



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

Summary of ACP's Key Recommendations for Health Reform November, 2008

Recommendations in Brief:

- **Coverage:** guarantee all Americans access to health coverage; create tax credits to subsidize coverage for low income persons to buy into the Federal Employees Health Benefits Plan (FEHBP), create new options for small businesses to buy into group coverage based on the FEHBP; expand Medicaid and SCHIP, support state experimentation.
- **Access to Primary Care:** create programs to eliminate medical education debt; lift Medicare GME cap for primary care specialties; increase Medicare FFS payments; pay for care coordination; adopt the Patient Centered Medical Home (PCMH) model; use anticipated savings from reduced hospital admission and ER admissions associated with primary care to fund primary care increases, transition to new payment methodologies for the PCMH.
- **Quality and Cost:** provide financial support to physicians to acquire electronic health records and other HIT initiatives; create an independent entity to fund and research comparative effectiveness of different treatments; create cost-sharing incentives; create new methods of physician payment aligning incentives with quality, primary care, prevention and care coordination; facilitate transparency in health care; enact professional liability reform.



Summary of Key Recommendations:

Expanding Coverage

- Congress should guarantee by law that everyone has access to affordable health coverage. Health insurance coverage and benefits should be continuous and not dependent on place of residence, employment status or income. Congress should specifically create a pathway to affordable and guaranteed coverage for all by:
 - Providing working Americans with incomes up to 200% FPL with advance, refundable, and sliding scale tax credits to buy into a program modeled on the Federal Employees Health Benefit Program (FEHBP) or to purchase qualified individual insurance plans. Also give small employers the option of buying into the same coverage options offered to federal employees. Congress should then consider additional options to assure affordable coverage for individuals above 200% of the FPL.
 - Giving states the option to expand Medicaid coverage to all residents up to 100% of the federal poverty level, with the additional cost of such expansion paid for by a dollar-to-dollar increase in the federal matching program.
 - Giving states the option to unify SCHIP and Medicaid coverage so that families are covered under a single program.
 - Mandating insurance market reforms as a condition of being eligible for federal subsidies, including guaranteed renewability, modified community rating, and no exclusion of persons or variation of premiums based on pre-existing conditions,
 - Creating a federal commission to develop biennial reports with recommendations concerning essential benefits and maximum out-of-pocket cost-sharing, for coverage options, including statutory language for an up or down vote in Congress. The Commission would recommend a coverage package that would include: preventive services, primary care services, chronic illness management, and protection from catastrophic health care expenses. Health plans will be required to provide the “benchmark” coverage in the plan, offer an actuarial equivalent that covers the most recent set of essential benefits recommended by the expert Commission, or offer a plan that is equal to an FEHBP fee-for-service or HMO plan.
 - Giving states the option of opting out of the federal coverage plan described above to create their own programs for universal health coverage supported by federal dollars. Federal dollars that would otherwise have been spent on the coverage options described above would be turned over to states that choose to develop such alternative programs.
 - Once affordable coverage is made available through the policies described above, Congress should adopt policies to ensure that all individuals participate in the plan by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.

Payment Reform and Patient Access to Primary Care

- Immediate steps must be taken to reverse the rapid decline in the number of physicians providing primary care internal medicine, family medicine and pediatrics.
- Congress should enact legislation that finds that primary care is facing a severe shortage of physicians and that primary care is associated with better outcomes and lower costs.
- Such legislation should provide for immediate and sustained increases in Medicare payments that are sufficient to attract and retain physicians in primary care. Specifically, Congress should:



- Require that Medicare take into account the impact of primary care in reducing the costs associated with preventable hospital admissions, emergency room visits, and other services reimbursed under the Medicare program, some of which fall outside of the Medicare Part B program, and use such anticipated savings to fund higher payments for services provided principally by primary care physicians.
- Require that Medicare pay for specific care coordination services by primary care physicians that currently are not reimbursed by Medicare.
- Direct Medicare to develop and implement a methodology to provide annual across-the-board payment increases for services provided principally by primary care physicians through a payment modifier, bonus or other methodology.
- Authorize the Secretary to apply such additional funds as may be needed to improve payments for primary care services, in addition to funds available from anticipated savings associated with primary care.
- Require that HHS study the process for obtaining expert recommendations on relative values, including representation of primary care physicians in the process.
- Expand the Medicare Medical Home Demonstration to a nationwide pilot and transition Medicare to a new payment methodology for qualified Patient-Centered Medical Homes. The PCMH payment methodology would consist of: risk-adjusted monthly care coordination payments, fee-for-service payments for visits, and performance-based payments.
- Repeal the Medicare Sustainable Growth Rate and replace it with a predictable and stable update formula that protects primary care physicians from cuts.
- Congress should also fund programs to eliminate debt for physicians who choose primary care and support primary care training programs. Specifically:
 - Establish and fund new scholarships and loan repayment programs to eliminate debt for physicians who are trained in a primary care specialty and who agree to serve in such capacity in critical shortage facilities or areas. Provide up to \$30,000 per year in scholarship or up to \$35,000 per year in principal and interest repayment on loans for each year of primary care service in a critical shortage facility or area, respectively. Critical shortage is defined as a geographic area, physician practice, or other facility that the Secretary determines has a critical shortage of primary care but that does not qualify under the Health Professionals Shortage Area designation in current law.
 - Allow residents in general internal medicine, family medicine and pediatric training programs to defer debt repayment until completion of their residencies.
 - Increase funding for Title VII Health Professions primary care programs and the National Health Services Corps.
 - Lift the cap on Medicare graduate medical education payments for primary care residency programs.
- Congress should fund state initiatives to implement Medicaid, SCHIP, or all-payer demonstrations of the Patient Centered Medical Home.

Improving Quality and Controlling Costs

- Congress should expand the primary care physician workforce and expand implementation of the Patient Centered Medical Home through the policies described.
- Congress should provide financial support to physicians to overcome the cost barriers to acquisition and use of electronic health records and other health information technologies that assists physicians in delivering evidence-based, patient-centered care and improve management of patients with chronic illnesses. Such incentives should include: a Medicare office visit “add on” payment when the encounter is supported by certified health information technologies; tax incentives and grants to physicians.



- Congress should create an independent entity to fund and conduct research on the comparative effectiveness of different treatments including consideration of the cost of such treatments. Physicians, payers, and patients should consider the results of such research on comparative effectiveness in the evaluation of clinical interventions. Cost should never be used as the sole criterion for evaluating a clinical intervention, but should be considered along with the explicit, transparent consideration of the comparative effectiveness of the intervention.
- Increased funding should be directed to outcomes research, best practices, and the development of evidence-based practice guidelines.
- Cost-sharing and other positive incentives should be created to encourage patients to be prudent purchasers and to participate in their health care. Cost-sharing levels should vary by income, and care should be taken so that patients who are unable to meet health improvement goals are not subjected to punitive measures.
- Medicare should take the lead in studying, evaluating and implementing new methods of payment for all physician services that would align incentives with quality, primary care, prevention and care coordination rather than paying solely on the basis of volume.
- A uniform billing and credentialing system should be created and implemented across all payers to reduce administrative costs.
- Medicare and other payers should facilitate transparency in health care by providing for public reporting of quality, efficiency and patient satisfaction consistent with the requirements of the Consumer-Purchaser Disclosure Project endorsed by ACP.
- Professional liability reforms should be enacted at a federal level to limit awards for noneconomic damages; restrict punitive damages and double compensation for certain items; allow for periodic payment of future damages and structured settlements; and provide for regulation of attorney fees.

More information and details on ACP's proposals for health care reform can be found in the following documents, accessed through ACP's website:

- Achieving Affordable Health Insurance Coverage for All within Seven Years: A Proposal from America's Internists:
http://www.acponline.org/advocacy/where_we_stand/access/7yrplan_update08.pdf
- State experimentation with Reforms to Expand Access to Health Care:
http://www.acponline.org/advocacy/where_we_stand/policy/state_exp.pdf
- Achieving a High Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries:
http://www.acponline.org/advocacy/where_we_stand/policy/highperf_hc.pdf
- Reform of the Dysfunctional Healthcare Payment and Delivery System:
http://www.acponline.org/advocacy/where_we_stand/policy/dysfunctional_payment.pdf
- The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care:
http://www.acponline.org/advocacy/where_we_stand/policy/adv_med.pdf
- E-Health and its Impact on Medical Practice:
http://www.acponline.org/advocacy/where_we_stand/policy/ehealth.pdf
- The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: A Report from the American College of Physicians January 30, 2006:
http://www.acponline.org/advocacy/events/state_of_healthcare/statehc06_1.pdf
- State of the Nation's Health Care Briefing 2008:
http://www.acponline.org/advocacy/events/state_of_healthcare/snhcbrief2008.pdf
- Linking Physician Payments to Quality Care:
http://www.acponline.org/advocacy/where_we_stand/policy/link_pay.pdf