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

January 15, 2010

The Honorable Harry Reid
Majority Leader
United States Senate
S-221 Capitol Building
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
H-232 Capitol Building
Washington, DC 20515

Dear Majority Leader Reid and Speaker Pelosi:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to present the AMA's recommendations for reconciling the House (H.R. 3962) and Senate (H.R. 3590) health system reform bills. Enabling every American to have access to affordable health insurance coverage is a top priority of the AMA, and we remain committed to work with Congress and the Administration to establish a foundation for a stronger, better performing health care system to increase access to high-quality care and reduce unnecessary costs. We believe that both bills make tremendous strides toward these goals. Below are our recommendations to address important issues of concern to physicians and for achieving our mutual objective of improving our health care system.

Repeal of the Medicare Sustainable Growth Rate

At the outset, we must again emphasize the absolute necessity of repealing the Medicare Sustainable Growth Rate (SGR) payment formula and replacing it with a system of Medicare payment updates that will reasonably reimburse physicians and preserve access to care for our nation's seniors and disabled. The reforms proposed in the House and Senate bills rely heavily on the Medicare system as a driver of change across the entire health care system. Delivery reforms will fail if the SGR remains the basis for physician payments. Further, Medicare and TRICARE patients will suffer a steady erosion of their choice of physicians. The AMA's support for passage of health system reform legislation is contingent on repeal of the SGR.

We appreciate the fact that the bills do nothing to further limit the ability of physicians to privately contract for their services. We hope to continue working with you on future legislation to enable physicians to privately contract in public and private health insurance programs without penalty.

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Medicaid

We are concerned that expanding Medicaid eligibility to more individuals will not necessarily lead to increased access to care given the current inadequate reimbursements in the Medicaid program. We support the provision of the House bill regarding increased payments for primary care services. This provision would bring Medicaid reimbursement rates for primary care in line with comparable Medicare rates within three years, and is necessary to ensure meaningful access to care under the proposed Medicaid expansion.

Independent Payment Advisory Board

The AMA opposes any provision that would empower an independent commission, such as the Independent Payment Advisory Board (IPAB), to mandate payment cuts for physicians, who are already subject to an expenditure target and other potential payment reductions as result of the Medicare physician payment formula. Substantial modifications of the IPAB proposal are essential. We have recommended significant modifications of the Senate provision in a separate letter to House and Senate leaders.

Value Based Payment Modifier

The AMA strongly supports properly designed quality improvement initiatives as well as efforts to 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. The Senate 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. Therefore, we oppose section 3007, as currently drafted. Core components needed to develop the cost/quality index are in their infancy, and as evidenced by ongoing problems with the Physician Quality Reporting Initiative (PQRI), we do not believe the Centers for Medicare and Medicaid Services (CMS) or other entities possess the resources, knowledge, or technical ability to achieve the goals mandated in section 3007. Rather, the House bill offers a better pathway to achieve the goals of section 3007.

We urge that section 3007 be replaced with House section 1123, which provides incentive payments for two years for efficient areas. Additionally, we urge adoption of section 1159 of the House bill, requiring an Institute of Medicine geographic variation study, with recommendations on modifying payments for Medicare providers based on a quality/cost value index. We also urge adoption of section 1160 of the House bill, modified to provide that Congress be required to affirmatively adopt the Secretary's implementation plan (developed pursuant to section 1159), in place of the current requirement under section 1160 that Congress enact a joint resolution to disapprove the Secretary's implementation plan.

Medical Liability Reform

To ensure that physicians and other health care providers are not subject to potential new causes of action or legal liabilities resulting from health system reform policies, the AMA strongly urges Congress to

include a modified rule of construction in the final bill indicating that all provisions that concern the development, recognition, or implementation of any guideline, best practice, other standard, including payment and delivery initiatives, are not be construed as establishing the standard of care or duty of care owed by health care providers to their patients in any medical liability action or claim.

The AMA supports the alternative liability reform incentive program specified in the House bill, with the following necessary revisions and clarifications: the incentive program should be adequately funded and provide states with the flexibility to explore a wide range of liability reform programs; the provision meant to protect existing and future state liability reform laws should be modified so that any state liability reform law (not just those on caps and on limiting attorneys' fees) is protected; and the final bill should not include a provision that would allow patients to opt-out of an alternative liability reform program at any time and to pursue their liability claim in court. Allowing a patient to opt-out of an alternative liability program at any time completely negates the value of evaluating an alternative to costly tort litigation.

The AMA also supports provisions that would extend Federal Tort Claims Act protections to cover volunteer physicians providing services at Federally Qualified Health Centers and employees and contractors of free clinics.

Quality Improvement, Data Reporting, and Public Reporting

The AMA is pleased that both bills make important strides in the development and integration of quality measurement. However, it is critical that provisions in the bills relating to the development, collection, and public reporting of performance information be reconciled in a way that avoids duplication and assures consistency in the measure development process. These various quality and public reporting provisions must be streamlined and coordinated, and they must be subject to generally accepted safeguards to ensure valid, accurate, and meaningful data.

To the extent that the final bill calls for public reporting of Medicare quality data, it must include strong safeguards to ensure that data is valid, accurate, and helpful to the end-user, with limited Secretarial discretion in determining whether to apply these safeguards. The Secretary should only select quality measures for public reporting under this section that have been endorsed through the multi-stakeholder process established in Senate bill section 3014.

Regarding the availability of Medicare data for performance measurement, Medicare is in the process of conducting pilot programs to review data, and the outcome of these efforts is uncertain. This provision must be amended to clarify and ensure that entities that publicly report data must employ certain data safeguards, including attribution methods and processes to ensure the accuracy and validity of the data. When entities use private data in public reporting, the

provision should be clarified to ensure that these entities can only use data that is collected and reported in accordance with safeguards required under this provision. Further, this provision should require that data reported on private payer measures can only be publicly reported if the measures are developed and

approved through a physician/multi-stakeholder consensus processes under sections 3011-3015. Attribution at the individual physician level must be piloted successfully before any public use, and risk adjustment methods must be proven adequate.

Physician Resource Use

The AMA supports providing physicians with confidential feedback on resource use and we urge retention of the House language, amended to include a Senate provision requiring the Secretary to seek endorsement of the episode grouper by the National Quality Forum (NQF). Requiring such endorsement will ensure multi-stakeholder input and widespread acceptability by the end-users of the episode grouper methodology, which will improve implementation of the physician resource use feedback program.

Physician Quality Reporting Initiative

We urge retention of the Senate language providing four years of PQRI bonuses, with adoption of the House position on PQRI to not impose penalties. An alternative would be retention of the House language that provides two years of positive incentives without penalties in the out years.

Comparative Effectiveness Research

The AMA supports the Senate bill as modified by Senator Reid's Manager's Amendment. The AMA has advocated for the creation of an independent entity responsible for comparative clinical effectiveness research which is essential to growing the evidence-base of medicine and will support the delivery of quality care and value. Representatives of practicing physicians should have a central and significant role on the governing body of the entity and the entity's purpose and mission should ensure that the research is scientifically rigorous and independent.

Administrative Simplification

The AMA strongly supports specific requirements to standardize and simplify health care administration as specified in section 115 of the House bill. Critical components in the House bill will aid in eliminating billions of dollars of unnecessary costs and administrative burdens from the current health care. In addition to the House bill's administrative simplification provision, we strongly urge the inclusion of a provision in the final bill that would require the Secretary of Health and Human Services to adopt a single, binding ICD-9 CM to ICD-10 CM and ICD-10 PCS cross walk to be effective by October 1, 2013, and made available publicly without charge.

Fraud and Abuse

The AMA supports efforts to curb fraud and abuse in public health care programs and generally supports the House bill provisions that increase funding for existing fraud and abuse programs to detect, investigate, and prosecute fraud and would promote the appropriate exercise of enforcement authority. However, there are provisions in the House bill that would ensnare unwitting individuals who do nothing

more than make an honest mistake in an environment of exceedingly complex regulations and policies. The AMA urges Congress to strike provisions that would lower the intent standard for violations of anti-fraud statutes. Regulators and prosecutors currently have a significant array of robust statutory authorities to prosecute fraud. What they lack is an adequate amount of resources and capacity to do so.

Health Care Workforce and Graduate Medical Education

The AMA generally supports the graduate medical education (GME) provisions in both the House and Senate bills that would provide more flexibility in the GME program. Although we support the redistributing of unfilled GME positions for undersupplied specialties and underserved areas, we 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. The AMA strongly supports the inclusion of a provision in the final health system reform bill that would lift the cap on GME by expanding 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.

Physician-Owned Hospitals

We continue to strongly oppose the language included in both bills that would essentially eliminate the ability of physicians to own and operate hospitals and would destroy the competitiveness of those already in existence (section 6001 of the Senate bill and section 1156 of the House bill). While policy makers continue to extol the virtues of collaboration and coordination between providers, we fail to see how the elimination of hospitals that are actually run by physicians does anything but limit patient choice of high-quality providers. Physician-owned hospitals consistently provide high-quality care and receive excellent marks for patient satisfaction. These facilities have been shown to provide more community benefit than their "not-for-profit" competition. Additionally, studies clearly show that hospitals that do not face competition have lower Medicare margins than others due to the lack of pressure to innovate, become more efficient, and offer higher quality service. While we fully support disclosure of ownership and investment information, we oppose the proposal to eliminate the whole-hospital exclusion under self-referral laws. At a minimum, Congress should not act to disadvantage the facilities currently in operation or under construction. The exceptions language for growth in both bills is drawn much too narrowly and in a manner that benefits only a few carefully selected facilities. Therefore, we urge amendment of this provision to broaden the "grandfather" and other provisions to allow existing facilities and those currently under development to effectively compete on a level playing field with other facilities and continue to provide access and high-quality care to patients, including in circumstances where general hospitals in rural and underserved areas would be forced to close absent physician investment.

Misvalued Codes Under the Physician Fee Schedule

Provisions addressing misvalued codes would repeal section 4505(d) of the Balance Budget Act of 1997 (section 3134 of the Senate bill and section 1122 of the House bill). 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 section 4505(d) of the BBA be retained in law

Primary Care and General Surgery Bonus

The AMA supports primary care and general surgery bonus payments treated as a funded workforce investment and paid for with new money. We support the 10 percent level in the Senate bill and the broader applicability under the House bill. If additional funds are not available to accomplish both, we recommend adoption of the House provision because it provides a broader and longer term investment.

Imaging Services

We believe that the imaging provisions in the final conference agreement should be modified to allow users of imaging modalities to submit data to CMS to determine appropriate utilization assumptions. The current provisions in both bills are too broad and should allow flexibility in determining appropriate utilization assumptions.

Conclusion

The 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 strongly believe that our recommendations, including a permanent replacement of the SGR, will create a sound foundation from which to implement health system reforms. We look forward to working with Congress as the reconciliation process moves forward.

Sincerely,

Michael D. Maves, MD, MBA

cc: Senator Max Baucus
Senator Tom Harkin
Senator Chris Dodd
Representative Steny Hoyer
Representative Charles Rangel
Representative Henry Waxman
Representative George Miller