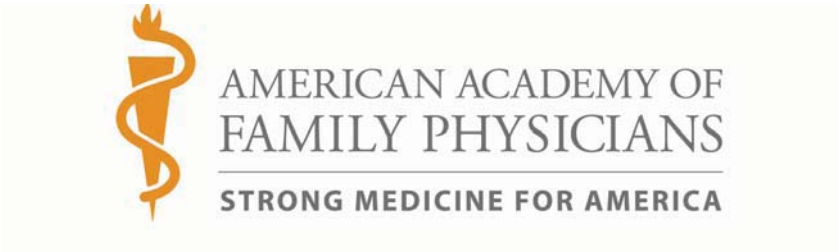


December 22, 2009

The Honorable Harry Reid
Office of the Majority Leader
U.S. Senate
S-221 Capitol Building
Washington, DC 20510

Dear Senator Reid:

On behalf of the 94,600 members of the American Academy of Family Physicians, thank you for your long-term commitment to health reform in the United States, and for introducing the Manager's Amendment to the *Patient Protection and Affordable Care Act*. This Amendment is generally a positive addition to major legislation that is the result of a great deal of work by the US Senate and its excellent staff.

As we indicated in an earlier letter, we greatly appreciate several features of this legislation, especially the provisions to extend health insurance coverage to as much as 94 percent of the American non-elderly population. Extending coverage to as many people as possible is a basic provision of AAFP's Health Care for All policy and it is an essential part of health reform. In addition, we applaud the legislation's much-needed reforms of the health insurance market, including the requirement for guaranteed issue and renewability; the prohibition on lifetime and annual limits; the extension of dependant coverage to age 26; and the prohibition of waiting periods longer than 90 days.

**Primary Care**
We continue to appreciate the legislation's recognition of the value of primary care with the creation of a 10 percent bonus payment for five years for physicians whose health care services are more than 60 percent primary care (Sec. 5501). This is a critically important step toward signaling to medical students that the federal government is committed to investing in primary care. As we have noted in previous communications, this provision should be strengthened if it is going to accomplish the task of encouraging more talented medical students to choose the primary care specialties.

We have recommended that the bonus payment be made permanent and that it be extended to all Medicare services provided by eligible physicians. In addition, 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).



2021 Massachusetts Ave., N.W. • Washington, DC 20036-1011 • 888.794.7481 • 202.232.9033 • Fax: 202.232.9044 • capitol@aafp.org

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 Senate should 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 and encourage medical student choice of primary care specialties.

The AAFP also appreciates the creation of the Primary Care Extension Program (Sec. 5405), as originally proposed by Kevin Grumbach, MD, a family physician in California We support the changes made to this program since it specifies a primary care department (Section 10501).. And 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 (Sec. 3134).

The AAFP appreciates the new section, S 2719A, Patient Protections in the Manager's Amendment, which allows beneficiaries, enrollees or patients to select their own primary care provider.

**Sustainable Growth Rate Formula**

We note that the Manager's Amendment no longer includes a temporary 0.5 percent increase in Medicare physician payment for 2010 (Section 10310). We know that the Senate understands that family physicians, and indeed all physicians, support a permanent fix to this long-term problem and strongly urge and expect the Senate to address this issue before the February 28, 2010 deadline established by the provisions of the extension of the 2009 SGR. Continued delay only makes fixing the formula more costly.

We also observe that Section 10501 removes the budget neutrality adjustment that would have offset half of the cost of the bonus payments for primary care and general surgery and are pleased with this change. However, we believe that the better use of primary care physicians will generate savings in all parts of Medicare and those savings ought to support the primary care physician payment.

**Patient Centered Medical Home**

We continue to appreciate the specific authority for Medicaid medical home demonstrations (Sec. 2703) and we believe the Center for Innovation at CMS will be a useful forum to test the medical home model in Medicare (Sec. 3021). However, both provisions are too limited and may jeopardize the validity of the demonstrations. The Medicaid demonstration is limited to "patients with chronic conditions" and the language of the Medicare Innovation Center gives preference to demonstrations of medical homes for "high-need applicable individuals." 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 their 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 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 new Section 10104, 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.

In addition, the Manager's Amendment establishes a new Section 10333, which provides grants to networks to coordinate care for low-income populations, including obtaining a primary care provider or medical home.

**Independent Payment Advisory Board**
The Manager's Amendment 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 Manager's Amendment. While the time for this exemption has been reduced to four years, we strongly object to this exclusion of certain segments of the health care system in this manner and urge ensuring that the Board's oversight is 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.

**Quality Improvement**
We continue to appreciate the legislation delaying the effective dates for payment reductions for physicians who do not report quality measures under CMS's Physician Quality Reporting Initiative (PQRI). While we support the use of evidence based performance measures to improve the quality and cost efficiency of care, we strongly recommend against the use of penalties to mandate participation. We should be supporting a culture of improvement in health care quality and not a system of penalties which burden individual physicians. This is particularly the case for the PQRI, since CMS, for reasons sometimes beyond its control, has not yet in our view been able to demonstrate that it can manage this program successfully.

We observe that the new section 10327 provides for "an additional 0.5 percent Medicare payment bonus to physicians who report quality measures to CMS via a qualified maintenance of certification program." This section is for years 2011-2014. Unfortunately, this amount still is financially inadequate. Physicians need an incentive that is sufficient to compensate practices for the cost of participating in the program.

We also note the new section 10331, which requires public reporting of performance information. The Secretary must establish a "Physician Compare" website through which beneficiaries may compare physician quality and patient satisfaction. The section allows physicians to have a "reasonable" opportunity to review his or her results before they are posted and provides feedback to the physician. While the Manager's Amendment begins this program in 2013, we believe that the first year should not include public reporting. Specifically, physicians should have a year to understand the new system and be able to make practice changes before public reporting via website goes into effect.

This section also establishes a pilot program, beginning in 2019, that will provide financial incentives to beneficiaries who choose high quality physicians as determined by the above factors. The Manager's Amendment also includes a new section 10332, which allows Medicare claims data to be released to measure provider performance.

We are concerned with the addition of this section since claims data are not related to quality. While we understand the movement to performance reporting, we want to ensure that public reporting should not be done until the accuracy of the information is assured.

**Workforce Development**

There is another innovation created by the legislation that could be a valuable mechanism to test effective training methods for primary care residents. The Teaching Health Center is a program to train primary care residents in non-hospital settings, like Community Health Centers, where most primary care is delivered (Sec. 5508). 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.

Your legislation includes several items that support the development of the primary care workforce, including the establishment of competitive grants to medical schools for the development of curricula that integrate quality improvement and patient safety in clinical education (Sec. 3508); creation of the national health care workforce commission (Sec. 5101); the improvement of the primary care student loan program (Sec. 5201); the increased funding for the National Health Service Corps' scholarship and loan repayment program (Sec. 5207); the reauthorization of Section 747 of Title VII training in family medicine program (Sec. 5301); and the distribution of unused residency positions to primary care (Sec. 5503). We appreciate these measures and would encourage increased funding for all of them.

We also appreciate the new language in the Manager's Amendment, Section 10501, the Workforce Commission, 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 also support language in Section 10501, which establishes a grant program to help entities "recruit students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities."

We support Section 10908, health professionals' state loan repayment tax relief, which would assist students going into underserved or health professional shortage areas to repay their loans.

**Medical Liability**

We appreciate the new Sections 10607 – 10608, State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation and Extension of Medical Malpractice Coverage to Free Clinics. We are very pleased that this extensive new section provides the states with grants to experiment with alternative dispute resolution systems. We also support the extension of medical liability coverage to free clinics.

**Additional Needed Improvements**

We would note that the legislation still could be improved by adding some provisions that have been dropped, or that have been suggested by the House, or that have been discussed separately. 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 teaching primary care physicians. The AAFP also believes the Senate should reinstate the student loan deferment program known as the 20/220 pathway.

We believe Congress should finally eliminate the anti-trust exemptions enjoyed by the health insurance plans. These exemptions give the insurance companies unfair advantages in negotiating rates with physicians and in coverage decisions for patients.

**Other Positive Additions to the Manager's Amendment:**
There are many other provisions to the Manager's Amendment that will improve the quality and efficiency of health care and we commend the Senate for including them. In particular, we would support the fact that the legislation:

- Requires health insurers to spend more of their premiums on clinical services, and permits plans to remain in the Exchange only if they do not greatly increase their premium costs.
- Bans pre-existing exclusions for children.
- Requires plans to establish an internal appeals process for coverage denials.
- Requires the Office of Personnel Management to evaluate and approve at least two non-profit, multi-state health plans to be offered on the state exchanges.
- Increases the federal share of the trust fund to cover basic health plans for non-Medicaid eligible individuals from 85 percent to 95 percent, while making the program available to legal immigrants with incomes below 133 percent of the Federal Poverty Level. Strengthens the bill's provisions allowing former foster children to enroll in Medicaid.
- Extends and improves funding for the Children's Health Insurance Program, while ensuring that alternative plans for children's coverage offered on the exchanges meet quality and cost standards.
- Requires the Secretary of Health and Human Services to develop new regulations to improve public notice and input on proposed Section 1115 waivers.
- Indicates that beneficiaries do not have to pay coinsurance for preventive services.
- Establishes a floor of 1.0 for practice expense in frontier areas.

Once again, family physicians commend you and your colleagues in the 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 fellow Senators our assistance in passing legislation that will accomplish these important goals.

Sincerely,

Ted Epperly MD

Ted Epperly, MD, FAAFP
Board Chair