October 27, 2009

Honorable Max Baucus
Chairman
Finance Committee
U.S. Senate
Washington, DC 20510

Honorable Kent Conrad
Chairman
Budget Committee
U.S. Senate
Washington, DC 20510

Honorable Harry Reid
Majority Leader
U.S. Senate
Washington, DC 20510

Honorable Tom Harkin
Chairman
Health, Education, Labor & Pensions Committee
U.S. Senate
Washington, DC 20510

Dear Mr. Chairmen and Majority Leader Reid:

On behalf of the American College of Physicians, representing 129,000 internal medicine physician and medical student members, I am writing to share our views on those key issues that the College would like included in health reform legislation. We commend you for your diligent efforts to enact comprehensive health reform this year, a goal we strongly support. As the Senate works to reconcile the Finance and HELP Committees' reform bills, ACP believes that it is essential that Congress provide access to affordable coverage for all Americans, ensure an adequate workforce with a sufficient number of primary care physicians, and accelerate the testing of payment and delivery system reforms to help physicians produce the best possible outcomes for patients. The College has provided feedback to the committees throughout the process and our intent here is to continue to provide constructive recommendations as you prepare a melded bill for floor consideration. Our detailed comments are noted below on specific provisions of the committees' bill that are important to the College.

PROVISIONS ACP SUPPORTS IN HEALTH REFORM LEGISLATION:

Coverage: The College is pleased that both Senate health reform bills would greatly reduce the number of uninsured by ensuring that individuals have access to affordable health insurance coverage. People who cannot afford coverage should be provided with help, in the form of tax credits, to buy coverage. We believe the public should have a wide choice of health plans and those plans should compete based on innovations to improve patient care, not on cherry-picking out the young and healthy; and all insurers should cover preventive services and other essential benefits. ACP supports provisions to reform the insurance industry so that coverage is no longer out of reach for people who have pre-existing conditions or who develop an illness while insured. The College is pleased that the HELP legislation provides strong insurance rate protections to ensure that premiums are kept affordable for vulnerable individuals. The College also strongly supports the establishment of a health insurance exchange to assist individuals and small businesses in finding affordable, high quality health care coverage. ACP is especially encouraged that the Finance bill would require all individual and small group health plans to abide by the rating and benefit requirements outlined in the bill, regardless of whether the plans are offered in or outside of the health insurance exchange. Creating a level playing field on which all plans must compete will prevent underinsurance and reduce the threat of adverse selection. The College believes that responsibility for improving the nation's health care system must be shared by all. Once coverage is made affordable, ACP supports an effective and fair individual mandate with a hardship exemption for those unable to afford insurance. In addition, ACP supports the HELP Committee's employer mandate, which would require employers, with the exception of small businesses, to either provide health insurance for their employees or pay a fee.

If a public plan is included in the final Senate health reform bill, we urge that physician participation be voluntary and the Secretary be given the authority to negotiate payment rates under the public plan, as opposed to basing them on Medicare rates. We believe that payments to physicians under the public plan should be competitive with those of other insurers and not replicate flaws, such as the undervaluation of primary care, in existing payment models.

Primary Care Bonus: ACP applauds the Finance committee for including a provision (Sec. 3031) that would provide a ten percent Medicare bonus payment to primary care physicians. This bonus payment recognizes the value of the care that primary care physicians provide to their patients and would provide a much needed incentive for additional medical students to choose careers in primary care medicine. The College has expressed concern to the committee that the eligibility criteria in qualifying for the bonus would not capture the majority of primary care internists, based on the thresholds stipulated in the provision. We continue to recommend that the Secretary be granted discretion to establish a mechanism to ensure that those who provide primary care services receive the bonus even if they do not meet the criteria included in the Finance bill. We appreciate the on-going efforts of committee staff in trying to accommodate our suggestions and we request that you include the bonus, with that modification, in the reconciled bill.

Workforce: Given congressional intent to expand health insurance to all Americans, an effort ACP greatly supports, it is equally essential that improvements be made to bolster the primary care workforce. Specifically, ACP supports the following provisions:

- **Establish a National Workforce Advisory Committee:** ACP appreciates and supports the inclusion of a national workforce advisory committee in the HELP and Finance bills 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 a health workforce commission to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity. The nation is already facing a shortage of primary care physicians, and general internists in particular, as the population ages and the number of residents with multiple chronic conditions grows. Expanding coverage to the uninsured will increase demand for services, particularly those provided by primary care physicians. We recommend that you include at least one primary care physician on the workforce commission, since perspectives of the primary care physicians will be critical to the effectiveness of the commission's efforts.

- **Increase Training in Ambulatory Care Settings:** We urge inclusion of a provision from the Finance bill (Sec. 3034) that will enhance the training of primary care physicians by increasing their exposure to practice in ambulatory care settings, namely by eliminating regulatory barriers that dissuade or prevent residency training programs from providing their residents with optimal training in non-hospital settings, such as physician practices and community health centers. Although patient care increasingly occurs in ambulatory settings, medical education has mostly occurred in inpatient hospital facilities. Primary care residents need the skills and experiences gained from training in ambulatory settings to better prepare for practice in such environments.

- **Grants for Teaching Health Centers:** ACP supports the provision (Sec. 3038) in the Finance bill that would provide grants and Graduate Medical Education funding for Teaching Health Centers to train primary care physicians in community based settings. Developing residency programs within community-based ambulatory primary care settings, such as teaching health centers, with the appropriate infrastructure investment, will help strengthen the primary care workforce.

- **Graduate Medical Education (GME) Slots for Primary Care:** The College supports a provision in the Finance bill (Sec. 3032) that will redistribute currently unused GME residency training slots as a way to encourage increased training 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 crisis in primary care, but this is a good step forward. ACP recommends that an additional 3,000 primary care physicians graduate each year for the next 15 years in order to meet the nation's anticipated health care needs. This will require 9,000 additional GME positions annually.

- **Enhanced Loan Repayment and Scholarship Programs:** We urge you to adopt a provision in the HELP bill (Sec. 431) that would increase funding for Title VII primary care training programs, including grants to schools to plan, develop, operate or participate in training programs in general internal medicine, family medicine, general pediatrics, and physicians assistance programs. We support the provision in the HELP bill (Sec. 431) that would provide need-based financial assistance in the form of traineeships and fellowships in primary care fields, and another provision (Sec. 413) that would create the Health Care Workforce Program Assessment to analyze workforce issues and the effectiveness of workforce programs authorized by the bill. Finally, the HELP bill (Sec. 427) provides increased funding for the National Health Service Corps, which is a critical program in helping bring new primary care physicians into areas of need.

- **Reinstatement of the 20/220 Pathway Program:** The HELP bill includes a provision (Sec. 456) to reinstate the 20/220 loan deferment program. ACP strongly supports this provision, as it allows for the deferment of interest and principal payments on educational loans during residency. This pathway is the economic hardship deferment qualification criterion that 67 percent of the nation's medical residents have relied upon to defer their student loan debts while completing residency training. Since Congress eliminated the 20/220 pathway, medical residents have been forced to start repayment of their loans during training or go into forbearance. With an average of $145,000 in medical education debt and an annual stipend of about $45,000, loan repayment during residency training is extremely burdensome.

New Payment Models: We appreciate the efforts of the HELP and Finance Committees to improve the quality of health care and care coordination through the adoption of the Patient Centered Medical Home. The College has long held that the medical home is a means to ensuring greater quality of care at lower cost. Specifically, ACP supports the following provisions:

- **Patient Center Medical Home within Medicaid**: We support the creation of a patient-centered medical home within Medicaid, as was included in the Finance bill, but urge that it not be limited only 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.

- **Medical Home Grants to States:** We urge inclusion of grants to eligible entities to establish community-based medical homes, as included in the HELP legislation. Facilitating community-based interdisciplinary teams to support and expand the capability of medical homes, promoting improved medication management with a focus on avoiding hospitalizations, and facilitating the use of resources that enable patients to better share in medical decisions are positive steps toward achieving more patient-centered care.

- **Creation of an Innovation Center within CMS**: We strongly support the provision (Sec. 3021) in the Finance bill that would create an Innovation Center within CMS (to test, evaluate, and expand, different payment structures) designed to foster patient-centered care and slow the rate of Medicare growth. We are pleased that the Finance bill would require CMS to **consider** testing the Patient Centered Medical Home, but encourage you to modify it to ensure that CMS **is required to implement** one or more national pilots of the Patient Centered Medical Home.

PROVISIONS THAT ACP BELIEVES SHOULD BE IMPROVED

Sustainable Growth Rate (SGR) "Patches": ACP greatly appreciates the recent efforts of Senate leaders and Sen. Stabenow (D-MI) in considering legislation, S. 1776, to permanently repeal the flawed SGR formula. The College was very disappointed that the Senate was not able to invoke cloture on the bill, but we continue to encourage you to enact a permanent repeal this year and stand ready to work with you to get this done.

The College appreciates the efforts of the Finance Committee in providing a 0.5 percent update in 2010 (Sec. 3101). However, the College believes that Congress needs to end the practice of enacting short-term patches that fail to provide the stability needed to initiate comprehensive physician payment reform or the assurance patients need that their access will not be reduced by devastating physician payment cuts. Therefore, we cannot support another temporary patch. We believe that the cost 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. It is equally important to note that if the Senate does not address a long-term solution to the SGR, it will only serve to blunt, if not eliminate, the intended positive impact of the primary care bonus payment.

Provide Additional Safeguards to and Legislative Oversight of a Medicare Commission (MC): ACP supports, in concept, the creation of a Medicare Commission (MC), an independent entity with the authority to make payment reform recommendations with reduced legislative oversight, provided certain conditions are met. We recognize the difficulty in making healthcare payment system decisions within the highly political legislative process, and the creation of such an independent commission would provide an improved means of addressing these important issues.

The MC, as included in Sec. 3403 of the Finance bill, does not meet several criteria we believe are necessary and important to serve the needs of our Medicare beneficiaries and the physicians who provide their care. However, below are recommendations for improving the current language:

- **Representation on the Commission**: In the Finance bill, the MC is to be composed of 15 members, and includes experts in fields related to healthcare finance, delivery and management and specifically requires representation of consumers and the elderly. While ACP does not take issue with that, we are concerned that the current language does not include specific primary care representation. The College believes it is essential that primary care have a voice on the Commission as these important decisions on payment are being made. We recommend that modifications be made to include specified committee representation of physicians who currently deliver care in a community setting, and at least one designated seat for a physician representative of a primary care field.

- **Congressional Authority**: The MC provision, as currently drafted, allows Congress' to only block implementation of the MC recommendations by passing alternative legislation that meets required savings benchmarks. Even then, this alternative legislation could be vetoed by the President, and then only overturned by a super-majority vote of both the House and Senate. This too severely restricts the ability of Congress to influence important Medicare payment decisions. The College

recommends a somewhat less restrictive approach in which MC proposals are implemented, unless Congress blocks such implementation by a simple majority vote in both houses through a fast-track joint resolution process. Under this approach, Congress would not have to develop an alternative and current law would remain in effect if the MC proposals are voted down.

- **Transparency**: Language in the Finance bill states that the MC "may hold such hearings sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable." This places too much authority with the MC in deciding when, or even if, to hold hearings on important Medicare payments issues. The MC could simply decide not to hold hearings, regardless of the reason, which would effectively prevent adequate stakeholder input. The College recommends that to ensure transparency in the Commission's proceedings and adequate opportunity for stakeholder input prior to proposals being submitted to Congress, that a minimum number of hearings be prescribed in the legislation.

- **Exemption of Certain Providers and not Others:** The MC in the Finance bill places physicians in an inequitable situation, when compared to other Medicare providers, as the focus of reductions in Medicare payments to meet savings requirements. The current language specifically exempts hospitals and hospice providers for up to 4 years from payment reductions by the Commission. This unfairly leaves physician payments as one of the few remaining means of obtaining required savings. It also is counter to the concept of aligning incentives across physicians, hospitals, and other providers to achieve better value for patients. In addition, the current provision places physicians vulnerable to Medicare payment cuts both from MC recommendations and the Sustainable Growth Rate (SGR) update methodology. ACP recommends, as a starting point, that modifications be made to exempt physicians (and any other Medicare providers) from further payment cuts through the MC process if reductions are already instituted for those providers under the SGR, or a similar process.

Physician Quality Reporting Initiative (PQRI) Penalties: ACP advocates for positive incentives for reporting on quality based measures, but we urge you to refrain from imposing payment reductions for non-reporting (or unsuccessful reporting), which could begin in 2012, under the Finance bill (Sec. 3002). The Physician Quality Reporting Initiative (PQRI) program has yet to demonstrate reliability despite its increasing number of participation options. We also believe that positive payments are far more effective than cuts in helping physicians make the practice and system changes needed to effectively improve on their performance.

Cost and Quality Payment Adjustment: While the College supports pilot-testing of new payment models to support physicians for providing high-quality and efficient care, it is premature to mandate a budget neutral adjustment to payments based on measurement of an individual physician's cost and quality, as the Finance bill does (Sec. 3007). The College does not support this provision. There are very few accepted measures of the outcomes of care or resource use. The College is concerned that health status and socioeconomic factors may not be appropriately accounted for. It is concerned that small practices could be disproportionally harmed as they face greater challenges in improving quality and efficiency. ACP notes that the PQRI provisions reward successful reporting while this provision essentially links payment to reporting score. ACP recommends that the Institute of Medicine study the reasons behind geographic variations in the quality and cost of care and make recommendations for reforms to address such variation as a more prudent alternative to this provision.

OTHER ISSUES OF IMPORTANCE TO ACP:

- **Administrative Simplification**: Administrative simplification that represents a combination of the provisions in the respective Finance (Sec. 3601) and HELP bills (Sec. 222) that would further streamline administrative requirements based on Health Insurance Portability and Accountability Act (HIPAA) framework and provide benefit protection and simplification pertaining to Medicare Advantage and the Medicare Prescription Drug program.

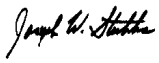
- **Comparative Effectiveness Research**: A well-funded entity to conduct unbiased comparative effectiveness research and disseminate the results.

- **Mis-valued Relative Value Units (RVUs):** ACP supports the requirement, Sec. 3134 of the Finance bill, that the Secretary periodically identify physician fee schedule services as being potentially mis-valued and make appropriate adjustments to the relative values of such services. ACP urges that the legislation dedicate funding to ensure that the Secretary has the necessary resources. Ensuring that each service is valued appropriately is essential as the majority of physicians will continue to be paid under the Resource Based Relative Value Scale (RBRVS) system until other payment models can be validated and because many of those new models are likely to use RBRVS payments as a base.

- **Innovation Center:** A well-funded Innovation Center with criteria to guide projects that specifies testing of the PCMH as indicated above.

We are 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 primary care physician. We appreciate your consideration of our suggestions and look forward to working with you to enact our goals as health reform legislation is considered in the Senate.

Sincerely,



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