seniors' access to care
- Implementation of medical liability reforms to reduce the cost of defensive medicine
- Streamlining and standardizing of insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

In addressing rising health care costs, the ultimate public policy goal should be to achieve better value for health care spending. As we review health system reform proposals in light of what is in the best interests of North Dakota, very few states have a higher combination of high quality and cost-effective medical care than North Dakota [Attachment 2]. Yet, while North Dakotans contribute equally to Medicare, we have some of the lowest Medicare reimbursement rates in the country simply because we are a rural state [Attachment 3].

The resolution adopted by NDMA states that physicians support "a health care system that provides the greatest possible access to high quality, cost-efficient care at an affordable cost," yet strongly makes the case that health system reform can only benefit North Dakota if it includes Medicare payment reform that results in reducing payment disparities that treat our state unfairly. Resources are needed from all our payor sources – both government and private insurers -- to ensure that we in North Dakota can recruit and keep good doctors and nurses and make sure we have the medical technology, available facility space and support needed to provide safe and efficient care for North Dakota patients. We need to ensure that good medical care is available when and where it's needed, and make sure that patients can choose their own physician and health plan.

The U.S. House now has two pieces of legislation going soon to the House floor for a vote. We are reviewing both bills to determine their potential impact on North Dakota - The Affordable Health Care for America Act (H.R. 3962) and another bill, The Medicare Physician Payment Reform Act of 2009 (H.R. 3961). The U.S. Senate leadership also hopes to finish its efforts to blend legislative proposals developed by the Senate Finance Committee and the Committee on Health, Education, Labor, and Pensions into a single bill for consideration on the Senate floor. That bill, probably with several potential versions of a public plan option, will be sent to the Congressional Budget Office to determine its total cost. Senate leaders have said they hope to bring their legislation to the floor by mid-November. The AMA raised many concerns with several provisions in the Senate Finance Committee proposal [Attachment 4]. If and when both the House and Senate approve bills, the conference committee will become the focus for a final product for consideration by both the House and Senate.

Public Health Insurance Option

NDMA became more actively engaged on the issue of a public health insurance option, as the original House legislation [H.R. 3200] would have tied provider reimbursement under a public option to Medicare reimbursement rates, which would be devastating to our state's health system in diminishing the resources available for daily operations including workforce recruitment. We supported Senator Conrad in his opposition to a public option tied to Medicare rates [Attachment 5], and a public option was not included in the Senate Finance Committee proposal.

We simply do not receive Medicare reimbursement that fully covers the costs involved with diagnosing and treating patients. In addition, if people currently insured by BCBSND shift to a public option at Medicare rates, our largest hospitals will experience a decrease in funding by millions of dollars that would not be offset by new payments for people previously uninsured.

The Affordable Health Care for America Act (H.R. 3962), which blends and updates the three versions of previous bills passed by the House committees of jurisdiction, purports to tie a public option to "negotiated rates." In our initial review, it is evident the specific language of the bill in Sec. 323 which requires the HHS Secretary to negotiate payment for the public option is ambiguous. The legislation would require negotiation of rates within a range of Medicare rates as a floor and commercial rates as a ceiling. There is no certainty as to what rates would be negotiated in North Dakota or who in North Dakota would negotiate those rates. There is an opt-out process for providers but there are no assurances that Medicare rates would not become the basis for payment in our state.

Disparity in Medicare Payments to North Dakota
We are working with many other states and our Congressional Delegation to eliminate the geographic inequities that exist in Medicare physician payments.

In the Senate Finance Committee, geographic equity for North Dakota physicians took a step forward with an amendment sponsored by Senator Charles Grassley and supported by Sen. Conrad. The amendment to the bill would reduce Medicare's geographic adjustments for physician practice expense by ¼ in January 2010 and then by one half in 2011 to help payment areas like North Dakota with practice expense geographic adjusters less than 1.0 (Amended Markup, p. 137). During the next two years, the Centers for Medicare & Medicaid Services (CMS) would be required to analyze and ensure that any geographic adjustments are accurate, or the 2011 changes would continue. We have been arguing for years that the geographic adjustments are not accurate. The impact of this Senate Finance Committee amendment would be to bring a 2.02% increase in 2010 and 4.04% increase in 2011 in Medicare fees to North Dakota in reimbursing physician services.

Another amendment would modify physician payments under the Medicare physician fee schedule based on a quality/cost index and on a budget-neutral basis. Payment adjustments would begin in 2015 based on 2014 performance, and all physician payments would be subject to a quality/cost adjuster by 2017 (Amended Markup, pp. 102-03).

In the House legislation (H.R. 3962), there are several provisions proposing Institute of Medicine studies of geographic differences in payment under Medicare, geographic variation in health care spending, and promoting high-value health care, including the validity and effects of the geographic adjusters used for Medicare physician and hospital payments, and to recommend improvements (Sec. 1157), to which CMS would be instructed to respond to with discretionary authority to spend up to $4 billion per year, for two years, to effect any needed increases in payment rates and to "hold harmless" providers that would otherwise have their payments reduced (Sec. 1158). Another proposed IOM study would look at geographic variation in health care spending with recommendations for changes to Medicare payment systems to address geographic variation and to improve the value of health spending in the program (Sec. 1159), for which the HHS Secretary would be instructed to develop an implementation plan for changing Medicare payment systems, as appropriate, based on those recommendations with an implementation plan to Congress. The plan would be implemented starting in 2013 unless Congress votes to disapprove it (Sec. 1160).

The House legislation, while including the IOM studies which might look favorably upon North Dakota's situation, does not guarantee that North Dakota will receive any relief from geographic adjusters or be rewarded for high-value health care spending.

Both the House legislation and Senate Finance Committee proposal extend two specific provisions important to North Dakota in addressing disparity provisions from previous legislation. The House legislation would extend important provisions relating to the reclassification of the hospital wage index for many parts of North Dakota (Sec. 1193) and extend the geographic floor for physician work (Sec. 1194).

Sustainable Growth Rate

Physicians across the country and in North Dakota are also very concerned about the current Medicare formula for physician service payments – the sustainable growth rate (SGR) which will result in payment cuts of 21.5% on January 1, 2010, unless Congress acts, with the cuts growing to about 40% by 2014 due to the flawed payment formula. For North Dakota, if the SGR impact for 2010 is not addressed, there will be $30 million less in Medicare payments to North Dakota in 2010 [Attachment 6]. The SGR sets spending targets and if those targets are exceeded nationally payments are cut accordingly. Just several days ago, the U.S. Senate was unable to garner 60 votes to debate a stand-alone bill (S. 1776) which would have repealed the SGR. The House has also now introduced a stand-alone bill, (H.R. 3961) to address the SGR.

Medical Liability Reform

NDMA continues to believe that meaningful medical liability reform is essential to any national health care cost containment strategy. The cost of our medical liability system is borne by everyone as defensive medicine adds billions of dollars to the cost of health care each year, which means higher health insurance premiums and medical costs for all Americans.

Health System Reforms

We continue to study the many provisions relating directly to the health care delivery system. The Senate Finance Committee proposal and House legislation include incentives and various pilot project and demonstration program opportunities relating to a myriad of health system issues, including new payment models such as accountable care organizations, medical home programs, payment incentives for primary care services, "comparative effectiveness research," national standards for quality improvement, new Medicaid state options and enhancements, primary care workforce enhancements, and prevention and wellness strategies and programs. Many of these of these provisions have the potential for providing additional resources to strengthen our health care delivery system in North Dakota.

The North Dakota Medical Association has supported our Congressional Delegation in this process of working toward meaningful health system reforms that would favorably impact North Dakota patients and our state's health care delivery system, and in the unique and important roles they have each played in this process. As the products of this process emerge, we will continue to work with our Delegation, with this committee and with our Legislative Assembly and Governor Hoeven in discussing health reform initiatives that can further improve the quality and cost-effectiveness of health care provided in our state.

Resolution

Introduced By: **NDMA Council**
Subject: **Health Care System Reform**

A resolution urging 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 unfair disparity in Medicare payments to North Dakota as recommended by the joint NDMA/NDHA Medicare Payment Task Force; supporting efforts of Senator Kent Conrad to initiate a Centers for Medicare and Medicaid (CMS) demonstration project to pilot rural models of health care delivery in North Dakota that focus on creating an accountable state system of care, assistance for health care infrastructure development, and fair payment for the provision of physician and hospital services; and urging the United States Congress to enact meaningful health system reform that ensures access by people in North Dakota to health care and enhances high quality, cost-efficient medical care.

Preamble

(1) WHEREAS, the North Dakota Medical Association (NDMA) is encouraged by the national attention to health system reform, and is committed to working with state leaders and our Congressional Delegation to consider meaningful health system reform that benefits the citizens of our state, builds on the strengths of our state's health care system and addresses its weaknesses, and enables physicians to continue to provide high-quality, cost-efficient medical care; and

(2) WHEREAS, NDMA recognizes that the United States Congress will consider a range of proposals to reform the nation's health care system through a deliberative process that will weigh the potential effectiveness of various initiatives in meeting Congress' goals, with eventual development of a proposal in conference committee between the U.S. Senate and House of Representatives, and appreciates the many years of work by our Congressional Delegation in reviewing and initiating proposals for health system reform and Medicare payment reform in light of the best interests of North Dakota patients, physicians and our health care system; and

(3) WHEREAS, NDMA recognizes that our Congressional Delegation, as well as our various components of organized medicine, will take strategic positions on various legislative vehicles as this process moves forward, all toward the goal of achieving meaningful health system reform; and

(4) WHEREAS, the primary strength of the legislation as introduced in the United States House of Representatives (HR 3200) is that it would extend coverage to the uninsured, make investments in the physician workforce and promote primary care, provide long-term relief from the Medicare Sustainable Growth Rate (SGR) physician payment formula, increase the nation's focus on preventive care and wellness initiatives, and simplify administrative burdens for physicians and patients; however, there are many provisions that raise cause for physician concern including proposed use of Medicare payment rates for "public option" insurance coverage and an uncertain result for North Dakota in addressing the disparity in Medicare physician and hospital payment rates for rural states, which resulted in NDMA expressing publicly on July 16, 2009, its support of Congressman Earl Pomeroy's opposition to the legislation without additional improvements; and

(5) WHEREAS, the Finance Committee of the United States Senate has released a framework for health system reform which differs substantially from the House package, making it imperative that NDMA provide further guidance to the North Dakota Congressional Delegation on the potential impact of health system reform on North Dakota; and

Current North Dakota Health System

(6) WHEREAS, in reviewing health system reform options, it is important to recognize that North Dakota faces challenges common to other areas of the country that are relatively disadvantaged in attracting health care professionals and in deploying resources to serve geographically dispersed communities. At the same time, the North Dakota health care system has done better than most with fewer resources to provide high quality care for North Dakota patients because of a "cooperative ethos" in North Dakota that has resulted in cooperative, interdependent relationships and a willingness to innovate in both the organization and regulation of services to achieve the reach, care coordination, and economies of scale for delivering quality and efficient care; and

(7) WHEREAS, what North Dakota has achieved is a collaborative model of health care delivery involving hospitals, physicians and others providing high quality health care through both structured and virtual integration, which is an example to the nation on how a state can provide its citizens with accessible, quality, and efficient health care despite the challenges of a rural setting; and

(8) WHEREAS, an excellent example of what North Dakota's health care delivery system has achieved is reflected in the *Dartmouth Atlas of Health Care* which finds that North Dakota is one of the most efficient states in treating chronically ill Medicare patients in the last two years of life, with costs more than 25 percent below the national average -- the lowest costs in the nation. North Dakota allocates fewer resources and spends less, while simultaneously receiving high marks on established quality measures; and

(9) WHEREAS, what is remarkable is that North Dakota has achieved these results under a draconian fee-for-service Medicare payment model that nationally rewards service overutilization and regional variation; at the same time through various geographic adjustments

provides low and inequitable Medicare reimbursement rates for hospitals and physicians in rural settings such as North Dakota; and

(10) WHEREAS, NDMA is working through the efforts of Senator Kent Conrad to initiate outside of the current health system reform efforts a Centers for Medicare and Medicaid (CMS) demonstration project to pilot rural models of health care delivery in North Dakota that focus on creating an accountable state system of care, assistance for health care infrastructure development, and fair payment for the provision of physician and hospital services; and

Medicare Payment Reform

(11) WHEREAS, health system reform proposals in Congress purport to build upon the current Medicare payment system which is fundamentally unfair to North Dakota and change to that underlying payment system is necessary if that system is to be used as a foundation for broader health system reform; and

(12) WHEREAS, the health care system in North Dakota is among the most cost efficient in the country in caring for Medicare patients but is assigned some of the lowest Medicare reimbursement rates. Despite the equal contribution by our states' residents to Medicare, our seniors receive a smaller benefit in Medicare redistributions for their care, resulting in fewer health system resources to ensure continuing access to high quality, cost-efficient medical care. This is a predictable consequence of the neglected inequity of Medicare geographic payment disparity caused by the fundamentally flawed methods known as Geographic Practice Cost Index (GPCI) adjustments to physician payment and the hospital wage index, both of which must be corrected; and

(13) WHEREAS, the continued devaluation by Medicare of physician work in North Dakota is unjustified and unfair, and renders the health care system in North Dakota unsustainable; and

(14) WHEREAS, NDMA has actively pursued Medicare payment reform to address the unfair disparity in physician payments to rural states such as North Dakota through our Congressional Delegation, most recently through physician and hospital leadership on the joint NDMA/ND Healthcare Association (NDHA) Medicare Payment Task Force convened by Senator Kent Conrad and Representative Earl Pomeroy, and through the efforts of Senator Byron Dorgan in calling on the leadership of the Senate Finance Committee to address the unfairness of Medicare physician and hospital payments that penalize rural states such as North Dakota that efficiently deliver high quality care; and

(15) WHEREAS, NDMA actively participates in the Geographic Equity in Medicare (GEM) Coalition of state medical societies and has signed on to a letter supporting the GEM recommendation to develop a value index into Medicare payment for physician and hospital payments (e.g., Kind, HR 2844 (cosponsored by Rep. Pomeroy); Klobuchar S 1249) and address inaccuracies in the calculation of GPCI adjustments or eliminate the GPCI adjustments; and

(16) WHEREAS, Senator Conrad has introduced legislation in S. 1157 cosponsored by Senator Dorgan to implement many of the recommendations of the NDMA/NDHA Medicare Payment Task Force; and

(17) WHEREAS, even if geographic disparity is not broadly addressed, legislation is needed specifically to extend a temporary increase in the Medicare physician work GPCI for certain areas which is set to expire at the end of 2009 which, in 2010, would prevent a 3.1% cut in payment rates for North Dakota physicians' services (currently included in HR 3200, S 1157); and

(18) WHEREAS, NDMA has also for several years vehemently decried the continuing application of the Sustainable Growth Rate (SGR) formula which, according to the 2009 Medicare Trustees report, on January 1, 2010, will result in North Dakota physicians facing an untenable, across-the-board cut of 21.5%, with the cuts growing to about 40% by 2014 due to the flawed payment update formula; and

(19) WHEREAS, an SGR repeal would prevent a loss of $30 million in 2010 for the care of elderly and disabled patients in North Dakota and repealing the SGR formula would prevent losses of $400 million to North Dakota physicians over the next five years for the care of elderly and disabled patients; and

(20) WHEREAS, an improved Medicare physician payment formula is necessary to ensure access to health care services throughout the nation, with replacement of the SGR with a new approach, such as an annual update system and a true cost of practice methodology as determined by a credible, practice-based, medical economic index; and

(21) WHEREAS, the U.S. House of Representatives legislation in HR 3200 as introduced is flawed, in that it contains a public plan with a payment structure that cements in place the current flawed Medicare rate plus 5%, inequitably penalizing rural areas that are providing high-quality, cost-efficient care, and does not adequately address geographic payment disparity for North Dakota; and

(22) WHEREAS, the joint NDMA/NDHA Medicare Payment Task Force developed principles for careful review of Medicare payment reform proposals to ensure that any new payment systems (including accountable care organizations, bundled or global payments) are appropriate for North Dakota, assessing risks and rewards, and recognizing North Dakota goals for cost containment and accountability [see Harold D. Miller, *Options for Improving Medicare Payments to North Dakota's Healthcare Providers*, Center for Healthcare Quality and Payment Reform, February 2009]; and

(23) WHEREAS, Rep. Pomeroy was instrumental in the introduction of HR 2959 (Welch), and is a cosponsor of that legislation, which would establish an accountable care organization pilot program; and

Health System Reform

Access Reforms

(24) WHEREAS, as advocates for patients and physicians in North Dakota, NDMA believes in a health care system that provides the greatest possible access to high-quality, cost-efficient care at an affordable cost; and

(25) WHEREAS, continued recognition of the importance of the physician-patient relationship is essential to maintaining health, requiring preservation of patient and physician choice, and allowing families and individuals to choose their own physician and health plan; and

(26) WHEREAS, all Americans should have broad, continuous, and portable health care coverage using an appropriate and affordable mix of public and private payer systems; and

(27) WHEREAS, health system reform should protect individuals and families from losing their health insurance coverage or financial ruin making available affordable plans for catastrophic health care coverage, and ensuring sustainable public programs for vulnerable populations with payment levels by government-funded programs sufficient to eliminate cost shifting onto other payors; and

Insurance Reforms

(28) WHEREAS, a robust private insurance market should be retained, eliminating barriers to competition and authorizing insurance products to cross state lines; and

(29) WHEREAS, exclusions due to pre-existing conditions should be eliminated, administrative processes simplified, overhead costs reduced, and fair and competitive market practices observed, including transparent and fair contracts with providers; and

(30) WHEREAS, health system reform should assist people who cannot afford private health insurance coverage to purchase coverage through tax credits and vouchers, and/or subsidy of small-employer purchase of health insurance coverage; and

(31) WHEREAS, Sen. Conrad advocates, in light of opposition to a government-run health plan, that the Senate should consider the creation of health care cooperatives (co-op) as a consumer coverage option to private insurance; and

(32) WHEREAS, a co-op option must be actuarially sound and not be granted an unfair advantage over private insurance, and not be able to leverage Medicare or any other public program to force physicians to participate; and

(33) WHEREAS, a co-op option should include the ability of physicians and hospitals to negotiate payment rates for medical services, and not be required to use Medicare payment rates or other rates that do not cover the cost of care; and

Medical Liability Reforms

(34) WHEREAS, the cost of defensive medicine in the United States has been estimated to exceed $210 billion per year, and meaningful reform of the national tort system to prevent non-meritorious lawsuits, and keeping current state legislative reforms in place, will reduce the waste of scarce resources by the defensive practice of medicine; and

(35) WHEREAS, health system reform should include comprehensive medical liability reform to ensure access to quality health care; and

Initiatives that Support and Fund High Quality, Cost-Efficient Care

(36) WHEREAS, health system reform should provide financial and technological support to implement physician-led, patient-centered medical homes to improve care coordination, including increased funding for services provided by primary care physicians, financed by savings rather than through across-the-board payment reductions in other physician services; and

(37) WHEREAS, increased funding of medical training for additional primary care physicians should be provided, with investment of needed resources to expand North Dakota's physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population, including more support for medical education and residency programs; and

(38) WHEREAS, investment in effective state health wellness and prevention initiatives should be increased, and be built upon initiatives created through NDMA participation in the Healthy North Dakota Vision 2020 relating to childhood healthy weight and worksite wellness; and

(39) WHEREAS, high quality health care at an affordable cost requires adoption of physician-developed, evidence-based preventive health and wellness measures and tools for use in scientifically-valid quality initiatives, and include comparative effectiveness research used only to help patient-physician relationships in choosing the best care for patients; and

(40) WHEREAS, health system reform should reduce inappropriate health spending variations if based on sound evidence; and

(41) WHEREAS, patient safety must continue to be a top priority, combining evidence-based accountability standards, committed financial resources, and rewards for performance to both ensure patient safety and incent patient responsibility; and

(42) WHEREAS, additional resources are needed to support connected and interoperable health information technology systems and tools which improve patient safety, advance care coordination, and increase administrative efficiency, to further enhance state-based efforts through the work of the North Dakota HIT Advisory Committee to develop a state plan and leverage current HITECH funding; and

Initiatives that Encourage Individual Responsibility

(43) WHEREAS, lifestyle choices, including alcohol and tobacco use, and an increased obesity rate due in part to diet and exercise decisions, are a significant contributor to high health care

costs, with obesity alone estimated to require additional expenditures approaching $147 billion per year; therefore, it is important to heighten consumer awareness of the effect of lifestyle choices on health, both through expanded educational programs and through financial incentives such as premium adjustments to reward behavior modification, and value-based (i.e., linked to effectiveness and cost of alternatives) co-payments and/or deductibles for all consumers with the exception of preventive services; and

(44) WHEREAS, health system reform should expand use of payment structures that offer incentives or reductions in premiums for enrollees who utilize preventive services and make appropriate lifestyle decisions, and promote price awareness and sensitivity among consumers and physicians;

THEREFORE, BE IT RESOLVED BY THE 2009 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION, that the North Dakota Medical Association urges 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 as recommended by the joint NDMA/NDHA Medicare Payment Task Force and address other needed payment reforms to ensure the future sustainability of North Dakota's health care system, including:

A. Address Medicare Payment Disparity: Work to implement the Medicare Payment Task Force recommendations (Conrad, S 1157) and the GEM recommendation to develop a value index into Medicare payment for physician and hospital payments (e.g., Kind, HR 2844; Klobuchar S 1249) and address inaccuracies in the calculation of GPCI adjustments or eliminate the GPCI adjustments. Implement at a minimum the recommendations of the NDMA/NDHA Medicare Payment Task Force, relating to geographic disparity:

Physicians:

-Eliminate the work GPCI
-Establish a threshold of 1.0 on the practice expense GPCI
-Establish an initiative to study and correct the methodology deficiencies in the GPCI calculations, including consideration of modification of the cost share weights in the practice expense GPCI

Hospitals:

-Create a wage index floor of 1.0
-Reduce the labor-related share for areas with a low wage index to 50%
-Extend Section 508 to reduce payment disparities (expires September 30, 2009)

B. Replace the Sustainable Growth Rate (SGR) Formula: Health system reform legislation should include provisions to eliminate all of the forecast SGR cuts and put in a place a new update formula as determined by a credible, practice-based, medical economic index; and

BE IT FURTHER RESOLVED that NDMA supports a principled approach to broader payment reform that does not negatively impact North Dakota and urges our Congressional Delegation to adhere to those principles adopted by the joint NDMA/NDHA Medicare Payment Task Force to ensure that any new payment systems (including accountable care organizations,

bundled or global payments) are appropriate for North Dakota, assessing risks and rewards, and recognizing North Dakota goals for cost containment and accountability, as follows:

1. Ensure that North Dakota hospitals and physicians are not penalized for providing services more efficiently and at higher quality; that North Dakota is not penalized for the value achieved from the value of teamwork and accountability from its current high quality, highly efficient health care system.

2. Ensure that for any services currently under-provided in North Dakota (recruitment problems), that those under utilization levels not be locked in to any baseline expenditure levels that may be imposed.

3. Ensure that new payment systems provide a means for ND to rebuild and strengthen its primary care base.

4. Ensure that performance measures emphasize current ND strengths. Ensure that performance thresholds are achievable and payment differentials are of sufficient magnitude to help offset ND's payment disadvantages.

5. Ensure that payments for physician services be more than what they would have otherwise under the current payment system. Recognize that the current SGR formula as a nationwide spending target has resulted in Medicare payment cuts for physicians in low spending regions in large part because of high Medicare expenditures in other regions; oppose any geographic (GPCI) adjustments in future bundled physician payments unless regional quality payments and regional spending targets are also included.

6. Ensure that if a total pool is divided among all high-performing providers in any payment scheme, rewards emphasize performance rather than improvement.

7. Recognize the negative implications of applying GPCIs to initiatives for incenting quality (e.g., PQRI) and technology (e.g., e-prescribing, health information technology); and

BE IT FURTHER RESOLVED that NDMA supports efforts of Senator Kent Conrad to initiate a Centers for Medicare and Medicaid (CMS) demonstration project to pilot rural models of health care delivery in North Dakota that focus on creating an accountable state system of care, assistance for health care infrastructure development, and fair payment for the provision of physician and hospital services; and

AND BE IT FURTHER RESOLVED that NDMA urges the United States Congress to enact meaningful health system reform that ensures access by people in North Dakota to health care and enhances high-quality, cost-efficient care. Meaningful health system reform includes:

A. Access reforms that create a health care system that:
1. Provides the greatest possible access to high quality care at an affordable cost through broad, continuous, and portable health care coverage using an appropriate and affordable mix of public and private payer systems;
2. Preserves patient and physician choice, and allows families and individuals to choose their own physician and health plan; and
3. Protect individuals and families from losing their health insurance coverage or financial ruin by making available affordable plans for catastrophic health care coverage, and ensuring sustainable public programs for vulnerable populations with payment levels by government-funded programs sufficient to eliminate cost shifting onto other payors.

B. Insurance reforms that:
1. Retain a robust private insurance market, eliminating barriers to competition and authorizing insurance products to cross state lines;
2. Eliminate restrictions on pre-existing conditions and simplify administrative processes, reduce overhead costs, and observe competitive market practices, including transparent and fair contracts with providers;
3. Assist people who cannot afford health care coverage to purchase private health insurance coverage through tax credits and vouchers, and/or subsidy of small-employer purchase of health insurance coverage; and
4. Consider the creation of health care cooperatives (co-op) as a consumer coverage alternative to private insurance that is actuarially sound and not granted an unfair advantage over private insurance, and not able to leverage Medicare or any other public program to force physicians to participate or use Medicare payment rates or other rates that do not cover the cost of care.

C. Comprehensive national medical liability reform that prevents non-meritorious lawsuits, addresses defensive medicine costs and stabilizes the national medical liability insurance market, and keeps current state legislative reforms in place including substantial North Dakota tort reforms that include limitations on damages and a certificate of merit law.

D. Initiatives for quality, cost-efficient care that include:
1. Support for physician-led, patient-centered medical homes to improve care coordination;
2. Increased funding for services provided by primary care physicians, financed by savings rather than through across-the-board payment reductions in other physician services;
3. Addressing physician shortages, including increased funding of medical training for additional primary care physicians, with investment of needed resources to expand North Dakota's physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population, including more support for medical education and residency programs;
4. Increased investment in effective, evidence-based state health wellness and prevention initiatives;
5. Support for adoption of scientifically-valid quality and patient safety initiatives that incent and reward the physician-led health care delivery team, that includes comparative effectiveness research used only to help patient-physician relationships in choosing the best care for patients;

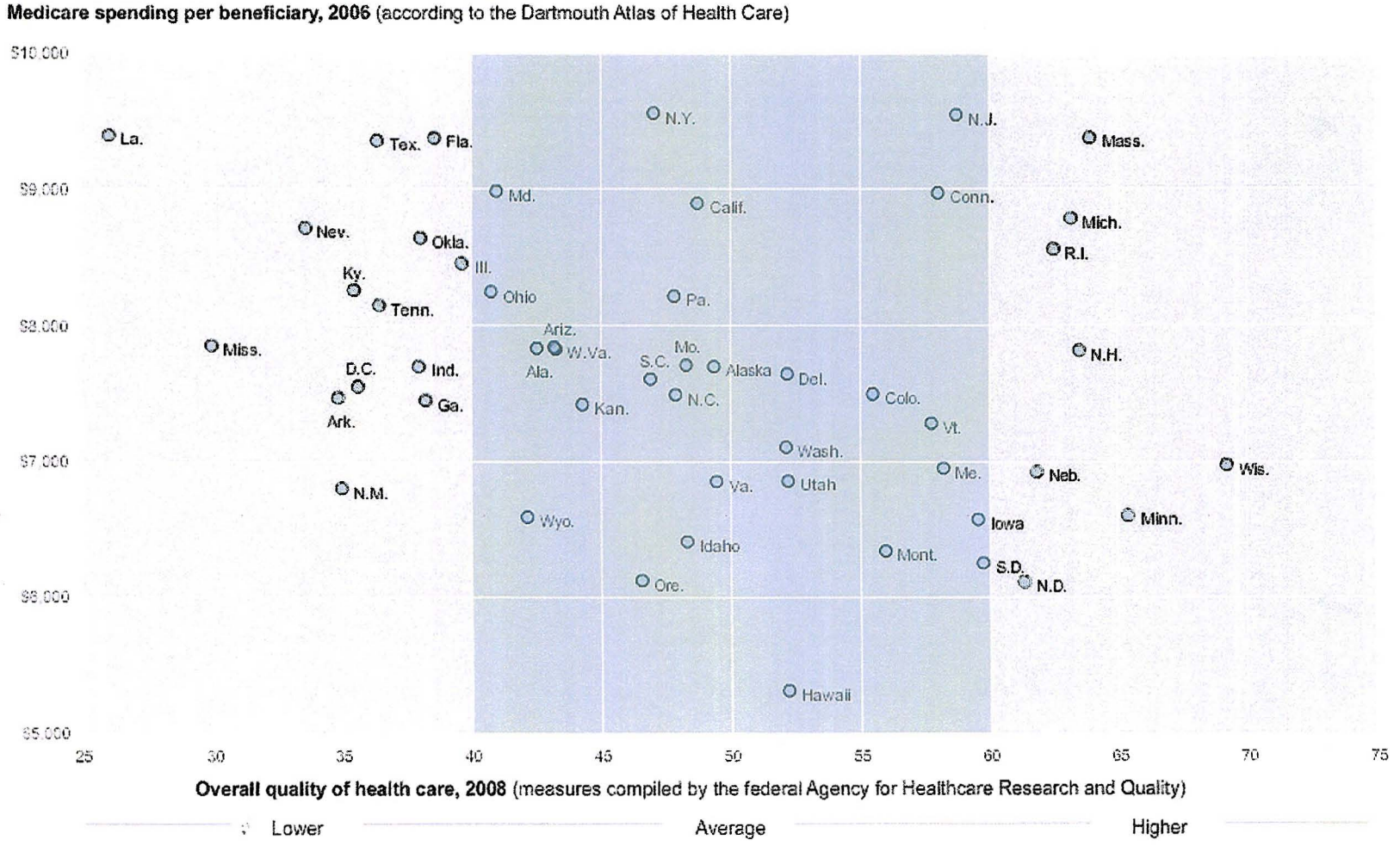
6. A high priority on patient safety, including the use of evidence-based quality measures developed by the Physician Consortium for Performance Improvement and financial support for the development of a federally-qualified patient safety organization for North Dakota;
7. Incentives for connected and interoperable health information technology systems and tools which improve patient safety, advance care coordination, and increase administrative efficiency, to further enhance state-based efforts through the work of the North Dakota HIT Advisory Committee to leverage current HITECH funding.

E. Initiatives that encourage individual responsibility, including:
1. Efforts to heighten consumer awareness of the effect of lifestyle choices on health, both through expanded educational programs and through financial incentives such as premium adjustments to reward behavior modification, and value-based (i.e., linked to effectiveness and cost of alternatives) co-payments and/or deductibles for all consumers with the exception of preventive services; and
2. Use of payment structures that offer incentives or reductions in premiums for enrollees who utilize preventative services and make appropriate lifestyle decisions.

Adopted September 25, 2009
Steven P. Strinden, Speaker of the House
North Dakota Medical Association

Comparing Cost and Quality of Health Care Across the Country

Researchers at Dartmouth Medical School have found huge geographic variations in Medicare spending per beneficiary, but areas that spend the most do not always produce better quality of care. Some point to the disparity as evidence of inefficiency; others say higher spending often reflects higher cost of living and sicker population.



http://www.nytimes.com/interactive/2009/09/08/us/cost-scatterplot.html

Proposed 2010 GPCIs and GAF by MEDICARE PAYMENT LOCALITY

Locality Name	Work GPCI	PE GPCI	MP GPCI	GAF
Alaska	1.500	1.090	0.646	1.288
San Mateo, CA	1.072	1.433	0.394	1.203
San Francisco, CA	1.059	1.441	0.414	1.201
Manhattan, NY	1.064	1.298	1.010	1.164
NYC Suburbs/Long I., NY	1.051	1.289	1.235	1.162
Santa Clara, CA	1.083	1.294	0.377	1.148
Northern NJ	1.057	1.228	1.116	1.134
Metropolitan Boston	1.029	1.291	0.764	1.133
Oakland/Berkley, CA	1.053	1.286	0.425	1.130
Queens, NY	1.032	1.239	1.220	1.130
Anaheim/Santa Ana, CA	1.034	1.269	0.811	1.128
DC + MD/VA Suburbs	1.047	1.218	1.032	1.121
Ventura, CA	1.027	1.265	0.766	1.121
Miami, FL	1.000	1.069	3.167	1.114
Los Angeles, CA	1.041	1.225	0.804	1.112
Marin/Napa/Solano, CA	1.034	1.265	0.432	1.112
Connecticut	1.038	1.185	0.980	1.100
Chicago, IL	1.025	1.080	1.940	1.084
Rest of New Jersey	1.042	1.126	1.116	1.082
Metropolitan Philadelphia, PA	1.016	1.097	1.617	1.075
Detroit, MI	1.036	1.040	1.906	1.071
Suburban Chicago, IL	1.017	1.068	1.629	1.063
Hawaii/Guam	0.998	1.161	0.665	1.056
Fort Lauderdale, FL	0.989	1.018	2.250	1.050
Rhode Island	1.013	1.088	0.996	1.045
Rest of Massachusetts	1.007	1.106	0.764	1.041
Baltimore/Surr. Cntys, MD	1.012	1.057	1.086	1.035
Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822	1.034
Seattle (King Cnty), WA	1.014	1.085	0.706	1.033
Houston, TX	1.016	0.986	1.345	1.016
Nevada	1.002	1.026	1.083	1.016
Delaware	1.011	1.046	0.678	1.013
Rest of California	1.007	1.058	0.549	1.012
New Orleans, LA	0.986	1.044	0.956	1.010
Dallas, TX	1.009	1.001	1.110	1.009
Atlanta, GA	1.009	1.014	0.836	1.004
East St. Louis, IL	0.989	0.919	1.793	0.990
Virgin Islands	0.997	0.978	1.009	0.989
Austin, TX	0.992	0.984	0.969	0.988
Portland, OR	1.002	1.015	0.472	0.987
New Hampshire	0.982	1.039	0.462	0.987
Rest of Florida	0.973	0.939	1.724	0.987
Galveston, TX	0.991	0.959	1.223	0.986
Brazoria, TX	1.019	0.922	1.223	0.985
Rest of Maryland	0.994	0.982	0.874	0.984
Fort Worth, TX	0.998	0.953	1.110	0.983
Southern Maine	0.980	1.025	0.492	0.981
Metropolitan Kansas City, MO	0.990	0.945	1.188	0.978
Colorado	0.986	0.992	0.641	0.975

Locality Name	Work GPCI	PE GPCI	MP GPCI	GAF
Ohio	0.993	0.927	1.232	0.973
Rest of Washington	0.987	0.974	0.693	0.970
Rest of Michigan	0.998	0.923	1.083	0.969
Metropolitan St. Louis, MO	0.993	0.931	1.075	0.969
Arizona	0.988	0.957	0.822	0.968
Rest of Pennsylvania	0.993	0.925	1.081	0.967
Minnesota	0.992	0.983	0.245	0.959
Vermont	0.968	0.983	0.489	0.956
Virginia	0.982	0.942	0.657	0.952
Beaumont, TX	0.984	0.875	1.346	0.950
Utah	0.977	0.907	1.026	0.948
Rest of Illinois	0.975	0.880	1.219	0.943
Rest of New York	0.997	0.921	0.425	0.942
New Mexico	0.973	0.890	1.096	0.942
Indiana	0.986	0.918	0.599	0.941
North Carolina	0.972	0.925	0.634	0.938
Wisconsin	0.988	0.921	0.409	0.936
Rest of Texas	0.968	0.879	1.065	0.933
Rest of Georgia	0.979	0.883	0.829	0.931
Rest of Oregon	0.968	0.927	0.472	0.931
Rest of Louisiana	0.970	0.878	0.892	0.927
Tennessee	0.978	0.889	0.608	0.925
South Carolina	0.975	0.906	0.446	0.924
West Virginia	0.973	0.827	1.353	0.924
Kansas	0.969	0.882	0.557	0.915
Idaho	0.967	0.883	0.546	0.914
Rest of Maine	0.962	0.893	0.492	0.914
Kentucky	0.969	0.860	0.652	0.909
Alabama	0.982	0.853	0.496	0.907
Mississippi	0.959	0.854	0.808	0.907
Wyoming	0.956	0.842	0.889	0.904
Iowa	0.965	0.870	0.434	0.903
Oklahoma	0.964	0.850	0.627	0.901
Nebraska	0.959	0.890	0.245	0.901
Rest of Missouri	0.949	0.821	0.997	0.895
Montana	0.950	0.847	0.673	0.894
Arkansas	0.961	0.846	0.446	0.891
South Dakota	0.942	0.864	0.420	0.888
North Dakota	0.947	0.844	0.387	0.880
Puerto Rico	0.904	0.694	0.250	0.787

Source: *Federal Register*, Vol. 74, No. 132, pages 33801-33804, July 13, 2009, CY 2010 Medicare Physician Fee Schedule Proposed Rule.

Calculation for the GAF: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI)

Without Congressional action by year-end 2009, the 1.0 floor on the Work GPCI will end as of January 1, 2010.

Data sorted in descending order by GAF, then by Work GPCI.

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YOUR OPINION

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Doctors prescribe reforms

By Dr. Kimberly Krohn

The North Dakota Medical Association supports Sen. Kent Conrad in opposing a "public option" that would be tied to Medicare reimbursement rates.

Very few states have a higher combination of high-quality and cost-effective medical care than North Dakota. Yet, while North Dakotans contribute equally to Medicare, we have some of the lowest Medicare reimbursement rates in the country simply because we are a rural state.

For example, an average office visit in a North Dakota clinic in 2010 will result in a much lower Medicare reimbursement ($47.84) than a physician treating a similar patient in San Francisco ($66) – 31 percent less. A Medicare payment for a mammogram screening in North Dakota will be reimbursed at $49.92, while that same screening in San Francisco is reimbursed at $73.82 – over 32 percent less for North Dakota. These are just two examples of how federal "geographic adjusters" impact North Dakota.

We simply do not receive Medicare reimbursement that fully covers the costs involved with diagnosing and treating patients. In addition, if people currently insured by Blue Cross Blue Shield of North Dakota shift to a public option at Medicare rates, our largest hospitals will experience a decrease in funding by millions of dollars that would not be offset by new payments for people previously uninsured.

Resources are needed from all our payer sources – both government and private insurers – to ensure that we in North Dakota can recruit and keep good doctors and nurses and make sure we have the medical technology, available facility space and support needed to provide safe and efficient care for patients. We need to ensure that good medical care is available when and where it's needed, and ensure that patients can choose their physician and health plan.

A "public option" tied to Medicare reimbursement will only make an already unfair situation worse for North Dakota, and would dismantle some of our nation's most successful but vulnerable delivery systems, which have produced highervalue, more cost-effective care. The promise of universal coverage could be dashed by just such a reduction in access.

NDMA is also advocating for reforms that provide the greatest possible access to medical care for patients at an affordable cost and provide incentives for better "value" that can actually reduce costs. Some examples are to encourage better preventive care and keep patients with chronic diseases healthier and out of the hospital. Promoting higherquality and more cost-effective care will reduce health care costs, as will good wellness and prevention initiatives.

We need support to implement patient-centered medical homes to improve care coordination, including increased funding for primary care services that does not come at the expense of good access to specialty care. We need to expand our health care work force, including more support for medical education and residency programs.

We need health insurance reforms that eliminate barriers to competition, eliminate exclusions for pre-existing conditions, and assist people who cannot afford private insurance to purchase coverage.

We need meaningful medical liability reform that reduces the waste of resources caused by the "defensive" practice of medicine. Finally, and perhaps most importantly, we need each and every resident of North Dakota to do what you can to live a healthy lifestyle. Let's reduce tobacco use through cessation and prevention and encourage each other in ways that decrease the incidence of obesity through good diet and exercise choices. The current debate offers a major opportunity for North Dakota to address the unfair reduction in health care resources by the federal government, and to embrace what is best for North Dakota patients.

Krohn, Minot, is president of the North Dakota Medical Association. Also signed by Dr. Robert Thompson, Grand Forks; Dr. Michael Booth, Bismarck; and Bruce Levi, Bismarck, executive director.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

September 21, 2009

The Honorable Max S. Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus:

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to thank you for your leadership and significant efforts to advance our mutual objective of achieving comprehensive health system reform this year.

We are encouraged that the Chairman's mark (America's Healthy Future Act of 2009) includes several provisions consistent with our policy. In general, we support the provisions in the mark that reform the health insurance market to provide more choice and better access to affordable coverage for individuals and small businesses, including provisions relating to guaranteed issue, guaranteed renewability, modified community rating, pre-existing condition limitations, nondiscrimination based on health status, adequacy of provider networks, and transparency. We also support: tax credits that are inversely related to income, refundable, and payable in advance to low-income individuals who need financial assistance to purchase private health insurance; establishing health insurance exchanges that offer more affordable choices; enhancing Medicaid coverage as a safety net; coverage for prevention and wellness initiatives without co-payments or deductibles; and establishing an independent institute to conduct clinical comparative effectiveness research.

The AMA has serious concerns about several provisions in the mark.

Medicare Physician Payment Formula

We deeply appreciate your support for a permanent repeal of the sustainable growth rate (SGR) during the full Senate's consideration of health system reform legislation. While the AMA appreciates that the mark would avoid a 21 percent cut in Medicare physician payments in January, a permanent repeal of the SGR must be enacted this year. Continuation of the SGR would subject physicians to cuts of 40 percent over the next several years. Permanently repealing the SGR formula is critical to the goal of ensuring security, stability, and access for seniors.

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Independent Medicare Commission

The AMA has serious concerns with the authorities granted to the Independent Medicare Commission in the mark and we look forward to working with you on significant changes to the proposal. Physicians are already subject to a spending target and additional payment penalties under other provisions in the mark. Creating a second target system could subject physician services to multiple payment cuts in a single year. Further, the provision does not appear to apply equally to all health care stakeholders. This presents a serious inequity if spending reductions are to be found from only a fraction of the program. Medicare spending targets must reflect appropriate increases in volume that may be a result of policy changes, innovations that improve care, greater longevity and unanticipated spending for such things as influenza pandemics. Congress should also retain the ability to achieve a different level of savings than proposed by the Medicare Commission to adjust for new developments that warrant spending increases.

Physician Quality Reporting Initiative

We appreciate the proposed improvements to the Physician Quality Reporting Initiative (PQRI) to require timely feedback and establish an appeals process. The AMA does not support a mandatory PQRI or penalties for physicians who do not successfully participate. Based on our experience with the PQRI to date, this program is fraught with administrative problems that have made it extremely difficult to assess whether a physician has successfully participated, and due to these problems penalties would be unwarranted. Further, not all physicians are currently eligible to participate in the PQRI due to the lack of approved measures for their service mix.

Physician Outlier Proposal

Given the limited experience the Centers for Medicare and Medicaid Services has had implementing the provider resource use reports authorized under current law, we believe it is unwise to authorize financial penalties on physicians identified as outliers. Private and state insurance programs have experienced serious problems with the accuracy and validity of episode grouper methodologies to "profile" physicians.

Medicare/Medicaid Enrollment Fee

Physicians should not be subject to the proposed $350 enrollment fee for participation in Medicare and Medicaid. While some may view the fee as a minor expense, we believe that it has the potential to discourage physician participation in the program. We understand that the intent of the proposed enrollment fee is to cover the cost of screening measures intended to curb potential fraud and abuse activities, particularly by unscrupulous durable medical equipment suppliers. Physicians are already subject to multiple fraud and abuse review processes by Medicare contractors, recovery audit contractors, and the Office of Inspector General, and the type of measures being proposed in the mark simply add a new burden on physicians whose reimbursement under Medicare already fails to keep pace with increasing practice costs.

Primary Care and General Surgery Bonuses

The AMA supports primary care and general surgery bonus payments treated as a funded workforce investment that is not offset through a reduction in payments to other physicians. We strongly encourage

you to identify other pay-fors to fully fund the proposed bonuses that do not make across-the-board cuts to other Medicare physician services.

Physician-Owned Hospitals

We oppose the proposal to eliminate the whole hospital exception to the Stark self-referral law. Physician-owned hospitals have achieved the highest quality scores in some markets and have been shown to provide more net community benefits through uncompensated care and taxes than not-for-profit competitors as a share of total revenues. In addition, a recent study by the Center for Studying Health System Change found that physician-owned hospitals do not adversely affect general hospitals' ability to care for patients. Limiting the viability of physician-owned hospitals will reduce access to high-quality health care and have a destructive effect on the economy in communities these hospitals serve. Proposed limits on existing physician-owned hospitals would put them at a competitive disadvantage, making it difficult for them to respond to the health care needs of their local communities. The provisions would also effectively shut down many physician-owned hospitals currently under development. We urge that this provision be removed from the mark.

Once again, the AMA is grateful for your leadership. We support many of the provisions in the mark to reform the insurance market and ensure affordable coverage for all Americans and look forward to working closely with you and your colleagues to resolve our outstanding concerns.

Sincerely,

Michael D. Maves, MD, MBA

AMERICAN MEDICAL ASSOCIATION ■ MEDICARE

North Dakota seniors need Congress to act on Medicare cuts formula: Choice of physicians at risk

- North Dakota is one of 21 states and the District of Columbia that made the American Medical Association's new "Access Hot Spots" list, which highlights areas where patients already face problems getting physician care, and the problem will get worse unless Congress repeals the broken Medicare physician payment formula. North Dakota has just 15 practicing physicians per 1,000 Medicare beneficiaries and 22% of the state's residents are estimated underserved living in health professional shortage areas.
- According to the 2009 Medicare Trustees report, on January 1, 2010, North Dakota physicians face an across-the-board cut of 21.5%, with the cuts growing to about 40% by 2014 due to a flawed payment update formula, the Sustainable Growth Rate or SGR.
- By repealing the SGR formula, Congress can avert these cuts. SGR repeal would prevent a loss of $30 million in 2010 for the care of elderly and disabled patients in North Dakota. **On average, legislation to repeal the SGR would prevent cuts of $16,000 to each North Dakota physician next year.**
- Unlike previous short-term "band-aids" that Congress has adopted to stave off cuts, health system reform legislation should include provisions to eliminate all of the forecast SGR cuts and put in a place a new update formula. Repealing the SGR formula would prevent losses of $400 million to North Dakota physicians over the next five years for the care of elderly and disabled patients.
- 7,055 employees, 98,257 Medicare patients and 31,664 TRICARE patients in North Dakota will be helped by the legislation that averts these cuts.
- Compared to the rest of the country, at 15 percent, North Dakota has an above-average proportion of Medicare patients.
- 6.9% of North Dakota residents report that they could not see a doctor in the last 12 months due to cost, there are 429 emergency department visits per 1,000 population in the state, and 27% of the state's Medicare beneficiaries age 65 and over live below 150% of the federal poverty level.
- 43 percent of North Dakota's practicing physicians are over 50, an age at which surveys have shown many physicians consider reducing their patient care activities.
- Legislation is also needed to extend a temporary increase in Medicare geographic adjustments for certain areas which is set to expire at the end of 2009. In 2010, therefore, the legislation would prevent an additional 3.1% cut in payment rates for North Dakota physicians' Medicare services on top of the 21.5% cuts across the country.

AMA AMERICAN MEDICAL ASSOCIATION

October 2009