



Frequently Asked Questions
America's Affordable Health Choices Act of 2009 (H.R. 3200)
Updated August 12, 2009

The House of Representatives Ways and Means, Energy and Commerce, and Education and Labor Committees have completed consideration of comprehensive health care reform legislation, the America's Affordable Health Choices Act of 2009 (H.R. 3200). Each committee has favorably reported the legislation, which means that it now moves to the full House of Representatives for a vote. Any changes adopted by each committee during the markup phase must be reconciled before consideration of the bill by the full House of Representatives. A vote by the House on H.R. 3200 is expected in September when members of Congress return from the August district work period.

Below are questions and answers about the legislation that we thought you might find helpful when speaking with ACP members or others. The Senate is expected to release competing legislation, but we do not have an exact timetable on that release. Once the House and Senate each pass a bill, the two houses of Congress will have to work together to come up with a compromise bill.

- 1. Does ACP's support for America's Affordable Health Choices Act of 2009 (H.R. 3200) mean that the College is satisfied with it? Will ACP be seeking changes? What are the College's priorities for changes?**

Why the American College of Physicians believes that America's Affordable Health Choices Act of 2009 (H.R. 3200) merits internists' support, even as ACP continues to work for improvements throughout the legislative process:

H.R. 3200 does much of what ACP asked Congress to do in terms of coverage, support for the primary care workforce, payment and delivery system reform, based on long-standing policies that have been adopted by this organization. No bill is perfect, but H.R. 3200 delivers on our major priorities in a way that is remarkably consistent with ACP policies, policies that were developed by the College's leadership over many years and always guide how ACP's leadership, Key Contacts and staff advocate for internal medicine physicians and their patients.

ACP's support for the bill to move forward does *not* mean that we are fully satisfied with it. H.R. 3200 is just one step in a long and complex legislative process that will allow for multiple opportunities for changes, and the final bill is likely to include some of the provisions in H.R. 3200 but not others. For instance, it is expected that the Senate will adopt a very different way of paying for health reform than the high income tax surcharge employed by the House. ACP will continue to pursue the best possible outcome for patients and internists including working to strengthen the payment reforms for primary care, influencing the design of a public plan option so that physician participation is voluntary and it does not use Medicare payment rates, and seeking inclusion of major reforms of the medical liability system. We also will oppose amendments that may be made throughout this process that are not in patients' and physicians' interests. And, ACP's support for a positive vote on H.R. 3200 in the House of Representatives is contingent on reviewing any amendments made by the committee.

To try to influence Congress to consider ACP's ideas to improve the bill, ACP will be far more effective for having come out with a positive statement on the many policies in the bill that are aligned with ACP policies. ACP wants to continue to be invited to the table and not to have to fight to be there. Destructive opposition will effectively remove ACP from being invited and place at great risk all of the positive changes that the bill would bring about -including the coverage, workforce, elimination of Medicare SGR cuts, and payment reforms to support primary care.

ACP would support any bill that accomplishes our goals in a way that is consistent with ACP policy, whether championed by Republicans or Democrats, and prefers that legislation has bipartisan support. Most importantly, ACP believes that the status quo is not in the best interests of doctors or patients, and that the risk of staying with the status quo is greater than the risk of change.

Coverage for All Americans

2. What is ACP's position on coverage for all Americans and on America's Affordable Health Choices Act of 2009 (H.R. 3200)?

We are pleased that America's Affordable Health Choices Act of 2009 includes policies on coverage, workforce, payment and delivery system reform, primary care, comparative effectiveness research, and administrative simplification that are strongly supported by the College. The legislation would help achieve one of ACP's long-standing policy objectives of affordable coverage for all: more than 97 percent of Americans would be covered if the plan is enacted, with the vast majority of those people covered by private insurance, not a government plan, according to the Congressional Budget Office. The College also strongly supports reforms that prohibit insurers from turning down or charging exorbitant rates to people with pre-existing conditions. Insurers also would be required to cover preventive and other essential benefits and spend at least 85 percent of the premium dollars collected on health care, instead of administrative costs. Since we recognize that changes will be made as health reform legislation makes its way through both the House and Senate, we intend to continue to provide the White House, and the House and Senate with our views on potential changes and how they would reflect ACP's priorities and policies.

We are committed to doing all that we can to get legislation enacted this year to ensure that all Americans will have access to affordable coverage and to a general internist or other primary care physician. America's Affordable Health Choices Act of 2009, H.R. 3200, will go a very long way toward achieving these goals. Change creates risk, but we do not believe that the status quo is in the best interests of ACP members and patients.

Public Plan

3. Does ACP support allowing uninsured individuals the option of obtaining insurance through a public plan administered by the federal government?

The question of whether a public plan should be among the options offered by a health exchange is an important one. Instead of the issue being framed as whether one is for or against a public plan, ACP believes that the question that should be asked is what combination of options, private and public, would best meet the needs of the public.

Accordingly, ACP's Board of Regents recently adopted guidelines for evaluating proposals that would include a combination of public and qualified private health plans based on the degree to which they would advance important policy objectives, including reforming payments to support patient-centered primary care, promoting fair competition between plans on a level playing field, redesigning benefits to

support prevention and wellness, ensuring adequate access to physicians within each plan, and ensuring that both patients and physicians can voluntarily choose the plans in which they participate. ACP believes that a public plan that meets these and other important policy objectives could appropriately be among the options offered to the public. ACP is committed to providing Congress and the White House with its perspectives on how to design private and public health insurance options to best meet the needs of patients.

4. Does ACP support the public insurance plan option outlined in America's Affordable Health Choices Act of 2009 (H.R. 3200)?

This is an issue that has elicited strong but divided opinion among ACP members. Some internists have expressed practical and philosophical concerns about the public plan, while others have said that they believe a public plan is essential.

ACP policy says: a public plan could appropriately be offered, along with qualified private plans, if participation in the public plan is voluntary, if it competes on a level playing field with private insurers, and if it is not locked into Medicare's payment rates. Under H.R. 3200, physician and patient participation in the public plan would be *voluntary*. The public plan would have to pay for itself through premiums collected, rather than being funded from the U.S. Treasury, to help place it on a level playing field with private insurers.

ACP has worked diligently in urging the House committees to change the provision in the legislation that called for the public plan to use Medicare rates (Medicare plus 5 percent for physicians who accept both Medicare and the public plan) for its first three years. After that, the public plan would set its own rates. The College believes that the public plan should instead be required to pay competitively with private insurers. The College is pleased that, during committee consideration of H.R. 3200, language was adopted that gives the Secretary authority to negotiate rates under the public plan, instead of basing them on Medicare.

5. Will the public plan lead to “rationing” and elimination of private insurance?

ACP does not believe that a public plan, if designed appropriately, will lead to rationing of care or elimination of private insurance. America's Affordable Health Choices Act of 2009 (H.R. 3200) does not give the public plan or the federal government any authority to ration or set explicit limits on care based on cost or other criteria. Like private health plan options, the public plan would be required to cover essential benefits, as recommended by an expert commission that would have representation from practicing physicians. As is the case with private health insurance plans, a public plan would have the authority to review the medical necessity and appropriateness of care provided by physicians and other clinicians. Unlike private insurers, however, publicly funded plans are generally required to be “transparent” in the medical review criteria that they use.

Many of those who are concerned that a public plan will lead to rationing of care believe that this will be the case if the public plan eventually crowds out all private insurers, giving the federal government sole authority over benefits paid under such a plan (i.e. a single payer system). The idea that the public plan would destroy private insurance is not supported by expert analysis. The Congressional Budget Office notes that because physician participation in the public plan is voluntary, and payments are likely to be the same or lower than payments under private insurance plans, it is difficult to estimate how many people would enroll in the public plan. The CBO suggests that enrollment in a public plan, at full implementation, could be as many as 8 or 9 million people out of the estimated 30 million who would get coverage through the exchange, many of whom though are currently uninsured, but even so, this would mean that most people in the exchange would be covered under private insurance. CBO also estimates

that the vast majority of persons—165 million, an increase of three million persons compared to current law—would be covered by their employers.

To address concerns that a public plan will crowd out private coverage, ACP advocates that a public plan compete on a level playing field with private insurers offered through an exchange—by, for instance, having to fund its operations solely out of premiums rather than access to tax payer dollars. America’s Affordable Health Choices Act of 2009 (H.R. 3200) includes such a requirement. In addition, the bill prohibits the public plan from accessing the U.S. Treasury to protect against insolvency. ACP also believes that safeguards are needed to ensure that a public plan reimburses physicians competitively with private insurers, as described above, because a public plan’s authority to set rates could give it a competitive advantage in the market compared to private plans. It should be noted, though, that in many parts of the country, a single dominant private insurer essentially has monopolistic power to set payment rates because there are no viable competitors offering health insurance. America’s Affordable Health Choices Act of 2009 (H.R. 3200) would effectively eliminate such market dominance by a single insurer by providing eligible individuals and small businesses a broad choice of qualified health plans, private and public.

6. Does H.R. 3200 prohibit private contracting?

No. We have found nothing in the law that takes away existing rights for physicians and patients to enter into voluntary contracts. Because participation is voluntary, no physician would be mandated to accept the public plan and its rates, just like no physician is required to accept the fee schedules offered by a private insurer, unless they voluntarily elect to participate with that insurer. Many private insurers also require, as a contractual condition of participation, that physicians accept the plan’s payment schedule as full payment.

Because participation in the public plan is voluntary, no physician will be required to accept patients enrolled in the public plan if they do not wish to accept its payment scale. Nationwide, only a relatively small number of persons—8 to 9 million, according to the CBO—are likely to be enrolled in the public plan.

7. Does H.R. 3200 prohibit private insurance and health savings accounts?

No. Persons and small businesses that are eligible to purchase coverage through a health exchange would be able to choose from a wide variety of health plans, all of which would be provided by private insurance plans, with the addition of a public plan option and potentially, a member-run non-profit health insurance cooperative. As noted above, the independent Congressional Budget Office estimates that the vast majority of Americans will be covered under private insurance, with only a relatively small number enrolled in the public plan. Health Savings Accounts, as they are today, would be able to market themselves to the public and enroll persons who choose to get their coverage through an HSA.

H.R. 3200 will require that all insurers, whether offered through an exchange or outside it, comply with insurance market reforms, including prohibitions on excluding persons with pre-existing conditions, guaranteed renewability, and modified community rating. ACP policy has long favored such reforms. Individual insurance companies will eventually have to comply with such requirements. The legislation provides for a “grandfather” period, though, where people can elect to keep their current individual coverage even if it doesn’t meet the new requirements.

8. Does ACP support the Comparative Effectiveness provisions of America’s Affordable Health Choices Act of 2009 (H.R. 3200)?

The comparative effectiveness provisions of the bill are consistent with ACP policy which emphasizes the importance of the increased availability of comparative effectiveness information to assist patients and their personal physicians in choosing the most safe and effective treatment. As medical science continues to advance and treatment options rapidly multiply, the need for information comparing the effectiveness of alternative treatments becomes more critical. Each day in the privacy of the examination room, patients are treated for conditions for which there are numerous treatment options. This includes treatment for common conditions like intermittent heartburn, to the more serious chronic conditions of high blood pressure or diabetes, and to the more immediate life and death issues of having to choose the best approach for the treatment of acute coronary syndrome or an aortic dissection. This legislation would increase the availability of valid data that compares the clinical effectiveness, side effects and cost of different viable treatments for the same condition. Supplemented by the physician's clinical experience and professional knowledge, this information would help ensure that a good treatment choice is made—one that meets the unique needs and preferences of the patient.

The comparative effectiveness provisions in HR3200, as introduced, are also consistent with ACP policy. They make clear the importance that this information be the result of scientifically valid research from a trusted source. The provisions ensure multi-stakeholder input to a transparent process that is dedicated solely to the development of comparative effectiveness information. The information will then be disseminated in a comprehensible manner for use by all relevant parties including patients, providers and healthcare payers.

During committee consideration of H.R. 3200 however, several amendments were adopted that, if strictly interpreted, could unduly hamper Medicare and other federal healthcare programs from using the CE information to obtain value within the system and to promote the thoughtful use of healthcare resources. ACP is actively working to have these amendments removed from the final bill.

Medical Liability Reform

9. President Obama noted in his recent address to the AMA that he is not advocating for caps on damages in professional liability cases but that he is open to considering other reforms to reduce “defensive medicine.” Where does ACP stand on this issue?

ACP believes that reform of medical liability system is essential. The College supports professional liability reform that:

- Limits awards for noneconomic damages at \$250,000;
- Eliminates punitive damages;
- Eliminates the collateral source rule (eliminates double compensation to plaintiffs for certain items);
- Allows for periodic payment of future damages and structured settlements; and
- Provides for attorney fee regulation in personal injury and medical malpractice cases.

ACP also supports the testing of alternative solutions, such as health courts, and other proposals developed by the AMA/Specialty Society Medical Liability Project.

America's Affordable Health Choices Act of 2009 (H.R. 3200) unfortunately does not include any medical liability reforms. (This may partly be due to the fact that the three committees that prepared the bill have no jurisdiction over liability reform.) While continuing to call for caps, ACP will also urge Congress and the White House to explore other models, such as health courts, to reduce the costs of defensive medicine.

Workforce

10. How will America's Affordable Health Choices Act of 2009 (H.R. 3200) help primary care?

America's Affordable Health Choices Act of 2009 (H.R. 3200) provides for an additional 5 percent increase, beginning in 2011, for designated evaluation and management services by general internists and other primary care physicians. The primary care bonus is increased to 10 percent for designated services in Health Professional Shortage Areas. H.R. 3200 also would increase Medicaid payments for primary care to be equivalent to Medicare. Although ACP continues to believe that a larger primary care bonus is needed-ACP has asked for at least 10 percent in all areas of the country – 15 percent in health professional shortage areas. Even so, ACP believes that the recognition of the need to increase payments for primary care is an important step forward. The bill has extensive provisions to increase the supply and improve the training of primary care physicians. America's Affordable Health Choices Act of 2009 (H.R. 3200) includes the following additional provisions to support primary care:

- Medicaid payments for primary care will be increased to equal the Medicare rates.
- Evaluation and management and preventive services will have a higher baseline spending target than other services.
- Pilot testing of the Patient-Centered Medical Home, which will pay primary care physicians in a qualified medical home for care coordination services not covered in the regular office visit fee.
- Creating a national advisory council to recommend workforce goals and develop metrics to assess workforce policies.
- Increasing funding for National Health Services Corps and increasing award amounts from \$35,000/year to \$50,000/year. Also establishes new program to allow half-time service in the NHSC.
- Increasing award amount for Scholarships for Disadvantaged Students from \$20,000/year to \$35,000/year.
- Establishing new loan repayment program to primary care physicians in areas of the country with an insufficient supply and high need for primary care.
- Eliminating barriers to training in non-hospital based settings to allow primary care residents to have increased exposure to ambulatory care settings.
- Distributing Graduate Medical Education training positions to primary care programs – would redistribute unused residency positions to training programs that would like to create or expand their primary care training programs.
- Providing grants to address health care disparities, and to develop interdisciplinary models of team-based care.
- Establishing a program for the training of primary care medical residents in community-based settings.

The bipartisan Preserving Patient Access to Primary Care Act (PPAPCA), H.R. 2530, introduced by Rep. Allyson Schwartz includes additional provisions that would complement those in America's Affordable Health Choices Act of 2009 (H.R. 3200) to comprehensively address recruitment and retention issues in primary care. PPAPCA was based directly on ACP's proposals to avert the primary care access crisis.

As H.R. 3200 has made its way through the legislative process, in its many forms, two provisions were unfortunately struck relating to student loan and scholarship programs. These programs would have benefitted primary care internal medicine and ACP is working to have the provisions reinstated before a final bill is considered.

11. ACP has called on the federal government to establish a health care workforce policy to provide 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. How does this compare to what has been proposed in America's Affordable Health Choices Act of 2009 (H.R. 3200)?

America's Affordable Health Choices Act of 2009 (H.R. 3200) establishes an Advisory Committee on Health Workforce Evaluation and Assessment to assess, evaluate and advise on the appropriateness of the nation's health workforce and make recommendations on policies to ensure that such workforce is meeting the nation's needs. The Advisory Committee will consist of 15 members with representatives of the health care workforce and health professionals, employers, third-party payers, and labor unions. ACP has proposed that at least one primary care physician be a member of the committee, specifically to address the current primary care physician shortage.

The Advisory Committee is charged with making recommendations regarding standardized methodology and procedures to enumerate the health care workforce. It would update these recommendations every five years. It would also review current and projected supply and demand, and make recommendations concerning priorities, goals, and performance outcome measures for Federal workforce programs.

12. Does ACP agree that nurses can fulfill many of the duties of primary care physicians? Does H.R. 3200 put nurses on an equal footing with physicians? Will an adequate number of nurses relieve some of the strain on primary care practices?

Physicians and nurses complete training with different levels of knowledge, skills, and abilities that while not equivalent, are often complementary. As trained health care professionals, physicians and nurses share a commitment to providing high quality care. However, physicians are often the most appropriate health care professional for many patients. Nurse practitioners play a role in meeting the current and growing demand for primary care, especially in underserved areas.

Workforce policies should ensure adequate supplies of primary care physicians and nurse practitioners to improve access to quality care and to avert anticipated shortages of primary care clinicians for adults. Workforce policies should recognize that training more nurse practitioners does not eliminate the need, nor does it substitute, for increasing the numbers of general internists and family physicians trained to provide primary care.

America's Affordable Health Choices Act of 2009 (H.R. 3200) pilots would allow PCMHs led by advanced practice nursing to participate in the pilots, within the scope of practice of their state licenses. ACP believes that in the PCMH model, care for patients is best served by a multi-disciplinary team where the clinical team is led by a physician. However, given the call for testing different models of the PCMH, ACP believes that PCMH demonstration projects and pilots that include evaluation of physician-led PCMHs could also test the effectiveness of nurse practitioner-led PCMH practices in accord with existing state practice acts and subject to the same standards of evaluation for physician-led PCMH practices, as H.R. 3200 would require.

H.R. 3200 would define nurse-practitioners as primary care providers in order to also qualify for some of the primary care training and scholarship programs. Nothing in the bill, however, would allow NPs to provide care that is beyond their state license.

Physician Payment and Delivery System Reform

13. Will the bonus payment included in America's Affordable Health Choices Act of 2009 (H.R. 3200) for primary care services be sufficient to recruit and retain additional primary care physicians?

ACP appreciates the House's efforts to provide an increase for primary care services but believes that the proposed bonus, by itself, is insufficient. America's Affordable Health Choices Act of 2009 (H.R. 3200) calls for a 5 percent bonus for designated services by primary care physicians in 2011 (10 percent bonus for the same services in health professional shortage areas). This \$5 billion bonus in new money out of the federal budget will be spent on primary care. It would become a permanent part of the Medicare payment system.

ACP recommends that the House provide at least a 10 percent increase in total Medicare payments for primary care physicians in 2010 followed by an additional 5 percent increase in the next four years. All reforms aimed at improving primary care are important but making significant progress to reduce the compensation gap is needed to send a strong signal to physicians-in-training, and in practice, that primary care is a valued and viable option. ACP's goal continues to be to raise payments to primary care physicians to be competitive with other specialties, through a combination of improvements in the fee-for-service system and other reforms to support the value of patient-centered primary care. Given pay-as-you-go rules, ACP does not believe, though, that it will be possible to get Congress to increase Medicare fee-for-service rates to be fully competitive within five years, as we have repeatedly urged.

Although the amount of the bonus payment in H.R. 3200 is disappointing and the potential upside for an increased amount still below our intent, it is important to look at the bonus in the broader context of what the bill would do to address the primary care workforce crisis. As noted above, the legislation includes restructuring federally-funded workforce programs and GME to increase the numbers of primary care physicians. It includes more than \$1.8 billion to pilot test the Patient-Centered Medical Home on a national basis, as described below. PCMHs led by primary care physicians will be eligible for monthly risk-adjusted care coordination payments for qualified patients, which if designed correctly will substantially increase payments to internists in qualified PCMHs. And, as explained further below, the bill eliminates pending cuts from the Medicare sustainable growth rate (SGR) and the accumulated cost associated with the SGR, and provides primary care services with a higher baseline update going forward. The legislation also raised Medicaid payments for primary care physicians to Medicare rates. (In most states, Medicaid pays primary care doctors substantially less than Medicare.) It improves the accuracy of the physician work and practice expense relative values, distributing any "savings" from such adjustment back to all other physician services, including undervalued evaluation and management services.

In sum, H.R. 3200 has the right mix of policies to support primary care, but ACP will continue to pursue a higher bonus payment. ACP also will be working to get a more precise estimate of what the combined impact of such payment and delivery reforms will be on internists.

14. How does ACP feel about the America's Affordable Health Choices Act of 2009's (H.R. 3200) efforts to reform the physician payment formula known as the Sustainable Growth Rate (SGR)?

ACP applauds the provisions in America's Affordable Health Choices Act of 2009 (H.R. 3200) that would eliminate the SGR accumulated debt, remove expenditures on physician-administered drugs from the SGR calculation, the MEI-based update for 2010, and a higher growth allowance for evaluation and management services going forward. Accounting for the funds to eliminate the accumulated debt is a huge step forward, because the hundreds of billions of dollars in accumulated budget costs associated with providing physicians with positive updates has been the single greatest obstacle to a permanent solution to the SGR problem. America's Affordable Health Choices Act of 2009 (H.R. 3200) also provides a higher overall physician spending target than the current SGR formula—GDP plus two percent for all evaluation and management and preventive services, GDP plus one percent for all other services. The current SGR formula limits growth for all services only to GDP. America's Affordable Health Choices Act of 2009 (H.R. 3200) also removes physician-administered drugs from the new formula, a longstanding goal of ACP, because inclusion of such drugs has been a major contributing factor to spending exceeding the SGR target.

The College is concerned, though, that even with these changes, the continued reliance on GDP (even with the additional growth factors) could result in payments not keeping pace with physicians' practice expenses, especially for services that are not included in the evaluation and management service/preventive services category. ACP's goal continues to be to replace the SGR with a new update system that provides fair, predictable, and stable updates for physicians. ACP continues to explore how this new payment formula would impact future updates, and resulting revenue impact, that would result from the changes.

15. Does ACP support separate SGR targets as a way to control growth in Medicare Part B spending?

ACP prefers that Congress refrain from expenditure targets that determine payment updates. The College's preference would be to implement payment reforms that encourage more efficient and effective care, e.g. the PCMH, and to only use expenditure targets if those efforts fail to control rising costs. America's Affordable Health Choices Act of 2009 (H.R. 3200) appears to believe that expenditure targets are needed while reforms are identified and implemented. However, ACP believes that if Congress determines that a spending target or targets are still required, we support the concept of providing primary care and preventive services with a higher expenditure target/positive updates. We also want to ensure, however, that services provided by internists, including subspecialists, in the non-primary care/prevention category receive adequate updates.

16. What is ACP's position regarding the possible inclusion of a provision to establish an Independent Medicare Advisory Council (IMAC) in HR 3200.

ACP recognizes that Congress is considering proposals to establish an IMAC, or similar entity, which would have broad authority to recommend changes in Medicare payment policies that would automatically go into effect unless Congress voted to block them. The College is currently considering this proposal and will be providing its recommendations to Congress at a later date.

Improve the accuracy and appropriateness of Medicare relative value units.

17. How does America's Affordable Health Choices Act of 2009 (H.R. 3200) bill improve the accuracy and appropriateness of Medicare relative value units (RVU)?

Inaccurate and mis-valued relative value units under the Medicare fee schedule contribute to the undervaluation of primary care services and may create incentives for increased and unwarranted volume. ACP

supports that America's Affordable Health Choices Act of 2009 (H.R. 3200) provides the Secretary with authority, direction and funding to identify mis-valued codes through such means as:

- Accepting recommendations through the existing processes—e.g. through recommendations from the American Medical Association's Relative Value Scale Update Committee;
- Conducting surveys, data collection, and other analytics; or
- Using conductors to identify and adjust values.

The College appreciates that the draft legislation aims to address the low assumed use of expensive equipment, such as MRI and CT machines, that results in higher than warranted payments.

While ACP appreciates that the legislation highlights the importance of making corrections to mis-valued services and takes some steps to do so, the College continues to recommend the following specific reforms to improve the accuracy and appropriateness of Medicare RVUs including:

- Establishing an expert process to identify potentially overvalued or mis-valued services for further review.
- Requiring that the Secretary study the processes it uses to obtain expert advice on relative value units, and specifically, the adequacy of representation of primary care and other physicians who have expertise in the work associated with treating patients with chronic illnesses.

The Patient-Centered Medical Home and Delivery System Reform

18. Does ACP support America's Affordable Health Choices Act of 2009 (H.R. 3200) to create a national pilot for the PCMH?

Yes, but we continue to work with Congress to ensure that the pilots are designed to include enough patients and practices to truly show the potential value of the model. ACP strongly supports a provision in America's Affordable Health Choices Act of 2009 (H.R. 3200) that would direct the Secretary to establish two national, well-funded medical home pilot programs to provide patient centered care to high-need beneficiaries. The legislation provides almost two billion dollars to fund the pilots. The new pilots provide the Secretary with substantial leeway to expand the components of the pilot program that are beneficial to the Medicare program, including regulations to implement on a permanent basis. The pilots evaluate both an Independent Patient Centered Medical Home (payment to the independent practice) and a Community Based Medical Home (payments made both to the independent practice and a non-profit community (state) entity that provides medical home services in coordination with the independent practice) model. While the legislation repeals the current Medical Home demonstration project previously approved under the Tax Relief and Healthcare Act of 2006, it maintains the elements important to the College that were to be part of the repealed project, i.e. strong primary care emphasis; encouraging small-medium size practice participation; bundled, risk-adjusted payment for care coordination and other activities not currently covered under the current fee schedule; and recognition of different levels of medical home practices. Given that the Independent practice model aspect of the pilot is scheduled to take place within six months of enactment, it is likely that much of the design, implementation and evaluation work used for the Medical Home project currently approved by Congress will be employed in this new pilot. The College does believe it very important that Medicare initiate testing of the PCMH in an expeditious manner.

The bill also provides dedicated funding to pilot-test, on a national scale, the idea of paying physicians for care coordination in a qualified Patient-Centered Medical Home. This embraces ACP efforts to get the pilots to include more patients than high cost ones.

19. How does ACP feel about the section in H.R. 3200 that establishes a Medicare and Medicaid Payment Innovation Center?

The College strongly supports the establishment of a Center within the Centers for Medicare and Medicaid Services (CMS) that would allow the agency to test innovative payment models and expand those that demonstrate the ability to increase quality and/or decrease aggregate program costs. We appreciate that H.R. 3200 dedicates significant funding for the Center's operations and enabling it to select models that may not be initially cost neutral as it is appropriate to enable investment in promising approaches with an assessment of cost in the context of program-wide spending. We support the bill's direction that CMS would receive input from individuals with expertise in medicine and health care management. We do, however, recommend that this be modified to establish a technical advisory panel of experts, which includes a slot for a primary care physician. In addition, we urge clarification as to how the Center would relate to demonstration/pilot projects CMS is currently conducting and would conduct as a result of other sections in H.R. 3200—including to test the Patient Centered Medical Home. Our intent is that experience with all models is assessed and acted on in a cohesive and prompt manner. The current payment system is broke and unsustainable. As there are no alternatives that have demonstrated success to the extent that wide-spread implementation is warranted, the ability to test, evaluate, and expand promising models on a fast-track is imperative.

20. Does the bill establish a pilot program that tests a model aimed at improving care of patients in the home setting?

Yes. The bill establishes a Medicare pilot project that tests a payment incentive and delivery model that aims to reduce expenditures and improve outcomes for severely ill beneficiaries that benefit from receiving care in their home. CMS would enter into agreements with "Independence at Home" practices, which are lead by a physician and include other clinical staff, such as nurses, pharmacists, social workers. These practices can be lead by a nurse practitioner but the nurse practitioner must be practicing consistent with state scope of practice law. High-risk beneficiaries with multiple chronic conditions who need assistance with activities of daily living would be eligible and beneficiary participation would be voluntary. Practices would receive 80 percent of savings generated under the model above a 5 percent savings threshold. Practices would be paid for comprehensive geriatric assessment and monthly care coordination services during the project but CMS could recoup these fees if a practice fails to generate the minimum threshold of savings. This pilot project is essentially self-funded even during its testing phase. At least two practices in up to 26 states would be included in the pilot project. CMS would expand the pilot if it is successful. ACP policy supports testing innovative models and expanding those that work. The College intends to ensure that "Independence at Home" practices coordinate with physicians who also care for participating beneficiaries to avoid fragmentation.

Administrative Simplification

21. Will the administrative simplification provisions included in the House bill save money and allow physicians to spend more time with their patients?

According to a recent article in *Health Affairs*, physicians reported spending almost a half-hour each day, three hours each week, and three weeks per year interacting with health plans. The study estimated that the value of the time practices spent interacting with health plans is \$23 billion to \$31 billion each year. For primary care practices, this translates to an average cost of \$64,859 annually per physician, or nearly one-third of the income plus benefits of the average primary care physician, regardless of the size of the practice. Significant administrative relief is needed to allow doctors to spend more time with their patients and to reduce the costs of health care.

America's Affordable Health Choices Act of 2009 (H.R. 3200) would create standardized health insurance forms and standards for claims attachments. It would increase electronic exchange of administrative and clinical data, and provide standardized quality reporting requirements for physicians.

ACP supports all initiatives to simplify administrative requirements. However, the administrative simplification provisions included in the House bill would be decided by rulemaking and other federal agencies. ACP would work with the appropriate entities to accomplish this goal.

The bill also requires a study of efficiency with which the Medicaid program is operated at the federal, state, and local level, which is to include issues related to processing physician claims for the services they furnish.

Other Health Reform Issues

22. How would the House health reform bill improve end of life care for patients? Could bureaucrats in Washington use this legislation to deny care to the elderly during the final stages of life?

The House health reform bill would provide a Medicare benefit for physician consultations with patients concerning end-of-life care planning. It ensures that the wishes of patients, not bureaucrats, will be implemented at the end of life. This end of life consultation is purely voluntary and patients do not need to have a consultation with their doctor if they do not wish to do so. This legislation will strengthen the relationship between patients and their personal physicians, and will help ensure that Medicare patients receive the care they desire during this most difficult transition.

23. How does ACP feel about the surcharge on high income individuals to help pay for reform?

ACP has not taken a position on the specific tax proposals in America's Affordable Health Choices Act of 2009 (H.R. 3200) but we encouraged the House to consider a variety of alternative financing sources, including ones to encourage individuals to be more prudent in their own health care decisions. ACP supports, for instance, the concept of setting a cap on how much of the premium for insurance provided by an employer would be treated as tax free income to employees. We agree on the need for the legislation to "pay for itself" and that responsibility for funding needs to be shared among businesses, individuals and taxpayers through the federal government. ACP policy only addresses tax issues that are directly related to health care, such as sliding scale tax credits for the uninsured, but we do not feel we have the expertise to address broader tax policy issues. ACP remains open to considering a variety of alternatives to finance health care reform. In addition, it should be recognized that the uninsured in the United States already generate a hidden tax on businesses, individuals and taxpayers--estimated by some studies to be as much as \$100 billion per year, or close the estimated cost of the bills being considered in the House and Senate--due to cost shifting when the uninsured receive care in emergency rooms, delay getting needed care until they are sicker and the cost of treatment is more expensive, and funding of safety net programs throughout the U.S. These costs show up in the health insurance premiums and taxes paid by all Americans.

24. How can the federal government possibly pay for comprehensive health care reform, as contained in H.R. 3200? Won't this bankrupt the country?

ACP believes that health reform should be funded in a way that is sustainable over the long term and does not contribute to the deficit. Our understanding is that the Congressional Budget Office has determined that H.R. 3200 will not add to the deficit, if the costs associated with replacing the flawed Medicare SGR formula are reflected in Medicare's baseline rather than being subject to pay-go offsets. We strongly agree that the budget costs associated with elimination of the Medicare SGR cuts should be reflected in the Medicare baseline assumption going forward and not fall under pay-go rules. Congress' own budget rules require it to fund health reform without adding to the federal deficit, so the final bill will have to be fully paid for without adding to the national debt. Congress likely will make changes in the bill to address the CBO's concerns that the current version does not contain costs sufficiently.

25. What happens if health care reform fails entirely?

ACP is committed to doing all that it can to get legislation enacted this year to ensure that all Americans will have access to affordable coverage and to a general internist or other primary care physician. America's Affordable Health Choices Act of 2009 (H.R. 3200), will go a very long way toward achieving these goals.

ACP believes that the current health care system is not sustainable and reform is essential. Does anyone really believe that physicians and patients will be better off if health reform falters and we continue the status quo? If the ranks of the uninsured are allowed to grow? If insurance companies are allowed to continue to turn down or charge exorbitant rates to people with pre-existing conditions? If small businesses can't hire people and pay decent wages or even keep their doors open because of the rising costs of health plan premiums? If the Medicare trust fund is allowed to go broke? If health care reform dies, and along with it, our best chance to begin to restructure workforce and payment policies to support primary care?

The U.S. health care system is a train wreck in waiting, and that 2009 may be our best and perhaps only chance to put it on a safer track. The U.S. has within its grasp the chance to enact legislation to provide affordable coverage to most Americans, to make the cost affordable and sustainable for families and businesses, and to begin to rebuild the primary care physician workforce. It is understandable why so many internists are unhappy with the way things are, and yet distrustful of the changes being proposed to make things better. But there will be far more reasons for internists to be discontented if health care reform is allowed to fail.