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

December 4, 2009

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Max Baucus
Chairman, Finance Committee
United States Senate
Washington, DC 20510

The Honorable Tom Harkin
Chairman, Health, Education, Labor & Pensions Committee
United States Senate
Washington, DC 20510

Dear Majority Leader Reid, Chairmen Baucus and Harkin:

On behalf of the American College of Physicians, representing 129,000 internal medicine physicians and medical student members, I am writing to share our views on key issues in H.R. 3590, the Patient Protection and Affordable Care Act. ***We commend the Senate for approving a motion to proceed to debate this legislation, which includes important and essential reforms that overall are consistent with ACP policy to expand coverage and reverse a shortage of primary care physicians.*** ACP remains firmly committed to working with you to get legislation enacted into law that provides coverage to all Americans, addresses the growing crisis in access to primary care, and reforms payment and delivery systems. Although there is much in this bill that is consistent with these goals and ACP policy, ***we also have significant concerns regarding several provisions*** and urge you to consider amending the legislation to address these issues prior to Senate passage of the bill. Our detailed comments are provided below.

Coverage

The College is pleased that the Senate health reform bill would provide coverage to almost all legal residents (94% according to the Congressional Budget Office) by ensuring that individuals have access to affordable health insurance coverage. Ensuring that all Americans have access to affordable coverage is one of ACP's top priorities. ACP supports provisions in the bill that would provide tax credits to individuals to buy coverage and ensure that all insurers cover evidence-based preventive services without imposing cost sharing requirements on patients. ACP supports provisions to reform the insurance industry so that coverage is no longer out of reach for people who have a pre-existing condition or develop an illness while insured. The College supports the establishment of a health insurance exchange to assist all individuals and small businesses in finding affordable high quality health care coverage. We support requiring that insurance plans provide coverage for preventive services that have an A or B rating from the U.S. Preventive Services Task Force, with no cost-sharing by the patient, as a *floor* on essential preventive benefits.

Sustainable Growth Rate

ACP is very concerned by the Senate's failure to enact S. 1776, which would have permanently repealed the flawed Sustainable Growth Rate (SGR). The provision in H.R. 3590 to replace the scheduled 21% reduction in Medicare physician payment rates in 2010 with a 0.5 percent increase continues the current flawed policy of "kicking the can" down the road. Congress must end the practice of enacting short-term patches that fail to provide the stability needed to initiate comprehensive payment reform and the assurance patients need that access will not be reduced by devastating pay cuts.

ACP recommendation: We urge you to enact a permanent repeal of the flawed SGR formula and replace it with a new payment system that will provide positive and predictable payment updates for physicians and a higher growth target, and update, for primary care and preventive services.

Improved Payments for Primary Care Services

ACP strongly supports and is appreciative of the intent of a provision in the Senate bill that would provide a 10 % Medicare bonus payment to designated services by primary care physicians, defined as general internists, family physicians, geriatricians, and pediatricians whose services consist principally of primary care services. This bonus payment is intended to recognize the value 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 and help struggling primary care practices keep their doors open.

However, ***the College continues to be very concerned that the eligibility criteria included in the Senate bill to qualify for the bonus would exclude a majority of primary care internists.*** This criteria specifies that in order to qualify for the bonus, a qualifying practitioner must furnish 60 % of their services in select codes- defined as office, nursing facility, home and domiciliary visits in non-Health Professional Shortage areas. According to a study by the Robert Graham Center, the criteria in the Senate bill would exclude 62 % of general internists from qualifying to receive the bonus. ***The provision would particularly exclude large numbers of primary care internists in rural areas who provide care to their patients in both the office and hospital setting—a hallmark of comprehensive primary care.***

The exclusion of a majority of primary care internists from the bonus is of great concern to us. It is a problem that we raised, going back months ago, in previous communications, yet the problem has not been resolved in the current bill. A primary care bonus mechanism that excludes a majority of primary care internists would undermine the intended goal of making primary care the foundation of a high-performing health care system. ***It is essential that this provision be changed so it does not exclude most primary care general internists.***

We also are concerned that the bonus provision would sunset after five years, which would expose primary care physicians to deep cuts in payments unless Congress extended the program.

ACP is aware that some other medical organizations are opposing the primary care bonus because half of it is funded by a very small (less than one half of one percent) budget neutral reduction in payments for other physician services. Although ACP continues to strongly prefer that increased payments for primary care be funded in a way that recognizes the value of primary care in reducing total Medicare expenses, such as the expenses associated with hospital admissions that are preventable when care is managed by a primary care physician, we strongly urge you to preserve the 10% primary care bonus amount and not agree to any change that would result in a lower bonus.

ACP recommendations: We urge you to modify the current bonus criteria to allow additional primary care physicians to qualify for the bonus. Specifically, we recommend that the language be modified to (1) revise the definition of designated primary care services eligible for the bonus to include hospital visits and (2) allow physicians in the designated primary care specialties to qualify for the bonus if *50*% of their total allowed charges consist of the designated primary care services, which would include hospital visits under the revised definition of designated services proposed above. We also urge that you make the bonus permanent. ACP also cautions against expanding the definition of primary care physicians to include non-primary care specialties or reducing the bonus amount below 10%, which would dilute the impact of this provision in encouraging more physicians to go into primary care.

The Senate bill, unlike the House legislation, does not have any provisions to increase payments to primary care physicians under the Medicaid program. ***ACP strongly urges you to include a provision in the final bill that increases Medicaid payments to primary care to no less than the Medicare rates.*** Such a provision is urgently needed to ensure that primary care physicians will be available for the more than 10 million persons with incomes up to 133% of the FPL who would now be covered by Medicaid.

Workforce:
Since H.R. 3590 would expand health insurance coverage to 31 million Americans, it is equally important to ensure that improvements be made to bolster the primary care workforce. Specifically, ACP offers comments on the following provisions:

- **Establish a National Workforce Advisory Committee:** ACP appreciates and supports the inclusion of a national 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 needs.

- **Increase Training in Ambulatory Care Settings:** We support a provision in the Senate bill that will enhance the training of primary care physicians by increasing their exposure to practice in ambulatory care settings.

- **Grants for Teaching Health Centers:** We support a provision in the Senate bill that would provide development grants and graduate medical education funding to establish or expand training programs in Teaching Health Centers to train primary care physicians.

- **Support for Training Programs and Enhanced Loan Repayment and Scholarship Programs:** We support provisions in the Senate bill that reauthorize and increase funding for Title VII Sec 747, Primary Care Training and Enhancement programs, support development of training programs; provide need-based scholarships, and increase faculty capacity for establishing interdisciplinary training programs. We are pleased that the Senate bill repeals language in Section 747 (42 USC 293k) that diverts two-thirds of annual appropriations to a single discipline, thereby seriously hampering efforts to train other primary care specialists, including future general internist clinicians. By repealing this provision, the Senate bill ensures equity across *all* disciplines and permits the allocation of training funds on the basis of merit and national need. We also support the increases in the Faculty Loan Repayment awards from $20,000 to $30,000 per year. In addition, we support increases in funding for the Scholarships for Disadvantaged Students program and the National Health Service Corps. We are disappointed that a provision in the HELP health reform bill to reinstate the 20/220 loan deferment program was not included in H.R. 3590.

- **Graduate Medical Education Slots for Primary Care:** We support the provision that would redistribute currently unused GME residency training slots as a way to encourage increased training in the areas of primary care and general surgery. While this is a good start toward expanding the primary care physician workforce, this provision will not train sufficient numbers of physicians needed to treat newly insured and established patients.

- **Funding for a primary care extension program:** We support this provision, which would provide educational and technical assistance to primary care practices.

  ACP recommendations: We urge you to include a provision to reinstate the 20/220 loan deferment program in the final Senate health reform bill. This provision, which allows for the deferment of interest and principal payments on educational loans during residency, is the economic hardship deferment criterion that 67 % of the nation's medical residents have relied upon to defer their student loan debts while completing residency training. We also urge increased funding for GME positions in primary care training programs. As a preliminary target, ACP recommends that the number of Medicare funded graduate medical education positions available each year in adult primary care specialties is increased in order to graduate 3,000 additional primary care physicians each year for the next 15 years to meet the nation's health needs. We also urge you to include a loan repayment program for physicians who go into general internal medicine, pediatrics, or family medicine and who practice in an area of the country or health care facility with a high need for such specialties. We urge that National Health Service Corps awards be increased from $35,000 per year to a maximum of $50,000 per year.

- **Definition of Primary Care Specialties:** We ask that physicians who are trained in a combined medicine-pediatrics program (med-peds) be included in the definition of primary care physicians and specialties wherever referenced in H.R. 3590. Physicians with combined training in pediatrics and internal medicine are an important part of the primary care workforce of children, adolescents, and adults.

Payment and Delivery System Reform and the Patient Centered Medical Home:
We appreciate the efforts of the Senate to accelerate the pilot testing of innovative models and payment systems to improve the delivery of care and to align incentives with the value provided. ACP offers several recommendations concerning the following provisions:

- **Patient Centered Medical Homes and the Creation of an Innovation Center within CMS:** We strongly support the provision in H.R. 3590 that would provide funding for 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 the Center would be required to consider the Patient-Centered Medical Home, but we recommend that specific requirements be added to fund one or more PCMH pilots under Medicare. The Department of Health and Human Services recently announced that it has put on hold the existing Medicare Medical Home pilot, which the Senate strongly supported in past legislation, because of uncertainty about whether Congress will continue to support the pilot or change the existing requirements. We support the creation of a patient-centered medical home within Medicaid, but believe that all Medicaid beneficiaries be allowed to receive care in a medical home.

  ACP recommendations: Provide specific authority and direction to HHS to implement a Medicare medical home pilot rather than leaving it to the Center to decide if and when it will be funded. Expand the Medicaid Patient Centered Medical Home eligibility to all patients, not just those with at least two chronic conditions or one chronic condition with the risk of developing another chronic condition.

- **Independent Medicare Advisory Board:** 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, but ***the current proposal does not provide sufficient safeguards*** so that Congress will have the final say over the Commission's recommendations, that there will be adequate representation of different stakeholders and experts, that the Commission will be able to recommend broad delivery system reforms affecting physicians, hospitals and other providers, and that cost-cutting won't have a higher priority than improving outcomes and value of care.

  ACP recommendations:

  Representation on the Board: The Senate health reform bill designates the commission to be composed of 15 members, and includes experts in fields related to health care 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. We recommend that modifications be made to include specified representation of physicians who deliver care in a community setting, and at least one designated seat for a primary care physician.

  Congressional Authority: We also remain concerned that the Senate legislation would only allow Congress to block implementation of Medicare Commission recommendations by passing alternative legislation that meets the required savings benchmarks. This legislation could be vetoed by the President and then only overturned by a super-majority vote of both the House and Senate. ACP recommends that Congress be able to block implementation of the Commission's recommendations 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 Board's proposals are not approved by Congress.

  Transparency: The Senate legislation states that the MC may hold hearings concerning their proposals if they consider these forums advisable. This places too much authority with the MC in deciding when, or even if, to hold hearings on important Medicare payment 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, that the legislation mandates the Commission to hold a minimum number of hearings before proposals are finalized.

Exemption of Certain Providers: The Senate legislation 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 from payment reductions by the Commission. This unfairly leaves physician payments as one of the few remaining means of obtaining required savings. It is also counter to the concept of aligning incentives across physicians, hospitals, and other providers to achieve better value for patients. ACP recommends that IMAB be allowed to make recommendations that apply broadly to all sectors.

- **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 failure to report successfully. While we appreciate that the 2014 initiation of payment penalties is two years later than included in the Senate Finance Committee bill, the Physician Quality Reporting Initiative (PQRI) program has yet to demonstrate reliability that would warrant making participation essentially mandatory. We support the other provisions in the bill that improve the PQRI.

  ACP recommendation: Eliminate the penalties for not successfully reporting on quality measures.

- **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, the College opposes the provision that would modify payment in a budget neutral manner based on an assessment of a physician's cost and quality of care. It is premature to mandate such a dramatic change as there are very few accepted measures of the outcomes of care or resource use and there are other confounding factors.

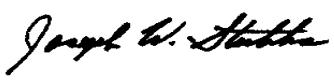
  ACP recommendations: Replace this provision with a provision directing the Institute of Medicine to study the reasons for geographic variations in the quality and cost of care and make recommendations for reform.

- **Mis-valued Relative Value Units (RVUs):** ACP supports the requirement that the Secretary periodically identify physician fee schedule services that are potentially mis-valued and make appropriate adjustments to the relative values of such services but believes that dedicated funding is needed for it to have its intended impact. ACP recommends that you dedicate $20 million in annual funding, which is the amount in the House of Representatives-passed bill, to ensure that the Secretary has the necessary resources. This is important 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 many of the models are likely to use RBRVS payments.

- **Comparative effectiveness research:** ACP s strongly supports provisions in the bill to fund independent research on the comparative effectiveness of different treatments to inform and empower shared decision-making.

In conclusion, ACP is pleased that H.R. 3590, the Patient Protection and Affordable Care Act, has many of the key policies needed to provide affordable coverage to all Americans, expand the primary care workforce, and improve payment and delivery system, and we remain firmly committed to the goal of getting legislation passed this year by the Senate that delivers on these essential policies and goals. We offer our recommendations for improving on the areas of concern in the spirit of achieving a final bill that would ensure that the policies intended to support primary care are sufficient to the need, to accelerate pilot-testing of innovative delivery models and payment reforms with appropriate congressional oversight, to ensure that the Patient-Centered Medical Home will be among the models to be tested on an accelerated and expanded basis, and to eliminate the cycle of endless Medicare physician payment cuts that threaten access to care. We look forward to continuing to work with you to achieve these objectives.

Sincerely,



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