



America's Affordable Health Choices Act (HR 3200)

introduced on July 14, 2009

Summary of Major Primary Care Provisions

PHYSICIAN PAYMENT PROVISIONS

Sustainable Growth Rate (SGR) Reform

The SGR will be rebased to eliminate the accumulated debt of \$285 billion. This will diminish the need for annual Congressional action to avoid unsustainable payment reductions. The Medicare payment update for 2010 will be based on the percentage increase of the Medicare Economic Index (MEI).

From 2010, Medicare payment will be made in two categories of services:

- Evaluation and Management, and Preventive Services
- All other physician services

Beginning in 2011, each of these categories would have separate conversion factors: the E/M and Preventive Services would be 2 percent, while all other services would be one percent.

Payment Incentive for Selected Primary Care Services

The bill specifies a 5-percent bonus for primary care services (paid on a monthly or quarterly basis). This bonus is 10 percent if these services are provided in a primary care shortage area. (The AAFP, along with ACP and AOA, has advised Congress that this bonus payment, while welcome and precedent-setting, should be at least 10 percent for all primary care physicians regardless of area of service.) To be eligible for this bonus, the provider must have allowed charges for primary care services that account for at least 50 percent of the provider's total allowed charges.

The definition of primary care provider is expanded for purposes of this bonus payment only to include physicians or NPs who specialize in obstetrics and gynecology. (The AAFP has notified Congress that the evidence shows that these specialists do not usually provide primary care services.)

Expansion of Medical Home Pilot Program

The legislation authorizes the creation of a Medical Home Pilot Program to evaluate the advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services to targeted high need beneficiaries. (The AAFP has notified Congress that this pilot should not be restricted to high-need beneficiaries.)

www.aafp.org

President

Ted Epperly, MD
Boise, ID

President-elect

Lori J. Heim, MD
Vass, NC

Board Chair

James D. King, MD
Selmer, TN

Speaker

Leah Raye Mabry, MD
San Antonio, TX

Vice Speaker

John S. Meigs, Jr., MD
Centerville, AL

Executive Vice President

Douglas E. Henley, MD
Leawood, KS

Directors

David W. Avery, MD, Vienna, WV
James Dearing, DO, Phoenix, AZ
Roland A. Goertz, MD, Waco, TX
Kenneth R. Bertka, MD, Holland, OH
David A. Ellington, MD, Lexington, VA
Glen R. Stream, MD, Spokane, WA

Jeffrey J. Cain, MD, Denver, CO
Thomas Allen Felger, MD, Granger, IN
George Wm. Shannon, MD, Columbus, GA
Jason Dees, DO (New Physician Member), New Albany, MS
Jennifer Bacani, MD (Resident Member), Wichita, KS
Amy McIntyre (Student Member), Cranston, RI

The legislation authorizes two models of medical homes for purposes of pilot-testing. One is called the Independent Patient-Centered Medical Home and the other is the Community-Based Medical Home. The first one is similar to the concept outlined in the Joint Principles of a Patient-Centered Medical Home, developed by the major primary care physician organizations. The second is based on the medical home approach created by the North Carolina Medicaid program that funds regional community resources that physician organizations can use to coordinate all of a patient's care.

Nurse practitioners are permitted to lead a patient centered medical home so long as the NP's practice is qualified and state law permits sufficient independent practice. The primary care physician organizations have agreed to accept this as long as the pilot program includes performance data for NP practices and as long as the NP practice is required to meet the same standards that a physician practice must meet.

The bill specifies that Physician Assistants (supervised by physicians) are allowed to participate in a patient centered medical home. The bill does not say that PAs would be allowed to lead a medical home team.

The bill requires that a Patient Centered Medical Home must provide on-going primary or principal care (i.e., first contact, continuous and comprehensive care); must coordinate care provided by a team; must provide for all of the patient's health care needs or arrange for appropriate care with other providers for all stages of life; must provide continuous access to care; must provide support for patient self management and coordination with community resources; must integrate information on patients that enables the practice to treat patients comprehensively and systematically; and must implement evidence based guidelines.

For purposes of this pilot, primary care is provided by physician or NP who practices in family medicine, general internal medicine, geriatric medicine or pediatric medicine. The bill also allows a physician who provides "principal care" to serve as medical home, if the practice qualifies by the same standards. Principal care means "integrated, accessible health care that is provided by a physician who is a medical sub-specialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the sub-specialist's expertise and for whom the sub-specialist assumes care management."

HHS will determine the amount of the per-beneficiary per-month fee that the pilot program pays to the medical home. CMS is encouraged to recruit practices with fewer than 10 physicians to participate in the pilot.

The Community Based Medical Home is a nonprofit community based or state based organization that provides medical home services, headed by a primary care physician or NP and employing community health workers.

Both pilots will begin within 2 years of the passage of the bill and will extend for up to 5 years.

A state may apply for approval of the use of Medicaid funds for a medical home pilot project to last for no more than 5 years with a 90-percent federal match for the first 2 years of the program and a 75-percent match for the next 3 years.

Bonus Payments for Services in Efficient Areas

The bill includes a 5-percent bonus for physician services furnished in an efficient area, which is defined as a county (or equivalent area) in the lowest fifth percentile of utilization based on per capita spending (in Part A and B). This bonus is available regardless of any other bonus payment that the physician qualifies for.

Modifications to the Physician Quality Reporting Initiative (PQRI)

The bill extends the 2-percent incentive payments of this program to 2012, and requires time feedback for those physicians who participate. The bill simplifies the appeals process and it allows PQRI reporting to be integrated into any E.H.R. reporting that the physician practice submits.

Increased Medicaid Payments to Primary Care Physicians

Fee for Service payments in Medicaid for E/M codes only would be increased to the Medicare rates by 2012.

Mis-valued Codes under the Physician Fee Schedule

HHS will periodically identify services that are potentially mis-valued and will have the authority to adjust the values of these services. The bill requires that HHS review the codes which have the fastest growth, which have substantial changes in practice expense, which are associated with technologies or services that have not changed in 3 years. In addition, HHS will look at multiple codes that are frequently billed in conjunction with a single service.

Accountable Care Organization (ACO) Pilot Program

The legislation creates an ACO pilot program to test payment incentive models to see if they promote accountability for a patient population and coordinate services under Parts A and B. The ACO also should encourage investment in infrastructure and redesigned care processes and reward physician practices for the provision of high quality and efficient health care services

The bill defines an ACO as a group of physicians or other physician organization model (which can be a hospital) that can receive and distribute the ACO incentive payments and includes "a sufficient number of primary care physicians for the applicable beneficiaries for whose care the group is accountable." HHS will determine how to specify if an ACO has enough primary care physicians.

The incentive payment models that the ACO may use include:

- the Performance Target Model, in which the ACO receives an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth.
- the Partial Capitation Model, in which the ACO would be at financial risk for some, but not all, of the items and services covered under Parts A & B.
- HHS may propose other payment models if they are designed to meet the goals of improved quality and better efficiency.

Required Coverage of Preventive Services

Medicaid programs must include in the list of covered preventive services those that are determined to have an "A" or "B" grade from the U.S. Preventive Services Task Force, as well as those vaccines recommended by the Director of the CDC. It removes tobacco cessation agents from the list of drugs excluded from Medicaid coverage. The bill allows states, at their choosing, to implement a family planning benefit for Medicaid-eligible individuals. Currently, states must submit a Section 1115 waiver and gain permission from the Secretary of HHS to implement such a benefit.

MEDICARE GRADUATE MEDICAL EDUCATION

Distribution of Unused Residency Positions

Unused residency slots can be assigned to hospitals that maintain their number of primary care residents and use the extra slots for primary care.

Increasing Training in Nonprovider Settings

If the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident is in a non-hospital setting, that time will be counted towards the determination of FTE. The Office of the Inspector General (OIG) shall monitor how well hospitals comply with this to determine if there is an increase of time spent by medical residents in training in non-provider settings, which is the goal of the legislation.

The bill creates a demonstration project for Teaching Health Centers, which would be eligible for GME funds. A teaching health center is defined as a non-provider setting (like a FQHC or rural health clinic) that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.

Counting Resident Time for Didactic and Scholarly Activities

If a residency training program in a non-hospital setting is primarily engaged in furnishing patient care, time spent by the resident in such a program in non-patient care activities such as didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient) shall be counted in determining FTE.

Medicaid Payment of GME

The bill creates a definition for, and explicit inclusion of, Medicaid payment for graduate medical education, in both hospital and non-hospital settings.

WORKFORCE DEVELOPMENT

Primary Care Workforce

The legislation requires improvements in the training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics and Physician Assistantships. It redefines Section 747 as "Primary Care Training and Enhancement" which drops dentistry and adds geriatrics. The bill specifies that the purposes of these grants are:

- to plan, develop, operate or participate in an accredited professional training program, including an accredited residency or internship program in family medicine, general internal medicine, general pediatrics, or geriatrics
- to provide financial assistance in the form of traineeships and fellowships to medical students, interns, residents or physicians in the above fields
- to plan, develop, operate or participate in an accredited program for the training of physicians who plan to teach in these fields including in community based settings
- to provide finance assistance to those who plan to teach in these fields, and
- to plan, develop, operate or participate in a program for physician assistant education.