AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

September 22, 2009

The Honorable Max Baucus
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Baucus:

On behalf of the 94,600 members of the American Academy of Family Physicians (AAFP), thank you for your tireless and persistent efforts to craft legislation that will improve the health of Americans while helping to reduce costs. Because of the complexity of the health care enterprise, such a laudable goal can be subject to pressure from those who fear change and those whose interests are threatened. But you have said many times that the alternative of the status quo leads to an unsustainable future, and family physicians agree.

In evaluating your legislative proposal, the *America's Healthy Future Act*, we have three principles for reform in mind:

- Effective reform must increase the number of people who are covered by at least basic health insurance, with the ultimate goal being that everyone in the nation is covered.
- To restrain the growth in costs and to improve health care quality, the health delivery system must be based on primary care, and we believe that the best way to achieve this is to allow everyone access to a patient-centered medical home.
- Coverage will be meaningless unless there are a sufficient number of primary care physicians to provide the needed health care, and strong investments in primary care education and training are necessary.

We have found that your proposed legislation, along with the modifications that you have announced today, incorporates major elements of all three provisions. As the Congressional Budget Office has estimated, perhaps as much as 94 percent of Americans (up from the current 83 percent) would eventually be covered because of provisions of your proposal. By eliminating cost sharing for evidence-based preventive care services and by providing a significant Medicare bonus of 10 percent for primary care services, the legislation signals that better access to primary care will pay dividends in better health and reduced cost increases. In addition, the legislation would provide strong signals about the value of education and training in family medicine and other primary care specialties by reallocating residency slots and clarifying

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the rules for training residents in ambulatory care settings. Finally, we support the much-needed insurance reforms in the bill and appreciate the attention to comparative effectiveness research and better coverage for patients in the so-called Part D gap.

Above all, we deeply appreciate your long-standing commitment to address the deepening disparity in payment for primary care physicians in a procedure-based payment system. We support the ten-percent Medicare bonus payment for designated primary care services, and gratefully acknowledge your responsiveness to our request to consider increasing the original amount of 5 percent. We are concerned, however, about the eligibility requirement of providing at least 60 percent of the physician's services in the specified primary care services. We recommend that the eligibility threshold be reduced to no more than 40 percent, to include the primary care physicians to whom this bonus is meant to apply. We also recommend that nurse practitioners and physician assistants would be eligible to receive the bonus directly only when they are operating within the limits of their licenses as determined by state law and that the bonus would be on the current applicable Medicare payment rates for such services when rendered by non-physicians. We also recommend that the budget neutrality requirement be applied to Medicare payments system-wide, since many of the savings achieved by this investment in primary care will be seen in non-physician services (like lower hospital readmissions and providing long-term health care at home rather than in more expensive institutional settings).

We appreciate the proposed legislation's creation of an innovation center in CMS because we share your frustration with the delays and limitations imposed on the agency in the implementation of its current demonstration authority. We agree that the center should consider testing models that promote broad payment and practice reform in primary care. We recommend dropping the limitations that your legislation would seem to impose on CMS in its testing of the patient-centered medical home, which is such a promising practice model. CMS has had authority to demonstrate the model for several years, but has been stymied by shifting requirements and conflicting goals. We suggest that CMS has studied the model sufficiently now to test it rigorously and to implement it if it proves successful in reducing costs and improving health. The agency should have the authority to test it broadly as well as on focused populations of beneficiaries.

As the Committee considers amendments, we offer some additional recommendations for your consideration. First of all, of course, is the need to address the broken Medicare payment formula, the so-called Sustainable Growth Rate (SGR) formula that annually requires Congress to override what it prescribed a decade ago. While the payment models for Medicare are bound to change in the years ahead, especially if health care costs and quality improvements are to be appropriately addressed, the fee-for-service payment system remains in operation. Patients need assurance that their physicians are not going to be forced to decline Medicare patients because the practice cannot sustain itself financially with potentially devastating payment reductions. Congress needs to replace the SGR, but until the new payment system is operational, Congress also should specify more than one year minimum patch. The sustained uncertainty induced by last minute changes to this annual formula is taking a serious toll on the credibility of the Medicare program and patients.

We applauded the President's comments on implementing a much delayed demonstration program that would provide grants to states to test some alternatives to medical liability reform on a limited basis. We encourage the Senate Finance Committee to add provisions to explore ways to reduce the use of defensive medicine and provide better systems of dispute resolution and patient safety. We continue to believe that the evidence shows a cap on non-economic

damages is an effective way to stabilize medical malpractice insurance premiums and has even reduced health care costs overall.

We greatly appreciate the provision in the legislation that would allow for the Board-approved Maintenance of Certification (MOC) program to serve as an eligibility standard for the bonus provided by the Physician Quality Reporting Initiative (PQRI). This allows CMS to devote its limited resources on the implementation of this program and gives physicians more confidence in its purpose and direction. In addition, we support your legislation's direction that CMS be required to provide more timely feedback to participating physicians and that CMS establish an appeals process for those physicians who do not qualify for incentive payments.

However, the legislation now proposes minimal bonuses for those physicians who successfully participate in the PQRI program and larger penalties for those eligible physicians who fail to participate. We do not support such a requirement; it already has proven to be counter productive. The PQRI is not yet an effective quality improvement program. More appropriate quality measures need to be developed and evaluated. CMS needs more testing and practice to determine how best to effectively design, accurately compile and objectively evaluate reports, and provide feedback to the physicians in a timely, dependable and credible way. Penalizing non-participation before CMS has had the experience of effectively managing the program assures that the program will fail to achieve its goals and will increase physician skepticism of its value.

We would like to call your attention to the Medicaid Medical Home demonstration that is authorized by your legislation. We agree with your intention to broaden the availability of this effective and helpful practice model, but would caution strongly against limiting it to chronically ill patients. All Medicaid beneficiaries should be eligible to participate in a medical home. We note that limiting eligibility limits the likelihood that physician practices would be able to devote the resources necessary to transform their practices into a patient-centered medical home. Such a practice model cannot be simply business as usual – the physician's practice team will have to invest considerable time and resources into making the practice a genuine medical home.

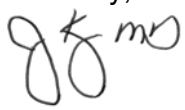
The legislation creates an independent Medicare commission that would have significant authority to reduce Medicare payments to providers if system-wide reduction targets were not met. We generally support the goal of establishing a commission to submit proposals to Congress to extend solvency and improve quality in the Medicare program. We agree that the creation of this commission could help make difficult but necessary changes to Medicare. We would recommend that you consider some improvements to the proposal:

- The commission should have designated representation of primary care physicians and also of Medicare patients. We urge that the proposal be modified to require the appointment of individuals with broad expertise, including at least one seat for a representative of a primary care physician specialty, similar to the requirements that now apply to the Medicare Payment Advisory Commission.
- The commission should be required to conduct its business in a transparent manner with procedures to ensure that stakeholders and the public will have input before it submits its proposals to Congress. We believe that Congress should have the option to simply disapprove of the commission's recommendation without having to pass an alternative with equivalent savings.
- Any changes in payment policies that result from the recommendations from this commission should to be implemented through the normal rulemaking process, just as

HHS is now required to use the rule-making process to implement changes in payment policies enacted by Congress.

Thank you for the thought and work that you and your excellent staff have devoted to this extremely important issue of health care reform. We continue to offer you our assistance as the Finance Committee (and the Senate) work through the many complexities of our vast health care enterprise.

Sincerely,



Jim King, MD, FAAFP
Board Chair