AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Before The
Senate Finance Committee
Regarding
Lessons Learned From A Year Of Implementation Of The Affordable Care Act

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The American Academy of Family Physicians (AAFP), representing 97,600 members nationwide, is pleased to submit this statement to the Senate Finance Committee as it considers the lessons learned from the first year of the *Patient Protection and Affordable Care Act* (ACA). The AAFP supported this legislation for many reasons, not the least of which is its goal of achieving health coverage for nearly everyone in this country. In addition, the ACA implemented numerous strategies for improving health care delivery and making more available affordable, high-quality care.

Members of the AAFP have a great deal of experience in delivering health care: family physicians treat one out of four patients in the U.S. In fact, more than 215 million office visits are made to family physicians each year; 59 million more than any other medical specialty. Family medicine is dedicated to treating the whole person, providing preventive care, coordinating care for multiple illnesses, promoting mental health and supporting better health behavior. Because of their focus on prevention and care coordination, family physicians help prevent many illnesses, treat early those illnesses that do occur and, when necessary, refer patients to the right specialist and advocate for them in this fragmented and complex health care system.

As the only medical specialty society devoted entirely to primary care, the AAFP is engaged in a wide array of health care issues, including health care coverage, cost, quality and safety of medical care, Medicare, Medicaid and CHIP, health information technology, funding for family medicine training, graduate medical education, the affordability and availability of prescription drugs, primary care research and medical liability reform. Family physicians have long worked with policy makers from both sides of the political aisle to advance health care policies that promote primary care. We are committed to continuing this work with the 112th Congress.

Expanded Coverage

For over 20 years, AAFP has been working to broaden health insurance coverage as the first step toward assuring that everyone has timely and effective access to the health care services they need. As the *Affordable Care Act* evolved over the two years it was debated, we were encouraged that several of the provisions of our Health Care for All policy remained in the successive drafts of the legislation. For example, we supported building on the current employer-based system of providing coverage, while improving the insurance market to create better access to coverage for small businesses and individuals who are neglected in the current

market. In our view, this always has included protecting insured individuals from losing coverage or being singled out for premium increases due to changes in health status, so that families with insurance are able to keep it. As long as these broad insurance reforms are part of a private market, a requirement for personal responsibility is necessary to avoid the problem of individuals waiting to buy insurance until health care costs arise. As part of the personal responsibility requirements, we have recommended subsidies or other mechanisms that will help low-income or high-risk individuals with the cost of coverage. We have agreed that subsidies also should be available for small businesses to enable them to offer health insurance to their employees. We have already seen the benefits for up to 2 million young adults up to age 26 -- a population that often went without insurance but still needed care or preventive services -- who now are allowed to remain on their parents' insurance. Finally, we have supported the rights of all consumers to be provided with adequate and comparable information that will enable them to choose the health insurance product that best meets their needs. Each of these important reforms is included in the *Affordable Care Act,* and family physicians understand that, as the research makes clear, the health of those in this county who have access to appropriate health care insurance will be better as a result.

Reformed Public Programs

Health insurance coverage alone cannot ensure access to care. The ACA made some notable strides in modernizing several federally funded health care programs; e.g., Medicare, Medicaid, Children's Health Insurance Program. We believe that the safety net provided by these and other public programs needs to be maintained and strengthened, and that payment levels must be sufficient to cover provider costs. As a result of the ACA's support for innovative programs, there is increased interest in new payment models, including shared savings and Accountable Care Organizations.

However, in the year since the passage of the ACA, we have learned that challenges remain. The Medicare physician payment system, in particular, must be fundamentally reformed to eliminate the sustainable growth rate (SGR) formula that has required repeated Congressional interventions to prevent steep annual payment cuts that threaten access to services. Medicare's current financing structure needs to be revised so that providers in a particular program category, for example Part A or Part B, can receive appropriate recognition for savings they are able to achieve in a different part of the program. Outreach efforts to encourage enrollment in Medicaid and the Children's Health Insurance Program (CHIP) should be improved, and

individuals eligible for Medicaid and CHIP should have the option of using public funds to help them purchase employer-sponsored health coverage.

Improved Quality

System reforms must empower physicians to improve health care quality and effectively use finite resources. Quality measurement programs that are designed simply to identify and penalize physicians and other providers whose results appear to fall below the top level of performance will not yield the system-wide improvements needed to assure access to high-quality health care for all patients. The AAFP support efforts in the ACA to expand and accelerate the development of meaningful quality measures and reliable data sources to build an evidence base for high-quality care. Broad adoption of truly connected and interoperable health information systems will help achieve quality improvement goals, but investments are needed to develop an infrastructure that will yield maximum results. Infrastructure needs are particularly acute in smaller physician practices.

The AAFP supports the ACA's Patient Centered Outcomes Research Institute for clinical comparative effectiveness research because it will provide physicians and patients with useful information about various diagnostic tools and treatment options, and we strongly believe that such research will contribute to individual health care decisions, which of course remain within the confines of the patient-physician relationship.

Increased Focus on Wellness and Prevention

The ACA created an important innovation in health care with the establishment of the Prevention and Public Health Trust Fund. The basic understanding of this fund is that improvements in the overall health status in the nation will serve to rein in costs and improve productivity. This fund also is supplemented with an investment in research to fill gaps in knowledge about the most effective health promotion strategies. These sorts of public investments are needed in education, community projects, and other initiatives that promote healthy lifestyles. As decisions are made about this program, AAFP believes that special emphasis should be placed on collecting data and developing strategies to eliminate regional, racial, ethnic, and gender health disparities. In addition, public investments and insurance plans should also support early access to care for mental health and for substance abuse disorders.

Reduced Costs

While the ACA represents a significant recognition of the importance of preventive health care and refocused health care delivery, there are several provisions that will help save costs both to the health system and to individual patients and payers. These provisions recognize that both private and public health insurance programs must be sustainable and steps need to be taken to control costs. The emphasis, for example, of the Center for Innovation in the Centers for Medicare and Medicaid Services (CMS) is to demonstrate cost savings to the system. Moreover, the provisions in the ACA related to the elimination of the Medicare prescription drug "doughnut hole" and the reduction and elimination of cost sharing for preventive health services address individual patient costs will help lower costs for patients. The AAFP believes these and other cost-saving provisions are crucial to the value of the ACA.

Through its impact on defensive medicine, liability pressure is also a major contributor to rising health care costs. Innovative approaches to reform such as health courts, early disclosure and compensation programs, administrative determination of compensation, and standards for expert witness qualifications, as promoted in the ACA, could help reduce these costs. Access to better information through funding of comparative effectiveness research can also help bend the cost curve by supporting better decision making by patients and physicians about diagnostic tests and treatment plans.

The ACA includes a controversial and unusual feature called the Independent Payment Advisory Board (IPAB) which will recommend reductions in Medicare health system costs to meet specified targets. While the AAFP has some concern about the process for implementing IPAB recommendations, we have felt that if the Board itself were properly constructed to include at least one representative of primary care physicians and one consumer representative, then there would be potential to help reduce some of Medicare's misvalued payment codes and other high system costs. In addition, we believe it is necessary to include a public comment period for the Board's recommendations before Congress is required to act; and we believe that the Board's review authority should extend to the entire range of health system entities, including hospitals, that contribute to cost increases. Without re-thinking how the IPAB operates, the scope of its authority and how it is constructed, this will likely be a missed opportunity for health system improvement.

Payment and Delivery System Reforms

We believe that the *Affordable Care Act* begins to make much needed investments in value-based payment methodologies that improve chronic disease management and care coordination, including but not limited to the Patient Centered Medical Home (PCMH). In addition, the ACA incudes pilot tests of other innovative approaches--such as Accountable Care Organizations (ACO), gainsharing, and payment bundles—that could create joint incentives for providers to coordinate and improve care and achieve cost efficiencies. However, current regulatory restrictions and antitrust laws that inhibit physicians, particularly those in smaller practices, from pursuing clinical integration strategies aimed at quality improvement and care coordination need to be identified and remedied. We understand that HHS and the Justice Department are attempting to reconcile the ACA's cost-saving reforms that require collaboration with the restrictions of the antitrust laws and regulations. This is an important and long overdue dialogue that AAFP has called for.

Family Medicine: Small Business Concerns

While the ACA takes important steps to recognize the high value of primary care services and the critical role such services play in a high-functioning health system, we have some concerns that health reform might not accommodate privately owned small and medium sized physician practices.

As many as 25 percent of family physicians serve their patients in either a solo or 2-physician practice. These practices flourish all over the country, in rural communities and in city neighborhoods. They provide up-to-date medical care and, with the use of information and communication systems, they ensure their patients find the community resources that will allow them to manage their chronic diseases and prevent them in the first place.

High-quality health care can be (and is being) delivered to patients, often in rural and underserved areas, by family physicians practicing alone or with a few other physician and health professional colleagues. Claims that health reform will (or must) lead to "vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups" are without merit and contradicted by the experience of family physicians all over the country.

The Patient-Centered Medical Homes and the Accountable Care Organizations are potential examples of these larger physician groups. However, AAFP believes that, properly constructed, an ACO can serve as a vehicle for disparate small physician groups to share some assets and support some community resources needed to coordinate care and help prevent disease. We would point out that a PCMH need not be a large physician practice. Indeed, physicians in solo, small or medium sized practices provide the important team-based primary care and preventive health services and chronic disease management called for in the health care reform law.

As we implement the health reform law, it is important to keep in mind that we should transform the practice of health delivery to reduce duplication and fragmentation of service and focus on coordinating care. But in doing so, we need not eliminate the variety of practices that make health care delivery most effective in different settings. We will continue to need small and medium sized practices and we should give these physicians the assistance they need to participate fully in our nation's renewed emphasis on primary care. For these and other reasons, the AAFP is eagerly awaiting the opportunity to review the proposed regulations that will signal the intent of HHS to implement the shared savings program under the ACA.

The Value of Primary Care

There are two ACA provisions related to payment that are important, not simply because they pay primary care differently than specialty care but also because they begin to acknowledge and recognize the value that primary care brings to the health care system. Beginning January 1, 2011, qualified primary care physicians – defined as those in family medicine, internal medicine, geriatric medicine and pediatric medicine – began receiving a 10-percent bonus for Medicare services. To qualify for the bonus, 60 percent of their Medicare allowed charges must be for primary care services as defined by evaluation and management (E/M) codes for office visits, nursing home visits and home visits. AAFP believes the 60-percent threshold is too high. As originally defined, the threshold would have had a particularly negative affect on rural primary care physicians because they are the ones who, by virtue of the fact that there are not as many specialist physicians nearby, provide more comprehensive care for their patients. This can skew the ratio of primary care to total services and would disqualify them for the bonus. Fortunately, the Centers for Medicare and Medicaid Services (CMS) through rulemaking, was able to make needed adjustments to mitigate the unintended consequence and up to 80 percent of family physicians will qualify for this bonus payment.

AAFP is concerned that this is just a 5-year program, scheduled to end Jan. 1, 2016, and that it applies only to payments for primary care services, not to all Medicare services that primary care physicians provide. We also believe that it needs to be significantly higher than 10 percent to achieve the goal of attracting sufficient numbers of medical students into primary care, as emphasized in the recent report of the Council of Graduate Medical Education (COGME). So a lesson learned from year one of the ACA is that this bonus must be increased and made permanent to have the desired effect. Nevertheless, it was important that ACA recognized that the current physician payment mechanism undervalues primary care and needs to be fixed.

The second payment program in the law also is a time-limited one. In 2013 and 2014, Medicaid payments for primary care and some preventive health care services will be increased in many states so that they are equal to Medicare payments. As a result, family physicians who care for Medicaid patients will, for two years, see significantly better payments in many states. This is another signal that primary care will ensure better health and better cost control.

Medicaid provider payments are a frequent target of state-level budget cuts during an economic downturn, which is the same condition that drives increased demand in the program. Not only have payments not kept pace with inflation, but they have actually decreased substantially. This has forced many physicians to close their practices to Medicaid patients. Family physicians have a strong commitment to serving the nation's most vulnerable patients, but payment in Medicaid must be adequate to cover the cost of providing essential primary care services. Thus, this ACA provision for payment at least equal to Medicare's is an incredibly important signal to the health care community that provider payments are inadequate. However, just as any business must develop a business plan based on projections, it is critical that the Medicaid increase be sustained for the medical practices to accept more Medicaid patients. Without this assurance, it is unclear what the response will be. Many physicians have voiced their concern that after the two years of increased payment, they will be forced to discharge these patients from the practice in order to remain fiscally solvent.

Another lesson learned relates to the Congressional decision to not include in ACA a provision to resolve the problem with the sustainable growth rate formula which affects Medicare payments. Despite the modest bonus for primary care and the recognition throughout the law of the importance of and high value of primary care, our members are sobered by approaching

29.5 percent cut in Medicare reimbursement for all physicians scheduled to take effect January 1, 2012.

AAFP urges Congress to act expeditiously to permanently fix this flawed Medicare payment formula. Among the approaches that could be considered is a permanent or at least an intermediate-term (e.g., three-year) fix that includes a positive differential payment of at least one percent for primary care services. Congress considered such a payment system as a replacement for the SGR early in the debate on health care reform, but it was not included in the final legislation. We would encourage consideration of a payment scheme that includes some mechanism to reduce the large and unproductive disparity in payment between primary care and other health care. We also would eventually look to a permanent formula that incorporates lessons learned from other provisions of the ACA that begin to steer Medicare payment away from relying solely on traditional fee-for-service by incorporating a blended payment system that supports care management and quality improvement, in addition to a reliable formula that supports the fee-for-service portion of the payment to physicians.

The Patient-Centered Medical Home model established in the legislation is incorporated into a new Medicaid state option that will help states implement and evaluate this model of coordinated care. While AAFP applauds the 90-percent match provided by the ACA to the states to assist in the establishment of this new Medicaid PCMH option, it does have a restriction that AAFP thinks is not helpful. The PCMH options will include only the so-called high-need patients, such as those with two or more chronic conditions. While the PCMH has demonstrated extraordinary results in both saving costs and improving health by preventing high-cost chronic conditions, restricting the number of patients in a practice who can be included in the PCMH is unfeasible. Providing different types of care for patients is impractical and possibly even unethical for any physician's practice. Limiting patient eligibility makes the cost of transformation for the practice much higher on a per-unit cost. Physicians are reluctant to invest in a total transformation of their practices into patient-centered medical homes for only a portion of their patient panel. Instead, they are going to become a patient-centered medical home for all of their patients. But if they are eligible to receive enhanced payment for only a small portion of their patients, then the PCMH does not meet the cost test, and it is unlikely that they will undergo this fairly costly and certainly time-consuming transformation.

Misvalued Codes under the Medicare Physician Fee Schedule

Family physicians, and other primary care physicians and providers, have been concerned with how CMS determines specific payments for medical services. The AAFP appreciates the provision of the ACA that requires HHS to periodically identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. Codes would be identified based on certain factors, including codes with the fastest growth. Adjustments to misvalued procedures would be subject to budget-neutrality requirements.

Teaching Health Centers Development Grants

The ACA directs the HHS Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for fiscal year 2010, $50 million for fiscal years 2011 and 2012. The law also provides $230 million to cover the expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. This is a critically valuable provision that could help identify the residency programs that bring residents to non-hospital sites for training in primary care.

State Medical Tort Litigation Alternatives

The ACA authorizes $50 million in demonstration grants to states to test alternatives to civil tort litigation. These models will be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients will be able to opt-out of these alternatives at any time.

HHS will provide technical assistance through guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events.

While the ACA included these demonstration grants, it does not completely nor adequately address the problems associated with medical liability in this country. The *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act* (HR 5), introduced in the 112th Congress, includes significant reforms that will help repair our nation's medical liability system, reduce the growth of health care costs, and preserve patients' access to medical care. Many

experts agree that the current tort system in the U.S. leads to an increase in health care costs. The proven reforms contained in the HEALTH Act, including the $250,000 cap on non-economic damages, would help reduce costs, while ensuring that patients who have been injured due to negligence receive just compensation. This bill provides a balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting non-economic damages to a quarter million dollars. In addition, the HEALTH Act protects effective state medical liability reform laws.

National Health Care Workforce Commission

The ACA made a significant step toward effective understanding of our health care workforce requirements by establishing the National Health Care Workforce Commission to:

- Disseminate information on promising health care professional retention practices;
- Communicate information on policies and practices that impact recruitment, education and training, and retention of the health care workforce;
- Work with federal, state and local agencies to review current and projected health care workforce supply and demand and make recommendations to Congress and the Administration regarding health care workforce priorities, goals and policies;
- Perform duties, including conducting reviews, making reports, making recommendations, conducting assessments and data collection and dissemination activities, related to the State Health Care Workforce Development Grant program;
- Study effective methods for financing education and training for health care careers.

Beginning in 2011, the Commission must submit to Congress and the Administration by October 1 of each year a report containing the results of reviews and recommendations concerning related policies. Beginning in 2011, the Commission must submit to Congress and the Administration by April 1 of each year a report that contains a review and recommendations related to at least one high priority area, which may include:

- Integrated health care workforce planning;
- Requirements for health care workers in the enhanced information technology and management workplace;

- Aligning Medicare and Medicaid graduate medical education policies with national workforce goals;
- Eliminating barriers to entering and staying in primary care;
- Educating and training, projected demands and integration with the health delivery system of the nursing workforce, oral health care workforce, mental and behavioral health care workforce, allied health and public health care workforce; emergency medical service workforce capacity; and a comparison of the geographic distribution of health care providers with identified workforce needs of states and regions.

To carry out its duties, the Commission is authorized to use existing information collected and assessed by its own staff or under arrangements, carry out or award grants or contracts for research and development where existing information is inadequate, and adopt procedures permitting interested parties to submit information for the Commission to use for reports and recommendations.

The AAFP supports the establishment of this commission. It is clear that impartial and informed decisions on how to promote the needed health care workforce are imminent. This commission is necessary to provide unbiased, informed and appropriate data and recommendations for how the federal government can best allocate its physician-training resources to achieve the best results. To perform this long-needed function, the commission will need to be sufficiently funded.

Establishment of Center for Medicare and Medicaid Innovation within CMS

The law creates the Center for Medicare and Medicaid Innovation (CMMI) within CMS to research, develop, test, and expand innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. This new Center is designed to experiment with the PCMH model and to use it more broadly as soon as it begins showing savings or improved quality. While the CMMI is still in its developmental stages, it is the AAFP's desire that the center will soon be able to begin meaningful and comprehensive implementation of the PCMH demonstrations. This Center is an extremely important tool to make our nation's health care delivery more efficient and more effective. It is vital that this Center retain its flexibility and scope. The AAFP believes it has the potential for being a powerful force for evidence-based, effective health care delivery.

Summary

For more than 20 years, the American Academy of Family Physicians has supported health care coverage for everyone. No one in this country should delay or forego needed care because of cost. Instead, we believe that the nation must:

- Provide health care in the broadest sense rather than focusing only on sick care -- we must constrain total spending by helping patients avoid preventable illness, efficiently managing the care of people who have chronic illness and improving the quality of that care; and we must provide health care coverage to people who cannot afford it or who have been turned away due to pre-existing conditions.
- Address the factors that drive up costs and lower quality: the fragmentation of care; the duplication of tests and services; and the disregard for chronic disease management, prevention and wellness care in favor of medical intervention.
- Build up the primary care physician workforce to meet the requirements of everyone who needs care.

The *Patient Protection and Affordable Care Act* already has made important strides toward achieving these bold and life-saving goals. It will expand insurance coverage by about 30 million people. Although this still falls short of coverage for everyone, the number of uninsured people will be reduced by more than half. It will encourage better health delivery models, emphasize the high value of primary care, support research and demonstrations of what works and what is needed, and it will help evaluate methods for controlling health care costs and improving health care quality.

In the year since it has been enacted, we also have learned:

- Medicare incentive payments to boost primary care reimbursement are necessary and welcomed but the specter of a 29.5-percent cut in Medicare payments for all physicians in January 2012 is a factor that keeps physicians as small businesses unsure, uncomfortable and only tenuously committed to the Medicare program.
- Primary care constitutes high-value services but according to the Commission on Graduate Medical Education (COGME) is still undercompensated. Thus, shortages and maldistributions continue; more autonomy and innovation is necessary in the education, training and reimbursement of primary care physicians.

- More concentration and movement have been noted around the patient centered medical home and Accountable Care Organizations even before the release of regulations. This is testimony that a change in the fee-for-service payment system is not unwelcome by payers and providers alike.
- Health Information Technology is critically needed in this country to ultimately adopt personalized electronic health records that will reduce errors in care and redundancy of costly procedures.
- Likewise, grants to establish or expand primary care residency programs in teaching health centers, which amount to $230 million from 2011 to 2015 are an important innovative step toward fortifying the primary care workforce.

Since the ACA became law, the American Academy of Family Physicians has continued and will continue to work for:

- Constructive health insurance reform for everyone in this country;
- Changes in health care delivery and payments systems that ensure high quality, affordable care for our patients; and
- Medical education reform that will rebuild our primary care physician workforce.

These three goals are key to building a better health care system. The health of our patients and the health of the nation depend on meeting them.