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 provide information regarding federal health care reform legislation and the impact of federal proposals on the state of North Dakota.

I was asked specifically to address the impact of what has become known as the "Frontier States" amendment which is included in the amended 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.

A primary consideration in our review these past months of proposed health system reform legislation is that the *current* Medicare payment system is fundamentally unfair to North Dakota and that change to the underlying payment system is necessary if that system is to be used as a foundation for broader health system reform. As early as 2001, the North Dakota Legislative Assembly formally recognized the unfairness of the Medicare payment system, by adopting 2001 HCR 3030 which called on Congress to increase Medicare reimbursement for health care providers, and to equalize Medicare rates.

Previous Testimony

At your meeting of August 6, we 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. I 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. The impact of the public option proposal in that original House legislation would have been devastating to North Dakota's health care system, in mandating medical service payments at Medicare rates and penalizing even more those rural areas that are providing high-quality, cost-efficient care.

At your meeting of November 3, we provided you with a resolution adopted by the NDMA in September 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. We also reviewed subsequent NDMA positions on the many legislative provisions being considered by Congress at that time, in both the second House bill (HR 3962) and the Senate Finance Committee proposal.

Much has occurred since November, including amendments and passage of the House bill (HR 3962) and amendments and the passage of the Senate bill, HR 3590, and the current effort by Democratic leadership to pass HR 3590 as amended in the House and a reconciliation bill in both chambers. We expect the reconciliation bill language to be released sometime today.

Prior to the vote on amendments to the Senate bill and passage of the Senate bill on December 24, NDMA provided comments to Senators Kent Conrad and Byron Dorgan on the Senate bill. **Those comments are provided as an attachment.**

Our comments recognized the difficulty in understanding fully the potential economic impact of the proposals in North Dakota or what impact the proposals may have in the future on patient care or on the ability of individual patients to receive the care they need. Our comments specifically pointed out areas of support and opposition within the array of health system delivery proposals relating to improving quality and performance, prevention and wellness, and the health care workforce and how those proposals might impact North Dakota patients and our health care delivery system.

Medicare Payment Reform and the Frontier States Amendment
As we've discussed previously, 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 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. **The current GPCI adjustments by state are attached.** The geographic adjustments lower payments as much as 32% below other states for professional codes and as much as 60% lower for technical fees for medical care provided by North Dakota physicians.

NDMA has advocated that Medicare payments be adjusted for *value*, rather than geography. One of the more significant provisions in HR 3590 would require the development and application of a value-based payment modifer that would begin rewarding physicians who provide high-quality, low-cost care and help address the current Medicare payment disparities that exist between states. For months, many of our Midwest state medical societies have been advocating that this value index (quality/cost) for Medicare payment be included in the final reform package.

The "Frontier States" amendment authored by Sen. Byron Dorgan would improve North Dakota's position dramatically in addressing the unfair geographic disparity of Medicare payments to physicians and hospitals by setting a threshold or floor for the geographic adjusters currently used to substantially decrease payments in North Dakota, South Dakota, Wyoming and Montana. The Frontier States amendment now included in the Senate bill would establish a 1.0 floor on the physician practice expense geographic adjuster (GPCI) and a 1.0 floor on the hospital wage index for states. The floors would only apply in states in which 50% or more of the counties within the state are "frontier," i.e., counties in which the population per square mile is less than six. This would apply to North Dakota, South Dakota, Montana, and Wyoming which currently are below the 1.0 floors.

Other states receive accommodation for increasing payments above other states based on a methodology that we have argued for years is clearly out-dated and inappropriate. The basis for the practice expense GPCI adjustment has been the use of proxies of apartment rental rates in rural America and only four wage categories for staff expenses. A recent AMA geographic analysis shows conclusively *that there are no practice expense differences from region to region, rural, urban, or inner city*. Previous surveys by *Medical Economics Magazine* and the Medical Group Management Association of practice expenses showed that rural areas had greater patient loads and, therefore, physicians needed more staff and space so their total practice costs were no less than urban areas.

One hospital administrator in North Dakota recently characterized the Frontier States amendment this way, in response to a negative characterization by a nationally syndicated columnist:

The Frontier States amendment would work to normalize an inequity that has existed for years. North Dakota currently receives the second lowest Medicare reimbursement in the country. In some cases we receive 50% of the reimbursement those in other states receive for the exact same patient diagnosis...the same tests, antibiotics, nursing intensity, etc. How can that reimbursement methodology possibly be equitable and fair to our citizens and those in other rural states compared to the Medicare reimbursement in Louisiana or Florida for example? While we consider our geography a "garden spot", believe it or not....others may not think so. Therefore it is a quite a challenge to recruit and retain physicians, nurses, radiology techs, pharmacists, etc. with less than fair (even "average") reimbursement to work with. If you look at the average age of plant in rural states such as North Dakota you would see that it is significantly higher than the rest of the country. This is because hospitals are forced to divert funding that would typically go into plant and equipment for medical technology into wages for our staffs in the hope that we can keep them in our cities. We simply cannot continue to do that with unfair Medicare reimbursement that lags so significantly behind the rest of the country.

... North Dakota has the best quality/cost quotient in the nation but yet our Medicare reimbursement is the second lowest. What a disconnect....what really needs to happen is a uniform payment methodology based on quality, one where states that demonstrate higher quality are rewarded for the effort. As it stands now rural states like North Dakota are penalized for outstanding performance because no reward mechanism for quality exists and, because of the geographical disparity in Medicare reimbursement, are actually "penalized" to even achieve "average" reimbursement when compared to other states throughout the country.

In our view, the Frontier States amendment is no different than existing Medicare payment accommodations made to other states challenged by geography such as Alaska, or for that matter any existing state receiving payments that exceed any payments received by any other state. In fact, Alaska receives the highest Medicare physician payments in the country to accommodate its geographic isolation challenges. While physicians face a 21.2% sustainable growth rate (SGR) cut and nationally decry how inadequately our Congress has "kicked the can" down the road on the SGR issue, we have long advocated that ***we actually take cuts similar to the 21% cut each***

and every year in our state because of the geographic adjusters that reduce all our Medicare payments.

The Frontier States amendment would have a substantial financial impact and go far beyond any other proposals in any of the federal health reform bills for addressing the Medicare payment disparity issue for North Dakota. Based on *Milliman* and CBO estimates, the Frontier States amendment would result in an annual $16.5 million increase for ND physician services (18.5%) beginning January 1, 2011. The amendment would also result in a $51.7 million increase for ND hospital inpatient services (12.8% increase) beginning January 1, 2011, and outpatient services (9.9% increase) beginning October 1, 2010. Over the ten-year period, this equates to $650–660 million. Overall for the states included (North and South Dakota, Montana and Wyoming), the CBO scored the amendment at $2 billion over ten years.

NDMA has consistently argued that the Medicare payment structure is critical to any application of health system reform designed to address the need to ensure that people have adequate and affordable insurance coverage and access to quality health care. Universal coverage does not guarantee that medical care will be available if reforms do not restructure payments to allow "frontier" states such as North Dakota and our health professionals and facilities to recruit and retain physicians, nurses and other health professionals, replace technology and equipment, keep abreast of rapidly changing medical technology and otherwise cover the costs of care.

The Frontier States amendment is one of several Medicare payment issues being pursued; however, only the Frontier States amendment and the value index are included in the Senate bill. Other payment issues are being addressed in other legislation. NDMA is working to:
1) Stop the Sustainable Growth Rate (SGR) cuts for 2010 (21.2% nationally for all physician services) and longer and provide reasonable increases for those years.
2) Work for a permanent solution to the SGR with a new physician Medicare payment policy.
3) Continue to advocate to accomplish changes in 2010 that address geographic disparity in Medicare payments for ND physicians and hospitals, including the Frontier States amendment and other amendments, a "value index," and Institute of Medicine studies on geographic disparity.
4) Ensure that our rural extenders (work GPCI floor of 1.0 and Section 508 wage index) are in fact extended for 2010 or longer.

Other Health System Delivery Reforms
Since each area of the country has its own health care history and traditions, its own gaps in infrastructure, and its own distinctive patient population, HR 3590 puts in place pilot programs to test health system delivery reforms.

These initiatives in HR 3590 include, among others: a national strategy to improve health care quality in Section 3011 including quality measure development and public reporting (Section 3013 – 3015); a hospital value-based purchasing program (Section 3001); "improvements" to the physician quality reporting initiative (Sections 3002, 3003); establishment of a CMS Innovation Center (Section 3021); a shared savings program for accountable care organizations (Section 3022); a national pilot program on payment bundling (Section 3023); a hospital readmissions

reduction program (Section 3025); a community-based care transitions program (Section 3026); creation of an interagency council to establish a national prevention and health promotion strategy (Section 4001) and outreach and education program (Section 4004); creation of a national commission to review health care workforce and projected workforce needs (Section 5101) including competitive workforce development grants (section 5102); grants for primary care training programs including faculty development (Section 5301); creation of a primary care extension program (Section 5405); and creation of a nonprofit Patient-Centered Outcomes Research Institute for comparative outcomes research (Section 6301).

While it is unknown at this time how these initiatives will develop, we told our Congressional Delegation that these strategic initiatives test almost every approach that leading healthcare experts have suggested (except proven medical liability reforms) to address health care cost and performance. **A listing of some of the major health system reform provisions as compiled by the Kaiser Foundation are provided in an attachment.**

Thank you for the opportunity to provide information on the impacts of federal health care reform. Throughout this process in Congress, our NDMA leadership has realized and respected the diverse perspectives of ND physicians on this controversial debate. We have consistently expressed a view that the current debate serves as an opportunity to ensure that geographic inequity is replaced by quality and cost efficiency as the basis for incentives in the Medicare payment system. We also see the debate as an opportunity to test models for health system delivery that recognize our strengths in North Dakota or provide new resources for improving the quality and efficiency of care provided patients in our state. If reform legislation is enacted in Congress, we will continue to work with the committee in assessing the impacts of the legislation in North Dakota.

HR 3590
Cost Containment, Quality Improvement, Prevention/Wellness and Workforce Provisions

Cost Containment

- ***Reduce annual market basket updates*** for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary)
- Establish an ***Independent Payment Advisory Board*** comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015.
- ***Reduce Medicare Disproportionate Share Hospital (DSH) payments*** initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year 2015)
- Allow providers organized as ***accountable care organizations*** (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)
- Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP ***different payment structures and methodologies*** to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011)
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for ***excess (preventable) hospital readmissions***. (Effective October 1, 2012)
- Reduce Medicare payments to certain hospitals for ***hospital-acquired conditions*** by 1%. (Effective fiscal year 2015)
- ***Increase the Medicaid drug rebate percentage*** for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. (Effective January 1, 2010)
- ***Reduce a state's Medicaid DSH allotment*** by 50%, or 25% for low DSH states, (and by lesser percentages for states meeting certain criteria) once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. (Effective October 1, 2011)

- Prohibit federal payments to states for ***Medicaid services related to health care acquired conditions***. (Effective July 1, 2011)
- Authorize the Food and Drug Administration to approve ***generic*** versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)
- ***Reduce waste, fraud, and abuse*** in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, and increase funding for anti-fraud activities. (Effective dates vary)

Improving Quality / Health System Performance

- Support ***comparative effectiveness research*** by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010)
- Award five-year demonstration grants to states to develop, implement, and evaluate ***alternatives to current tort litigations***. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)
- Establish a national Medicare pilot program to develop and evaluate paying a ***bundled payment*** for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016)
- Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with ***primary care services in their home*** and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012)
- Establish a ***hospital value-based purchasing program*** in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)
- ***Improve care coordination for dual eligibles*** by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)
- Create a new ***Medicaid state plan option*** to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a ***health home***. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011)

- Create new demonstration projects in ***Medicaid to pay bundled payments for episodes of care*** that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).
- Develop a ***national quality improvement strategy*** that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011)
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to ***coordinate and integrate health care services for low-income uninsured and underinsured*** populations. (Funds appropriated for five years beginning in FY 2011)
- Require ***disclosure of financial relationships*** between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)

Prevention / Wellness

- Establish the National Prevention, Health Promotion and Public Health Council to ***coordinate federal prevention, wellness, and public health activities***. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment)
- Establish a ***grant program*** to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)
- Improve prevention by covering only ***proven preventive services and eliminating cost-sharing for preventive services*** in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)
- Provide Medicare beneficiaries access to a ***comprehensive health risk assessment and creation of a personalized prevention plan***. (Health risk assessment model developed within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010)
- Require qualified health plans to provide at a minimum ***coverage without cost-sharing for preventive services*** rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)
- Provide grants for up to five years to small ***employers that establish wellness programs***. (Funds appropriated for five years beginning in fiscal year 2011) Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health

policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)

- Permit employers to offer ***employees rewards***—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)

Workforce and other Investments

- Improve workforce training and development:
  - Establish a multi-stakeholder Workforce Advisory Committee to develop a ***national workforce strategy***. (Appointments made by September 30, 2010)
  - Provide a 10% ***bonus payment to primary care*** physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015
  - Increase the number of ***Graduate Medical Education (GME) training positions*** by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish ***Teaching Health Centers***, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010)
  - Increase workforce supply and support training of health professionals through ***scholarships and loans***; support primary care training and capacity building; provide ***state grants*** to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010)
  - Address the projected shortage of ***nurses*** and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011)
  - Support the development of training programs that focus on primary care models such as ***medical homes, team management of chronic disease, and those that integrate physical and mental health services***. (Funds appropriated for five years beginning in fiscal year 2010)
- Establish a ***new trauma center program*** to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research,

and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)

- Improve access to care by ***increasing funding for community health centers and the National Health Service Corps*** (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).
- Impose additional requirements on non-profit hospitals to conduct a ***community needs assessment*** every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)
- Reauthorize and amend the ***Indian Health Care Improvement Act***. (Effective dates vary)

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.

Iowa Medical Society: Prepared 09/2009

Proposed 2010 Medicare GPCIs and Payments by Payment Locality

With Comparisons to Highest, Mean and Median Payments

Mid-level Office Visit (99213)

Locality Name	Work GPCI	PE GPCI	Mal GPCI	Payment	% of Highest Payment	% of Mean Payment	% of Median Payment
Alaska	1.500	1.090	0.646	$ 69.60	100.0%	128.3%	131.3%
San Mateo, CA	1.072	1.433	0.394	$ 66.13	95.0%	121.9%	124.8%
San Francisco, CA	1.059	1.441	0.414	$ 66.00	94.8%	121.7%	124.5%
Manhattan, NY	1.064	1.298	1.010	$ 63.38	91.1%	116.9%	119.6%
NYC Suburbs/Long I., NY	1.051	1.289	1.235	$ 63.11	90.7%	116.4%	119.1%
Santa Clara, CA	1.083	1.294	0.377	$ 62.90	90.4%	116.0%	118.7%
Oakland/Berkley, CA	1.053	1.286	0.425	$ 61.94	89.0%	114.2%	116.9%
Metropolitan Boston	1.029	1.291	0.764	$ 61.89	88.9%	114.1%	116.8%
Northern NJ	1.057	1.228	1.116	$ 61.57	88.5%	113.5%	116.2%
Anaheim/Santa Ana, CA	1.034	1.269	0.811	$ 61.54	88.4%	113.5%	116.1%
Queens, NY	1.032	1.239	1.220	$ 61.31	88.1%	113.1%	115.7%
Ventura, CA	1.027	1.265	0.766	$ 61.18	87.9%	112.8%	115.4%
DC + MD/VA Suburbs	1.047	1.218	1.032	$ 60.92	87.5%	112.4%	115.0%
Marin/Napa/Solano, CA	1.034	1.265	0.432	$ 60.90	87.5%	112.3%	114.9%
Los Angeles, CA	1.041	1.225	0.804	$ 60.61	87.1%	111.8%	114.4%
Connecticut	1.038	1.185	0.980	$ 59.77	85.9%	110.2%	112.8%
Miami, FL	1.000	1.069	3.167	$ 58.90	84.6%	108.6%	111.1%
Rest of New Jersey	1.042	1.126	1.116	$ 58.59	84.2%	108.0%	110.5%
Chicago, IL	1.025	1.080	1.940	$ 58.13	83.5%	107.2%	109.7%
Metropolitan Philadelphia, PA	1.016	1.097	1.617	$ 57.85	83.1%	106.7%	109.2%
Hawaii/Guam	0.998	1.161	0.665	$ 57.62	82.8%	106.3%	108.7%
Detroit, MI	1.036	1.040	1.906	$ 57.37	82.4%	105.8%	108.3%
Suburban Chicago, IL	1.017	1.068	1.629	$ 57.16	82.1%	105.4%	107.9%
Rhode Island	1.013	1.088	0.996	$ 56.66	81.4%	104.5%	106.9%
Rest of Massachusetts	1.007	1.106	0.764	$ 56.62	81.4%	104.4%	106.8%
Seattle (King Cnty), WA	1.014	1.085	0.706	$ 56.20	80.8%	103.7%	106.0%
Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822	$ 56.17	80.7%	103.6%	106.0%
Fort Lauderdale, FL	0.989	1.018	2.250	$ 56.01	80.5%	103.3%	105.7%
Baltimore/Surr. Cntys, MD	1.012	1.057	1.086	$ 55.98	80.4%	103.2%	105.6%
Rest of California	1.007	1.058	0.549	$ 55.11	79.2%	101.6%	104.0%
Delaware	1.011	1.046	0.678	$ 55.10	79.2%	101.6%	104.0%
Nevada	1.002	1.026	1.083	$ 54.92	78.9%	101.3%	103.6%
New Orleans, LA	0.986	1.044	0.956	$ 54.75	78.7%	101.0%	103.3%
Houston, TX	1.016	0.986	1.345	$ 54.67	78.6%	100.8%	103.1%
Dallas, TX	1.009	1.001	1.110	$ 54.52	78.3%	100.5%	102.9%
Atlanta, GA	1.009	1.014	0.836	$ 54.46	78.3%	100.4%	102.8%
New Hampshire	0.982	1.039	0.462	$ 53.82	77.3%	99.3%	101.5%
Portland, OR	1.002	1.015	0.472	$ 53.78	77.3%	99.2%	101.5%
Virgin Islands	0.997	0.978	1.009	$ 53.47	76.8%	98.6%	100.9%
Southern Maine	0.980	1.025	0.492	$ 53.45	76.8%	98.6%	100.9%
Austin, TX	0.992	0.984	0.969	$ 53.43	76.8%	98.5%	100.8%
Rest of Maryland	0.994	0.982	0.874	$ 53.30	76.6%	98.3%	100.6%
Galveston, TX	0.991	0.959	1.223	$ 53.13	76.3%	98.0%	100.2%
Fort Worth, TX	0.998	0.953	1.110	$ 53.01	76.2%	97.8%	100.0%
Colorado	0.986	0.992	0.641	$ 53.00	76.2%	97.7%	100.0%
Brazoria, TX	1.019	0.922	1.223	$ 52.96	76.1%	97.7%	99.9%
East St. Louis, IL	0.989	0.919	1.793	$ 52.87	76.0%	97.5%	99.8%
Rest of Florida	0.973	0.939	1.724	$ 52.84	75.9%	97.4%	99.7%
Metropolitan Kansas City, MO	0.990	0.945	1.188	$ 52.70	75.7%	97.2%	99.4%

Locality Name	Work GPCI	PE GPCI	Mal GPCI	Payment	% of Highest Payment	% of Mean Payment	% of Median Payment
Rest of Washington	0.987	0.974	0.693	$ 52.65	75.6%	97.1%	99.3%
Arizona	0.988	0.957	0.822	$ 52.43	75.3%	96.7%	98.9%
Ohio	0.993	0.927	1.232	$ 52.39	75.3%	96.6%	98.8%
Minnesota	0.992	0.983	0.245	$ 52.38	75.3%	96.6%	98.8%
Metropolitan St. Louis, MO	0.993	0.931	1.075	$ 52.27	75.1%	96.4%	98.6%
Rest of Michigan	0.998	0.923	1.083	$ 52.21	75.0%	96.3%	98.5%
Rest of Pennsylvania	0.993	0.925	1.081	$ 52.12	74.9%	96.1%	98.3%
Vermont	0.968	0.983	0.489	$ 52.06	74.8%	96.0%	98.2%
Virginia	0.982	0.942	0.657	$ 51.65	74.2%	95.3%	97.5%
Rest of New York	0.997	0.921	0.425	$ 51.20	73.6%	94.4%	96.6%
Utah	0.977	0.907	1.026	$ 51.15	73.5%	94.3%	96.5%
Indiana	0.986	0.918	0.599	$ 51.07	73.4%	94.2%	96.4%
Beaumont, TX	0.984	0.875	1.346	$ 50.99	73.3%	94.0%	96.2%
Wisconsin	0.988	0.921	0.409	$ 50.93	73.2%	93.9%	96.1%
North Carolina	0.972	0.925	0.634	$ 50.91	73.2%	93.9%	96.1%
New Mexico	0.973	0.890	1.096	$ 50.71	72.9%	93.5%	95.7%
Rest of Illinois	0.975	0.880	1.219	$ 50.69	72.8%	93.5%	95.6%
Rest of Oregon	0.968	0.927	0.472	$ 50.63	72.7%	93.4%	95.5%
Rest of Georgia	0.979	0.883	0.829	$ 50.32	72.3%	92.8%	95.0%
Rest of Texas	0.968	0.879	1.065	$ 50.26	72.2%	92.7%	94.8%
South Carolina	0.975	0.906	0.446	$ 50.25	72.2%	92.7%	94.8%
Tennessee	0.978	0.889	0.608	$ 50.14	72.0%	92.5%	94.6%
Rest of Louisiana	0.970	0.878	0.892	$ 50.04	71.9%	92.3%	94.4%
Kansas	0.969	0.882	0.557	$ 49.64	71.3%	91.5%	93.7%
Rest of Maine	0.962	0.893	0.492	$ 49.63	71.3%	91.5%	93.6%
Idaho	0.967	0.883	0.546	$ 49.59	71.3%	91.5%	93.6%
West Virginia	0.973	0.827	1.353	$ 49.49	71.1%	91.3%	93.4%
Kentucky	0.969	0.860	0.652	$ 49.22	70.7%	90.8%	92.9%
Alabama	0.982	0.853	0.496	$ 49.18	70.7%	90.7%	92.8%
Nebraska	0.959	0.890	0.245	$ 49.12	70.6%	90.6%	92.7%
Iowa	0.965	0.870	0.434	$ 49.05	70.5%	90.5%	92.6%
Mississippi	0.959	0.854	0.808	$ 49.01	70.4%	90.4%	92.5%
Oklahoma	0.964	0.850	0.627	$ 48.79	70.1%	90.0%	92.1%
Wyoming	0.956	0.842	0.889	$ 48.74	70.0%	89.9%	92.0%
Montana	0.950	0.847	0.673	$ 48.40	69.5%	89.3%	91.3%
Arkansas	0.961	0.846	0.446	$ 48.36	69.5%	89.2%	91.2%
South Dakota	0.942	0.864	0.420	$ 48.25	69.3%	89.0%	91.0%
Rest of Missouri	0.949	0.821	0.997	$ 48.18	69.2%	88.8%	90.9%
North Dakota	0.947	0.844	0.387	$ 47.84	68.7%	88.2%	90.3%
Puerto Rico	0.904	0.694	0.250	$ 42.68	61.3%	78.7%	80.5%
Mean Payment				**$ 54.22**			
Median Payment				**$ 53.00**			

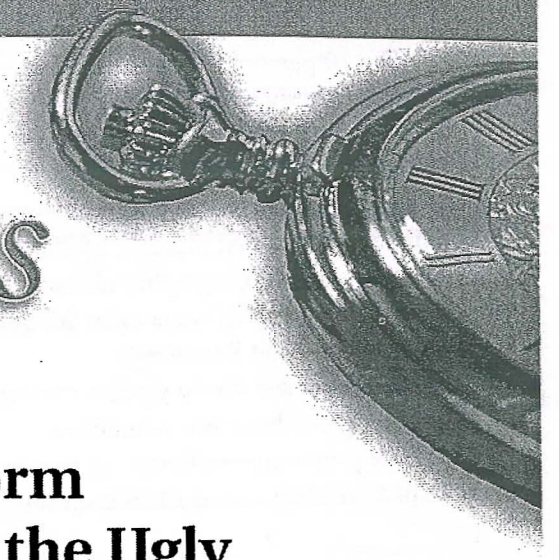
2010 Payment Formula: [(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x CF

Without Congressional action by year-end 2009, the 1.0 floor on the Work GPCI will end as of January 1, 2010 and the Conversion Factor (CF) will be cut by 21.5% to $28.3208, the lowest CF ever since the RBRVS was implemented in 1992 when the CF was $31.0010.

Data sorted in descending order by Payment.

Iowa Medical Society: Prepared 9/2009

NDMA Briefings



By Bruce Levi, Executive Director

Health System Reform –The Good, the Bad, and the Ugly

With national health care reform being debated in Congress, our NDMA goal over these past many months has been to work very closely with our ND Congressional Delegation on Medicare payment and health system reform issues. We appreciate the continued dialogue with the Delegation and staff and their listening to our views on the potential impact of reforms on North Dakota patients, physicians and our state's healthcare system.

We have also kept state leaders apprised, including interim legislative committees and the Governor's office.

Our various national and state specialty societies, the AMA and other physician organizations have taken varying strategic positions on health system reform as this process has continued to move forward – as we now are down to two bills in Congress, HR 3692 which was passed narrowly by the House along with a companion bill, HR 3961, which would provide a "permanent" fix to the Medicare physician SGR formula, and HR 3590 which was passed on Christmas Eve.

Now that both the House and Senate have passed bills, a process for negotiating a reconciliation of the two bills will occur, likely in a conference committee through January and into February.

Your NDMA leadership realizes and respects the diverse perspectives of ND physicians on this controversial debate. We see the current debate as an opportunity to ensure that geographic inequity is replaced by quality and cost efficiency as the basis for incentives in the Medicare payment system. We see the debate as an opportunity to test models for health system delivery that recognize our strengths in North Dakota or provide new resources for improving the care provided patients in our state.

At the same time, with concerns over the economic viability of the various proposals and efforts to constrain medical practice, we are watching the debate with both guarded optimism and concern, and weighing in as necessary.

NDMA Advocacy

In September, the NDMA House of Delegates adopted a ten-page resolution setting forth NDMA priorities and principles on health system reform, many of those principles built through the work of our Medicare Payment Task Force convened by Senator Kent Conrad with ND hospitals, which began its work early in 2008. We have repeatedly gone back to these priorities in reviewing proposals throughout the fall months, including active opposition to a public insurance option tied to Medicare rates and a Medicare "buy-in" program tied to existing Medicare rates.

On December 14, NDMA sent a letter to Senators Conrad and Byron Dorgan, expressing general concerns with the Senate bill, HR 3590, and specific provisions which NDMA opposes, as well as areas of support.

The Senate bill does not include a Medicaid "buy in" or public option. While many of the points in NDMA's December 14 letter to Senators Conrad and Dorgan were satisfactorily addressed, many were not.

These amendments include the following significant changes:

• The 10 percent payment bonus for primary care and general surgery in underserved areas will no longer be offset by cuts in other physician services to maintain budget neutrality.

• A "Frontier States" amendment was included through Senator Dorgan that places a 1.0 floor on the physician practice expense geographic adjuster (GPCI) and a 1.0 floor on the hospital wage index for qualifying states (ND, SD, Montana and Wyoming).

• The proposed tax on elective cosmetic surgery and medical procedures was eliminated.

• The proposed enrollment fee for physicians who participate in Medicare and Medicaid was eliminated.

Frontier State Amendment Addresses Medicare Payment Disparity

Throughout the process, NDMA has advocated for our Delegation to work to establish parity for ND physicians and hospitals in the Medicare payment system. In our rural states the geographic practice cost indices (GPCIs) lower payments as much as 32% below other states for professional codes and as much as 60% lower for technical fees.

The "frontier states" amendment now included in the Senate bill would establish a 1.0 floor on the physician practice expense geographic adjuster (GPCI) and a 1.0 floor on the hospital wage index. The floors would only apply in states in which 50% or more of the counties within the state are "frontier," i.e., counties in which the population per square mile is less than six. This would apply to North Dakota, South Dakota, Montana, and Wyoming which currently are below the 1.0 floors.

The "frontier states" amendment would have a substantial financial impact and go far beyond any other proposals for addressing the Medicare payment disparity issue for North Dakota. Sen. Dorgan reports, based on *Milliman* and CBO estimates, that the "frontier states" amendment would result in a $16.5 million annual increase for physicians services (18.5%) beginning January 1, 2011. The amendment would also result in a $51.7 million increase for hospital inpatient (12.8% increase) beginning January 1, 2011, and outpatient services (9.9% increase) beginning October 1, 2010. Over the ten-year period, this equates to $650 – 660 million. Overall for the states included, the CBO scored the amendment at $2 billion over ten years.

The majority of the Medicare geographic adjustment is due to practice expense GPCIs derived from alleged practice expense differences. *What's new is that we now have proof those alleged differences and prejudices against rural physicians and states are wrong.*

The basis for the practice expense GPCI adjustment has been the use of proxies of apartment rental rates in rural America and only four wage categories for staff expenses. On the other hand, survey data, not proxy data, has been used for many years by CMS to adjust RVU amounts for the practice expense portion of all fees. For 2010, the CMS rule made major adjustments to RVU amounts and therefore made significant payment changes to various specialties on the basis of the latest AMA Practicing Physician Information (PPI) Survey.

Our GEM (Geographic Equity in Medicare) Coalition in 2008 requested that the AMA geographically analyze that same nationwide PPI survey that CMS and almost all specialty societies have gone on record as supporting the validity. The geographic analysis results came out November 5, and they show conclusively *that there are no practice expense differences from region to region, rural, urban, or inner city.* Previous surveys by Medical Economics magazine and MGMA of practice expenses showed that rural areas had greater patient loads and, therefore, physicians needed more staff and space so their total practice costs were no less than urban areas.

So, now we have the proof; and health system reform must include significant Medicare payment reform.

The disparity in Medicare payments for North Dakota physicians and hospitals is addressed in several other provisions in the Senate bill. HR 3590, in addition to the "frontier states" amendment, would extend the temporary physician work geographic adjuster floor of 1.0 through the end of 2010, and reduce physician practice expense geographic adjustments by one fourth in January 2010 and then by one half in 2011. Additionally, during the next two years, CMS would be required to analyze and ensure that any geographic practice expense adjustments are accurate, or the 2011 changes would continue. This reanalysis and adjustments to the geographic practice expense cost index would take important steps to close the gap between Medicare reimbursement and the cost of providing services in predominantly rural areas, on a national basis.

NDMA also supports the development and application of a cost/quality index modifier as proposed in the Senate bill, to eventually replace the geographic adjusters.

The House bill, HR 3962, provides a $300 million windfall to California by redesignating GPCI payment localities in that state, and that state only. North Dakota would also likely benefit from House provisions requiring the Institute of Medicine to study geographic adjustment factors and geographic variation. The HHS Secretary would

be authorized to implement the IOM recommendations of one study, on geographic adjustment factors in Medicare payment. The Secretary also would be authorized to implement the recommendations of the second study, on geographic variation in health spending and promotion of high-value health care in Medicare, unless Congress votes to disapprove it.

Medicare SGR Fix

Both the House and Senate passed a 2-month extension of expiring appropriations for the Department of Defense that included a 2-month extension of the sustainable growth rate (SGR). In other words, the legislation stops the 21% Medicare pay cut scheduled take effect on January 1 for a period that will expire March 1, 2010. Importantly, the SGR issue has been taken off the main health system reform legislation and will be addressed separately.

According to AMA, Sen. Majority Leader Harry Reid stated his intent to pass legislation to permanently repeal the SGR formula. The House already passed a separate bill in HR 3961 which would provide a permanent fix to the SGR formula.

A permanent repeal of the sustainable growth rate (SGR) is critical to the goal of ensuring security, stability, and access for seniors, and to provide the essential foundation for the development of any new payment models and delivery reforms.

Health System Reforms

Health system reform is more than just payment reform. NDMA's letter of Dec. 14 to Senators Conrad and Dorgan identified other areas of the legislation NDMA supports and opposes with respect to insurance coverage and health system reforms.

We pointed out there are provisions in the bill NDMA supports that expand insurance coverage and improve access to medical care, including those provisions that:

- Reform the health insurance market to provide *more choice and 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;
- Provide *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;
- Establish health insurance exchanges that offer more affordable choices;
- Reduce overpayments to Medicare Advantage plans;
- Enhance Medicaid coverage;
- Provide coverage for prevention and wellness initiatives without co-payments or deductibles; and
- Create an independent comparative effectiveness research entity that will develop information to enhance patient-physician decision making about treatment options.

The provisions on health system reform in HR 3590 do not provide a "master plan" for reducing health care costs. What they offer are pilot programs and studies.

Congress is listening to those who suggest that pilot programs are what is needed since each area of the country has its own health care history and traditions, its own gaps in infrastructure, and its own distinctive patient population. "To figure out how to transform medical communities, with all their diversity and complexity, is going to involve trial and error. And this will require pilot programs – a lot of them." Atul Gawande, *Testing, Testing,* The New Yorker (December 14, 2009)

The system reform initiatives in HR 3590 include, among others: a national strategy to improve health care quality including quality measure development and public reporting (Section 3013 – 3015); a hospital value-based purchasing program (Section 3001); "improvements" to the physician quality reporting initiative (Sections 3002, 3003); establishment of a CMS Innovation Center (Section 3021); a shared savings program for accountable care organizations (Section 3022); a national pilot program on

payment bundling (Section 3023); a hospital readmissions reduction program (Section 3025); a community-based care transitions program (Section 3026); creation of an interagency council to establish a national prevention and health promotion strategy (Section 4001) and outreach and education program (Section 4004); creation of a national commission to review health care workforce and projected workforce needs (Section 5101) including competitive workforce development grants (section 5102); grants for primary care training programs including faculty development (Section 5301); creation of a primary care extension program (Section 5405); and creation of a nonprofit Patient-Centered Outcomes Research Institute for comparative outcomes research (Section 6301).

NDMA told the ND Delegation that while these strategic initiatives test almost every approach that leading healthcare experts have suggested (except proven medical liability reforms), it is unknown at this time how these initiatives will develop, making it difficult to comment on their potential impact in North Dakota. Many of the principles we enunciated in our Medicare Payment Task Force address directly how any payment initiatives might be structured to better suit North Dakota, including the negative implications of applying the current geographic adjusters to initiatives to incent quality (PQRI) and technology (e-prescribing, HIT) or being locked in to current baseline expenditures. We need to ensure that North Dakota hospitals and physicians are not penalized for providing services more efficiently and at higher quality, or penalized for the teamwork and accountability that has created value in our North Dakota healthcare system.

We also said the Senate bill is wholly inadequate in addressing one of the major cost drivers in healthcare, that being the costs of defensive medicine. The costs of practicing defensive medicine are not merely anecdotal; the CBO has recently estimated that comprehensive tort reform could save the federal government $54 billion over the next 10 years. Other studies suggest medical liability reforms could result in national savings of $242 billion a year, more than 10% of America's health expenditures.

Other Issues

NDMA's letter of Dec.14 addressed many other issues in the Senate bill. These are summarized below.

NDMA opposes the hospital productivity adjustments that will reduce Medicare payments to ND hospitals.

NDMA supports establishing a mechanism to test innovative payment methods for medical homes that provide patient-centered coordinated care and for accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, but expressed concerns regarding the need for adequate resources for ND to participate in these initiatives.

NDMA opposes a provision that would empower an independent commission to mandate payment cuts for physicians, who are already subject to an expenditure target and other potential payment reductions under the Medicare physician payment system.

NDMA supports efforts to strengthen primary care services financed by savings rather than across-the-board payment reductions in other physician services. This was corrected in the Senate amendment.

NDMA opposes any tax on medical services, including the five percent excise tax on elective cosmetic surgical and medical procedures in the Senate bill. This was removed in the Senate amendment.

NDMA supports the proposed improvements to the Physician Quality Reporting Initiative (PQRI) but opposes mandatory PQRI participation or the imposition of penalties on physicians who do not successfully participate. *In addition, in North Dakota, we have consistently expressed our dismay at the notion that our PQRI bonus payments are reduced by geographic adjusters – the same geographic adjusters that have resulted in some of the lowest Medicare payments in the country for North Dakota physician services.* It is ironic that one of the states with the highest quality of care like North Dakota receives a reduced bonus payment in the federal government's physician quality reporting initiative.

NDMA opposes the imposition of Medicare provider enrollment fees on physicians. These were removed in the Senate amendment.

NDMA, like AMA, does not believe a new public health insurance plan is essential to ensuring competition in a reformed insurance market that provides access to, and choice among, a variety of private plans. The Senate amendment removed the public option.

NDMA supports additional resources for quality improvement processes, but has strong concerns about the requirements for public reporting of performance information given the problems with the existing PQRI.

NDMA supports specific requirements to standardize and simplify health care administration in order to eliminate billions of dollars of unnecessary costs and administrative burdens from the current system.

There is a wide array of fraud and abuse provisions in the Senate bill that NDMA opposes because they would penalize all physicians, casting a wide net in order to find a select number of individuals who are intent on defraud-

ing public health care programs. Most troubling are provisions that would penalize physicians where they had no intention of defrauding federal health care programs and any wrongdoing was the result of an honest mistake.

NDMA also opposes the expansion of the Recovery Audit Contractors (RAC) program as it is currently structured.

NDMA supports several provisions on healthcare workforce initiatives, although more could be done.

NDMA generally supports the graduate medical education (GME) provisions in the bill but points out that filling vacant GME resident slots alone will not be enough to address the predicted physician shortages that are estimated at 85,000-124,000 in multiple undersupplied specialties. NDMA supports the inclusion of GME provisions that would redirect unfilled Medicare-supported GME positions and expand the number of Medicare-supported GME positions by 15 percent, with preference given to primary care, general surgery, non-hospital community based settings, and other areas of need.

Under the bill, health plans may not discriminate against any health care provider, acting within their state scope of practice law, who want to participate in the plan. NDMA is urging clarification that this provision does not allow *expansion* of the scope of practice for non-physician allied health practitioners.

The imaging cuts provided in the bill and the 2010 CMS final rule on physician Medicare payments may have a serious effect on access to these services in North Dakota. NDMA opposes the bill's utilization rate provision for advanced imaging equipment as too broad. It should allow medical specialties that represent users of the various imaging modalities to submit data to CMS to determine an appropriate assumption for utilization, and this revised provision should override recent regulatory changes to the utilization rate announced under the final physician fee schedule rule for 2010.

Clearly, the good, the bad, and the ugly are evident in both the legislation and process being used in deliberating on health system reform. The resolution of many outstanding issues will be necessary in the final conference agreement. The debate is not over. As Senate and House leadership now focus on reconciling the bills passed in both chambers, NDMA will continue to advocate for you and your patients.

Looking to the 2011 Session

While 2010 is a year of preparation for the 2011 ND legislative session, the state's interim committee process is a very active one for healthcare. There are many interim studies, including studies by the ND Legislative Council's interim Industry, Business & Labor Committee, Health & Human Services Committee and other committees focusing on unmet health care needs, access to psychiatric services and mental health commitment procedures, factors impacting the cost of health insurance, the needs of pregnant minors and whether additional education and social services would enhance the potential for a health child and a positive impact for the minor, consideration of workers compensation laws with respect to prior injuries, preexisting conditions and degenerative conditions, and others.

These studies are important – we continue to put our testimony and other documents on the NDMA website and work with our physician leadership and organizations as necessary to ensure that physicians are well represented in the interim. The interim IB&L Committee has been particularly active in focusing in on federal health reform implications for North Dakota, and will meet for the fourth time on January 7 at the UND School of Medicine.

The NDMA Commission on Legislation, chaired by Dr. Fadel Nammour, will soon begin work on developing a preliminary NDMA agenda for the 2011 session.

Other activities are ongoing as well. The process for determining the location of the Bismarck Center for Family Medicine continues, in implementing the appropriation of $5.4 million provided by the 2009 ND Legislative Assembly. The new ND Health Information Technology Advisory Committee established by the legislature is working on leveraging federal funds. The State Health Information Exchange Cooperative Agreement Program grant application was submitted on November 15 for $5.34 million. In anticipation of the receipt of the grant, a request for proposals was issued for strategic and operational planning services. NDMA established a "clinical workgroup" to assist in advising the committee work and the new state HIT office as we work to develop a health information exchange function for our state. There is also an effort ongoing to obtain federal funding for an HIT Regional Extension Center.

As the work continues, your help in supporting NDMA is critical in ensuring we have the resources and expertise to continue to be successful. I strongly encourage you to join or rejoin NDMA in 2010 along with your colleagues who see the value of our continuing to work together on policy issues.

Best wishes for the new year!

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December 14, 2009

Senator Kent Conrad
530 Hart Senate Office Building
United States Senate
Washington, DC 20510

Senator Byron Dorgan
322 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senators Conrad and Dorgan,

As your work continues in the Senate on amendments to HR 3590, the *Patient Protection and Affordable Care Act*, the North Dakota Medical Association (NDMA) remains committed to achieving enactment of comprehensive health system reform legislation that results in both geographic equity in the Medicare payment system and improves access in our state to affordable, high-quality, cost-efficient medical care.

We continue to greatly appreciate your commitment to these goals, and for your efforts in working with us to achieve meaningful reforms that make a difference for North Dakota.

HR 3590 includes a number of provisions that are consistent with the NDMA's reform priorities as we set forth in the recommendations and principles developed by our Medicare Payment Task Force, as well as the resolution adopted by the NDMA House of Delegates in September. Our ongoing goal has been to facilitate your role in the legislative process, and in that spirit we actively supported your opposition to a public insurance option tied to Medicare payments rates which would be devastating to North Dakota's healthcare delivery system. We encourage you to resist any additional efforts to expand the current Medicare payment inequities to health system reform initiatives, including a Medicare "buy-in" program tied to existing Medicare rates, and to continue to seek to establish parity for North Dakota physicians and hospitals in the Medicare payment system.

In North Dakota, there are a significant number of physicians who have expressed concerns about the underlying financial viability of either the House or Senate bill. There are many economic opinions on the effect of this massive legislation; enough so that everyone can choose the outcome they desire, and find an economic argument in support or opposition to any legislative proposal. *Clearly, it remains difficult in this environment to understand fully the potential economic impact of the proposals in North Dakota or what impact the proposals may have in the future on patient care or on the ability of individual patients to receive the care they need.*

And so, we are watching the debate with both guarded optimism and concern. We continue to review the position statements released by national medical specialty organizations and the American Medical Association for their application to North Dakota, and will forward those materials as we receive them.

Based on our own review, there are provisions in HR 3590 that NDMA supports and provisions NDMA opposes. Many of these comments apply as well to similar provisions contained in the House bills, HR 3692 and HR 3961.

In sum, we support the provisions in the bill that expand insurance coverage and improve access to life sustaining medical care, including those provisions that:

- Reform the health insurance market to provide *more choice and 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;
- Provide *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;
- Establish health insurance exchanges that offer more affordable choices;
- Reduce overpayments to Medicare Advantage plans;
- Enhance Medicaid coverage;
- Provide coverage for prevention and wellness initiatives without co-payments or deductibles; and
- Create an independent comparative effectiveness research entity that will develop information to enhance patient-physician decision making about treatment options.

We also appreciate that several physician-related provisions in the bill represent improvements over earlier proposals, including the elimination of a five percent Medicare payment cut for "outlier" physicians, changes to the Medicare quality reporting provisions, and reductions in proposed Medicare enrollment fees.

Health System Delivery Reforms

The provisions on health system reform in HR 3590 are not as straight forward as Medicare payment reform, and some suggest there is no "master plan" for reducing health care costs. What it offers is pilot programs and studies.

Some suggest that pilot programs are what is needed since each area of the country has its own health care history and traditions, its own gaps in infrastructure, and its own distinctive patient population. "To figure out how to transform medical communities, with all their diversity and complexity, is going to involve trial and error. And this will require pilot programs – a lot of them." Atul Gawande, *Testing, Testing*, The New Yorker (December 14, 2009)

These initiatives in HR 3590 include, among others: a national strategy to improve health care quality in Section 3011 including quality measure development and public reporting (Section 3013 – 3015); a hospital value-based purchasing program (Section 3001); "improvements" to the physician quality reporting initiative (Sections 3002, 3003); establishment of a CMS Innovation Center (Section 3021); a shared savings program for accountable care organizations (Section

3022); a national pilot program on payment bundling (Section 3023); a hospital readmissions reduction program (Section 3025); a community-based care transitions program (Section 3026); creation of an interagency council to establish a national prevention and health promotion strategy (Section 4001) and outreach and education program (Section 4004); creation of a national commission to review health care workforce and projected workforce needs (Section 5101) including competitive workforce development grants (section 5102); grants for primary care training programs including faculty development (Section 5301); creation of a primary care extension program (Section 5405); and creation of a nonprofit Patient-Centered Outcomes Research Institute for comparative outcomes research (Section 6301).

While these strategic initiatives test almost every approach that leading healthcare experts have suggested (except proven medical liability reforms), it is unknown at this time how these initiatives will develop, making it difficult to comment on their potential impact in North Dakota. Many of the principles we enunciated in our Medicare Payment Task Force address directly how any payment initiatives might be structured to better suit North Dakota, including the negative implications of applying the current geographic adjusters to initiatives to incent quality (PQRI) and technology (e-prescribing, HIT) or being locked in to current baseline expenditures. We need to ensure that North Dakota hospitals and physicians are not penalized for providing services more efficiently and at higher quality, or penalized for the teamwork and accountability that has created value in our North Dakota healthcare system.

The Senate has worked diligently to improve access to high quality care at the lowest possible cost. In that regard, we understand the political realities of enacting proven medical liability reforms, including limitations on attorneys' fees and non-economic damages. While we recognize those realities, the Section 6801 "sense of the Senate" is wholly inadequate in addressing one of the major cost drivers in healthcare, that being the costs of defensive medicine. The costs of practicing defensive medicine are not merely anecdotal; the CBO has recently estimated that comprehensive tort reform could save $54 billion over the next 10 years—and other estimates are much higher. NDMA joins the AMA and all physician groups urging Congress to make further progress, reducing waste of resources that is the byproduct of defensive medical practice.

Medicare Payment Reforms

As concluded in our joint NDMA/NDHA Medicare Task Force, we need to move to a Medicare payment system that rewards quality and cost efficiency and we appreciate your efforts in this regard. 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. Clearly, for North Dakota, if we fail to reform the flawed Medicare payment system, we will have failed at health system reform.

Geographic Disparity

The disparity in Medicare payments for North Dakota physicians and hospitals is addressed in several provisions in HR 3590. Section 3102(a) extends the temporary physician work geographic adjuster floor of 1.0 through the end of 2010. Section 3102(b) would reduce physician practice expense geographic adjustments by one fourth in January 2010 and then by

one half in 2011. Additionally, during the next two years, CMS would be required to analyze and ensure that any geographic practice expense adjustments are accurate, or the 2011 changes would continue. This reanalysis and adjustments to the geographic practice expense cost index take important steps to close the gap between Medicare reimbursement and the cost of providing services in predominantly rural areas.

We believe the inclusion of the Section 3102(b) language in health care reform legislation will help to correct the long-standing inequities that lead to disparities in care provided and will require CMS by 2012 to change the way they measure potential geographic practice cost differences.

In our Medicare Payment Task Force we recommended permanent 1.0 floors for both the work GPCI and practice expense GPCI, and encourage you to seek amendments to implement those recommendations. We encourage you to review the House language in Section 1125 of HR 3692 as well, which provides a $300 million windfall to California by redesignating GPCI payment localities in that state, and that state only. Under the House bill, North Dakota would not receive the scope of relief provided California, but would likely benefit from provisions requiring the Institute of Medicine to study geographic adjustment factors and geographic variation (HR 3692, Sections 1157-1159). The Secretary would be authorized to implement the recommendations of one study, on geographic adjustment factors in Medicare payment. The Secretary also would be authorized to implement the recommendations of the second study, on geographic variation in health spending and promotion of high-value health care in Medicare, unless Congress votes to disapprove it. We continue to support provisions for reforming provider payment to promote quality and efficiency.

We also support the "Frontier States" amendment being advanced by Senator Dorgan, which would put 1.0 floors in place for the Medicare practice expense GPCI and the hospital wage index. The amendment would apply to six states. There are many states NDMA has worked with in our GEM Coalition over the years that experience the same disparities and might "come on board" in support of such an amendment that would apply to their state as well.

We support the extension of the Section 508 reclassifications of the hospital wage index in Section 3137 and the reform initiative to be undertaken by the HHS Secretary. We strongly support any efforts to improve the hospital wage index for North Dakota beyond that contemplated by Section 3137.

Cost/Quality Index Modifier

One of the more significant provisions in HR 3590 is Section 3007 which would require the development and application of a cost/quality index modifier. We disagree with the AMA opposition to the bill's call for the creation of a value-based payment modifer that would begin rewarding physicians who provide high-quality, low-cost care and help address the current Medicare payment disparities that exist between states.

For months, the member state medical societies of our Geographic Equity in Medicare (GEM) Coalition have been advocating for such a modifier to ensure the inclusion of Medicare payment

reform in the final reform package. The NDMA agrees that any value-based payment system needs to be valid, accurate and verifiable, but disagrees that we should wait for the perfect system before attempting to address the current situation that penalizes high-quality, low-cost, states such as North Dakota. The reality is that the current bill has a lengthy timeline that will allow for CMS to develop a workable solution.

Sustainable Growth Rate
While NDMA appreciates that HR 3590 would avoid a 21 percent cut in Medicare physician payments in January, a permanent repeal of the sustainable growth rate (SGR) is critical to the goal of ensuring security, stability, and access for seniors, and to provide the essential foundation for the development of new payment models and delivery reforms. The SGR must be replaced this year with a system that keeps pace with the cost of running a practice and is backed by a fair, stable funding formula. We oppose further temporary patches to the payment formula that serve to increase both the severity of future cuts and the cost of a permanent solution.

We need to once and for all eliminate the cycle of endless Medicare physician payment cuts that threaten access to care.

Hospital Productivity Improvements
While the hospital industry on a national basis agreed to slow increases in Medicare payment rates in recognition of the increased revenue supposedly realized through covering more uninsured Americans and the potential for significant ongoing productivity improvements, we are not convinced these reductions are in the best interests of North Dakota's health care delivery system. The "economy-wide" productivity adjustments in Section 3401 are likely to adversely affect North Dakota hospitals, as medical services have not historically shown productivity increases at the rate of some other technologies in our national economy. These "productivity adjustment" reductions (Section 3401) only serve to offset any gains we can achieve in addressing Medicare payment disparity. They may also threaten access to care, as the Chief HHS Actuary notes, "[o]ver time, a sustained reduction in payment rates, based on productivity expectations that are difficult to attain, would cause Medicare payments to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable."

New Payment Systems
The House and Senate bills would establish a Medicare and Medicaid Payment Innovation Center (Section 3021) with broad authority for the HHS Secretary to test innovative payment methods for medical homes that provide patient-centered coordinated care, for accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, and for bundled hospital acute and post-acute care. The bill also would implement a national, voluntary shared savings program (Section 3022) for accountable care organizations. The Secretary would have broad authority to sustain and spread effective payment methods, although participation by providers in new payment methods would be voluntary. Without more detail, it is difficult to ascertain whether North Dakota physicians and hospitals would benefit – *or suffer*. In past incarnations, *Accountable Care Organization models* have presented a troubling issue:

ND begins at a tremendous disadvantage among states *because of our low Medicare payments.* In order to participate in an ACO model for providing care, North Dakota will require *upfront funding* to create the infrastructure necessary to succeed.

Independent Medicare Advisory Board

We agree with AMA policy that specifically opposes any provision such as Section 3403 that would empower an independent commission to mandate payment cuts for physicians, who are already subject to an expenditure target and other potential payment reductions under the Medicare physician payment system. Further, Section 3403 does not apply equally to all health care providers, and for the first four years significant portions of the Medicare program would be walled off from savings. This presents a serious inequity if spending reductions are to be obtained from only a fraction of the program. In addition, 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. These are critical issues with the potential for significant adverse consequences for the program, which must be properly addressed through a transparent process that allows for notice and comment. Congress should also retain the ability to achieve a different level of savings than proposed by the Medicare Board to adjust for new developments that warrant spending increases, and maintain its ultimate accountability for the sustainability and stability of the Medicare program.

Primary Care and General Surgery Bonus

NDMA supports efforts to strengthen primary care services financed by savings rather than across-the-board payment reductions in other physician services. While we support primary care and general surgery bonus payments, Section 5501 would fund half the cost of the bonuses through an across-the-board reduction in all other services. We oppose budget neutrality offsets and therefore strongly encourage the identification of other financing mechanisms to avoid across-the-board payment cuts for other physician services. We understand that some national specialty societies are also advocating that the bonus criteria be modified to allow additional primary care physicians to qualify for the bonus.

Tax on Cosmetic Surgical and Medical Procedures

The bill in Section 9017 imposes a five percent excise tax on elective cosmetic surgical and medical procedures performed by a licensed medical professional collected at the point of service. NDMA strongly opposes taxes on physician services to fund health care programs or to accomplish health system reform. Taxing medical services at the federal level is a major policy change. We have serious concerns that this revenue stream would be expanded in the future to encompass a broad array of other health care items and services that may not be considered "medically necessary or covered services."

Physician Quality Reporting Initiative

The proposed improvements to the Physician Quality Reporting Initiative (PQRI) in Sections 3002 and 3003 to require timely feedback and establish an appeals process are encouraging, as well as extending the period of bonus payments to allow for further program improvements and broader physician participation. However, we oppose mandatory PQRI participation or the imposition of penalties on physicians who do not successfully participate. Beginning in 2014,

physicians who do not submit measures to PQRI will have their Medicare payments reduced. Based on physicians' 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. Further, not all physicians are currently eligible to participate in the PQRI with endorsed measures that are relevant to their service mix.

In addition, in North Dakota, we have consistently expressed our dismay at the notion that our PQRI bonus payments are reduced by geographic adjusters – the same geographic adjusters that have resulted in some of the lowest Medicare payments in the country for North Dakota physician services. It is ironic that one of the states with the highest quality of care like North Dakota receives a reduced bonus payment in the federal government's physician quality reporting initiative. The legislation does nothing to change that.

Provider Enrollment Fees

We oppose the imposition in Section 6401 of Medicare provider enrollment fees on physicians. Given the multiple screening procedures that already apply to physicians in various licensing and credentialing processes, we believe this is an unnecessary duplication of review processes and another administrative burden with the potential of further discouraging physicians from participating in the Medicare and Medicaid programs.

Community Health Insurance Option

NDMA, like AMA, does not believe a new public health insurance plan is essential to ensuring competition in a reformed insurance market that provides access to, and choice among, a variety of private plans. We note that HR 3590 in Sections 1323 and 1324 includes provisions that are essential to maintaining a level playing field among public and private options. We believe the requirement in Section 1323 that the HHS Secretary "negotiate" provider reimbursement rates is inadequate in that while the negotiated rate could be as high as the average reimbursement rates paid by private health insurers offering plans through the exchange, there is no language establishing a floor which could become Medicare rates or something less.

We are concerned, however, that the bill does not specify that public plan enrollees would receive insurance payments if they seek services from out-of-network physicians. *Consistent with our view that patients and physicians have the right to privately contract without penalty*, we urge that the bill language be amended to clarify that public plan enrollees would have access to out-of-network physicians, with the right to assign their benefits just as federal employees have under the Blue Cross/Blue Shield standard option plan.

Quality Improvement/CMS Innovation Center

NDMA supports additional resources for quality improvement processes. We have strong concerns, however, about the requirements for public reporting of performance information in Section 3002 given the problems with the existing PQRI. If done correctly, public reporting has the potential to help provide appropriate and accurate information to patients, physicians, and other stakeholders. If not approached thoughtfully, however, public reporting can have unintentional adverse consequences for patients, such as reduced access for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, or economic and

cultural characteristics that contribute to lower levels of adherence to established protocols or less favorable outcomes. As noted by the AMA, several critical issues must be resolved before public reporting provisions can be implemented, including: (1) correctly attributing care to those involved in the care; (2) appropriate risk-adjustment; and (3) ensuring accurate, user-friendly, and relevant information that is helpful to consumers/patients, physicians and other stakeholders. *Moreover, physicians and other providers involved in the treatment of a patient must have the opportunity for prior review and comment and the right to appeal with regard to any data that is part of the public review process.* Any such comments should also be included with any publicly reported data.

Administrative Simplification

Similar to AMA, we support specific requirements to standardize and simplify health care administration in order to eliminate billions of dollars of unnecessary costs and administrative burdens from the current system. The AMA strongly recommends inclusion of several additional, critical components.

Program Integrity Funding, Reporting Requirements, New Penalties

There is a wide array of fraud and abuse provisions in HR 3590 (Section 6401 et seq.) that we and the AMA oppose because they would penalize all physicians, casting a wide net in order to find a select number of individuals who are intent on defrauding public health care programs. *Most troubling are provisions that would penalize physicians where they had no intention of defrauding federal health care programs and any wrongdoing was the result of an honest mistake.* For example, HR 3590 would amend the intent requirement for violations of the federal health care program Anti-Kickback Statute to now include "a person [who does] not have actual knowledge of this section or specific intent to commit a violation."

We also oppose the expansion of the Recovery Audit Contractors (RAC) program as it is currently structured. Besides imposing substantial administrative and cost burdens on providers, the program creates a strong financial incentive for RACs to identify appropriate payments as overpayments.

Health Care Workforce

NDMA supports provisions in the bill that would authorize increased funding for the National Health Service Corps and funding for Title VII health professions and diversity programs in order to address the need for more physicians and other health care professionals. More could be done in many areas, as expressed by national medical specialties such as the American College of Physicians. We also generally support programs that increase basic nursing education opportunities and provide workforce incentives, as well as other initiatives in order to increase the supply of registered nurses. In lieu of the proposed nurse-managed health clinics, we agree with the AMA in supporting fully integrated multidisciplinary health care teams that are comprised of nurses and other health care professionals, *which are led by physicians* to ensure that patients get the best possible care.

The NDMA agrees with AMA, and recommends that the proposed expansion of Title VII geriatric career incentive and academic career awards programs be extended to physician

specialists and that all expansions occur with additional, not existing, funding. While we support the establishment of a health care workforce advisory committee, we do not support limiting the number of appointed physicians and health educational professionals. In order to help medical students better manage their high student debt burdens averaging now over $155,000, *the NDMA and AMA strongly support inclusion in the final bill of the economic hardship loan deferment provision from the "Affordable Health Choices Act" (S. 1679), which would restore the loan deferment program known as the "20/220 pathway" that a majority of medical residents can qualify for.* We and the AMA also support broader provisions in the final bill that would alleviate high medical student debt burdens through tuition assistance, loan deferment, and loan forgiveness for service programs for *all* undersupplied specialties, including programs for medical teaching faculty.

Graduate Medical Education

Although the AMA generally supports the graduate medical education (GME) provisions in the bill (Section 5503), we agree with AMA that filling vacant GME resident slots alone will not be enough to address the predicted physician shortages that are estimated at 85,000-124,000 in multiple undersupplied specialties. *Like AMA, we strongly support the inclusion of GME provisions in the final health system reform bill from S. 973/H.R. 2251, the "Resident Physician Shortage Reduction Act of 2009," which would redirect unfilled Medicare-supported GME positions and expand the number of Medicare-supported GME positions by 15 percent,* with preference given to primary care, general surgery, non-hospital community based settings, and other areas of need. We also caution against the inclusion of any provisions in the final bill that would *authorize the government to dictate the content of medical school or residency curricula* either directly or as a condition for receiving funds.

Physician Resource Use

Private and state insurance programs have experienced serious problems with the accuracy and validity of episode grouper methodologies to "profile" physicians. We agree with AMA's support for providing physicians with *confidential* feedback on resource use, and recommend that CMS be allocated appropriate funding to help construct a fair and workable system while expanding the physician feedback program, as required under Section 3003.

Antidiscrimination Provisions for Health Plans

Under the bill in Section 1201, health plans may not discriminate against any health care provider, acting within their state scope of practice law, who want to participate in the plan. We urge clarification that this provision does not allow *expansion* of the scope of practice for non-physician allied health practitioners.

Imaging Cuts

The imaging cuts provided in the bill and the 2010 CMS final rule on physician Medicare payments may have a serious effect on access to these services in North Dakota. We agree with the AMA that the bill's utilization rate provision for advanced imaging equipment is too broad (Section 3135). It should allow medical specialties that represent users of the various imaging modalities to submit data to CMS to determine an appropriate assumption for utilization, and this revised provision should override recent regulatory changes to the utilization rate announced

under the final physician fee schedule rule for 2010. The AMA also does not support the multiple procedure payment reduction.

Independence at Home Demonstration Program
We agree with the AMA's general support for testing independence at home medical models in Section 3024, but like AMA we have some structural concerns, including that the demonstration program should be led by physicians.

Employee Retirement Income Security Act
We agree with the AMA's concern that HR 3590's omission of clarifying language contained in S 1796 regarding Employee Retirement Income Security Act (ERISA) preemption may result in the *preemption of current state-enforced insurance regulations*. Both HR 3590 and S 1796 contain language indicating that ERISA preempts state law insurance regulations to the extent those regulations are applied to self-insured ERISA plans. Such language reflects the current state of ERISA preemption doctrine with respect to state law regulation of self-insured ERISA plans. However, section 2715(e) of HR 3590 deletes language from section 2225 of S 1796 clarifying that ERISA does not preempt state laws regulating fully-insured ERISA plans. The deleted language in Section 2225 merely preserved the current state of ERISA.

In conclusion, we appreciate the ongoing opportunity to discuss health system reform legislation being considered in the Senate. Please continue to consider NDMA as a resource to you in your deliberation as we work together to accomplish what is best for North Dakota patients, our healthcare workforce and our state's healthcare system.

Sincerely,

Kimberly T. Krohn, MD, President

Robert A. Thompson, Immediate Past President

Bruce T. Levi, Executive Director