Health Care Reform Policy: Moving from volume to quality?

William P. Moran MD MS
Chair, SGIM Health Policy Committee
December 6, 2009
Health Policy Committee

Chair/Co: Moran/Sessums (Rich)
Education: Schwartz/Jackson (Reynolds)
Research: Wilson (Selker)
Clinical Practice: Goodson/Joy
Com/Membership: Harris/Litvin
SGIM Staff: Jetton
CRD: Ruscio, Dennis, Miller

12/10/2009
Health policy resources

- SGI M Website: Health Policy
- Quick hits
- CRD monthly reports
- Sub-Committee members
- http://thomas.loc.gov

HPC asks that you encourage your division members to respond to SGI M alerts

12/10/2009
SGIM Hill Day 2010
“Primary Care: Making Health Care Reform Work”

February 24, 2010, 9 a.m
Dinner the evening before Hill Day
invited speaker
Agenda

- Cost, access and quality of care
- Proposals evolving in Congress
- Quality and Payment reform
  - CER
  - Workforce
  - Clinical practice and quality
    - The Patient-centered Medical Home
- Paying for it all?
We spend twice as much as other industrialized nations...

Per capita health care spending of select OECD nations, 2003

Source: The Commonwealth Fund
US Health care expenditures as percentage of GDP

US Health care expenditures as percentage of GDP

What happens if we do not make a change?

The Entire US Economy becomes Healthcare in 2082!

Source: CBO Long-Term Outlook for Health Care Spending, Dec 2007
Costs to individuals are too high

Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers’ Earnings 2000 - 2006

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

There was a time in the mid-90s when the rate of cost increase slowed dramatically...
How did Managed Care systems control cost?

- Access to care?
- Key role of primary care?
- Coordination of care?
- Patient education?
- Gate keeping?

AND what is important to keep in mind as we try to improve quality and control cost?
Then there is the uninsured...

- ~ 48 million uninsured
- 80 million under-insured
- In March, 2009, almost 11,000 Americans lost their health insurance *every day*
The Young Invincibles

They’re young and healthy, and insurance is expensive. As long as they don’t catch the flu, slip on the ice, crash a bike, snowboard into a tree, rupture an appendix, or get hit by a bus, everything will be fine. Right?
Massachusetts Health Care Reform Is a Pioneer Effort, but Complications Remain

On 12 April 2006, Massachusetts introduced health care reform legislation “to provide access to affordable, quality, accountable health care” that became law in a bipartisan vote of 154 to 2 in the House of Representatives and 37 to 0 in the Senate. When then-governor Mitt Romney (R) signed the groundbreaking legislation, Chapter 58 of the Acts of 2006, he declared that “an achievement like this comes around once in a generation, and it proves that government can work when payment of health insurance premiums for employees.

The law carried a first-ever individual mandate requiring residents to buy health insurance if they do not already have it and imposed financial penalties for nonparticipation. Meanwhile, it also maintained a modified health care safety net fund to cover the cost of care for people who remained uninsured because they could not afford or were ineligible for health insurance, such as undocumented immigrants.

In 1988, it enacted a controversial universal health care law that was never implemented and was eventually repealed. That law was followed by a successful bid in the mid-1990s to expand Medicaid and to subsidize drugs for seniors.

This latest health care reform law took effect over the course of 1 year and was fully in place by 1 July 2007. As of 1 January 2008, approximately 300,000 people had already signed up for new coverage. So far, approximately 200,000 of these have...
Massachusetts Health Care Reform Is a Pioneer Effort, but Complications Remain

Mandatory enrollment (penalties)

Expansion of Medicaid

State Insurance Exchange

Basic benefits (including medications)

Subsidized premiums

On 12/10/2009, approximately 300,000 people had already signed up for new coverage. So far, approximately 300,000 of those have
Massachusetts is different… Free care pool funding mechanism was already in place Lower uninsured rate

On 12 legislation affordable, “care” that the vote of 15 Representative Senate. W... then-governor Mitt Romney (R) signed the groundbreaking legislation. Chapter 58 of the Acts of 2006, he declared that “an achievement like this comes around once in a generation, and it proves that government can work when people... medical uninsured; never reluctantly reamed by a 190s to Medicaid and to subsidize drugs for seniors.

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Has not achieved 100% coverage
Insurance exchange problems
Cost for uninsured remains high
Primary care shortage

Massachusetts Health Care Reform Is a Pioneer Effort, but Complications Remain

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And then there is the challenge of quality....

- Safe
- Patient centered
- Timely
- Effective
- Efficient
- Equitable
Although US costs are highest ... the quality of care is far from optimal

- RAND: Americans get evidence-based care only 55% of the time
- IOM: Up to 98,000 Americans die each year due to avoidable medical errors
- CDC: 2 million acquire nosocomial infections annually; 90,000 die
- WHO: US is 32nd in the world
Transformative Change

Equitable Access to Care

Insurance Reform

Comparative effectiveness research

Workforce changes

Physician payment reform and
delivery system redesign
I have consulted CRD to get their predictions...
And CRD has researched the legislation in depth...
Transformative Change
Equitable Access to Care
Insurance Reform
Comparative effectiveness research
Workforce changes
Physician payment reform and delivery system redesign

"Large-scale incremental change"
Understanding The Game: How Our Laws Are Made

INTRODUCTION
Bill introduced in House

Legislation often begins as similar proposals in both houses

Bill introduced in Senate

COMMITTEE ACTION
Referred to House committee, which holds hearings and recommends passage

Referred to Senate committee, which hold hearings and recommends passage

FLOOR ACTION
House debates and passes

Senate debates and passes

House and Senate Members confer, reach compromise on all differences between the two versions

ENACTMENT INTO LAW
House and Senate approve compromise

President signs into law or vetoes

All bills must be approved by the House and Senate in identical form before they can be sent to the president
Health Care Committees of Jurisdiction

- **Senate**
  - Finance – *Sen. Baucus (MT)*
  - Appropriations

- **House**
  - Education & Labor – *Rep. Miller (CA)*
  - Appropriations
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4 months?
And how sausage is made...
H.R. 2502

111TH CONGRESS
1ST SESSION

Comparative Effectiveness Research: House Ways and Means and Senate Finance

Be it enacted by the Senate and House of Representa-
tives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Patient-Centered Out-
comes Research Act of 2009”.

Comparative Effectiveness Research

• Who determines the research agenda? A board including industry?

• Where is CER housed- AHRQ, NIH or a new entity?

• Is the science threatened by politics? Intimidated?

• How will cost be handled? Not considered?

• How much are we willing to spend on CER and where will it come from?

5 comes Research Act of 2009”.
Schwartz Act

A BILL

To amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and to improve patient access to primary care services, and for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
4 (a) SHORT TITLE.—This Act may be cited as the
5 “Preserving Patient Access to Primary Care Act”. 
Schwartz Act

A BILL

• Reforming payment systems under Medicare to support primary care.

• Coverage of patient-centered medical home services.

• Medicare primary care payment equity and access provision.

• HHS study and report on the process for determining relative value under the Medicare physician fee schedule

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

4 (a) SHORT TITLE.—This Act may be cited as the

5 “Preserving Patient Access to Primary Care Act”.
HELP “Affordable Health Choices Act”

A BILL

To make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce.

1 Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

2 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

3 (a) Short Title.—This Act may be cited as the “Affordable Health Choices Act”.

4 (b) Table of Contents.—The table of contents of this Act is as follows.
A BILL

To make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care work

CBO: $2.6 trillion over 10 years and covers only 16 million uninsured
IN THE HOUSE OF REPRESENTATIVES

M. ______________ introduced the following bill; which was referred to the
Committee on __________________________

A BILL

To provide affordable, quality health care for all Americans
and reduce the growth in health care spending, and
for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3 SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES,
4 AND SUBTITLES.
5 (a) Short Title.—This Act may be cited as the
House Tri-Committee bill

IN THE HOUSE OF REPRESENTATIVES

Access to Coverage and Choice
Affordability
Shared Responsibility
Controlling Costs
Prevention and Wellness
Workforce Investments

Reforming SGR and the
Physician Payment System:
Rewarding Primary Care,
Coordination, and Efficiency

(a) Short Title.—This Act may be cited as the
Beyond access and cost:

Workforce changes
Emphasis on Primary Care
Physician payment reform
Quality measurement and reporting
Delivery system reform (PCMH)
Proportions of Third-Year Internal Medical Residents Choosing Careers as Primary Care General Internists, Hospitalists and Subspecialists

![Bar chart showing percentages of respondents choosing careers in General internal medicine, Subspecialty, and Hospitalist from 1998 to 2005.](chart.png)
Factors Associated With Medical Students’ Career Choices Regarding Internal Medicine

Karen E. Hauer, MD
Steven J. Durning, MD
Walter N. Kernan, MD
Mark J. Fagan, MD
Matthew Mintz, MD
Patricia S. O’Sullivan, EdD

Context Shortfalls in the US physician workforce are anticipated as the population ages and medical students’ interest in careers in internal medicine (IM) has declined (particularly general IM, the primary specialty serving older adults). The factors influencing current students’ career choices regarding IM are unclear.

Objectives To describe medical students’ career decision making regarding IM and to identify modifiable factors related to this decision making.


Results Of 1177 respondents, 274 (23.2%) planned careers in IM, including 24 (2.0%) in general IM. Only 228 (19.4%) responded that their core IM clerkship made a career in general IM seem more attractive, whereas 574 (48.8%) responded that it made a career in subspecialty IM more attractive. Three factors influenced career choice regarding IM: educational experiences in IM, the nature of patient care in IM, and lifestyle. Students were more likely to pursue careers in IM if they were male (odds ratio [OR] 1.75; 95% confidence interval [CI], 1.20-2.56), were attending a private school (OR, 1.88; 95% CI, 1.26-2.83), were favorably impressed with their educational experience in IM (OR, 4.57; 95% CI, 3.01-6.93), reported favorable feelings about caring for IM patients (OR, 8.72; 95% CI, 6.03-12.62), or reported a favorable impression of internists’ lifestyle (OR, 2.00; 95% CI, 1.39-2.87).

Conclusions Medical students valued the teaching during IM clerkships but expressed serious reservations about IM as a career. Students who reported more favorable impressions of the patients cared for by internists, the IM practice environment, and internists’ lifestyle were more likely to pursue a career in IM.

JAMA. 2008;300(10):1154-1164

2% of Medical Students plan to pursue a career in General Internal Medicine
Schwartz Act...inducements

A BILL

To amend the Public Health Service Act and the Social

Recruitment incentives.
Debt forgiveness, scholarships, and service obligations.
Deferment of loans during residency and internships.
Immigration and Nationality provisions.
Educating Medical Students about Primary Care Careers.

2 tives of the United States of America in Congress assembled,

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

(a) SHORT TITLE.—This Act may be cited as the “Patient Protection and Affordable Care Act”.

The only ‘short’ part of this 2074 page bill…
H.R.3590
Patient Protection and Affordable Care Act

TITLE III
IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System
Part I – LINKING PAYMENT TO QUALITY OUTCOMES IN MEDICARE

Sec. 3002. Improvements to the physician quality reporting initiative.

- Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare.
- Creates appeals and feedback processes for participating in PQRI.
- Establishes a participation pathway for physicians completing Maintenance of Certification program.
- In 2014, physicians who do not submit to PQRI will have their Medicare payments reduced. In the Finance bill, penalties would have begun in 2012.

- House Bill: Does not include penalties for not reporting. Only extends the incentive payments through 2012.
Part I – LINKING PAYMENT TO QUALITY OUTCOMES IN MEDICARE

Sec. 3003. Improvements to the physician feedback program.

- Expands Medicare’s physician resource use feedback program to develop of individualized reports by 2012.
- Reports will compare the per capita utilization of physicians to other physicians who see similar patients.
- Reports will be risk-adjusted and standardized

The original Finance bill included a penalty for providers whose resource use is at or above the 90th percentile of national utilization.

House Bill: Improves the feedback portion of the PQRI program, but not to this extent.
Part I – LINKING PAYMENT TO QUALITY OUTCOMES IN MEDICARE

Sec. 3007. Value-based payment modifier under the physician fee schedule.

• Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver.

• Quality and cost measures will be risk-adjusted and geographically standardized.

• The Secretary will phase-in the new payment system over a 2-year period beginning in 2015. *No similar provision was in the original Finance bill.*

*House Bill:* No provision
Part I - LINKING PAYMENT TO QUALITY OUTCOMES IN MEDICARE

Sec. 3008. Payment adjustment for conditions acquired in hospitals

• Starting in FY2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare.

• Report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.
Part I - LINKING PAYMENT TO QUALITY OUTCOMES IN MEDICARE

Original Finance bill provision: A new payment adjustment to hospitals ranked in the top quartile of the national, risk-adjusted hospital acquired condition rates would be applied. CMS would calculate national and hospital-specific data, and this data would be shared with hospitals and publicly reported on the Hospital Compare website. Beginning on October 1, 2014, hospitals in the top quartile would receive 99 percent of their otherwise applicable Medicare payments.

- House Bill: No provision.
PART II--NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

- SEC. 3011. NATIONAL STRATEGY
- SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY
- SEC. 3013. QUALITY MEASURE DEVELOPMENT
- SEC. 3014. QUALITY MEASUREMENT
- SEC. 3015. DATA COLLECTION; PUBLIC REPORTING
Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation.

- research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program.
- Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare.
- Successful models can be expanded nationally.

House Bill: Includes the same provision.
Part III – Encouraging Development of New Patient Care Models

Sec. 3022. Medicare shared savings program.

- Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. *This was included in the original Finance bill.*

- **House bill**: Includes a similar provision that would allow ACOs who achieve cost savings to share that savings as an incentive payment.
Part III – Encouraging Development of New Patient Care Models

Sec. 3023. National pilot program on payment bundling.

- Direct the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program.

- Requires the Secretary to establish this program by January 1, 2013 for a period of five years.

**New Provision:** Before January 1, 2016, required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.

- **House Bill:** Does not include a similar pilot.
Part III – Encouraging Development of New Patient Care Models

Sec. 3025. Hospital readmissions reduction program.

- Beginning in FY2012, adjusts payments for hospitals paid under DRG payment system based on the dollar value of each hospital’s percentage of potentially preventable Medicare readmissions – three conditions and risk adjusted readmission measures that are currently endorsed by the National Quality Forum.
- Secretary has authority to expand the policy to additional conditions in future years
- Directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

House Bill: Includes the same provision.
Subtitle B – Improving Medicare for Patients and Providers

Part I – Ensuring Beneficiary Access to Physician Care and Other Services

Sec. 3101. Increase in the physician payment update.

- Replaces the scheduled 21 percent payment reduction to the Medicare physician fee schedule for 2010 with a 0.5 percent positive update. *This was included in the original Finance bill.*

- **House bill**: Does not include a SGR patch for 2010. The House passed a stand alone SGR fix.
April 29, 2008

Kerry N. Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Dear Mr. Weems,

On behalf of the American Medical Association/Specialty Society RVS Update Committee (RUC), I am pleased to submit work relative value recommendations and direct practice expense inputs specifically for the Medicare Medical Home Demonstration project to the Centers for Medicare and Medicaid Services (CMS).

The RUC’s recommendations are enclosed, along with several supporting documents regarding patient eligibility and physician panel size which served as the basis for the physician work and clinical staff time determinations. The attachments also include two price quotes regarding an electronic medical records system for use in the development of medical equipment inputs for the Tier 3 medical home. In addition to the recommended
Part III – Improving Payment Accuracy

Sec. 3134. Mis-valued codes under the physician fee schedule.

- Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates.
- Strengthens the Secretary’s authority to adjust fees schedule rates that are found to be mis-valued or inaccurate. *This was retained from the Finance bill.*

- *House bill:* Includes the same provision.
Subtitle E – Ensuring Medicare Sustainability
Sec. 3403. Independent Medicare Advisory Board.

- Creates an independent, 15-member Medicare Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care.
- When Medicare costs are projected to be unsustainable, the Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same savings.
- Congress would be allowed to consider an alternative provision on a fast-track basis.
- The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

*This was retained from the Finance bill.*
- *House bill:* Does not include a similar provision.
"‘medical home’ programs... if designed carefully, may be a way to improve the value of physician and other health care services."
Joint Principles of the Patient-Centered Medical Home
AAFP, ACP, AOA, AAP March, 2007

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety are hallmarks
- Enhanced access
Joint Principles of the Patient-Centered Medical Home
AAFP, ACP, AOA, AAP March, 2007

Payment Reform
- Reflect value of work outside visits
- Pay for associated coordination of care
- Support adoption of IS for quality improvement
- Support enhanced communication
- Recognize value of remote monitoring
- Allow separate FFS payments
- Recognize case mix
- Physician share savings
- Additional payments for measurable quality improvements
Patient-Centered Primary Care Collaborative
Is PCMH Ready For Prime Time?

Despite much enthusiasm for widespread implementation, the patient-centered medical home remains a promising approach to chronic care that awaits more data.

ABSTRACT: Robert Berenson and colleagues caution that the patient-centered medical home (PCMH) faces many challenges. Its successful adoption will depend on its being precisely defined and demonstration that it is cost saving and scalable across varied clinical settings. Until these issues are addressed in current and upcoming pilot programs, caution about the PCMH’s role in the care of people with chronic illnesses is warranted.

[Jaan E. Sidorov *Health Affairs* 27, no. 5 (2008): 1231–1234; 10.1377/hlthaff.27.5.1231]
Subtitle F—Health Care Quality Improvements

Sec. 3502. Grants or contracts to establish community health teams to support the patient-centered medical home.

- Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

- New provision. The bill also includes a health home option under Medicaid.
Subtitle F—Health Care Quality Improvements

House bill: Medical home pilot program. An expansion and reorientation of the medical home demo in Medicare. Establishes a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes.

There are two models:

1) the *independent patient-centered medical home*, structured around a provider, is targeted at the top half of high-need Medicare beneficiaries with multiple chronic diseases, and

2) the *community based medical home*, which may include any eligible beneficiary, is targeted at a broader population of Medicare beneficiaries and allows for State-based or nonprofit entities to provide care-management supervised by a beneficiary designated primary care provider.

Provides approximately $1.8 billion for the pilot programs. The Secretary is authorized to expand the program only if quality measures have been met and budget neutrality is demonstrated.
Physician and Non-Physician Changes 1960 - 2050

- All Physicians
- Not a Primary Care Physician
- Primary Care Physician
- Family Medicine
- Non-Primary Care NP and PA
- Primary Care NP and PA
TITLE V—HEALTH CARE WORKFORCE
Subtitle B—Innovations in the Health Care Workforce

- Sec. 5101. National health care workforce commission.
- Sec. 5102. State health care workforce development grants.
- Sec. 5103. Health care workforce assessment.
TITLE V—HEALTH CARE WORKFORCE
Subtitle C—Increasing the Supply of the Health Care Workforce

- Sec. 5201. Federally supported student loan funds.
- Sec. 5202. Nursing student loan program.
- Sec. 5203. Health care workforce loan repayment programs.
- Sec. 5204. Public health workforce recruitment and retention programs.
- Sec. 5205. Allied health workforce recruitment and retention programs.
- Sec. 5206. Grants for State and local programs.
- Sec. 5207. Funding for National Health Service Corps.
- Sec. 5208. Nurse-managed health clinics.
- Sec. 5209. Elimination of cap on commissioned corps.
- Sec. 5210. Establishing a Ready Reserve Corps.
Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.

Sec. 5302. Training opportunities for direct care workers.

Sec. 5303. Training in general, pediatric, and public health dentistry.

Sec. 5304. Alternative dental health care providers demonstration project.

Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.

House – Does not repeal the ratable reduction (which sent 2/3 of funds to family medicine).
Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years.

To be eligible for the bonus, 60 percent of the providers allowed charges must be primary care as identified by the following codes: 99201 through 99215, 99304 through 99340, and 99341 through 99350.

Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services.

House bill: Provides a 5 percent bonus with no time limit for physicians practicing primary care as defined by their specialty and 50 percent of their allowed charges must be in primary care. Eligible professionals practicing in health professions shortage areas will receive an extra 5 percent.
ACP recommendations for cost control  

- Reduce inappropriate utilization of services, including technology, and encourage clinically effective care based on comparative effectiveness research.
- Pay appropriately for health care services, and encourage adoption of innovative models of health care delivery such as the Patient-Centered Medical Home.
- Ensure accurate pricing of services.
- Assure an appropriate physician workforce specialty mix.
- Reduce administrative costs.
- Reduce costs from medical malpractice and defensive medicine.
- Promote wellness, prevention, chronic disease management and encourage patient responsibility for health and cost consciousness.
Questions? Comments?