

**Comments from the American College of Physicians on the House Tri-Committee
Draft Proposal on Healthcare Reform
July 2, 2009**

The American College of Physicians (ACP), representing 128,000 internists and medical students, appreciates the opportunity to provide comments concerning the Tri-Committee's draft proposal on healthcare reform. We appreciate consideration of these policy recommendations and look forward to working with the Tri-committees to improve patient care and reduce health care costs as Congress considers health reform legislation this year. ACP has conducted a review of the following policy provisions included in the discussion draft and, where appropriate, provides recommended changes to the legislative language but also seeks clarification in some areas. We also would call attention to the official ACP statement for the record of the Energy and Commerce Committee's hearing on the legislation, which expresses strong support for the overall policy goals of the draft legislation and most of the key policy directions.

Payment, Workforce and Delivery System Reform

A. PAYMENT REFORM

Sustainable Growth Rate (SGR): ACP applauds the proposals to eliminate the accumulated deficit associated with Medicare's flawed Sustainable Growth Rate (SGR) formula; taking physician-administered drugs and clinical diagnostic laboratory tests out of the formula; providing a higher baseline target rate of growth than under current law; and providing the highest growth allowance for evaluation and management services, which are commonly furnished by primary care physicians. Elimination of the accumulated SGR "overhang" is imperative if comprehensive payment reform is to be successful. We present the following recommendations in the spirit of providing constructive ideas for additional improvements in the update formula.

Recommendation

ACP believes that any spending targets to replace the SGR should provide fair and stable updates for all physicians. We recommend that the committee consider alternatives to maintaining the link between the growth targets for physician services and the growth in GDP as proposed in Section 1121. As we have seen in recent years, economic growth is inherently unpredictable and is therefore ill-suited to be the most significant factor in determining the baseline for growth in physician services. We urge the Tri-committees to consider alternatives such as basing the growth target(s) on the Medicare Economic Index (MEI) plus an additional growth factor. As the MEI and physician services growth are clearly linked, there is a rational basis for using this index as the major factor in determining the baseline for such growth.

The College would recommend that the legislation clarify that any amount by which physician services exceed a baseline determined principally by growth in the overall economy not be carried over from year to year. There is a high probability that allowing spending above a target to accumulate as in the present, flawed SGR formula would in time result in a large deficit that would again make fair updates impossible and result in a need for the nation's physicians, patients and the Congress to again confront large scheduled cuts in the payments for physician services. ACP recommends the following related to the "evaluation and management services and Medicare-covered preventive services" expenditure target:

Modify Paragraph (1) of subsection 1121(d) by adding language that directs the Secretary to include in this expenditure category such evaluation and management services as are principally provided by primary care physicians and are associated with primary care.

Tri-committee summary documents have referred to this expenditure target category as a “primary care” target. The current language, with its discretion to the Secretary, leaves open the possibility that this category may include many evaluation and management services other than those that are associated with primary care or principally provided by primary care physicians. We believe that the committee’s intent is to allow primary care services to have a higher growth allowance to help promote payment updates that are viable and sustainable and by doing so, help make the primary care field more attractive to new physicians as well as those currently in this field. The separate targets and updates for primary care would be more likely to achieve this result if the link to primary care physicians were strengthened.

We also recommend that the committee consider establishing a higher floor on the updates for the primary care/preventive services category. This could be accomplished by modifying paragraph (2) of subsection 1121(d) to assure that updates for the primary care and preventive be non-negative, i.e., that this category would not be subject to cuts in its conversion factor. The College is concerned that, even with a higher target rate, primary care and preventive services would be vulnerable to future cuts, especially if the target continues to be linked to GDP (even with the additional 2 percent growth allowance).

Bonus Payment: The College greatly appreciates the Tri-committee’s proposal to boost the nation’s primary care infrastructure by means of bonus payments for these services as would be provided by Section 1303 of the bill. We offer the following recommendations to ensure that the bonus will have the desired impact of making primary care more attractive to new physicians and to help retain established primary care physicians in practice.

Recommendation

Since many of the other payment changes to support primary care will take years before they are implemented on a scale that will affect workforce decisions, we believe that a higher bonus payment structure would send the most immediate signal to medical students and established physicians in practice of Congress’ commitment to reducing inequities in payment for primary care. For this reason, ACP strongly urges that the amount of the bonus payments specified by paragraph (1) of the text that would be added to Subsection 1833(p) of the Social Security Act by Section 1303 of the Tri-committee draft be increased to 10 percent (with a comparable increase in the bonus for primary care in health professional shortage areas—i.e. from 10 to 15%).

In addition, ACP recommends that the primary care bonus start beginning in 2010, as opposed to the 2011 date listed in the discussion draft. This would be accomplished by striking “2011” in 1303(p)(1) and replacing it with “2010”.

Our reading of the legislative language also is that the committee intends for the primary care bonus to be permanent “beginning on” the effective date of implementation. If our interpretation is not correct, then we would ask that paragraph (1) of the text that would be added to Subsection 1833(p) of the Social Security Act by Section 1303 of the Tri-committee draft be modified to clarify that the bonus payments be permanent and not sunset after the initial year of implementation or subsequent years after enactment.

ACP agrees with the specialties identified in the definition of “primary care practitioner.” As the bonus is intended to boost the numbers of primary care physicians, ACP believes it is essential that the criteria for

eligibility for the bonus not unintentionally exclude many general internists or family physicians who are providing primary care, but who may not meet the threshold “of a primary care physician’s allowed charges must constitute at least 50 percent of such physician’s total allowed charges.”

This could be the case, for instance, if the Secretary were to narrowly define the services that would constitute “at least 50 percent of such physician’s allowed charges” in a way that could exclude many services that are provided by primary care physicians. A primary care internist in a rural area, for instance, may have a substantial portion (more than half) of their allowed charges be for services, such as inpatient visits and consultations and some ancillary procedures, that may not strictly be defined as primary care by the Secretary.

Accordingly, ACP recommends that a third criterion for eligibility for the bonus be added to paragraph (3) of the modification to subsection 1833(p) of the Social Security Act that would result from Section 1303 of the Tri-committee draft. This criterion would direct the Secretary “to develop a methodology to assure that physicians who are trained in a primary care field who provide first contact, continuous, and comprehensive care to patients” be eligible for bonus payments even if they do not meet the requirement that at such primary care physicians’ allowed charges being at least 50 percent of such physician’s total allowed charges.

B. WORKFORCE

Enhancement of Medicare and Medicaid payment enhancements for primary care services alone is not sufficient to avert the shortage of primary care physicians. Workforce incentives must also be provided. ACP appreciates the inclusion in the discussion draft of multiple workforce provisions that would help address the shortage.

National Center for Health Care Workforce Analysis: In the United States, the numbers and types of health care professionals being trained are largely determined by the availability of training programs, the number of applicants, and inpatient service needs of academic medical centers. But, institutional service needs are a poor indicator of national health workforce requirements, particularly as patient care has continued to shift from inpatient to outpatient settings. The nation needs sound research methodologies embedded in its workforce policy to determine the nation’s current and future needs for appropriate numbers of physicians by specialty and geographic areas. The College strongly supports Section 2271, which would establish the National Center for Health Care Workforce Analysis.

National Advisory Committee: The College believes that the federal government should establish a permanent national commission on the health care workforce to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity, including training and retaining more primary care physicians whose training is appropriate for the present and anticipated health care needs of the nation. We therefore support the creation of the Advisory Committee on Health Workforce Evaluation and Assessment that would be created by Section 2261 of the discussion draft.

Recommendation

The College however recommends that the Advisory Committee on Health Workforce Evaluation and Assessment be made a permanent national commission. Representatives from national primary care medical organizations should have a seat on the Advisory Committee. The Advisory Committee should determine the optimal mix and numbers of primary care physicians per population and as a percentage of the total physician workforce; provide recommendations for policies to achieve the desired goals,

including changes in medical education, GME, and payment policies; and report annually on progress in attaining such goals, including new policies, should results fall short of the benchmarks.

The Advisory Committee should identify specific metrics to evaluate the impact (success or failure) of each policy that is implemented to expand the primary care physician workforce, including measures of medical student and new physician choice of specialty, measures of the career plans of established physicians, and measures of patient access to primary care.

The Advisory Committee should recommend policies, including changes in graduate medical education funding, to achieve targets and metrics to evaluate the success of each policy intervention. As a preliminary target, ACP recommends that the number of Medicare-funded graduate medical education (GME) positions available each year in adult primary care specialties be increased in order to graduate 3000 additional primary care physicians each year for the next 15 years to meet the nation's anticipated health care needs. With an estimated shortage of 44,000 – 46,000 primary care physicians anticipated by 2025, the federal government must act now to eliminate such a deficit. ACP estimates that by increasing the number of Medicare-funded GME positions in adult care primary care specialties in order to graduate an additional 3,000 primary care physicians annually for the next 15 years, the federal government will ensure that an adequate number of primary care physicians are trained and practicing by 2025. Since primary care residency programs take 3 years to complete, each graduate will need to be funded for 3 years. Therefore, an additional 9,000 Medicare-funded GME positions will be needed each year in order to graduate 3,000 primary care physicians. This funding can be phased in with 3,000 the first year, 6,000 the second, and 9,000 the third year and beyond. Assuming roughly 90,000 current Medicare-funded GME positions, the additional 9,000 positions represent an increase of 10 percent.

Medical Education Debt: ACP appreciates the provisions that would augment the nation's primary care physician workforce through debt relief in exchange for service. Specifically, the College supports the provisions in Sections 2201 and 2202 of the draft that would provide for increased funding for the National Health Service Corps. The College is also supportive of the new scholarship and loan repayment program for those who agree to work in Health Professions Needs Areas as outlined in Sec. 2211. Medical school scholarships and loan repayment programs in exchange for service in underserved areas for those pursuing careers in primary care are essential for those who are interested in careers in these critical but less remunerative specialties. The College also supports the establishment of the Primary Care Student Loan Fund in Sec. 2212.

Recommendation

The College recommends however that the additional scholarships to medical students and loan repayment awards through the increased funding of the NHSC program be targeted to primary care physicians in order to have the most impact on the supply of primary care physicians in the workforce.

One issue related to medical education debt that is not addressed in the discussion draft is the deferment of educational loans throughout the duration of training in primary care residency programs. ACP recommends allowing the deferment of interest and principal payments on educational loans until after completion of residency training in primary care specialties. During residency training, physicians receive a stipend in acknowledgment of the patient care services they provide. However, medical residents receive far less income and typically work many more hours per week (up to 80 hours) than their counterparts with postgraduate degrees in other professions. Loan repayment in residency makes it even more difficult for physicians-in-training to start or support a family and leaves little discretionary income for products that will advance physicians' professional development (e.g., conferences, journal subscriptions). By deferring payment of interest and principal on medical student loans until after completion of postgraduate training, residents will have increased funds necessary for professional

development and more of an opportunity for a reasonable lifestyle. This will reduce financial pressure for residents to moonlight to supplement their income. It will also better enable young physicians who want to enter primary care careers to do so with less pressure to enter a more lucrative specialty in order to pay off their student debts. ACP therefore recommends that the Tri-Committee include in the discussion draft SEC. 103, Deferment of Loans during Residency and Internships, from S. 1174, The Preserving Patient Access to Primary Care Act.

Medicare Graduate Medical Education: ACP appreciates the requirement that hospitals dedicate assignment of additional resident positions gained through redistribution of unused resident positions to primary care specialties contained in Subsection 1501 of the discussion draft. However the language, as written, is unclear regarding the total number of additional primary care residency positions that would be gained through this redistribution. As mentioned earlier in these comments, the College recommends an additional 9,000 primary care residency positions annually through 2025 in order to meet the estimated shortfall of 44-46,000 primary care physicians anticipated by 2025. ACP requests further clarification on this provision.

The College has endorsed the Preserving Patient Access to Primary Care (H.R. 2350/S. 1174) and the Resident Physician Shortage Reduction Act (H.R. 2251/S. 973). These bills would increase the number of Medicare-supported training positions for medical residents by 15 percent (approximately 15,000 slots). The training slots would be targeted preferentially to institutions that increase the number of residency positions in primary care and general surgery. The College urges the Tri-Committee to ensure that a minimum of 9,000 additional primary care residency positions be established through the provisions in Subsection 1501 of the discussion draft.

Title VII: The College is supportive of the provision in Sec. 2213 that would provide grants to hospitals, medical schools, physician assistant training programs or public or private entities to plan, develop, operate or participate in an accredited professional training program including residency or internship programs in Family Medicine, General Internal Medicine, General Pediatrics or Geriatrics for medical students, interns, residents, or practicing physicians. The College is pleased that these grants can also be used for need-based financial aid and for the training of physicians teaching in community-based settings. Capacity building in primary care to medical schools to establish, maintain or improve academic units or programs that improve teaching in primary care specialties is especially important and the College is pleased that Section 2213 includes grants for this purpose.

The College supports the increase in loan repayment and scholarship amounts as outlined in Sec. 2242, For Scholarships for Disadvantaged Students, Loan Repayments and Fellowships Regarding Faculty Positions, and Educational Assistance in the Health Professions Regarding Individuals from Disadvantaged Backgrounds. The College also supports Sec. 2251 which would provide grants to address health disparities by promoting cultural and linguistic competency and Sec. 2252 which would provide grants to develop and operate programs for innovations in interdisciplinary care training to promote team based models to prepare and train health professionals to reduce health disparities and improve patient care.

Recommendation

While these changes and additions to Title VII of the Public Health Service Act are important, the College encourages the Tri-Committee to recognize the importance of Section 747 under Title VII, which has been the most important federal intervention to help build and maintain the primary care medical and dental training infrastructure in this country, by doubling the authorization from its current funding levels to \$198 million.

Increasing Training in Non-provider Settings: With a disproportionate amount of inpatient training and limited exposure to ambulatory care settings, internal medicine residents are more or less trained to become hospitalists and are choosing careers in hospital medicine at rapidly increasing rates. The College believes that

residents in primary care training programs need increased exposure to the ambulatory care setting, in a practice environment that demonstrates the satisfaction to be gained from providing ongoing care to patients. We appreciate the inclusion of Section 1502 of the draft which would result in an increase in the training that would be able to take place in such settings. We are also supportive of the provision in Section 1502 that calls for a demonstration project for approved teaching health centers (federally qualified health center or rural health center) to receive payment for not only the direct costs of its own GME activities for primary care residents but also for the direct costs of GME activities of its contracting hospitals in a manner similar to the manner in which payments would be made to a hospital if the hospital were to operate such a program. The College supports efforts to provide incentives to develop and/or expand primary care training programs that expose residents to both inpatient and nonhospital settings including changes in the GME funding stream.

C. DELIVERY SYSTEM REFORM

New Payment models: ACP very much appreciates the strong emphasis that the Tri-committee draft places on the Patient Centered Medical Home as evidenced by the proposal to fund national pilots of community-based and practice-based Patient Centered Medical homes and provide generous funding for these pilots from the Federal Supplementary Medical Insurance (Part B) Trust Fund. We also appreciate the establishment of a medical home pilot program in the Medicaid program by Section 1822 of the Tri-committee draft. ACP applauds the significant financial commitment aimed at facilitating an environment in which these pilot tests can succeed.

Recommendation

The College believes that it is important to ensure that such pilots have the greatest beneficial impact on physicians and patients. To do so, it will be important that small physician practices be encouraged to participate. For this reason we urge the Tri-committees to modify the language of paragraph (4) of Subsections (c) and (d) of Section 1866(E) that would be added to the Social Security Act by Section 1302 of the Tri-committee draft to include a requirement that the pilots be designed to include the participation of physicians in practices with fewer than three full-time equivalent physicians.

ACP also believes the pilots must target the appropriate set of patients. This description is included in Subparagraphs (c)(1)(A) and (d)(1)(A) of Section 1866(E) that would be added to the Social Security Act by Section 1302 of the Tri-committee draft. We recommend that the Tri-committee replace the patient eligibility threshold that includes the sickest 50 percent of patients with the more inclusive threshold of “one or more chronic conditions”.

The experience with the Medicare Medical Home Demonstration established by Section 204 of division B of the Tax Relief and Health Care Act points to the importance of requiring the medical home pilots that would be established by the Tri-committee draft to be commenced within a shorter period of time. For this reason, ACP supports the requirement that the implementation of the Independent Patient Centered Medical Home pilot begin no later than 6 months after enactment which is included in Subparagraph (c)(1)(E) of Section 1866(E) that would be added to the Social Security Act by Section 1302 of the Tri-committee draft.

While ACP appreciates the provision in Section 1822 of the Tri-committee draft for a medical home pilot program in the Medicaid program, we believe the program would be of even greater value if states were given explicit authority to establish “all payer” medical home pilots. Such authority should be added to the definition of a medical home pilot program in Subsection 1822(b) of the draft.

Additional Issues of Interest:

A. COVERAGE

ACP strongly supports health care reform that will provide all Americans with access to affordable health insurance, comparable to the options available to federal employees. To that end, ACP evaluated this discussion draft based on the degree to which it would advance important College policy objectives on coverage, 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.

The discussion draft is generally consistent with ACP policy in the following areas:

- Expanding Medicaid to cover everyone at or modestly above the Federal Poverty Level (Division B, Title VIII, Part 1, Sec. 1801. Eligibility for individuals with income below 133-1/3 percent FPL.) The College supports expanding Medicaid to individuals up to 100 percent of FPL. Since this provision calls for a more generous expansion of Medicaid, ACP would be supportive provided that adequate safeguards against “crowd out” are established.
- Providing individuals and small businesses a choice of health plans offered through an exchange (Division A, Title II, Subtitle A, Sec. 202. Exchange-eligible individuals and employers). This provision is consistent with ACP policy.
- Providing sliding scale subsidies for individuals with incomes between 133-400 percent FPL to purchase coverage through such an exchange (Division A, Title II, Subtitle C, Individual Affordability Credits). Although ACP policy recommends that an expert advisory commission be established to provide recommendations on expanding coverage to individuals with incomes above 200 percent FPL, we agree that individuals above 200 percent of the FPL will need assistance in ensuring access to affordable coverage. Accordingly, ACP is open to supporting advance, refundable, and sliding-scale tax credits for individuals above 200 percent of the FPL but recommends that mechanisms be created to guard against “crowd out” of employer-based coverage.
- Requiring that all health plans (excluding grandfathered individual insurance plans), both within and outside the exchange, abide by rules relating to acceptance of all individuals without regard to pre-existing conditions or health status, guaranteed renewability, and modified community rating. The College strongly supports insurance reform efforts that require health plans to accept and renew policies for all applicants, utilize modified community rating rules to mitigate dramatic premium fluctuations, and prevent exclusions or limitations of coverage for pre-existing conditions. ACP also supports requiring health care insurers to disclose their medical expense ratio to plan enrollees and potential enrollees.
- Eliminating cost-sharing requirements for preventive services (Division A, Title I, Subtitle C, Sec. 122(c)(1) No cost-sharing for preventive services). ACP strongly believes preventive, patient-centered care should be at the core of a reformed health care delivery system, and the College is encouraged that preventive services would be included in the essential benefit package and that cost-sharing for such procedures would be prohibited.
- Shared financing including requirements that employers contribute to coverage or face a penalty and that individuals obtain coverage once it is available and affordable, with appropriate hardship exemptions (Division A, Title III, Subtitle B, Employer Responsibility). This is consistent with ACP policy.

- Requiring that all qualified health plans provide an essential benefits package, including preventive and primary care services, as recommended by a health benefits advisory committee (Division A, Title I, Subtitle C, Standards Guaranteeing Access to Affordable Coverage). The College supports efforts to establish a Health Benefits Advisory Committee comprised of practicing providers and other health care experts to recommend an essential benefit package that all qualified health plans would be required to offer.

Advisory Committee: The discussion draft establishes an Advisory Committee chaired by the Surgeon General and made up of practicing providers and other health care experts charged with recommending an essential benefits package; the Secretary will determine if recommended standards should be adopted. (Division A, Title I, Subtitle C, Sec. 123. Health Benefits Advisory Committee). Because the College strongly believes that a reformed health care system should have patient-centered primary care at its core, ACP recommends that an advisory committee include a practicing primary care physician among its members. While the draft language states that “at least one practicing physician or other health professional” (page 28, lines 11-12) be among the members of the advisory committee, ACP recommends designating at least one primary care physician be appointed to the Benefits Advisory Committee.

Recommendation

On page 28, line 11-12, after “and at least one practicing physician” strike “or other health professional” and insert “including a primary care physician and other health professional as determined by the Secretary”

B. PUBLIC PLAN OPTION

ACP believes that a public plan could appropriately be among the options made available to individuals and employers if the public plan abides by: the same insurance reforms and provides the same essential benefits required of private health plans, that it is administered by an entity that does not have oversight of the Exchange, that health care providers are not required to participate in the public health insurance plan, and if both the public and private plans adopt delivery system reforms that put primary care at the center of a patient’s health care plan and establish a reimbursement structure that incentivizes care coordination, rewards positive health outcomes, and promotes use of best practices and effective drugs and devices.

The discussion draft is generally consistent with ACP policy in the following areas:

- Provider participation: The College is encouraged that the draft language does not appear to specifically state that providers are required to participate in a public health insurance plan (Division A, Title II, Subtitle B Section 225). However, ACP is concerned that the Secretary may be enabled to make such a requirement, based on the degree of discretion the Secretary has in this regard. ACP would like to ask the Tri-Committee for clarification on this provision as well as intent. The College believes that the federal government, or its designee, should not require health care providers to participate in any new public or private insurance plan operating in a health insurance exchange.
- Innovative payment models: ACP supports giving the public plan wide latitude to implement innovative payment models, beginning in year 1 (2013), and especially appreciates identification of the Patient-Centered Medical Home (PCMH) as among such innovative models (Division A, Title II, Subtitle B, Sec. 224. Modernized Payment Initiatives and Delivery System Reform). The College strongly supports efforts to reform the health care delivery system by implementing reforms and payment models that improve quality, health outcomes, and cost-effectiveness.

- Level playing field: ACP supports requiring that the public plan adhere to requirements applicable to the private insurance product offered in the exchange, including provide essential core benefits including prevention (Division A, Title II, Subtitle B, Sec. 220 (b)(2) Ensuring a Level Playing Field). This language reflects College policy.
- Financing through enrollee premiums: ACP supports efforts to ensure that the public insurance plan is fully-financed by enrollee premiums and cannot use taxpayer dollars to cover expenses (Division A, Title II, Subtitle B, Sec. 222. Premiums and Financing). ACP recommends delegating the Secretary of Health and Human Services, rather than the Commissioner who runs the Exchange, as the entity with oversight of the public insurance plan. This will reduce any potential conflict of interest and ensure that the public plan operates on a level playing field with private plan competitors. (Division A, Title II, Subtitle B, Sec. 221 Establishment and Administration of a Public Health Insurance Option).

Payment structure within the public plan: The discussion draft proposes to base reimbursement within the public plan on the Medicare payment structure in the first three years following implementation. ACP believes this would have a negative impact on physician participation. Such policy could particularly have an adverse impact on primary care physicians, since Medicare pays primary care physicians far less than other payers in many markets. ACP believes it is important that public and private insurers continue to design, test, and implement innovative health care delivery and payment models that promote patient-centered care, reward physicians for value-based practice, and facilitate effectiveness and efficiency across the health care sector. A public plan should be given the capability to adopt successful innovative payment models that achieve these goals. ACP is encouraged that the discussion draft includes language that would promote and eventually establish innovative payment models that move our health care system from a volume-based model to one that incentivizes patient-centered, preventive care. The College is particularly supportive of efforts to include the patient-centered medical home model as part of the public health insurance plan. However, instead of initially relying on the existing inefficient Medicare fee-for-service model, ACP believes implementation of a new payment model should occur when the public health insurance plan is first established.

The College has strong concerns that basing the public plan reimbursement on the flawed Medicare fee-for-service system for the first three years of implementation, even if a 5 percent bonus is attached to the base payment for practitioners who participate in the Medicare and public health insurance plan, would be particularly harmful to primary care physicians in markets where private payers pay substantially more than the Medicare rates.

Recommendation

The College recommends that the Secretary should be instructed to develop payment methodologies using the following guidance when the public plan is implemented in 2013:

- Payments have incentives for appropriate, high-quality, efficient, coordinated, and patient-centered care, informed by pilot tests of models that have shown to be effective in improving the quality and effectiveness of care provided. Specifically, such models should:
 - Improve the accuracy, predictability, and appropriate valuation of primary care services and pay primary care physicians competitively with other specialties;
 - Promote value and appropriate expenditures on physician services;
 - Support patient-centered care and shared decision-making;
 - Align incentives across the health care system;
 - Encourage optimal number and distribution of physicians in practice and sufficient member access to physicians in all specialties and regions;
 - Support use of health information technology;

- Recognize differences in physician practice characteristics;
- Reduce existing and avoid imposing new administrative burdens on physicians except as needed to ensure program integrity;
- Not carry over the flaws in existing Medicare payment methodologies including the sustainable growth rate formula and undervaluation of primary care.

Once a payment model has been determined for the public insurance plan, the College supports periodic review of such payment method to ensure adequacy of provider reimbursement. MedPAC or a similar entity should be required to review and issue annual reports on physician payments allocated by private and public plans operating in the health insurance connector. The entity should make recommendations on annual payment updates to ensure the continued participation of physicians and to strengthen payment parity between primary care physicians and specialists operating within the public plan. Should physician participation in the public plan drop, the entity reviewing payment levels for connector plans will recalibrate payment rates to increase physician participation to sufficient levels.

ACP recommends the following be inserted at the appropriate place in the draft language:

Division A, Title II, Subtitle B, Sec. 22X. Payment Advisory Commission: To ensure the effectiveness and integrity of a new payment system, an advisory commission, which shall include a primary care physician among its membership, shall be created to regularly review the viability and adequacy of the new payment system and disclose the commission’s findings to the public. The responsibilities of this advisory commission should include the following:

- The commission should issue an annual report with comparative data on how payment rates under the public plan compare to those from private insurers and with recommendations on updates in public plan payments to ensure that the payment rates to physicians are competitive and to ensure maximum physician participation in the public plan.
- The commission should report on physician participation in the public plan by specialty, geographic locale, and other criteria as needed to ensure that enrollees in the public plan will have sufficient access to primary and specialty care.
- The commission should also compare payment rates of primary care physicians with those of other specialists and recommend payment adjustments as needed to ensure that payments to primary care are competitive with other specialty choices.
- The administrator of the public plan should have the authority to change payments as needed to increase physician participation based on the recommendations of the advisory commission.

C. PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI):

Division B, Title I, Subtitle B, Part 1, Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI): The College supports extension of PQRI through 2012, with the current 2% incentive payment. As ACP policy supports positive incentives for quality reporting, the College is especially pleased that there is no penalty associated with unsuccessful participation. Additionally, ACP supports providing PQRI participants with more timely feedback; establishing an appeals process; and developing a plan to integrate electronic reporting of quality measures with requirements for earning incentive payments for electronic health record use.

Recommendation

Insert page 203, line 6: Division B, Title I, Subtitle B, Part 1, Sec. 1124 (c): Add a provision that stipulates that physicians are paid the PQRI bonus for two successive years if they complete Maintenance of Certification (MOC) with a "qualified practice assessment." The College supports this as a voluntary option as it provides an alternative mechanism for physicians to fulfill the PQRI requirement. There is

data available that physician participation in the practice improvement module of the MOC is related to positive improvements in practice performance.

D. COMPARATIVE EFFECTIVENESS RESEARCH:

Division B, Title IV, Subtitle A, Sec. 1401. Comparative Effectiveness Research: The College is pleased that the Center for Comparative Effectiveness, while established within AHRQ, has significant protections from undue government or private sector influence, including an independent multi-stakeholder oversight commission, transparent operations, strong conflict of interest policy, and funding outside of the appropriations process. The Center is funded on a fair share per capita assessment on government and private sector health plans, built up to \$375 million by 2013, which is significantly more than AHRQ is currently funded for comparative effectiveness research.

The College strongly supports the establishment of an adequately funded, independent entity, to sponsor and/or produce trusted research on comparative effectiveness. The College believes that the federal government should have a significant role in the funding, implementation, and maintenance of this comparative effectiveness entity, but takes no formal position on the structure of such an entity, and recommends that the entity be protected from undue public and private interference and have a sustainable funding source.

E. ENHANCED MEDICAID PAYMENTS:

Division B, Title VIII, Part 3, Sec. 1821. Payments to primary care practitioners. ACP strongly supports raising Medicaid payments to primary care physicians to be equal to Medicare. The historically low Medicaid payment rates in many areas discourage physician participation. While we support increasing Medicaid payment to both primary care physicians and primary care nurse-practitioners who are providing care within the limits of their state licenses, we do not believe that this provision should change long-standing Medicare payment policies that differentiate between the more extensive years of training and different skill set provided by physicians compared to nurse-practitioners. Specifically, the Medicare requirement that nurse-practitioners are currently paid at 80 percent of the amount paid to physicians should be retained.

Recommendation

Retain the concept that eligible non-physician practitioners be paid under Medicaid at 80 percent of the amount that Medicare would pay as if a physician furnished the service.

F. IMAGING:

Division B, Title I, Subtitle B, Part 3, Sec. 1147. Payment for imaging services: ACP supports increasing the assumption on the utilization of equipment and further discounting the technical component payment for single-session imaging involving contiguous body parts. ACP has long held that the assumption on utilization of advanced imaging equipment needs to be increased to better reflect actual use. ACP has supported the reduction in technical component payment for contiguous body part imaging and opposed the CMS decision to halt implementation of the change at the half-way point of the transition to the discount stipulated in the bill. It is appropriate that the “savings” that would result from the relative value unit reductions resulting from these changes go back into the pool of dollars available to pay for physician services to be redistributed through increased payments for other services.

Recommendation

Revise (a) – as found on page 213 – “Adjustments in Practice Expense to Reflect Higher Presumed Utilization...”, by making the change apply to only advanced imaging services, e.g. MRI, CT. We recommend against assuming the higher utilization rate for non-advanced imaging modalities such as x-ray, sonogram, ultrasound, and echocardiogram. These modalities are common in physician offices.

Concerns expressed by MedPAC and others about the potential of overpaying for equipment based on incorrect utilization assumptions have focused on advanced imaging. Non-advanced imaging services are relatively low in cost and have not experienced rapid utilization growth. They generally provide safe, convenient access to clinical information necessary to treat patients.

If the intent is on improving the accuracy of the equipment utilization assumption for all imaging services, the College recommends directing the Secretary to establish categories of imaging services and to assign a category-specific utilization rate assumption to each rather than necessarily locking in a particular utilization assumption in statute.

G. STUDY OF MIS-VALUED CODES:

Division B, Title I, Subtitle B, Part 1, Sec. 1122. Misvalued codes under the physician fee schedule: ACP supports identifying and adjusting mis-valued codes and is pleased with the direction, discretion, and funding that the discussion draft provides to accomplish these objectives, which primarily focus on ensuring that payment for specific services is not excessive.

It is appropriate that the “savings” that would result from the relative value unit reductions resulting from these changes go back into the pool of dollars available to pay for physician services to be redistributed through increased payments for other services.

Recommendation

- Revise the language to include the creation of an expert panel that would focus on identifying mis-valued codes—with a focus on overvalued services—that would supplement efforts by HHS and existing processes. MedPAC has recommended such a panel. While this section would enable the Secretary to use contractors to identify and adjust values, a standing panel with expertise is preferable and most likely to be successful in meeting the goals of this section.

ACP also recommends that language be added to the bill that would direct that HHS conduct a study of the processes in place for evaluating RVUs are fair, objective and balanced. ACP is concerned that physicians who have expertise and experience in providing comprehensive and longitudinal care to patients may lack sufficient input and influence. HHS could conduct this study concurrent with its efforts to identify and adjust mis-valued services as directed by this section and report on the results to the Medicare committees of jurisdiction. We specifically recommend that study language that is included in Title III, Sed. 307 of the Preserving Patient Access to Primary Care Act, H.R. 2350. The study could inform these other efforts in addition to providing valuable assessment of the elements that influence the process.

- Mandate an HHS study and report on the process for determining relative values under the Medicare physician fee schedule by inserting Title III, Sec. 307 as found in the Preserving Patient Access to Primary Care (H.R. 2350/S. 1174), in the appropriate place.

H. ADMINISTRATIVE SIMPLIFICATION:

Division A, Title V, Sec. 501. Immediate Investments: ACP supports the provisions in the discussion draft to simplify administrative requirements. Administrative burden presents a challenge to all physician practices, especially small primary care practices. Reducing burden is an essential compliment to payment changes to effectively improve the practice environment.

Conclusion:

In conclusion, ACP supports the overall policy directions of the draft bill on coverage, workforce, and payment reform, and especially appreciates that attention to enhancing the nation's primary care infrastructure to achieve these goals. We offer these recommendations in the spirit of building upon and strengthening the policies proposed in the draft. We look forward to working with the Tri-committees in refining the bill so that the legislation that is ultimately enacted will be as effective as it can be in realizing our shared vision for the future of health care in America.