Frequently Asked Questions (FAQs)

Additional Policy Issues of Interest for Leadership Day 2014

Where does ACP stand on recently-introduced legislation in the Senate that seeks to improve access to primary care services, specifically through support for primary care payment and workforce policies?

On April 9, 2014, the *Expanding Primary Care Access and Workforce Act* (S. 2229), was introduced by Sen. Bernard Sanders (I-VT). A summary of the legislation, as provided by Sen. Sanders, can be found here.

This legislation is quite broad and seeks to improve access to primary care services through a myriad of different ways, including increased funding for federal primary care workforce programs supported by ACP like the National Health Service Corps, Title VII Health Professions, Teaching Health Centers, and the National Health Care Workforce Commission. It also extends the Medicaid Pay Comparability Program, ensuring that Medicaid rates for primary care services will remain equal to Medicare through FY2020, and permanently reauthorizes the 10 percent Medicare primary care bonus – both supported by ACP. Unfortunately, S. 2229 also contains several provisions of concern to ACP that preclude us from supporting the bill as introduced:

- Section 5 of the bill requires that when determining physician fees for payments under Medicare, the Secretary of Health & Human Services shall only consider recommendations from organizations representing physicians if they have at least 50 percent representation by primary care physicians. Although not specifically stated, it appears that this provision would prohibit the Centers for Medicare and Medicaid Services (CMS) from directly considering recommendations from the Relative Value Scale Update Committee (RUC), of which ACP is a member. ACP would not support such a requirement, nor would it be politically feasible. Such a restriction also raises First Amendment questions. The Administrative Procedures Act gives individuals and groups the right to petition government and comment on proposed regulations. It is under this authority that the RUC submits recommendations to CMS. Federal law should not prohibit CMS from obtaining input from the RUC, or others, as long as it is in compliance with the Administrative Procedures Act.

- Section 6 requires that medical schools receiving federal funding maintain a family medicine or primary care department and requires that all 3rd year students complete an eight week primary care rotation. While most medical schools have family medicine rotations or community medicine rotations, the standard rotation is typically some multiple of 4 weeks (4, 8, 12 weeks) and in the case of internal medicine may be divided between the 3rd and 4th year. ACP cautions that it may be physically impossible for many medical schools to have all their students take such a rotation during their 3rd year as there are only so many training slots available. To mandate the year and the length will be burdensome for some medical schools and may have unintended consequences for some programs.

- Section 7 raises the cap on the number of Medicare-supported residency training slots by 2,000 to be allotted to approved residency programs in family medicine. ACP is concerned that the expansion in residency spots excludes internal medicine. Both family physicians and general internists provide the majority of adult primary care in the United States. Internists' training is solely directed to care of adult patients; consequently, internists are especially focused on the care of adult and elderly patients with multiple complex chronic diseases. Their services are going to be increasingly necessary in taking care of an aging population with growing incidence of chronic disease. It is critical that any expansion in residency slots include internal medicine.

While ACP appreciates the efforts of Sen. Sanders to improve access to primary care services, we are urging him to address the concerns noted above and to modify the legislation accordingly.

Where does ACP stand on the ICD-10 issue, and when do practices need to complete the transition?

On April 1, 2014, the *Protecting Access to Medicare Act* (H.R. 4302) was enacted into law. It delayed for one year until April 1, 2015 a scheduled 24 percent physician payment cut as a result of the flawed Sustainable Growth Rate (SGR)

formula and extended other various provisions of law set to expire. One provision of the legislation extended the compliance date for the transition to ICD-10 to Oct. 1, 2015, as noted by CMS on its website. It is at that time that the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. Practices will have to be in compliance on that date and ACP has created a host of resources for practices to help them transition to ICD-10, which can be found here.

ACP did not support the *Protecting Access to Medicare Act*, mostly because we objected to the fact that the bill created another one-year "patch" to the SGR, rather than repealing the SGR altogether. In addition, ACP has not actively advocated for any additional extension of ICD-10 since it was initially delayed to Oct. 1, 2014 because, over the past several months, CMS has taken our concerns about the rollout of ICD-10 seriously and made major strides to address them. In brief, these concerns included: (1) the need for thorough end-to-end testing and (2) that physicians should be allowed to use clinical terminologies (such as SNOMED) at the point of care, which are much better at accurately capturing the nuances of health conditions and clinical care—and then have those terminologies mapped to ICD-10 on the back end. This end-to-end testing is now planned for June of this year. Additional smaller scale testing is already underway, and CMS no longer opposes the use of clinical terminologies at the point of care. All of these approaches are the real permanent solution to the ICD-10 problem; therefore, unless the testing raises significant issues, a delay would be unlikely to help. Additionally, it is important to note that many stakeholders, physicians included, have already invested significant resources in preparing for this change to occur on the previously scheduled timetable.

What is ACP's position on the recent release of Medicare Part B data?

In April, the CMS released Medicare physician payment data, placing a massive database on its website that allows access to nearly all payments made in 2012. This release revealed information for more than 880,000 health care professionals in all 50 states who collectively received $77 billion in payments in 2012 for services delivered to beneficiaries under the Medicare Part B fee-for-service program.

ACP and other medical societies had urged CMS to take a more measured approach to the release of Medicare payment data after the agency announced in January that it would begin honoring Freedom of Information Act requests for payment data. That decision came eight months after a federal judge lifted a 33-year-old injunction that had barred public access to Medicare reimbursement data that identified specific physicians.

ACP generally supports the release of such information as part of a greater trend toward transparency. "This is data, and the public has a right to it," ACP President Dr. David Fleming said. "Everybody needs to know more about this so we can do more to control costs while we enhance quality and improve the health care we provide."

However, ACP and other groups had asked CMS to give them a chance to review the data for errors and other problems before releasing it to the public. ACP plans to work with other medical societies to develop information for its members and the public that should allow for better understanding of the data—what it actually reflects, as well as its limitations. ACP also will continue to talk with CMS about ways to improve future releases of Medicare payment data. To read more about ACP's views on this issue, please see a recent ACP Advocate Blog posting by Robert Doherty, Senior Vice President of Governmental Affairs and Public Policy.

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

Sponsored by Rep. Tom Price (R-GA), the *Medicare Patient Empowerment Act* (H.R. 1310) was introduced on March 21, 2013. It has not been scheduled for consideration in either House committee having jurisdiction over Medicare, nor has it been scheduled for consideration by the full House.

This legislation 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. The legislation applies to a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, physical or occupational therapist or a qualified speech-language pathologist, or a qualified audiologist.

While the American Medical Association (AMA), the American Osteopathic Association (AOA) and numerous other physician groups have endorsed this legislation, ACP has not endorsed it because it lacks some important patient protections. If those protections were added, we would support it.

In the last Congress, ACP provided feedback to Dr. Price regarding this legislation, which existed as H.R. 1700 at the time. The College stated that while ACP appreciates and supports the goal of the legislation, we have concerns that the legislation does not include sufficient patient protections in cases where patients do not have a free choice of physicians that, if not addressed, could negatively impact access to care for some patients.

The College has long-standing policy that 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. ACP policy goes on to state that certain patient protections are essential under any Medicare private contracting agreement. From an ethical standpoint, ACP believes that the physician's first and primary duty is to the patient. Physicians should be cognizant of their professional obligation to care for the poor and of medicine's commitment to serving all classes of patients who are in need of medical care.

While H.R. 1310 contains many provisions that are consistent with ACP policy, including: (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 for dual Medicare-Medicaid eligible patients; and (3) a requirement that private contracts cannot be entered into at a time when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation. However, there are other important protections absent from H.R. 1310 that are critical to ensuring adequate patient access to care, such as: (1) 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; (2) a prohibition on private contracts in other cases where the patient is not able to exercise free choice of physician; (3) clarification that private contracting arrangements should not apply at a time when emergency or urgent care is being rendered, even if the treating physician and patient had previously entered into a private contract.

What is the Independent Payment Advisory Board (IPAB) and what is ACP's position on it?

The Affordable Care Act (ACA) established an Independent Payment Advisory Board (IPAB) which must submit recommendations to Congress, beginning in 2014, to reduce the growth of Medicare expenditures if a specified growth threshold is passed, while maintaining or improving the quality of care delivered. The Department of Health & Human Services (HHS) has announced that the growth rate will not be exceeded for 2014. The Secretary of HHS would be required to implement these recommendations on a fast-track basis unless Congress passed an alternative proposal that provided an equivalent amount of budgetary savings. Congress can also amend or dismiss these recommendations through a supermajority vote – at least a two-thirds vote in the Senate.

ACP supports the general concept of an independent body developing recommendations to implement payment reform that helps to effectively maintain the fiscal integrity of the Medicare system. ACP believes that it is very difficult for Congress to make Medicare payment and budgetary decisions due to its limited healthcare expertise and the influence of significant special-interest lobbying efforts on the political process. Thus, these important decisions required by Congress are often inadequately informed, unduly influenced by special interests, or avoided. The College believes that an independent board of physicians and other health care experts that both informs Congress on means to effectively control the unsustainable growth of Medicare healthcare expenditures and provides an increased requirement for Congress to address this important issue would be more likely to achieve needed Medicare changes. The College further believes that

the IPAB has the potential to serve this role, but requires some significant modification. Thus, rather than repeal IPAB, the College advocates for modifications to this current-law provision.

ACP policy calls for the following changes to the current IPAB provision of the ACA:

- Congress should be allowed to override IPAB recommendations with a majority rather than a super majority vote. The College agrees with the position of many of the other physician organizations that the current-law provision removes too much authority from Congress and their ability to be accountable to the public**.** This change would appropriately return adequate authority to Congress.

- It should be required that a physician who provides primary care services be a member of the IPAB. Given the multitude of research data reflecting the important role of primary care as a foundation for any effective and efficient healthcare system, ACP believes the inclusion of a member with these practice credentials is imperative.

- The current-law provision should include language to more clearly ensure that the savings obtained through IPAB recommendations and implementation either improves or at least maintains the quality of care provided.

- The IPAB should be able to consider all Medicare providers and suppliers when developing payment delivery and expenditures change proposals, as opposed to the current situation where certain groups have been excluded. Payment delivery changes and reductions should not be the burden of a restricted number of Medicare providers and suppliers.

- The IPAB authority should be expanded to make recommendations regarding Medicare coverage and benefits. It is important in order to efficiently use limited healthcare resources that decisions in these areas be based on a process that considers both clinical effectiveness and cost issues.

Several legislative initiatives have been proposed in Congress, both by Republicans and Democrats, to repeal the IPAB. However, ACP continues to advocate for modifications to the IPAB as opposed to repeal.

Does ACP have a position on internist Vivek Murthy, MD, nominee to become the next Surgeon General of the United States?

Yes, ACP strongly supports Dr. Murthy's nomination as he is a strong advocate for increasing access to health care, has extensive experience in public health, and is an ACP member. In February, the Senate held a confirmation hearing on his nomination and voted favorably to approve him. However, Dr. Murthy has yet to be approved by the full Senate.

There has been some opposition in Congress to his nomination, namely concerns that he has been too political in his support of the Affordable Care Act and advocacy of addressing deaths and injuries from firearms as a public health issue. The National Rifle Association is urging Senators to vote no on Dr. Murthy's confirmation. During his confirmation hearing, Dr. Murthy stated that his priorities as Surgeon General would be fighting obesity and building effective collaborative partnerships to increase public health.

ACP issued a letter of support in advance of his hearing, which can be found here. The White House and Senate Majority Leader Reid have put off bringing Dr. Murthy's nomination to a confirmation vote in the Senate, reportedly because of concern that several "vulnerable" Democrats running for re-election in conservative-leaning states would vote against him because of his views on deaths and injuries from firearms being a public health issue, potentially denying him the majority vote required to confirm him. It is currently anticipated that the confirmation vote will not occur until after the November mid-term elections, in a lame-duck session of Congress. If asked, Leadership Day attendees can express support for Dr. Murthy's nomination and speak to his qualifications to serve as Surgeon General. Until Senator Reid and the White House decide to bring his nomination to the floor for a vote, it is premature to make an all-out push for his confirmation at Leadership Day.

What are ACP's recommendations on reducing gun-related injury and death in the United States?

In April 2014, ACP released a new policy paper that offers nine strategies to address the societal, health care, and regulatory barriers to reducing firearms-related violence, injuries, and deaths in the United States. Principal among ACP's nine strategic imperatives is the recommendation to approach firearm safety as a public health issue so that policy decisions are based on scientific evidence. As such, ACP strongly supports universal criminal background checks to keep guns out of the hands of felons, persons with mental illnesses that put them at greater risk of harming themselves or others, people with substance use disorders, and others who current regulations prohibit from owning guns.

Since 1995, ACP has raised concern about the epidemic of firearm violence and advocated for policies to reduce the rate of firearm injuries and deaths. Eighteen years later, while the overall rate of death, injury and disability related to firearms in the U.S. has declined significantly, it is still alarmingly high: the U.S. rate of firearm-related deaths is the highest among industrialized countries.

The horrific mass shooting that occurred in December 2012 in Newtown, CT in which six adults and 20 children were killed at Sandy Hook Elementary School, and others prior and since, have brought the need to reduce firearm violence to the forefront of national discussion. The toll of firearms-related injuries and deaths, though, is much greater than those associated with mass shootings; every day, in almost every community, people are killed or injured by firearms. Firearm violence is not only a criminal justice issue, but also a public health threat. A comprehensive and multifaceted approach is necessary to reduce the burden of firearm-related injuries and death on individuals, families, communities, and society in general. As an organization representing physicians who have first-hand experience with the devastating impact on the health of their patients resulting from firearms-related injuries and deaths, we have a responsibility to be part of the solution in trying to mitigate these needless tragedies.

What is the status of federal legislation addressing firearms-related injury and death?

The *Safe Communities, Safe Schools Act of 2013* (S. 649) was introduced in the Senate on March 21, 2013 by Majority Leader Harry Reid (D-NV). S. 649 would require background checks for all firearm sales and prohibit "straw man" purchases that currently circumvent existing background checks. These measures would help keep firearms out of the hands of persons who intend to use them to harm others without infringing on Second Amendment rights. S. 649 was brought before the full Senate for a vote in April, 2013 but failed to garner the 60 votes needed for passage. The Senate also rejected a ban on assault-style weapons and high capacity magazines. Future congressional action on S. 649 or other gun control measures is unclear at this time.

ACP was disappointed by the outcome of the Senate vote on S. 649. For more than 15 years, the College has advocated for reasonable, evidence-based policies to reduce firearms injuries and deaths, including background checks and a ban on assault weapons and high capacity magazines.

In January 2013, ACP released a statement in support of the President's call for a comprehensive plan to prevent firearms-related violence. In April, just prior to the Senate vote on S. 649, ACP distributed a letter to all senators noting the importance of the debate on firearms and calling for a vote on the measure. Until a decision is made by Senate leadership to reconsider the *Safe Communities, Safe Schools Act of 2013*—which is not expected for the remainder of the 113th Congress—there regrettably is no specific "ask" we are making for this Leadership Day. If asked, Leadership Day attendees can reaffirm ACP's support for the bill and urge that the Senate take it up again, and seek introduction and enactment of a similar bill in the House.

What is the status of the Teaching Health Centers (THCs) program, as established under the Affordable Care Act?

ACP supported the establishment of THCs and the THC grant program, as established under the Affordable Care Act (ACA), which provides grants and Graduate Medical Education (GME) funding for THCs to train primary care physicians in community based, ambulatory patient care settings. The THC development grants can be used for activities associated

with establishing or expanding a primary care residency training program including curriculum development, faculty and trainee recruitment, training, and retention, and accreditation. More details on the program can be found here.

The President's FY 2015 budget included $520 million for a new Targeted Support for Graduate Medical Education Program, which will incorporate two existing HRSA programs: the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. This new competitive grant program will fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training, with a focus on ambulatory and preventive care, in order to advance the ACA's goals of high value health care that reduces long-term costs. Current awardees in those programs will be eligible to compete for funding through the Targeted Support's competitive grant program, with a minimum of $100 million set aside specifically for children's hospitals in FY 2015. The budget proposes to continue mandatory funding for the new Targeted Support for Graduate Medical Education program annually in FYs 2015-2024, for a total investment of $5.2 billion. Because the budget is only a blueprint for spending and does not have the force of law, Congress would need to authorize and appropriate funds for this program in order for it to become operational.

The President's FY 2015 budget did not request any funds for the ACA authorized THC development grants. ACP continues to support the THC concept and is supportive of efforts by several ACP members to develop a proposal that would establish a different funding mechanism for THCs and make changes in the program that may make it more applicable and appropriate for internal medicine training. Currently, however, no legislation has been introduced in the Senate that would make their proposed changes in THC funding and structure. If or when such a THC bill is introduced, ACP would evaluate it compared to policy, as it does with any bill, and determine if we would endorse it. In the meantime, ACP has made preserving GME funding and increasing residency positions for primary care and other specialties facing shortages a priority.

What is ACP's position on the *Better Care, Lower Cost Act,* legislation introduced by Senator Ron Wyden (D-OR) and Eric Paulsen (R-MN) to address care for patients with chronic illness?

The *Better Care, Lower Cost Act* (S. 1932/ H.R. 3890) was introduced in both the House and Senate in January 2014. It would establish an integrated chronic care delivery program (Better Care Program or BCP) that promotes accountability and better care management for chronically ill patient populations. It also coordinates items and services under Medicare parts A (Hospital Insurance), B (Supplementary Medical Insurance), and D (Voluntary Prescription Drug Benefit Program), while encouraging investment in infrastructure and redesigned care processes that result in high quality and efficient service delivery for the most vulnerable and costly populations. A summary of the legislation, as provided by Sen. Wyden, can be found here.

ACP is in the process of evaluating this legislation in relation to ACP policy. A preliminary analysis indicates that while we support the intent of this legislation, which is to increase access to care for the chronically ill, there are provisions in the bill that are inconsistent with ACP policy and that preclude ACP from fully supporting the bill in its current form. However, pending a thorough evaluation of the bill, we welcome the opportunity to work with the sponsors to modify the legislation so that it is more consistent with ACP policy.

The legislation creates the "Better Care Program," allowing health plans and groups of providers to form "Better Care *Plans"* or "Better Care *Practices,"* (BCPs) respectively focused on delivering services to beneficiaries with chronic illness. Such plans or practices can be formed by a health plan or group of providers of services and suppliers, or a health plan working with such a group. Qualified BCPs would be responsible for delivering the full continuum of covered primary, post-acute care, and social services—it does not include long-term care services. This program would be voluntary (attribution based on beneficiary enrollment) and open to Medicare enrollees suffering with chronic illnesses. Participating plans and practices would receive risk-adjusted, capitated payments broadly based on payment processes currently used within the Medicare Advantage Part C program. The program requires two-sided risk regarding costs compared to a risk-relevant control group. An additional quality bonus is available. The BCPs are similar to Medicare Accountable Care Organizations (ACO) focused on a chronic illness population with some differences that include: 1) voluntary beneficiary enrollment rather than prospective or retrospective attribution; 2) the requirement to accept 2-sided

risk; 3) separated payment components based on cost and quality; 4) allowing for elements of a value-based insurance design (e.g. varied cost-sharing approved by the Secretary to incentivize the use of high-value, high-quality services that have been clinically proven to benefit BCP eligible individuals); and 5) specifically highlighting the use of technology that enhance communication between patients, providers, and communities of care.

The Act also:

- Establishes at least three Chronic Care Innovation Centers to facilitate improved effectiveness, quality, and safety in providing care to a chronically ill population.
- Establishes a timeline for hospitals to implement training curriculum that is consistent with the delivery of team-based care for a chronically ill population. Failure to implement would result in a reduction in direct and indirect graduate medical education (GME) payments.

The legislation is broadly consistent with ACP policy regarding ACOs and advanced payment models. It is voluntary for both physicians and beneficiaries and appears worthy of testing/evaluation. However, ACP has concerns about several provisions in the bill**:**

The bill conditions both direct and indirect GME payments on the Secretary engaging with the medical community in developing curricula that meet the following requirements:

- ✓ The curricula are new, forward thinking, and evidence-based.
- ✓ The curricula address the need for team-based care and chronic care management.
- ✓ The curricula include palliative medicine, chronic care management, leadership and team-based skills and planning, and leveraging technology as a care tool.

The curricula shall include appropriate focus on care practices required for rural and underserved areas. If a hospital has not begun to implement curricula that meet the above requirements, payments otherwise made to a hospital under this subsection may be reduced by a percentage determined appropriate by the Secretary.

The College supports innovation in curricula but does not support government mandating changes in the curricula as a condition of GME and IME payments. ACP looks forward to engaging in further conversations will the sponsors on ways to move forward the many elements of the proposal we support as well as potential improvements relating to our concerns on curricula mandates tied to GME/IME funding.