Advocating for Family Medicine

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January 12th, 2010

The Honorable Harry Reid
Office of the Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington DC, 20510

The Honorable Steny Hoyer
Majority Leader
U.S. House of Representatives
Washington DC, 20510

The Honorable Mitch McConnell
Office of the Republican Leader
U.S. Senate
Washington, DC 20510

The Honorable John Boehner
Minority Leader
U.S. House of Representatives
Washington DC, 20510

Dear Majority Leader Reid, Speaker Pelosi, Majority Leader Hoyer, Republican Leader McConnell, and Republican Leader Boehner:

On behalf of the American Academy of Family Physicians and the Council of Academic Family Medicine, we are writing to commend your efforts to date to bring health care reform legislation to fruition. We write to engage you in this last phase of this great undertaking in preparation of enactment of this critical legislation. As you consider the merging of the House and Senate versions of Health Care Reform legislation, we hope you take the following perspective into account.

As we have indicated previously, we greatly appreciate many of the features of both Senate and House versions of this legislation, particularly the provisions to extend health insurance coverage to as much as 94 to 96 percent of the American non-elderly population. This letter contains our views on many provisions that are critical to the development and sustenance of the primary care physician workforce for America.

Below please find our recommendations for final health care reform language on the following subjects:

- Primary care bonus payments
- Primary care extension program
- Equalizing Medicaid payment rates with Medicare payment rates
- Misvalued physician services
- Sustainable growth rate formula
- Patient Centered Medical Home
- Independent Payment Advisory Board

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- Expansion of residency slots
- Teaching Health Centers
- Title VII primary care cluster
- National Health Service Corps
- Primary care student loan programs
- Distribution of unused residency positions and related counting of time in nonhospital settings

Primary Care
We continue to appreciate the Congress's support for primary care. Much of this legislation would improve the value of primary care in the delivery of health care. In particular, we would urge that the final legislation include the creation of a 10-percent bonus payment for primary care physicians. This is a critically important first step toward signaling to medical students that the federal government is committed to investing in primary care.

We have recommended that, as is done in the House bill (Sec. 1303), this bonus payment be made permanent and that it be extended to all Medicare services provided by eligible physicians. In addition, as specified in the House bill, the eligibility threshold should be a more realistic 50 percent of a physician's services in primary care. The Robert Graham Center has estimated that a 60-percent threshold will allow only 59 percent of family physicians to qualify for the bonus, while a 50-percent threshold will allow 69 percent to qualify ("Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges," The Robert Graham Center, May 2009, table 3).

The higher threshold disadvantages physicians in rural and underserved areas who are called on to perform a higher percentage of non-primary care services precisely because of the lack of other providers.

We strongly believe that the final version of this legislation should contain the House provision (Sec. 1721) that will equalize Medicaid payment rates nationally with those of Medicare as they relate to primary care services. This is probably one of the most important steps that Congress can take to support those physicians who currently provide primary care services, increase the likelihood that the poorest patients can find a physician to care for them and encourage medical student choice of primary care specialties.

We also appreciate the creation of the Primary Care Extension Program in the Senate bill (Sec. 5405) and believe this should be included in final legislation. Modeled after the proven USDA agricultural extension program and existing primary care support programs in New Mexico, North Carolina, and Oklahoma, this program would link primary care practices to communicate best practice information with each other. Doing so will help improve the health of the nation by making improvements in areas such as chronic disease management, coordination of care, and other common issues that primary care physicians face on a daily basis. Use of this important information and providing support to physician practices will help modernize our healthcare system and provide medical homes for all of the new patients covered under health reform.

Misvalued Physician Services
We believe that the increased authority for CMS to identify misvalued physician services and make appropriate adjustments to the relative value of those services is appropriate and needed. Both the House and Senate versions contain language to give CMS and the Secretary more authority over setting these values, but we believe the Senate provision is the stronger one (Sec. 3134).

Sustainable Growth Rate Formula
We are encouraged by the passage of a permanent fix to this longstanding problem in the House of Representatives, and we know that the Senate understands the need for a resolution to this issue. We encourage you to either include a provision in this legislation, or enact separate legislation before the February 28, 2010 deadline established by the extension of the 2009 SGR, to solve this problem permanently and in a manner favorable to primary care as in the House proposal.

Patient Centered Medical Home
The support in both the House and Senate bills for the Patient Centered Medical Home is welcome. The model is one built on primary care as a basis for a more effective and more efficient system for delivering health care. It is not just a chronic disease management system, but rather a major transformation in how primary care physicians, leading a team of health care professionals and community service providers, can give patients health care that will prevent disease as well as manage and treat the disease that occurs.

While the House bill has been changed to remove limitations on the patient population eligible for participation in the Community-based Medical Home Model (Sec. 1302), other provisions in both bills would continue to limit the patient's eligibility. Such limitations may jeopardize the validity of the demonstrations. We have several concerns with these limitations.

In the first place, there are enormous practical and ethical problems with physicians providing different standards of care to portions of a practice's patient population. Therefore, those practices that participate in a medical home demonstration will offer the same care to all of their patients. However, the legislation may specify too few individuals to justify the effort and expense that a physician practice must accept if it is to transform itself into a Patient Centered Medical Home. As a result, too few practices may be able to participate.

In addition, the medical home is particularly effective in providing the prevention and wellness health care that much of the legislation attempts to promote. We believe that the medical home is especially helpful in preventing chronic diseases, as well as managing the chronic diseases that do emerge. But the demonstrations are designed to test only half of the model's real potential. We would strongly recommend the elimination of the limitations on the medical home demonstrations in both Medicare and Medicaid, so that physicians can provide the best possible care to all of their patients.

Nevertheless, we do appreciate the Senate provision (Sec. 1301, Treatment of Qualified Direct Primary Care Medical Home), which allows the Secretary to allow plans to provide coverage through a qualified primary care medical home in the new Exchange.

Independent Payment Advisory Board
The final Senate bill language (Sec. 10320) renames the Independent Medicare Advisory Board (IMAB) as the Independent Payment Advisory Board. We note this expanded section requires the Board to make annual recommendations to all entities on improving quality and reducing the rate of cost; does not allow the reduction of premium support for beneficiaries; and in 2020, and requires the Board to make *binding* recommendations to Congress if overall health spending is greater than Medicare spending.

It still appears that major segments of the health care system, like the nation's hospitals, are exempt from the scope of the Board's recommendations in the bill that the Senate approved. We strongly object to this exclusion of certain segments of the health care system in this manner and urge that the Board's oversight be inclusive of all segments of the health care system.

In addition, we continue to believe that membership on the IPAB should specifically include a qualified primary care physician and a representative of the consumer community. We also believe it is essential for the recommendations of the Board to be subject to a public comment period before its decisions become final and before Congress is required to act on them.

Workforce Development
We appreciate the efforts of both the House and Senate to look at new ways of addressing workforce issues. One issue that seems to still be in play, although there is no provision in either bill, is the question of expansion of residency positions. As we have noted before in other communications, we are pleased that bill language to expand residency slots by fifteen thousand (or even some number less than that) was not included in the final versions of either bill. We are not opposed to carefully planned increases in residency positions, but we feel they must follow certain principles – ones that are aimed at creating a better health care system for our nation by increasing the ratio of primary care to non-primary care physicians, not expanding the physician workforce beyond our country's needs,

and ensuring that the nation is getting the type and quantity of providers that will help increase access to medical care, increase quality of care for all Americans, and help bend the cost curve. We need true reform in graduate medical education and not a continuation of the status quo. The language currently in discussion (most recently considered as Senate Amendment 2909) does not meet those principles. We have offered suggestions for revising that language, but they were not accepted. Although it is important that the language of any GME legislation, for example, move us toward our goals, it is even more important that all of the proposed health reform legislation ultimately creates a better healthcare system for our nation. We appreciate previous decisions made to leave this expansion out of the final health care reform legislation, and believe those decisions were correct.

There is another innovation created by both the House and Senate that could be a valuable mechanism to test effective training methods for primary care residents. The Teaching Health Center provisions are aimed at modernizing funding for the training of primary care residents in non-hospital settings, like Community Health Centers, where most primary care is delivered. We continue to urge Congress to allow Medicare Graduate Medical Education payments (Direct and Indirect) to be used for training and to be directed to non-hospital entities. By limiting such funding to only Direct Medical Education dollars (as in the House demonstration project) and to utilize a grant or appropriations mechanism (as included in both House and Senate versions) rather than Medicare GME, primary care training is once again given short-shrift when compared to other specialty training. However, it is imperative that the funding for Teaching Health Centers not be drawn from the funds that support Title VII Health Professions Grants, which is the only federal program that supports the education and training of primary care students and residents, and is a linchpin in developing primary care physicians. We strongly urge the final legislation to adequately fund both programs rather than pit them against each other.

Each bill includes language that would reauthorize the current Title VII primary care cluster (Senate Sec. 5301; House Sec. 2213) The House version, however, includes a mandatory funding mechanism, (Sec. 2216), that we believe is critical for the development of primary care training over the next several years. We ask your support for including this mechanism and funding level in the final legislation.

Several items that support the development of the primary care workforce are included in each bill and we endorse them, including: the increased funding for the National Health Service Corps' scholarship and loan repayment program (Senate Sections 5207 and 10503; House Sections 124, 2201, and 2202); the distribution of unused residency positions to primary care and general surgery, (Senate Section 5503; House Section 1501), the retention of residency positions from closed hospitals, (Senate Sec. 5506; House Sec. 1504), and language to clarify to CMS what constitutes appropriate training in the non-hospital setting (Senate Sections 5504 and 5505; House Sections 1502 and 1503).

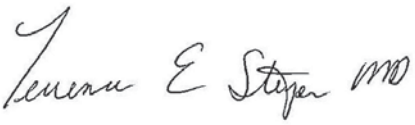
We support the inclusion of several provisions in the Senate bill including: the improvement of the primary care student loan program, which is much stronger in the Senate version (Senate Sec. 5201; House Sec. 2212), the establishment of competitive grants to medical schools for the development of curricula that integrate quality improvement and patient safety in clinical education (Section 3508); establishment of a grant program to help entities recruit students most likely to practice medicine in underserved rural communities, provide rural-focused training and experience, and increase the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities (Section 5606), and the creation of a health professionals' state loan repayment tax relief (Sec. 10908), which would assist students going into underserved or health professional shortage areas to repay their loans.

In addition, we are very supportive of the creation of a national health care workforce commission, language of which is included in both bills. We support the inclusion of language from the Senate bill (Sec. 5105) which adds an "analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation'' as a high-priority area for the Commission. We believe the advice from the commission on needed numbers and make-up of the physician and non-physician workforce is critical to help Congress make determinations regarding the funding of residency positions. The make-up of the commission in the final legislation is critically important, and we ask that you ensure the inclusion of primary care and family medicine physicians on the commission.

Additional Needed Improvements
We would note that the legislation still could be improved by adding some provisions that have that have been discussed separately, but are not included in either bill. For example, we recommend that CMS be given authority to pilot test the use of Graduate Medical Education funds for direct support of primary care residencies to find out if there are better methods of supporting the teaching primary care physicians. We continue to believe that Congress must come to grips with reforming the manner in which primary care training is funded so that the responsibility for such training resides with the community and program, rather than the hospital.

Once again, family physicians commend you and your colleagues in the House and Senate for the many months of deliberations and extensive work that have gone into the development of this legislation. The nation cannot continue with the expensive and wasteful health care system that we currently endure. It harms patients and it misspends scarce health care dollars. We greatly appreciate your legislation steering the nation toward a more patient-friendly, primary care based health system; we are convinced such a change will make health care in the U.S. stronger, more effective and more efficient. And we will continue to offer you and your legislators our assistance in passing legislation that will accomplish these important goals.

Sincerely,



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