ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults®*

September 21, 2009

The Honorable Max Baucus
Chairman, Senate Finance Committee
511 Hart Senate Office Building
Washington, DC 20510

Dear Senator Baucus:

On behalf of the American College of Physicians, an organization representing 129,000 internal medicine physician and medical student members, I am writing to express the College's views regarding several key provisions included in your health care reform legislation, the America's Healthy Future Act of 2009. We commend you for your diligent efforts to enact comprehensive health reform this year, a goal we strongly support, and are pleased that your mark includes many proposals, consistent with ACP policy, to expand coverage and reform physician payments. ACP would like to express its views regarding several provisions concerning access to health care coverage, disease prevention and wellness, and improving the quality and efficiency of health care. As noted below, there are several issues that we ask be addressed during the Senate Finance Committee markup of this legislation.

Title I - Health Care Coverage

Improving Access To Affordable Health Care

ACP strongly supports efforts to expand coverage to the uninsured and reform the insurance market. The College is particularly encouraged that the Chairman's Mark of the America's Healthy Future Act of 2009 would prohibit insurers from denying coverage based on a patient's preexisting condition. Further, the Mark includes language that would establish guaranteed issue and renewal of insurance policies so that access to health care cannot be denied. Limits on premium rates will also provide that the cost of health insurance would not place an undue burden on individuals and families. The College also strongly supports the establishment of a health insurance exchange to assist individuals and small businesses in finding affordable, high quality health coverage. Ensuring access to preventive and primary care is crucial to reducing the rates of chronic disease and improving health and well-being for all. ACP is particularly encouraged that the Chairman's Mark would require all insurance plans to provide a core set of benefits that include preventive and primary care services. The College is a strong advocate for expanding Medicaid to reduce the number of uninsured as well as providing subsidies for the purchase of health insurance and is very pleased that the Mark would provide these improvements to make quality health insurance more accessible. ACP also supports a requirement that once affordable coverage options are made available, with sufficient federal subsidies, all individuals should be required to purchase coverage, with a hardship exemption.
We urge you to ensure that the subsidies in the final bill are sufficient to ensure that an individual mandate does not impose an economic hardship on persons who would be required to buy coverage.

Title II - Promoting Disease Prevention and Wellness

Medicaid Medical Home

We support the intent of the proposal to establish a patient centered medical home within Medicaid. This legislation would allow Medicaid enrollees to designate a provider as a health home. Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician office, or physician group practice. We are concerned that the medical home provision would limit enrollment to beneficiaries with "at least two chronic conditions or one chronic condition and at risk of developing another chronic condition." ACP believes that all Medicaid beneficiaries should be eligible to participate in a medical home, not just those with chronic conditions. We also recommend that state based medical homes should include patients that receive health care through Medicare and private insurance providers. This policy is consistent with Secretary Sebelius' plan for a new state-based medical home pilot that will include Medicare as well as Medicaid and private payers.

Title III - Improving the Quality and Efficiency of Health Care

Physician Quality Reporting Initiative (PQRI)

ACP supports positive incentives for reporting on evidence-based quality measures, but we do not support the provisions to impose payment reductions for non-reporting (or unsuccessful reporting) beginning in 2011. The PQRI program has yet to demonstrate reliability despite its increasing number of participation options. CMS has yet to release information on the experience of many of these options and has yet to commit to establishing reporting through electronic health record (EHR) systems, which is likely the most promising long-term option. It not only is premature to essentially make PQRI reporting mandatory by imposing payment cuts for non-reporting or unsuccessful reporting, but we also believe that positive incentives are far more effective than cuts in helping physicians make the practice and system changes needed to effectively improve on their performance. Plus, the payment penalty—which can be imposed even if a physician reports quality data but is determined to be unsuccessful—would erode other payment improvements intended to assist primary care physicians.

ACP supports the provision to establish participation in Maintenance of Certification (MOC) as an option to qualify for positive PQRI incentive payments for a two year period of time. It provides an alternative to qualify for the bonus that will reduce redundancy for physicians who are participating in a qualified MOC program and who also wish to successfully participate in PQRI. Within internal medicine, the American Board of Internal Medicine has a well-respected MOC program that has been shown to result in positive improvements in performance and has been found to be very valuable by physicians who have participated in the program.

ACP also supports the other PQRI improvements included in the legislation: more timely reporting feedback; establishing a successful reporting determination appeals process; and directing CMS to integrate PQRI with EHR meaningful use reporting requirements. The College notes, however, that these improvements—and the timing of their implementation—are not sufficient to justify instituting a payment penalty for failure to successfully report.

CMS Innovation Center

We support your proposal to require the Secretary to create an innovation center within CMS (to test, evaluate, and expand different payment structures) designed to foster patient-centered care, improve quality, and slow the rate of Medicare growth. We are pleased that the Center would be required to consider testing models that promote broad payment and practice reform in primary care, including patient-centered medical homes for high need beneficiaries and models that transition primary care practices away from fee-for-service and toward comprehensive payment reforms. We believe, though, that HHS should specifically be required to implement one or more national pilots of the Patient-Centered Medical Home. ACP appreciates that the Secretary would be given flexibility in implementing new medical homes and would not be constrained by upfront Medicare budget neutrality rules. We also appreciate that you have included ACP's recommendations for the center including that: it has the authority to broadly test innovative payment models, not just limited to high cost patients with multiple chronic diseases; it has established criteria for prioritizing the selection of models for broad testing and dissemination; and outside experts and stakeholders will be consulted regularly.

Primary Care Bonus Payment

We strongly support the intent of the proposal to provide primary care physicians with a ten percent Medicare bonus payment for designated services but have several recommendations to make the proposal even more effective. We appreciate your responsiveness to concerns expressed by ACP and other representatives of primary care specialties on the need to increase the bonus from the 5% as originally proposed in your options paper. We are very concerned, though, that the current criteria to qualify for the bonus would exclude most primary care internists.

The summary of the Chairman's Mark states that the bonus payment would be available to primary care practitioners who have a specialty designation of internal medicine, family medicine, geriatric medicine, or pediatric medicine (or are advanced practice nurses or physician assistants).

The Mark states that qualifying practitioners must also furnish sixty percent of their services in the select codes –defined as office, nursing facility, home and domiciliary visits in non-Health Professional Shortage Areas. We believe that the sixty percent threshold may disqualify many general internists (and other primary care physicians) who truly furnish primary care from receiving the bonus: data from the Robert Graham Center suggests that only 38 percent of general internists would qualify at the 60 percent threshold.

A primary care bonus mechanism that excludes a majority of general primary care internists—which in all likelihood would exclude most general internists in Montana--would undermine your goal of making primary care the foundation of a high-performing health care system, and would likely result in many primary care physicians feeling that they had been unfairly denied participation in the primary care bonus structure, leading to even greater disillusionment among primary care physicians with the Medicare program.

We recommend that you lower the allowed charges threshold to no more than 40 percent to ensure that the bonus meets your intent of supporting physicians who, by specialty designation and practice characteristics, are primary care physicians. Alternatively, the bill could direct the Secretary to establish a mechanism to ensure that those who provide primary care services receive the bonus even if they do not meet the allowed charges threshold stipulated in this legislation.

We support the specialty designation criteria but ask that language be added that the application of the bonus to advanced practice nurses or physician assistants would be available only when they are operating within

the limits of their licenses as determined by state law, and that the bonus would be on the current applicable Medicare payment rates for such services when rendered by non-physicians.

ACP looks forward to continuing to work with you to ensure that general internists and other primary care physicians who truly provide primary care services are not excluded from receiving the bonus included in this legislation.

The provision also calls for offsetting the bonus with a .5 percent budget neutrality reduction for all physician services. We urge you to find ways to fund the primary care bonus in a way that does not require direct offsets in payments for other physician services, since such offsets will undermine the broad support that now exists across specialties for the primary care bonus program. We continue to believe that funding for primary care should take into consideration the evidence that the availability of primary care physicians in a community consistently is associated with better outcomes and lower costs of care.

Graduate Medical Education and Workforce

ACP strongly supports the provision in the Chairman's Mark that would establish a Workforce Advisory Committee that will set the nation on a path toward recruiting, training and retaining a health workforce that meets the nation's current and future health care needs. ACP has long advocated for the establishment of a permanent national commission on the health care workforce to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity, including training and retaining more primary care physicians whose training is appropriate for the present and anticipated health care needs of the nation. ACP recommends that the legislation require that at least one primary care physician be included on the committee, since the perspectives of primary care physicians will be critical to the effectiveness of the commission's efforts.

We are also pleased to see the Chairman's Mark would establish a policy to redistribute currently unused GME residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. It is important to note that redistributing currently unused slots to primary care will not by itself solve the workforce crisis in primary care. Substantial incentives in physician payment and delivery system reform must also be implemented in order to encourage students to choose a path in primary care. ACP recommends that an additional 3,000 additional primary care physicians graduate each year for the next 15 years in order to meet the nation's anticipated health care needs. We believe that an additional 9,000 Medicare-funded GME positions will be needed each year in order to graduate the 3,000 primary care physicians needed to ensure a sufficient supply of primary care physicians.

Sustainable Growth Rate

We are very concerned that the Mark does not provide a structure and funding for a solution to the perennial problem of physician payment cuts resulting from the flawed Sustainable Growth Rate (SGR) formula. Although we appreciate your efforts to replace the scheduled 21 percent reduction in Medicare physician payment in 2010 with a positive increase, we believe that it is essential that Congress eliminate the accumulated cost associated with past efforts by Congress to enact short-term fixes to the flawed SGR payment formula. We believe that Congress must not wait another year to replace the SGR with a formula that provides positive, predictable updates. Also, since experience shows that Congress is unlikely to allow continued cuts in payments to physicians under the SGR formula, we believe that costs of replacing the SGR with a system of positive and stable updates should be accurately reflected in Medicare baseline spending assumptions and not be subject to pay-as-you-go budget offsets. Stable, predictable and positive updates are essential to provide a foundation on which other reforms in this legislation can be built. We note, for

instance, that the positive impact of a 10 percent bonus to primary care providers for select E/M services would be significantly muted if not completely eliminated if the SGR formula stays in place unchanged for 2011 and beyond.

Independent Medicare Commission (IMC)

We generally support the goal of establishing a 15-person independent Medicare Commission (MC) that would submit proposals to Congress to extend Medicare solvency and improve quality in the Medicare program but believe that safeguards are needed to appropriately protect beneficiaries and other stakeholders from unintended adverse consequences. We agree that the creation of an independent Commission could facilitate the process of making necessary changes to Medicare that are currently difficult to make under the current legislative process. While the proposed legislation currently contains a number of provisions that appropriately protect beneficiaries and other stakeholders from unintended adverse effects, the College recommends that the Commission be structured as follows:

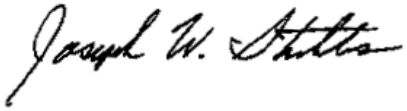
- The Commission should be large enough in size and have designated representation of primary care physicians and other key stakeholders and health policy experts. The Mark does not specify constituencies to be represented and only calls for appointment by the President. We urge that the Mark be modified to require the appointment of individuals with broad expertise, including at least one seat for a representative of a primary care physician specialty, similar to the requirements that now apply to appointment and composition of the Medicare Payment Advisory Commission.
- The Commission should be required to conduct its business in a transparent manner with procedures to ensure that stakeholders and the public will have input before it submits its proposals to Congress. Other than the stipulation that MedPAC and GAO would receive draft recommendations and provide input to Congress, the Mark does not include any requirement that the Commission seek input from outside parties before submitting its recommendations to Congress. Such public review and comment requirements should be added to the legislation. We support a requirement that the committees of jurisdiction would have 90 days to act on MC recommendations. ACP believes that Congress should have the authority to disapprove of MC recommendations with a simple majority (and not super majority) vote. It is unclear if the Mark would give Congress such authority. We also believe that Congress should have the option to simply disapprove of the MC recommendation without having to pass an alternative with equivalent savings.
- ACP also believes that any changes in payment policies that result from the recommendations from the MC should to be implemented through the normal rulemaking process, just as HHS is now required to use the rule-making process to implement changes in payment policies enacted by Congress.
- ACP believes that physicians and other providers should not be subjected to potential payment cuts under multiple processes, such as might occur if physician spending continues to be influenced by an expenditure target at the same time as the MC might recommend other reductions in physician payments. We agree with your proposal to direct the MC not to recommend cuts when existing update process dictates cuts.
- ACP policy calls for MC recommendations to improve quality and value and not deny coverage or benefits for patients solely on the basis of cost. Although the MC provision appears to be consistent with these positions, we are concerned that any requirement that the MC produce a prescribed level of savings could result in cost reductions taking priority over improving outcomes of care.

Medical Liability Reform

ACP is encouraged by the Sense of the Senate language, which encourages states to develop and test alternatives to the current civil litigation system. We recommend that the Senate enact legislation to specifically authorize federally funded state demonstration projects to develop and test these alternative methods, including health courts, which offer a specialized administrative process where judges, experienced in medicine and guided by independent experts, determine contested cases of medical negligence rather than a lay jury. The demonstration projects need to provide sufficient funding and financial incentives for states to design programs that are specifically designed to test alternatives to the current litigious system. We also continue to believe that a cap on noneconomic damages has been shown to be among the most effective ways to stabilize medical malpractice insurance premiums and should be the centerpiece of any legislative proposal to reform the medical professional liability insurance system.

We remain committed to doing all that we can to get legislation enacted this year that will ensure that all Americans have access to affordable coverage and to a general internist or other primary care physician. We look forward to working with you to achieve these goals and appreciate your attention to the suggestions in this letter for improving the bill as it is marked up in the Finance Committee.

Sincerely,



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