AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

December 2, 2009

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

Dear Senator:

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 *Patient Protection and Affordable Care Act*. This is a major piece of legislation that is the result of a great deal of work by you and your excellent staff, and of the Finance and HELP Committees.

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. We also note that the provision of the government health plan (the "public option") requires HHS to negotiate payment rates with physicians as any health plan does, and that physician and patient participation is voluntary (Sec. 1323).

Primary Care

We certainly 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 an important step toward signaling to medical students that of the nation is committed to investing in primary care. As we have noted in previous communications with the Senate Finance Committee, this provision should be strengthened if it is going to accomplish the task of encouraging more talented medical student 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). The higher threshold disadvantages physicians in rural and underserved

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areas who are called on to perform a higher percentage of non-primary care services precisely because of the lack of other providers.

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. 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).

Sustainable Growth Rate Formula

While there are many other provisions of the *Patient Protection and Affordable Care Act* that are commendable, there are a few of the major features of the bill that we would suggest need some improvements. For example, we appreciate the legislation's acknowledgment of the unacceptability of the pending 21-percent reduction in physician payments due to the past actions of Congress which have failed to address the flawed Sustainable Growth Rate (SGR) formula. However, this legislation misses an important opportunity to finally fix the formula. We strongly encourage the Senate to discard this decade-old formula that generates an ever-growing deficit. Continued delay only makes fixing the formula more costly.

Patient Centered Medical Home

We also 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.

Independent Medicare Advisory Board

The legislation creates an Independent Medicare Advisory Board (IMAB), which we believe has the potential to become a useful mechanism to address health system costs (Sec. 3403). But it cannot do so if major segments of the health care system, like the nation's hospitals, are exempt from the scope of the IMAB's recommendations. We strongly object to this exclusion of certain segments of the health care system in this manner and urge the Senate to change the legislation to ensure that the IMAB oversight is inclusive of all segments of the health care system.

In addition, we continue to believe that membership on the IMAB 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 IMAB 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 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 has not yet in our view been able to demonstrate that it can manage this program successfully.

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 Senate 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.

Additional Improvements
We would note that the legislation 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 recommend elimination of cost-sharing for preventive health services and strongly believe that the Senate should equalize Medicaid payment rates nationally with those of Medicare as they relate to primary care services. 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.

Finally, the health reform legislation should address the medical liability system in this country. At a minimum, Congress should provide sufficient funding for states to experiment with alternative dispute resolution systems.

Once again, family physicians commend you and your colleagues in the Senate for the many months of deliberations and hard bargaining 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