Frequently Asked Questions (FAQs)

Additional Policy Issues of Interest for Leadership Day 2015
May 20-21, 2015

What is the status of legislation and ACP's support for reimbursement for advance care planning counseling sessions between physicians and their patients to address end of life care issues?

ACP has been a longstanding advocate for improving health for patients at the end of life and encourages physicians to discuss end of life care plans with their patients. We support legislation introduced by Rep. Earl Blumenauer (D-OR), known as the Personalize Your Care Act, that would provide for Medicare coverage of end of life care counseling sessions between doctors, patients, and their families to develop plans that meet the needs of the patients at the end of life. This bill has been introduced by Rep. Earl Blumenauer (D-OR) in the last several legislative sessions and is expected to be introduced again this year.

ACP staff has met with officials from the Centers for Medicare and Medicaid Services (CMS) on multiple occasions to urge Medicare coverage of advance care planning consultations. We were disappointed that last November, CMS released a payment rule that did not cover "complex advance care planning services" among doctors, patients, and their families. Complex advance care planning refers to the most difficult, emotional, and lengthy discussions between people with serious illnesses and their doctors, to work through issues such as choosing a surrogate if they become unable to make decisions, resuscitation and life support, and whether to continue treatments that may no longer be working but cause significant pain. We have also written multiple letters to CMS in support of this type of coverage. We hope that CMS will reconsider this decision and make complex advance care planning a covered service within Medicare in the next final rule that will be issued later this year.

We have also joined other health care stakeholders such as the Institute for Patient and Family Centered Care and the National Partnership for Women and Families in a letter that was sent to CMS to request Medicare coverage of advance care planning services. We also teamed up with provider and patient advocacy groups to conduct joint meetings on Capitol Hill to request lawmakers to contact CMS to urge reimbursement for end of life care counseling sessions between doctors and their patients.

Can you provide an update on ACP's activities to reduce the administrative complexities faced by physicians while managing their practices?

ACP has launched a new initiative, **Patients Before Paperwork,** to reinvigorate the patient-physician relationship by reducing unnecessary practice burdens. ACP has identified the top priorities for reducing administrative burdens for physician including: electronic health record usability, quality reporting requirements, and dealing with insurance companies. We are planning a campaign to educate ACP members, other physicians, consumer advocates, and policy makers on what makes up administrative complexities and how to reduce the burdens to restore the joy of practicing medicine and reinvigorating the patient-physician relationship.

ACP has also been active on this front on Capitol Hill and with our regulatory affairs staff in working to ease the burden of electronic health record reporting requirements for our members. We sent a letter last year in support of legislation known as the Flexibility in Health IT Reporting Act, offered by Rep. Renee Ellmers (R-NC) that would reduce the reporting period for eligible professionals participating in the Medicare and Medicaid EHR incentive payment program from one full year to 90 days in 2015. We also support the current version of this legislation, H.R. 270, that was introduced by Representatives Ellmers and Kind (D-WI) in January of this year.

We were pleased that earlier this year, CMS announced its goal to modify requirements for meaningful use reporting for eligible professionals. CMS stated their intention to issue a new Stage 3 rule for meaningful use requirements that would shorten the EHR reporting period this year to 90 days instead of a full year. CMS recently released its Stage 3 proposed rule that included this decision to shorten the EHR reporting requirement.

ACP remains engaged in this process to ease reporting requirements through a health care stakeholder organization made up of hospitals, health IT, and provider groups known as the FLEX-IT coalition. This alliance conducts meetings with lawmakers on

Capitol Hill to discuss challenges associated with electronic health record reporting. It has also met with officials at CMS as it issues rules associated with meeting meaningful use requirements.

Can you describe ACP's efforts to reduce the disparity in payments between hospital out-patient departments and community-based physician office settings?

ACP has joined a coalition of health care providers, insurers, patient-advocacy organizations, and consumer groups to advocate for reducing the disparity of payments for health care services provided in hospital outpatient facilities rather than office based settings. Medicare and private insurers pay significantly more for the same services in outpatient departments versus office based settings. This disparity in payments increases health care spending and creates incentives for reduced access for health care services in office based settings. This link (insert link to handout) provides additional evidence in the case for site neutral reform payments.

Members of the coalition are currently meeting with lawmakers on Capitol Hill to make a case for reducing the disparity in payments in hospital out-patient facilities and physician offices and we sent a letter to Capitol Hill to raise awareness of this issue. In his FY 2016 budget proposal, President Obama recommends that reducing this disparity in payments from current rates to the rate provided under the Medicare physician fee schedule would save an estimated $29.5 billion over 10 years.

What is the status of the "Safe Harbor" medical liability reform bill from last Congress, the Saving Lives, Saving Costs Act, H.R. 4106?

While the bill did not pass in the last Congress, Representatives Andy Barr (R-KY) and Ami Bera (D-CA) intend to reintroduce the bill shortly for the current 114th Congress. The College has been working closely with both Rep. Barr and Rep. Bera's offices to provide feedback and ensure that both Democrats and Republicans can cosponsor the legislation as a bipartisan alternative to reduce costs associated with defensive medicine. ACP fully supports their efforts.

The Act's major provisions remain unchanged: physicians who document adherence to certain evidence-based clinical-practice guidelines and, when applicable, appropriate use criteria, would receive a safe harbor from medical malpractice litigation. The bill would provide 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 would determine if defendant physicians complied with the guidelines, which are to be recognized as the standard of care. The panel would use its 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 would 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 would 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 because 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 because these principles do not support the use of unnecessary tests or procedures.

What was the ultimate outcome of President Obama's nomination for Surgeon General of the United States, Vivek Murthy, MD?

Dr. Vivek Murthy, MD, MBA, an ACP member, was confirmed by the U.S. Senate in December 2014 to be the new Surgeon General of the United States.

Dr. Murthy was an esteemed faculty member at Harvard Medical School and hospitalist at Brigham and Women's Hospital in Boston, Massachusetts. He is a strong advocate for the provision of health insurance coverage to all Americans and is a proven leader who can build coalitions among diverse individuals to ensure better health for our communities.

Dr. Murthy was nominated to be United States Surgeon General in November 2013, requiring U.S. Senate confirmation. ACP strongly supported his nomination and actively advocated for his confirmation.

What is ACP's position on the Resident Physician Shortage Reduction Act of 2015? Are there differences between the House and Senate versions?

ACP supports the Resident Physician Shortage Reduction Act of 2015 (S. 1148 and H.R. 2124), introduced in the Senate by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and in the House by Representatives Joseph Crowley (D-NY) and Charles Boustany (R-LA). Specifically, the bills would provide for 15,000 additional GME positions—3,000 per year—for medical residents over five years from 2017 to 2021.

The Senate bill, S. 1148, would require at least 50 percent of the new positions to be allocated to specialties such as primary care, which are currently facing shortages. The House bill, H.R. 1148, would require one-third of the positions go to teaching hospitals over their cap. At least 50 percent of remaining new positions would be allocated to specialties facing current shortages.

Both bills would require a report from the National Health Care Workforce Commission by 2018 to determine and identify specialty shortages. Until then, a 2008 Health Services and Resources Administration (HRSA) report would be utilized.

The current Medicare graduate medical education (GME) funding limits on residency training positions have impeded the establishment of new residency programs and additional training positions in existing programs. Increasing the overall pool of physicians will not assure that adequate numbers enter and remain in practice in primary care (general internal medicine, family medicine, and pediatrics). Instead, a more targeted approach is needed, as S. 1148 and H.R. 2124 strive to do, recognizing the nation's increasing demographic demands for health care, by strategically increasing the number of Medicare-funded GME positions in specialties facing shortages.

Click here to see ACP's support letters for S. 1148 and H.R. 2124.

What is the status of the Teaching Health Center Graduate Medical Education (THCGME) program as established by the Affordable Care Act (ACA)?

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.

For FY2016, the THCGME's funding situation was particularly urgent and faced a funding cliff because its mandatory funding was set to expire with no current budget authority. The College was therefore pleased that the recently-passed *Medicare Access and CHIP Reauthorization Act*, H.R. 2, increased THCGME funding to $60 million for fiscal years 2016 and FY2017 (through the use of mandatory funding, the same kind of funding used for programs such as Medicare).

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.

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. Because IPAB, as currently authorized by the ACA, does not include the modifications we believe are necessary, we are not actively opposing the bills to repeal IPAB, however.

What is the *21st Century Cures* initiative and what does it contain that is of interest to ACP?

Last year, the House Energy & Commerce Committee began to take a comprehensive look at what steps it could take to accelerate the pace of cures in America. The committee began to explore the full arc of this process – from the discovery of clues in basic science, to streamlining the drug and device development process, to unleashing the power of digital medicine and social media at the treatment delivery phase. For the past year, the committee has held hearings on this topic, asked for feedback from stakeholders, and released legislative discussion drafts for comment – all with the intent of developing and introducing comprehensive legislation. The health subcommittee held a "mark-up" session on the discussion draft on May 14th, and unanimously approved it. It is expected that the draft will be considered by the full committee the week of May 18th.

At the time of this document's drafting, there were numerous sections of the May discussion draft that were not yet fully developed. This bill would reauthorize funding for the National Institutes of Health (NIH) research and establish an NIH innovation fund, as well as new programs to support young, emerging scientists. It will also support telemedicine as a method of health care delivery and the movements toward true interoperability of health records, yet details of how these laudable goals will be achieved are not yet available; it is critical that these goals be achieved in a way that enhances patient-physician collaborations and meaningfully engages all stakeholders involved, particularly front-line clinicians. ACP will continue to engage in a supportive way with the Energy and Commerce Committee and provide input as this bill moves forward.

As ACP continues to analyze the discussion draft, we have identified several key areas of interest including:

- **National Institutes of Health (NIH)** - ACP is strongly supportive of reauthorization of the funding for NIH research, the establishment of an NIH innovation fund, as well as new programs to support young, emerging scientists.
- **Interoperability of electronic health records** – ACP welcomes the movement toward true interoperability of health records and wants to see it achieved in a way that makes sense for all stakeholders involved, and particularly for the clinicians providing care. We have provided a significant amount of feedback to the Committee staff in this area,

including noting the need to move away from artificial incentives and penalties, and toward true engagement of front-line clinicians in the development of interoperable platforms.

- **Telemedicine** - ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient-physician collaborations; improve health outcomes; increase access to care and members of a patient's health care team; and reduced medical costs when utilized as a component of a patient's longitudinal care. Therefore, we are supportive of finding a solution to the patchwork of laws and rules that currently hamper the spread of telemedicine.
- **Vaccines** – ACP signed onto a letter with the March of Dimes and other stakeholders, including other medical societies and patient groups, that calls for improvements in the discussion draft in a number of areas, such as rigid deadlines for ACIP recommendations. The imposition of these "standard timelines" would not adequately recognize the fact that the data are sometimes not forthcoming in a timely manner and could force ACIP to take votes based on incomplete information.

I've heard that Maintenance of Certification (MOC) is going to be required for physicians to participate successfully in the new Merit-Based Incentive System (MIPS) that is being established as part of the new MACRA law that repeals the SGR—and that if they do not participate, they will be penalized. Is that true?

No, this is not the case.

- The Merit-Based Incentive Payment System (MIPS), as outlined in *Medicare Access and CHIP Reauthorization Act of 2015* (H.R. 2) will effectively merge and streamline the three distinct current law incentive programs, resulting in in a new MIPS program that has 4 components: (1) Quality, (2) Resource Use, (3) Meaningful Use , and (4) Clinical Quality Improvement Activities.
- These four components will each contribute to an overall composite score for clinicians and/or groups of clinicians—rather than each program being measured and incentivized separately.
- The newly established Clinical Quality Improvement Activities component will include a menu of recognized activities within a set of subcategories that will be established in collaboration with professionals.
    - **Within the subcategory of patient safety and practice assessment, <u>one</u> of the options for achieving points is through practice assessments related to maintaining certification—however this is <u>not a required approach</u> that physicians or practices must pursue, it is simply one option that is available to them among many.**
- **ACP supported the inclusion of maintenance of certification as an option for this subcategory within the overall clinical quality improvement activities due to the potential for it to reduce burden on physicians.** If physicians are already pursuing these activities for MOC purposes, then ACP believes they should receive credit for them for this purpose as well.