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### NEXT WEEK IN WASHINGTON...

Over 225 family physicians and students will convene for a two day conference in Washington, DC. Speakers at the Family Medicine Congressional Conference include Obama health care advisor Chris Jennings; Senate Majority Whip, Sen. Dick Durbin (D-IL); health workforce expert, Fitzhugh Mullan, MD; and several Congressional staff members. In addition, Rep. Xavier Becerra (D-CA) will address participants at a reception sponsored by FamMedPAC and the AAFP Grassroots program.

## 1. SENATE COMMITTEE LOOKS AT HOW TO FINANCE HEALTH CARE REFORM

As the Senate Finance Committee continues to probe the issues related to reforming the health care system, on Tuesday, May 12, Senator Max Baucus, who chairs the committee, presided over a roundtable discussion with representatives of the insurance industry and the academic community. The discussion centered on measures that the Congress could take to raise the revenue necessary to pay for the changes that they will propose for the health care system. Much of the discussion concerned whether to eliminate the tax exemption that employers have for the health insurance that they offer to employees. While eliminating it would raise a significant amount of tax revenue – one economist estimated it would be about \$250 billion annually – most Senators agreed with Sen. Baucus when he noted that the committee would not approve with doing away with the exemption entirely. However, he was open to capping the amount that would be exempt. Another option discussed was the elimination of tax exemptions for non-profit hospitals (which would raise about \$6 billion a year) and increased in the excise taxes on alcohol, cigarettes and products (like soda drinks) containing sugar. Finally, there was some discussion of eliminating the tax subsidy for health savings accounts.

Meanwhile, the AAFP has responded to the Committee's first options paper that dealt with reforms to the health care delivery system. A copy of that response is attached.

## 2. PRIMARY CARE, SUBSPECIALTY MEDICINE CLASH AT CONGRESSIONAL HEARING

On May 14, the Senate HELP committee held a fractious hearing on health care delivery reform. Acting Chairman Sen. Sherrod Brown (D-OH) began by decrying the lack of coordination in health care; the widespread agreement around the PCMH as a concept but lack of agreement on how it should be implemented.

Pediatrician Marsha Raulerson, MD, spoke strongly about her use of the PCMH; her use of telemedicine in situations where subspecialists are not available and her desire for assistance with incorporating HIT into rural practices.

“Buzz” Cooper, MD, was predictably irascible and commented that the PCMH is untested and is comparable to the "FDA approving a drug after only 4 people have taken it." He emphasized the severe shortage of physicians in all specialties and stated we must use Nurse Practitioners and Physician Assistants since they “are quite capable of performing independently since their education level has been rising.” He also stated that “looking at primary care objectively is now “politically unacceptable” and that physicians are back to old turf battles.

Steven Schlossberg, MD, stated that primary care is not always the most efficient and effective way to treat patients; that data shows that subspecialists are more skilled when it comes to working in their field; and that he opposes budget neutrality. He also speculated that subspecialists are not moving to rural areas since they prefer working in a group due to the complexity of their activities and that everyone may need to reset expectations for rural health care, i.e., rural citizens simply may not get access to everything.

### **3. GRASSROOTS REPORT**

AAFP Key Contact Mark Krotowski, MD attended a Health Care Town Hall with his Representative, Edolphus Towns (D-NY). Dr. Krotowski spoke about the Patient-Centered Medical Home, Health Care Coverage for All, and funding for more Family Medicine Residency programs.

This week, the AAFP issued an action alert to all members of AAFP Connect for Reform. The email alert called on members to contact Sen. Baucus (D-MT) about the important role of primary care should play in health care reform. In just three days, family physicians have sent more than 245 emails to the Senator.

### **4. HOUSE COMMITTEE DRAFTS PLANS FOR HEALTH REFORM**

A summary from the House Energy and Commerce Committee meeting was leaked on Thursday, May 14, in which committee Democrats outlined their proposals for health care reform legislation. Among the proposals being considered is a requirement that U.S. residents have health insurance and the federal government subsidize the cost of coverage for families with incomes up to \$88,000. In addition, the plan also would require that employers offer coverage to full-time employees or pay a percentage of their payroll to the government.

The committee plan also called for the establishment of a "national health exchange," in which private and public plans could compete. The exchange would first be open to U.S. residents without employer-sponsored health insurance and small businesses, but eventually would be available to large businesses as well.

The summary also included a proposal that would establish a new public plan run by HHS that would be subject to the same market reforms and consumer protections as private plans and would have geographic adjusters for price. The summary stated that the plan, which would be separate from the exchange, would not be subsidized by the government and "would build on Medicare providers and rates, similar to the practices of private plans today." The proposal would create a public advisory committee to recommend benefits packages, loosely based on the Federal Employees Health Benefit Program, which would be available through the exchange.

## 5. FAMMEDPAC CONTINUES TO PROMOTE AAFP'S AGENDA

FamMedPAC participated in several events this week as Senators and Representatives court physician input on the healthcare debate.

Government Relations staff attended a meeting with **Sen. Ron Wyden (D-OR)**, who sits on the Senate Finance Committee. The discussion centered on the senator's *Healthy Americans Act* (S. 391) which he boasts is the only comprehensive reform bill that is in legislative language, has been introduced, has bipartisan support and has a zero scoring in the early years (and savings in the out years). In responding to a question, he hinted that Medicare reform (i.e., physician payment) may have to wait until health reform has been enacted. He did speak in favor of needed refinements to bad Medicare Advantage payment formulas but not in his state where good Medicare Advantage plans exist. He frequently touted the need for care coordination and the strengthening of physician workforce (including primary care) and said he favored creating a "presumption of reasonableness" if a physician is acting in accordance with established guidelines as a means to decreasing the amount of defensive medicine that is being practiced. He repeatedly said he wants to change from the 1940s model that favors insurance companies and employers to one that favors patients and doctors.

At a PAC event sponsored by FamMedPAC, **Sen. Charles Grassley (R-IA)**, ranking member of the Senate Finance Committee, discussed health reform as primary care focused. We made our case for increased payment for primary care, recognizing the value of primary care, strengthening the primary care workforce and modernizing primary care training and funding. The senator and his staff said that SGR may be a patch for a few years until health care reform changes are phased in, but then he assumes the problem will be taken care of by health care reform.

GR staff attended a health care industry meet and greet with freshman **Rep. Glenn Nye (D-VA)**, which was sponsored by the cardiologists since that is Nye's father's profession. He seemed to have a good grasp of the nuances in health care reform. After a discussion of AAFP's positions, several of the subspecialist groups brought up the budget neutrality issue and how increases to primary care could impact their members. Nevertheless, the other groups present all talked about the importance of primary care but stated that their subspecialists' fields were either in short supply or undervalued in a new system.

**Sen. Kent Conrad (D-ND)**, the Chair of the Senate Budget Committee, held a PAC event in which he assured all present that health care reform would be voted on this year. When pressed about why the Senate budget resolution included only a two-year SRG fix rather than reforming Medicare physician payment, Sen. Conrad pointed out that once we reform the whole system, it will be easier to address the SGR.

## 6. WEST VIRGINIA GOVERNOR VETOES MEDICAL HOME LEGISLATION

On Thursday, May 7th, West Virginia Governor Joe Manchin (D) vetoed legislation containing a medical home demonstration program. Gov. Manchin explained his veto as coming on a technical matter that he believed would render the legislation unconstitutional. He vowed to sign the bill into law upon receipt of a corrected version.

## 7. NORTH CAROLINA PASSES CLEAN INDOOR AIR ACT

The North Carolina General Assembly sent Governor Bev Perdue (D) a bill to prohibit smoking in public and work places. The Governor announced she intends to sign the legislation. The Tarheel State becomes the second state with a tobacco industry, after Virginia, to pass a clean indoor air act. The Senate passed the bill Monday, May 11th, 30-18, with House concurring on Wednesday, May 13th, 62-56. Once signed, the law will take effect on January 2, 2010.

## ATTACHMENT

# American Academy of Family Physicians Response to the Senate Finance Committee's Options Paper, "Transforming the Health Care Delivery System"

### Major Provisions for Family Physicians

- (1) *Physician Quality Reporting Initiative (PQRI) Improvements and Requirement (pp. 5-7)* – This section would bolster the quality improvement program that includes incentive payments of 2 percent in 2009 and 2010 for those physicians who report on specific quality measures. The options paper suggests an alternative program that would provide the PQRI incentive to those physicians who are currently engaged in a Maintenance-of-Certification (MOC) Program conducted by a qualified medical specialty board – the American Board of Family Medicine (ABFM) for family physicians – and who complete a qualified MOC continuous assessment program (like ABFM's Part IV module) every 2 years. No further reporting would be required. Improvements would be made to the PQRI program by providing an appeals process for those who participated but did not qualify, requiring more timely feedback from the Centers for Medicare and Medicaid Services (CMS), and removing geographic adjustments from the calculation of the incentives.

**AAFP Comments:** We commend the Committee for the improvements to PQRI outlined in the options paper. All three would be welcome from the perspective of family physicians.

One issue is that the proposal would require a biennial process, whereas the current ABFM MOC program calls for a Part IV module to be done only every three years (for the 10 year MOC process). We would recommend that the legislation require eligibility for the PQRI to be on a three-year cycle, rather than biennially.

The proposal also includes a suggestion of a penalty in later years for those physicians who do not participate in a quality improvement program. Medicare patients would be better served if the legislation fostered a culture of improvement not a culture of punishment, and we would recommend deleting these penalties. We would note that the penalties are based on non-participation, not non-compliance, which is the term used in the paper. Physicians might not participate because the bonus payments are lower than the costs of implementing the changes required to their practices.

- (2) *Primary Care and General Surgery Bonus (p. 10)* -- Physicians and other providers, who furnish "at least 60 percent of their services in specified ambulatory settings" would be eligible for a bonus payment of at least 5 percent for certain evaluation and management (E/M) services. The bonus program would be authorized for five years. This bonus (and a similar one for general surgery in rural underserved areas) would be paid for by an across-the-board reduction in payments for all other codes.

**AAFP Comments:** Along with the American College of Physicians (ACP) and the American Osteopathic Association (AOA), we have delivered to the committee extensive suggestions for improving this section. (A copy of that statement is attached.) It must be noted that if the purpose of this bonus payment is to provide incentives to medical students to choose primary care and to sustain those already in practice, it is insufficient in amount and duration. The three major primary care physician organizations that receive Medicare

payments (AAFP, ACP and AOA) have told the Finance Committee that Congress should require that Medicare mandate a more substantial primary care payment increase in 2010 as a powerful signal of its intent to transform health care around patient-centered primary care. Our suggestion is that total Medicare payments for services provided by primary care physicians should be increased by no less than 10 percent on January 1, 2010, which would then be followed by further annual increases of 5 percent in 2011-14. These bonus payments should be cumulative, so that by 2014, the primary care bonus payment is 30 percent. (If the 2010 increase instead is applied only to the proposed limited set of E/M services, then payments for such E/M services provided by primary care physicians would need to be increased to achieve the same net gain in total payments).

For the primary care bonus, eligibility should be limited to specific physician specialties, (i.e., family medicine, general internal medicine, general pediatrics, and geriatrics) that achieve the 60-percent threshold.

- (3) *Payment for Transitional Care Activities (pp. 10-11)* – To help pay physicians for providing integrated, transitional care management for chronically ill patients, the document outlines a proposal to reimburse physicians for using nurse care managers (or other non-physician professionals, like diabetes educators) to provide in-person services for patients who have been discharged from the hospital within the previous six months for a stay related to one of six specific major chronic diseases.
- (4) *An Additional Chronic Disease Management Payment (p. 11)* – The paper includes a brief description of a “modest supplemental fee” that Medicare would pay to a primary care practice that provides a covered evaluation and management service to a beneficiary within 30 days after discharge from a hospital after a stay for one of the major chronic diseases and who is not readmitted within 60 days after the initial discharge.

**AAFP Comments:** In this payment for transitional care activities, there is a potential unintended consequence. Many of the chronic diseases that are listed, if managed well, would not result in hospitalization at all. In this case, a primary care practice that actually keeps chronically ill patients out of the hospital would not be eligible for this bonus payment.

It is also likely that the Medicare program will save more money by avoiding readmission for those patients who otherwise need hospital care. Yet the proposal seems to make this the lesser bonus (“a modest supplemental fee”). Those that successfully prevent hospitalization should receive an appropriate bonus and that money should come from Part A of the Medicare Trust Funds. It is important to note that this reform would not only benefit patients but also extend the life of the Part A Trust Fund, since the bonus paid will be less than the cost of the hospitalization that is avoided. Also, this section needs to provide some incentive for the hospitals to ensure that a primary care physician is involved in the patient's care upon discharge.

- (5) *CMS Chronic Care Management Innovation Center (pp. 11-13)* – In an attempt to accelerate the implementation of reforms in payment, delivery of services, and providing of benefits, this section describes the creation of a new center in CMS to test and disseminate payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare patients. Examples of models that might qualify include the patient centered medical home. This proposal includes an

option to establish a Medicare Rapid Learning Network to conduct smaller scale evaluation of emerging care management models.

**AAFP Comments:** The section that creates a CMS Chronic Care Management Innovation Center focuses on patients with multiple chronic conditions and names the Patient Centered Medical Home as a means of providing services for these patients. While the PCMH would indeed likely be helpful for Medicare patients with multiple chronic conditions, the PCMH really is a model for all Medicare (and health care in general). It is much more than a chronic disease management system. At the least, the section should drop the requirement that the Center work only for Medicare patients with multiple chronic diseases.

The proposed CCMIC should develop a group of standing Practice Based Research Networks with whom the agency could contract to do rapid, real time testing of payment and practice innovations that can be much faster than CMS's current demonstration authority. These networks could be effectively employed to conduct preliminary research and design work that are essential for more effective long-term demonstrations and pilots.

- (6) *Sustainable Growth Rate (SGR) (pp. 16-17)* – The options paper suggests two approaches to the SGR for the next several years:
- Update the fee schedule by 1 percent in 2010 and 2011, by 0 percent in 2012 and then revert to current law in 2013, which would mean a significant decline in the payment rate.
  - Update the fee schedule by 1 percent in 2010 and 2011, then reverting to current law with a floor to the decreased payment of -3 percent in 2012. Beginning in 2014, the fee schedule update “for localities with a 2-year average fee-for-service growth rates at or greater than 110 percent of the national average would have a -6 percent floor.”

**AAFP Comments:** We should not postpone resolving the annually recurring problem of the SGR. It needs to be eliminated not just to provide stability to the Medicare payment system, but also to accurately reflect the actual practice costs that physicians bear. Along with the American Medical Association, we support replacing the SGR with a realistic baseline for physician payments incorporated into the federal budget. We would support transitioning from the SGR to new payment models. This transition should include positive, funded updates.

- (7) *Medicare Shared Savings Program (i.e., Accountable Care Organizations) (pp. 17-18)* – This recommendation arises from a sense that the fee-for-service system cannot provide effective mechanisms for better efficiency and that Medicare payment should migrate to Accountable Care Organizations (ACO), as recommended by MedPAC. Under this option, Medicare would allow groups of providers who meet cost-reduction thresholds to share in the savings they achieve. The option requires substantial participation by primary care physicians, since the paper defines a qualified ACO as one that includes primary care providers with at least 5000 Medicare patients.

**AAFP Comments:** The paper places a great deal of faith in the efficacy of Accountable Care Organizations, but these are untested models that need careful monitoring in multi-year demonstrations. We are particularly concerned that these models, which are designed to reduce costs, may not support quality improvement. Quality, after all, does not always produce savings. There is a concern that solo, small and medium sized practices, and especially those in rural areas, would not be able to secure the financial and technical

resources needed to create the formal legal structures mandated by the recommendation. Consequently, this proposal might make hospitals the employers of primary care practices or force consolidation of many functioning small independent practices into large multi-jurisdictional institutions. This has serious antitrust implications which would need addressing and would require a great deal of legal guidance and governance. This proposal also has implications for the use of Health Information Technology that is responsive to the needs of primary care, not just to those of a hospital or large multi-jurisdictional medical group. Our experiences in the 1990s with hospital purchase of primary care practices should serve as a caution for how this proposal is implemented.

- (8) *Extension and Expansion of the Medicare Health Care Quality Demonstration Program (p. 19)* – This option would permanently authorize Section 646 of the Medicare Modernization Act, which requires 5-year Medicare demonstration programs to examine factors that encourage improved patient care quality. The Sec. 646 programs would have to include multi-payer projects and would be given pilot authority (i.e., a more rapid implementation schedule).

**AAFP Comments:** This is a positive proposal that will help accelerate the implementation of the Patient-Centered Medical Home and other proposals that are designed to improve the quality of patient care. CMS has struggled to initiate the Medicare Medical Home Demonstration program since it was authorized in 2006. Even after the demonstration program begins, it will take five more years to test and evaluate the model. The agency needs to have the authority to be more nimble in implementing models like the Patient-Centered Medical Home that would help improve quality for patients and potentially contain costs for them and for the federal government.

- (9) *Health IT – Encouraging Health Information Technology (HIT) Use and Adoption in Support of Delivery System Reform Goals (pp. 19-21)* – The paper suggests that providers other than physicians should be eligible for bonus payments for HIT use if the provider practices outside of a physician office. In addition, the paper suggests the HIT bonus payments should be offered to other health care providers that were not included in the Medicare and Medicaid incentives in other legislation. Finally, the paper encourages the development of additional HIT incentives to help support care coordination and quality improvement goals.

**AAFP Comments:** We agree with the Committee's proposal to expand eligibility for HIT support. Medicare incentive payment to include nurse practitioners and others who practice outside of the physician office, provided funding is increased appropriately. We believe it will help in the analysis of health care efficiency and quality if all of the providers have the necessary tools to report on their practice. We also know that care coordination requires more extensive use of HIT in all practice settings and it requires access to data that is not normally available to providers, like whether a prescription is being filled.

- (10) *Improving Quality Improvement (pp. 21-23)* – Building on recent legislation that supports the process to develop and evaluate health performance measures, this option would further strengthen that process.

**AAFP Comments:** We support this proposal to involve stakeholders in offering guidance to HHS in the development of national priorities and goals, on the selection of performance measures, and on maintaining these measures as new evidence and data emerge with time

and experience. We have long believed that quality measures that are developed with the input of physicians could advance medical diagnosis and treatment.

- (11) *Comparative Effectiveness Research (pp. 24-25)* – The paper touches on several options to establish a long-term framework to set national priorities for comparative clinical effectiveness research. For example, the paper describes a private non-profit independent institute that would be created to oversee the nation's comparative clinical effectiveness research program.

**AAFP Comments:** The provisions included in the options paper regarding comparative effectiveness research are very good. However, while the options include using "systematic reviews, observational studies, clinical trials and randomized controlled trials," we would recommend adding "practice-based network research" along with traditional clinical trials. This sort of "real-world" research is done through the practices of family physicians and other primary care physicians not just highly regimented controlled clinical trials. The results are much more usable by primary care practices because these networks are able to study clinical effectiveness, practicality, barriers to effectiveness and dissemination methods.

- (12) *Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians (pp. 33-34)* – The paper suggests that 80 percent of the residency training slots that have not been filled in the last three years be pooled for redistribution. Seventy-five percent of these slots would be allocated toward primary care or general surgery residencies for at least 5 years.

**AAFP Comments:** We support the concept of redistribution of unused GME residency slots, but we are concerned that this proposal (pp. 33-34) will not increase the number of primary care residents. The reality is that many unused slots are already in primary care, or in rural or small community hospitals. The ultimate result of this proposal might well be to decrease the number of primary care residency slots in favor of specialist residents in urban and suburban hospitals.

Therefore, we would recommend that all of the new residency slots created in this process be designated as primary care or general surgery. However, this recommendation is insufficient in itself to create support in the hospitals for primary care residencies. The recommendation also should include a larger payment for specific primary care residencies (i.e., general internal medicine, family medicine, geriatrics, general pediatrics). The recommendation should include a policy that GME should follow the resident and that payments can be made directly to the primary care residency program. Finally, the Committee should consider broadening the base for GME by requiring all health plans to contribute to GME. For more details on this proposal, see the separate letter to the Committee from the Academic Family Medicine Advocacy Alliance (AFMAA), which AAFP fully supports.

- (13) *Promoting Greater Flexibility for Residency Training Programs (pp. 34-35)* – The paper proposed including counting time for certain non-patient care activities, such as didactic and scholarly activities in a non-hospital setting for purposes of calculating GME payments, removing current disincentives placed on training programs that rely on volunteer supervisory physicians to provide training in outpatient settings and flexibility in the operation of residency programs involving more than one teaching hospital.

**AAFP Comments:** We particularly appreciate including the section on “Promoting Greater Flexibility for Residency Training Programs” (pp. 34-35), since it calls on CMS to consider counting time for certain non-patient care activities in a non-hospital setting for purposes of calculating GME payments. We would recommend the Committee be as specific as possible in this area, given the history at CMS of misunderstanding Congressional intent. Again, the AFMAA leaders have spoken to this issue in their letter, and the AAFP strongly agrees with their recommendations.

(14) *Proposal on Development of a National Workforce Strategy (pp. 36-37)* – The paper suggests the need to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas, like increasing access to primary care services. In response, the paper notes the option of establishing a national health workforce commission. An alternative is to provide additional resources to support the workforce-related activities of CMS and HRSA and to encourage increased collaboration.

**AAFP Comments:** In the development of a national workforce strategy, the proposal should include a stipulation that HRSA be required to obtain and track nurse practitioner data, including the number trained and credentialed, where they practice and what their practices consist of. Such data is already collected for physicians and physician assistants. In addition, data should be collected on all providers’ referral patterns, test and measurement frequency, outcomes, and complexity of patients (risk-assessment). This can be accomplished by improving the Health Resources and Services Administration’s (HRSA) research capacity and access to data, including Medicare’s.

(15) *Medicare Advantage: Pay for Chronic Care Management (pp. 40-41)* – The paper notes that the Finance Committee would consider proposals to pay Medicare Advantage plans a bonus for chronic care management along with competitive bidding. This would be structured essentially as performance bonus of \$22 to \$37 per enrollee per month.

**AAFP Comments:** Regarding the performance bonus payment for Medicare Advantage plans that provide chronic care management (pp. 40-41), we would note that Medicare Advantage plans already are paid 12 percent more than fee for service. Consequently, the payment structure already provides Medicare Advantage plans with an incentive to offer chronic care management. The bonus proposed in this option should instead be directed to providing additional payment to primary care practices.