

Frequently Asked Questions (FAQs)

Additional Policy Issues of Interest for Leadership Day 2011

Does the College support the Independent Payment Advisory Board (IPAB), as enacted in the Affordable Care Act (ACA)?

While ACP supports the concept of an independent payment board, the current-law provision does not meet key ACP conditions for support, as outlined below. That said, however, ACP is not calling for a repeal of the IPAB but rather will seek to make improvements that are in line with ACP policy.

As written, the IPAB is a 15-member board of healthcare experts appointed by the President, with the consent of the Senate, which would submit proposals to Congress to extend Medicare solvency and improve quality in the Medicare program. More specifically, beginning in 2014, proposals for Medicare cost reductions from the Board would be required when Medicare costs are projected to increase faster than inflation indicators. The targeted level of cost reduction would be the lesser of the level of excess spending or a defined level that would increase each year. The target growth in 2019 and beyond would be Gross Domestic Product (GDP) per capita plus 1 percent. The Secretary of Health & Human Services (HHS) would be required to implement the provisions included in the IPAB proposal, unless Congress passes an alternative proposal with an equivalent amount of budgetary savings.

The ACP Board of Regents, in September 2009, discussed and approved a position on entities like the IPAB that provided significant regulatory and budgetary authority to a non-elected body. The College's position supports the concept of an independent body developing proposals to implement payment reform that promotes quality and value (and not simply focus on cost) on a fast-track basis. The College believes that making difficult Medicare payment and budgetary decisions is very difficult within a political process so influenced by lobbying, and that an independent board serving in this role should have some protection from undue influence. Within this framework, the College developed a set of criteria that such an independent body must meet to receive the College's support. The current-law IPAB provision does not fulfill the following critical criteria, and therefore the College does not support the provision as written:

- It does not ensure adequate primary care representation on the Board.
- It does not provide sufficient protections to ensure that the cost reductions will not adversely affect the delivery of quality services. While the provisions do address quality considerations, the emphasis is too strongly focused on cost reduction.
- It does not provide the elected members of Congress with sufficient ability to override the IPAB proposals. The College believes that the proposals offered by the IPAB should be subject to a simple majority vote in Congress.
- It does not treat all providers and suppliers under Medicare equally. The current provision exempts hospice and hospitals from any consideration for reductions based on the Board's recommendations over the first several years. This unfairly leaves physician payments as one of the few remaining means of obtaining required savings.

Since enactment of this provision in the ACA, much controversy has continued to surround it. The President has sought to strengthen the IPAB while some in Congress have been working to repeal it. Since January, legislation has been introduced to repeal the IPAB; none of which have passed either chamber. More detail on the political situation surrounding the issue can be found at:

<http://www.nytimes.com/2011/04/20/us/politics/20health.html?scp=1&sq=Obama%20Panel%20to%20Curb%20Medicare%20Finds%20Foes%20in%20Both%20Parties&st=cse>

Does ACP support H.R. 1256, the *Medicare Physician Payment Transparency and Assessment Act*, which would alter how Medicare fee-for-service payments to physicians are determined under the RBRVS process?

ACP is currently reviewing this legislation. It will be a topic of discussion during the May 22nd meeting of ACP's Medical Practice and Quality Committee in light of the fact that it proposes significant changes to the Resource-Based Relative Value Scale (RBRVS) process. In summary, the bill, which was recently introduced by Rep. Jim McDermott (D-WA),

would add public and transparent data collected from independent analysts to compare to recommendations of the American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC).

Congress requires that the Centers for Medicare and Medicaid Services (CMS) use the RBRVS to determine Medicare fee-for-service payments to physicians. The RBRVS measures the resource costs required to provide each physician service, ranking each service relative to all other services. These resource costs are expressed in the form of relative value units (RVUs). The total relative value assigned to each service is divided into three components: physician work, practice expense, professional liability insurance.

CMS maintains the RBRVS through annual and periodic updates to RVUs assigned to each service and changes to the underlying methodology. The annual changes are limited to CMS value assignments to services for which a new procedure code is established (or an existing procedure code is significantly altered). Generally, all services for which a procedure code already exists are considered to be appropriately valued. The periodic review, which takes place every five years and is known as the "Five-Year Review," provides an opportunity to re-assess the accuracy of the values assigned to existing services. CMS relies, to a large extent, on recommendations from the RUC, which is comprised of representatives appointed by major physician specialty organizations and supported by an advisory group representing a broader group of specialties. While CMS makes the final decision on the relative value assigned to each service, the agency has accepted approximately 90 percent of the recommendations it has received from the RUC since Medicare began using the RBRVS as the basis for physician payments in 1992.

The Medicare Payment Advisory Commission (MedPAC) recommended improvements to the process for reviewing the relative value of physician services in its June 2006 report, http://www.medpac.gov/publications/congressional_reports/Mar06_Ch03.pdf. These recommendations sought to address concerns that primary care encounters and other evaluation & management (E/M) services were being devalued over time. MedPAC recommended, among other things, that the secretary of HHS should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. The Secretary, in consultation with the expert panel, should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work. This is significant because mis-valued services distort incentives and may result in the overuse or underuse of specific services on the basis of financial, as opposed to clinical, reasons. Inappropriate valuation of services also affects physicians' decisions to enter or remain in specialty fields that perform undervalued services. Refining the RBRVS remains crucial until new payment models are designed and implemented on a widespread basis. Innovative payment models are likely to be tested, and even models that dramatically change incentives may still, at least in part, be based on current fee-for-service payment rates that are built by RVUs. In addition, Medicare can make payment policy changes within the context of the RBRVS to facilitate a transition to models of care that focus more explicitly on improving care coordination.

The ACA contains a provision, which ACP supported, that promotes identification and correction of mis-valued physician fee schedule services. Congress included the provision on the belief that too little attention is devoted to monitoring whether services have become overvalued. The provision contains two main parts: providing direction to the Secretary of HHS, largely carried out through CMS, for identifying and correcting mis-valued services; and requiring the Secretary of HHS to establish a process to validate relative value units for physician fee schedule services.

Where does ACP stand on S. 454, the *Strengthening Program Integrity and Accountability in Health Care Act of 2011*, which is intended to address waste, fraud and abuse in Medicare?

While ACP is still evaluating the possible implications of this legislation, we do have some concerns at this time. S. 454, introduced in March by Senator Charles Grassley (R-IA), would mandate that the Secretary of HHS suspend Medicare and Medicaid payments pending investigation of credible allegations of fraud. Furthermore, it would require the Secretary to extend to up to 365 calendar days, for particular categories of service providers or suppliers in which fraud, waste, or abuse is likely, the number of days in which Medicare claims are required to be paid in order to ensure that they are clean claims. The legislation also authorizes the Secretary to exclude from federal health programs any physician entity affiliated with an entity under investigation for fraud. Entities may only be excluded from federal health programs if they

were affiliated with a sanctioned entity during a time in which fraud occurred. And, among other things, directs the Secretary to make available to the public Medicare claims and payment data.

While ACP agrees that waste, fraud and abuse need to be addressed in Medicare, the College has concerns that the far-reaching consequences of S. 454 could unduly penalize physician practices for mere allegations of fraud. The legislation states directly that the secretary “shall” suspend Medicare and Medicaid payments [to a physician practice] pending investigation of “credible allegations” of fraud. The possible implication of this is that a physician practice might not receive Medicare or Medicaid payments for up to 365 calendar days if under investigation for fraud or if the Secretary determines that there is a likelihood of fraud, waste or abuse. Furthermore, if a physician practice was affiliated with any entity that is being investigated for fraud, at the time that fraud was allegedly committed, that physician practice could be barred from participating in federal health programs. In ACP’s view, this could do irreparable damage to a physician practice that has not been involved in any impropriety.

ACP policy states that fraud and abuse laws have created an atmosphere in which physicians feel that almost all of their behavior is suspect. In particular, many physicians believe that inadvertent billing and coding errors made in the context of a complex system are being treated as fraud. The College seeks to: 1) reduce unnecessary burdens for physicians who do not engage in illegal activities and; 2) prevent and punish legitimate fraud.

Where does ACP stand on H.R. 1700, the *Medicare Patient Empowerment Act*, which addresses private contracting for services under the Medicare program?

ACP is currently evaluating this legislation in relation to ACP policy and will consider it during the upcoming May 22nd meeting of the College’s Medical Practice and Quality Committee. Introduced by Rep. Tom Price (R-GA) on May 3, 2011, H.R. 1700 would permit, among other things, Medicare beneficiaries and health care professionals the right to contract for items and services outside of the Medicare system and not be penalized. Medicare beneficiaries would still retain their Medicare benefits even if they enter into a private contract with a physician. The bill also prohibits contracting with beneficiaries who are dually eligible for both Medicare and Medicaid and when a beneficiary is in an urgent medical care situation.

In evaluating the bill, ACP’s Medical Practice and Quality Committee will assess if it sufficiently addresses ACP’s current policies on private contracting including safeguards for patients. Current ACP policy supports the primacy of the relationship between a patient and his/her physician, and the right of those parties to privately contract for care, without risk of penalty beyond that relationship, provided that the following patient protections are included: (1) a requirement that physicians disclose their specific fee for professional services covered by the private contract in advance of rendering such services, with beneficiaries being held harmless for any subsequent charge per service in excess of the agreed upon amount; (2) a prohibition on private contracting in cases where a physician is the "sole community provider" for those professional services that would be covered by a private contract; (3) a prohibition on private contracts in other cases where the patient is not able to exercise free choice of physician; (4) a prohibition on private contracting for dual Medicare-Medicaid eligible patients; (5) a requirement that private contracts cannot reduce patient access to care in cases of emergency or life-threatening illness; and (6) a requirement that CMS and MedPAC monitor Medicare beneficiary access to health care and report to Congress and the public if access problems develop as a result of private contracting.