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Industry, Business & Labor Committee
ND Legislative Council
April 28, 2010

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

NDMA provided testimony to you on three previous occasions, and I was asked for this meeting to comment on potential impacts of the federal legislation on physician workforce needs, and other general observations regarding impacts.

At your meeting of March 18, NDMA addressed the impact of what has become known as the "Frontier States" amendment which was included in the U.S. Senate bill (HR 3590), and the extent to which the proposal impacts the long-standing need to address the unfair geographic disparity in Medicare payments for North Dakota hospitals and physicians. We also shared with you the comments we provided the ND Congressional Delegation prior to the U.S. Senate vote on HR 3590 in December, and reviewed many other aspects of the Senate bill relating to proposed health system delivery reforms.

Subsequent to your March meeting, the Congress enacted health system reform legislation, *The Patient Protection and Affordable Care Act* (HR 3590) and *The Healthcare and Education Affordability Reconciliation Act of 2010* (HR 4872). Prior to the votes on the Senate bill and reconciliation package during the week of March 21, NDMA provided comments to the ND Congressional Delegation. Those comments are provided as an attachment, setting forth both the perceived benefits of the legislation as well as the concerns shared by the medical community at the time the legislation was enacted.

The health system reform legislation is now law. While the legal and political wrangling will likely go on for years, the physicians of North Dakota remain committed to their patients. We want to continue the work of keeping what's good and fixing what's broken in our health care system.

It is NDMA's view that patients and their doctors must work together to take advantage of this change – to take advantage of any opportunity to improve the access and care we provide to our patients. We must also take advantage of opportunities to improve the new law.

Previous NDMA Testimony

At your meeting of August 6, NDMA provided you with the joint NDMA/ND Hospital Association principles and recommendations for Medicare payment reform made in conjunction with an 18-month study conducted with our ND Congressional Delegation. We also at that time provided you with our position statement from July 2009 in opposition to HR 3200, the original (tri-committee) health reform bill introduced in the U.S. House of Representatives. The impact of the public option proposal in that original House legislation would have been devastating to North Dakota's health care system.

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

Last September, NDMA adopted principles to guide our comments on Medicare payment reform and national health system reform. Those principles were provided to the committee at your meeting on November 3.[i] That resolution urged the North Dakota Congressional Delegation as part of health system reform to pursue multiple avenues for Medicare physician and hospital payment reform that address the current unfair geographic disparity to North

Dakota and address other needed payment reforms to ensure the future sustainability of North Dakota's health care system. At that November meeting we also reviewed NDMA positions on the many legislative provisions being considered by Congress at that time.

Legislation Impacts

The American Medical Association has developed several fact sheets; two are attached that generally address impacts of the federal legislation on physicians and patients.

The federal legislation makes strides in expanding health care coverage and improving access to quality medical care. It also takes a significant step forward in addressing the current unfair geographic disparity of Medicare payments for physician and hospital services. At your March 18 meeting, NDMA presented information on the impacts of the Frontier States amendment.[ii] In addition to the Frontier States amendment, a separate provision included in the Senate bill (HR 3590, Section 3102) and amended in the reconciliation bill by Senator Charles Grassley of Iowa provides additional relief by reducing the impact of practice expense variations in the Medicare geographic adjustors with a stepped phase-in for 2010 and 2011. In other words, North Dakota will benefit earlier (in 2010) from the changes in the practice expense adjustor which increased Medicare payments for physician services from what otherwise would have been a one-time increase in 2011 through the Frontier States amendment. The AMA has developed a fact sheet that shows the changes resulting from the Grassley amendment and the Frontier States amendment, as attached. Medicare payments for physician services across North Dakota increased by 3.9% for 2010 and another 7.7% increase will be realized for 2011 – larger increases than any other state.

It has been suggested that the health system reforms signed into law will cover an estimated 32 million uninsured patients by 2019. But the question being asked is whether there will be enough physicians to care for them, and whether projected shortages of physicians, especially in primary care, could make it harder for patients to access care. While there are provisions in the federal legislation aimed at addressing projected workforce shortages, there is a need to do more to address the projected shortages in physicians and other healthcare professionals. For physicians, there is at least a ten-year period of time or "pipeline" from college entry until a physician is ready to practice medicine.

A recent article from the American Medical News as attached highlights this issue, *Health reform's next challenge: Who will care for the newly insured?* In Massachusetts, which mandates individual health coverage, that state has the country's lowest uninsured rate and highest physician-to-population ratio, but patients there still face long waits to see doctors. Access to care could be worse in states like North Dakota with fewer physicians and more uninsured patients, according to the article.

The UND School of Medicine & Health Sciences advisory council has proposed a plan approved by the State Board of Higher Education for consideration in the Board's budget that would look to expand upon our state's proven ability to "home grow" North Dakota physicians. The plan was developed prior to consideration for any additional workforce needs caused by the impacts of federal legislation, using current rates of retention of our students and residents in North Dakota and assuming our state as things stand today will experience a projected shortfall in 2025 of about 210 physicians. Many medical schools across the country are increasing class size, and the UNDSMHS advisory council plan includes a proposal over time for 16 additional medical student slots for each of the medical student classes, 30 additional health science students in each class, and 17 additional residency slots per year. The committee may benefit from a more detailed presentation of this proposal by the UNDSMHS at a future meeting. It is clear from NDMA's perspective that there is a need to focus on physician recruitment and retention strategies to ensure good access to care for North Dakota patients. The need for these strategies existed before the enactment of federal health reform legislation, and is likely now an even greater need after reform.

As I described for you in testimony at your March 18 meeting, the federal legislation includes many provisions impacting the health care delivery system. Each area of the country has its own health care history and traditions, its own gaps in infrastructure, and its own distinctive patient population. The federal legislation takes the approach of recognizing that positive transformation of medical service delivery will involve trial and error, requiring several years of demonstration programs and pilot projects. North Dakota hospitals and physicians will need to consider whether to participate in these programs as the opportunities present themselves, including the shared savings program for accountable care organizations (Section 3022); the national pilot program on payment bundling (Section 3023); the community-based care transitions program (Section 3026); and others.

Other initiatives in the federal legislation will likely impact the provision of health care in our state including, among others: a national strategy to improve health care quality (Section 3011) including quality measure development and public reporting (Sections 3013–3015); a hospital value-based purchasing program (Section 3001); a hospital readmissions reduction program (Section 3025); 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).

As noted at your last meeting, 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 and to what extent North Dakota physicians and hospitals will participate in them.

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

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[i] As set forth in the NDMA resolution of September 25, 2009, NDMA principles for "meaningful" health system reform include Medicare payment reform and:

A. Access reforms that create a health care system that:

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

B. Insurance reforms that:

1. Retain a robust private insurance market, eliminating barriers to competition and authorizing insurance products to cross state lines;
2. Eliminate restrictions on pre-existing conditions and simplify administrative processes, reduce overhead costs, and observe competitive market practices, including transparent and fair contracts with providers;
3. Assist people who cannot afford health care coverage to purchase private health insurance coverage through tax credits and vouchers, and/or subsidy of small-employer purchase of health insurance coverage; and

4. Consider the creation of health care cooperatives (co-op) as a consumer coverage alternative to private insurance that is actuarially sound and not granted an unfair advantage over private insurance, and not able to leverage Medicare or any other public program to force physicians to participate or use Medicare payment rates or other rates that do not cover the cost of care.

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

D. Initiatives for quality, cost-efficient care that include:
1. Support for physician-led, patient-centered medical homes to improve care coordination;
2. Increased funding for services provided by primary care physicians, financed by savings rather than through across-the-board payment reductions in other physician services;
3. Addressing physician shortages, including increased funding of medical training for additional primary care physicians, with investment of needed resources to expand North Dakota's physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population, including more support for medical education and residency programs;
4. Increased investment in effective, evidence-based state health wellness and prevention initiatives;
5. Support for adoption of scientifically-valid quality and patient safety initiatives that incent and reward the physician-led health care delivery team, that includes comparative effectiveness research used only to help patient-physician relationships in choosing the best care for patients;
6. A high priority on patient safety, including the use of evidence-based quality measures developed by the Physician Consortium for Performance Improvement and financial support for the development of a federally-qualified patient safety organization for North Dakota;
7. Incentives for connected and interoperable health information technology systems and tools which improve patient safety, advance care coordination, and increase administrative efficiency, to further enhance state-based efforts through the work of the North Dakota HIT Advisory Committee to leverage current HITECH funding.

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

[ii] 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.

amednews.com
American Medical News

PROFESSION

Health reform's next challenge: Who will care for the newly insured?

Projected shortages of physicians, especially in primary care, could make it harder for patients to access care.

By KEVIN B. O'REILLY, amednews staff. *Posted April 12, 2010.*

The health system reforms signed into law in March will cover an estimated 32 million uninsured patients by 2019. But there may not be enough physicians to care for them.

The nation likely will see a shortage of about 160,000 physicians by 2025 -- leaving too few to keep up with the flood of newly insured patients seeking care for long-neglected health problems.

"It's sort of a race against time," said Edward Salsberg, director of the Assn. of American Medical Colleges' Center for Workforce Studies, whose 2025 physician supply estimate includes a shortage of 46,000 primary care physicians and 41,000 general surgeons, even after accounting for the supply of international medical graduates.

Several reform provisions are aimed at addressing the projected work force crisis, especially in primary care.

From 2011 through 2015, for example, primary care physicians and general surgeons who work in health professional shortage areas will get a 10% Medicare pay bump for certain services. In 2013 and 2014, Medicaid will increase pay to Medicare levels for primary care services delivered by primary care physicians. Unused residency slots will be shifted to programs that promise to train more primary care doctors and general surgeons. And a national work force commission will analyze the shortage problem and issue guidance for a competitive state grant program.

In Massachusetts, 40% of family physicians and 60% of internists do not accept new patients.

The American Medical Association lauded the health reform provisions but said further changes are needed to strengthen the physician work force, noting that at least 21 states and 17 medical specialty societies already are reporting doctor shortages.

"It's clear that there is more to be done to attract the best and brightest students to careers in medicine and to keep practicing physicians caring for patients," said AMA President-elect Cecil B. Wilson, MD. "The current average medical student debt is $155,000, and students and residents need help identifying funding sources and managing financial issues. Congress must lift the cap on government-funded medical residency training slots so that all future medical students can finish their training and become full-fledged physicians. Medical liability reform and permanent repeal of the broken Medicare physician payment formula will help physicians stay in medical practice."

Work force experts and some physician leaders say health reform provisions and other efforts may not avert a crisis, given the crush of the newly insured.

"We are going to have a lot more insured people, and it isn't only that they'll be getting routine services," said Richard "Buz" Cooper, MD, professor of medicine at the University of Pennsylvania School of Medicine and co-chair of the Council on Physician and Nurse Supply. "These people aren't routine. They have a lifelong reservoir of poor health."

Joseph W. Stubbs, MD, said reducing the number of uninsured should not be the last step in reform.

"Coverage is not equivalent to access," said Dr. Stubbs, president of the American College of Physicians, which supported the health system overhaul. "The system -- right now -- does not have enough primary care physicians to handle that many new patients who are seeking a personal physician to coordinate and manage their care."

The Massachusetts experience

Dr. Stubbs said Massachusetts' health reform, which mandates individual health coverage, sheds light on how the overhaul may play out nationwide.

"We've seen from the experience in Massachusetts that it is a framework in which you can get almost everyone insured," said Dr. Stubbs, an Albany, Ga., general internist. "The big logjam, and the big critical feature, is that if there's a shortage of primary care physicians, costs will go up substantially, because more patients will have to resort to higher health care utilization due to avoidable usage of emergency rooms."

The U.S., on average, has 79.4 physicians per 100,000 residents.

Forty percent of Massachusetts family physicians no longer accept new patients, up from 30% in 2007, according to a June 2009 study by the state medical society. Nearly 60% of internists have stopped taking new patients, up from 49% in 2007. The average wait for an appointment with a primary care doctor in the state is 44 days, the report said.

The Massachusetts Medical Society said 2009 marked the fourth consecutive year of a primary care physician shortage there. Yet by some measures, the Bay State was in better shape to handle the influx of newly insured patients than other states will be when the state insurance exchanges and federal subsidies take effect in 2014.

For every 100,000 residents, Massachusetts has 107.8 active primary care physicians providing patient care -- the third best ratio in the nation, according to the AAMC's November 2009 physician work force report. Nationally, the rate is 79.4 per 100,000 residents.

So, if Massachusetts doctors are turning away new patients, experts wonder, how will physicians in other states fare?

Katherine Atkinson, MD

Months after Massachusetts' sweeping health reforms took effect in 2007, Amherst family physician Katherine J. Atkinson, MD, hired a nurse practitioner and opened her practice to new patients.

"It opened the floodgates," she said.

In two weeks, her two-physician family practice accepted 50 new patients, many of them previously uninsured, before closing the doors again to newcomers. The new patients often had complicated medical problems that had been unaddressed for years.

"It's a lot harder to get things under control. It takes so much teaching, and it takes a lot of time and energy," Dr. Atkinson said. "Then you get a letter from the insurance company saying you spent too much money on their care."

Dr. Atkinson has lost money on many of these patients due to low insurance pay. Her advice to physicians around the country?

"I'd be hesitant about having an open panel for the first six months after this goes into effect, unless there's something dramatically different that's done," she said.

Debt burdens

Lori Heim, MD, president of the American Academy of Family Physicians, said health reform's focus on primary care already has reached medical students, with 9% more U.S. seniors choosing family medicine in 2010, compared with a 7% drop last year.

A Texas medical school has a family medicine track that leads to a medical degree in 3 years.

"The actions taken so far are in the right direction," Dr. Heim said, "but they are not sufficient to where we need to be in 10 years. If we rest on our laurels and say, 'We've done it,' we will not have moved the needle far enough."

Pediatricians, too, said additional steps should be taken to reduce the disparity in pay between primary care physicians and subspecialists.

"A lot more needs to be done to meet the needs of patients in the primary care setting," said Beth A. Pletcher, MD, chair of the American Academy of Pediatrics' work force committee. "The reimbursement change is helping, but it is insufficient to meet the needs of children in this country."

In the past, IMGs have stepped in to fill the primary care gap left by U.S. medical students choosing other specialties. But, work force experts said, IMGs alone cannot counteract the overall physician shortage caused by a cap on new Medicare-funded residency training slots. The AAMC and others pushed for 15,000 new federally-funded residency positions, but the idea did not make it into law.

Meanwhile, health system reform includes some education loan forgiveness and repayment incentives for physicians who work in shortage areas. One medical school is taking a more direct approach to encourage medical students to choose primary care.

In March, the Texas Tech University Health Sciences Center School of Medicine in Lubbock announced a three-year medical degree family medicine track. Students will compete for spots in the Liaison Committee on Medical Education-approved program. If accepted, their medical school tuition will be cut in half, through the absence of a fourth year and forgiveness of the first year's tuition, said the school's dean, Steven Berk, MD.

But medical schools alone cannot resolve the primary care shortage, Dr. Berk said. "There have to be several different approaches. This is one of them."

The looming physician shortage should prompt experimentation, said Penn's Dr. Cooper. Physicians will have to redesign their practices -- delegating more responsibility to nurse practitioners, physician assistants and medical assistants -- to handle the influx of patients.

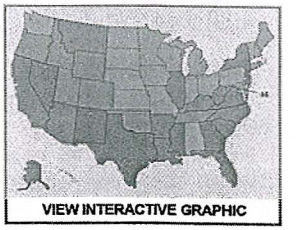
"We are now fighting a war with too few troops," said Dr. Cooper, senior fellow at the University of Pennsylvania's Leonard Davis Institute of Health Economics. "Nothing's going to be the way it used to be. Practices will have to be reorganized. This is not to do with legislation, but with the real world that takes care of real patients."

This content was published online only.

ADDITIONAL INFORMATION:

Physician supply and patient demand

Massachusetts has the country's lowest uninsured rate and highest physician-to-population ratio, but patients there still face long waits to see doctors. Access to care could be worse in states with fewer physicians and more uninsured patients, experts say.



VIEW INTERACTIVE GRAPHIC

Sources: "2009 State Physician Workforce Data Book," Assn. of American Medical Colleges, November 2009 (**www.aamc.org/workforce/statedatabook/statedata2009.pdf**); "Health Coverage & Uninsured," Kaiser Family Foundation State Health Facts (**www.statehealthfacts.org**)

Health reform's work force measures

A proposal to increase residency slots by 15,000 did not make it into health reform, but several other work force-related provisions were included. The new law:

- Provides a 10% Medicare pay bump for certain services provided by primary care physicians and general surgeons who work in health professional shortage areas, effective from 2011 through 2015.
- Increases Medicaid primary care pay to match Medicare levels for primary care physicians in 2013 and 2014.
- Provides $1.5 billion in mandatory spending for the National Health Service Corps to get more primary care practitioners to health shortage areas.
- Redistributes unused Medicare-funded residency slots to programs that agree to train more primary care physicians and general surgeons. Promotes training in outpatient settings where most primary care is delivered.
- Invests in and improves upon grants, scholarships and loan repayment programs in fields such as primary care, dentistry, nursing and mental health.

- Strengthens grant programs for primary care training, especially programs that prioritize training in patient-centered medical homes.
- Establishes a national work force commission to coordinate and implement work force planning and analysis.
- Authorizes a new competitive state health care work force development grant program.

Sources: House Energy and Commerce Committee, Senate Democratic Policy Committee

WEBLINK

"2009 State Physician Workforce Data Book," Assn. of American Medical Colleges, November 2009 **(www.aamc.org/workforce/statedatabook/statedata2009.pdf)**

"Health Coverage & Uninsured," Kaiser Family Foundation State Health Facts **(www.statehealthfacts.org)**

"MMS Physician Workforce Study Finds Continued Shortages in Primary Care," Massachusetts Medical Society, Sept. 14, 2009 **(www.massmed.org/workforce)**

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"Will Generalist Physician Supply Meet Demands Of An Increasing And Aging Population?" abstract, *Health Affairs*, April 29, 2008 **(content.healthaffairs.org/cgi/content/abstract/27/3/w232)**

"Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices?" The Robert Graham Center: Policy Studies in Family Medicine and Primary Care, March 2, 2009 **(www.josiahmacyfoundation.org/documents/pub_grahamcenterstudy.pdf)**

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How the passage of federal health system reform legislation impacts your practice

On March 23, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) into law. A number of key provisions in the new law may have an immediate impact on your practice and your patients, while others have a much longer time frame before they will take effect.

Medicare payment changes

Although Congress will address the flawed sustainable growth rate formula in separate legislation later this year, H.R. 3590 includes a number of payment improvements for physicians that, combined, will result in immediate and significant Medicare payment increases for many physicians.

- ***10 percent incentive payments for primary care physicians.*** All physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges will be eligible for a 10 percent bonus payment for these services from 2011–16.
- ***10 percent incentive payments for general surgeons performing major surgery in health professional shortage areas.*** All general surgeons who perform major procedures (with a 10- or 90-day global service period) in a health professional shortage area will be eligible for a 10 percent bonus payment for these services from 2011–16.
- ***5 percent incentive payment for mental health services.*** For 2010, Medicare will increase payment for psychotherapy services by 5 percent.
- ***Geographic payment differentials.*** The national average "floor" on Medicare's geographic payment adjustment (commonly known as the GPCI) for physician work expired at the end of 2009. The law re-establishes that floor in 2010. In 2010 and 2011, Medicare will also reduce the GPCI adjustment for physician practice expenses in rural and low-cost areas. And, beginning in 2011, the practice expense GPCI adjustment will be brought up to the national average for "frontier" states (Montana, North Dakota, South Dakota, Utah and Wyoming). Physicians in 56 localities in 42 states, Puerto Rico and the Virgin Islands will benefit from these geographic payment adjustments.
- ***Medicare quality reporting incentive payments extended.*** Incentive payments of 1 percent in 2011 and 0.5 percent from 2012–2014 will continue for voluntary participation in Medicare's Physician Quality Reporting Initiative (PQRI). An additional 0.5 percent incentive payment will be made to physicians who participate in a qualified Maintenance of Certification Program (quality practice-based learning programs through specialty boards). Following the practice now in place for hospitals, beginning in 2015 physician payments will be reduced if they do not successfully participate in the PQRI program. In 2015, the penalty will be 1.5 percent; in subsequent years it will be 2.0 percent.

Continued on page 2

Medicaid payment changes

Separate legislation, the Health Care Education Affordability Reconciliation Act (H.R. 4872), still pending at press time, would raise Medicaid payments to family medicine physicians, general internists and pediatricians for evaluation and management services and immunizations to at least Medicare rates in 2013 and 2014. The legislation also provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

Administrative simplification

Beginning in 2010, national rules will be developed and implemented between 2013 and 2016 to standardize and streamline health insurance claims processing requirements. Physicians should benefit from the changes because it will be easier to track claims and, in many cases, should improve physician revenue cycles and lower overhead costs.

Employer requirement to offer coverage

Employers with more than 50 employees with at least one full-time employee who receives a premium tax credit are required to offer health insurance coverage to their employees or be assessed a range in fees, effective in 2014. Employers with 50 employees or less, who represent the vast majority of physician practices are exempt from this requirement. A range of small business tax credits for employers contributing at least 50 percent of the costs of coverage for their employees will also be established, with credits phasing out as firm size and average employee wages increase.

Medical liability protection and grants

The Secretary of Health and Human Services (HHS) is authorized to award five-year demonstration grants to states to develop, implement and evaluate alternative medical liability reform initiatives, such as health courts and early offer programs, beginning in 2011. Medical liability protections under the Federal Tort Claims Act will be extended to officers, governing board members, employees and contractors of free clinics.

Preventive and screening benefit expansions

Beginning in 2010, Medicaid will be required to cover tobacco cessation services for pregnant women. In 2011, cost-sharing for proven preventive services will be eliminated in Medicare and Medicaid. Medicare payments for certain preventive services will be increased to 100 percent of payment schedule rates (that is, co-payments will be eliminated), and incentives will be available to encourage Medicare and Medicaid beneficiaries to complete behavior modification programs.

In the private sector, beginning in 2010, health plans will be required to provide a minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women.

Medicare prescription drug coverage

Medicare patients whose prescription expenses reach the so-called Medicare Part D coverage "doughnut hole" ($2,700 to $6,150) in 2010 will receive a $250 rebate. During the next 10 years, the beneficiary co-insurance rate for this coverage gap will be narrowed in phases from the current 100 percent to 25 percent in 2020.

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How health system reform affects patients

March 29, 2010

The Patient Protection and Affordable Care Act, health system reform legislation signed into law by President Obama on March 23, has many significant benefits for patients—those who already have health insurance and those who don't. While some benefits take effect in 2010, many others will be phased in over several years to allow the health care system to absorb the changes ahead. Here's a snapshot of those benefits.

Patient benefits that take effect in 2010

For patients with private health insurance:

- Your insurer can no longer drop you from your plan if you get sick.
- Children ages 18 and younger can no longer be denied private insurance coverage if they have a pre-existing medical condition. (While some ambiguities have been raised about application of this provision, implementing regulations will clarify that the prohibition on pre-existing condition exclusions for children will begin as planned in September. America's Health Insurance Plans (AHIP) has stated it will fully comply with the regulations.)
- For adults with pre-existing medical conditions who cannot obtain private insurance coverage, a temporary national "high-risk pool" will be established to provide coverage, with financial subsidies to make premiums more affordable, until all insurers are required to cover people with pre-existing conditions in 2014.
- Young adults up to age 26 can remain as a dependent on their parents' private health insurance plan.
- Your health insurance benefits can no longer run out because of a long or expensive illness because insurers can no longer impose lifetime financial limits on benefits.
- Preventive services for women, such as mammograms, and immunizations for children must be covered by insurers, with no co-payments or deductibles required.

In addition, Medicare patients who will hit the coverage gap known as the "doughnut hole" this year under the prescription drug benefit will receive a $250 rebate from Medicare.

Patient benefits that take effect during the next four years

In the private health insurance market:

- U.S. citizens and legal residents cannot be denied private health insurance coverage for any reason, beginning in 2014. All U.S. citizens and legal residents must obtain health insurance coverage or pay a minor tax penalty (although there are some exemptions). This is to ensure that everyone is in the insurance pool so no one can get a "free ride" by not having affordable coverage and then going to an emergency room for care.
- State-based health insurance exchanges will begin operating in 2014, where people who do not have access to employer-based insurance can shop and compare the benefits and costs of private health insurance plans. These exchanges will create insurance pools that will allow people to choose among affordable coverage options. All insurance companies in the exchange must provide at least a minimum benefit package, as well as additional coverage options beyond a basic plan.
- Federal subsidies through tax credits or vouchers will be provided in 2014 to people who cannot afford the full cost to help them purchase coverage through the exchanges.
- Beginning in 2011, states can require insurance companies to submit justification for premium increases and can impose penalties for excessive increases.

For patients enrolled in Medicare or Medicaid:

- You no longer will pay any cost sharing for a number of preventive services, effective Jan. 1, 2011.
- If you are subject to the "doughnut hole" for your Medicare drug coverage, you will receive a 50 percent discount on those prescription drugs beginning Jan. 1, 2011.
- A series of pilot programs will be implemented during the next four years to help find new ways to improve quality and lower the cost of the care you receive from your doctors, hospitals and nursing homes in the Medicare and Medicaid programs.
- Medicaid coverage will be expanded in 2014 to all eligible children, pregnant women, parents and childless adults under age 65 who have incomes at or below 133 percent of the federal poverty level.

AMA AMERICAN MEDICAL ASSOCIATION

Health reform law raises GPCIs

Table shows estimated payment increase in each state

April 9, 2010

The American Medical Association (AMA) estimates that the new health system reform law will increase average Medicare physician payment rates in 42 states and territories by raising practice expense geographic practice cost indexes (GPCI). Separate GPCIs determine Medicare payment adjustments in each locality for physician work, practice expense and professional liability insurance components of the Medicare physician payment schedule.

For 2010, the law reinstates a floor of 1.00 on the work GPCI that expired Dec. 31, 2009. In 2010 and 2011, Medicare will increase the practice expense GPCI in all payment localities that have a practice expense GPCI below 1.00.

Beginning in 2011, the practice expense GPCI will be increased to 1.00 in five states: North Dakota, Montana, South Dakota, Utah and Wyoming. These changes will be specified in Centers for Medicare & Medicaid regulations.

The table below shows AMA estimates of how much average payment rates will increase in each locality. Impacts will vary by service depending on the proportion of work and practice expense.

Locality	2010 payment increase for average service			2011 pay increase for average service (PE GPCI only)
	Pay increase due to work GPCI	Pay increase due to PE GPCI	Pay increase due to combined work and PE GPCI	
Alabama	1.0%	3.5%	**4.6%**	**3.5%**
Alaska	0.0%	0.0%	**0.0%**	**0.0%**
Arizona	0.7%	1.0%	**1.6%**	**1.0%**
Arkansas	2.3%	3.8%	**6.1%**	**3.8%**
Anaheim/Santa Ana, CA	0.0%	0.0%	**0.0%**	**0.0%**
Los Angeles, CA	0.0%	0.0%	**0.0%**	**0.0%**
Marin/Napa/Solano, CA	0.0%	0.0%	**0.0%**	**0.0%**
Oakland/Berkley, CA	0.0%	0.0%	**0.0%**	**0.0%**
San Francisco, CA	0.0%	0.0%	**0.0%**	**0.0%**
San Mateo, CA	0.0%	0.0%	**0.0%**	**0.0%**
Santa Clara, CA	0.0%	0.0%	**0.0%**	**0.0%**
Ventura, CA	0.0%	0.0%	**0.0%**	**0.0%**

Continued on page 2

Locality	2010 payment increase for average service			2011 pay increase for average service (PE GPCI only)
	Pay increase due to work GPCI	Pay increase due to PE GPCI	Pay increase due to combined work and PE GPCI	
Rest of California	0.0%	0.0%	**0.0%**	**0.0%**
Colorado	0.8%	0.2%	**0.9%**	**0.2%**
Connecticut	0.0%	0.0%	**0.0%**	**0.0%**
DC + MD/VA Suburbs	0.0%	0.0%	**0.0%**	**0.0%**
Delaware	0.0%	0.0%	**0.0%**	**0.0%**
Fort Lauderdale, FL	0.5%	0.0%	**0.5%**	**0.0%**
Miami, FL	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Florida	1.4%	1.3%	**2.8%**	**1.3%**
Atlanta, GA	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Georgia	1.2%	2.7%	**3.9%**	**2.7%**
Hawaii/Guam	0.1%	0.0%	**0.1%**	**0.0%**
Idaho	1.9%	2.8%	**4.7%**	**2.8%**
Chicago, IL	0.0%	0.0%	**0.0%**	**0.0%**
East St. Louis, IL	0.6%	1.8%	**2.4%**	**1.8%**
Suburban Chicago, IL	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Illinois	1.4%	2.8%	**4.2%**	**2.8%**
Indiana	0.8%	1.9%	**2.7%**	**1.9%**
Iowa	2.0%	3.1%	**5.2%**	**3.1%**
Kansas	1.8%	2.8%	**4.6%**	**2.8%**
Kentucky	1.8%	3.4%	**5.2%**	**3.4%**
New Orleans, LA	0.7%	0.0%	**0.7%**	**0.0%**
Rest of Louisiana	1.7%	2.9%	**4.6%**	**2.9%**
Southern Maine	1.1%	0.0%	**1.1%**	**0.0%**
Rest of Maine	2.2%	2.6%	**4.7%**	**2.6%**
Baltimore/Surr. Cntys, MD	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Maryland	0.3%	0.4%	**0.7%**	**0.4%**
Metropolitan Boston	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Massachusetts	0.0%	0.0%	**0.0%**	**0.0%**
Detroit, MI	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Michigan	0.1%	1.7%	**1.8%**	**1.7%**
Minnesota	0.4%	0.4%	**0.8%**	**0.4%**
Mississippi	2.4%	3.5%	**5.9%**	**3.5%**

Continued on page 3

Locality	2010 payment increase for average service			2011 pay increase for average service (PE GPCI only)
	Pay increase due to work GPCI	Pay increase due to PE GPCI	Pay increase due to combined work and PE GPCI	
Metropolitan Kansas City, MO	0.5%	1.2%	1.8%	1.2%
Metropolitan St Louis, MO	0.4%	1.6%	**1.9%**	**1.6%**
Rest of Missouri	3.0%	4.4%	7.4%	4.4%
Montana	2.9%	3.7%	**6.7%**	**7.5%**
Nebraska	2.4%	2.7%	5.1%	2.7%
Nevada	0.0%	0.0%	**0.0%**	**0.0%**
New Hampshire	1.0%	0.0%	1.0%	0.0%
Northern NJ	0.0%	0.0%	**0.0%**	**0.0%**
Rest of New Jersey	0.0%	0.0%	0.0%	0.0%
New Mexico	1.5%	2.6%	**4.1%**	**2.6%**
Manhattan, NY	0.0%	0.0%	0.0%	0.0%
NYC Suburbs/Long I., NY	0.0%	0.0%	**0.0%**	**0.0%**
Poughkpsie/N NYC Suburb, NY	0.0%	0.0%	0.0%	0.0%
Queens, NY	0.0%	0.0%	**0.0%**	**0.0%**
Rest of New York	0.2%	1.8%	2.0%	1.8%
North Carolina	1.6%	1.7%	**3.3%**	**1.7%**
North Dakota	3.2%	3.9%	7.0%	7.7%
Ohio	0.4%	1.6%	**2.0%**	**1.6%**
Oklahoma	2.1%	3.6%	5.7%	3.6%
Portland, OR	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Oregon	1.8%	1.7%	3.5%	1.7%
Metropolitan Philadelphia, PA	0.0%	0.0%	**0.0%**	**0.0%**
Rest of Pennsylvania	0.4%	1.7%	2.1%	1.7%
Puerto Rico	6.4%	8.5%	**14.9%**	**8.5%**
Rhode Island	0.0%	0.0%	0.0%	0.0%
South Carolina	1.4%	2.2%	**3.6%**	**2.2%**
South Dakota	3.4%	3.3%	6.8%	6.7%
Tennessee	1.2%	2.6%	**3.9%**	**2.6%**
Austin, TX	0.4%	0.4%	0.8%	0.4%
Beaumont, TX	0.9%	2.9%	**3.8%**	**2.9%**
Brazoria, TX	0.0%	1.7%	1.7%	1.7%
Dallas, TX	0.0%	0.0%	**0.0%**	**0.0%**

Continued on page 4

Locality	2010 payment increase for average service			2011 pay increase for average service (PE GPCI only)
	Pay increase due to work GPCI	Pay increase due to PE GPCI	Pay increase due to combined work and PE GPCI	
Fort Worth, TX	0.1%	1.0%	1.2%	1.0%
Galveston, TX	0.5%	0.9%	**1.4%**	**0.9%**
Houston, TX	0.0%	0.3%	0.3%	0.3%
Rest of Texas	1.8%	2.8%	**4.6%**	**2.8%**
Utah	1.3%	2.1%	3.4%	4.3%
Vermont	1.8%	0.4%	**2.1%**	**0.4%**
Virginia	1.0%	1.3%	2.3%	1.3%
Virgin Islands	0.2%	0.5%	**0.6%**	**0.5%**
Seattle (King Cnty), WA	0.0%	0.0%	0.0%	0.0%
Rest of Washington	0.7%	0.6%	**1.3%**	**0.6%**
West Virginia	1.5%	4.1%	5.6%	4.1%
Wisconsin	0.7%	1.8%	**2.5%**	**1.8%**
Wyoming	2.6%	3.8%	6.4%	7.6%

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March 20, 2010

The Honorable Earl Pomeroy
United States House of Representatives
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Washington, DC 20515

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

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

Dear Congressman Pomeroy and Senators Conrad and Dorgan,

As you review HR 3590, the *Patient Protection and Affordable Care Act* and HR 4872, *The Health Care & Education Affordability Reconciliation Act of 2010 (the "reconciliation package")*, we remind you of the commitment of the North Dakota Medical Association (NDMA) to achieve 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 for patients. We greatly appreciate your willingness over these past months to listen to physicians representing not only NDMA but other physician specialty societies and our North Dakota hospitals and clinics, and for the assistance of your staffs in working through the substantive issues and the difficult and sometimes awkward and problematic process pursued by Congress in working toward reform.

The reconciliation package is the beginning point for meaningful health system reform, and cannot be the end. Physicians dedicate their lives to helping patients live healthier and longer, and we know that the present course of health system delivery and finance may not be sustainable. While physicians in North Dakota share many concerns and have diverse views on health system reform, we urge the Congress to move forward. Starting over is not a realistic alternative for reforms in the near term. If passed, the reconciliation package needs improvement and we look forward to working with you on the next steps to address the many outstanding issues.

Medicare Payment Reform

Last September, we shared with you a resolution adopted by the NDMA House of Delegates urging you, as part of the effort to enact meaningful health system reform, to pursue Medicare physician and hospital payment reform that addresses the unfair disparity in Medicare payments. We appreciate the work

we undertook together with each of you and the North Dakota Hospital Association in our 2008-09 Medicare Payment Task Force to prepare for this issue. We concluded that change to the underlying Medicare payment system is necessary if that system is to be used as a foundation for broader health system reform. Since that time, supporting research from the American Medical Association has shown conclusively that there are no practice expense differences among physicians from region to region, rural, urban, or inner city. 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.

It is clearly time to resolve this long-standing payment inequity for North Dakota, and we greatly appreciate your efforts to do so. As concluded in Medicare Payment Task Force, we need to move to a Medicare payment system that is both equitable and rewards quality and cost efficiency.

Frontier States Amendment

NDMA strongly supports the "Frontier States" amendment included by our Congressional Delegation in the reconciliation package. This initiative would dramatically improve the prospects for maintaining the sustainability of North Dakota's health care system in addressing the unfair geographic disparity of Medicare payments to physicians and hospitals. 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.

In our view, the Frontier States amendment is no different than existing Medicare payment accommodations made to other states challenged by geography. In fact, Alaska receives the highest Medicare physician payments in the country. While physicians across the country bemoan each year the pending sustainable growth rate (SGR) cuts and then work with Congress to stop them, we have long advocated that in North Dakota *we actually take substantial cuts each and every year in our state because of the geographic adjusters* that reduce our Medicare payments.

The Frontier States amendment would have a substantial financial impact, resulting in an annual $16.5 million increase in reimbursement for North Dakota physician services (18.5%) beginning January 1, 2011. The amendment would also result in a $51.7 million increase for North Dakota 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 in additional resources for our health care delivery system to recruit and retain physicians, nurses and other health professionals, address technology, equipment and plant needs, improve the quality and safety of care provided to our patients, and cover the costs of care. NDMA has consistently argued throughout this debate that addressing the inequity in Medicare payment is a critical precondition to any health system reforms. Universal insurance coverage does not guarantee that medical care will be available if reforms do not restructure payments to allow "frontier" states to cover the costs of care.

SGR Cuts and Rural Extenders

NDMA appreciates the ongoing efforts of Congress to address the SGR issue in legislation outside the reconciliation package. While we would have preferred that Congress follow the lead of the House in HR 3961 by implementing a permanent repeal of the SGR as supported by

Congressman Pomeroy, *we will continue to advocate for a permanent SGR repeal and development of a fair and relevant Medicare payment methodology.* It is imperative that a permanent SGR fix be accomplished soon as it reflects the commitment of Congress to the critical goal of ensuring security, stability, and access for seniors and military families, and provides the essential foundation for the development of new payment models and delivery reforms. We are particularly concerned that the "savings" identified from a 21.2% cut in Medicare physician payments not come to fruition.

NDMA supports the inclusion in the reconciliation package of the extension of the physician work GPCI 1.0 threshold, Section 508 wage index reclassification, and other rural provisions.

New Payment Systems

NDMA has advocated that Medicare payments be adjusted for *value*, rather than geography. One of the more significant provisions in the reconciliation package (Section 3007) would require the development and application in 2015 of a value-based payment modifier that would begin rewarding physicians who provide high-quality, cost-efficient care. In supporting the value-based payment modifier, NDMA has stressed that any value-based payment system needs to be valid, accurate, verifiable and achievable. NDMA also appreciates Congressman Pomeroy's efforts to receive commitments from the Secretary of Health and Human Services to take additional steps to address geographic variation in Medicare reimbursement and bring additional GPCI relief by advancing by one year the practice expense GPCI provision in the Senate-passed bill (Section 3102) that would start to narrow the gap on the practice expense GPCI between high and low cost areas. This provision would start in 2010 rather than 2011 under the budget reconciliation package (manager's amendment), allowing North Dakota to benefit from that provision prior to the implementation of the practice expense GPCI provision of the Frontier States amendment in 2011.

The reconciliation package would establish a Medicare and Medicaid Payment Innovation Center (Section 3021) 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, as supported by Congressman Pomeroy. NDMA supports the need for innovation, particularly innovation that builds on the current strengths of our integrated and collaborative health care system, and will continue to explore with the Centers for Medicare and Medicaid the concept of a statewide quality improvement network for North Dakota as initiated by Senator Conrad. These efforts will require resources to create the infrastructure necessary to succeed.

Health System Reform

The reconciliation package includes many provisions that are consistent with the NDMA's reform priorities as set forth in the recommendations and principles developed by our Medicare Payment Task Force, and the resolution adopted by the NDMA House of Delegates in September 2009. ***NDMA continues to support the provisions in the bill that expand insurance coverage and improve access to quality 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;
- Strengthen primary care services financed by savings rather than across-the-board payment reductions in other physician services, including primary care and general surgery bonus payments;
- Strengthen Medicare by reducing costs for prescription drugs, expanding coverage for preventive care, providing more help for low-income beneficiaries, and supporting coordinated care that responds to patients' needs without reducing Medicare's basic benefits;
- Provide coverage for prevention and wellness initiatives without co-payments or deductibles;
- Create an independent comparative effectiveness research entity that will develop information to enhance patient-physician decision making about treatment options; and
- Improve workforce training and development, although more could be done to address physician shortages which are particularly prevalent in North Dakota.

At the same time, many physicians and physician specialty societies have expressed concerns about the overall financial viability of the reconciliation package. As we noted in our December 14 letter to Senators Conrad and Dorgan, it remains difficult to understand fully the potential economic impact of the insurance coverage and tax proposals in North Dakota.

National physician specialty societies have taken diverse positions on the reconciliation package. On one hand, the American College of Physicians is urging Congress to enact the reconciliation package although it suggests the package "falls short" in some respects. The American Academy of Family Physicians takes a similar position. The ACP said the reconciliation package has essential policies to expand coverage, increase funding for programs to train more primary care physicians, increase Medicare payments for office and other outpatient visits by primary care physicians, and accelerate pilot-testing of innovative payment and delivery system reforms. The American Psychiatric Association also supports health system reform moving forward, with reservations similar to those of NDMA and other organizations. The APA particularly supports provisions in the reconciliation package that would require a basic benefit package for all qualified health benefit plans in the health insurance exchange, including mental health and substance-use disorder treatment, and extending this coverage requirement to all health insurance plans within five years. On the other hand, a coalition of 23 organizations representing surgeons and anesthesiologists oppose the reconciliation package, including the American Academy of Ophthalmology, the American Association of Orthopaedic Surgeons, the American College of

Surgeons, and the American Society of Anesthesiologists. The concerns of the coalition center around the expansive authority of the Independent Payment Advisory Board, mandatory participation in future years by physicians in the flawed Physician Quality Reporting Initiative (PQRI), concerns that the reconciliation fails to recognize looming physician workforce shortages that will jeopardize patient access to specialty care, and the absence of proven medical liability reforms.

Particularly troubling is the creation of the Independent Payment Advisory Board in Section 3403. *NDMA continues to oppose any 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. 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 Advisory Board to adjust for new developments that warrant spending increases, and maintain its ultimate accountability for the sustainability and stability of the Medicare program.

Another NDMA concern is that the reconciliation package is inadequate in not incorporating *proven medical liability reforms* to address 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. Other studies suggest medical liability reforms could result in national savings of $242 billion a year, more than 10% of America's health expenditures.

While NDMA supports improvements contained in the reconciliation package to the Physician Quality Reporting Initiative (PQRI) and additional resources for quality improvement processes, we continue to oppose mandatory PQRI participation or the imposition of penalties on physicians who do not successfully participate. It has not been shown that the current program improves quality in any meaningful way.

As noted in our December 14 letter, NDMA generally supports the graduate medical education (GME) provisions in the bill; however, 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. There is also a need for better financial support for our medical students, who typically graduate from medical school with large amounts of debt.

Previous Amendments

Several concerns expressed by NDMA in our letter of December 14 were addressed positively in HR 3590 amendments. Others were not. These amendments reflect 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.
- The "Frontier States" amendment as authored by 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.

The reconciliation package released Thursday in HR 4872 also includes positive amendments, including these provisions:

- Improves Medicaid payment rates for primary care physicians to equal 100 percent of Medicare payment rates, including payments for office visits and immunizations, in 2013 and 2014, with 100 percent federal funding for the increased costs to states (Section 1202).
- Extends health insurance market reforms (dependent coverage up to age 26, prohibition of lifetime limits and rescissions, limitations on excessive waiting periods) to grandfathered plans six months after enactment. For group health plans, the bill prohibits pre-existing condition exclusions in 2014, restricts annual limits six months after enactment, and prohibits them in 2014 (Section 2301).
- Closes the Medicare prescription drug donut hole through a process beginning in 2010 and completed by 2020 (Section 1101).
- Increases the federal medical assistance percentage (FMAP) paid to states for individuals newly enrolled in Medicaid as a result of the expansion of eligibility to 133% FPL (100 percent for 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent for 2020 and later years), repeal of the special FMAP for Nebraska, and changes the formula used to calculate the amount of increased FMAP that will be paid to states that had expanded Medicaid eligibility to adults (Section 1201).

HR 4872 would also raise the imaging equipment utilization rate assumption, the time during office hours that imaging equipment is assumed to be in operation, from the current 50% rate to 75% for equipment priced over $1 million which radiologists argue will result in more imaging cuts and restrict access to care.

Health System Reform Initiatives

Each area of the country has its own health care history and traditions, its own gaps in infrastructure, and its own distinctive patient population. The reconciliation package recognizes that positive transformation of medical service delivery will involve trial and error, requiring several years of demonstration programs and pilot projects, which have largely been ignored in the public debate. If the reconciliation package is enacted, North Dakota hospitals and physicians will consider whether to seek participation in these programs, including the shared savings

program for accountable care organizations (Section 3022); the national pilot program on payment bundling (Section 3023); the community-based care transitions program (Section 3026); and others.

Other initiatives in the reconciliation package include, among others: a national strategy to improve health care quality (Section 3011) including quality measure development and public reporting (Sections 3013–3015); a hospital value-based purchasing program (Section 3001); a hospital readmissions reduction program (Section 3025); 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).

As noted in our letter of December 14, 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 and to what extent North Dakota physicians and hospitals will participate in them.

Next Steps

The pending reconciliation package contains many provisions that would enhance access to high quality, cost-efficient care in North Dakota, most notably the Frontier States amendment which would strengthen the financial viability of hospitals and physician practices and accomplish substantial improvement in addressing the current disparity in Medicare payments for North Dakota hospitals and physicians. We acknowledge and applaud your efforts in successfully bringing the Frontier States amendment forward in this difficult process.

The reconciliation package marks an important step toward improving the health of North Dakota people, but our work is far from done. Additional congressional action is needed to address many outstanding issues. We look forward to working with you on the next steps to strengthen our health care system.

Sincerely,

Kimberly T. Krohn, MD, MPH, President

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Immediate Past President

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