



Physicians Caring for Texans

May 15, 2009

The Honorable Max Baucus
Chair, Finance Committee
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, D. C. 20510-6200

Dear Senator Baucus,

On behalf of the nearly 44,000 physician and medical student members of Texas Medical Association, please consider the following comments in response to the policy options identified by the Senate Finance Committee for “transforming the health care delivery system.” We very much appreciate the opportunity for input and your willingness to reach out to key stakeholders who will be working with you on health system reform issues.

General Observations, Principles

TMA recognizes both the timeliness of and urgency for system reform. Our organization has worked through a succession of committees, councils, and governing bodies to identify problems in our current system and to propose solutions. Currently TMA’s Task Force on Health System Reform is developing a summary of key proposals that outline “what we’re for.” We will share that document with you early next month upon its completion. Also, a previously charged TMA committee developed guiding principles for national system reform, which are included below. We commend them to you as an important source of content for defining what is essential in a comprehensive, efficient health care system that promotes access to high quality, cost-effective health care for all Americans.

These principles were debated and approved by TMA House of Delegates, and determined to be of equal importance in deciding how best to reform our health care delivery system:

- Promote portable and continuous health care coverage for all Americans using an affordable mix of public and private payer systems.
- Promote patient safety as a top priority for reform, recognizing an effective mix of initiatives that combine evidence based accountability standards, committed financial resources and rewards for performance that incent and ensure patient safety.
- Adopt physician developed, evidence based tools for use in scientifically valid quality/patient safety initiatives that incentivize and reward the physician led health care delivery team, and include comparative effectiveness research used only to help patient-physician relationships choose the best care for patients.
- Preserve patient and physician choice and the integrity of the patient-physician relationship.

- Incorporate physician developed, evidence-based measures and preventive health and wellness initiatives into any new or expanded health benefit package as a means to promote a healthier citizenry.
- Recognize and support the role of safety-net and public health systems in delivering essential health care services within our communities, to include essential prevention and health promotion public health services.
- Support the development of a well-funded, nationwide emergency and trauma care system that provides appropriate emergency and trauma care for all Americans.
- Support public policy that fosters ethical and effective end of life care decisions, to include requiring all Medicare patients to have an advance directive that a Medicare enrollee can discuss as part of a covered Medicare visit with a physician.
- Provide sustainable financing mechanisms that ensure the aforementioned affordable mix of services, and create personal responsibility among all stakeholders for financing and appropriate utilization of the system.
- Invest needed resources to expand the physician led workforce to meet the health care needs of a growing and increasingly diverse and aging population.
- Provide financial and technological support to implement physician-led, patient-centered medical homes for all Americans, including increased funding and compensation for services provided by primary care physicians and the services provided by non primary care, specialist physicians as part of the patient-centered medical home continuum.
- Through public policy enactments, require accountability and transparency among health insurers to disclose how their premium dollars are spent, eliminate pre-existing condition exclusions, simplify administrative processes and observe fair and competitive market practices.
- Reform the national tort system to prevent non meritorious lawsuits, keeping Texas reforms in place as enacted by the Texas Legislature and constitutionally affirmed by Texas voters.
- Abolish the Medicare SGR annual update system and initiate a true cost of practice methodology that provides for annual updates in the Medicare Fee Schedule as determined by a credible, practice expense-based, medical economic index.
- Support the implementation of an interoperable National Electronic Medical Records System, financed and implemented through federal funding.
- Require payers to have a standard, transparent contract with providers that cannot be sold or leased for any other payer purposes without the express, written consent of the contracted physician.
- Support efforts to make health care financing and delivery decision-making more of a professionally advised function, with appropriate standard setting, payment policy and delivery system decisions fashioned by physician led deliberative bodies as authorized legislatively.

Comments on April 29, 2009 Senate Finance Committee Policy Options

Medicare Physician Payment: A viable physician workforce is the key to a sustainable Medicare program that ensures beneficiary access to high quality, affordable health care. We are concerned that the policy options noted do not provide for the repeal of the broken and fiscally unsustainable SGR formula used to determine payment updates. TMA fully appreciates the need and resources required to re-engineer the physician payment system, and urges that SGR repeal and replacement should be a top priority. Without that key reform, much of the rest of the potential long term efficiencies and savings in the system sought by the president and Congress will not be possible to achieve.

Scarcity Area Bonuses: TMA supports the concept of bonus payments for primary care physician and general surgeon services in scarcity areas. However, we recommend that these services not be subject to budget neutrality rules, and that any savings that may accrue to any reduction in associated services provided in hospitals be used as new revenue to improve the physician payment system.

PQRI: TMA strongly supports efforts to improve quality through the development of evidence-based quality and performance standards and reporting incentives that allow CMS to provide feedback to physicians about the care their patients receive. We do not support a penalty approach in this regard, as it de-incentivizes physician buy-in for the program and participation in Medicare generally. Many of our leaders and members have been active in the national quality movement, including participation in the National Quality Forum and the Physician Consortium for Performance Improvement. We support those ongoing efforts to promote quality and incorporate workable quality initiatives in our health care delivery system.

Medicare Shared Savings: TMA is committed to working with other stakeholders to effect savings in the Medicare program by improving coordination of care in all settings. We urge caution in considering public policy that involves bundling of services absent evidenced-based findings and data from existing pilot programs that distinguish workable from unworkable approaches. This is an area that demands careful study and an incremental approach in planning and implementation. Current pilot efforts, as an example, for the ACE Medicare demonstration project are just now underway, and their impact and success are yet to be determined. Physicians should have a central role in the design and execution of demonstration projects in this regard.

Antitrust Reform: TMA believes antitrust reform must be an integral part of system reform. Antitrust reform will be necessary for the objectives of the president and the Congress to succeed in achieving greater coordination of care, the establishment of the medical home concept, and appropriate clinical integration.

Readmissions and Transitional Care: TMA understands and supports efforts to reduce unnecessary readmissions to hospitals. A current national working group looking at this issue and related development of quality measures and transitional care protocols between in- and outpatient care settings will be crucial in identifying workable approaches. As a part of re-engineering our payment system, new policies should be enacted to introduce a new mix of additional services not currently authorized for payment by CMS. These services, which include telephonic assessment, prevention and other health promotion/wellness visits, are important for health promotion, better care coordination, and ultimately reduction of readmissions for acute care services.

Health Information Technology: HIT is an important component of virtually all proposed system reform strategies. TMA believes an incentive-based approach is more likely to succeed in virtually all practice settings than one that relies on penalties for failure to incorporate HIT systems. Also, the specifications of the Stimulus Package, ARRA, for funding eligibility and any sanctions that pertain to physicians also should apply to any other provider groups who are authorized to receive payment.

Comparative Effectiveness Research: TMA supports the establishment of an independent body to conduct this research, with the major involvement of physicians in the development, governance, and management of that organization. Additionally, TMA strongly believes that comparative effectiveness research should be used only as a decision support tool, and not for determining payment or coverage designs. This is an extremely important distinction that is crucial to the ongoing integrity of the patient-physician relationship.

Physician Hospital Investment, Ownership: TMA strongly supports physicians' rights to own and invest in hospitals. Along with that we recognize of and support appropriate disclosure of ownership and investment information. We urge the Committee not to consider limitations on physician ownership and investment in hospitals if the innovation, cost savings, and access to cost effective care provided in these facilities is to continue and flourish. TMA further recommends that existing provisions in the Stark self-referral statutes that would effectively prohibit physician owned hospitals be eliminated in any system reform proposal that goes forward.

Physician Workforce: TMA believes the long term success of health system reform entirely depends on a well-complimented, vibrant and stable physician work force to enhance physician retention. Both segments of the physician pipeline, medical education and GME, need to be expanded and funded in order to educate and train more physicians for Texas. TMA welcomes the potential for unused Medicare GME slots to be reallocated to Texas to allow for some degree of the needed growth in residency training positions. It is also critically important that the Medicare GME funding caps be lifted and TMA supports the intent of the "Resident Physician Shortage Reduction Act of 2009" recently introduced in both congressional houses.

Medicare Enrollment: TMA appreciates the Committee's emphasis on revamping and streamlining enrollment in the Medicare program. Texas has experienced significant ongoing problems with the enrollment process and fully supports a more simple, workable, and accountable method for enrolling physicians. We respectfully suggest that existing problems be addressed before adding additional requirements that may either exacerbate current system dysfunctions or create new ones. Also, the resources for contractors to adequately execute enrollment responsibilities must be made available if a new enrollment system is to be more workable.

Data Issues: TMA believes that the need for expanding data gathering capabilities for system reform and associated data banking must be very carefully considered and planned. We urge the Committee to provide strong safeguards to protect patient and physician confidentiality and allow appropriately limited access for quality, performance, or program integrity uses. Also, we strongly feel that accountability features must be included to accurately portray, analyze, and represent data for any quality or performance purposes.

Mr. Chairman and Committee members, thank you for the opportunity to comment, and we look forward to your future deliberations and recommendations. We look forward to working with other stakeholders, the Congress and the administration in developing workable system reform provisions.

Sincerely,

A handwritten signature in black ink, appearing to read "William H. Fleming". The signature is written in a cursive, somewhat stylized script.

William H. Fleming, MD
President
Texas Medical Association

WHF/rj