



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  

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STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Before the Energy and Commerce Committee  
U.S. House of Representatives

Regarding  
Health Reform Legislation

Presented By  
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Chairman Waxman, Ranking Member Barton and members of the Energy and Commerce Committee. I am Ted Epperly, MD, President of the American Academy of Family Physicians, which represents 94,600 members across the United States.

On behalf of the Academy of Family Physicians, I am pleased to comment on your discussion draft legislation to reform health care in this country. Your preliminary bill goes a long way toward providing quality, affordable health care coverage for everyone in the US. The AAFP has called for fundamental reform of the US health care system for two decades. We commend the Energy and Commerce, Ways and Means, and the Education and Labor Committees for their leadership and commitment to find solutions to this complex national priority. Finally, we appreciate including efforts to improve primary care throughout the draft bill.

In addition, we call your attention to a joint letter you have received from the American Academy of Family Physicians, American College of Physicians and American Osteopathic Association. Together, these three organizations represent over 300,000 physicians and who want Congress, the Administration, and the American people to know that the nation's primary care physicians are in strong support of health care reform. Continuation of the current physician training system and flawed physician payment system is a steep pathway to decreased access to and growing cost of health care for all Americans. We must take advantage of this historic opportunity for change and enact meaningful, sustainable, comprehensive health care reform.

The AAFP by virtue of established policy is highly supportive of many sections of this draft legislation. As such, my comments today will be germane to those sections not only consistent with our policy but also of most interest to family physicians.

### **FOCUS ON PRIMARY CARE: KEY TO REFORM**

As the nation has learned through the years, simply paying for more of the same fragmented, uncoordinated, procedure-based health care will not make us healthier and certainly will not contain the accelerating costs of health care. Thus, we believe that making primary care the foundation of health care in this country is critical.

Primary care is the only form of health delivery charged with the long term care of the whole person. The primary care relationship, with its comprehensive nature, has the most effect on health care outcomes. More specifically, AAFP defines primary care as care provided by physicians trained for and skilled in comprehensive first contact and continuing care for people with any undiagnosed sign, symptom, or health concern not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, hospital, critical care, long-term care, home care and day care). Primary care is performed and managed by a personal physician leading a team of, and collaborating with other health professionals, and using consultation or referral, as appropriate. Primary care emphasizes a team approach, which may include nurse practitioners and physician assistants.

An abundance of studies demonstrate that Primary care is cost-effective because it includes coordination of health care services. It also promotes active communication [joint decision-making] between patients and the health care team and makes the patient a partner in his or

her health. This is termed “patient self management support,” which emphasizes the partnership aspect of this mode of care.

Thus, it is the Academy’s view that a reformed system should provide health coverage for all, promote primary care, support coordination and reduce fragmentation of care, minimize administrative complexity, prohibit denial of insurance on the basis of a preexisting condition, require an affordable basic benefit package that includes prevention and wellness and protect against catastrophic costs.

The Academy believes the key to designing a new health care system is to reemphasize the centrality of primary care by:

- Redesigning the manner of primary care delivery modeled on a “patient-centered medical home,” i.e., every patient having a personal physician in charge of their care;
- Aligning financial incentives to support this system, and,
- Taking steps to ensure the adequacy of our primary care workforce.

Many of these key provisions are contained in your draft legislation.

## **AFFORDABLE HEALTH CARE CHOICES**

This section allows individuals to keep their current insurance if desired; makes numerous changes to the insurance industry; establishes a public plan option and requires individuals to purchase health insurance. The AAFP, with some caveats, supports these provisions as an important foundation to cover all individuals.

### *Insurance Market Reforms*

Specifically, we support the health insurance exchange contained within the bill, i.e., a market where Americans can one-stop shop for a health care plan -- private or public -- compare benefits and prices, choose the option that is best meets their own needs. In addition, the AAFP [although with no policy on a specific amount] supports the sliding scale subsidy amounts so that individuals can purchase meaningful coverage. We also advocate for guaranteed availability and renewability of coverage and the prohibition of preexisting condition exclusions and denials.

### *Benefits*

Regarding the benefit provisions, the AAFP has long-supported tiering benefits so that basic benefits, such as primary care provided by or through the medical home; prenatal care; well-child care; immunizations; basic mental health care, evidence-based preventive services; chronic care management; and hospice care, will have no financial barriers, thus, no co-payments. We believe it is important to incentivized that which we know is important and effective.

As a result, we support the bill’s provisions that make available four different tiers of benefits packages and allow consumers to select the one that best meets their needs, as well as the requirement for a core set of benefits for essential health services. We believe that insurance without adequate benefits is meaningless.

We also believe that an independent advisory committee, chaired by the Surgeon General, to “recommend and update the core package of benefits,” ideally would be less prone to political concerns and ensure equality among benefit plan offerings.

Academy policy also states that “health care will be a shared responsibility of individuals, employers, government, and the private and public sectors”. Thus, we applaud the section of the bill that requires all individuals have coverage and allows individuals to maintain their current coverage, if desired.

#### *Public Plan*

The AAFP supports a public plan option that is consistent with the following principles:

- Recognizes the value of, and promotes primary care, including through adoption of the Patient-Centered Medical Home (PCMH).
- The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.
- The public plan cannot be Medicare.
- The new public plan must be actuarially sound.
- The public plan cannot leverage Medicare (or any other public program) to force providers to participate.
- The public plan should not be required to use Medicare-like payment methods permanently.
- The insurance market rules and regulations governing the public plan must be the same as those governing private plans.
- The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace.
- Public and private insurers should be required to adhere to the same rules regarding reserve funds.
- The public plan would also need to contribute to value-based initiatives that benefit all payers.

We also support the variety of payment mechanisms that can be employed by the public plan, in particular, the PCMH and care management. In addition, we applaud the emphasis on care that improves health outcomes; decreases health disparities; addresses geographic variations; prevents or manages chronic illness and supports care that is integrated, patient-centered and of high quality and efficient. These goals all are entirely consistent with AAFP policy.

#### *Administrative Complexity*

We appreciate any efforts to reduce the burdensome nature of the current insurance system and thus are supportive of the provisions included in the bill that will reduce administrative complexity, e.g., standardized claims forms.

### **MEDICARE AND MEDICAID IMPROVEMENTS**

Medicare is a critical component of the U.S health system and must be preserved and protected. Efforts to remedy the Medicare physician payment system are needed and the House discussion draft of health reform legislation begins to take bold, appropriate steps to do so.

#### *Sustainable Growth Rate*

The AAFP acknowledges the committee’s recognition of the longstanding problems associated with the outdated, dysfunctional formula known as the Sustainable Growth Rate (SGR) and we applaud members for proposing its rebasing. This is an important, necessary and welcomed step. Eliminating the past scoring debt accumulated by this arcane, inexact and clinically

irrelevant method is imperative to restoring stability and predictability to this insurance program for our nation's seniors.

#### *PCMH Pilot Program*

We also wish to applaud the committee for including a "medical home pilot program" in Medicare. We appreciate the inclusion of urban, rural and underserved areas, as well as a number of models, such as the Independent Patient-Centered Medical Home and Community-Based Medical Home Model. Your definition of the Patient-Centered Medical Home is entirely consistent with the one established by the AAFP and other primary care organizations. We also support the PCMH demonstration project in Medicaid.

The section also requires the Secretary to establish standards for and review of these models, as well as a payment methodology. At the conclusion of the pilot, the Secretary will perform an analysis of the various projects and we are confident that family physicians will be shown to have provided high quality care at a lower cost to the federal government. We appreciate the fact that these additional payments will have no impact whatsoever on payment for other evaluation and management codes.

#### *Bonus for Primary Care Services*

We also applaud the inclusion of a bonus of 5 percent for primary care services and up to 10 percent for those services provided in a health professions shortage area. These payments would be provided for evaluation and management services, as well as other physician services deemed as "ensuring accessible, continuous, coordinated and comprehensive care." We support the inclusion of the specific designation of family physician (along with general internists, general pediatrics and geriatrics) and the threshold for the bonus being 50 percent, which according to our analysis would mean that 68 percent of family physicians would qualify.

To ensure that the primary care bonus is targeted to and received by those physicians who ensure accessible, continuous, coordinated and comprehensive care, Congress should consider granting 'deemed status' to certain specialties such as family medicine that are, by definition, primary care and make this bonus permanent. In addition, we would encourage Congress to explore the calculation of this bonus by both identified codes and specialty designation. If structuring in this way results in a lower score, it might provide the opportunity to increase the bonus to the 10-percent level in all areas.

#### *PQRI*

The provisions intended to streamline the Physician Reporting Quality Initiative (PQRI) are necessary and welcomed. The discussion draft calls for expedited feedback to providers, providing them with a more efficient appeals process. As this program matures, we would request your consideration of additional incentives for physicians that are both clinically and economically meaningful. Consistent with this would be support of maintenance of certification (MOC) as automatically qualifying for the PQRI bonus.

#### *Patients with Limited English Proficiency*

We appreciate the bill's requirement to perform a study, and then demonstration project, on how Medicare providers can be reimbursed for providing translation and other services to beneficiaries with limited English proficiency. Communication is the foundation of effective medical care and family physicians want to bridge this language gap with our patients but also realize that it costs money to provide translation or other services.

### *Comparative Effectiveness Research*

The AAFP also strongly supports the inclusion of comparative effectiveness research in the draft bill. Specifically, we support the establishment of a Center for Comparative Effectiveness Research (CER) within the Agency for Healthcare Research and Quality.

If we wish to improve patient care and control costs in this country, this type of research is crucial. It is only with CER that we can provide evidence-based information to patients and physicians for use in making health care decisions. As Alexander and Stafford said in the June 17<sup>th</sup> issue of JAMA: “Without attention to timeliness, transforming evidence into practice, inclusion of strategies beyond drugs and devices, minimizing regulatory mixed messages, and the comparative costs of therapies, current investments in comparative effectiveness will fall far short of their ultimate potential for improving the health and health care of all. The primary problem is not the absence of knowledge regarding comparative effectiveness, but the absence of the necessary mechanisms to put this knowledge to work.” A sizable portion of this research agenda, then, should focus on how this research reaches front-line practices and whether the bench research holds up under real-world situations and in the majority of patients. For this reason AHRQ should be the largest focus of the CER agenda.

Our policy on this issue is guided by the following principles:

- Comparative effectiveness research is critically important to our members – family physicians see patients with common problems every day for which there is no solid clinical evidence.
- As CER develops, some therapies will be proven to work better than others and the deliverers of those therapies will challenge the results. Nevertheless, the health of the public should trump individual business concerns.
- We are pleased that the National Institutes of Health (NIH), like the Agency for Healthcare Quality and Research (AHRQ), will be receiving funding to perform CER. We believe a core values of CER include consideration of different patient populations, comorbidities, cultural differences and values, which will be challenging but important.

In addition we believe CER should use a broad range of methodologies, including randomized controlled clinical trials, observational studies and other approaches, including “practice-based network research (PBNR),” which, when used in tandem with controlled clinical trials produces the real-world information useful to physicians in their practices. Likewise, the composition of the Advisory Council should include clinical researchers who conduct practice-based network research.

### *Graduate Medical Education*

It is clear from numerous government and private studies that more Americans depend on family physicians than on any other medical specialty and that family physicians are the main source of primary health care for the Medicare population. Sixty percent of people aged 65 and older identify a family doctor as their usual source of health care. Rural and Hispanic seniors also are more likely to identify a family physician as their source of health care. In addition, nearly one-half of the physicians who staff the nation’s Community Health Centers are family physicians. And, since 1971, the National Health Service Corps has placed more than 18,000 health care providers in underserved areas – and almost half of the doctors were family physicians.

The majority of health care is provided in physicians' offices now and will be in the future. We believe that primary care physicians should comprise about 45 percent of the physician workforce. The training of these primary care physicians should be modernized to promote the methods of health care delivery in the 21<sup>st</sup> century. A sufficient and appropriately trained primary care workforce is essential for a healthier population in the US. This includes expansion of primary care training positions and reversing the loss of training capacity over the last decade. It also means not allowing more growth of subspecialty training since this allows more potential primary care physicians to choose subspecialization. The growth of subspecialty positions over the last decade cut the number of internal medicine graduates choosing primary care careers in half. Finally, the modernization requires more training to occur outside of hospitals—a model based what was presumed best in 1965 and not where most people get care now. The Patient Centered Medical Home will not be in a hospital for most people—so training should not be either.

Thus, we encourage Congress to include provisions necessary to achieve the desired goals which include adequate numbers of primary care physicians to meet the health care needs of all. If health care reform and coverage for all is to be successful, there must be a sufficient number of primary care physicians to care for the population. The Academy wants to help Congress guarantee coverage by ensuring adequate access to care.

In order to ensure an adequate primary care physician workforce, Congress should provide the necessary emphasis on primary care training which would include carving out and dedicating a funding stream that provides incentives to grow the numbers of practicing primary care physicians. The best way to do this is to modernize primary care graduate medical education by increasing accountability and responsiveness for same through the primary care residency programs. Funding for physician training, especially primary care, should be derived from all payers, not Medicare and Medicaid alone. A modest contribution by private insurers of approximately \$20 per insured per year would be sufficient to modernize and fund primary care GME. By directly funding primary care residency programs and holding them accountable for producing a workforce consistent with the population needs and other goals associated with health care reform, Congress will have taken responsible steps to ensure both care AND coverage.

The Academy supports the demonstration project that would allow Direct GME funding to be directed to a federally qualified health center (FQHC) and would encourage the expansion of this demonstration to include residency programs and other nonhospital settings that develop and operate a primary care training program.

We also support:

- redistribution of unused residency slots to primary care and encourage accountability provisions to ensure that these slots do indeed create primary care physicians.
- Language intended to permanently resolve the volunteer preceptor issue and the didactic training issue.
- preservation of residency slots from closed hospitals

The Academy also supports provisions that are directed toward increasing accountability of GME training programs as recommended by the Medicare Payment Advisory Commission. The study to be conducted by the Government Accountability Office on the evaluation of training programs, including whether programs have the appropriate faculty expertise to teach the topics required to achieve such goals is consistent with the goal of increased accountability and we

hope will provide an assessment of the degree to which GME dollars are directed to and used by programs that are responsive to community need, especially in terms of meeting the primary care needs of current and future populations

## **PUBLIC HEALTH AND WORKFORCE DEVELOPMENT**

The AAFP strongly supports a cohesive, comprehensive strategy to align the US health care workforce with a reformed health care system. We are concerned about the decline in the number of medical students pursuing a career in primary care, at a time when the demand for primary care services will only be increasing. The National Health Care Workforce Commission proposed in the discussion draft is needed to recommend the appropriate numbers and distribution of physicians, including primary care physicians, general surgeons, and other specialties facing critical shortages, policies to achieve such workforce goals, and benchmarks to evaluate the impact of such policies.

### *Primary Care Student Loan Funds*

The AAFP has long supported loan repayment and scholarship programs and is grateful that the discussion draft includes the Primary Care Student Loan program. Along with the other primary care organizations, we support establishing a loan repayment program, not to exceed \$35,000 per year, for individuals agreeing to serve as physicians in general internal medicine, general pediatrics and family medicine in areas that are not Health Professional Shortage Areas, but that have a critical shortage of primary care physicians in such fields and excluding these repayments from an individual's gross income. We support National Health Service Corps which also plays a vital role.

We suggest that the government study the impact of student debt on choice of specialty, minority representation in training and practice in primary care specialties, including recommendations for achieving a primary care workforce that is more representative of the US population.

### *Revitalizing Training in Primary Care*

The AAFP has long called for the revitalization of Title VII Training in Primary Care Medicine. We believe that successful health system reform will require a larger primary care workforce. Title VII Training in Primary Care Medicine programs provide support vital to family medicine education and training. We must increase this investment in effective programs that encourage medical students to enter primary care specialties.

The AAFP has requested \$215 million, which was recommended by the HRSA Advisory Committee for Training in Primary Care Medicine and Dentistry, for the programs within Title VII Section 747 for fiscal year 2010. However, we note that the discussion draft limits the authorization for Sections 723, 747 and 748 to \$200 million. It is not clear from the draft how the authorized funding would be distributed among those sections, but we are concerned that this authorized level will not be adequate.

The problems associated with primary care medicine are multifaceted and thus require multifaceted solutions. Increasing the value and prestige and importance of the primary care specialty is critical to luring the best and the brightest into this specialty. Reimbursement, student scholarships, loan forgiveness and tax credits are all parts of the solution.

## **CONCLUSION**

Thank you for the opportunity to provide our thoughts on your draft bill. Due to its length, we continue to analyze its provisions, specifically, the sections on quality, fraud and abuse and the lengthy Medicaid section.

We acknowledge that reforming the health care system is a complex endeavor. But, without meaningful reform, one fifth of our economy is projected to be health care costs within only 10 years. Currently, 47 million Americans are uninsured and scores more underinsured. Half of all bankruptcies in this country are caused by health care related debt and many of those who declare bankruptcy *do* have health insurance. Now is time to reform the system. We urge Congress to invest in the health care system we want, not the one we have.