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

December 1, 2009

The Honorable Harry Reid
Majority Leader
United States Senate
522 Hart Senate Office Building
Washington, DC 20510

Dear Senator Reid:

The American Medical Association (AMA) remains committed to achieving enactment of comprehensive health system reform legislation that improves access to affordable, high-quality care and reduces unnecessary costs. We do not believe that maintaining the status quo is an acceptable option for physicians or the patients we serve.

Overview of Provisions that AMA Supports

H.R. 3590, the "Patient Protection and Affordable Care Act," includes a number of provisions that are consistent with the AMA's reform priorities. In general, we support the provisions in the bill 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. We also support: tax credits that are inversely related to income, refundable, and payable in advance to low-income individuals who need financial assistance to purchase private health insurance; establishing health insurance exchanges that offer more affordable choices; reducing overpayments to Medicare Advantage plans; enhancing Medicaid coverage as a safety net; coverage for prevention and wellness initiatives without co-payments or deductibles; and the creation of an independent comparative effectiveness research entity that will develop information to enhance patient-physician decision making about treatment options.

Improved Provisions

The AMA also appreciates 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. Nonetheless, we continue to have serious concerns about certain provisions in the bill, and we look forward to working with you and your Senate colleagues to secure additional changes to promote stable and sound health system reforms.

The following are comments and recommendations on policy issues that the AMA believes the Senate must address during the floor debate before voting on a final bill.

Medicare Physician Payment Formula

While the AMA appreciates that H.R. 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.

Independent Medicare Advisory Board

AMA policy specifically opposes 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. Therefore, we oppose the Independent Medicare Advisory Board as currently designed in H.R. 3590, and we look forward to working with you on significant changes to the proposal. Further, the provision does not apply equally to all health care stakeholders, 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.

Value Based Payment Modifier

While the AMA strongly supports efforts to develop quality improvement programs and to appropriately address geographic variation, we oppose redistributing Medicare payments among providers based on outcomes, quality, and risk adjustment measurements that are not scientifically valid, verifiable, and accurate. Section 3007 of the bill requires the development and application of a cost/quality index modifier, and presumes the availability of policy tools and

a level of precision that do not currently exist. Core components needed to develop the cost/quality index are in their infancy, and the Centers for Medicare and Medicaid Services (CMS) lacks the resources to develop and implement them. In addition, there are fundamental, technical problems with the basic concept of adjusting payments at the individual physician level, as well as with adjusting payments based on outcomes for the previous year's patient case mix.

Necessary processes must occur for appropriate implementation and use of quality measures under the cost/quality index, including appropriate development, testing, and endorsement of measures. For example, cost-of-care measures require adequate risk adjustment methodologies and agreed upon methods for determining attribution of the care provided. Yet, to date, risk adjustment and attribution models are woefully inadequate. We recommend further study of geographic variation as well as funding for the transparent development and testing of measures that recognize necessary components of agreed upon risk adjustment and attribution models that would be most useful for addressing geographic and quality of care variations.

Primary Care and General Surgery Bonus

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

Tax on Cosmetic Surgical and Medical Procedures

The bill 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. The AMA strongly opposes taxes on physician services to fund health care programs or to accomplish health system reform. We believe that additional revenues generated to help finance health system reform should come from broad-based taxes.

Procedures that are excluded from the tax are "elective cosmetic surgical and medical procedures that are necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease." While the exception is broad, it nonetheless remains ambiguous as to the full scope of its application. The last phrase "disfiguring disease" limits the reach of the exception and potentially excludes disfiguring conditions. Also, it is not clear how "disfiguring" would be defined, which in any given case is subjective. Further, 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

We appreciate the proposed improvements to the Physician Quality Reporting Initiative (PQRI) to require timely feedback and establish an appeals process, as well as extending the period of bonus payments to allow for further program improvements and broader physician participation. However, the AMA opposes mandatory PQRI participation or the imposition of penalties on physicians who do not successfully participate. 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.

Physician-Owned Hospitals

While the AMA supports the disclosure of physician hospital ownership and investment information, we oppose the proposal to eliminate the whole hospital exception to the Stark self-referral law. Physician-owned hospitals have achieved the highest quality scores in some markets and have been shown to provide more net community benefits through uncompensated care and taxes than not-for-profit competitors as a share of total revenues. In addition, a recent study by the Center for Studying Health System Change found that physician-owned hospitals do not adversely affect general hospitals' ability to care for patients. Limiting the viability of physician-owned hospitals will reduce access to high-quality health care and have a destructive effect on the economy in communities these hospitals serve. Proposed limits on existing physician-owned hospitals would put them at a competitive disadvantage, making it difficult for them to respond to the health care needs of their local communities. The provisions would also effectively shut down many physician-owned hospitals currently under development. We urge that this provision be removed from H.R. 3590.

Provider Enrollment Fees

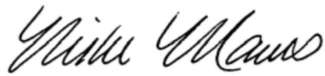
The AMA opposes the imposition of Medicare provider enrollment fees on physicians. Given the multiple screening procedures that already apply to physicians in various licensing and credentialing processes, we believe this is an unnecessary duplication of review processes and another administrative burden with the potential of further discouraging physicians from participating in the Medicare and Medicaid programs. We urge that physicians not be subject to the proposed Medicare enrollment fee.

Conclusion

The AMA strongly believes that addressing these issues will create a better foundation for health system reform. In addition to these principal concerns, we offer for your consideration a number of other policy refinements and technical changes that we believe will improve the bill, which are described in the attached Addendum.

Once again, the AMA wishes to reiterate its commitment to working with Congress and the Administration to enact comprehensive reforms. There are many aspects of H.R. 3590 that we support, and we recognize that improvements have been made already to earlier versions of the legislation. We are committed to continuing to work constructively with you and your Senate colleagues to make essential refinements to H.R. 3590 as the legislative process continues.

Sincerely,



Michael D. Maves, MD, MBA

Enclosure
cc: United States Senate

Comments of the American Medical Association Regarding
H.R. 3590, the "Patient Protection and Affordable Care Act"

Addendum

The following are additional comments and suggestions for policy refinements or technical changes that the AMA believes would improve the bill.

Significant Policy Recommendations

Community Health Insurance Option. While the 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 are pleased to note that H.R. 3590 includes provisions that are essential to maintaining a level playing field among public and private options. Notably, the bill would require all coverage options offered in a health insurance exchange to: be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not explicitly limit enrollees' access to out-of-network physicians. 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. The AMA supports additional resources for quality improvement processes. We have strong concerns, however, about the requirements for public reporting of performance information 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. **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. The AMA 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. **We strongly recommend inclusion of the following critical components**: (1) eliminate the use of hundreds of varying companion guides by requiring the Secretary of HHS to adopt a single, binding, uniform interim companion guide (not just operating rules), for each of the standards for version 5010 (version 5010 is the updated version of the HIPAA electronic transactions required for use by physicians and others on January 1, 2012); (2) require the adoption of additional standards such as those for first report of injury, and clarify that an electronic funds transfer (EFT) standard must be adopted and implemented prior to mandating the use of EFTs; (3) define terms such as "code set," "companion guide," "operating rules," and "standard" in accordance with AMA's recommendations to avoid multiple interpretations; (4) authorize concurrent State enforcement jurisdiction to ensure health plan compliance; (5) to avoid the creation of multiple, conflicting cross walks, require the adoption and use of a single, mandated ICD-9 CM to ICD-10 CM and ICD-10 PCS cross walk, which must be effective October 1, 2013, and which must be available publicly without charge; (6) require the adoption and use of binding operational guidelines and instructions for each of the standards code sets, which will result in substantial savings; and (7) eliminate millions of different bundling edits and multitudes of different payment rules by fostering transparency and consistency with the required adoption and use of uniform claim edits and payment rules.

Program Integrity Funding, Reporting Requirements, New Penalties. There is a wide array of fraud and abuse provisions in H.R. 3590 that the AMA opposes because they would penalize all physicians to cast 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, H.R. 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."

The AMA also opposes 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.

Finally, the AMA has significant concerns that mandating that all physicians who order Medicare-covered items or services be required to enroll in the Medicare program will produce significant access problems to beneficiaries who are already facing challenges in finding physicians who accept Medicare. The AMA urges the removal of this provision.

Health Care Workforce. The AMA 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. The AMA also generally supports programs that increase basic nursing education opportunities, 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, the AMA supports 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 AMA further recommends that the proposed expansion of Title VII geriatric career incentive and academic career awards programs also 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 AMA strongly supports 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 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, we strongly believe 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. **The AMA strongly supports 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.

Technical Recommendations

Physician Resource Use. Private and state insurance programs have experienced serious problems with the accuracy and validity of episode grouper methodologies to "profile" physicians. The AMA supports providing physicians with confidential feedback on resource use, and recommends that CMS be allocated appropriate funding to help construct a fair and workable system while expanding the physician feedback program, as required under this provision.

Misvalued Codes Under the Physician Fee Schedule. This provision is unnecessary since it likely would duplicate ongoing efforts already undertaken by the AMA/Specialty Society RVS Update Committee (RUC) to review and adjust potentially over-valued codes. We are also concerned about repeal of Section 4505(d) of the Balanced Budget Act of 1997. While this provision includes obsolete requirements that could be repealed, it also includes important requirements specifying that actual and valid data are used in determining practice expense relative value units and specifying that physician organizations are consulted about methodology and data to be used in developing these relative values. We urge that these provisions be retained in law.

Antidiscrimination Provisions for Health Plans. 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. We urge clarification that this provision does not allow expansion of the scope of practice for non-physician allied health practitioners.

Imaging. The AMA believes the bill's utilization rate provision for advanced imaging equipment is 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. The AMA also does not support the multiple procedure payment reduction.

Independence at Home Demonstration Program. The AMA generally supports testing independence at home medical models, as provided for in the bill, but we have some structural concerns, including that the demonstration program should be led by physicians.

Employee Retirement Income Security Act. The AMA is concerned that H.R. 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 H.R. 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 H.R. 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

preemption, namely, that ERISA does not preempt state insurance regulations. H.R. 3590's deletion of this language raises the possibility that H.R. 3590 could be read to bring about significant expansion in the current scope of ERISA preemption and result in the nullification of many patient and provider protections and legal requirements that states currently use to regulate the conduct of insurance companies operating within their jurisdictions.

Reporting on and Public Disclosure of Physician – Industry Financial Interactions. The AMA has not opposed reasonable measures that will increase transparency in the financial interactions between physicians and manufacturers of drugs, biologicals, and medical supplies. The AMA does not oppose H.R. 3590 provisions requiring industry to track, compile, and submit reports on such interactions (as opposed to physicians). We applaud the inclusion of language that explicitly provides that physicians have the opportunity to review and correct these reports prior publication. We also were pleased by the decision to curb the potential for fraud and identity theft by prohibiting the widespread public disclosure of national provider identifiers. Nonetheless, we oppose reporting on and disclosure of unrelated ownership interests held by immediate family members of physicians. This infringes on the privacy rights of family members without a legitimate or compelling public interest and flies in the face of fundamental fairness. Finally, we urge that language be added to the bill to clearly state that all state reporting requirements are preempted. As we have stated previously, the existing patchwork of reporting requirements with weak preemption language simply serves to create confusion. H.R. 3590 is comprehensive and will provide a rich source of information needed to make apples-to-apples comparison of information across the country and minimize the potential for an administrative quagmire.