Frequently Asked Questions (FAQs)

Additional Policy Issues of Interest for Leadership Day 2019
May 14-15, 2019

1. **What does the Advancing Medical Resident Training in Community Hospitals Act of 2019 (H.R. 1358) do for Medicare Graduate Medical Education (GME)? Does ACP support it?**

ACP and the Alliance for Academic Internal Medicine (AAIM) supports the Advancing Medical Resident Training in Community Hospitals Act of 2019 (H.R. 1358), which was introduced by Rep. Ron Kind (D-WI-03) and Rep. Mike Gallagher (R-WI-08) on February 26, 2019. This legislation makes technical adjustments to the current policy for new teaching hospitals to allow hospitals to host a small number of resident rotators for short durations without setting a permanent full-time equivalent (FTE) resident cap or a Per Resident Amount (PRA). It also proposes to eliminate any cap of 3 or less that was set after Oct. 1, 1997, or caps of 1 or less set before that date. The legislation is intended to address a growing problem encountered by some community hospitals when they take residents for away rotations, even for brief periods, only to find out that this can trigger a CMS-imposed residency cap, even though the hospital does not currently have a teaching program. Some community hospitals are afraid to take residents for a rotation from another hospital because that might start the cap-setting process. This legislation represents a positive step forward for many hospitals that trigger this residency cap, so often inadvertently, which has implications on their ability to become teaching hospitals. For questions or further information, please contact Al Steinmann, MD at alwin.steinmann@sclhealth.org

2. **Did ACP release a new position paper in April, 2019 that is particularly relevant for 2019 Leadership Day priorities?**

Yes, ACP recently released a position paper, "Improving the Affordable Care Act's Insurance Coverage Provisions," which was published in the *Annals of Internal Medicin*e. It provides a set of recommendations to strengthen the Affordable Care Act (ACA) and lay the foundation for health care reforms that will lead to universal coverage for all Americans.

ACP's paper calls for efforts to bolster the ACA:

- The 400 percent federal poverty level premium tax credit eligibility cap should be eliminated, and the amount of premium tax credits for all income levels should be enhanced;
- The federal government should stabilize the marketplace by establishing a permanent reinsurance program;
- Sustained funding is needed for dedicated outreach, consumer assistance, and education to promote open enrollment, provide in-person and virtual enrollment assistance, and respond to inquiries from the community;
- Federal and/or state governments should ensure that all individuals enroll in coverage by developing an auto-enrollment program;
- All states should fully expand Medicaid eligibility;
- Congress should enact legislation to authorize the development of a public insurance plan to ensure enrollees have access to a variety of coverage options in their area. Potentially, the public option could be expanded to serve as a stepping stone to universal coverage.

ACP is committed to supporting policies that work to achieve universal health care coverage, and supported the passage of the ACA in 2010.

3. **With respect to step therapy protocols, what are the details behind the Safe Step Act of 2019 (H.R. 2219)?**

ACP supports the Safe Step Act of 2019 (H.R. 2279), which was introduced by Rep. Raul Ruiz (D-CA- 36) and Rep. Brad Wenstrup (R-OH-2) on April 10, 2019. This bill would require health insurers to provide an exceptions process for any medication step therapy protocol based on clinical decision-making, medical necessity, and other patient needs.

"Step therapy" requires patients to first "try and fail" certain treatments before being allowed access to other, potentially more appropriate treatments, which can harm patients, undercut the physician-patient decision-making process, and create burden. Physicians do not currently have ready access to accurate patient benefit and formulary information, as there is no capability making this information available through EHRs. This lack of transparency makes it difficult to determine what treatments are preferred by a particular payor at the point of care.

The Safe Step Act would require private insurance with step therapy to offer a true exception process to step therapy. One of the following set of circumstances would be necessary for an exception: 1) the treatment is contraindicated; 2) the treatment is expected to be ineffective; 3) the treatment will cause or is likely to cause an adverse reaction in the individual; 4) the treatment is expected to decrease the patient's ability to perform daily activities or their job or adhere to the treatment plan; or 5) the patient is already stable with the original prescribed drug.

4. **How does the administration's Fiscal Year 2020 budget proposal impact ACP's funding priorities?**

A proposed budget is required to be submitted by the president to Congress by law. However, it is only a blueprint for spending and any funding request level or new program proposal would have to be subsequently approved by Congress. For fiscal year (FY) 2020, the administration requested $542 billion for non-defense discretionary (NDD) spending, funding that goes through the annual appropriations process that Congress must approve. This funding level is what is known as a sequester level budget cap as originally imposed by the Budget Control Act (BCA) of 2011. This sequester-level cap for NDD spending is $55 billion less than the FY 2019 enacted level for the same type of funding. ACP is greatly concerned that the President's FY 2020 Budget proposed this funding cut, which would lead to dozens of programs being slashed. Congress must also act to pass legislation to ensure that these programs are adequately funded in FY 2020, that there are no interruptions in their funding due to a government shutdown, and that the budget sequester cap be permanently lifted for FY 2020 and beyond.

The Budget requested billions of dollars less for several of ACP's federal health care priorities, including, the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and the Office of the National Coordinator for Health Information Technology (ONC). In addition, the Budget eliminated the Title VII health professions programs—which is home to one of ACP's top priorities, the Primary Care Training Expansion (PCTE) program. This is the only federal program that directly funds general internal medicine training.

However, it is unlikely that Congress will adhere to the President's budget request during the FY 2020 budget and appropriations process. The House of Representatives is already moving through the full Appropriations Committee several of the twelve annual appropriations bills, including the Labor-HHS-Education spending bill, for FY 2020. However, Congress will need to agree on a budget deal that raises the NDD spending cap and funds programs at sustainable levels for FY 2020 and beyond.

5. **What is ACP's position on legislation that would guarantee health care coverage through a single payer system known as "Medicare for All"?**

ACP policy supports a health system that provides universal coverage to ensure that all people within the United States have access to health care without unreasonable financial barriers. ACP believes that universal coverage may be achieved through two pathways, a single-payer financing model in which one government entity is the sole payer of health care costs, or a pluralistic system, which involve government entities as well as multiple for-profit and/or not-for-profit private organizations.

The passage of the Affordable Care Act significantly lowered the rate of uninsured in this country but did not provide universal coverage. The debate continues concerning how to provide affordable access to health insurance for those who do not have it. ACP's Health and Public Policy Committee is now examining the advantages and disadvantages to different policies to achieve universal health care coverage, including the single payer system; offering persons the option to enroll in a publicly-funded program or keep their employer or individual coverage; continuing to expand on the

ACA while offering a Medicare buy-in option for persons aged 50 through 64 and a public option in all exchanges; and other approaches to determine which may work best in this country. ACP believes that before we endorse any one approach to universal coverage, certain questions need to be explored of any proposed model, such as:

- Will all Americans be required to get their coverage through a single government-financed system and need to give up their employer based or individual coverage?
- Will Americans conclude that the coverage is better or worse than what they have now?
- What will be the impact on reducing the amount of administrative burdens imposed on physicians and their patients and the total amount of money that the United States spends on administration?
- Will the government contract with insurance companies to run the new system, like is the case today with Medicaid managed care?
- How will physicians, hospitals, and others who deliver health care services be compensated? Will internal medicine specialists in particular be compensated at a level that sustains their practices and supports the demonstrated value of the care they provide, particularly to patients with more complex diagnoses and illnesses?
- How will costs be controlled?

Several variations of so-called "Medicare for All" legislative proposals, or a Medicare (type) public option, have been introduced in the 116th Congress but ACP has not taken a position on any one of them. While various committees of jurisdiction in the House are holding hearings on the concept of "Medicare for All," there is no consensus among members of Congress on whether, or how specifically, to advance any particular legislative reforms – at this point in time, and legislation to enact either a Medicare for All, or offering a public option to all who want it, will not advance through both the House and Senate, and be signed by the president, in this Congress and with the current administration. Congress' hearings however may advance the discussion of the pros and cons of different proposals, and help inform ACP's internal evaluation of each. In the meantime, ACP is supporting legislation, as noted above, that would build upon and improve coverage under the ACA, some of which may have a reasonable chance of attracting bipartisan support

6. What is ACP's view of the recent CMS announcement of new payment and delivery models to support primary care?

ACP is encouraged that the Centers for Medicare and Medicaid Services (CMS) is testing new delivery and payment models designed to support the role of care provided by primary care physicians. CMS announced in April that two new alternative payment models, Primary Care First and Direct Contracting, will be created to provide additional voluntary options for primary care physicians and their practices to be paid for keeping patients healthy and out of the hospital. The Primary Care first model "will focus on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance-based payments. The Direct Contracting model is directed at large systems that have experience and capabilities to take on substantial financial risk for large numbers of patients. ACP believes that the new models are a step in the right direction in recognizing the quality and value of care that internists provide to their patients. Specifically, ACP is pleased that CMS has considered our recommendations to provide a variety of payment and delivery models that support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones. Of note, ACP is hopeful that the new models will emphasize the important role primary care plays in value-based care delivery, that models are voluntary and have a range of risk options, and that practices should use population health management data to reap potential benefits. Additionally, ACP is supportive of the fact that the new models aim to reduce administrative burdens—potentially allowing physicians to spend more time with their patients.

The success and viability of these models will depend on the extent that they are supported by payers in addition to Medicare and Medicaid, are adequately adjusted for differences in the risk and health status of patients seen by each practice, are provided predictable and adequate payments to support and sustain practices (especially smaller

independent ones), are appropriately scaled for the financial risk expected of a practice, are provided meaningful and timely data to support improvement, and are truly able to reduce administrative tasks and costs, among other things ACP will continue to evaluate the new payment and delivery models based on such considerations, and we look forward to working with CMS and to continue advocating for ways to support the value of primary care for physicians and for all patients across the health care system. See here for further information on the Primary Care First model or the Direct Contracting model.

7. **What is the current status of undocumented children or young people, also known as *Dreamers*, who entered the country without proper documentation for lawful entry due to the actions of their parents?**

After the 2016 election, President Trump directed his Attorney General at the time, Jeff Sessions, to review potential changes to the Deferred Action for Childhood Arrivals (DACA) program, which ensured that certain individuals (known as *Dreamers*) without lawful immigration status who were brought to the United States as children would be granted temporary lawful status in this country and would not be deported. ACP was displeased that on September 5, 2017, Attorney General Jeff Sessions announced that DACA was being rescinded as the administration believes that the "program is unlawful and unconstitutional and cannot be successfully defended in court.

On January 9, 2018, a federal judge ruled that President Trump's decision to rescind the DACA program was illegal; the administration appealed this ruling, and in November of last year the Ninth Circuit Court of Appeals upheld the initial court ruling against the effort to end DACA. The administration also urged the Supreme Court to overturn this decision of the lower court, but the Supreme Court has declined to consider the DACA issue during its current term, which will require the federal government to continue to implement DACA through the remainder of this year.

The potential termination of DACA threatens to deny the United States the talents of more than half a million individuals who are making enormous contributions to our country, and will particularly undermine public health and medical education. More specifically, ACP is concerned about the potential deportation of undocumented medical students, residents, fellows, practicing physicians, and others who came to the United States due to the actions of their parents and have obtained or are eligible for DACA status. Without the protections afforded to them by DACA, these students and physicians would be forced to discontinue their studies or their medical practice and may be deported. In April, ACP endorsed legislation, the Dream and Promise Act of 2019 (H.R. 6), which would provide a pathway to citizenship for *Dreamers*. In order to gain lawful permanent resident status under this bill, *Dreamers* must:

- Acquire a degree from a U.S. institution of higher education; or complete at least two years in good standing in a bachelor's or higher degree program or in an area career and technical education program at a post-secondary level in the U.S.
- Complete at least two years of military service, and if discharged, received an honorable discharge.
- Be employed for periods of time totaling at least three years and at least 75 percent of the time that the person has had employment authorization.

H.R. 6 is now pending in the House Committees on the Judiciary and Education and Labor. It is anticipated that the bill will be considered and passed in the Democratically controlled House, but it is unclear if it would receive consideration in the Senate. There are off and on discussions among lawmakers in both chambers, and the administration, on a comprehensive immigration bill that might include provisions to permanently allow *Dreamers* to remain in the United States, create a path to citizenship for them, strengthen border security, and revise policies affecting legal immigration.

8. **The Fair Accountability and Innovative Research (FAIR) Drug Pricing Act (H.R. 2296/S. 1391) was just introduced. Does ACP support it? What does it do?**

Yes, ACP supports the FAIR Drug Pricing Act of 2019 (H.R. 2296/S. XXX), introduced in the House of Representatives by Rep. Janice Schakowsky (D-IL-09) and Rep. Francis Rooney (R-FL-19) on April 12, 2019, and in the Senate by Sen. Tammy Baldwin (D-WA) and Sen. Mike Braun (R-IN) on May 9, 2019. The FAIR Drug Pricing Act would require drug companies to

disclose and provide more information about imminent drug-price increases, including data about research and development costs. More transparency would help provide much-needed information for clinicians, patients as well as Members of Congress and regulators about the cost and development of medications. The bill was not included in the printed ACP's *Leave-Behind* (LB) on the High Cost of Prescription Drugs (as contained in your folders) because it was introduced too late to be added, but it is included in the electronic version of that *Leave-Behind* as posted on the Leadership Day website. We urge attendees to include mention of this bill as part of your "asks" of Congress on prescription drugs.

The FAIR Drug Pricing Act would require drug manufacturers to notify the U.S. Department of Health and Human Services (HHS) and submit a detailed transparency and justification report 30 days before a price increase of prescription drugs that cost $100 or higher by more than 10 percent in one year or 25 percent over three years. The report would require manufacturers to provide: a justification for each price increase; manufacturing, research and development costs for the qualifying drug; net profits attributable to the qualifying drug; marketing and advertising spending on the qualifying drug, and; other information as necessary. The bill would not prohibit manufacturers from increasing drug prices, but rather for the first time give clinicians and their patients advance notice of price increases and bring much-needed transparency to the opaque prescription-drug market. Hopefully these disclosures would incentivize companies to reassess the all-too-often and routine high drug price increases.

9. What's the status with the surprise billing issue and what is Congress doing about it? Where does ACP stand?

Reports of high and unanticipated "surprise" medical bills, especially in emergency situations for patients who do have health insurance coverage and are being treated at in-network facilities, have resulted in calls for the federal government to take both legislative and regulatory action. Most recently, the administration put forward a set of principles and requested that Congress take action. In the Senate, there are bipartisan efforts taking place, including by a group of six senators to develop legislation that would prevent surprise bills and reduce costs in situations where patients were not able to avoid unreasonable bills despite their best efforts. The Senate Health, Education, Labor, and Pensions Committee has also been trying to find consensus on the issue. There have been several bills introduced on the surprise billing issue. ACP has been engaging with Congress and the committees with jurisdiction over the issue, as well as other stakeholders, about surprise billing and will continue to do so as legislation continues to be developed. In February, ACP joined other physician groups in laying out a set of policies to address the issue.

In 2017, the College released the "Improving Health Care Efficacy and Efficiency Through Increased Transparency" position paper. In it, ACP makes several recommendations that would help to ameliorate surprise billing situations while helping patients and containing costs.

ACP supports efforts to provide greater protections for patients from unexpected out-of-network health care costs, particularly for costs incurred during an emergency situation or medical situation in which additional services are provided by out-of-network clinicians without the patient's prior knowledge. While the College reaffirms the right of physicians to establish their own fees and to choose whether or not to participate as an in-network physician, ACP supports establishing ways to hold patients harmless for "surprise" bills for out-of-network services for which a patient was unable to obtain estimates for services prior to receipt of care or was not given the option to select an in-network clinician.

ACP also believes that network adequacy also needs to be addressed so that there are enough in-network physicians in all settings. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care. Evidence exists that narrow networks contribute to out-of-network costs. Adequate access to all types of care in the health plan's network could help reduce surprise billing and the need for out-of-network services. Many patients may have no choice but to utilize out-of-network facilities and services, such as in emergency situations.

Efforts to reduce the negative impact of surprise billing should be made at the state and federal levels. Legislation aiming to limit surprise billing should, at a minimum, include one or more of the following components:

- Support for increased pricing and out-of-pocket cost transparency;
- Dispute resolution process that holds patients harmless for surprise bills;
- Assessment of economic impact on patients, clinicians, and payers.