AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

July 16, 2009

The Honorable Henry Waxman
Chairman
House Energy & Commerce Committee
Washington, D.C. 20515

The Honorable Charles Rangel
Chairman
House Ways & Means Committee
Washington, D.C. 20515

The Honorable George Miller
Chairman
House Education and Labor Committee
Washington, D.C. 20515

Dear Chairmen:

On behalf of the 94,600 members of the American Academy of Family Physicians, thank you for the positive steps you have taken toward broader, affordable coverage that will mean improved health care based on primary care. We believe that the *America's Affordable Health Choices Act* (H.R. 3200) will make significant progress toward payment and delivery system reforms and contribute to building a primary care workforce for the future. AAFP supports this legislation and we will be pleased to work with your committees to improve it further.

I would like to highlight several provisions of the legislation that family medicine feels will genuinely support primary care in an improved health care system, and I would like to recommend some additional improvements.

- **Health Insurance Reforms:** The bill will provide our patients with a wide range of insurance options, including that of maintaining their current health plan. AAFP supports the bill's proposals to reform the insurance industry so that coverage must include people who have pre-existing conditions or who develop an illness while insured. Family medicine agrees with the bill's assurance of parity in benefits for mental health and substance abuse disorders and the inclusion of genetic non-discrimination laws. We support sliding scale tax credits, coverage of evidence-based preventive services with no cost-sharing, and expansion of Medicaid to cover the poor.

- **Public Plan Option:** As Dr. Ted Epperly, AAFP President, stated in his testimony to the Ways and Means Committee and to the Health Subcommittee of the Energy and

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- Commerce Committee, the AAFP supports a public plan option that is consistent with the following principles:
    - The plan recognizes the value of, and promotes primary care, including through adoption of the Patient-Centered Medical Home (PCMH).
    - The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.
    - The public plan cannot be Medicare.
    - The new public plan must be actuarially sound.
    - The public plan cannot leverage Medicare (or any other public program) to force providers to participate.
    - The public plan should not be required to use Medicare-like payment methods permanently.
    - The insurance market rules and regulations governing the public plan must be the same as those governing private plans.
    - The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace.
    - Public and private insurers should be required to adhere to the same rules regarding reserve funds.
    - The public plan would also need to contribute to value-based initiatives that benefit all payers.

  The public plan option developed by your committees reflects most of these principles very well. While the AAFP has concern about tying the plan's payment rates to Medicare, as Dr. Epperly testified, we appreciate that this link is limited to 3 years and includes a 5-percent incentive payment. We understand that the provision that allows physicians to opt-out of the public plan without penalty makes participation voluntary, but we would recommend that this be as administratively simple as possible.

  We also support the variety of payment mechanisms that can be employed by the public plan; in particular, the patient-centered medical home (PCMH) and care management models. In addition, we agree with the emphasis on care that improves health outcomes; decreases health disparities; addresses geographic variations; prevents or manages chronic illness and is integrated and patient-centered.

  We also believe that the public plan should be able to use innovative payment models to support patient-centered primary care, and appreciate the reference in the bill to medical homes as being among the new payment and delivery models that the public plan should consider adopting. We look forward to continued dialogue on the design of the public plan option.

- **Medicaid**: HR 3200 contains a number of enhancements which the AAFP supports. These include expanded coverage for low-income Americans, payment parity with Medicare, expanded coverage of preventive services and a provision for Medicaid payments for graduate medical education.

  Primary Care Payment: The AAFP supports the proposal to raise primary care payment rates to parity with Medicare rates by 2012. However, we are disappointed that the parity provision specifically excludes the preventive services listed in section 1848(j)(5)(A)(ii). Preventive services are the backbone of quality, evidence-based and

cost-effective primary care and we would recommend that Congress include these services for equal payment.

Medical Home Pilot Program: We are pleased that the legislation includes a medical home pilot program for Medicaid. The provision will allow additional states to implement pilots, while not pre-empting those already in place.

Expanded Coverage: We are pleased that the bill provides coverage for most all Americans below 133.33 percent of FPL with the federal government paying for the expansion. We appreciate that the bill improves federal financial participation in territorial Medicaid programs and extends Transitional Medical Assistance for two years.

Preventive Care: The AAFP supports the proposal to require preventive services such as coverage of services graded "A" and "B" by the US Preventive Services Task Force, CDC-recommended vaccines, and FDA-approved tobacco cessation drugs.

Graduate Medical Education: We agree with the proposal to protect Medicaid payments for graduate medical education and commend the recognition of the key role Medicaid, like Medicare, plays in preparing physicians for practice.

- **Workforce:** The bill would establish a national health workforce policy to help set goals and policies to achieve a sufficient and optimal number and distribution of physicians and other clinicians.

  We support including policies to increase the number of physicians in family medicine, general internal medicine, general pediatrics and geriatrics, including increased funding from a dedicated trust fund. We also are pleased that the legislation reauthorizes Title VII, section 747 Training in Primary Care Medicine. We support policies to facilitate increased training in office-based primary care practices. We also agree on the need to increase GME training positions for primary care specialties.

  Teaching Health Centers: We support the development and operation of Teaching Health Centers but recommend that these important new training entities be funded with Medicare GME dollars rather than with variable grant funding under Title VII. It is vital that the Medicare meet the training and patient care needs of the 21st century by supporting sustained funding of such training as strongly as Medicare supports non-primary care training.

  Training centered in community-based ambulatory care sites must be the future of primary care. Innovations in service delivery, such as the Patient-Centered Medical Home, require reform of and innovation in training. In this rapidly changing health care environment, the Teaching Health Center, whether sponsored by a community health center, a Family Medicine Center, or another community-based site, is an innovation that will produce primary care physicians who are essential to help meet the patient care needs of our nation.

  We suggest that the legislation include a provision to restore the economic hardship deferment for medical students known as the "20/220 pathway." The language of the *Medical Economic Deferment for Students (MEDS) Act* (HR 1615) provides for this important debt relief.

- **Payment and delivery system reforms:** HR 3200 makes several changes to how health care would be delivered and the AAFP appreciates the broad effort to improve the position of and reliance on primary care in that delivery system. The legislation frequently demonstrates recognition of the value of primary care as the foundation for health care reform. It is our strong contention that investment in primary care will yield not only better health for everyone, but also more efficiencies, less waste and less duplication.

  Sustainable Growth Rate: We are very pleased that the bill would eliminate the accumulated Medicare SGR payment cuts, provide a new framework for future updates that allow for spending on physician services to increase at a rate greater than GDP, and create a higher spending baseline target for evaluation and management and preventive services, including those associated with primary care.

  Primary Care Bonus: We appreciate the legislation increasing Medicare payments by 5 percent for designated services provided by primary care physicians and we also support the bill's increase in payments by 10 percent in primary care physician shortage areas. However, the language in H.R. 3200 changes the definition of "primary care services" from the language in the draft bill in a way that could exclude many primary care physicians from being eligible for the bonus. We recommend that the eligibility criteria be modified to ensure that they incorporate the services typically provided by family physicians and other primary care physicians, and we will be happy to work with you on this.

  We also are concerned about the expansion of the definition of physicians who are considered primary care providers solely for the purposes of this bonus, and we would recommend returning to the original definition (with the addition of the broader primary care services noted above). As Dr. Marc Rivo and others have shown (see "Defining the Generalist Physician's Training," *JAMA* 19, May 18, 1994), family medicine, internal medicine, and pediatrics – along with geriatrics – are the only specialties that prepare residents and physicians in the broad competencies necessary for primary care practice.

  Increased Primary Care Bonus: AAFP, the American College of Physicians and the American Osteopathic Association – the three organizations that represent most of the physicians who treat Medicare patients – have written to you earlier to request that the committees increase the primary care bonus to at least 10 percent. The goal of this bonus payment is to signal to medical students that an effective and efficient health care system depends on an adequate number of primary care physicians to provide the vast majority of health care services. The primary care physicians believe that a 5-percent incentive is insufficient to send that signal.

  Patient-Centered Medical Home Pilot: We also support the dedicated funding that is provided to pilot-test, on a national scale, payment of physicians for care coordination in a qualified Patient-Centered Medical Home. However, we have a serious concern with the limitation of eligibility to high-need beneficiaries, who represent the top 50th percentile of costs. We recommend that Congress adopt a more inclusive eligibility threshold, such as the current Medicare medical home demonstration criterion for eligibility which is based on patients with one or more chronic conditions.

  Accountable Care Organizations: The legislation includes authorization for an alternative payment model within fee-for-service Medicare to reward physician-led

organizations that take responsibility for the costs and quality of care received by their patients over time. This model, called an Accountable Care Organization (ACO), has promise for some larger practices that have access to a broad array of health care and community resources, but may be problematic for solo and small practices that are often in rural and underserved areas with few of these resources. We recommend that Congress consider assistance to such practices as part of the demonstration programs.

Primary Care Extension Programs: We are pleased that the legislation would provide funding for community-based groups that have the capabilities and relationship with qualified PCMHs to provide care management, patient education, and disease management, similar to the North Carolina Medicaid program. We urge Congress to expand this concept to fund primary care extension programs, which would provide primary care practices with a wide range of support services relating to education, practice transformation, and sharing of best practices. (See Kevin Grumbach, MD and James Mold, MD, "A Health Care Cooperative Extension Service – Transforming Primary Care and Community Health," *JAMA* 301, June 24, 2009, p. 2589.)

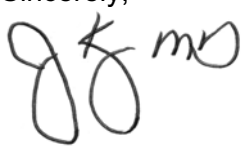
Comparative Effectiveness Research: The AAFP strongly supports the proposal to fund independent, transparent and evidence-based research on the comparative effectiveness of different treatments to inform physician-patient decision-making. We believe that such research will lead to better care for patients, not denials of needed care. We also are pleased by provisions in the bill to simplify and reduce the costs associated with interactions with health plans.

Physician Payments Sunshine Provision: The AAFP has reviewed this section and would like clarification on some of the Continuing Medical Education (CME) sections. Not only are we committed to supporting CME for physicians to continue to study, advance scientific knowledge and maintain a commitment to medical education, but we also adhere to all relevant standards. We are unclear as to whether the reporting requirements also apply to sponsoring organizations, such as ours, who produce what is referred to as Certified CME.

In summary, we are pleased that *America's Affordable Health Choices Act* includes policies on coverage, workforce, payment and delivery system reform, primary care, comparative effectiveness research, and administrative simplification that are strongly supported by family physicians. We will continue to be a resource for you as this bill proceeds through your legislative deliberations in the weeks ahead.

We are committed to assisting Congress in the effort to ensure that all Americans have access to affordable choices for health care provided by a family physician. *America's Affordable Health Choices Act* will go a long way toward achieving this.

Sincerely,



Jim King, MD, FAAFP
Board Chair