November 2, 2009

Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

Honorable Steny Hoyer
Majority Leader
U.S. House of Representatives
Washington, DC 20515

Honorable Henry Waxman
Chairman
House Energy & Commerce Committee
Washington, DC 20515

Honorable Frank Pallone
Chairman
House Energy & Commerce Health Subcommittee
Washington, DC 20515

Honorable Charles Rangel
Chairman
House Ways & Means Committee
Washington, DC 20515

Honorable Pete Stark
Chairman
House Ways & Means Health Subcommittee
Washington, DC 20515

Honorable George Miller
Chairman
House Education and Labor Committee
Washington, DC 20515

Honorable Robert Andrews
Chairman
House Education and Labor Health Subcommittee
Washington, DC 20515

Honorable John Dingell
Chairman Emeritus
House Energy & Commerce Committee
Washington, DC 20515

Dear Representatives Pelosi, Hoyer, Waxman, Pallone, Rangel, Stark, Dingell, Miller and Andrews:

The American College of Physicians, representing 129,000 internal medicine physician and medical student members, is pleased to inform you of our support for the key policies in the "Affordable Health Care for America Act," H.R. 3962, that will expand health insurance coverage to 96% of all legal residents in the United States; promote the value and importance of primary care, prevention and wellness; and reform payment and delivery systems to achieve better value for patients, defined as the best care delivered as efficiently as possible. ACP is the nation's largest physician specialty society and the second largest physician membership organization in the United States.

Specifically, ACP strongly supports the following policies in H.R. 3962:

Coverage:

- A health exchange to provide small businesses, individuals and families who do not have access to affordable coverage through their employer, and who do not qualify for other federal programs, with the group purchasing discounts and choices of plans available to larger employers and federal employees. We believe that a public plan could be among the choices available through the exchange, provided that

it is funded out of premiums, is not tied to Medicare physician participation agreements, and pays negotiated and competitive rates instead of the Medicare rates, as H.R. 3962 would do.
- Sliding scale, advance, refundable tax credits to help eligible persons, up to 400% of the FPL, to buy coverage through the exchange.
- Requirements that all health plans cover essential benefits, including preventive services with no cost-sharing.
- Requirements that all insurers, including those in the small and individual markets, abide by rules to prohibit them from turning down, charging higher rates, or cancelling coverage based on a person's health status or pre-existing condition.
- Annual and lifetime caps on how much individuals and families would be required to pay for health care so that no American has to declare bankruptcy because of health care.
- A requirement that larger employers either provide coverage or pay into a pool to help fund coverage for the uninsured, and a requirement that individuals purchase coverage once affordable options are available to them.
- Conversion of Medicaid from a categorical program to one that covers all of the poor and near-poor, with sufficient federal funding so this does not become an unfunded mandate on states, and with reforms in Medicaid physician payments to ensure increased access to primary care physicians.

Primary care, prevention and wellness:

- Investment of $57 billion to increase Medicaid payments to primary care physicians so that they are no less than the comparable Medicare rates. Without such steps to bring Medicaid payments up to par with other payers, the tens of millions of persons who will be added to the Medicaid program will find it increasingly difficult to find a primary care physician who is accepting additional Medicaid patients.
- Investment of $4.7 billion to fund a 5% increase in Medicare payments for evaluation and management services provided by primary physicians (10% in health professional shortage areas). We are pleased that the increased payments will now apply to hospital visits—as well as office, home, nursing home, and emergency room visits-- and that the criteria to qualify for the increased payments has been revised from the earlier bill to ensure that primary care physicians who see a large number of patients in the hospital are not unintentionally excluded. We also are pleased that the increased payments would be permanent and not subject to expiration after five years. We urge you to work with your colleagues on the Senate side so that the final bill increases the primary care bonus to at least 10% nationwide, based on the services and eligibility criteria in H.R. 3962.
- A national commission to recommend the appropriate numbers and mix of health professionals; new community-based training programs for primary care; increased funding and expansion of the National Health Services Corp and Title VII health professions training programs; increased funding for need-based scholarships; increased funding for primary care intern and residency programs; new loan repayment programs for physicians who go into and meet a service obligation in a specialty, including a primary care specialty, in an area of the country that has a critical need for such specialists; and redistribution of unused Graduate Medical Education residency positions to primary care internal medicine and family practice. We believe that additional expansion of primary care GME positions will be needed in the future to reverse an estimated shortage of 45,000 primary care physicians for adults.
- Investment of $34 billion to fund public health investments in wellness and prevention and another $10.7 billion to fund coverage of preventive services under Medicaid.

Reform of delivery and payment systems:

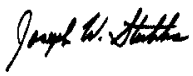
- A combined investment of $2.3 billion to fund Medicare and Medicaid pilots of the Patient-Centered Medical Home. We are pleased that the Medicare community-based medical home pilot no longer will be restricted to "high cost" beneficiaries, as proposed earlier, but recommend that the same change be made for the independent practice-based pilot.

- Study by the Institute of Medicine (IOM) on geographic variation and growth in volume and intensity of services in per capita health care spending among the Medicare, Medicaid, privately insured and uninsured populations. The IOM is instructed to conduct public hearings and provide an opportunity for comment prior to completion of the study report. Based upon findings, the IOM shall recommend changes to payment for items and services under Medicare Part A and B to promote high value care. The recommendations shall also consider an appropriate phase-in that takes into account the impact of these payment changes on providers and facilities. ACP agrees that the IOM has the necessary expertise and credibility to conduct such a study, and we are pleased that Congress would have the final legislative authority to accept or not accept, by a simple majority vote, changes in payment methodologies based on the IOM study.
- A better process to review potentially mis-valued services under the Medicare fee schedule. ACP supports the need for a better and more rigorous process to identify mis-valued services, but recommends that an independent advisory expert panel be convened to advise HHS on the selection and review of such RVUs. This process should supplement and not replace the existing RVS Update Committee (RUC) process.
- Center for Innovation to accelerate selection, testing, and implementation of innovative models to align Medicare incentives with value.
- Positive and non-punitive incentives for successful participation in the Physicians Quality Reporting Initiative.
- Independent research on the comparative effectiveness of different treatments to inform clinical decision-making and coverage decisions.
- Funding for state programs to improve patient safety and pilot test alternatives to the current medical liability tort system. We believe that additional steps are needed, though, to reduce the costs of defensive medicine, to limit excessive and unwarranted awards for non-economic damages, and to design and implement new models, such as health courts, to provide alternatives to costly and unpredictable jury trials.

It is important to recognize that the goal of reforming physician payments to achieve better value cannot be achieved unless Congress repeals the flawed Medicare sustainable growth rate formula (SGR) and replaces it with a new update system that will yield positive and predictable updates. Although H.R. 3962 does not have any provisions relating to the SGR, we appreciate your support for "The Medicare Physician Payment Reform Act of 2009," H.R. 3961, and your commitment to seeing this bill enacted into law this year. H.R. 3961 would repeal the SGR, eliminate all of the accumulated payment cuts, and create a new system that would provide a growth target of GDP plus two percent for primary care and preventive services and GDP plus one percent for all other services.

In conclusion, the American College of Physicians believes that H.R. 3962 has the key policies needed to make health insurance coverage affordable for almost all Americans, to begin to re-align federal policies to support primary care, prevention and wellness, and to reform delivery and payment systems to create better value for patients. Although we believe that additional steps will be required to reverse a catastrophic shortage of primary care physicians for adults, to make the cost of health care sustainable, to reduce the costs of defensive medicine, and to ensure that all Americans have access to affordable coverage, H.R. 3962 would represent an historic step forward to achieving ACP's desired future of a U.S. health care delivery system that provides access, best quality care and health insurance coverage for 100% of its people.

Yours truly,



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President