



MAINE MEDICAL ASSOCIATION

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TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

IN SUPPORT OF

L.D. 540, AN ACT TO IMPLEMENT THE INSURANCE REFORM RECOMMENDATIONS OF THE ADVISORY COUNCIL ON HEALTH SYSTEMS DEVELOPMENT

Joint Standing Committee on Insurance & Financial Services
Room 220, Cross State Office Building
Tuesday, March 8, 2011, 1:00 p.m.

Good afternoon Senator Whittemore, Representative Richardson, and Members of the Joint Standing Committee on Insurance & Financial Services. My name is Andrew MacLean and I am speaking in favor of L.D. 540 on behalf of the Maine Medical Association (MMA). The MMA is a professional association of more than 3400 Maine physicians, residents, and medical students whose mission is “to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.”

Our debate about the Dirigo Health Program locally during the past eight years and our more recent debate about the *Affordable Care Act* make it clear that our society lacks consensus about much regarding the financing and delivery of health care services in this country. But, we do seem to have consensus about the need for payment reform as part of the response to the ills of our current approach. You all have heard the criticisms of current health care payment policies. Payment methodologies do not sufficiently reward preventive measures and primary care, the types of services that maintain health. The methodologies value tests and procedures more than evaluation and management services (the “E&M Codes”). The methodologies pay for volume of services provided rather than health. As Representative Graham put it, “[w]e pay for illness and we don’t pay for health.” L.D. 540 presents you with an opportunity to take modest steps towards implementation of payment reform in Maine based upon the excellent work of the multi-stakeholder Advisory Council on Health Systems Development over several years. Those of us who address you regularly about health care issues often disagree, but I expect that you will hear broad consensus support for the payment reform principles set out in Section 4 of the bill. They represent, no doubt, the aspirations of us all for our health care system.

I have attached as additional background on the topic of payment reform, the American Medical Association’s (AMA’s) *Report of the Council on Medical Service on Medicare Physician Payment Reform* (CMS Report 6-A-09).

I thank Representative Graham for pursuing payment reform and thank the Committee for considering the MMA’s views on the subject. I would be happy to respond to any questions you may have.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-09

Subject: Medicare Physician Payment Reform
(Resolution 110, A-08)

Presented by: David O. Barbe, MD, Chair

Referred to: Reference Committee A
(Steven E. Larson, MD, Chair)

1 At the 2008 Interim Meeting the House of Delegates adopted the recommendations in Council on
2 Medical Service (CMS) Report 4, “Emerging Medicare Physician Payment Methodologies” (Policy
3 D-390.964, AMA Policy Database), which called for members of the House and the Federation to
4 provide comments to the Council on bundling, gainsharing, the medical home, and pay-for-
5 performance as strategies for reforming the Medicare physician payment system. The intent of the
6 report was to help the American Medical Association (AMA) effectively shape and respond to
7 proposals for Medicare payment reform by giving members of the House of Delegates and the
8 Federation the opportunity to discuss and express their views on the reform strategies most often
9 proposed by policymakers.
10

11 In addition to Council Report 4-I-08, several resolutions recently presented to the House of
12 Delegates addressed payment reforms under consideration by the Centers for Medicare and
13 Medicaid Services and the health policy community. At the 2008 Annual Meeting, the House of
14 Delegates referred Resolution 110 (A-08), introduced by the Infectious Disease Society of
15 America, which asked that the AMA “oppose all public and private efforts to bundle providers’
16 payments around a hospitalization and follow-up outpatient care...[and] work with appropriate
17 public and private officials and advisory bodies to ensure that bundled payment reforms do not lead
18 to hospital-controlled payments.” Aware that the Council was preparing to study bundling as one
19 of the Medicare physician payment alternatives, the Board of Trustees assigned Resolution 110
20 (A-08) to the Council so that it could be addressed as part of its report for the 2009 Annual
21 Meeting.
22

23 In addition, the House of Delegates adopted Resolution 121 (A-08), which asked that the AMA
24 prepare a report on gainsharing arrangements between physicians and hospitals. Gainsharing was
25 one of the methodologies specifically discussed in Council on Medical Service Report 4 (I-08), and
26 that report outlined issues and concerns typically raised by gainsharing proposals. The Council
27 also received numerous comments on the gainsharing methodology, as part of the feedback
28 received from the Federation regarding Council Report 4-I-08.
29

30 Finally, at the 2008 Interim Meeting, in addition to considering CMS Report 4-I-08, the House
31 took action on several resolutions focused specifically on the promotion of care coordination and
32 the medical home (i.e., Resolutions 804, 803, 819 and 820). The medical home concept was one of
33 the methodologies highlighted in Council Report 4-I-08, and generated extensive discussion at the
34 Interim Meeting. CMS Report 8, also before the House at this meeting, focuses on the medical
35 home concept, and responds to action taken by the House at the 2008 Interim Meeting.

1 Based on the Council's study and input received from the Federation, this report provides
2 recommendations to help ensure that alternative physician payment methodologies are designed
3 and implemented in ways that do not disadvantage or disenfranchise groups of physicians or
4 patients.

5
6 A COLLABORATIVE RESPONSE TO THE URGENT NEED FOR REFORM

7
8 The spending projections for Medicare under current law manifest mounting pressure on the
9 federal budget, pending exhaustion of the Part A trust fund, and growth in costs that is
10 unsustainable in the long-term. Long-standing AMA Policy H-330.898 presents both short- and
11 long-term strategies for Medicare reform, and reflects the AMA's commitment to ultimately
12 transition Medicare to a system of pre-funded financing. More recent policies (e.g., H-330.896 and
13 D-330.928) advocate a series of interim steps to help strengthen the program, including
14 restructuring beneficiary cost sharing, and offering beneficiaries a choice of plans for which the
15 federal government would contribute a standard amount toward the purchase of coverage. In
16 addition, several AMA policies and directives call for a repeal of the Sustainable Growth Rate
17 (SGR) (e.g., H-390.855, H-390.852, D-390.969), and support the right of physicians to be able to
18 balance bill patients the difference between Medicare payment rates and the physician's normal
19 charge (e.g., H-385.991, D-390.986). Policy D-390.974 supports ensuring that physicians are fully
20 informed regarding their choice of involvement with the Medicare program (i.e., as a participating
21 physician, a non-participating physician who accepts assignment on a case-by-case basis, and the
22 right to opt-out of Medicare).

23
24 Unrelenting AMA efforts to secure permanent changes in the SGR formula appear to finally be
25 making an impact. The Administration's 2010 budget proposal adopted a more realistic forecast of
26 Medicare physician spending than has been used in previous budgets by acknowledging that severe
27 physician payment cuts called for by the flawed SGR formula are not a viable source of budget
28 savings. Significantly, the budget proposal includes \$329.6 billion over 10 years "to account for
29 expected Medicare payments to physicians." The AMA is working with the Federation to urge
30 Congress to follow the Administration's lead and support adoption of a new Medicare baseline for
31 physician payments.

32
33 The AMA is encouraged by the opportunity presented by the Administration's budget, yet it is
34 clear that Congress expects physicians to demonstrate a real commitment to change. There is
35 widespread agreement that payment reforms are needed to make health care less fragmented,
36 achieve better health outcomes, and reduce the rate of growth in health care costs. In particular,
37 many policymakers are questioning the appropriateness of Medicare's fee-for-service physician
38 payment policies. Current debate over broader Medicare physician payment policies reflects a
39 desire to control volume growth, align incentives to reward appropriate, high-quality delivery of
40 care, and discourage the inefficient use of resources. Citing the *Dartmouth Atlas* and other sources
41 that attribute geographic variation in health care utilization to inefficiencies in care delivery, policy
42 leaders are advocating the use of payment mechanisms that are intended to realign the incentives
43 inherent in the current fee-for-service system by moving from a volume-based payment system to
44 one based on value and the quality of care delivered.

45
46 While the Council does not accept the premise that fee-for-service payment policies, per se, are
47 responsible for excessive cost growth or inefficiencies in health care delivery, the scrutiny of
48 physician incentives and payment policies requires the AMA to take a leadership role in advocating
49 for meaningful Medicare physician payment reform adaptations that preserve the assets of the
50 current delivery system but also enhance the sustainability of the program and facilitate improved
51 access to care and better value.

1
2 FEEDBACK RECEIVED ON COUNCIL ON MEDICAL SERVICE REPORT 4-I-08
3

4 The Council requested feedback on the issues and options raised in Council Report 4-I-08
5 from the Federation through various mechanisms, including the recommendations in the report
6 (D-390.964), an announcement in the November 29, 2008 “Advocacy Update,” and two requests
7 sent electronically to the executive directors of the state medical associations and national medical
8 specialty societies on November 17, 2008 and January 19, 2009. In addition, the AMA convened
9 two meetings of Federation staff to discuss Medicare payment methodologies – a fly-in in Chicago
10 on October 29, 2008, and a webinar conducted on February 20, 2009. For the fly-in and webinar,
11 the AMA invited staff from selected national medical specialty societies that comprise the largest
12 portion of Medicare physician payment, selected state medical associations based on Medicare
13 geographic spending variations, the American Osteopathic Association, and the Medical Group
14 Management Association. The Council is grateful for the feedback it received from the
15 participants at these meetings, in testimony provided at the 2008 Interim Meeting, and in comments
16 provided at the “Alternative Medicare Physician Payment Methodologies” educational session,
17 held on November 9 at the 2008 Interim Meeting, and at the 2009 Presidents’ Forum, held on
18 March 9. The Council greatly appreciates the efforts of the individuals and medical societies that
19 provided written comments on these issues.
20

21 CMS Report 4-I-08 focused primarily on four Medicare physician payment methodologies:
22 gainsharing, bundling, the medical home, and pay-for-performance. With the exception of the
23 medical home, which is addressed in more detail in CMS Report 8-A-09, there was little consensus
24 on the viability or appeal of any one of these potential payment methodologies. The vast majority
25 of Federation comments indicated the need for additional information on how a new payment
26 policy might be designed and implemented before any “support” could be offered on behalf of
27 physicians. Many commenters indicated that demonstration projects could help identify strengths
28 and weaknesses of various payment designs, and that permanent action should be delayed until
29 meaningful data can be gathered and analyzed.
30

31 The need for well-designed and evaluated demonstration projects notwithstanding, several medical
32 societies expressed concern about the implementation details of the proposed methodologies. For
33 example, the potential for conflicts between hospitals and physicians was often cited as an obstacle
34 to successful implementation of bundling or gainsharing arrangements. Federation comments
35 reflected a fear that hospitals would assume too much control over physician payments under either
36 a bundling or a gainsharing structure, unless specific safeguards were put in place to prevent this.
37 Several medical societies also expressed concern that bundling or gainsharing arrangements have
38 the potential to adversely affect patient care. Societies emphasized the need for careful risk-
39 adjustment methodologies and flexible structures that allow physicians to provide appropriate care
40 for individual patients without being penalized.
41

42 Federation comments suggested that some physicians have accepted (though not necessarily
43 embraced) the concept of pay-for-performance as a way to link payment and incentives to quality
44 outcomes, although significant concerns remain about its implementation. Consistent themes
45 emerged about the importance of providing high quality and appropriate care to patients, and the
46 sense that better methods of data collection and dissemination could help physicians initiate
47 changes at the local level that could increase efficiencies and provide greater value for their
48 patients. Comments reflected two “gaps” in data collection and dissemination: clinical
49 effectiveness research that could offer physicians baseline information about the best treatments
50 and technologies available for specific conditions or illnesses (i.e., comparative effectiveness
51 research [CER]), and practice-oriented data that could help physicians learn from and measure

1 themselves against their peers. Consistent with concerns about bundling and gainsharing,
2 comments reflected the fact that improvements in risk adjustment methodologies are necessary to
3 ensure that payment reforms do not result in cost savings only when physicians treat the healthiest
4 patients. Physicians also expressed the need for freedom and flexibility to make innovations in
5 their practices and to pursue collaborative local arrangements that could help them increase
6 efficiencies.

7
8 Although several members of the Federation expressed strong support for the medical home model
9 and its potential to enhance care coordination, many medical societies pointed to the need for
10 additional information about this methodology. Specifically, concerns were raised about
11 implementation of the medical home model with regard to funding sources, criteria for medical
12 home eligibility, and the risk of the medical home model being implemented in a way that creates a
13 barrier for patients seeking specialty treatment. These issues are discussed further in CMS Report
14 8-A-09, but reflect themes common among most of the Federation comments on all of the payment
15 methodologies. Comments generally addressed the need to prevent “budget neutral” financing
16 mechanisms, ensure participation options for a broad range of specialists and practice sizes, and
17 encourage incentive structures that ensure the highest quality patient care.

18 19 CONSISTENT THEMES AMONG FEDERATION COMMENTS

20
21 Given the complexity of issues associated with pursuing a new physician payment structure, it is
22 not surprising that the comments received from members of the Federation did not yield a clear
23 consensus about a preferred methodology among those currently being discussed. Yet the Council
24 notes that there was a high level of consistency about the general principles that should be
25 considered when developing or evaluating a Medicare physician payment reform strategy,
26 regardless of the methodology. Support for or opposition to a specific payment methodology
27 appears to be based less on the merit of the methodology, per se, than on the likelihood that the
28 payment design will offer maximum benefits with minimal harm.

29
30 Many of the areas of opportunity or concern expressed about the individual payment
31 methodologies discussed in the Council Report 4-I-08 were in fact applicable to all of the
32 methodologies, and mirrored those presented in the Appendix of that report. Specifically, the
33 Federation offered consistent support for opportunities to enhance patient care through increased
34 care coordination and adherence to performance standards; allowing physicians to share in savings
35 resulting from increased efficiencies in patient care; and identifying ways to improve patient care
36 and lower costs.

37
38 Similarly, most of the concerns that were raised were about issues such as budget neutrality and
39 funding sources; calculation and distribution of payment incentives; the ability of physicians to
40 participate regardless of patient mix, specialty or practice type; and the need to ensure that
41 incentives are adequate to cover administrative requirements.

42 43 DISCUSSION

44
45 Council Report 4-I-08 highlighted four Medicare physician payment methodologies that seemed to
46 be receiving the most attention from policymakers, while acknowledging the presence of other
47 options and the likelihood that physician payment reforms would likely involve a hybrid approach
48 that combines features of various proposals. Based on the comments received from members of
49 the Federation, the Council determined that the AMA should focus its advocacy more broadly than
50 support for (or opposition to) any specific reform strategy. The Council believes that the House of
51 Delegates needs to establish general policy that allows the AMA to work with Congress and

1 policymakers to establish support for a framework for reform that allows maximum flexibility for
2 physicians to experiment with alternative approaches to achieving savings for the Medicare
3 program while improving care coordination and quality.
4

5 A more flexible approach to Medicare reform has been the subject of recent presentations and
6 articles by members of the health policy community. For example, at the 15th Princeton
7 Conference on health policy, held in May 2008, Stuart Guterman of the Commonwealth Fund's
8 Program on Medicare's Future, outlined a payment reform proposal that placed medical practices
9 along a continuum from small, independent practices to large, vertically-integrated multispecialty
10 practices allied with one or more hospitals. The proposal envisioned adjusting the design and
11 amount of payment incentives based on where practices fall on the continuum, in order to
12 accommodate the unique resource needs and availability of different practice sizes and styles.
13 Similarly, a July 2, 2008 *JAMA* commentary by Stephen Shortell, MD, and Lawrence Casalino,
14 MD, described five potential models of accountable care systems, each of which could have
15 payment rates shaped to a greater or lesser extent by performance measurement and care
16 coordination results, depending on the capabilities of each system.
17

18 Through comments received from members of the Federation, the Council identified a set of
19 general principles that should guide the development and implementation of any Medicare
20 physician payment reform proposal. These principles derive from a need to ensure that payment
21 reforms are designed to support, rather than undermine, physician efforts to provide the best quality
22 care to their patients in the most efficient and effective manner. It is also critical that future
23 Medicare physician payment rates adequately reflect the cost of medical practice. Current fee-for-
24 service levels do not cover the full cost of treating Medicare patients, forcing doctors to cost shift
25 to private payers, and increasing costs throughout the health care system. The Council believes
26 that the principles outlined in this report will provide AMA leadership with a strong framework on
27 which to base their advocacy efforts, while also permitting enough flexibility to ensure that the
28 AMA is able to be a strong negotiator in policy discussions.
29

30 The Council notes several areas where policy changes or additional support will be necessary in
31 order to facilitate experimentation with innovative and meaningful payment reforms. Support for
32 investment in comparative effectiveness research, and in better methods of data collection and
33 dissemination about physician practice patterns will help provide physicians with the data and
34 information necessary to ensure that they are providing the best care to their patients in the most
35 effective and efficient manner. Development of more sensitive risk adjusters will ensure that data
36 can be accurately interpreted and that neither physicians nor patients are harmed by analyses that
37 do not adequately reflect differences in all the conditions that affect care delivery and outcomes.
38

39 The AMA also needs to help ensure that physicians have the freedom and the resources to create
40 organizational structures that can help maximize physician involvement in reform opportunities.
41 This is especially important for smaller, independent practices, which might otherwise be forced to
42 become absorbed by hospitals or multi-specialty practices in order to participate in innovative care
43 and shared-savings opportunities. Examples of organizational structures that are intended to
44 encourage and facilitate care innovations are the "bonus-eligible organization" (BEO) described in
45 a December 2008 Congressional Budget Office "budget options" report on health care, and
46 "accountable care organizations" (ACOs) such as those described by the Medicare Payment
47 Advisory Commission and Elliot Fisher of the Center for Health Policy Research at the Dartmouth
48 Institute for Health Policy and Clinical Practice. Both BEOs and ACOs facilitate "shared savings"
49 arrangements, where participating physicians agree to work together to manage and coordinate care
50 for patients, and qualify for bonus payments if the organization as a whole meets certain quality
51 and spending benchmarks. In general, these organizations must have a formal legal structure to

1 enable them to receive and distribute bonuses to participating physicians, but the practices
2 themselves remain independent.

3
4 Physicians should have the flexibility to participate in alternative physician payment experiments
5 coordinated through other types of entities as well. The Council believes that the strongest and
6 most viable opportunities for physician payment innovation will emerge from experiments
7 developed and implemented by physician-driven groups, such as medical societies, organized
8 medical staffs, independent practice associations or individual physician practices. The AMA has
9 been actively engaged in efforts to secure changes in antitrust and other laws that will be critical to
10 ensuring the flexibility and collaboration necessary to pursue these innovations

11
12 Significant changes must be made to the Medicare program in order to ensure that physicians are
13 able to continue serving Medicare patients. The Council realizes that real Medicare payment
14 reform needs to involve a comprehensive approach to financing as well as physician payment and
15 incentives. AMA policy is strong regarding the importance of pluralism, patient choice and
16 responsibility, and the right of physicians to balance bill in order to obtain payment in full for their
17 services. These long-term and comprehensive reforms should remain a key element of the AMA's
18 Medicare advocacy efforts.

19
20 As noted, the intent of Policy D-390.964 has been accomplished through the extensive feedback
21 the Council received from the Federation on the Medicare physician payment reform issues
22 addressed in CMS Report 4-I-08. Accordingly, the Council recommends that Policy D-390.964 be
23 rescinded.

24 25 RECOMMENDATIONS

26
27 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
28 110 (A-08), and the remainder of the report be filed:

- 29
30 1. That our American Medical Association (AMA) advocate for the development and
31 adoption of Medicare physician payment reforms that adhere to the following principles:
32
- 33 a) promote improved patient access to high-quality, cost-effective care;
 - 34 b) be designed with input from physician community;
 - 35 c) ensure that physicians have an appropriate level of decision-making authority over
36 bonus or shared-savings distributions;
 - 37 d) not require budget neutrality within Medicare Part B;
 - 38 e) be based on payment rates that are sufficient to cover the full cost of sustainable
39 medical practice;
 - 40 f) ensure reasonable implementation timeframes, with adequate support available to
41 assist physicians with the implementation process;
 - 42 g) make participation options available for varying practice sizes, patient mixes,
43 specialties, and locales;
 - 44 h) use adequate risk adjustment methodologies;
 - 45 i) incorporate incentives large enough to merit additional investments by physicians;
 - 46 j) provide patients with information and incentives to encourage appropriate utilization of
47 medical care, including the use of preventive services and self-management protocols;
 - 48 k) provide a mechanism to ensure that budget baselines are reevaluated at regular
49 intervals and are reflective of trends in service utilization. (New HOD Policy)

- 1 2. That our AMA continue to advocate for adequate investment in comparative effectiveness
2 research that is consistent with AMA Policy H-460.909, and in effective methods of
3 translating research findings relating to quality of care into clinical practice. (Directive to
4 Take Action)
5
- 6 3. That our AMA advocate for better methods of data collection, development, reporting and
7 dissemination of practical clinical decision-making tools for patients and physicians, and
8 rapid, confidential feedback about comparative practice patterns to physicians to enable
9 them to make the best use of the information at the local and specialty level. (Directive to
10 Take Action)
11
- 12 4. That our AMA urge physician organizations, including state medical associations and
13 national medical specialty societies, to develop and recruit groups of physicians to
14 experiment with diverse ideas for achieving Medicare savings, including the development
15 of organizational structures that maximize participation opportunities for physician
16 practices. (Directive to Take Action)
17
- 18 5. That our AMA continue to advocate for changes in antitrust and other laws that would
19 facilitate shared-savings arrangements, and enable solo and small group practices to make
20 innovations that could enhance care coordination and increase the value of health care
21 delivery. (Directive to Take Action)
22
- 23 6. That our AMA support local innovation and funding of demonstration projects that allow
24 physicians to benefit from increased efficiencies based on practice changes that best fit
25 local needs. (Directive to Take Action)
26
- 27 7. That our AMA work with appropriate public and private officials and advisory bodies to
28 ensure that bundled payments, if implemented, do not lead to hospital-controlled payments
29 to physicians. (Directive to Take Action)
30
- 31 8. That our AMA reaffirm Policy D-330.924, which calls for a commitment to total reform of
32 the current Medicare system by making it a high priority on the AMA's legislative agenda,
33 and that the AMA's reform efforts continue to be centered on our long-standing policies of
34 pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-
35 390.854), defined contributions (D-330.937), and balance billing (D-380.996, H-385.991,
36 D-390.969). (Reaffirm HOD Policy)
37
- 38 9. That our AMA rescind Policy D-390.964. (Rescind HOD Policy)

Fiscal Note: Staff cost estimated to be \$4,580 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.