



AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

November 24, 2008

The Honorable Max Baucus
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

Dear Chairman Baucus:

On behalf of the 93,300 members of the American Academy of Family Physicians, thank you for your policy paper, entitled *Call to Action: Health Reform 2009*, released last week. Family physicians appreciate your long-standing commitment to reforming the nation's health care system so that our nation's patients receive better quality and less costly care. That commitment comes with the recognition of the critical role that primary care plays in such health care. Your proposal says it well: "Primary care is the keystone of a high-performing health care system."

Your paper effectively outlines many of the problems with health care in this nation today:

- More than 46 million are uninsured
- Another 25 million are underinsured and face terrible financial pressures if there is a health crisis in their family
- Many in the country cannot purchase insurance because of their pre-existing conditions
- Employers who want to offer health care plans are forced by spiraling costs either to curtail eligibility or to drop coverage altogether in order to stay competitive
- Unacceptable disparities in health care delivery persist
- Health care is uncoordinated and fragmented, making it duplicative, expensive and less effective.

Your proposal provides a thorough and comprehensive review of the current health care system's flaws and needs. The recommendations are wide-ranging and thoughtful and they contribute positively to the discussion of how to achieve health care reform. There is much in your paper that family physicians agree needs to be accomplished. We particularly support several of the steps related

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to primary care that you have suggested are necessary for the reform of the delivery of health care and we commend you for your bold leadership in identifying those measures so clearly.

Health Care for All

Above all, we agree with your vision of the health care system. Every American should have health coverage. Prevention and coordination of chronic disease often are lacking in this nation's health care system. And finally, all participants – government, employers, insurers, hospitals, physicians and other providers and patients – must share the burden of controlling health care costs, realigning incentives to provide better care rather than more care and using health care responsibly and knowledgeably.

The American Academy of Family Physicians has devoted considerable time and effort to develop a proposal for health care coverage for all that focuses on redirecting resources to primary care and preventive health services, promoting a patient-centered medical home for all, allowing for individual choice and shared responsibility and assuring coverage for catastrophic health care costs. A copy of the AAFP's framework for health care for all is on our website at: <http://www.aafp.org/online/en/home/policy/policies/h/healthcare.html>

Patient-Centered Medical Home

Family physicians agree with the statement in your white paper that, "Expanding Medicare's role in testing the medical home model ... would promote quality and efficiency." We believe that a patient-centered medical home (PCMH) is a more effective and efficient model of health care delivery. This new model produces better care and lower costs. In a patient-centered medical home:

- Patients have a relationship with a personal physician.
- A practice-based team takes collective responsibility for the patient's ongoing care.
- This team is responsible for providing and arranging all the patient's health care needs.
- Patients can expect care that is coordinated across care settings and disciplines.
- Quality is measured and improved as part of daily work flow.
- Patients experience enhanced access and communication.
- Practice uses Electronic Health Records (EHR), registries, and other clinical support systems.

We welcome your recommendation to enhance the federal government's role in examining this model and putting it into practice as quickly as possible.

And we support your proposal "to invest in community health teams that include nurses, nutritionists, and social and mental health workers." This has proven quite successful in North Carolina's Medicaid program and would likely serve rural underserved areas particularly well. However, we suggest that you might



want to include translation services as part of the professionals that are recruited for these community health teams.

We strongly agree with your recommendation that patient participation in the medical home model should be encouraged by reducing or eliminating co-payments for those services provided in medical homes. Your emphasis on assuring that the medical home is patient-centered and consumer friendly is absolutely correct. The medical home, if it is to be a successful transformation of health care in this country, can be neither physician-centered, nor even practice-centered. It must be patient-centered.

The Value of Primary Care

In several places in your report, you note that primary care services are undervalued and that payment for these services needs to be increased. We certainly agree and we appreciate your commitment, evident to us for several years, to rectify this.

One of the reasons that this has been so difficult to remedy in the past has been the artificial barriers that Congress has created between segments of the Medicare payment system. The evidence points to system-wide savings if the patient-centered medical home were widely implemented. We recommend that Congress look at these more broadly based savings when considering how to increase payment for primary care.

We greatly appreciate your acknowledgement of the difficulties created by a budget-neutral solution to the undervaluing of primary care services. We agree that the necessary reforms must be crafted in collaboration with the entire physician community, but we hope that attempts to address this will include examination of how to use the resulting savings across all of Medicare. Your recommendation to examine more fully opportunities for gain-sharing, or collaboration between hospitals and physician practices in sharing savings, is an important step in this direction.

Medicare's Physician Payment Formula

We certainly agree that the Sustainable Growth Rate (SGR) formula for Medicare payments to physicians is broken and must be fixed. We agree further that the Centers for Medicare and Medicaid Services (CMS) has the opportunity to reduce the cost of addressing the problem by removing the cost of physician-administered drugs. It is also true that the Gross Domestic Product (GDP) is not a valid proxy for medical costs and should be dropped from the calculation of physician payment. We would recommend that Congress reset the budget baseline to eliminate the deficit created by postponing payment of temporary SGR patches. Aside from these administrative and accounting issues, Congress will have to consider other means of paying for quality health care provided to Medicare patients, and we will continue to work with you and your excellent staff in finding appropriate and effective alternatives.



Health Information Technology (HIT)

Your paper also notes that “financial assistance for smaller primary care practices to adopt health information technology” would be needed and could be an additional incentive for the practices to collaborate with community health teams mentioned earlier. This is a good insight and corresponds to what we hear frequently from family physicians. The principal barrier for small practices to using HIT is the up-front cost, as you note later in your paper. Given the tight margins within which most small practices work, the funds for investing in HIT simply are not available in their budgets. But adoption of HIT by these primary care practices is a critical piece of health reform because the benefits of this investment, particularly those associated with care coordination, translate to system-wide savings. If direct financial assistance allowed these small practices to make use of the community health teams, that is an additional benefit for the practice and the patient. Along these lines, we have been working with the House Small Business Committee on adapting the existing small business loan program to provide financing options specifically for small practices to purchase HIT hardware and software. But other assistance programs will be needed.

Health Care Quality

We appreciate your support for measures to improve health care quality and systems to allow practices to report their efforts to meet well designed quality and resource-efficiency metrics. We agree that quality improvement requires clinicians to be engaged in developing meaningful measures. We support federal resources for physicians who want to report on their progress in meeting these measures and in using the feedback information to achieve better results. However, we share your concerns with the Medicare program, the Physician Quality Reporting Initiative (PQRI), which many of our members have found to be confusing and non-transparent. They also report that PQRI’s incentives are insufficient to cover the costs of participating. In addition, our members are concerned about excessive record keeping and inaccurate data that cannot be corrected. If done right, the PQRI can be of assistance in improving health care and we would like to be involved in the efforts to make this program effective.

Investments in the Primary Care Workforce

We agree as well that the Medicare Graduate Medical Education (GME) program has provided major funding for teaching hospitals. Family physicians are encouraged by your interest in determining whether payments from Medicare GME should place greater emphasis on providing training in critical focus areas, such as primary care and by your view that “GME funding should be used to train residents outside traditional hospital settings.” For several years, the staff of CMS has foisted a blinkered re-interpretation of the GME rules on residency training at non-hospital sites that has had the effect of encouraging hospitals to reduce training in family medicine residency programs and other primary care settings. We hope that either Congress or the new Administration will revisit this



issue to make clear the importance of using GME for primary care training at ambulatory sites.

We also agree with your commitment to increase the number of racial and ethnic minorities who enter our health workforce. You are correct that Title VII of the *Public Health Service Act* merits re-examination in this regard, and we are pleased to report that we have been working with Senator Clinton on a bill (*Health Professions and Primary Care Reinvestment Act, S. 3708*) to reauthorize Title VII to be more responsive to current health care needs.

There are many other elements to the comprehensive reform that your paper envisions that we are interested in discussing with you and your staff. In the meantime, I would like to emphasize our great admiration for your outstanding work on health care reform. We commend you for your leadership and we look forward to a productive and timely collaboration on how to provide better health care for our patients. Please continue to call on us as you proceed in this important effort.

Sincerely,

James King, MD, FAAFP
Board Chair

