



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

## AMERICA'S AFFORDABLE HEALTH CHOICES ACT (HR 3200)

As Reported by the  
Committees on Energy and Commerce, Ways and Means and Education and  
Labor

### Major Primary Care Provisions

#### DIVISION B – MEDICARE AND MEDICAID IMPROVEMENTS

##### TITLE I – IMPROVING HEALTH CARE VALUE

##### Subtitle B – Provisions Related to Medicare Part B

###### Sec. 1121. Sustainable Growth Rate Reform

- Update for 2010 will be the percentage increase of the Medicare Economic Index (MEI)
- The SGR will be rebased to eliminate the accumulated debt
- From 2010, Medicare payment will be made in two categories of services:
  - Evaluation and Management, and Preventive Services
  - All other physician services
- Beginning in 2011, each of these categories would have separate conversion factors:
  - The E/M and Preventive Services would be 2 percent
  - All other services would be 1 percent
- Accountable Care Organizations will have their own expenditure targets.

###### Sec. 1122. Misvalued Codes under the Physician Fee Schedule

- HHS will periodically identify services that are potentially misvalued
- HHS will adjust the values of these services.
- HHS will look at the codes which have the fastest growth, which have substantial changes in practice expense, which are associated with technologies or services and have not changed in 3 years. In addition, HHS will look at multiple codes that are frequently billed in conjunction with a single service.

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Sec. 1123. Payments for Efficient Areas

- 5 percent bonus for services furnished in an efficient area.
- An efficient area is a county (or equivalent area) in the lowest fifth percentile of utilization based on per capita spending (in Part A and B).

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI)

- 2 percent incentive payments are extended to 2012
- Feedback must be timely
- An appeals process is simplified
- PQRI reporting can be integrated into E.H.R. reporting

Sec. 1186 Negotiation of Lower Covered Part D Drug Prices on Behalf of Medicare Beneficiaries

- Requires the Secretary to negotiate prices for Part D drugs.

Title I, Subtitle D, Division A, Sec. 138 Information on End of Life Planning

- Requires information to be given to individuals on end-of-life planning, e.g., living wills or powers of attorney.
- Language specifies that patients are not required to make these plans; need not consent to any medical benefit restrictions, and that this cannot hasten death or promote suicide in any way.

**TITLE II – HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS**

Sec. 223 (a) Negotiation of Payment Rates

- Rates under the public plan will be negotiated with providers. (The original language linked payments in the first three years to Medicare + 5 percent, with the Secretary of HHS having the discretion to determine how rates would be set in future years.)

Sec. 242 (a) Equal Treatment of Certain Employed Individuals

- Exempts a greater number of small businesses from pay or play requirements; annual payroll must be greater than \$500,000.

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Secs. 251-253 Health Insurance Cooperatives

- Allows states to establish not-for-profit or cooperative health plans that could compete in the plan.

Sec. 223 (a) Formulary under Public Option

- Adds a formulary for prescription drugs under the public health insurance plan.

Sec. 223 (b) Establishment of a Provider Network

- Providers may opt-out of participating in the public plan.

Sec. 2929 Enrollment in Public Health Insurance Option is Voluntary

- Emphasizes that participation in a public plan is voluntary.

## **TITLE III – PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES AND COORDINATED CARE**

### Sec. 1301. Accountable Care Organization Pilot Program

- The ACO pilot program will test payment incentive models to see if they promote accountability for a patient population and coordinate services under Parts A and B
- The ACO also should encourage investment in infrastructure and redesigned care processes and reward physician practices for the provision of high quality and efficient health care services
- An ACO is a group of physicians or other physician organization model (which can be a hospital) that can receive and distribute the ACO incentive payments and includes “a sufficient number of primary care physicians for the applicable beneficiaries for whose care the group is accountable.
- The ACO will report on quality measures and will provide CMS with data necessary to monitor and evaluate the pilot program.
- The incentive payment models that the ACO may use include:
  - the Performance Target Model, in which the ACO receives an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth.
  - the Partial Capitation Model, in which the ACO would be at financial risk for some, but not all, of the items and services covered under Parts A & B.
  - HHS may propose other payment models if they are designed to meet the goals of improved quality and better efficiency.

### Sec. 1302. Medical Home Pilot Program

- Medical Home Pilot Program is authorized to evaluate the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services to high need beneficiaries and to targeted high need beneficiaries.
- 2 models of medical homes are authorized in the pilot:
  - Independent Patient-Centered Medical Home
  - Community-Based Medical Home
- Nurse practitioners are permitted to lead a patient centered medical home so long as the NP is qualified and state law permits sufficient independent practice
- Physician Assistants (supervised by physicians) are allowed to participate in a patient centered medical home
- Patient Centered Medical Home must provide on-going primary or principal care (i.e., first contact, continuous and comprehensive care); must coordinate care provided by a team; must provide for all of the patient’s health care needs or arrange for appropriate care with other providers for all stages of life; must provide continuous access to care; must provide support for patient self management and coordination with community resources; must integrate information on patients that enables

the practice to treat patients comprehensively and systematically; and must implement evidence based guidelines.

- Primary care is provided by physician or NP who practices in family medicine, general internal medicine, geriatric medicine or pediatric medicine [Note: does not specify general pediatrics]
- Principal care means “integrated, accessible health care that is provided by a physician who is a medical sub-specialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the sub-specialist’s expertise and for whom the sub-specialist assumes care management.”
- HHS will determine the amount of the per-beneficiary per-month fee
- Practices with fewer than 10 physicians will be encouraged to participate in the pilot.
- The Community Based Medical Home is a nonprofit community based or state based organization that provides medical home services, headed by a primary care physician or NP and employing community health workers.
- The pilots will begin within 2 years of the passage of the bill and will extend for up to 5 years.

#### Sec. 1303. Payment Incentive for Selected Primary Care Services

- 5 percent bonus for primary care services (on a monthly or quarterly basis)
- The bonus is 10 percent if these services are provided in primary care shortage area
- The definition of primary care provider for purposes of this bonus payment only is expanded to include physicians or NPs who specialize in obstetrics and gynecology.
- To be eligible for this bonus, the provider must have allowed charges for primary care services that account for at least 50 percent of the provider’s total allowed charges.

### **Title V – MEDICARE GRADUATE MEDICAL EDUCATION**

#### Sec. 1501. Distribution of Unused Residency Positions

- Unused residency slots can be assigned to hospitals that maintain the number of primary care residents and use the extra slots for primary care.

#### Sec. 1502. Increasing Training in Nonprovider Settings

- If the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident is in a non-hospital setting, that time will be counted towards the determinate of FTE
- OIG shall monitor this to determine if there is an increase of time spent by medical residents in training in non-provider settings.
- Demonstration project for Teaching Health Centers makes eligible for GME a teaching health center, which is defined as a non-provider setting (like a FQHC or rural health clinic) that develops and operates an

accredited primary care residency program for which funding would be available if it were operated by a hospital.

Sec. 1503. Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

- If a residency training program in a non-provider setting is primarily engaged in furnishing patient care, time spent by the resident in such a program in non-patient care activities such as didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient) shall be counted in determining FTE.

Sec. 1505. Improving Accountability for Approved Medical Residency Training

- GAO will conduct a study to evaluate the extent to which medical residency training programs are meeting the goals of the GME program and have the appropriate faculty expertise to teach the topics required to achieve these goals.
- The GAO report will include how medical residency training programs could be further encouraged to meet the GME program goals by means such as development of curriculum requirements and assessment of the accreditation process.

Title V, Division C – Pathway for Biosimilars

- This new section allows biologics manufacturers to have 12 years of exclusive use before generics can be developed.

**Title VII – MEDICAID AND CHIP**

**Subtitle A – Medicaid and Health Reform**

Sec. 1701. Eligibility for Individuals with Income below 133-1/3 Percent of the FPL.

- Provides coverage for individuals below 133-1/3% of the Federal Poverty Level (FPL).
  - Eligibility is expanded beyond the traditional Medicaid categories (low-income women and children, the disabled, low-income elderly) to the vaguely-titled “non-traditional individuals” with family income below 133-1/3% FPL.
  - The Federal government would cover the cost of the expansion.

Sec. 1702. Requirements and Special Rules for Certain Medicaid Enrollees and for Medicaid Eligible Individuals Enrolled in a Non-Medicaid Exchange-Participating Health Benefits Plan.

- Requires states to enroll an individual applying for benefits through the National Health Insurance Exchange in Medicaid if determined eligible.

Sec. 1704. Reduction in Medicaid DSH

- Requires review and reform of Medicaid Disproportionate Share Hospital payments.

- DSH payments to states to be reduced beginning in 2016

### **Subtitle B – Prevention**

#### Sec. 1711. Required Coverage of Preventive Services

- Adds to the list of covered preventive services those that are determined to have an “A” or “B” grade from the U.S. Preventive Services Task Force, as well as those vaccines recommended by the Director of the CDC.

#### Sec. 1712. Tobacco Cessation

- Removes tobacco cessation agents from the list of drugs excluded from coverage.

#### Sec. 1714. State Eligibility Option for Family Planning Services

- Allows states, at their choosing, to implement a family planning benefit for Medicaid-eligible individuals. Currently, states must submit a Section 1115 waiver and gain permission from the Secretary of HHS to implement such a benefit.

### **Subtitle C – Access**

#### Sec. 1721. Payments to Primary Care Practitioners

- Fee for Service payments in Medicaid would be increased to the Medicare rates by 2012
  - Only applies to E&M codes as defined under Section 1121 above
  - Preventive services are excluded

#### Sec. 1722. Medical Home Pilot Program

- A state may apply for approval of a medical home pilot project to last for no more than 5 years with a 90-percent federal match for the first 2 years of the program and a 75-percent match for the next 3 years.

#### Sec. 1726 ACO Pilot Program

- Adds an accountable care organization pilot program under Medicaid.

### **Subtitle E – Financing**

#### Sec. 1744. Payments for Graduate Medical Education.

- Creates a definition for, and explicit inclusion of, payment for graduate medical education.
  - Includes both hospital and non-hospital settings.
- States will be required to report how Medicaid GME payments are calculated, the institutions receiving the funds, types and fields of education being supported, workforce or other goals to which the funding

is supplied, and additional information to assist in review of overall health workforce study.

## **DIVISION C – PUBLIC HEALTH AND WORKFORCE DEVELOPMENT**

### **TITLE II – WORKFORCE**

#### **Subtitle A – Primary Care Workforce**

Sec. 2213. Training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics and Physician Assistantship

- Sec. 747 becomes “Primary Care Training and Enhancement” [losing dentistry and adding geriatrics, formerly Section 753 of the Public Health Service Act]
- Purposes of Sec. 747 grants are:
  - to plan, develop, operate or participate in an accredited professional training program, including an accredited residency or internship program in family medicine, general internal medicine, general pediatrics, or geriatrics
  - to provide financial assistance in the form of traineeships and fellowships to medical students, interns, residents or physicians in the above fields
  - to plan, develop, operate or participate in an accredited program for the training of physicians who plan to teach in these fields including in community based settings
  - to provide finance assistance to whose who plan to teach in these fields, and
  - to plan, develop, operate or participate in a program for physician assistant education.

Sec. 2214. Training of Medical Residents in Community-Based Settings

- Sec. 748 authorizes grant or contracts to plan and develop primary care residency training programs in the teaching health centers (THC) in Sec. 1502.
- THC would receive direct GME payments.