



## ACP Facts

### Background

The American College of Physicians (ACP) is a national organization of internists – specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internists are major providers of primary care in the United States. They are especially well-trained in the diagnosis of puzzling medical problems, in the ongoing care of complicated illnesses, and in caring for patients with more than one disease. Internists not only treat disease but also coordinate health care and play a critical role in preventing disease and promoting health and well-being.

### Internists and Subspecialists

An M.D. or D.O. who completes a three-year internal medicine residency program is an internist. The *general internist* is an expert in the general care of the adult but also may have special areas of expertise. A *subspecialty internist* is an internist with one to three years of additional training in a particular organ (nephrology/kidney), system (endocrinology/glands), or age group (geriatrics). Some internists practice a combination of both general and subspecialty medicine.

### Mission and History

The ACP mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine. ACP was founded in 1915 to promote the science and practice of medicine. In 1998, ACP merged with the American Society of Internal Medicine (ASIM), which was established in 1956 to study economic aspects of medicine.

### Membership

With 137,000 members, ACP is the largest medical specialty organization and second-largest physician group in the United States. ACP provides information and advocacy for its members as they practice internal medicine and related subspecialties such as cardiology and gastroenterology. ACP members are also involved in medical education, research, and administration.

Levels of ACP membership are **Medical Student**, **Associate**, **Member**, **Fellow** (FACP), **Honorary Fellow**, and **Master** (MACP). Fellowship and Mastership recognize achievements in internal medicine. Masters are selected for outstanding contributions to medicine.

### ACP Publications

*Annals of Internal Medicine*, published weekly online and twice-monthly in print, is one of the top medical journals in the world. *ACP JournalWise* summarizes the most important medical articles from more than 120 journals. *ACP Internist* is an award-winning semi-monthly newspaper for internists, while *ACP Hospitalist* is written for those in hospital practice.

## Activities

The ACP Washington, D.C., office monitors and responds to policy issues that affect public health and the practice of medicine. Activities include development of policy statements and communication with legislative and administrative sectors of government.

The **Center for Ethics and Professionalism** seeks to advance physician and public understanding of ethics and professionalism issues in the practice of medicine in order to enhance patient care by promoting the highest ethical standards.

## Education and Information Resources

ACP supports the optimal practice of medicine by providing opportunities for continuing medical education. ACP medical education programs include its annual scientific meeting, **Internal Medicine 2014**, was held in Orlando, Florida April 10-12. **Internal Medicine 2015** will be held April 30-May 2 in Boston, Massachusetts.

ACP's **Medical Knowledge Self-Assessment Program (MKSAP)** gives internists an opportunity to test their knowledge and compare their results with national averages. In addition, ACP offers postgraduate board review courses, recertification courses, and chapter/regional meetings. For future internists, ACP provides education and career information, produces **MKSAP for Students**, and administers an In-Training Examination for residents. ACP **Smart Medicine** is a web-based clinical decision support tool that provides evidence-based recommendations for all point-of care categories.

The **Center for Practice Improvement and Innovation** helps internal medicine practices achieve quality performance while succeeding in today's health care environment. The Center offers practical written guides, practice management tools, and personalized advice. The **Medical Laboratory Evaluation Program (MLE)** offers proficiency testing for laboratories in the United States and abroad.

ACP works with internists and health literacy and communication experts, through the **Center for Patient Partnership in Healthcare**, to create innovative health information tools to help patients better understand and manage their health. Resources include patient education brochures and DVDs for physicians who wish to raise awareness and educate their patients and communities.

## Structure

ACP is governed by an elected Board of Regents. The Board is advised by a network of ACP committees and by the ACP Board of Governors, which is composed of elected Governors in chapters and regions of the United States, Canada, Central and South America, Japan, Saudi Arabia and Southeast Asia (which includes: Indonesia, Malaysia, the Philippines, Singapore, Thailand). ACP sponsors the Council of Subspecialty Societies, which represents 25 subspecialty societies and internal medicine organizations. ACP is represented in the American Medical Association, the Council of Medical Specialty Societies, and other organizations.

## Officer and Staff Spokespersons

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## Summary of ACP's Key Priorities on Workforce, Payment, and Delivery System Reform

May 21-22, 2014

### **Enact Legislation to Eliminate Medicare's Physician Payment System, as Agreed Upon by Medicare Committees**

Congress should work in a bipartisan fashion to enact, in 2014, the *SGR Repeal and Medicare Provider Payment Modernization Act* (H.R.4015/S. 2000), as introduced by the chairs of the Medicare committees on Feb. 6, including resolving any remaining disagreements over its budgetary impact. This legislation represents unprecedented bipartisan agreement on the part of the three committees in the House and Senate with jurisdiction over Medicare, the House Energy & Commerce and Ways & Means Committees and the Senate Finance Committee, on policy to repeal Medicare's Sustainable Growth Rate (SGR) formula and replace it with a new value-based payment and delivery system.

### **Extend Expiring Medicaid Payment Policy for Primary Care Services through at least 2016**

Enacted in 2010, the Medicaid Pay Comparability program is designed to increase Medicaid payment for primary care and related services and vaccinations to 100 percent of Medicare rates in years 2013 and 2014. This program was based on studies that show that disproportionately low Medicaid payment rates, which in many cases are below the costs of delivering care, make it impossible for primary care physicians and other related medical specialists to take care of substantial numbers of Medicaid patients, creating severe access problems for the most vulnerable patients. With more than 10 million more persons expected to join Medicaid, both in states that have agreed to expand the program as well as those maintaining their own eligibility standards, it is critical that Congress extend the Medicaid Pay Comparability program through at least 2016 and by doing so, prevent an across-the-board Medicaid primary care payment cut on January 1, 2015.

### **Enact Bipartisan Medical Liability "Safe Harbor" Legislation and Initiate a Pilot on Health Courts**

Work in a bipartisan fashion to enact the *Saving Lives, Saving Costs Act* (H.R. 4106), which would provide safe harbor protections from medical liability lawsuits for physicians who document adherence to clinical practice guidelines; Enact other innovative reforms that will reduce the costs of medical liability insurance and defensive medicine, including a pilot of health courts, a no-fault alternative that would have medical liability claims heard by expert judges instead of lay juries.

### **Reform and Sustain Graduate Medical Education (GME) Financing; Re-align the Program with the Nation's Workforce Needs**

Congress should preserve and strategically reform funding for teaching hospitals:

- ✓ Preserve funding for GME in FY2015; stop the 2 percent cut to GME under sequestration, and protect Indirect Medical Education from cuts.
- ✓ Cosponsor and urge enactment of legislation that will increase the number of GME training positions in primary care specialties (including internal medicine) and others facing shortages, as included in the *Resident Physician Shortage Reduction Act* (S.577 and H.R. 1180) and the *Training Tomorrow's Doctors Today Act* (H.R. 1201).
- ✓ Introduce legislation to support GME financing reform by introducing more transparency and accountability and requiring that all payers contribute to GME funding.

### **Ensure Sufficient Funding for Federal Health Care Workforce Programs**

Congress should also fully fund the following essential federal health programs to help ensure an adequate physician workforce:

- ✓ The National Health Service Corps (NHSC), which has a proven track record of training and recruiting physicians in primary care and other specialties in shortage to serve in underserved areas.
- ✓ Section 747, Training in Primary Care Medicine, the only federal program dedicated to funding and improving training of primary care physicians.
- ✓ National Health Care Workforce Commission, which will make recommendations on how to ensure a sufficient physician workforce to meet the demand, including examination of barriers to primary care. This commission was authorized in 2010 but has yet to convene due to lack of funding from Congress.

**Congress, Our Patients Are Counting on You:**  
***Don't Let the Opportunity for Full SGR-Repeal Slip Away in 2014!***

May 21-22, 2014

Medicare's physician payment system, known as the Sustainable Growth Rate (SGR), is fatally flawed, antiquated, and does not keep pace with the actual cost of providing health care services under Medicare. This year has seen Congress get as close as it ever has to repealing the SGR, and replacing it with a new payment and delivery system based on value to patients. After working steadily throughout 2013, with the input of ACP and others in the physician community — as well as other stakeholders — the chairmen and ranking minority members of all three committees in the Congress with jurisdiction over Medicare, the Senate Finance Committee, House Ways and Means Committee, and House Energy and Commerce Committee, agreed on bicameral and bipartisan SGR-repeal legislation. Identical bills were introduced in the House and Senate on February 6, 2014, the *SGR Repeal and Medicare Provider Payment Modernization Act* (S. 2000 in the Senate and H.R. 4015 in the House). This legislation had, and continues to have, the strong support of virtually all specialty societies as well as state medical societies.

Another significant factor adding to the momentum for SGR-repeal this year is the fact that the Congressional Budget Office's (CBO) estimate of the cost of repeal has dropped dramatically. While, less than two years ago, in August, 2012, it was estimated to cost \$245 billion, CBO's estimate in April, 2014 was \$124 billion. There are no guarantees that the cost will remain this low, however. In fact, in recent weeks, the estimate has increased slightly. Although still at a very low level historically, the estimate of the cost of repeal had been as low as \$116.5 billion in December, 2013. This provides an additional incentive for Congress to move repeal legislation sooner rather than later.

Despite the support for this legislation and the lower price tag, Congress has not yet passed it in a form agreeable to both chambers. Instead, to avert the 24 percent SGR cut that would have taken effect on April 1, 2014, both bodies turned to an approach it had used 16 times before in the last 11 years — a patch which extended the current payment rates for one year, though March 31, 2015 at a cost of \$15.8 billion. The total cost of all the patches is higher than CBO's current estimate of the cost of repeal and, with each additional patch, the cost of permanent repeal increases. Nearly all of medicine, including ACP, was opposed to this patch, strongly urging Congress to instead work out their differences on the budgetary impact of SGR-repeal and pass S. 2000/H.R. 4015, as agreed to by the Medicare committees of jurisdiction and introduced on February 6.

ACP again urges Congress to not let this opportunity for full SGR-repeal slip away in 2014, but rather to put aside partisan differences, find a budgetary solution to SGR-repeal that both chambers can agree to, and pass S. 2000/H.R. 4015 so we can finally be rid of this flawed formula.

**What would the SGR Repeal and Medicare Provider Payment Modernization Act, S. 2000/H.R. 4015 do?**

- It repeals the SGR—permanently and immediately. Future payment updates no longer depend on a flawed SGR formula that has created instability in Medicare payments, contributed to access problems, and hindered real payment reform.
- It guarantees positive baseline updates for five years, versus the 24 percent cut that would have taken effect on 4/1/2014 (and likely be followed by the scheduling of more SGR cuts afterward). Even if Congress were to override ensuing SGR cuts, based on past experience, the Medicare physician fee schedule would be subjected to another multi-year freeze, at best--and quite likely, across-the-board cuts.
- Physicians and other health care practitioners would be given the opportunity to earn higher updates for quality improvement for joining in a Patient-Centered Medical Home or other Alternative Payment Model. Physicians would be empowered to determine their own annual update, above and beyond the baseline updates, based on performance in a new merit-based incentive program or participation an alternative payment model (APM). Under current law, all physicians get the same (negative) scheduled SGR updates.

- S. 2000/H.R. 4015 would add \$128 billion to physician payments over 10 years versus \$120 billion in cuts that would be brought about under current law by the SGR, at a time when fiscal realities are causing across-the-board cuts in many other programs.
- It would cancel the existing Physician Quality Reporting System (PQRS) and EHR Meaningful Use penalties at the end of 2017. These dollars would be added back to physician payments instead of going to the federal government. Under current law, in 2018, physicians could face:
  - ✓ PQRS -2 percent in 2018 and beyond
  - ✓ Meaningful Use -4 percent in 2018, -5 percent in 2019
- It also cancels any potential negative adjustments that physicians may face as part of the Medicare Value-Based Payment Modifier Program in 2018 and beyond.
- It unifies the current PQRS, Meaningful Use, and Medicare Value-Based Payment Modifier program into a single reporting program starting in 2018, creating an opportunity for physicians to work to harmonize measures and streamline reporting.
- Recognizing the strong evidence on their effectiveness in improving quality and lowering costs, Certified Patient-Centered Medical Home (PCMHs) and PCMH subspecialty practices will get the highest possible scores for clinical practice improvement under the new Merit-based Payment Incentive System and will be able to bill and be reimbursed for chronic care management starting in 2015; advanced PCMHs can qualify as an APM and get 5 percent annual bonuses for six years without taking direct financial risk.
- It provides \$40 million per year in technical assistance to small practices.
- It mandates a process to improve the accuracy of Medicare relative value units (RVUs).

**Given all this support, what is the holdup on enactment of the bicameral, bipartisan legislation to repeal the SGR once and for all and replace it with a value-based payment and delivery system?**

As in years past, a significant challenge remains in identifying a way of paying for the legislation that will be agreeable to both parties in both bodies. Republicans and Democrats in Congress are at loggerheads over how to come up with the estimated \$124 billion dollars to pay for SGR-repeal, or whether to even pay for it at all. While the House did pass the SGR-repeal policy as contained in H.R. 4015, it chose an objectionable offset to pay for the legislation – delay of the current-law individual insurance mandate – that was not realistically going to be considered by the Senate. By extension, the Senate has been unable to find agreement on how to bring this legislation to the floor, despite valiant efforts on the part of several lawmakers. Rather than resolving to work together in a serious way to find common ground on how to address the budgetary impact of SGR repeal in a way that is agreeable to both bodies, the parties remain entrenched in their differing opinions on the matter. The resulting sentiment among physicians and their patients is utter frustration and disappointment because the bipartisan policy reforms contained in H.R. 4015/S. 2000 are being held hostage to partisanship.

There must be a way forward out of this state of brinksmanship. ACP is counting on Congress to get this done this year – we are simply too close to let this slip away – and we continue to stand ready to work with lawmakers, as we have throughout the process, to get this legislation enacted in 2014.

**What are ACP members asking Congress to do?**

- ✓ Take tangible steps immediately to resolve partisan differences on how to pay for S. 2000/H.R. 4015, as introduced on February 6, that can pass both chambers.
- ✓ Schedule this legislation, with mutually agreed-upon offsets, for consideration on the House and Senate floor with the intention of passage and enactment this year.
- ✓ Oppose any further patches to the SGR and instead focus on full repeal, as agreed to by the House and Senate Medicare committees of jurisdiction.

## **Expiring Medicaid Payment Policy Puts Care in Jeopardy for the Nation's Most Vulnerable**

May 21-22, 2014

The Medicaid program currently provides coverage for more than 62 million low-income Americans, including more than 20 million nonelderly adults. Primary care physicians and related subspecialists are not required to participate in the Medicaid program, and many practices traditionally have not been able to accept significant numbers of Medicaid patients because reimbursements do not keep pace with their costs of providing services. In all but a few states, Medicaid payment rates are much lower—as much as 60 percent less—than the amounts allowed by Medicare. This differential, studies show, is a major reason why Medicaid patients have trouble accessing physicians.

In 2010, the federal government enacted into law the Medicaid Pay Comparability program, which is designed to increase Medicaid payment for designated primary care services and immunizations to 100 percent of Medicare rates in years 2013 and 2014. This was done to reduce proven barriers to Medicaid enrollees gaining access to primary care and related services. Internal Medicine and pediatrics (and their medical subspecialties), and family medicine are the specialties that are eligible for this program.

Unless Congress intervenes, the Medicaid Pay Comparability program will expire at the end of this year, which puts access to primary care services in jeopardy for so many of this nation's most vulnerable citizens. It will be these low-income individuals who bear the brunt of harm if payment rates for Medicaid primary care services are allowed to fall back to 2012 levels. In some states, this could mean a cut of 60 cents on the dollar for primary care services, which is simply not sustainable if we are to meet the health care needs of the growing Medicaid population.

### **What is the impact of Medicaid payment rates on access to care/physician participation in Medicaid?**

Medicaid in most states pays primary care physicians at rates that are well below Medicare (and private insurance). In 2012, before this provision of law took effect, average Medicaid payment rates for primary care services were 58 percent of Medicare rates. Studies show that low Medicaid payment levels in many states are associated with fewer physicians accepting large numbers of Medicaid patients into their practices, resulting in reduced access to persons covered under Medicaid.

- Decker SL. In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Raising Fees May Help. *Health Aff.* 2012;31(8);1673-1679. Accessed at <http://content.healthaffairs.org/content/31/8/1673.abstract>
- Shen and Zuckerman: The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries. <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2005.00382.x/abstract>

In April 2014, ACP conducted a survey of a representative sample of its members who spend the majority of their professional time engaged in direct patient care. It found that 46 percent of the respondents indicated they had enrolled in the Medicaid Pay Comparability program via their State Medicaid program and would accept fewer Medicaid patients in 2015 (40 percent) or drop out of Medicaid entirely in 2015 (6 percent) if the Medicaid Pay Comparability program were allowed to expire on December 31, 2014.

### **How does the Medicaid Pay Comparability program work, practically speaking?**

This program applies to all evaluation and management services (i.e. office visits, hospital visits, and consultations) and vaccine administration services furnished by primary care physicians (i.e., general internists, pediatricians, and family physicians). It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association and the American Board of Physician



Specialties. Physicians qualifying for this enhanced payment by meeting the above qualifications must formally “attest” that they provide primary care services and meet one of the required specialty designations through a procedure defined by the Medicaid Director of their state. Physicians who are in those designated specialties, but not board certified (are Board eligible), can also qualify if at least 60 percent of the codes billed by the physician for all of CY 2012 are for the evaluation and management and vaccine administration codes specified in the regulation.

The rules required that states amend their Medicaid plans to include this program and then submit those amendments for approval to the Centers for Medicare and Medicaid Services (CMS). Many states did not turn in these plan changes for federal approval, even though they were due by the end of March 2013. The extension of current Medicaid rates beyond 2014 is particularly important because of the program’s slow start up—with many states only now beginning to pay at the higher Medicare rates—combined with a lack of assurance that it will be extended beyond 2014 has not allowed an adequate enough time to demonstrate the program’s effectiveness in improving access.

### **How would extending this program help ensure Medicaid enrollees’ access to primary care, vaccinations, and other needed medical services in each state?**

This program will help vulnerable patients obtain access to primary care in states that are expanding Medicaid, as well as states that are maintaining their current eligibility rules:

- Beginning this year, states have federal support to expand their Medicaid programs to include all adults living at up to 138 percent of the federal poverty level. In 2012, the United States Supreme Court upheld the Medicaid expansion provision but found that the penalty to states for not participating in the Medicaid expansion (loss of the federal government funding for the existing Medicaid program) was unconstitutionally coercive, making Medicaid expansion a voluntary option for the states.
- If implemented by states as now expected by the Congressional Budget Office after the Supreme Court ruling, Medicaid expansion is projected to add more than 10 million individuals to the Medicaid population. In states where the expansion was in effect in February, enrollment increased by 8.3 percent as noted in a recent New York Times article: ([http://www.nytimes.com/2014/04/05/us/politics/health-law-helps-increase-medicaid-rolls-by-3-million.html?\\_r=2](http://www.nytimes.com/2014/04/05/us/politics/health-law-helps-increase-medicaid-rolls-by-3-million.html?_r=2)). States that have declined (at least so far) to expand Medicaid also are experiencing a substantial increase in the number of persons enrolled in Medicaid. The most recent data suggests that as of February, Medicaid enrollment has increased an average of 1.6 percent in states that have not expanded the program. In some non-expansion states, Medicaid enrollment also is experiencing much bigger increases than the average: Florida, for instance, saw an 8.2 percent Medicaid enrollment increase as of February.
- If Congress does not extend the current program, which is paid entirely by the federal government, primary care physicians and other related medical specialists in almost all of these states will likely experience huge Medicaid payment cuts on January 1, 2015—endangering patient access to primary care and other related services and vaccines, at the same time as the population enrolled in Medicaid is surging in both the expansion and non-expansion states. States would then be put in positions of allowing the cut to go into effect, or picking up the cost.

Extending these current Medicaid rates at least through 2016 would demonstrate that it is effective in improving access to physician services. In addition, the United States is facing a shortage of more than 45,000 primary care physicians by 2020, growing to a shortage of more than 65,000 primary care physicians by 2025, according to AAMC. The Medicaid Pay Comparability program, combined with other payment reforms, can help bolster the number of students choosing careers in primary care. Studies show that primary care is associated with better outcomes and lower costs.

Organizations that support an extension of this program include ACP, the American Academy of Family Physicians, the American Osteopathic Association, and the American Pediatric Association. ACP also supports extending the program to primary care services for ob-gyn physicians if they meet the same billing criteria as non-board certified physicians in the other eligible specialties.

### **What are ACP members asking Congress to do?**

- ✓ Prevent an across-the-board Medicaid primary care cut on January 1, 2015 by extending the current-law Medicaid Pay Comparability program through at least 2016.

## **Enact Bipartisan Medical Liability “Safe Harbor” Legislation and Initiate National Pilot on Health Courts**

May 21-22, 2014

Our nation’s medical liability system is in a state of disrepair and, absent reforms, we will continue to see unnecessary costs to the health care system as a whole, and adverse consequences for patient care. While the U.S. medical liability tort system is intended to deter injuries caused by negligent medical care and provide fair compensation to injured patients, the current system does not adequately address these objectives. Patients often have to wait years before their medical liability claims are considered and the outcomes may vary depending upon the state in which the lawsuit is filed. Physicians also feel threatened by lawsuits and may order more tests and procedures for patients than needed to protect themselves from medical liability claims. The Congressional Budget Office (CBO) estimated in 2011 that the federal government could save \$57 billion over 10 years by reforming our medical liability tort system.

Over the past several years, Congress has been unable to reach a bipartisan agreement to enact legislation to reform our medical liability laws. In the past, the House of Representatives has passed legislation that includes caps on noneconomic damages and other reforms that would lower the cost of defensive medicine but this legislation has not been considered by the Senate. The Affordable Care Act authorized \$50 million in grant funding for states to test innovative medical liability reform and patient safety improvement models beyond traditional tort reform but Congress has not appropriated these funds. The Agency for Health Quality Research (AHRQ) developed a grant program that allowed states to apply for funding test medical liability reforms to lower health costs and improve patient safety. This program concluded in 2013 and we are awaiting a report from AHRQ on the results of this initiative.

It is important that Congress continue to pursue common-sense, innovative alternatives to reform the medical liability system; ones that can gain bipartisan support. A promising bipartisan bill has been introduced this year that provides Congress with a new option to address tort reform. Representatives Andy Barr (R-KY) and Ami Bera (D-CA) have introduced the *Saving Lives, Saving Costs Act* (H.R. 4106) that would provide safe harbor protections from medical liability lawsuits for physicians who document adherence to clinical practice guidelines. This legislation could be a pathway forward and lead to other, equally innovative reforms such as initiating a national pilot on health courts, which would utilize an administrative process and specialized judges, experienced in medicine and guided by independent experts, to determine cases of medical negligence without juries.

### **What kinds of innovative approaches are needed in addressing today’s failing medical liability system?**

Any solution to the broken medical liability system in the U.S. should include a multifaceted approach. Because no single program or law by itself is likely to achieve the goals of improving patient safety, ensuring fair compensation to patients when they are harmed by a medical error or negligence, strengthening rather than undermining the patient-physician relationship, and reducing the economic costs associated with the current system. A multifaceted approach should allow for innovation, pilot-testing, and further research on the most effective reforms.

ACP provides nine approaches in its recent policy paper, “Medical Liability Reform: Innovative Solutions for a New Health Care System,” that should be incorporated into a multifaceted medical liability reform initiative. These include:

- Continued focus on patient safety and prevention of medical errors;
- Passage of a comprehensive tort reform package, including caps on non-economic damages;
- Minimum standards and qualifications for expert witnesses;
- Oversight of medical liability insurers;
- Testing, and if warranted, expansion of communication and disclosure programs;
- Pilot-testing a variety of alternative dispute resolution models;
- Developing effective safe harbor protections that improve quality of care, increase efficiency, and reduce costs;



- Expanded testing of health courts and administrative compensation systems;
- Research into the effect of team-based care on medical liability, as well as testing of enterprise liability and other products that protect and encourage team-based care.

**H.R. 4106, the Saving Lives, Saving Cost Act:** On February 27, 2014, Representatives Andy Barr (R-KY) and Ami Bera (D-CA) introduced the *Saving Lives, Saving Costs Act*, which provides a bipartisan alternative to reduce costs associated with defensive medicine. The intent of H.R. 4106 is multi-faceted. It offers physicians who document adherence to certain evidence-based clinical-practice guidelines and, when applicable, appropriate use criteria, a safe harbor from medical malpractice litigation; aims to reduce the practice of defensive medicine and resulting health care costs; improves quality of care and patient safety, permits organizations with relevant expertise to participate in the selection of clinical practice guidelines, and permits professionals with relevant expertise to participate and benefit from liability reform.

Equally important is that H.R. 4106 provides a mandatory review of evidence by an independent review panel of three qualified experts in the field of clinical practice, before the costly discovery phase of a medical liability case, if the physician can document adherence to clinical guidelines. The panel will determine if defendant physicians complied with the guidelines, which are to be recognized as the standard of care. The panel should use their medical expertise to determine when departing from recommendations in the guidelines is appropriate for individual patients. The findings, opinions, and conclusions of the review panel shall be admissible as evidence in any and all subsequent proceedings before the court, including for purposes motions for summary judgment at trial. If the panel made a finding that there was an applicable practice guideline that the physician adhered to, the court shall issue summary judgment in favor of the physician unless the claimant is able to show otherwise by clear and convincing evidence.

This legislation is consistent with ACP principles that encourage the use of evidence-based guidelines, and ACP believes it will improve quality of care and patient safety since these practices are consistent with trusted quality measures approved by physician specialties. Clinical guidelines will also have the potential to lower costs associated with defensive medicine since these principles do not support the use of unnecessary tests or procedures.

**Authorize a National Pilot on Health Courts:** Health courts would offer patients access to a specialized “no fault” administrative process where judges, experienced in medicine and guided by independent experts, determine contested cases of medical negligence without the unpredictability and unfairness of jury trials.

- Health courts are designed to facilitate speedy decisions, promote consistency and reliability of verdicts, discourage the filing of unnecessary claims, and justly compensate patients, while improving the physician – patient relationship. Quality information gathered from health court claims can be used to track common problems and design responses to improve patient safety.
- The health court model is predicated on a “no fault” system, meaning compensation programs that do not rely on negligence determinations. The central premise behind no-fault is that patients need not prove negligence to access compensation. Instead, patients must only prove that they have suffered an injury, that it was caused by medical care, and that it meets the severity criteria. The goal of the no-fault concept is to improve upon the injury resolution of liability.

ACP has prepared a detailed section-by-section framework for legislation (available upon request) to authorize and fund a national pilot of health courts, which we hope will be considered as the basis for the introduction of a bipartisan health courts pilot bill in the 113<sup>th</sup> Congress.

#### **What are ACP members asking Congress to do?**

- ✓ Cosponsor H.R. 4106, the *Saving Lives, Saving Cost Act* in the House; introduce a companion bill in the Senate.
- ✓ Introduce legislation, based on ACP’s framework, to authorize and fund a national pilot on health courts.

## **Reform and Sustain Graduate Medical Education Financing and Support Other Programs to Ensure an Adequate Physician Workforce**

*This document was developed jointly with the Alliance for Academic Internal Medicine (AAIM)*

May 21-22, 2014

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. If we are to address the physician workforce crisis, sufficient funding for graduate medical education (GME), coupled with a more strategic approach to using that funding, is critical. In addition, funding for federal programs aligned to improving the primary care workforce and ensuring access to primary care physicians must be preserved.

GME is the process by which graduated medical students progress to become competent practitioners in a particular field of medicine. These programs, referred to as residencies and fellowships, allow trainees to develop the knowledge and skills needed for independent practice. GME plays a major role in addressing the nation's workforce needs, as GME is the ultimate determinant of the output of physicians. Recognizing the important public good GME provides to the nation and by extension in helping to ensure needed care to patients, the federal government is the virtual sole explicit provider of GME funding, with the majority of support coming from Medicare which currently provides approximately \$9.5 billion annually.

### **How is GME currently financed?**

The costs of GME are recognized by Medicare under two mechanisms: direct graduate medical education payments (DGME) to hospitals for residents' stipends, faculty salaries, administrative costs, and institutional overhead; and an indirect medical education (IME) adjustment developed to compensate teaching hospitals for the higher costs associated with teaching. Current Medicare GME payments are based on calculations originally set in 1984 and do not account for additional direct training costs incurred by teaching hospitals, affiliated medical schools, and practices that have surfaced as GME has evolved during the last 25 years. Additionally, the number of Medicare-supported positions is capped at 1996 levels. With sharply increasing numbers of allopathic and osteopathic medical students and looming physician workforce shortfalls, especially in primary care, the current "choke-point" in the physician supply chain is residency training.

Much attention has been focused on Medicare's support of GME, especially monies for IME. The Medicare Payment Advisory Commission (MedPAC) has stated that 50 percent of the IME adjustment represents overpayment to hospitals and should be distributed to hospitals as an incentive program tied to educational objectives. While we agree that some of the costs covered by the IME adjustment have decreased, we also contend that other costs related to DGME expenditures have risen, primarily due to increased regulatory demands. DGME reimbursement amounts were set in 1986 and have been adjusted only for inflation. Studies evaluating the costs of residency programs support higher DGME costs over time. In fact, the increase in DGME costs appear to roughly offset the decrement in IME costs, such that across the entire system, current reimbursement does approximate actual costs of training residents (recognizing that significant variation exists across different states and institutions). Significant reductions in IME payments would result in a failure to cover necessary direct costs and could have a devastating effect on GME programs.

The Institute of Medicine (IOM) has convened a special committee to assess current GME financing mechanisms and explore possible reforms, and we support that effort. This study by IOM has not yet been released but is expected to be soon. In the meantime, we urge IOM to include the following in its study: an accurate assessment of current training costs, establish a mechanism for monitoring this in the future, seek to minimize inequalities across the system, and encourage training programs in underserved areas and regions, structure GME funding to help address physician workforce needs, and evaluate changes in direct medical education costs, which are heavily influenced by new accreditation requirements.

### **What strategic reforms to GME financing are we proposing?**

**Lifting the Caps on GME:** The existing caps on the number of Medicare-funded GME positions available makes it impossible to fund GME training positions in the numbers needed to slow or reverse growing shortages of physicians in primary care and other fields. The caps should be strategically lifted to align spending with the nation's healthcare workforce policy needs. New primary care slots should also be added in underserved geographic areas.

We support legislation that has been introduced in both the House and Senate that would increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. The *Resident Physician Shortage Reduction Act, S. 577, H.R. 1180*, introduced by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY) and the *Resident Physician Shortage Reduction Act, H.R. 1201*, introduced by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), would provide for approximately 15,000 additional GME positions for medical residents and require at least 50 percent of the new positions to be allocated to specialties, such as primary care, that face a shortage.

**Establish an All-Payer GME System:** ACP and AAIM, along with many other medical associations, have long-supported an all-payer GME system. Most proposals for the establishment of an all-payer system would create a GME trust fund in which Medicare and Medicaid would continue to contribute to GME, but private payers would do so as well through a modest assessment on health insurance premiums. Such a funding system would be more equitable and provide stability to the GME funding stream. An all-payer system could also be an important contribution to deficit reduction by spreading the responsibility for funding of GME to all who benefit from it instead of the federal government bearing a disproportionate share of the cost as it does today. The all-payer system should be linked to the nation's health care workforce needs to ensure an adequate supply of physicians with an appropriate specialty mix and distribution.

### **What other federal programs are important in ensuring an adequate physician workforce?**

Without a robust primary care physician workforce, the nation's health care system will become increasingly fragmented and inefficient. Hundreds of studies show that the numbers and percent of physicians in primary care disciplines practicing in a region, state or country is positively associated with better health outcomes and lower costs. See: [http://www.acponline.org/advocacy/current\\_policy\\_papers/assets/primary\\_shortage.pdf](http://www.acponline.org/advocacy/current_policy_papers/assets/primary_shortage.pdf). Unless changes to the U.S. health care system are met by adequately funded GME programs as well as an adequate supply of well-trained primary care physicians, increasing access to high quality and affordable health care will not be possible. Congress should fund the following programs at the levels indicated:

**Section 747, Primary Care Training and Enhancement/Title VII**, at \$71 million, is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine and promote interdisciplinary training that helps prepare physicians to work with other health professionals, such as physician assistants, patient educators and psychologists.

**National Health Service Corps (NHSC)**, at \$810 million, funds training for thousands of primary care clinicians who provide care to tens of millions of persons in underserved communities by providing scholarships and loan forgiveness to primary care physicians who serve in underserved communities.

**National Health Care Workforce Commission**, at \$3 million, is a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy, analyzing and making recommendations for eliminating barriers to entering and staying in careers in primary care. However, to date, Congress had not provided the necessary funding for the Commission to be convened, preventing this advisory body from embarking on its vital mission.

### **What are ACP members asking Congress to do?**

- ✓ Preserve funding for Graduate Medical Education in FY2015; stop the 2 percent cut to GME under sequestration; and protect IME from cuts.
- ✓ Cosponsor and urge enactment of legislation that will strategically increase the number of GME training positions in primary care specialties (including internal medicine) and other specialties facing shortages, such as those included in *S.577, H.R. 1180* and *H.R. 1201*.
- ✓ Introduce legislation to support GME financing reform by introducing more transparency and accountability and requiring that all payers contribute to GME funding.
- ✓ Ensure full funding for other vital federal physician workforce programs including Title VII, and the NHSC.
- ✓ Fully fund the National Health Care Workforce Commission, which has yet to become operational because Congress has not provided the necessary funding.

## Key Indicators Regarding Payment Rates under Medicaid

Prepared by the American College of Physicians (ACP): Division of Governmental Affairs and Public Policy

May 21, 2014

State	A: Uninsured	B: Total Medicaid Enrollment FY2010	C: If State Expands Medicaid, Estimated X Additional People Will Be Eligible for Medicaid	D: Before Pay Parity, % of Office-based Primary Care Doctors Who Did Not Accept New Medicaid Patients in 2011-2012	E: Medicaid to Medicare Pay Ratio (Primary Care)	F: Cut of X Cents on the Dollar for Primary Care Services if not Extended
AL	660k	1.02m	397,000	45.20%	70%	.30
AK	129k	128k	46,000	23.70%	127%	NA
AZ	1.1m	1.5m	354,000	34.40%	75%	.25
AR	510k	721k	254,000	18.30%	70%	.30
CA	7m	11.4m	2,456,000	46.30%	43%	.57
CO	737m	618k	291,000	43.90%	74%	.26
CT	286k	712k	113,000	36.50%	71%	.29
DE	92k	225k	37,000	21.80%	98%	.02
DC	50k	214k	20,000	36.70%	80%	.20
FL	3.9m	3.7m	1,552,000	35.70%	49%	.51
GA	1.8m	1.9m	843,000	43.80%	70%	.30
HI	102k	266k	45,000	36.20%	57%	.43
ID	258k	228k	126,000	15.30%	89%	.11
IL	1.8m	2.8m	700,000	41.10%	54%	.46
IN	801k	1.2m	438,000	44%	55%	.45
IA	301k	562k	130,000	12.90%	77%	.23
KS	369k	394k	171,000	36.80%	82%	.18
KY	647k	920k	366,000	30.10%	72%	.28
LA	866k	1.2m	392,000	36%	75%	.25
ME	130k	376k	59,000	42.30%	63%	.37
MD	756k	975k	224,000	29.20%	70%	.30
MA	242k	1.7m	108,000	22%	68%	.32
MI	1.1m	2.3m	676,000	23.20%	46%	.54
MN	462k	936k	168,000	8.90%	73%	.27
MS	454k	772k	293,000	16.50%	90%	.10
MO	834k	1.07m	402,000	44.40%	57%	.43
MT	178k	128k	73,000	9.90%	94%	.06
NE	234k	266k	99,000	17.50%	76%	.24
NV	621k	340k	204,000	26.60%	68%	.32
NH	158k	168k	58,000	23.50%	60%	.40
NJ	1.3m	1.06m	349,000	54%	50%	.50
NM	422k	576k	162,000	16.60%	85%	.15

State	A: Uninsured	B: Total Medicaid Enrollment FY2010	C: If State Expands Medicaid, Estimated X Additional People Will Be Eligible for Medicaid	D: Before Pay Parity, % of Office-based Primary Care Doctors Who Did Not Accept New Medicaid Patients in 2011-2012	E: Medicaid to Medicare Pay Ratio (Primary Care)	F: Cut of X Cents on the Dollar for Primary Care Services if not Extended
NY	2.2m	5.6m	811,000	25.20%	42%	.58
NC	1.6m	1.8m	720,000	21.30%	85%	.15
ND	70k	83k	29,000	10.20%	135%	NA
OH	1.5m	2.3m	705,000	32.80%	59%	.41
OK	632k	856k	303,000	37.40%	97%	.03
OR	559k	643k	292,000	32.80%	72%	.28
PA	1.4m	2.4m	613,000	34.10%	56%	.44
RI	126k	216k	51,000	37%	33%	.67
SC	765k	293k	389,000	22.80%	74%	.26
SD	110k	134k	49,000	13.50%	69%	.31
TN	850k	1.5m	459,000	32%	NA	NA
TX	6.2m	4.8m	2,036,000	35.40%	61%	.39
UT	407k	350k	145,000	22.20%	74%	.26
VT	47k	196k	18,000	28.40%	81%	.19
VA	1.02m	1.02m	412,000	40.70%	74%	.26
WA	948k	1.4m	375,000	30.50%	66%	.34
WV	267k	416k	154,000	27.20%	74%	.26
WI	566k	1.3m	266,500	15%	60%	.40
WY	93k	87k	31,000	No data	96%	.04

**Highlighted** rows indicate states that will be expanding Medicaid in 2014.

**Column A: Uninsured:** The number of uninsured in each state.

**Column B: Total enrolled in Medicaid before expansion:** Total number of Medicaid enrollees before full Medicaid expansion occurred in 2014.

**Column C: Projected enrollment with expansion:** Number of additional enrollees eligible to enroll in the state Medicaid program.

**Column D: Percent of office-based primary care physicians who did not accept new Medicaid patients in 2011-2012:** Primary care physicians defined as internal medicine, general and family medicine, or pediatrics. Data gathered 2011-2012, before pay parity went into effect.

**Column E: Medicaid to Medicare Pay Ratio:** Shows state's Medicaid program payment for primary care services compared with Medicare reimbursement before implementation of Medicaid pay parity in 2013.

**Column F: Cents on the Dollar Cut:** Depicts cents on the dollar cut for primary care services if pay parity is not extended beyond 2014.

#### Example of How to Use Data:

Prior to implementation of Medicaid parity for primary care services, there were [Column A] uninsured in [state]. In FY2010, the Medicaid system provided coverage to over [Column B]. [If/When][state] fully expands Medicaid in 2014, an estimated additional [Column C] people will be eligible for Medicaid. But having health insurance doesn't mean one can access health care. Many doctors are reluctant to participate in the Medicaid program because of its historically low reimbursement rates. Before pay parity was implemented, [Column D] of primary care physicians stated that they would not be accepting Medicaid patients in the coming year. In [state], the payment for primary care services was [Column E] percent of Medicare in 2012. The pay parity provision is a step in the right direction to ensure that the new Medicaid enrollees can access the care they need when they need it. If pay parity isn't extended, it will amount to a cut of [Column F] cents on the dollars for primary care services delivered under Medicaid.