



The Capitol Key

A newsletter service for the Key Contacts of the American College of Physicians by ACP Services Inc.

June 2007

Leadership Day 2007

ACP Service's Leadership Day 2007 (May 15-16) was attended by a record 302 participants from 42 states. Attendees prepared for their congressional visits on Tuesday with a full day's program of learning what a typical visit consists of, a full overview of health legislation from Bob Doherty, Senior Vice-President, and from congressional staff panels on Health Information Technology and Physician Payment and Quality. Early Wednesday morning, busses brought attendees to Capitol Hill for talks by Rep. Burgess (R-TX), an OB/GYN on the House Committee on Energy and Commerce, who has supported primary care issues, and Rep. Kaptur (D-OH), who was set to unveil the HealthCARE Act, H.R. 2351, legislation to expand health insurance.

ACP Services holds its annual Leadership Day each spring to provide a convenient means for ACP members to speak directly to their members of Congress and staffs about issues of concern to internists, and in turn, for these congressional members to hear of these issues directly from constituents. Chapter offices make all congressional appointments and organize which Chapter members will visit each office. ACP staff provides all background material and the documents to leave with each office. This year, 2007, marked the 15th

anniversary of Leadership Day.

Health care remains a key issue of concern for many congressional lawmakers. A number of health care related bills have already been

introduced and more are expected. The top-priority issues discussed during the visits, however, were (1) replacing the SGR with positive, stable, and predictable payments for all physicians with additional incentive payments for voluntary participation in quality improvement programs; (2) the patient-centered medical home (PCMH); and (3) SCHIP reauthorization and expansion of coverage to more uninsured persons. Other issues for discussion were liability reform, funding for health programs and student loan debt relief.

With many participants returning to Leadership Day from previous years and 67 percent of all attendees being Key Contacts, many arrived with a good understanding of the issues and the knowledge that legislation often takes years to work its way through Congress. For those new to Leadership Day and not (yet) Key Contacts, they often had their fellow Chapter colleagues to learn from and strategize with about who would talk about what issues during the visits. The perspective brought by the many medical students attending was noticed by many.

In 2008, Leadership Day (May 13-14) and Internal Medicine 2008 (annual session; May 15-17) are both in Washington, DC. If you have not done so already, please mark your calendars and plan to attend this historic event.

IT IS NOW CLEAR TO ME THAT MEDICINE WILL BENEFIT MORE FROM INFLUENCING ONE HILL DECISION MORE THAN A GREAT MEDICAL BREAKTHROUGH.

LIOR SHAMAI, DO
ACP ASSOCIATE
FLORIDA



Michael F Rein, MD FACP, Virgil H. Goode, Jr. (R-VA), William E Fox, MD FACP, and David E. Winchester, MD



Members of some of the California delegation meet with Rep. Stark (D-CA).

2007 Awards Dinner

While in Washington, DC, in between a full day's briefing and a full day on Capitol Hill, participants attended the 2007 Leadership Day Awards dinner. Special recognition was given to those persons who have made significant contributions to ACP Services advocacy

programs and health care issues important to internists. The awards presented were:

Key Contact of the Year: Robert M. McLean, MD, FACP, New Haven, CT. During 2006, Dr. McLean's contributions to advocacy was highlighted by his personal delivery of ACP's white paper on the "Advanced Medical Home" directly into (former) Rep. Johnson's (R-CT) hands. His achievement was the result of his diligently establishing a relationship with Rep. Johnson over the years. Rep.

Johnson was engaged by the concept and discussed the AMH in her congressional hearings several weeks later. Subsequently, AMH pilot testing was mandated in the December 2006 Medicare legislation.

Top Ten Key Contacts: Dawn E. Clancy, MD, FACP, Johns Island, SC; S. A. Dean Drooby, MD, FACP, Oklahoma City, OK; Jacqueline W. Fincher, MD, FACP, Thomson, GA; Richard W. Frieden, MD, Chico, CA; Sharon C. H. Mead, MD, FACP, Glen Head, NY; Kay M. Mitchell, MD, FACP, Jacksonville, FL; Lawrence M. Phillips, MD, Floral Park, NY; Mark W. Purtle, MD, FACP, Des Moines, IA ; Susan E. Sprau, MD, FACP, Santa Monica, CA; and Robert G. Strickland, MD, FACP, Albuquerque, NM.

Certificate of Appreciation: ACP participates in the Relative Value Scale Update Committee (RUC). RUC makes relative value recommendations to the Centers for Medicare and Medicaid Services (CMS). ACP's representatives, J. Leonard Lichtenfeld, MD, MACP, and M. Douglas Leahy, MD, FACP, were recognized for their extraordinary contributions.

Joseph F. Boyle Award for Distinguished Public Service: Caroline M. Clancy, MD, Director of the Agency for Health care Research and Quality (AHRQ). Dr. Clancy was recognized for her outstanding public service in advancing health services research.

"I ENCOURAGE YOU ALL TO BE RELENTLESS OPPORTUNISTS IN YOUR ADVOCACY WORK."

ROBERT M. MCLEAN, MD, FACP

Words from Robert McLean



Robert M. McLean, MD, FACP, accepting his Key Contact of the Year award.

Below is the acceptance speech given by Key Contact of the Year, Robert M. McLean, MD, FACP.

As I look around this room and this organization, I see many individuals who expend remarkable effort and energy to improve our health care system, and I am truly honored to be given this Key Contact of the Year Award. So much of the time, I think of how much more I could be doing in our advocacy efforts.

I think I am here now because I have been opportunistic and lucky.

And when you are a lucky opportunist,

you get things done!

I encourage you all to be relentless opportunists in your

advocacy work. If you have a legislator in an influential position on an important committee for health care legislation, you have to take advantage of any and every opportunity you have with that legislator or staff.

It may take years of visits and contacts to develop a relationship. But it all pays off when that legislator decides to listen to you at just the right time for some ACP policy to become part of a legislative bill because that legislator had the will and the position to make it happen.

So many of our ACP policies and suggestions for health system improvement are rational and altruistic in ways that they do not need a "hard sell" to legislators—they really just need a legislator willing to take the time to read it, understand its importance, and then be in a position to implement it.

It is our role as advocates to be persistent, but friendly and helpful, messengers. Someday, you just may get lucky.

Thank you.



From the Chair

Thank you to the over 200 Key Contacts who participated in Leadership Day. Key Contacts—two-thirds of attendees—were a visible group throughout the meeting. It was wonderful to see all the Key Contacts stand up for a round of applause during the Awards dinner.

The main issues discussed during the visits were (1) replacing the SGR with positive, stable, and predictable payments for all physicians with additional incentive payments for voluntary participation in quality improvement programs; (2) the patient-centered medical home (PCMH); and (3) SCHIP reauthorization and expansion of coverage to more uninsured persons; (4) liability reform; (5) funding for health programs; and (6) student loan debt relief. Not all issues, of course, could be discussed at each meeting. The topics discussed often depended on the interest of the member of Congress. As ACP groups came through our gathering room in between their Hill meetings, it was amazing how many reported the feedback they got from the congressional offices who appreciated the diversity of the ACP group. The high number of medical students discussing their lack of desire to enter primary care was especially powerful.

Not everyone can make it to Leadership Day though. While it's a great opportunity for a large group of us to be seen and heard on Capitol Hill, it is only one day—and only one part of the work we need to do. Your in-district visits, your phone calls, letters and e-mails keep the messaging going throughout the year. So, please, keep your messaging going. We're at the start of a new Congress and the bills we support need more co-sponsorship (this issue of *The Capitol Key* asks you to take action for a number of bills).

Maybe you can make it next year when Leadership Day (May 13-14) and Internal Medicine 2008 (annual session; May 15-17) are both in Washington, DC.

David L. Bronson, MD, FACP
Chair, Board of Governors

KEEP IN TOUCH

Don't forget to let the Washington Office know of the advocacy activity you initiate on your own. Have you had meetings or sent a letter to your congressional offices? Written an advocacy piece for a publication?

Jolynne Flores
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Health Information Technology Bill Based on ACP Policy Introduced



Lynne M Kirk, MD, MACP, testifies before the House Committee on Small Business, Subcommittee on Regulations, Healthcare and Trade.

In March, then-ACP President Lynne Kirk, MD, FACP, testified before the House Committee on Small Business, Subcommittee on Regulations, Healthcare and Trade regarding the difficulty solo and small physician practices face in purchasing and maintaining health information technology (HIT). Dr. Kirk stated, "Congress has an important role in promoting HIT adoption and providing the necessary initial and ongoing funding

mechanisms to assist physicians in solo and small practices. Unfortunately, without adequate financial incentives, solo and small physician practices and their patients will be left behind the technological curve." Dr. Kirk went on to point out that, "Depending on the size of the practice and its applications, acquisition costs on average \$44,000 per physician. The average annual ongoing costs are about \$8,500 per physician," Dr. Kirk pointed out. "The 'business case does not exist to make this kind of capital investment."

In response, Reps. Charles Gonzalez (D-TX) and Phil Gingrey, MD (R-GA) introduced bipartisan legislation that builds into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services for solo and small physician practices. The amount of the add-on would relate to the complexity of HIT adopted by the practice, but more importantly, the ongoing payment recognizes the lifetime costs associated with maintaining such systems. This legislation, H.R. 1952, the "National Health Information Incentive Act of 2007," currently has 13 cosponsors, and is based entirely on ACP-approved policy.

Please see page 8 to see if your representative is sponsoring H.R. 1952. If not, please contact your representative and ask him or her to support the National Health Information Incentive Act of 2007. You may contact your legislators through our Legislative Action Center Web site at www.acponline.org/lac.

Take Action

Bipartisan Access Bill Based on ACP Policy Introduced



David C. Dale, MD, FACP, ACP President listens as both Rep. Kaptur (D-OH) and Rep. LaTourette (R-OH) introduce the HealthCARE Act of 2007.

During Leadership Day, House members Marcy Kaptur (D-OH) and Steven LaTourette (R-OH) re-introduced legislation to expand health insurance coverage to millions of

uninsured Americans. The legislation, H.R. 2351, the Health Coverage, Affordability, Responsibility and Equity (HealthCARE) Act of 2007, is modeled after ACP's seven-year plan to expand access to care to all Americans. ACP President, David Dale, MD, FACP, stated at a joint press conference with Reps. Kaptur and LaTourette, "ACP is confident that this framework can succeed where other health reform proposals have failed. By offering robust incentives and choices to states, employers, and consumers, instead of 'one-size-fits-all' government mandates, the HealthCARE Act has the potential of unifying, instead of dividing, key stakeholders."

The bill would give states new options to expand coverage through existing public programs. It would also expand existing programs and give individuals a tax credit to buy coverage from private plans. The House legislation would expand access to care through the following measures:

- States will be given new options to extend health insurance coverage to low-income working Americans, without imposing unfunded mandates on financially strapped state treasuries;

- States will have the option to redesign their health care delivery programs to emphasize prevention, care coordination, quality, and the use of health information technology through the patient-centered medical home;
- Advance, refundable tax credits will be made available to uninsured working Americans with incomes up to 200% of the federal poverty level;
- The tax credit will provide a premium subsidy equal to what the federal government now provides to its own employees;
- Tax credit recipients will have the options of buying coverage through state purchasing group arrangements modeled after the Federal Employees Health Benefits Program, giving them the same types and variety of health plan options now available only to federal employees, or from qualified non-group insurers;
- Small employers will have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees; and
- An expert advisory commission will recommend essential benefits that participating health plans will be encouraged to offer, as well as ways to expand coverage to those with incomes above 200% of the federal poverty level.

Supporters of the legislation include ACP and Families USA. Please see page 8 to see if your representative is sponsoring H.R. 2351. If not, please contact your representative and ask him or her to support the bill. You may contact your legislators through our Legislative Action Center Web site at www.acponline.org/lac.

Take Action



Bills to Watch

| Number | Name | Introduced by |
|-----------|--|---|
| H.R. 1952 | National Health Information Incentive Act of 2007 | Reps. Gonzalez (D-TX) and Gingrey (R-GA) |
| H.R. 2351 | HealthCARE Act of 2007 | Reps. Kaptur (D-OH) and LaTourette (R-OH) |
| H.R. 2584 | High-Need Physician Workforce Incentives Act of 2007 | Reps. Burgess (R-TX) and Cuellar (D-TX) |
| H.R. 2244 | Geriatric Assessment and Chronic Care Coordination Act of 2007 | Rep. Green (D-TX) |
| S. 1340 | Geriatric Assessment and Chronic Care Coordination Act of 2007 | Sen. Lincoln (D-AR) |

Congress Must Act Again on the SGR

Although Congress acted late last year to avert the 5 percent cut in the Medicare fee schedule that would have taken effect this past January, physicians and their patients face what would be a devastating cut of 9.9 percent in 2008 and untenable cuts of nearly 40 percent over the next eight years.

The SGR cuts payments to all physicians, but is especially detrimental to primary care physicians in small practices who already are under-reimbursed and have very low practice margins. The SGR cuts also deprive physicians in primary care practices of the resources needed to invest in health information technology and quality improvements.

In its report to Congress this past March, the Medicare Payment Advisory Commission (MedPAC) observed that the SGR is considered to be flawed. The report went on to point out that this mechanism neither rewards physicians who restrain volume growth nor punishes those who prescribe unnecessary services. MedPAC recommended that, for 2008, the Medicare fee schedule conversion factor be increased based on the projected change in input prices. The latest forecast suggests that this update would be approximately 1.7 percent.

Upon release of the MedPAC report, the College expressed strong support for the Commission's observation that the SGR is flawed and called upon the Congress to repeal it. ACP proposes that Congress replace the SGR with a new update framework that: provides positive and predictable baseline payments; establishes a transition period leading to repeal of the SGR; and creates powerful incentives for physicians to design, implement and participate in programs to improve quality and achieve more efficient use of resources.

ACP members should urge their legislators to request that their leaders work with the medical profession to replace the SGR.

ACP recommends that Congress take the following actions:

- Replace the 9.9 percent reduction in Medicare payments for physician services scheduled for 2008 with an update of approximately 1.7 percent that reflects the projected increase in input prices as recommended by MedPAC;
- Mandate a positive update in 2009 that also reflects increases in the costs of providing services as determined by MedPAC;
- Set a firm date for when the SGR will be repealed.
- During the transition to full repeal of the SGR, put a process in place to establish annual updates by legislation based on MedPAC's recommendation of a percentage update that reflects increases in input costs of providing services.

The congressional committees with jurisdiction over Medicare Part B, the House Ways and Means and Energy and Commerce committees and the Senate Finance Committee, are planning to begin formal consideration of legislation to address the scheduled cuts in the Medicare fee schedule when they return from their upcoming Independence Day recess.

ACP Key Contacts should take advantage of the recess, June 30-July 8, to contact legislators while they are back in their home states and districts to request prompt action to avoid the devastating cuts.

**Take
Action**

Status

Referred to Committee on Energy and Commerce and Committee on Ways & Means

Referred to Committee on Energy and Commerce, Committee on Ways & Means, Committee on Education and Labor, and Committee on Rules

Referred to Committee on Energy and Commerce and Committee on Ways & Means

Referred to Committee on Energy and Commerce and Committee on Ways & Means

Referred to Committee on Finance

ACP Testifies on Strategies to Increase Information on Comparative Clinical Effectiveness

On June 12, 2007, David C. Dale, MD, FACP, ACP President, testified before the House Committee on Ways & Means, Subcommittee on Health on strategies to increase research and information on comparative clinical effectiveness. He stated that ACP “supports Congressional efforts to provide Medicare and all stakeholders with improved access to information about the relative strengths and weaknesses of various clinical products, procedures and services based on the best available evidence from clinical effectiveness research.”

The United States currently does not have a systemic means of producing comparative information on the relative effectiveness of drugs, durable equipment, therapies and procedures. This is in marked contrast to the activities conducted in a number of other countries, including Canada, Great Britain, Germany and Australia. ACP is asking Congress take efforts, including allocation of secure and sustained funding, to develop or support a trusted entity that systematically develops evidence on the relative effectiveness of various alternative healthcare services. The entity should be an unbiased independent entity, with transparent proceedings, strong stakeholder involvement, a prioritization process to ensure the evidenced produced has the greatest impact, and established processes that ensure that the evidence developed is accessible in a comprehensive form to all stakeholders.

Dr. Dale presented a number of points for Congress to consider. ACP is asking Congress to:

Provide Medicare and all stakeholders with improved access to information about the relative strengths and weaknesses of various clinical products, procedures and services;

Consideration should be given to increase support for the work of the AHRQ as the “trusted entity” for comparative effectiveness research, with inclusion of secure and sustained funding that is not subject to the political pressures often associated with the annual appropriations process;

Recognize that the greatest value of developed comparative effectiveness data at this time is to help answer the question of what works best for whom and use of this information to enable physicians and patients to engage in informed and shared decision-making—a key element of the Patient-Centered Medical Home.

Be deliberate in potentially using clinical or cost comparative effectiveness data to modify the Medicare benefit design; and finally,

Recognize that the value of a systemized approach to developing comparative effectiveness evidence can be leveraged through the establishment of mechanisms to

facilitate the implementation of health information technology (HIT) throughout the health care system.

Due to pay-as-you-go rules, it could be difficult for Congress to pass comparative effectiveness legislation this year, in part because it would require initial spending without immediate savings.

Geriatric Assessment and Chronic Care Coordination Act of 2007

On May 9, 2007, Senator Lincoln (D-AR) and Rep. Green (D-TX) introduced the Geriatric Assessment and Chronic Care Coordination Act of 2007 (S. 1340 and H.R. 2244, respectively). This legislation represents significant change in Medicare by providing an additional benefit for geriatric patients with multiple chronic diseases.

The Geriatric Assessment and Chronic Care Coordination Act of 2007 would provide for Medicare Part B coverage of geriatric assessments and chronic care coordination services for eligible individuals. It would authorize Medicare coverage when a physician provides a comprehensive review of a geriatric patient’s medical condition. If a patient was diagnosed with multiple chronic illnesses, Medicare would also provide an additional benefit for care coordination.

The American College of Physicians recently submitted testimony in support of this legislation to the Senate Special Committee on Aging, which conducted a hearing on recognizing the need for chronic care coordination in Medicare. ACP notes that enactment of this legislation “would represent a major and essential step forward to re-aligning Medicare benefits and payment policies to incorporate key elements of the patient centered medical home.” A Patient Centered Medical Home, a model of care designed to provide the most effective and efficient care to the patient, designates a personal physician to coordinate all of a patient’s health care needs. The medical home includes the use of health information technology, the coordination of specialty and inpatient care, disease management and prevention, health maintenance, and diagnosis and treatment of acute and chronic illnesses.

Please see page 8 to see if your senators and representative are sponsoring the Geriatric Assessment and Chronic Care Coordination Act of 2007. If not, please contact your them and ask them to support the bill. You may contact your legislators through our Legislative Action Center Web site at www.acponline.org/lac.

**Take
Action**

Take Action Now

www.acponline.org/lac

NATIONAL HEALTH INFORMATION INCENTIVE ACT OF 2007 (H.R. 1952)

Sponsor

Rep Gonzalez TX-20

Co-sponsors (as of 6/20/07)

Rep Alexander LA-5
 Rep Boren OK-2
 Rep Burton IN-5
 Rep Cuellar TX-28
 Rep Gerlach PA-6
 Rep Gingrey GA-11
 Rep Green TX-29
 Rep Hirono HI-2
 Rep Jindal LA-1
 Rep Johnson GA-4
 Rep Marshall GA-8
 Rep Payne NJ-10
 Rep Velazquez NY-12

If your representative is not listed, go to the Legislative Action Center to ask them so sponsor H.R. 1952.

Take Action

HIGH-NEED PHYSICIAN WORKFORCE INCENTIVES ACT OF 2007 (H.R. 2584)

Sponsor

Rep. Burgess TX-26
 Rep. Cuellar TX-28

Co-sponsors (as of 6/20/07)

Rep Castle DE
 Rep Emerson MO-8
 Rep Gilchrest MD-1
 Rep Granger TX-12
 Rep LaTourette OH-14
 Rep Platts PA-19
 Rep Ros-Lehtinen FL-18
 Rep Smith TX-21

If your representative is not listed, go to the Legislative Action Center to ask them so sponsor H.R. 2351.

Take Action

GERIATRIC ASSESSMENT AND CHRONIC CARE COORDINATION ACT OF 2007 S. 1340 AND H.R. 2244

SENATE

Sponsor

Sen Lincoln AR

Co-sponsors (as of 6/20/07)

Sen Boxer CA
 Sen Casey PA
 Sen Clinton NY
 Sen Collins ME
 Sen Kerry MA
 Sen Kohl WI
 Sen Mikulski MD
 Sen Murray WA
 Sen Sanders VT

HOUSE

Sponsor

Rep Green TX-29

Co-sponsor

Rep Boren OK-2
 Rep Upton MI-6

If your senators and representative is not listed, click below go to the Legislative Action Center to ask them so sponsor S. 1340 and H.R. 2244.

Take Action

HEALTH COVERAGE, AFFORDABILITY, RESPONSIBILITY AND EQUITY (HEALTHCARE) ACT OF 2007 (H.R. 2351)

Sponsor

Rep Kaptur OH-9
 Rep LaTourette OH-14

Co-sponsors (as of 6/20/07)

Rep Clay MO-1
 Rep Grijalva AZ-7
 Rep Hastings FL-23
 Rep Norton DC

If your representative is not listed, go to the Legislative Action Center to ask them so sponsor H.R. 2351.

Take Action