ACP
American College of Physicians
Internal Medicine | Doctors for Adults

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 133,000 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.

25 Massachusetts Avenue, NW, Suite 700, Washington, DC 20001-7401, 202-261-4500, 800-338-2746
190 North Independence Mall West, Philadelphia, PA 19106-1572, 215-351-2400, 800-523-1546, www.acponline.org

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 2013**, was held in San Francisco April 11-13. **Internal Medicine 2014** will be held April 10-11 in Orlando.

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.

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 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, and Japan and Saudi Arabia. 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

2013-14 President	Molly Cooke, MD, FACP, San Francisco, CA
2013-14 Chair, Board of Regents	Charles Cutler, MD, FACP, Norristown, PA
*President-elect**	David A. Fleming, MD, MA, FACP, Columbia, MO
*Chair-elect, Board of Regents**	Robert M. Centor, MD, FACP, Huntsville, AL
Executive Vice President and CEO	Steven E. Weinberger, MD, FACP, Philadelphia, PA

** to take office as 2014-2015 President and Chair, Board of Regents, 4/12/14*

ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

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

May 21-22, 2013

Eliminate Medicare's Sustainable Growth Rate (SGR) and Transition to Better Payment Systems

Work in a bipartisan fashion to include the following elements in any Medicare physician payment reform proposal: (1) elimination of the SGR, (2) ensure stable and positive payments for all physicians for at least five years, with a higher baseline update for Evaluation and Management codes without regard to specialty and, (3) create multiple pathways and opportunities for physicians who participate in innovative value-based models, including Patient-Centered Medical Homes, to benefit from graduated incentive payments during the transition to a reformed payment system, starting as early as 2014. In the House, co-sponsor the *Medicare Physician Payment Innovation Act* (H.R. 574), as introduced on Feb. 6 by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV) and in the Senate, introduce a companion bill.

Ensure Full Funding for Essential Health Programs

Congress should reverse the trillions in across-the-board sequestration cuts, which do not take into consideration the importance or effectiveness of any particular program or activity, with a fiscally-responsible alternative that addresses the real cost-drivers in health care, as proposed by ACP. Congress should fully fund the following essential federal health programs that support the workforce, health research, and the public health:

- ✓ 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.
- ✓ Agency for Healthcare Research and Quality (AHRQ), which leads the way in identifying new delivery system methodologies to help facilitate the provision of care that is both of the highest quality and delivered as efficiently as possible—consistent with a high value health care system.
- ✓ National Institutes of Health (NIH), which is critical in providing research to prevent and treat diseases and improve care for all Americans.
- ✓ Health Resources and Services Administration (HRSA), which funds programs to improve access to health care services for people who are uninsured, isolated or medically vulnerable. This includes the funding of community health centers that provide primary health care as a safety net for some 50 million of our fellow citizens who would not otherwise have access to these essential services.
- ✓ Centers for Disease Control (CDC), which is involved with a wide range of indispensable public health programs, including emergency preparedness and response, environmental health, workplace safety and health, infectious and chronic diseases and conditions, injury prevention and control, and healthy living.

Authorize and Fund a National Pilot of No-fault Health Courts

Congress should work together to enact innovative reforms that will reduce the costs of medical liability insurance and defensive medicine, including:

- ✓ Pilot on Health Courts: Based on a legislative framework developed by ACP, Congress should introduce and enact legislation to authorize and fund state pilots 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 Financing; Re-align the Program with the Nation's Workforce Needs

Congress should preserve funding for GME and align it with workforce policy goals to ensure that taxpayers are getting optimal value from their investment in GME.

- ✓ Preserve funding for Graduate Medical Education in FY2014 and halt cuts to GME under sequestration.
- ✓ Enact legislation that will increase the number of GME training positions, especially in primary care specialties. Specifically, co-sponsor the *Resident Physician Shortage Reduction Act* (S.577 and H.R. 1180); House members should co-sponsor the *Training Tomorrow's Doctors Today Act* (H.R. 1201) and Senate members should introduce and co-sponsor a companion bill.
- ✓ Introduce legislation to support GME financing reform by introducing more transparency and accountability and requiring that all payers contribute to GME funding.

ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

Eliminate Medicare's Sustainable Growth Rate and Transition to Improved Payment Models for Patients and Physicians

May 21-22, 2013

There is widespread agreement that Medicare's Sustainable Growth Rate (SGR) formula is fatally flawed and should be replaced. The College believes a successor payment framework should create stable and positive updates for all physician services; provide incentives for primary, preventive and coordinated care; accelerate development and testing of new models developed with physicians' input; and establish a transition to the most effective new payment models.

The unworkable SGR formula determines the annual payment updates to physicians for the services they provide under the Medicare and TriCare programs. (TriCare, the health insurance program for military families, uses the same flawed SGR formula as Medicare.) Every year since 2001, the SGR has resulted in annual scheduled payment cuts that jeopardize access to care for our nation's Medicare beneficiaries and military families. The scheduled cuts also act as a barrier to physicians investing in health information systems and in acquiring other practice capabilities to improve the value of care provided to patients. Congress typically enacts short-term "patches" to avert payment reductions. If Congress does not intervene, the estimated SGR cut scheduled for Jan. 1, 2014 is nearly 25 percent. Further exacerbating the problem, physicians are now contending with a 2 percent reduction in payments under Medicare, effective on April 1 of this year, as a result of across-the-board sequestration cuts.

There is bipartisan recognition in Congress that now is the time to replace the SGR. Many believe that this year holds great promise for accomplishing that long sought-after goal. One reason for this is that, in May 2013, the Congressional Budget Office (CBO) lowered its estimate of the cost of repeal to $139 billion, a significant reduction from an earlier estimate of $245 billion in August 2012. And, because Congress must offset the cost of repeal, the obstacle is not nearly as formidable at the present time. As this cost is based, in part, on the cost of physician services, there is no guarantee the price tag for repeal will remain at the current level so it is imperative that Congress act now while the cost is still at a reduced level.

If the SGR is repealed, what should replace it?

As in the 112th Congress, ACP worked with Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV) again in 2013, culminating in the reintroduction of bipartisan Medicare physician payment reform legislation, the *Medicare Physician Payment Innovation Act of 2013*, H.R. 574, on February 6, 2013. The bill, which is strongly supported by the College, would eliminate the SGR once and for all and transition to better payment and delivery systems that are aligned with value. Specifically, this legislation would repeal the SGR formula, provide more than 5 years of stable physician payments, with positive increases for all physician services, and higher payments for primary care, preventive and care coordination services, and establishes a process for practices to transition to new, more effective, models of care by 2019. This legislation represents a positive step forward in advancing comprehensive SGR reform and ACP has urged the committees of jurisdiction in the House to use H.R. 574 as a basis for physician payment reform legislation currently under development.

In early February, 2013, House Energy and Commerce Chairman Fred Upton (R-MI) joined with House Ways and Means Chairman Dave Camp (R-MI) to circulate a draft framework for a proposal to repeal the SGR. ACP is pleased that the joint committee proposal includes reforms that are similar to those in the Schwartz-Heck legislation. The draft proposal from the committee chairs would provide a period of predictable payment rates for physicians, reform Medicare's fee for service system to reflect the quality and efficiency of care provided, and provide options for physicians to transform their practices into new models of care.

On April 3, the chairmen released a revised draft of their framework that contained additional details. This "second iteration" took into account many of the comments received from stakeholder groups, including ACP, on the initial draft. ACP provided feedback in the form of a letter to this second iteration that can be viewed at: http://www.acponline.org/advocacy/where_we_stand/assets/eliminating_sgr.pdf

On May 7, ACP testified at a House Ways & Means Subcommittee on Health Hearing examining options for repealing the SGR formula and reforming the Medicare physician payment system to reward quality and value. ACP's written testimony, as submitted for the record, can be viewed at:
http://www.acponline.org/acp_policy/testimony/ways_and_means_medicare_physician_payment_testimony_2013.pdf

What are ACP's specific recommendations to reform the SGR, as included in our May 7 testimony?

1) Eliminate the SGR.
2) Establish positive baseline updates, with a higher baseline for evaluation and management (E/M) services, for at least five years.
3) Establish a graduated incentive program for physicians to qualify for higher fee-for-service (FFS) payment updates, above their baseline, for participating in a program to improve outcomes and effectiveness of care, with the amount of the incentive allowance being based on how much the program or programs they are participating in incorporate core elements associated with better outcomes and effectiveness of care.
4) Create a process for the Centers for Medicare & Medicaid Services (CMS) to "deem" private sector programs to qualify physicians for the graduated incentive program, such as those from specialty societies, based on standards to ensure that those programs have the key features needed to advance quality and effectiveness of care.
5) Specifically allow practices that are accredited or recognized as Patient Centered Medical Homes (PCMH) and PCMH-neighborhood (PCMH-N) practices that meet standards for selection to qualify for graduated incentive payments, effective on January 1, 2014. Just as PCMHs consist of a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes, the PCMH-N recognizes those non-primary care practices that engage in processes that facilitate patient-centeredness, care coordination and integration with the primary care practice, and a culture of quality improvement.

What are ACP members asking Congress to do?

- ✓ Work in a bipartisan fashion to include the following elements in any Medicare physician payment reform proposal: (1) eliminate the SGR, (2) ensure stable and positive payments for all physicians for at least five years, with a higher baseline update for E/M codes without regard to specialty and (3) create multiple pathways and opportunities for physicians who participate in innovative value-based models, including PCMHs and PCMH-Ns, to benefit from graduated incentive payments during the transition to a reformed payment system, starting as early as 2014.
- ✓ Reverse the 2 percent cut to Medicare physician payments under sequestration.
- ✓ House members should cosponsor and pass in the House H.R. 574, *the Medicare Physician Payment Innovation Act of 2013*; Ask Senators to introduce and pass in the Senate companion legislation to H.R. 574.

For more information on ACP's positions, please visit the Advocacy section of ACP Online,
http://www.acponline.org/advocacy/

ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

Enact a Fiscally-and Socially-Responsible Alternative to Sequester Cuts

May 21-22, 2013

The American College of Physicians (ACP) believes that sequestration, or across-the-board cuts, will compromise essential programs to improve the access, quality and safety of health care in the United States and must not be allowed to stand. Across-the-board cuts, which do not take into consideration the importance or effectiveness of any particular program or activity, are not an appropriate method of governing. ACP recognizes that Congress has a responsibility to reduce the budget deficit, which will include reductions or elimination of unnecessary spending on programs that have little public benefit. However, critical programs to ensure that patients have access to physicians, to support research to prevent and cure illness, to improve public health, to prevent disease, and to improve quality and access to care need to be funded at a level that allow them to function effectively. Policymakers should work to improve the effectiveness of care provided, make necessary and appropriate changes in entitlement programs-including Medicare cost-sharing, reform payment and delivery systems, and support the proven value of primary care.

What specific concerns does ACP have about the impact of the sequester on key federal health programs?

PHYSICIAN WORKFORCE

Within the Title VII Health Professions program, the **Section 747, Primary Care Training and Enhancement** is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine to maintain and expand the pipeline of primary care production. Under sequestration, the Section 747 program will see a reduction of $1.96 million; with fewer grant dollars, residency programs will not be able to fund new initiatives relating to increased training in inter-professional care, the patient-centered medical home, and other new competencies required in our developing health system.

The **National Health Service Corps (NHSC)** funds training for thousands of primary care clinicians who provide care to tens of millions of persons in underserved communities, providing scholarships and loan forgiveness to enable primary care physicians to be trained to serve in underserved communities. A loss of $15.3 million, as is expected under sequestration, for the NHSC could result in as many as 272 fewer scholarships and loan repayment awards, resulting in 272,000 fewer individual patients served by NHSC primary care clinicians in FY2013.

Sequestration will have a significant impact on Medicare's long-standing support for **Graduate Medical Education (GME)** and ultimately will limit teaching hospitals' and physicians' ability to care for all patients and train the next generation of physicians due to the 2 percent cut. GME funding is crucial for training physicians in the specialties facing critical workforce shortages—including internal medicine, family medicine, and geriatrics.

On April 1, **payments for all Medicare services** provided by physicians on or after that date have been reduced by 2 percent as a direct result of sequestration. Unfortunately, threats of payment cuts are nothing new to physician practices, and a 2 percent cut from sequestration is in addition to the nearly 25 percent Medicare SGR cut set to go into effect on January 1, 2014 due to the sustainable growth rate (SGR) formula. Continued cuts in payments to physicians will cause access problems for patients, job losses and/or furloughs and more.

PUBLIC HEALTH

The **Health Resources and Services Administration (HRSA)** funds programs to improve access to health care services for people who are uninsured, isolated or medically vulnerable. Due to sequestration, HRSA loses $312 million in discretionary funding and $73 million in mandatory funding. Community health centers, which provide primary health care as a safety net for some 50 million of our fellow citizens, will be forced to reduce their capacity and serve 900,000 fewer patients; these are Americans who already have difficulty accessing essential health care services.

The **Centers for Disease Control and Prevention (CDC)** is involved with a wide range of indispensable public health programs, including emergency preparedness and response, environmental health, workplace safety and health, infectious and chronic diseases and conditions, injury prevention and control, and healthy living. Since 2008, more than 46,000 state

and local jobs in health agencies and health departments have been lost, representing nearly 21 percent of the total state and local health department workforce; under sequestration, the CDC loses $575 million in FY2013.

HEALTH RESEARCH

The **Agency for Healthcare Research and Quality (AHRQ)** leads the way in identifying new delivery system methodologies to help facilitate the provision of care that is both of the highest quality and delivered as efficiently as possible—consistent with a high value health care system. Because AHRQ is primarily funded through intergovernmental transfers, it is not subject to sequestration. However, the Patient-Centered Outcomes Research Trust Fund, which transfers a portion of its funding to AHRQ, is subject to sequestration, causing AHRQ to sustain a $3.093 million reduction.

The **National Institutes of Health (NIH)** is critical to funding research to prevent and treat diseases and improve care for all Americans. Under sequestration, for FY2013, the NIH loses $1.544 billion; it is estimated that Research Proposal Grant (RPG) success rates will drop from 18 percent in FY2011 to 14 percent in FY2013.

What are ACP's ideas for achieving savings and better outcomes?

ALTERNATIVES TO SEQUESTRATION

Across-the-board cuts that do not take into consideration the importance and effectiveness of different health care programs is the wrong way to reduce the deficit. The right way is to enact a balanced package of reforms that focus on changes that can be made to further restrain health care cost increases and eventually reduce per capita health care spending. Such reforms could include:

- Transition to new payment systems aligned with value; please see the handout entitled, *Eliminate Medicare's Sustainable Growth Rate and Transition to Improved Payment Models for Patients and Physicians* for more information.
- Establish a national, multi-stakeholder initiative to reduce marginal and ineffective care and promote high-value care.
- Provide patients and clinicians with information on the comparative effectiveness of different treatments.
- Establish patient incentives and insurance designed to encourage high-value care and reduce use of low-value treatments and tests.
- Reduce the costs of defensive medicine; please see the handout entitled *Authorize and Fund a National Pilot of No-Fault Health Courts* for more information.
- Preserve and broaden financing for Graduate Medical Education and allocate GME funding more strategically, based on an assessment of national workforce priorities and goals; please see the handout entitled, *Reform and Sustain Graduate Medical Education Financing and Ensure an Adequate Physician Workforce* for more information.
- Authorize Medicare to negotiate prescription drug prices.
- Enact a cap on the deductibility of employer-sponsored health insurance.
- Create a single shared cost-sharing structure for the different parts of Medicare.

More information on ACP's recommendations to reduce costs, with estimates of potential savings, is available at: http://www.acponline.org/advocacy/where_we_stand/medicare/super_comm_menu.pdf.

What are ACP members asking Congress to do?

Congress should:

- ✓ Reverse the $1.2 trillion in across-the-board sequestration cuts;
- ✓ Enact alternative reforms to improve health outcomes and achieve savings, as suggested by ACP; and
- ✓ Stop the cuts to vital programs that ensure access to physicians, support research to prevent and cure illness, improve public health, prevent disease, and improve quality and access to care.

For more information on ACP's positions, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/.

ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

Reform and Sustain Graduate Medical Education Financing and Ensure an Adequate Physician Workforce

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

May 21-22, 2013

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, full 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 financing currently structured?

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. This year there were more U.S. medical students who did not receive residency positions through the National Residency Matching Program (NRMP) than available positions after the match. It is imperative that we thoughtfully preserve this vital component of medical education and maintain adequate training positions for our medical graduates.

Much attention has been focused on Medicare's support of GME, especially monies for IME. In fact, the President's Fiscal Year (FY) 2014 budget proposes cuts to IME payments by 10 percent over 10 years starting in FY 2015. And, the budget sequester has already imposed a two percent across-the-board cut to Medicare program payments—including GME. The Medicare Payment Advisory Commission (MedPAC) has stated that 50 percent of the IME adjustment represents overpayment to hospitals. While we agree that the costs covered by the IME adjustment have decreased, we also contend that 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. We are concerned that because Medicare payments have not kept pace with the rising costs associated with DGME and given this program's determinant role in the physician workforce, it is that much more critical that any cuts to DGME or IME currently in effect or under consideration be withdrawn immediately.

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 adjusted to align spending with workforce policy goals. There are several introduced bills that we have endorsed 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. S. 577, H.R. 1180, and

H.R. 1201 would provide for, among other things, 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 are currently facing a shortage.

Establish an All-Payer GME System: ACP and AAIM, along with many other medical associations, have long-supported the concept of 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.

Support Reform Studies: The Institute of Medicine (IOM) has convened a special committee to assess current GME funding mechanisms and explore possible reforms, a process we support. It is important that this process include an accurate assessment of current training costs, establish a mechanism for monitoring this in the future, seek ways to minimize inequalities across the system, encourage training programs in underserved areas and regions, and structure GME funding to help address physician workforce needs. The IOM and Congress should also consider additional funding sources for GME such as private payers since, as a public good, GME benefits all of society, not just Medicare patients.

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

There are numerous federal programs and initiatives specifically designed to help ensure an adequate primary care workforce. And, because it is proven through hundreds of studies that access to primary care not only improves health outcomes but also reduces costs, it is in the best interest of Congress and the public to see to it that these programs are fully funded going forward. Examples include:

- **Section 747, Primary Care Training and Enhancement/Title VII** 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)** 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** 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 critical advisory body from embarking on its vital mission.

What are ACP members asking Congress to do?

- ✓ Preserve funding for Graduate Medical Education in FY2014 and halt cuts to GME under sequestration.
- ✓ Enact legislation that will increase the number of GME training positions, especially in primary care specialties. Specifically, co-sponsor the Resident Physician Shortage Reduction Act (S.577 and H.R. 1180); House members should co-sponsor the Training Tomorrow's Doctors Today Act (H.R. 1201) and Senate members should introduce and co-sponsor a companion bill.
- ✓ 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 such as 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.

For additional information on ACP's views regarding GME, please read its most recent paper at: http://www.acponline.org/advocacy/where_we_stand/policy/gme_policy.pdf.

ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

Authorize and Fund a National Pilot of No-Fault Health Courts

May 21-22, 2013

Health care costs in this country continue to rise and numerous studies show that a substantial contributing factor in that rise has been through costs associated with the practice of "defensive medicine." While the U.S. medical liability tort system is supposedly intended to deter injuries caused by negligent medical care, and provide compensation to those who experience such injuries, the current system does not deter physician negligence, provide timely compensation to injured patients, or resolve disputes fairly in favor of injured parties. In order to protect themselves from being inappropriately sued, some physicians may feel compelled to order more tests and procedures than are needed, refuse to take certain high-risk patients, decline to provide certain higher-risk services, decide not to practice in geographic areas that are associated with a greater incidence of malpractice suits, or even leave specialties that are more prone to being sued. The practice of "defensive medicine" results in the delivery of health care that has minimal medical benefit and is a major driver of rising health care costs. The Congressional Budget Office (CBO) estimates that as much as $62 billion could be saved each year by reforming the medical liability tort system; other studies estimate the costs are even higher.

Very little progress has been made in Congress to advance any significant, comprehensive medical liability reforms. Attempts at reform have been made, such as state demonstration grants for alternatives to current tort litigation, as enacted under the Affordable Care Act, but those grants (to date) have not been funded by Congress. The House of Representatives, to its credit, has on several occasions passed legislation that included caps on non-economic damages and other reforms that have been proven to reduce the costs of defensive medicine, but the Senate has not acted on those measures. The Agency for Healthcare Research and Quality (AHRQ) is funding numerous on-going projects on medical liability reform, such as patient safety initiatives and alternative dispute resolution demonstrations, all of which will conclude in 2013.

With Democrats and Republicans seemingly at odds over how best to reform the medical liability system, ACP believes that members from both sides of the aisle can work in a bipartisan fashion, and have in the past, on the concept of health courts. As an alternative to traditional medical malpractice reforms, health courts (also known as health care tribunals or medical courts) utilize an administrative process and specialized judges, experienced in medicine and guided by independent experts, to determine cases of medical negligence without juries. An effective approach to making progress on medical liability reform in this Congress must be one that can muster bipartisan support in both chambers.

What can health courts achieve in helping to resolve medical liability claims?

ACP believes that Congress should consider alternative approaches to addressing the costs of our broken medical liability system that *fundamentally change the way that claims are considered and adjudicated rather than just capping the damages that can be awarded under the existing tort system.* Health courts offer a highly promising alternative to the existing tort system for adjudicating medical liability claims. 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.

- Under today's judicial system, judges and juries decide medical malpractice cases with little or no medical training. The majority of medical liability cases involve very complicated issues of fact, and these untrained individuals must subjectively decide whether a particular physician deviated from the appropriate standard of care. Therefore, it is not at all surprising that juries often decide similar cases resulting in very different outcomes. Circumstances in one particular case may lead to no compensation for the plaintiff, while similar circumstances can result in a multi-million dollar verdict in another. It is this kind of uncertainty that is a substantial contributor to instability in the insurance market.

- A national pilot of health courts would allow for evaluation of an alternative resolution process for medical malpractice claims. Health courts utilize an administrative process and specialized judges, experienced in medicine and guided by independent experts, to determine cases of medical negligence without juries. Health courts would provide fair compensation for injuries caused by medical care, reduce costly and time-consuming

litigation, reduce medical liability costs, provide guidance on standards of care, reduce the practice of defensive medicine, and 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. Decisions made by health courts would serve as precedent to other courts and act as guidance to the physician community in overall efforts to improve patient quality and patient safety.

Health courts have received widespread and bipartisan support from Congress, interest groups, and physician membership organizations. President Obama included funding for pilot projects for health courts in his Fiscal Year 2012 budget and former Massachusetts Governor Mitt Romney supports funding for states to adopt the health court model. Legislation that would authorize the use of health courts was proposed in 2004 by Former Senate Majority Leader Bill Frist (R-TN). The following year, Senators Max Baucus (D-MT) and Mike Enzi (R-WY) as well as Jim Cooper (D-TN) and Mac Thornberry (R-GA) introduced legislation that would provide states with grants to administer health courts. The American Medical Association, the American College of Obstetricians and Gynecologists, and the Common Good have also endorsed the use of health courts. The bipartisan National Commission on Fiscal Responsibility and Reform (Simpson-Bowles) recommended that "specialized 'health courts' for medical malpractice lawsuits" should be among the policies to be pursued as part of "an aggressive set of reforms to the tort system."

ACP has prepared a detailed section-by-section framework for legislation 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 113th Congress. The section-by-section summary of this framework can be found in the document entitled, *Medical Injury Compensation Act of 2013: Section-by-Section Summary*.

What are ACP members asking Congress to do?

- ✓ Introduce legislation, based on ACP's framework, which would authorize and fund a national pilot of health courts.

For more information on ACP's positions on medical liability reform, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/medical_liability_reform.html

ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

Medical Injury Compensation Act of 2013

Section-by-Section Summary
May 21-22, 2013

FINDINGS

The judicial system has failed in keeping up with the complexity and the appropriate standards of medical care. Decisions in one court as to what is determined to be the appropriate standard of care are irrelevant in another court. It is often these inconsistencies that contribute to a costly judicial system that does little to promote deterrence and to improve patient safety. To address this problem, health courts (also known as "medical courts" or "health care tribunals") would be established that would utilize specialized judges with a specific background in medical malpractice, along with the assistance of independent experts, to guide decisions on appropriate standards of care. Under this expedited "no-fault" process, contested cases would be resolved without juries and patients could obtain fair compensation for injuries caused by medical care.

PURPOSE

This bill would establish a national pilot of no-fault health courts to resolve medical liability claims. The Secretary of Health and Human Services would provide such funds as are necessary for a five-year pilot of health courts in all 50 states and the District of Columbia to include the following elements: the health court pilot would not super-cede any state laws including laws to cap non-economic damages, impose limits on contingency fees, or require other alternative dispute resolution processes; the health courts would be offered as a voluntary option for any person who has had a medical liability claim in lieu of traditional courts and juries.

SECTION 1

Establishing of Health Court Review Boards

Health court review boards would be established to review patient claims and validate claims of medical negligence. These review boards shall be composed of 3 to 7 members, at least one-half shall be medical experts (physicians and other health care professionals) of the same or similar specialty as the case. The review board would review medical charts, interview patients, physicians, and nurses; and investigate other relevant evidence to determine medical negligence.

Evidentiary Assessment

If the evidence points to clear negligence, the patient would immediately be awarded compensation for actual economic damages and non-economic damages according to a predetermined schedule. At this point, if the patient accepts the determination, there would be no further legal proceeding. If the patient does not accept the ruling or the review board finds no clear evidence of medical negligence or that additional medical review is necessary, the patient would have the option to appeal to the health court.

SECTION 2

Option to Appeal to Health Court

This optional phase would only be triggered if the patient appeals the ruling of the review board, or if the review board determines further inquiry is necessary. One of the desired goals of health courts would be to take the bias out of expert testimony by utilizing qualified, independent expert witnesses paid directly by the court. These experts would guide judges in determining the appropriate and accepted standard of care. Such independent experts should be qualified and have up-to-date training on quality measures and standards that could be set by agencies such as the Agency for Healthcare Research and Quality (AHRQ), the Ambulatory Care Quality Alliance (AQA), or other quality standard setting organizations.

SECTION 3

Structure of Health Court

The court would be made up of specialized judges – similar to tax courts, bankruptcy courts, and family courts – with a specific background in medical malpractice to guide decisions on the appropriate standards of care, along with the assistance of independent experts.

SECTION 4

Rulings of the Health Court

Decisions made by the health court would serve as precedent to other courts and act as guidance to the physician community in overall efforts to improve quality and patient safety.

SECTION 5

Report and Evaluation

The Secretary of Health and Human Services would report to Congress, at the conclusion of the five year health court pilot, on the impact of health courts on reducing the cost of medical liability premiums, reducing health care costs associated with defensive medicine, on the predictability and fairness of compensation awarded by the health courts to injured persons, and how the experience of patients and physicians who participated in the health court alternative compared to those who brought a claim through a traditional court. The Secretary shall include recommendations on legislation to convert the health court pilot into a permanent program.