AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Submitted to the HELP Committee

Regarding

Health Insurance Exchanges and Ongoing State Implementation of the Patient Protection and Affordable Care Act

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American Academy of Family Physicians (AAFP), representing 97,600 members nationwide, is pleased to submit this statement for the record to the Senate HELP Committee regarding the first year of the *Affordable Care Act* (ACA). The AAFP supported this legislation for many reasons, not the least of which is its goal of achieving health coverage for nearly everyone in this country. In addition, the ACA implemented numerous strategies for improving health care delivery and making affordable, high-quality care more available.

Background

Members of the AAFP have a great deal of experience in delivering health care: family physicians treat one out of four patients in the U.S. In fact, more than 215 million office visits are made to family physicians each year; 59 million more than any other medical specialty.

Family medicine is dedicated to treating the whole person, providing preventive care, coordinating care for multiple illnesses, promoting mental health and supporting better health behavior. Because of their focus on prevention and care coordination, family physicians help prevent many illnesses, treat early those illnesses that do occur and, when necessary, refer patients to the right specialist and advocate for them in this fragmented and complex health care system.

As the only medical specialty society devoted entirely to primary care, the AAFP is engaged in virtually all health care issues, including health care coverage, cost and quality, Medicare, Medicaid and CHIP, health information technology, funding for family medicine training, graduate medical education, the affordability, availability and safety of prescription drugs, primary care research and medical liability reform.

Family physicians have long worked with policy makers from both sides of the political aisle to advance health care policies that promote primary care. We are committed to continuing this work with the 112th Congress. Since Congress is focused on either repealing, replacing or maintaining the *Affordable Care Act*, below are our comprehensive comments regarding all aspects of the law. The first section will refer to issues under the jurisdiction of the committee, but we also will include portions that refer to other primary care issues in the health law.

Reliable, High Quality and Affordable Coverage

For over 20 years, AAFP has been working to broaden health insurance coverage as the first step toward assuring that everyone has timely and effective access to the health care services they need. As the *Affordable Care Act* evolved over the two years it was debated, we were encouraged that several of the provisions of our *Health Care for All* policy remained in the various drafts of the legislation. For example, we supported building on the current employer-based system of providing coverage, while improving the insurance market to create better access to coverage for small businesses and individuals who are neglected in the current market. In our view, this always has included protecting insured individuals from losing coverage or being singled out for premium increases due to changes in health status, so that families with insurance are able to keep it. As long as these broad insurance reforms are part of a private market, a requirement for personal responsibility is probably necessary to avoid the problem of individuals waiting to buy insurance until health care costs arise.

As part of the personal responsibility requirements, we have recommended subsidies or other mechanisms that will help low-income or high-risk individuals with the cost of coverage. We have agreed that subsidies also should be available for small businesses to enable them to offer health insurance to their employees. Finally, we have supported the rights of all consumers to be provided with adequate and comparable information that will enable them to choose the

health insurance product that best meets their needs. Each of these important reforms is included in the *Affordable Care Act*.

High Quality, Efficient Delivery System
System reforms must empower physicians to improve health care quality and effectively use finite resources. Quality measurement programs simply cannot identify and penalize physicians and other providers whose results appear to fall below the top level of performance. Such programs will not yield the system-wide improvements needed to assure high-quality health care for all patients.

The AAFP supports the ACA's Patient Centered Outcomes Research Institute for clinical comparative effectiveness research. The new institute will provide physicians and patients with useful information about various diagnostic tools and treatment options, and we strongly believe that such research will contribute to better individual health care decisions.

Family physicians provide care to individuals throughout their lives, including patients with numerous chronic illnesses. As a result of this broad scope of practice, it is not surprising that our members deal constantly with gaps in medical knowledge. As practicing family physicians, our members may feel as though they spend more time "practicing in the gaps," than practicing medicine that is supported by randomized clinical trials.

Given the complexities of clinical care and the multitude of treatment options available for many conditions, as a nation, we cannot expect, afford or in many cases ethically conduct, all the randomized clinical trials that would be needed to fill in the existing gaps in knowledge. As a result of this practical consideration, the AAFP is a strong supporter of ongoing development and support of comparative effectiveness research.

The AAFP also supports efforts in the ACA to expand and accelerate the development of meaningful quality measures and reliable data sources to build an evidence base for high-quality care. Broad adoption of truly connected and interoperable health information systems will help achieve quality improvement goals, but we need to continue to invest to develop an infrastructure to support this plan. Infrastructure needs are particularly acute in smaller physician practices.

Increased Focus on Wellness and Prevention
The ACA created an important innovation in health care with the establishment of the Prevention and Public Health Trust Fund. The basic goal understanding of this fund is that improvements in the overall health status in the nation will serve to rein in costs and improve productivity. This fund also is supplemented with an investment in research to fill gaps in knowledge about the most effective health promotion strategies. These sorts of public investments are needed in education, community projects, and other initiatives that promote healthy lifestyles. As decisions are made about this program, AAFP believes that special emphasis should be placed on collecting data and developing strategies to eliminate regional, racial, ethnic, and gender health disparities. In addition, public investments and insurance plans also should support early access to care for mental health and substance abuse disorders.

Primary Care Workforce
The ACA made a significant step toward effective understanding of our health care workforce requirements by establishing the National Health Care Workforce Commission to:

- Disseminate information on promising health care professional retention practices;

- Communicate information on policies and practices that impact recruitment, education and training, and retention of the health care workforce;
- Work with federal, state and local agencies to review current and projected health care workforce supply and demand and make recommendations to Congress and the Administration regarding health care workforce priorities, goals and policies;
- Perform duties, including conducting reviews, making reports, making recommendations, conducting assessments and data collection and dissemination activities, related to the State Health Care Workforce Development Grant program;
- Study effective methods for financing education and training for health care careers;

Beginning in 2011, the Commission must submit to Congress and the Administration by October 1 of each year a report containing the results of reviews and recommendations concerning related policies. Beginning in 2011, the Commission must submit to Congress and the Administration by April 1 of each year a report that contains a review and recommendations related to at least one high priority area, which may include:

- Integrated health care workforce planning;
- Requirements for health care workers in the enhanced information technology and management workplace;
- Aligning Medicare and Medicaid graduate medical education policies with national workforce goals;
- Eliminating barriers to entering and staying in primary care;
- Educating and training, projected demands and integration with the health delivery system of the nursing workforce, oral health care workforce, mental and behavioral health care workforce, allied health and public health care workforce; emergency medical service workforce capacity; and a comparison of the geographic distribution of health care providers with identified workforce needs of states and regions.

To carry out its duties, the Commission is authorized to use existing information collected and assessed by its own staff or under arrangements, carry out or award grants or contracts for research and development where existing information is inadequate, and adopt procedures permitting interested parties to submit information for the Commission to use for reports and recommendations.

The AAFP supports the establishment of this commission. It is clear that impartial and informed decisions on how to promote the needed health care workforce are imminent. This commission is necessary to provide unbiased, informed and appropriate data and recommendations for how the federal government can best allocate its physician-training resources to achieve the best results. To perform this long-needed function, the commission will need to be sufficiently funded.

Small Physician Practices and Patient-Centered Medical Homes

While the ACA takes important steps to recognize the high value of primary care services and the critical role such services play in a high-functioning health system, we have some concerns that health reform might not accommodate privately owned small and medium physician practices.

As many as 25 percent of family physicians serve their patients in either a solo or 2-physician practice. These practices flourish all over the country, in rural communities and in city neighborhoods. They provide up-to-date medical care and, with the use of information and

communication systems, ensure that their patients find the community resources that will allow them to manage their chronic diseases, and prevent them in the first place.

High-quality health care can be (and is being) delivered to patients, often in rural and underserved areas, by family physicians practicing alone or with a few other physician and health professional colleagues. Claims that health reform will (or must) lead to "vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups" are without merit and contradicted by the experience of AAFP members.

The Patient-Centered Medical Homes (PCMHs) and the Accountable Care Organizations (ACOs) are potential examples of these larger physician groups. However, AAFP believes that, properly constructed, an ACO can serve as a vehicle for disparate small physician groups to share some assets and support some community resources needed to coordinate care and help prevent disease. We believe that a PCMH need not be a large physician practice. Indeed, physicians in solo, small or medium sized practices provide the important team-based primary care and preventive health services and chronic disease management called for in the health care reform law.

As we implement the *Affordable Care Act*, it is important to keep in mind that we should transform the practice of health delivery to reduce duplication and fragmentation of service and focus on coordinating care. However, we should not eliminate the variety of practices that make health care delivery most effective in different settings. We will continue to need small and medium sized practices and we should give these physicians the assistance they need to participate fully in our nation's renewed emphasis on primary care. It is for these and other reasons that the AAFP is eager to review the proposed regulations from HHS to implement the shared savings program under the ACA.

Payment and Delivery System Reforms

We believe that the *Affordable Care Act* begins to make much needed investments in value-based payment methodologies that improve chronic disease management and care coordination, including but not limited to the Patient Centered Medical Home. In addition, the ACA incudes pilot tests of other innovative approaches creating joint incentives for providers to coordinate and improve care and achieve cost efficiencies--such as accountable care organizations, gainsharing, and payment bundles--to assess their feasibility for widespread implementation. However, current regulatory restrictions and antitrust laws that inhibit physicians, particularly those in smaller practices, from pursuing clinical integration strategies aimed at quality improvement and care coordination need to be identified and remedied. We understand that HHS and the Justice Department are attempting to reconcile the ACA's cost-saving reforms that require collaboration with the restrictions of the antitrust laws and regulations. The AAFP has long called for this important and long overdue action.

Reduced Costs

The ACA recognizes the importance of preventive health care and refocused health care delivery in containing costs. In addition, there are several other provisions that will help save money both for the health system and for individual patients and payors. These provisions recognize that both private and public health insurance programs must be sustainable and that steps need to be taken to control costs. For example, the goal of the Center for Innovation in CMS is to demonstrate cost savings to the system, while the provisions in the ACA ultimately eliminate the Medicare prescription drug "doughnut hole," and reduce and eliminate cost sharing

for preventive health services, helps save money for patients. The AAFP believes these provisions are crucial to the value of the ACA.

The ACA includes a controversial and unusual feature called the Independent Payment Advisory Board (IPAB), which will recommend reductions in Medicare health system costs to meet specified targets. While the AAFP has some concern about the process for implementing IPAB recommendations, we have felt that if the Board were constructed to include at least one representative of primary care physicians and one consumer representative, then there would be potential to help reduce some of the misvalued payment codes and other high system costs. In addition, we believe it is necessary to include a public comment period for the Board's recommendations before Congress is required to act and that the Board's review authority should extend to the entire range of health system entities, including hospitals that contribute to cost increases. Without re-thinking how the IPAB operates, the scope of its authority and how it is constructed, this likely will be a missed opportunity for health system improvement.

Medicare Payment

There are two ACA provisions related to payment that are important, not simply because they pay primary care differently than specialty care but also because they begin to acknowledge and recognize the value that primary care brings to the health care system. Beginning January 1, 2011, qualified primary care physicians – defined as those in family medicine, internal medicine, geriatric medicine and pediatric medicine – began receiving a 10-percent bonus for Medicare services.

To qualify for the bonus, 60 percent of their Medicare allowed charges must be for primary care services as defined by evaluation and management (E/M) codes for office visits, nursing home visits and home visits. AAFP believes the 60-percent threshold is too high. As originally defined, the threshold would have had a particularly negative affect on rural primary care physicians because they are the ones who, by virtue of the fact that there are not as many specialist physicians nearby, provide more comprehensive care for their patients. This can skew the ratio of primary care to total services and would disqualify them for the bonus. Fortunately, the Centers for Medicare and Medicaid Services (CMS) through rulemaking, was able to make needed adjustments to mitigate the unintended consequence and up to 80 percent of family physicians will qualify for this bonus payment.

AAFP is concerned that this is just a five-year program, scheduled to end January 1, 2016, and that it applies only to payments for primary care services, not to all Medicare services that primary care physicians provide. We also believe that it needs to be significantly higher than 10 percent to achieve the goal of attracting sufficient numbers of medical students into primary care, as emphasized in the recent report of the Council of Graduate Medical Education (COGME). So we believe a lesson learned from year one is the recognition that this bonus must be increased and made permanent in order to have the desired effect. Nevertheless, it was important that ACA recognized that the current physician payment mechanism undervalues primary care and needs to be fixed.

Medicaid Payment Parity

The second payment program in the law also is a time-limited one. In 2013 and 2014, Medicaid payments for primary care and some preventive health care services will be increased in many states so that they are equal to Medicare payments. As a result, family physicians who care for Medicaid patients will, for two years, see significantly better payments in many states. This is another signal that primary care will ensure better health and better cost control.

Medicaid provider payments are a frequent target of state-level budget cuts during an economic downturn, which is the same condition that drives increased demand in the program. Payments that not only have not kept pace with inflation, but have actually decreased substantially, have forced many physicians to close their practices to Medicaid patients. Family physicians have a strong commitment to serving the nation's most vulnerable patients, but payment in Medicaid must be adequate to cover the cost of providing essential primary care services. Thus, this ACA provision for payment at least equal to Medicare's is an incredibly important signal to the health care community that provider payments are inadequate.

Sustainable Growth Rate Formula

Another issue is the congressional decision not to include in the ACA a provision to resolve the problem with the sustainable growth rate formula that affects Medicare payments. Despite the modest bonus for primary care and the recognition throughout the law of the importance of and high value of primary care, our members are sobered by approaching 29.5 percent cut in Medicare reimbursement for all physicians scheduled to take effect January 1, 2012.

AAFP urges Congress to act expeditiously to permanently fix this flawed Medicare payment formula. Among the approaches that could be considered is an intermediate-term (e.g., three-year) patch that includes a positive differential payment of at least one percent for primary care services. Congress considered such a payment system as a replacement for the SGR early in the debate on health care reform, but it was dropped. We encourage consideration of a payment scheme that includes some mechanism to reduce the large and unproductive disparity in payment between primary care and other health care.

We also eventually seek a permanent formula that incorporates lessons learned from other provisions of the ACA that begin to steer Medicare payment away from relying solely on traditional fee-for-service by incorporating a blended payment system that supports care management and quality improvement, in addition to a reliable formula that supports the fee-for-service portion of the payment to physicians.

Misvalued Codes Under the Medicare Physician Fee Schedule

Family physicians, and other primary care physicians and providers, have been concerned with how CMS determines specific payments for medical services. The AAFP appreciates the provision of the ACA that requires HHS to periodically identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. Codes would be identified based on certain factors, including codes with the fastest growth. Adjustments to misvalued procedures would be subject to budget-neutrality requirements.

Medicaid Maintenance of Effort Requirements

The AAFP believes that all patients should have health care coverage through a primary care based system built around the patient-centered medical home. In the patient-centered medical home model, patients receive health care from a physician leading a medical team that coordinates the preventive, acute and chronic health care needs of patients. This comprehensive approach uses the best available evidence and most appropriate technology. The maintenance of efforts provisions contained in the *Affordable Care Act* require states to maintain eligibility levels for Medicaid and CHIP.

Relaxing or eliminating the MOE provisions would move the US health care system further from that goal. As written, the law's provisions allow states to trim enrollment of certain adult

patients. In February 2011, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Director letter clearly outlining the application of the MOE provisions.

The MOE provisions make cutting provider payments more attractive to state budget writers. A core reason for the maintenance of effort provisions is to preserve access. Family physicians, who are on the front lines of serving Medicaid patients, need to know the payment rates their practices receive are stable. To create business stability and certainty for family physicians, Congress should extend the MOE provision to include Medicaid payment rates.

The goal of the MOE provisions is to protect the most vulnerable patients currently enrolled in Medicaid and CHIP: low-income pregnant women, children, the disabled and the elderly. Loosening maintenance of effort requirements for these populations will force them to seek more expensive, less efficient care through emergency departments—care for which the states and federal government ultimately pay for anyway. These provisions help America's most needy individuals get continuous, high-quality and more cost-efficient care. A recent study of Patient-Centered Medical Home (PCMH) pilot programs from around the country demonstrated over 30 percent less ER use by patients with a PCMH versus the control group and a 50 percent reduction in overall cost growth.

Medicaid and PCMH

The Patient-Centered Medical Home model established in the legislation is incorporated into a new Medicaid state option that will help states implement and evaluate this model of coordinated care. While AAFP applauds the 90-percent match provided by the ACA to the states to assist in the establishment of this new Medicaid PCMH option, it does have a restriction that AAFP thinks is not helpful. The PCMH options will include only the so-called high-need patients, such as those with two or more chronic conditions. While the PCMH has demonstrated extraordinary results in t both saving costs and improving health by preventing high-cost chronic conditions, restricting the number of patients in a practice who can be included in the PCMH in unfeasible.

Providing different types of care for patients is impractical and possibly even unethical for any physician's practice. Limiting patient eligibility makes the cost of transformation for the practice much higher on a per-unit cost. Physicians are reluctant to invest in a total transformation of their practices into patient-centered medical homes for only a portion of their patient panel. Instead, they are going to become a patient-centered medical home for all of their patients. But if they are only eligible to receive enhanced payment for a small portion of their patients, then the PCMH does not meet the cost test, and it is unlikely that they will undergo this fairly costly and certainly time-consuming transformation.

Teaching Health Centers Development Grants

The ACA directs the HHS Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for fiscal year 2010, $50 million for fiscal years 2011 and 2012. The law also provides $230 million to cover the expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. This is a critically valuable provision that could help identify the residency programs that bring residents to non-hospital sites for training in primary care.

State Medical Tort Litigation Alternatives Demonstration

The ACA authorizes $50 million in demonstration grants to states to test alternatives to civil tort litigation. These models will be required to emphasize patient safety, the disclosure of health

care errors, and the early resolution of disputes. Patients will be able to opt-out of these alternatives at any time.

HHS will provide technical assistance through guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events.

While the ACA included these demonstration grants, it does not completely nor adequately address the problems associated with medical liability in this country. the *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act* (HR 5), introduced in the 112th Congress, includes significant reforms that will help repair our nation's medical liability system, reduce the growth of health care costs, and preserve patients' access to medical care.

Many experts agree that the current tort system in the U.S. leads to an increase in health care costs. The proven reforms contained in the HEALTH Act, including the $150,000 cap on non-economic damages, would help reduce costs, while ensuring that patients who have been injured due to negligence receive just compensation. This bill provides a balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting non-economic damages to a quarter million dollars. In addition, the HEALTH Act protects effective state medical liability reform laws.

AAFP believes this reform is necessary to produce the comprehensive changes to our nation's health care delivery system. It is time for this legislation which will repair the current litigious climate that continues to increase health care costs and compromise patients' access to care.

Establishment of Center for Medicare and Medicaid Innovation within CMS
The law creates the Center for Medicare and Medicaid Innovation within CMS to research, develop, test, and expand innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. This new Center is designed to experiment with the PCMH model and to use it more broadly as soon as it begins showing savings or improved quality. While the CMMI is still in its developmental stages, it is the AAFP's desire that the center will soon be able to begin meaningful and comprehensive implementation of the PCMH demonstrations. This Center is an extremely important tool to make our nation's health care delivery more efficient and more effective. It is vital that this Center retain its flexibility and scope. The AAFP believes it has the potential for being a powerful force for evidence-based, effective health care delivery.

Summary
For more than 20 years, the AAFP has supported health care coverage for everyone. No one in this country should delay or forego needed care because of cost. Instead, we must:

- provide health care rather than focusing only on sick care -- we must constrain total spending by helping patients avoid preventable illness, efficiently managing the care of people who have chronic illness and improving the quality of that care; and we must provide health care coverage to people who cannot afford it or who have been turned away due to pre-existing conditions.
- address the factors that drive up costs and lower quality: the fragmentation of care; the duplication of tests and services; and the disregard for chronic disease management, prevention and wellness care in favor of medical intervention.

- build up the primary care physician workforce to meet the needs of everyone who needs care.

The ACA makes important strides in these directions by advancing models such as the patient-centered medical home, in which a qualified physician's practice provides and coordinates continuous and comprehensive care and preventive services, and coordinates health services when illness requires a larger team. We look forward to working with you on these important provisions.