AMA
AMERICAN
MEDICAL
ASSOCIATION

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

March 5, 2010

Deondra Moseley
Centers for Medicare & Medicaid Services
S2-22-25
Baltimore, MD 21244

Dear Ms. Moseley:

On behalf of the medical student and physician members of the American Medical Association (AMA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) *Advance Notice of Methodological Changes for Calendar Year (CY) 2011 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter* issued on February 19, 2010.

Medicare Advantage

In light of the deep payment cut that went into effect on March 1, 2010, to physicians who provide essential health care to beneficiaries in regular Medicare, it is imperative that overpayments to MA plans administered by private insurance companies be curtailed. Instead, as in years past, the Advance Notice estimates that the change in the national per capita Medicare Advantage growth percentage for aged and disabled enrollees combined in CY 2011 will result in an increase. The projected **1.38 percent increase is in stark contrast to the 21.3 percent across-the-board cut for Medicare physician payment rates that went into effect Monday and while the cut was reversed the differential is further underscored by yet more cuts scheduled for future years in Medicare physician payment rates. The AMA urges the Administration, along with the Congress, to take all steps necessary to establish parity in Medicare payment rates between physicians and other health care providers, such as Medicare Advantage plans.** There is no basis to justify this significant disparity in payment between MA plans, in which only about 24 percent of Medicare patients are enrolled, and the steep cuts shouldered by physicians under the Medicare fee-for-service program, in which over three quarters (76 percent) of our nation's Medicare patients are enrolled.

As taxpayers and beneficiaries in regular Medicare continue to subsidize private insurance companies to deliver the same benefit that physicians offer in regular Medicare, the March 1 cut in payment, even though reversed, has precipitated massive chaos and uncertainty. The Medicare Payment Advisory Commission (MedPAC) concluded that in aggregate the MA program continues to be more costly than regular Medicare. With the 21.3 percent cut in place, MA payments per enrollee would have been 113 percent of comparable spending for 2010 in regular Medicare. While the cuts were reversed, MA payments will be 109 percent of regular Medicare. In either case, there remains no policy rationale to support this disparate treatment. When first established, the Medicare+Choice program (precursor to MA) was promoted as a means to promote a cost-effective alternative to regular Medicare that would encourage competition and efficient behavior. It was not anticipated nor envisioned that the MA program would subsidize with taxpayer dollars inefficient market behavior of insurance companies that would cost more per beneficiary than regular Medicare.

The AMA supports patient choice and meaningful competition. This entails placing MA and regular Medicare on equal footing. By favoring MA plans over Medicare fee-for-service in funding, the government has created a two-tiered system for seniors in which managed care health plans are adequately funded, while fee-for-service physician services shoulder substantial funding shortfalls that threaten the viability of physician practices and seniors' access to their physicians.

As we have stated in the past, the AMA has strongly supported comprehensive health care reform as well as related initiatives to transform the physician payment system so that it results in the delivery of quality care to patients. To that end, the AMA has been supportive of initiatives to promote the adoption of health information technology and quality improvement. **However, these initiatives are not sustainable without a *stable, reliable, and predictable* physician payment system that provides positive payment updates to physicians that accurately reflect increases in physicians' practice costs.**

In addition to concerns with the payment differential between regulation Medicare and MA, we remain concerned with the practice of MA plans to use the Risk Adjustment Data Validation audits as a vehicle to not only provide information required by Medicare, but to go on a fishing expedition for information that is costly and expensive for physicians. We urge CMS to rein in the plans' chart reviews and their associated administrative burdens on physicians, and to require MA plans to bear the costs associated with pulling and duplicating requested documentation. Currently, MA plans have no incentive to minimize the burden on physician offices that are taxed with over broad requests that are far in excess of the documentation required by CMS. For example, after learning of a recent massive MA audit in Connecticut, a CMS official observed that the *national* sample for Risk Adjustment Data Validation audits appears to be smaller than the number of records requested *by one company in Connecticut alone*.

Medicare Part D

The AMA strongly supports the proposal that Medicare Part D plans cover 7-14 day trial prescriptions. With new treatment plans, physicians and patients should not be asked to shoulder the expense of a 30 or 90 day prescription when it is not clear that it will be an effective course of treatment for the patient. Providing for a 7-14 day prescription will ensure that the Medicare program and patients do not needlessly incur additional costs. It saves patients money in co-pays, and it reduces waste and disposal of unused drugs.

We appreciate the opportunity to provide these comments and look forward to working with CMS to help achieve a health care system that enables physicians to deliver quality care to patients.

Sincerely,

Michael D. Maves, MD, MBA