Understanding the Current Fiscal Environment and Its Impact on ACP's Funding Priorities

2014 Leadership Day on Capitol Hill

Background

Where Things Stand

In this election year, Congress continues to be deeply focused on the budget, spending, and the national deficit. ACP's policy priorities will need to be understood in the context of their impact on federal spending. Leadership Day attendees need to be keenly aware that fiscal constraints continue to dominate the landscape and will challenge ACP advocacy efforts. Congressional staff, particularly in Republican offices, will likely question ACP policy priorities that have a cost, regardless of the merit of those priorities. ACP members should continue to focus on advancing ACP's policy priorities based on their expertise as physicians/future physicians and how these issues impact their practices, patients, and local communities. While ACP acknowledges the current fiscal constraints in place, we will continue to work diligently for investments in primary care and other priority programs that we believe will not only improve health outcomes but also help save federal resources in the future.

The background information below provides updates on the current fiscal state of the federal government, including basics about the budget, the annual appropriations process and ACP funding priorities, updates on across-the-board spending cuts known as sequestration and the federal debt ceiling, and several introduced bills that are of importance to ACP. Leadership Day attendees should be familiar with these fiscal issues because they have a tendency to frame much of the debate in Congress, and could also be very relevant in your meetings with lawmakers.

Background

Budget 101

The federal government runs on a fiscal year, from October 1 to September 30. We are currently in fiscal year 2014 (FY2014). This is not to be confused with Medicare, which operates on a calendar year, from January 1 to December 31; for Medicare, we are currently in calendar year 2014 (CY2014).

By law, the President must submit a budget proposal to the legislative branch, no earlier than the first Monday in January, and no later than the first Monday in February, although these deadlines in practice are often missed. The budget proposal is a detailed blue-print for spending and contains specific proposed spending amounts for each federal department and agency and also usually contains legislative proposals on presidential priorities.

The House Budget Committee and the Senate Budget Committee each develop a budget resolution, which is introduced in their respective chamber and voted on by their respective members. The budget resolution lays out the framework for Congress and sets forth spending targets and broad legislative proposals. The budget resolution includes an overall top line discretionary number, meaning the total amount of discretionary spending (defined below) that can be allocated by the Appropriations Committees, but it does not tell the Appropriations Committees how much each department gets in funding. The budget resolution includes legislative text with broad revenue and spending numbers but it does not give explicit language to the authorizing committees how to reach those numbers. The budget resolution is a non-binding resolution, meaning it does not have the force of law and the President does not sign it. The statutory deadline for having a conference budget resolution, meaning both chambers of Congress have passed the same resolution, is April 15, but Congress routinely misses the deadline. For FY2014 and FY2015, the Bipartisan Budget Act (BBA), enacted in December 2013, permits the House and Senate to deem the budget passed by using the previously agreed to overall topline numbers.

The spending side of the federal budget has two main components: mandatory spending and discretionary spending. **Mandatory spending** is not subject to the annual appropriations process and congressional approval. It includes programs such as Medicare, Medicaid, and Social Security. **Discretionary spending** is subject to the annual appropriations process

and congressional approval each year. Discretionary spending can also be called appropriated spending because the money is given out each year through the annual appropriations process, which Congress must approve.

In March, the President released his FY2015 budget proposal, which contains many policies that are largely consistent with ACP policy, including support for federal agencies and health programs that support primary care. Most notable is key funding for Title VII Health Professions programs, the National Health Service Corps, Graduate Medical Education (GME) and public health programs. A detailed analysis of the President's budget can be found here.

In April, the House majority released its FY2015 budget proposal which, for the most part, is not consistent with ACP policy. It seeks to repeal the newly created health exchanges and Medicaid expansion option, as authorized under the Affordable Care Act. It would also turn the Medicaid program into a "block grant," which could reduce the number of people eligible for the program and their benefits, contrary to ACP policy. While this budget did pass the House, it is not expected to be considered by the Senate, nor is there any indication that the Senate plans to craft its own budget.

For more in-depth information about the House Republican FY2015 Budget Resolution and the President's FY2015 Budget proposal, as they compare to ACP policy, please see here.

Appropriations

In order to fund the federal government, Congress must pass their annual appropriations bills by the beginning of the fiscal year, which is October 1. Funding for the various federal agencies and their programs falls under one of 12 appropriations bills. So many of ACP's funding priorities fall under discretionary programs, which means that Congress must agree to fund them every year. If the October 1 deadline is not reached, Congress must pass a continuing resolution—a CR—which funds the government for a set amount of time, routinely at levels equal to the past fiscal year. If an appropriations bill is not passed, then the federal government, departments and agencies do not have any funds and will shut down.

FY2014 Appropriations - Completed: The Consolidated Appropriations Act of 2014 (CAA) (H.R. 3547), also known as an omnibus, became law in January 2014 and included all 12 of the annual appropriations—or spending—bills for FY2014. It funds the entire federal government through September 30, 2014, which means that we do not have to endure the threat of a possible government shutdown over appropriations through September. It includes a topline spending amount of $1.012 trillion in discretionary spending (spending that results from appropriations bills), $520 billion for defense discretionary and $492 billion for non-defense discretionary spending.

FY2015 Appropriations - Underway**:** The annual appropriations process for FY2015 is currently underway, which means Congress is now considering how to fund federal government programs starting on October 1. Both the House and Senate Appropriations Committees intend to consider the 12 appropriations bills, preferably each separately, through their respective committees sometime in the spring. For FY2015, there will be a $2 billion increase in the overall topline discretionary amount, to $1.014 trillion.

With the FY2014 appropriations process complete, ACP is now advocating for funding for key federal health programs, most of which fall under "discretionary" spending, which must be approved by Congress. For Leadership Day this year, we want to see that the following discretionary programs are sufficiently funded come October 1.

- Title VII Health Professions: The health professions' education programs, authorized under Title VII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA), support the training and education of health care providers to enhance the supply, diversity, and distribution of the health care workforce, filling the gaps in the supply of health professionals not met by traditional market forces, and are critical in helping institutions and programs respond to the current and emerging challenges of ensuring that all Americans have access to appropriate and timely health services.

Within the Title VII program, ACP urges funding for the Section 747, Primary Care Training and Enhancement program at $71 million in FY2015, in order to maintain and expand the pipeline for individuals training in primary care. The Section 747 program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefited from Title VII training models emphasizing interdisciplinary training that have helped prepare them to work with other health professionals, such as physician assistants, patient educators, and psychologists. Without a substantial increase in funding, for the fourth year in a row, HRSA will not be able to carry out a competitive grant cycle for physician training; the nation needs new initiatives supporting expanded training in multi-professional care, the patient-centered medical home, and other new competencies required in our developing health system.

- National Health Service Corps (NHSC): This federal program is vital in that it addresses the supply of primary care physicians for adults, which is dwindling while the demand for primary care is expected to grow at a rapid rate. The NHSC provides scholarships and loan forgiveness to enable primary care physicians to be trained to serve underserved communities. The program receives dedicated mandated funding from the Affordable Care Act (ACA) as well as discretionary dollars subject to the annual appropriations process.

  ACP urges $810 million in funding for the NHSC in FY2015, as requested in the President's FY2015 budget; this amount includes the $310 million in already authorized mandatory funding. Since the enactment of the ACA, the NHSC has awarded over $1 billion in scholarships and loan repayments to health care professionals to help expand the country's primary care workforce and to meet the health care needs of underserved communities across the country. With field strength of nearly 9,000 clinicians, NHSC members are providing culturally competent care to more than 10.4 million people at nearly 14,000 NHSC-approved health care sites in urban, rural, and frontier areas. The increase in funds would expand NHSC field strength to 15,000 and would serve the needs of more than 16 million patients, helping to address the health professionals' workforce shortage and growing mal-distribution. The programs under NHSC have proven to make an impact in meeting the health care needs of the underserved, and with increased appropriations, they can do more.

- National Health Care Workforce Commission: ACP urges full funding for the National Health Care Workforce Commission, as authorized by the ACA, at $3 million in FY2015. The Commission is authorized to review current and projected health care workforce supply and demand and make recommendations to Congress and the Administration regarding national health care workforce priorities, goals, and polices. Members of the Commission have been appointed, but have yet to begin work due to a lack of funding from Congress. Most Republican members of Congress have been unwilling to support funding for the Commission because it was authorized by the ACA, which they oppose and have pledged to repeal. The College believes the nation needs a comprehensive workforce policy founded on sound research to determine the nation's current and future needs for physicians by specialty and geographic areas. The work of the Commission is imperative to ensure that federal dollars to support workforce programs and Graduate Medical Education are spent wisely and in the most effective way possible, based on an independent assessment of health care workforce needs Funding for the Commission should be a priority for Congress, without regard to their views on the ACA.

- Agency for Healthcare Research and Quality (AHRQ): AHRQ is the leading public health service agency focused on health care quality. AHRQ's research provides the evidence-based information needed by consumers, clinicians, health plans, purchasers, and policymakers to make informed health care decisions. ACP is dedicated to ensuring AHRQ's vital role in improving the quality of our nation's health and recommends a funding level of $375 million. This amount will allow AHRQ to help providers help patients by making evidence-informed decisions, fund research that serves as the evidence engine for much of the private sector's work to keep patients safe, make the healthcare market place more efficient by providing quality measures to health professionals, and ultimately, help transform health and health care.

- Insurance Marketplaces: ACP supports $629 million in funding for the Centers for Medicare and Medicaid Services, Program Management for Marketplaces as requested in the President's FY2015 budget in order to carry

out its duties as necessary. Such funding would allow the federal government to continue to administer the insurance marketplaces as authorized by the ACA if a state has declined to establish an exchange that meets federal requirements. CMS now manages and operates some or all marketplace activities in over 30 states. Without adequate funding, it will be much more difficult for the federal government to operate and manage a federally-facilitated exchange in those states, raising questions about where and how their residents would obtain and maintain coverage. Inadequate funding would also make it more challenging for CMS to improve the next enrollment process for the marketplace plans created by the ACA, which will begin on November 15, 2014, and to exercise necessary oversight over the marketplace plans (such as oversight to ensure that the plans are meeting physician and hospital network adequacy standards). It is ACP's belief that all legal Americans – regardless of income level, health status, or geographic location – must have access to affordable health insurance, and although the ACA will fall short of covering all Americans, it will substantially reduce the number of uninsured legal residents. CMS need to be provided the funding needed to ensure that the ACA is implemented effectively.

Sequestration Update

The Budget Control Act (BCA), enacted in 2011, put forth instructions that if Congress could not find a means to reduce the federal deficit by a specified amount over a certain time period then across-the-board cuts, known as "sequestration," would be imposed. Sequestration was triggered in March 2013 and set into motion billions of dollars in automatic across-the-board reductions in virtually all federal agencies, which had devastating consequences for many federal health programs. In December 2013, the Bipartisan Budget Act (BBA), H.J. Res 59, was enacted and restored $63 billion over two fiscal years in discretionary spending that would have been cut under sequestration, $45 billion in FY 2014 and $18 billion in FY 2015. The $63 billion was divided evenly between defense and non-defense discretionary spending. The BBA also established the overall topline number discretionary spending level for FY2014 at $1.012 trillion and for FY2015 at $1.014 trillion.

ACP strongly urged Congress to replace the sequestration cuts to essential health programs in 2013 with a more responsible approach that takes into account the importance of each program and its effectiveness. ACP has provided Congress with recommendations for achieving hundreds of billions in healthcare savings in a more responsible way that targets the true cost-drivers in health care. Sequestration, by comparison, arbitrarily cuts highly effective and needed health care programs, such as NIH. Sequestration has also imposed a 2 percent payment cut on physicians, hospitals, and other Medicare providers, which will remain in effect until FY 2024 unless Congress replaces sequestration with a more responsible approach. ACP is pleased that the BBA partially restored sequestration cuts for discretionary spending in FY2014 and FY2015. However, it is important to note the BBA left in place sequestration for certain mandatory spending that was not exempt from sequestration including the sequestration cuts in Medicare payments to physicians and hospitals. Nonexempt mandatory sequestration is 7.2 percent for FY2014 and 7.3 percent for FY2015. Nonexempt Medicare spending is limited to a 2 percent sequester cut to providers by the BCA (the law exempts beneficiaries from the cuts).

Debt Ceiling Update

The debt ceiling authorizes the U.S. Treasury Department to borrow funds up to a certain amount in order to meet the United States' current fiscal obligations, which includes spending authorized by Congress as well as interest on the debt; it is not authority to borrow money for new spending but rather to cover expenses already incurred by the federal government. In February, Congress passed and the President signed into law legislation that extends the debt ceiling borrowing authority until March 15, 2015.

Graduate Medical Education (GME)

GME is a formal clinical training provided by approved residency and fellowship programs to physicians who have received an MD or a DO degree (or a foreign equivalent). It involves a period of training lasting at least three to seven years in which physicians are directly supervised in their learning as they progressively assume more responsibility for patient care.

GME Financing: The federal government recognizes the importance of supporting medical education and is the single largest contributor to GME. Funding is primarily provided through the Medicare program, which is an entitlement program where funding is mandatory. Medicare subsidizes education and training for over 90,000 residents in more than 1,100 hospitals. The number of federally funded GME positions was capped in 1997 and this limit has remained in place ever since, though there have been some exceptions that have allowed for some minor growth.

The costs of GME are recognized by Medicare under two mechanisms: (1) direct graduate medical education payments (DGME) to hospitals for residents' stipends, faculty salaries, administrative costs, and institutional overhead, and (2) indirect medical education (IME) adjustment developed to compensate teaching hospitals for the higher costs associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized services that are available in teaching hospitals. Because the results from IME payments are not as concrete as DGME payments, since the amount is tied to a hospital's Medicare inpatient volume and case mix along with their training program size (subject to their resident cap number), more scrutiny is being given to IME payments. Although the Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME payments teaching hospitals receive are higher than the actual cost of treating Medicare patients, it has not recommended cuts in IME payments. Rather, it has recommended that IME payments be linked to performance measures that teaching hospitals would have to meet in order to receive their full IME adjustment. However some lawmakers have used MedPAC's findings to support cuts to IME as a cost saving measure rather than reallocating those funds.

With increased focus on the national deficit, entitlement programs, such as Medicare, face greater scrutiny. There has been an increased interest in transparency and accountability for the nearly $10 billion that the federal government spends on GME annually. This means that funding for GME is at risk, as noted below, which is of concern to ACP:

- In his FY2015 budget request, President Obama also called for a $14.6 billion reduction of IME payments. The proposal would reduce IME payments by 10 percent, beginning in 2015. In addition, the Health and Human Services Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high-value health care delivery. ACP is not supportive of the proposal, and believes that GME funding should be preserved so that training programs can develop the most robust programs and meet the requirements stipulated by their Residency Review Committees (RRCs). However, ACP acknowledges that there needs to be more transparency and accountability to ensure funds are appropriately designated toward activities related to the educational mission of teaching and training residents with the skills and experiences necessary to meet the nation's health care needs. ACP has not endorsed recommendations by MedPAC and others to create a performance-based GME payment system. The College acknowledges that such a system is an idea that is worth exploring but cautions that it should be thoughtfully developed and considered in a deliberate way to ensure that goals are achieved without destabilizing the system of physician training. More details on the College's policy on the issue can be found here.

- Congress, in its effort to find obligatory offsets to pay for the cost of various pieces of legislation, has targeted GME funding in years past. This threat continues to exist today as Congress continues to search for ways to pay for its legislative initiatives.

- The federal government's vital investment in training physicians also is threatened by the automatic 2 percent across-the-board cut in Medicare program payments to physicians and hospitals, including Medicare GME payments, as a result of the "sequester" mandated by the BCA which has been extended to FY2024 by the one-year SGR patch bill, the *Protecting Access to Medicare Act of 2014* (H.R. 4302).

GME Reform: There have been calls for broad reform of the Graduate Medical Education (GME) system to achieve a greater alignment of financing with the public's health care workforce needs. The Institute of Medicine has formed a committee that will develop a report with recommendations for policies to improve graduate medical education (GME), with an emphasis on the training of physicians. Specific attention will be given to increasing the capacity of the nation's clinical workforce that can deliver efficient and high quality health care that will meet the needs of our diverse population.

To that aim, in developing its recommendations the committee will consider the current financing and governance structures of GME, the residency pipeline, the geographic distribution of generalist and specialist clinicians; types of training sites; relevant federal statutes and regulations; and the respective roles of safety net providers, community health/teaching health centers, and academic health centers.

In addition, the President has outlined in his FY2015 budget proposal targeted support for GME. The budget requests $530 million in FY2015 for a new competitive grant program that will fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training, with a focus on ambulatory and preventive care, in order to advance the Affordable Care Act's goals of higher value health care that reduces long-term costs. The new Targeted Support for Graduate Medical Education Program will incorporate two existing HRSA programs, the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. Current awardees in those programs will be eligible to compete for funding through the Targeted Support's competitive grant program, with a minimum of $100 million set-aside specifically for children's hospitals in FY 2015. The Budget proposes to continue mandatory funding for the new Targeted Support for Graduate Medical Education program annually in FYs 2015-2024, for a total investment of $5.2 billion.

The President's budget is meant to support 13,000 residents over 10 years, which is consistent with ACP policy of expanding GME slots although insufficient to reverse a growing shortage of primary care physicians for adults and other specialties (including many internal medicine subspecialties) also facing shortages. 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.

As outlined in ACP's policy paper entitled, *Aligning GME Policy with the Nation's Health Care Workforce Needs*, ACP makes the following key recommendations to Congress.

- GME financing should be transparent, and all payers should be required to contribute to a financing pool to support residencies that meet policy goals so that the costs of GME financing are spread across the health care system.
- Payment of Medicare GME funds to hospitals and training programs should be tied to the nation's health care workforce needs and place a priority on primary care in order to create a well-functioning health care system.
- GME caps should be strategically lifted, as needed, to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages.

The existing GME caps need to be strategically adjusted to increase the number of funded positions in specialties that have been shown by independent studies to be facing the greatest shortages, including internal medicine and other primary care disciplines. However, Congress would have to agree to enact these increased funding levels and the caps for the specific specialties facing the greatest shortages; if these specialties receive increased funding, overall GME funding levels would have to increase to maintain current GME funding levels for all other specialties. The AAMC has recommended that all GME caps and funding for all specialties be increased, which would add hundreds of billions of dollars more to Medicare expenditures on GME. While ACP agrees with the AAMC on the need for adequate GME funding, we have recommended the more strategic approach described above of selectively increasing GME funding for programs to train physicians in the specialties facing the greatest shortages. ACP also supports the concept of all-payer financing of GME, which would require that all insurers contribute to a fund to finance GME as a public good. Spreading the base of funding to all payers would help ensure sufficient and stable funding for GME and relieve Medicare from bearing a disproportionate share of the funding.

ACP-Endorsed Legislation: Several bills have been introduced that address the need to increase funding for graduate medical education and to strategically lift the caps on GME residency positions, particularly for primary care specialties.

- *The Resident Physician Shortage Reduction Act* (S. 577 and H.R. 1180), 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 Michael Grimm (R-NY), will increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. Specifically, the bill will provide for approximately

15,000 additional GME positions for medical residents. It will require at least 50 percent of the new positions to be allocated to specialties such as primary care that are currently facing a shortage. The current Medicare GME funding limits on residency training positions are impeding 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 by strategically increasing the number of Medicare-funded GME positions in adult primary care specialties, as this bill proposes to do.

- *Training Tomorrow's Doctors Today Act* (H.R. 1201), introduced in the House by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), authorizes the Secretary of Health and Human Services to increase the number of GME slots by 15,000 over the next five years, providing additional opportunities for residents who choose careers in primary care or general surgery as it mandates that any hospital that receives funding for additional residency positions shall ensure that not less than 50 percent of the new slots are used to train residents in primary care or other residents in specialties facing shortages.

  H.R. 1201 would also establish and implement procedures under which payment for indirect medical education is adjusted based on the reporting of quality measures of patient care specified by the Secretary of Health and Human Services. ACP believes that the concept of a performance based GME payment system is worth exploring but cautions such a system must be thoughtfully developed and evaluated with input from a variety of stakeholders including physicians involved in primary care training.

- *The Primary Care Workforce Access and Improvement Act* (H.R. 487), introduced in the House by Representative Cathy McMorris Rogers (R-WA), authorizes the Secretary of Health and Human Services to conduct a five-year Medicare pilot project that would direct a share of Graduate Medical Education funding to medical education entities to test different models of primary care training. This bill gives the HHS Secretary the authority to test new models of care that demonstrate the capability of improving the quality, quantity, and distribution of primary-care physicians. Improved models of ambulatory training and exposure to team-based approaches to patient care, such as the patient-centered medical home, are essential to making careers in general internal medicine and other primary care specialties more attractive and relevant.

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

The Affordable Care Act at Age Four

2014 Leadership Day on Capitol Hill

Background

Where Things Stand

The Affordable Care Act (ACA) was enacted in March 2010 – just over four years ago – implementing sweeping reforms across the health care system. It remains controversial to this day, just as it was when it was enacted. This stems not only from the continued partisan differences between Republicans and Democrats on the merits of the law but also because it ushered in comprehensive changes to how health care is delivered in this country, which concerned many Americans in terms of how it would affect them personally. A recent study concluded that Americans are still conflicted about the law, but are less negative about its impact.

Enrollment

The majority of the ACA's many provisions take effect in 2013 and 2014 and, with few exceptions; the rollout of its many policies since 2010 has gone well, as so many Americans are now enjoying the many protections afforded by the law. Since enrollment began in the new health insurance marketplaces on Oct. 1, 2013, preliminary estimates indicate that as of April 15, over 8 million Americans have obtained coverage through a qualified health plan offered through an exchange (either through a federally operated exchange, or a state-run exchange); this exceeds the original enrollment estimates set by the Congressional Budget Office (CBO) prior to the troubled roll-out of the healthcare.gov portal last Fall. Several hundred thousand people have obtained coverage from an ACA-qualified plan that they purchased from an insurance company or broker outside of the exchanges. Although the exchange open enrollment period for this year ended on April 15, people whose circumstances change (such as by having a baby) can continue to enroll in a qualified health plan throughout the year. In addition, another 5 million have been estimated to have obtained coverage through Medicaid or the Children's Health Insurance Plan (CHIP) program, and several million people under the age of 26 have obtained coverage through the ACA under their parents' plans. As a result, the total number of people who have obtained coverage through the ACA is estimated to be between 14.4 and 23.5 million.

Even though there is still much to be learned about ACA enrollment in 2014, the numbers to date show that the law is meeting ACP's goal of substantially expanding coverage to the uninsured and offering improved benefits and consumer-protections to many more.

The Politics

The political parties continue to be divided on the ACA. Most Democrats are unified in their support for it, and continue to tout its benefits and protect its funding, although some Democrats running for re-election in more conservative parts of the country are reluctant to champion their support for the ACA and/or are seeking changes in it (but not repeal). Republicans continue to try to dismantle the law, by every means available to them, including scheduled House votes to repeal it or by restricting funding for its many provisions through the appropriations process. Not to over simplify the arguments, but to most Republicans, the law represents a massive federal reach into the lives of most Americans, where government controls how care is delivered. Many Republicans also are concerned that the country cannot afford the ACA, even though the CBO says it will lower the deficit. The negative stigma of the ACA is so strong with most Republicans that the mere mention of most policies derived from it is met with scrutiny. Yet the ACA relies principally on competition between private insurers to expand coverage with government premium subsidies and consumer protections; it does not give the government the authority to regulate the decisions of physicians and other providers or ration benefits.

To Democrats, the law means expanding access to health care for millions of uninsured Americans, ensuring that all health plans provide coverage for services like mental health and prevention, prohibiting insurance company practices that exclude or overcharge people with pre-existing conditions, and banning annual and lifetime caps on benefits. Some Democrats prefer a single payer system, but believe that the ACA is a step toward the goal of universal coverage. Most

Democrats agree that the ACA is an historic achievement, on par with the creation of Medicare in 1965, in extending access affordable health care.

The gap between each party's views on the ACA is so great that they have been unable to achieve bipartisan consensus on its future or possible changes in it.

ACP offered a qualified endorsement of the ACA when it was enacted in 2010 because, on balance, it advances many of ACP's key priorities related to: expansion of health coverage to nearly all legal U.S. residents; payment and delivery system reforms to support primary care; and workforce improvements that will help ensure that all patients have access to an internist. The ACA is not a perfect product, but it takes substantive steps to improve upon our broken health care system, which is not sustainable without such reforms. Over the past few years, the College has urged Congress to fully fund the ACA but to also improve upon it and advance other reforms, as described in more detail below. ACP's intent all along has been to advocate in a constructive way to help ensure that implementation of the ACA will be the best that it can be.

The background information below outlines key ACA provisions of importance to the College and their status four years after enactment of the ACA. While we have no specific "asks" of Congress on these provisions, Leadership Day attendees should be familiar with these issues as they are routinely discussed in congressional offices.

Background

Health Insurance Exchanges

The ACA establishes health insurance exchanges, which are marketplaces that offer one-stop-shopping to eligible individuals and small businesses to purchase more affordable health insurance coverage that fits their own needs. Each state had an option to establish its own exchange and make it operational by October 2013, allow the federal government to operate an exchange for them, or create a quasi-federal-state exchange to operate in the state.

In 2011, states began receiving funding to help establish and operate the exchanges but by 2015 they must be self-sufficient. Open enrollment for all state, federal, and partnership exchanges began on October 1, 2013, with a very rocky rollout of the federal enrollment portal and in some states as well. Those technical difficulties appear to have been largely remedied but the federal government and some states elected to extend the deadline for open enrollment beyond April 1, 2014 for extenuating circumstances. More information about the enrollment period can be found here.

As of April 2014, 17 marketplaces are operated by states, 27 are run by the federal government, and 7 are partnership marketplaces managed by the state and federal government. The federal government has distributed over $3.8 billion to states to help fund their exchange planning and implementation activities. To view where each state stands on establishing an exchange, please see here.

As noted earlier in this document, over 8 million people have obtained coverage through a qualified plan offered in an exchange. Although it is not yet known how many of the more than 8 million have paid their premiums for their qualified exchange plans, preliminary estimates are that more than 85 percent will end up doing so, which is typical for other health insurance options offered through an open-enrollment process. Some of the people who will end up not paying their premium will have gotten coverage through an employer, causing them not to continue coverage through an ACA exchange plan.

It also is not known yet precisely how many of the people who obtained coverage to date through the ACA were previously uninsured. The Rand Corporation estimates that approximately 9 million of the people who obtained coverage were previously uninsured. Gallup and other polling firms have also reported a substantial decrease in the number of surveyed Americans who say they are without health insurance coverage. The CBO projects that 12 million previously uninsured persons will obtain coverage in 2014.

It also is not known precisely how many of the newly enrolled through the exchanges are younger people, although the Administration reported on April 15 that 35 percent were under the age of 35. Most independent experts expect that enough young people will have enrolled to prevent a "death spiral" in premiums.

It is estimated that approximately 3 percent of the population, or about12 million people, had the health plans they had bought on the individual insurance market (non-grandfathered plans) canceled because they did not meet the ACA's benefit, cost-sharing, consumer protection, and other standards. They were offered the opportunity to buy a plan that meets the ACA's requirements. Many were able to find a plan with comparable premiums, cost-sharing and benefits, although some of them ended up paying more than they were before, and/or felt that they were being forced to buy a plan with benefits they did not want. Many others were able to buy a better ACA-qualified plan at a premium they could afford, especially since more than 70 percent of them qualified for the ACA's premium subsidies. The Administration also made it easier for people to continue to keep their "cancelled" policies if their state agrees. The Rand Corporation recently reported that fewer than a million of those whose insurance was cancelled remain without health insurance.

You may be asked in Republican offices about the "canceled" insurance policies and whether more people lost coverage as result than gained it. Although it is not advisable for you to debate the ACA with them, factually speaking (and as noted above), the millions who have gained coverage far outnumber the relatively small percentage of the population that had their individual plans canceled and had to pay more and/or were unable to find an affordable replacement policy. Yet it is true that some people who had their policies canceled, and in some cases are now paying more for a replacement policy, have expressed strong unhappiness to their members of Congress about being forced to switch. ACP cautions you not to express personal agreement with comments you may hear in Republican offices that contradict ACP's support for the ACA—remember, you are representing ACP—but to listen politely, and offer to have the ACP staff send more information on the enrollment numbers, and any other information on why the College supports the ACA, if asked.

Finally, the vast majority of Americans who get coverage from their large employers are mostly unaffected by the changes that the ACA made this year, since their plans already meet the ACA's benefit and consumer protection requirements. In addition, the deadline by which large employers had to offer a plan that meets the ACA's requirements or pay a penalty was delayed by the Administration for one year, until January 1, 2015.

ACP believes that the successful implementation of these health insurance exchanges, along with coverage expansions for the uninsured, is critical to ensuring near universal health coverage for this nation's citizens and legal residents, a long-held policy goal of the College. At the same time, ACP has offered recommendations to the Administration and those involved in implementing the exchanges on the potential challenges that can create barriers to care. The trend to narrow provider networks and to restrictive formularies, which can make it difficult for patients to see the physicians they trust and get the medications they need. While such trends pre-date and are not limited to health plans offered through the ACA, ACP observed that the federal government has a particular responsibility to address such barriers to access in federally qualified plans. State regulatory agencies and the insurance industry itself also have important roles. In a February 2014 letter to then-Administrator of Health and Human Services, Kathleen Sebelius, ACP called for a balanced, constructive and transparent approach to allow patients/consumers to make informed choices, to reduce unnecessary interruptions in continuity of care, and to ensure fairness and due process for clinicians and patients, including improvements in federal and state regulatory oversight of qualified health plans.

Subsidies

Equally important are the subsidies provided through the ACA, not only to individuals and families but to small business as well. The ACA provides tax credits, starting in 2014, to assist U.S. citizens and legal residents who do not have access to health coverage through the exchanges to purchase it on their own. The tax credits are available on a sliding-scale basis to people with incomes between 133 percent and 400 percent of the Federal Poverty Level. As for small businesses, the ACA provides tax credits to small businesses to help them purchase employee health insurance. Beginning in 2014, the amount of the tax credit is a maximum of 50 percent of the employer's contribution (35 percent for non-profit firms) towards their employees' health insurance premium.

Medicaid Expansion

Beginning in 2014, the ACA includes a provision giving states the option to expand Medicaid eligibility to individuals with incomes at or below 133 percent[1] of the federal poverty level, which translates to $14,856 for an individual and $30,657 for a family of four, although actual income amounts will be updated in 2014. The federal government pays the full cost of this expansion from 2014 through 2016 and finances no less than 90 percent of the cost in subsequent years. When the ACA was enacted in 2010, this provision required states to expand their Medicaid programs or risk losing their federal Medicaid funds for their existing Medicaid programs. However, after numerous states filed lawsuits against the federal government citing that this provision of law was unduly coercive, the U.S. Supreme Court ruled that the financial penalty on the states for not expanding their Medicaid programs was unconstitutional. Therefore, on June, 28, 2012, the Supreme Court gave states the option to expand their Medicaid program without the threat of a reduction in federal funding.

Most Republicans in Congress are strongly opposed to the ACA's Medicaid expansion, for ideological (overall opposition to the ACA), fiscal (concern that it will cost federal taxpayers too much), and other reasons. Instead, congressional Republicans generally support movement toward a finite "block grant" to states for use in caring for their uninsured and underinsured. Under a block grant, the federal government would provide a set amount of money to the states to use as they see fit to provide coverage to the poor, providing flexibility to the states to determine eligibility, benefits, and other decisions now set by federal law but ending Medicaid as a guaranteed benefit (entitlement) program for eligible persons. The block grants also would likely provide much lower levels of funding to the states compared to the current federal "match" and the additional funds being provided through the ACA. Republicans called for "block-granting" Medicaid in their budget resolution that passed the House on April 10, 2014 but has no chance of succeeding in the Democrat-controlled Senate.

Most Republican governors have so far declined to accept the offer of federal dollars to expand Medicaid to persons up to 133 percent of the FPL, again for ideological reasons (opposition to the ACA) and also, because of concerns that Medicaid expansion will cost the states too much, that the federal government cannot be counted on to provide the funds authorized by the ACA, and because they want more flexibility in how the program would be implemented in their states. However, as of April 2014, 27 states including the District of Columbia have come out in favor of accepting the ACA's dollars to expand Medicaid, including several states with Republican governors and/or legislatures, arguing that it is in the best interests of their states, both fiscally and in terms of access to care for their poorer residents.

Under the ACA, there is no deadline for a state to expand Medicaid, although the amount of federal funding will gradually decline from 100 percent to 90 percent over the next seven years—so states that wait will be leaving federal dollars behind for each year that they wait. In exchange for agreeing to expand Medicaid, some governors from more conservative states (Republicans but also some more conservative Democratic governors) are seeking waivers from the Obama Administration to "privatize" Medicaid by turning it over to managed-care plans. The Obama Administration has indicated a willingness to allow such privatization as long as the benefits, eligibility and cost-sharing standards for enrolled persons are generally the same as conventional Medicaid. The Obama Administration, congressional Democrats, and virtually all Democratic governors strongly support the ACA's Medicaid expansion provision, arguing that it is essential to ensure access to care for the poor and near-poor. To view where each state stands on expanding their Medicaid program, please see here.

As noted earlier in this document, ACP believes it is critical that states choose to participate in Medicaid expansion in order to achieve near universal health coverage for all citizens and legal residents in this country. This provision is consistent with long-standing ACP policy for expanding Medicaid to all of the poor- and near-poor. If all states participate, this provision would expand coverage to up to 33 million previously uninsured people in 2022—resulting in coverage for about 94 percent of all legal residents. ACP is particularly concerned that people with incomes at or below the federal poverty level *will have no access to subsidized coverage* if their states turn down ACA's Medicaid expansion.

[1] The ACA expands Medicaid to 133 percent of the federal poverty level plus a 5 percent technical adjustment, which increases the eligibility level to 138 percent.

This is because under the ACA, Medicaid coverage is the *only* coverage option available for persons with incomes at or below the FPL—they are ineligible for subsidized coverage through the health exchanges, because Congress, when it enacted the ACA, could not have anticipated that the Supreme Court would have made the Medicaid coverage optional for the states. This means that many of the most vulnerable and poorest persons will have no access to coverage in states that turn down the Medicaid expansion.

In September 2012 and again in March 2014, ACP initiated the involvement of its chapter governors to influence state governments to accept federal funding to extend Medicaid coverage to their poorest residents. Dubbed the *ACP Medicaid Patient Advocacy Campaign*, this effort provided chapters with uniquely-customized state-specific reports on the benefits of states accepting federal dollars to expand their Medicaid programs. Based on available information to date, almost all ACP chapters are participating in this campaign.

Patient Protections and Insurance Market Reforms

The ACA also created new patient protections and other reforms designed to curb abuses by health insurers. Starting in 2010, new requirements for health insurers were put in place, many of which are expanded in 2014. Some key examples include: increasing the age to 26 for which dependents can remain covered under their parents' health insurance, banning pre-existing conditions exclusions for children in 2010 and for all starting in 2014, restricting insurers from imposing annual or lifetime dollar limits on coverage, requiring insurers to cover core preventive services such as immunizations and other services recommended by the U.S. Preventive Services Task Force. And, starting in 2011, if an insurer in the small group market directs less than 80 percent of an individual's premium to anything other than to clinical and quality care improvement costs (85 percent in the large group market), the insurer will be required to refund the difference to the enrollee.

Enhanced Medicaid Reimbursement Rates for Primary Care Services

The ACA includes a provision to increase Medicaid payment rates for certain primary care services to at least the level of Medicare in 2013 and 2014. This is the Medicaid Pay Comparability Program of the ACA. This initiative provides for higher Medicaid payments to physicians practicing a specialty designation of family medicine, general internal medicine or pediatric medicine. It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association and the American Board of Physician Specialties. The continued preservation and enhancement of this provision is a top priority for ACP for Leadership Day this year and for the rest of 2014, and those details are discussed in the backgrounder, *Expiring Payment Policies Could Mean Cuts to Primary Care and Other Internists' Services*.

Medicare Bonus Payment for Primary Care Services

In calendars years 2011-2015, the ACA provides a 10 percent bonus payment on select primary care services furnished by primary care physicians. To qualify for the bonus, a physician must be self-designated in a primary care specialty, defined as general internal medicine, family practice, geriatrics, and pediatrics, and he or she must predominantly provide select primary care services to be eligible. This program is a priority for ACP but because it is an election year and the program does not expire until the end of 2015, ACP will not be actively pushing for an extension of the program during this Leadership Day. However, Leadership Day attendees need to be familiar with it and be prepared to discuss it with lawmakers as another critical component in helping to ensure access to primary care services. More details about this program can be found in the backgrounder, *Expiring Payment Policies Could Mean Cuts to Primary Care and Other Internists' Services*.

Support for Primary Care

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of over 45,000 primary care physicians by 2020, growing to a shortage of over 65,000 primary care physicians by 2025.

The ACA contained numerous key provisions to enhance the primary care workforce, including improvements to loan and scholarship programs under Title VII of the Public Health Service Act that help recruit and retain medical students in the practice of primary care. The ACA also permanently reauthorized the National Health Service Corps (NHSC), a federal program that provides scholarship and loan forgiveness to enable primary care physicians to be trained to serve in underserved communities. It includes an increase in full-time awards for the NHSC from $35,000 to $50,000 per individual and a new part-time award program. The ACA also redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots for primary care and general surgery. Sixty-five percent of the slots must be redistributed to primary care and general surgery. Funding for these programs is an important priority for ACP at Leadership Day and those specific details can be found in the backgrounder, *Understanding the Current Fiscal Environment and Its Impact on ACP's Funding Priorities*.

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

Attendees wishing to gain a broader understanding of the Affordable Care Act can view ACP's Internist's Guide to Understanding Health System Reform.

The Quest for SGR-Repeal: The Progress and Challenges to Date

2014 Leadership Day on Capitol Hill

Background

Where Things Stand

The issue of reforming Medicare's physician payment formula, known as the Sustainable Growth Rate (SGR), has been a long-sought priority of organized medicine for the last 10 years. In fact, it is difficult to remember a time when ACP has not been advocating for repeal of the SGR, which indicates just how great the challenges have been in Congress to find bipartisan agreement on a solution to the SGR dilemma.

We are in a different place this year with the SGR, under completely different circumstances than in years past, because a bipartisan, bicameral agreement has been reached among the chairs and ranking members of the Medicare committees in Congress on the fundamental policy reforms to replace the SGR formula. Since May 2013, we have seen unprecedented progress by the Medicare authorizing committees in the House and Senate in crafting legislation that eliminates the SGR and moves us toward a value-based payment and delivery system. On Feb. 6, 2014, the *SGR Repeal and Medicare Provider Payment Modernization Act* (H.R.4015 in the House and S. 2000 in the Senate) was introduced, with the support of the chairman and ranking members of the House Ways and Means, House Energy and Commerce, and Senate Finance Committees. ACP applauded this effort and fully endorsed the legislation, along with so many related subspecialties. This legislation gives us reason to be more optimistic about the chances for SGR-repeal. Our chance has finally come, in 2014, to finally get rid of the SGR forever, and we have the legislation to do it now. If SGR-repeal is allowed to fail in 2014, we will lose momentum on all the progress that has been made to date, and will have to start all over again in the 114th Congress. Enactment of this legislation is a top priority for Leadership Day this year.

Our optimism over the progress that has occurred is tempered with doubt because a significant challenge remains in getting SGR-repeal across the finish line: how to pay for it. Republicans and Democrats in Congress are at loggerheads over how to come up with the estimated $124 billion dollars to pay for SGR-repeal, or whether to even pay for it at all, which is discussed in detail in the background below. These differences of opinion among the parties on how or whether to pay for SGR-repeal cannot be underestimated in this tight budget environment, especially in an election year when each party wants desperately to hold the majority. And yet, in its perverse reasoning, Congress proceeded to pass legislation on March 31 enacting a one-year delay, at a cost of $15.8 billion, in scheduled SGR cuts that were supposed to take effect on April 1. These SGR "patches," as they are known, have been enacted virtually every year since the SGR formula was created, which only serves to increase the cost every year of full SGR-repeal. Nearly all of medicine opposed this patch.

In light of these factors, advocacy on the SGR issue has never been more important than this year. At Leadership Day and throughout the year, ACP will be aggressive, by every means necessary, in our efforts to influence the political will of Congress to get SGR-repeal done this year. Background information on the SGR is provided below, including the very basics of the SGR formula itself, an explanation of the *SGR Repeal and Medicare Provider Payment Modernization Act*, more details of the politics surrounding the issue, and key aspects of our advocacy efforts to date.

Background

The Sustainable Growth Rate Formula: the Basics

The SGR formula was enacted by Congress as part of the Balanced Budget Act of 1997 (BBA). This outdated formula determines payments to physicians for the services they provide under Medicare. Specifically, the formula limits growth in spending for physicians' services by linking updates to target rates of spending growth. A critical factor in the determination of the target rate is projected growth in the real gross domestic product (GDP) per capita. The law provides for a mechanism for enforcement of the target rate of growth. When spending increases exceed the targeted rate of growth, payments are automatically reduced across the board. Since the formula does not accurately keep pace with the actual cost of physicians' services, this typically results in scheduled payments cuts to physicians under Medicare virtually every year.

The SGR formula does not control volume and, in fact, cuts payments without regard to the quality or efficiency of care provided by an individual physician. Every year since 2001, the current, fatally flawed SGR formula has threatened to impose steep cuts in Medicare physician fee schedule payments for care provided to America's seniors. While Congress

typically acts to avert payment reductions, the average Medicare payment rate this year is essentially the same as it was in 2001.

Key Components of the *SGR Repeal and Medicare Provider Payment Modernization Act*

This legislation was introduced on Feb. 6, 2014 as the *SGR Repeal and Medicare Provider Payment Modernization Act*, H.R. 4015/S. 2000. It represents unprecedented bipartisan agreement on the part of the three committees in the House and Senate with jurisdiction over Medicare, the House Energy & Commerce and Ways & Means Committees and the Senate Finance Committee, on policy to repeal Medicare's SGR formula and replace it with a new value-based payment and delivery system. All three committee unanimously approved the legislation.

H.R. 4015/S. 2000 halts all scheduled SGR cuts, restores more than a hundred billion dollars to payment for physician services, offers multiple opportunities for physicians in private practice to earn higher updates, and gives the profession the leading role in offering alternative payment models, and designing the measures to evaluate performance.

This bill is the product of an unprecedented effort by organized medicine: it is supported not only by ACP, but also the American College of Surgeons, American Academy of Family Physicians, American Medical Association, and almost all of the state medical societies and specialty societies. View the joint support letter here. The impact of this legislation on physicians is as follows and a more detailed accounting of how its provisions are an improvement over current law can be found here:

- It guarantees positive baseline updates for 5 years, versus a 24 percent cut on 4/1/2014 (and likely more SGR cuts afterwards). Even if Congress were to override the next SGR cut, past practice tells us we would get another multi-year freeze, at best--and quite likely, across-the-board cuts.
- The SGR results in scheduled pay cuts no matter what you do, versus giving you the opportunity to earn higher updates for quality improvement or being in a Patient-Centered Medical Home or other Alternative Payment Model. Physicians are empowered to determine your own annual update, above and beyond the baseline updates, based on your performance in a new merit-based incentive program or participation an alternative payment model (APM). Under current law, all physicians get the same (negative) scheduled SGR updates.
- It adds $128 billion to physician payments over 10 years versus $120 billion in cuts from the SGR, at a time when fiscal realities are causing across-the-board cuts in many other programs.
- It cancels the existing Physician Quality Reporting System (PQRS) and EHR Meaningful Use penalties at the end of 2017, adding these dollars back to physician payments instead of going to the federal government. Under current law, you could be facing the following penalties in 2018:
  - ✓ PQRS -2.0 percent in 2018 and beyond
  - ✓ Meaningful Use -4 percent in 2018, -5 percent in 2019
- It also cancels any potential negative adjustments that physicians may face as part of the Medicare Value-Based Payment Modifier Program in 2018 and beyond.
- It unifies the current PQRS, Meaningful Use, and Medicare Value-Based Payment Modifier program into a single reporting program starting in 2018, creating an opportunity for us to work to harmonize measures and streamline reporting.
- Certified Patient-Centered Medical Home (PCMHs) and PCMH subspecialty practices will get the highest possible scores for clinical practice improvement under the new Merit-based Payment Incentive System and will be able to bill and be reimbursed for chronic care management starting in 2015; advanced PCMHs can qualify as an APM and get 5 percent annual bonuses for six years without taking direct financial risk.
- It provides $40 million per year in technical assistance to small practices.
- It mandates a process to improve the accuracy of Medicare relative value units (RVUs).

Congressional Action on the SGR in 2014

SGR-Repeal Legislation:

The introduction of the *SGR Repeal and Medicare Provider Payment Modernization Act* (H.R. 4015/S. 2000) on Feb. 6 set in motion a series of activities in both the House and Senate that only accelerated with the approach of the April 1 scheduled SGR cuts. Soon after introduction, it was clear that a vote on H.R. 4015/S. 2000 was only going to come after direct negotiations between leaders of the House and Senate took place on how to pay for it – only they were not talking, much to the dismay of ACP and most of medicine. Despite agreement on the policy behind H.R. 4015/S. 2000, Republicans and Democrats were far apart, and still are, on how to deal with the budget impact of this legislation and SGR-repeal in general. In April, the Congressional Budget Office (CBO) estimated the cost of SGR-repeal at $124 billion. The *SGR Repeal and Medicare Provider Payment Modernization Act*, as introduced, is estimated to cost $138 billion, as it contains related policies that have a cost impact. Republicans and Democrats have fundamental philosophical differences over how to pay for the cost of SGR-repeal or even if it should be paid for. Rather than work together, in a serious way, to find common ground on how to address the budget impact of SGR-repeal, Republicans and Democrats have remained to this day entrenched in their differing opinions on the matter.

Republicans have been insisting that SGR-repeal be paid for and, on Mar. 14, 2014, the Republican-controlled House passed H.R. 4015 with a "pay for" that delayed the Affordable Care Act's (ACA) individual insurance mandate for five years, which ACP opposed because it was contrary to existing College policy. Delaying the individual insurance requirement, according to the CBO, will increase the number of uninsured and result in higher premiums. Also, by linking enactment of H.R. 4105 with a provision to fundamentally alter the ACA by delaying the individual insurance requirement, the GOP-controlled House knew that it was passing a bill that would be unacceptable to the Democratic-controlled Senate and President Obama. The Obama Administration issued a statement that the President would veto the bill if sent to him with a delay in the ACA's individual insurance requirement.

The Democratic-controlled Senate refuses to consider H.R. 4015/S. 2000 with a "pay for" that in any way harms or dismantles the ACA. In the Senate, agreement on how to bring SGR-repeal legislation to the floor for a vote – even among Democrats – has been fraught with difficulties. The Senate Finance Committee was chaired by then-Senator Max Baucus (D-MT) at the time that agreement was reached on S. 2000 on February 6. Senator Baucus shortly thereafter resigned from the Senate to become ambassador to China. He was replaced by Senator Ron Wyden (D-OR) as the new Chairman of the Finance Committee. Chairman Wyden has been diligent in his efforts to enact SGR-repeal legislation this year. In March, Senator Wyden introduced two bills (S.2110 and S.2157) with identical policy to that contained in the *SGR Repeal and Medicare Provider Payment Modernization Act* plus extension of several other expiring health-related programs–but each with different methods of addressing the budget issue (e.g. one includes a "pay for" that uses unspent war funds, called Oversees Contingency Operations—OCO—funds, the other offers no "pay for"). Majority Leader Reid has not yet scheduled any SGR-repeal legislation for floor consideration in the Senate this year. Meanwhile, the reaction of House leaders and key Senate Republicans, including Senator Orrin Hatch (R-UT), the ranking member of the Senate Finance Committee, to the "pay fors" proposed by Senator Wyden has been that of opposition, believing that unspent war funds are not a legitimate source of funding (i.e. budget gimmicks) and no "pay for" is just as objectionable because it would (on paper) raise the national deficit another $138 billion.

As of May 1, talks are at a standstill between the House and Senate on the matter with no real urgency for action because an SGR "patch" was enacted in law on April 1, delaying scheduled SGR cuts until April 1, 2015.

SGR "Patch" Legislation:

On April 1, 2014, the President signed into law H.R. 4302, legislation delaying a scheduled 24 percent SGR cut until April 1, 2015. This was the 17th SGR "patch" in the last 11 years. Despite strong urging from most physician organizations, including ACP and its Advocates, that Congress vote down the "patch" and stop pushing off permanent SGR-reform to the future, both the House and Senate succeeded in passing H.R. 4302. In a March 31 statement, ACP expressed disappointment and frustration on Senate passage of the "patch," as it had a few days earlier when the House passed the measure. Although ACP clearly did not want the 24 percent scheduled SGR cut to go into effect on April 1, the College opposed the patch—even though it would postpone the cut until April 1 of 3015—because another patch would give Congress an excuse to put off action on permanent SGR repeal until the 114th Congress. Instead of a patch, ACP argued that Congress could stop the 24 percent scheduled SGR cut on April 1, and all future SGR cuts, by passing permanent repeal based on the bipartisan, bicameral bill agreed to by the Medicare committees.

During floor consideration of H.R. 4302, debate on the measure was fierce with many members of Congress on record as wanting full SGR-repeal but under intense pressure by chamber leaders to agree to another "patch" so scheduled cuts did not go into effect. In those final days leading up to April 1, the issue became so politically charged that passage of H.R.4302 was not assured in either chamber. In a last-minute sleight-of-hand, the House even resorted to passing the measure by voice vote when no one was in the chamber to object because it did not have the required support of 2/3rds majority of House members to secure passage. The implications of that voice vote meant that no House members were held accountable for how they would have voted on the measure because there was no recorded vote. The Senate passed H.R. 4302 by a recorded vote of 64 to 35.

ACP Advocacy and Next Steps

ACP advocacy on permanent SGR-repeal has been steadfast since the three Medicare authorizing committees began crafting the bipartisan legislation that was eventually introduced as the *SGR Repeal and Medicare Provider Payment Modernization Act* (H.R.4015/S. 2000) on Feb. 6, 2014. ACP fully endorsed this legislation, as introduced, and diligently worked in collaboration with nearly all of organized medicine to convince Congress to pass it before the April 1, 2014 scheduled SGR cut. ACP was both disappointed and frustrated when Congress could not muster the political will necessary to shepherd this legislation through both chambers before April 1.

The main obstacle standing in the way of enactment of H.R. 4015/S. 2000 has been the failure of Congress to find agreement on the budget impact of SGR-repeal. Throughout the entire process, ACP has stated that it is Congress' responsibility to decide how to pay for the cost of SGR-repeal, as budget matters do not fall within the expertise of ACP or its members. For that reason, we have not offered specific offsets applicable to SGR-repeal. What we have proposed, since 2011, is a broad array of policy reforms that, if enacted, could produce significant savings to the federal government, but at no time did we offer them as a possible offset for the cost of SGR-repeal.

As noted above in the context of H.R. 4015/S. 2000, both the House and Senate have put forth possible ways to offset the cost of SGR-repeal. Those ideas included: delaying the ACA's individual insurance mandate, as put forth by House Republicans; using billions in unspent war funds known as Overseas Contingency Operations (OCO) funds that would no longer be needed as the United States withdraws its military presence from Iraq and Afghanistan, as put forth by Senate Democrats; not paying for SGR-repeal at all but in the process add $138 billion to the national deficit, as put forth by Senate Democrats. ACP has largely and intentionally stayed out of the fray during the congressional debate on the budget issues surrounding SGR-repeal. However, we felt compelled to address the budget matter in the following instances during House and Senate floor debate in March:

- ACP opposed Republican efforts in the House to offset the cost of SGR-repeal by delaying the ACA's individual insurance mandate, as this was in direct contradiction with long-standing ACP policy. Without a requirement to purchase insurance through the newly-established health exchanges, healthy individuals would delay or decide not to purchase insurance, creating a risk pool comprised primarily of sick enrollees who would drive up the cost of coverage and destabilize the insurance market. The House succeeded in passing H.R. 4015 using the individual mandate as a "pay for," but the Senate would not consider it.

- ACP supported Senator Ron Wyden's efforts, as the new Finance Committee Chair, to pass SGR-repeal using either OCO funds or with no "pay for" at all. It was clear to ACP that the Senate needed to pass SGR-repeal legislation, namely S. 2000, with its own "pay for" so that both chambers were then on equal footing, which would then precipitate direct negotiations between House and Senate leaders on how to solve their budget differences. ACP supported Senator Wyden's efforts so congressional leaders could move forward with those direct discussions that would ideally result in a compromise on the budget issue and ultimate passage of the SGR-repeal policy as agreed to by the Medicare authorizing committees. In 2014, the Senate Majority Leader has not scheduled S. 2000, or any other SGR-repeal legislation, for a floor vote because it still unclear whether either of the "pay fors," as proposed by Senator Wyden, or any other pay-fors, could garner the 60 votes needed in the Senate.

That said, ACP's advocacy message on the SGR has been clear: House and Senate leaders need to enter into direct negotiations, resolve the budgetary impasse on SGR-repeal in a way that can pass both chambers, and enact the SGR-repeal policy as agreed to by the Medicare authorizing committees – before the end of the year.

As noted at the outset of this document, the circumstances surrounding the SGR this year are different than they have been in the past. Some key reasons include:

- The policy crafted by the committees in H.R. 4015/S.2000 is like nothing we have seen before because it not only eliminates the antiquated SGR formula but it systematically transforms how healthcare is delivered, in a way that advances so many of ACP's long-standing policies.
- The committees in both the House and Senate have approved this legislation, and in a bipartisan fashion, which has never happened.
- The cost to repeal the SGR has decreased substantially from previous years at $124 billion, as estimated by the Congressional Budget Office in April. This cost has increased slightly from CBO's February estimate, which means that if Congress further delays permanent SGR-repeal, the cost may continue to increase.

ACP believes that it is still possible for Congress to reach agreement, this year, on full SGR repeal and how to pay for it, but our window of opportunity for enactment of H.R. 4015/S.2000 is fleeting because the 113th Congress will end at the end of this year. That means that in January 2015, if not enacted by then, this legislation is dead. The new 114th Congress will begin in January, with many newly-elected members of Congress, the committees of Medicare jurisdiction will be reformulated, leadership in the House and Senate could change, and all legislation must be reintroduced. In other words, as far as H.R. 4015/S. 2000, we literally would have to begin the entire process again, and in a different political and legislative environment.

Continued ACP advocacy, on the part of its governance, Advocates, and its entire membership is critical if we are to bring about comprehensive SGR reform this year.

For more information on ACP's positions on payment and delivery system reforms, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/physician_payment/.

Expiring Payment Policies Could Mean Cuts to Primary Care and Other Internists' Services

2014 Leadership Day on Capitol Hill

Background

Where Things Stand

The federal government enacted into law two critical programs in 2010 to increase payment levels temporarily for primary care services under Medicare and Medicaid. Unfortunately, both programs will soon expire, which not only puts access to primary care services in jeopardy for so many Medicare and Medicaid beneficiaries but it could also mean significant payment cuts for physicians.

Of most immediate concern to ACP is the Medicaid Pay Comparability program, which ensures that Medicaid payments for primary care services will be no less than comparable Medicare rates for calendars years 2013 and 2014. Internal Medicine (including internal medicine subspecialists), pediatrics and its medical subspecialties, and family medicine are the specialties that are eligible for this program. This program is set to expire at the end of the year, at a time when so many states are choosing to expand their Medicaid programs, which only increases the demand for primary care physicians treating Medicaid patients in those states The enhanced Medicaid payments serve as incentives for eligible physicians to maintain or increase their Medicaid patient population in all states, whether or not a given state has elected to expand its Medicaid program. If Congress does not extend the program, internists in all but a few states will see deep cuts in Medicaid payments on January 1, as much as 60 cents on the dollar in some states! A top priority for ACP in 2014 is to urge Congress to extend this program for at least two years beyond 2014.

Another program benefitting primary care, this time under Medicare, will expire in 2015 if Congress does not step in to reauthorize the program. The Primary Care Incentive Program (PCIP) begins to address inequities in payments for primary care by providing a 10 percent bonus payment, in addition to the usual Medicare fee schedule amount, for designated primary care services provided by internists, family physicians, geriatricians and pediatricians, provided that 60 percent of the total billings of a physician in an eligible specialty are for the designated primary care services. The bonus program took effect on January 1, 2011 and will continue through 2015. While not in immediate danger of expiring or losing federal funding, the PCIP is also a critical component in what ACP views as an on-going effort to address disparities in payments that are major barriers to physicians entering and remaining in primary care specialties. Come 2016, the expiration of this program will again translate into deep cuts for physicians providing primary care services. ACP wants to see Congress reauthorize this program beyond 2015. However, we do not intend to aggressively advocate for extension this year because we recognize that Congress, in this difficult budget environment and in an election year, will not realistically view this as a priority at this time.

Our advocacy efforts to extend the Medicaid Pay Comparability program will be especially important this year and we are mobilizing a coalition effort behind it. Like any federal program that needs reauthorization, the Medicaid Pay Comparability program will encounter scrutiny by members of Congress about its effectiveness, its budget impact, and the soundness of its mission. The background information below is designed to help Leadership Day attendees understand these issues in the current political environment and we are working to provide you with Medicaid state-specific information that can bolster our message with lawmakers.

Background

The Medicaid Pay Comparability Program

The Medicaid Pay Comparability program will expire at the end of 2014 unless Congress intervenes to extend it. It was signed into law in 2010, as part of the Affordable Care Act (ACA), and was designed to increase Medicaid payment for primary care services to 100 percent of Medicare rates in 2013 and in 2014. Under current law, primary care services are defined as all evaluation and management services and vaccine administration services furnished by primary care physicians, i.e., general internists, pediatricians, and family physicians. It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American

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

The Benefit to Physicians Providing Primary Care:

The increase applies to both fee-for-service and managed care Medicaid plans. The positive financial impact for physicians treating Medicaid patients is significant as Medicaid in most states pays primary care physicians at rates that are well below Medicare (and private insurance). In 2012, before this provision of law took effect, average Medicaid payment rates for primary care services were 58 percent of Medicare rates. A state-by-state accounting of Medicaid-to-Medicare payment ratios can be found here. We encourage Leadership Day attendees to examine these state ratios closely because lawmakers will likely be astounded at just how little Medicaid pays physicians compared to Medicare.

The policy of increasing Medicaid payment rates to no less than the comparable Medicare payments is based on well-established research that shows that low Medicaid payment levels in many states is associated with fewer physicians accepting large number of Medicaid patients into their practices, resulting in reduced access to persons covered under Medicaid:

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

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

Medicaid Expansion and the Need for Primary Care:

Medicaid currently provides coverage for more than 50 million Americans, including more than 20 million nonelderly adults. Under the ACA, states will have federal support beginning in 2014 to expand their Medicaid programs to include all adults living at up to 138 percent of the federal poverty level. In 2012, the United States Supreme Court upheld the Medicaid expansion provision but found that the penalty to states for not participating in the Medicaid expansion (loss of the federal government funding for the existing Medicaid program) was unconstitutionally coercive. Therefore, the Supreme Court gave states the option to expand their Medicaid program without the threat of a reduction in federal funding. If implemented by states as now expected by the Congressional Budget Office after the Supreme Court ruling regarding the ACA in June 2012, Medicaid expansion is projected to add more than 10 million individuals to the Medicaid population.

The Medicaid Pay Comparability program was included in the ACA because primary care physicians, including internal medicine subspecialists who provide primary care, will be particularly affected by the Medicaid expansion because millions of new patients will enter the health care system and many will have complex health care needs. Primary care physicians and subspecialists are not required to participate in Medicaid, and many practices do not accept Medicaid patients because reimbursement rates are relatively low and the administrative barriers are significant. Further, people who are currently eligible for Medicaid, but not enrolled, will likely enroll in Medicaid coverage to comply with the individual mandate included as part of the ACA, adding more beneficiaries to the program. Many of these new Medicaid patients will be adults who seek care from internists. These increased-payment rates apply to all states; independent of the state's decision regarding participation in the Medicaid expansion opportunity provided through the ACA.

Program Implementation Difficulties:

While the Medicaid Pay Comparability program became effective in January of 2013, its rollout went more slowly than expected, hampered by delays at the state level. The rules required that states amend their Medicaid plans to include this program and then submit those amendments for approval to the Centers for Medicare and Medicaid Services (CMS). Many states did not turn in these plan changes for federal approval, even though they were due by the end of March 2013.

ACP voiced concerns about problems with the roll-out, and provided extensive resources to ACP members along the way. Until the states submitted their amended Medicaid plans to CMS, and received subsequent approval, the payment increases did not flow to physicians. In addition, under the federal rules, physicians must "attest" to the states that they meet the necessary requirements to receive the Medicaid payment increase. Each state is different as to the attestation period, and the time period they gave physicians to attest varied. If a physician did not attest in time, he or she did not get paid.

These difficulties with the roll-out have made it very challenging to assess the overall impact to date of the Medicaid Pay Comparability Program on patient access to care, health outcomes, and physician satisfaction. Equally frustrating is the fact that this program is set to expire when it has not been operational long enough to accurately assess its true effectiveness.

ACP Advocacy**:**

ACP has been a champion of the Medicaid Pay Comparability program, stemming back to the earliest days before the ACA became law. A top priority for ACP is to extend this program, for at least two more years, although we would prefer the longest possible extension, and ideally, permanent reauthorization. Furthermore, a coalition including ACP, the American Academy of Family Physicians, the American Osteopathic Association, the American Pediatric Association, American Congress of Obstetrics and Gynecology, and others has mobilized behind this effort and we are developing a multi-pronged approach that will involve direct face-to-face advocacy with members of Congress, joint letters to lawmakers, and identifying key lawmakers willing to introduce legislation to extend the program. (Although ob-gyn physicians are not currently eligible for the Medicaid Pay Comparability program, ACP supports adding them as a designated eligible specialty as part of a bill to extend the program because ob-gyn physicians see a large number of Medicaid patients and for many women, are their only source of primary care services. As envisioned, ob-gyn physicians would qualify if at least 60 percent of the codes billed by the physician are for the E&M codes and vaccine administration codes specified in the program, as explained below).

ACP believes that extending these Medicaid rates at least through 2016 would demonstrate that it is effective in improving access to physician services, both for persons enrolled in the existing Medicaid program and persons who may become newly eligible for Medicaid in states that choose to accept the federal dollars to expand Medicaid. The extension is particularly important because its slow start up—with many states only now beginning to pay at the higher Medicare rates—combined with a lack of assurance that it will be extended beyond 2014 has not allowed an adequate enough time to demonstrate the program's effectiveness in improving access.

As noted above, ACP is also on record as including in the statute physicians practicing obstetrics and gynecology as qualified specialties, subject to the current eligibility requirement that at least 60 percent of their Medicaid billings are the primary care services as defined by the authorizing legislation, for the purposes of qualifying for the Medicaid primary care increases. For many women, an ob-gyn is the only physician they see regularly during their reproductive years and the only point of entry into the health care system. As of 2010, Medicaid programs in 30 states and the District of Columbia recognized ob-gyns as primary care providers in their managed care organizations. With nearly half of births in the United States now financed by Medicaid, inclusion of ob-gyns will improve the continuity of care, particularly for those women who were previously on Medicaid for pregnancy-related services.

It must be noted that there is a cost associated with extending the program which means, in this tight fiscal environment, Congress will insist on finding a way to pay for it. While that is a challenge, it will not deter us from making the best argument possible in favor of extending this program. In calendar year (CY) 2013, the federal cost of this program for

Medicaid and the Children's Health Insurance Program (CHIP) was approximately $5.835 billion with $235 million in state savings. In CY 2014, the federal cost for Medicaid and CHIP is approximately $6.055 billion with $310 million in state savings. In addition, there continue to be partisan differences over the merits of this program, namely because many Republicans question the usefulness of the very Medicaid program itself, and continue to seek avenues to turn Medicaid into a block grant program to reduce costs borne by the federal government.

Primary Care Incentive Program (PCIP)

This program begins to address inequities in payments for primary care by providing a 10 percent bonus payment, in addition to the usual Medicare fee schedule amount, for designated primary care services provided by self-designated internists, family physicians, geriatricians and pediatricians. (Physicians who self-designate in an internal medicine subspecialty are not eligible.) In order to qualify for the bonus, at least 60 percent of Medicare allowed charges of these physicians must consist of the designated primary care services: office, nursing facility, domiciliary, and home services. The program was implemented in January 2011 and will continue through 2015. Mandatory funds have been provided for this program, which does not appear to be in any immediate danger of being repealed or defunded by Congress, ACP continues to advocate for its preservation and for its extension beyond 2015.

CMS has determined that the 10 percent bonus is based on the amount "actually paid" to the physician for the designated service –with co-payments and deductibles excluded from the bonus calculation. Based on this "actual payment" methodology, the typical yearly payment for a qualified primary care physician is approximately $8,000 for the bonus year. Payments are made on a quarterly basis. Eligibility for the bonus is determined at the individual physician level. Multiple general internists in the same group practice can receive the bonus. The determination as to which physicians qualify is based on the revenue associated with each individual physician during the prior assessment period. Physicians do not have to register for this program. Medicare automatically determines eligible physicians based upon claims.

ACP applauded Congress for enacting this program back in 2010 because in the context of overall Medicare reform, which includes the need for permanent repeal of the Sustainable Growth Rate (SGR) physician payment formula, the Medicare bonus is a positive step forward in addressing disparities in payments that are major barriers to physicians entering and remaining in primary care specialties.

This program is a priority for ACP but we will not actively push for extension of the Medicare bonus at this time because Congress, sadly, tends to only seriously engage on issues that have a compelling degree of "immediacy" to them. Since this program does not expire until the end of 2015, and because it is an election year, lawmakers will likely not consider it a priority. Leadership Day attendees still need to be aware of the importance of this program as part of our on-going efforts to increase access to primary care services in the longer term.

For more information on ACP's positions on payment and delivery system reforms, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/physician_payment/.

"Safe Harbor" Legislation and other Reforms to Address the Practice of Defensive Medicine

2014 Leadership Day on Capitol Hill

Background

Where Things Stand

Despite the recognition by both parties on the need to reform our nation's medical liability laws to address the practice of defensive medicine, Republicans and Democrats remain divided on policy solutions that would deal with this issue. Sadly, physicians today often feel compelled to order a diagnostic test or treatment that is not necessarily the best option for the patient, but an option that mainly serves the function to protect the physician against the patient as potential plaintiff. Equally problematic is the fact that medical liability claims under today's trial-by-jury system may take years to be decided, and verdicts and award amounts may hinge on the laws and legal climate of the state in which they are filed.

As outlined in a new policy paper by ACP, evidence suggests that traditional tort reforms, particularly noneconomic damage caps, may help reduce liability claims and health care costs. Yet even in states where stringent tort limits have been enacted, physicians remain concerned about medical liability, which may undermine career satisfaction and influence their relationship with patients. It remains unclear whether traditional tort reform improves patient safety and outcomes. There has been a renewed focus on medical liability reforms that move beyond traditional tort reforms, toward creating alternatives to jury trials in favor of quick decisions made by judicial experts, enhanced liability protection for physicians who follow established clinical guidelines and take responsibility for errors, and risk management efforts that focus on ensuring patient safety.

On April 10, ACP's then-President, Dr. Molly Cooke, commented, "Perhaps more promising is the testing of innovative liability protection models, such as health courts, enterprise liability, safe harbor protections, and disclosure laws, which seek to break through the political impasse and create a system that encourages the prevention of errors, improved patient safety, and timely resolution of legitimate claims. Both proponents and opponents of tort reform must realize that the existing health care system allows for too many preventable injuries and that fear of liability undermines the patient-physician relationship."

In the past, Republicans in Congress have attempted to enact national caps on non-economic damages in malpractice cases to improve patient care and reduce the costs associated with the practice of defensive medicine. The majority of Democrats remain opposed to this effort because they believe that it would limit a patient's ability to obtain just compensation for their injuries and to have their day in court. Some Republicans also object to the federal government overriding state medical liability laws by enacting a national cap on non-economic damages. While most Republicans continue to support national caps, they have largely abandoned the effort to enact such legislation because they cannot do so while Democrats control the Senate and the White House. Republicans are also quick to note that several states have already enacted caps that are as stringent, if not more, than those proposed by Congress.

With ACP's support, bipartisan legislation has emerged as a new pathway forward that will provide safe harbor protections from medical liability lawsuits for physicians who document adherence to clinical practice guidelines. This legislation, the *Saving Lives, Saving Costs Act* (H.R. 4106) was introduced in February by Representatives Andy Barr (R-KY) and an ACP Fellow, Rep. Ami Bera (D-CA). ACP worked closely with these Representatives and provided substantial input to these offices to ensure that this legislation was as consistent as possible with our policies. ACP endorsed this legislation, and while it did not include a pilot to test health courts as an innovative alternative to traditional reforms, it is a positive step forward in finding common ground on an issue that Congress has struggled with. We look forward to working with these members to advance this legislation through Congress. More detailed information about H.R. 4106 can be found below, including an update on ACP's effort to also advance the concept of health courts.

Background

According to one estimate, annual medical liability system costs are about $55.6 billion in 2008 dollars, or 2.4 percent of total health care spending. Reflected in this estimate are costs related to claims payments; administrative expenses; and

defensive medicine, which occurs when physicians and other health care professionals provide services (or avoid high-risk patients and services), to prevent a medical liability claim. The Congressional Budget Office (CBO) estimated that in 2009, providers would incur $35 billion in direct medical liability costs, including premiums, settlements, awards, and administrative costs not included in insurance.

Physicians, especially those in high-risk specialties and those practicing in select geographic regions, continue to pay high premiums for liability insurance, although rates in much of the nation have moderated in recent years. In 2012, 60 percent of medical liability premiums nationwide remained level compared with the previous year, while 26 percent decreased, and 15 percent increased.

The medical liability system is rife with inefficiencies and fails to proportionately compensate patients. According to one estimate, only 22 cents of every dollar that goes into the medical liability system is directed to patient compensation. The system spends an enormous amount of money to compensate a small percentage of patients, distributing large awards to the 2 percent of injured patients who bring a suit to court following an unintended medical episode. Most patients who are injured as a result of negligence do not even receive compensation, often because they are unable to find legal representation or they elect not to file a claim.

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

ACP provides nine approaches in its recent policy paper that should be incorporated into a multifaceted medical liability reform initiative.

- Continued focus on patient safety and prevention of medical errors;
- Passage of a comprehensive tort reform package, including caps on noneconomic damages;
- Minimum standards and qualifications for expert witnesses;
- Oversight of medical liability insurers;
- Testing, and if warranted, expansion of communication and disclosure programs;
- Pilot-testing a variety of alternative dispute resolution models;
- Developing effective safe harbor protections that improve quality of care, increase efficiency, and reduce costs;
- Expanded testing of health courts and administrative compensation systems;
- Research into the effect of team-based care on medical liability, as well as testing of enterprise liability and other products that protect and encourage team-based care.

H.R. 4106, the Saving Lives Saving Costs Act

On Feb. 27, 2014, Representatives Andy Barr (R-KY) and Rep. Ami Bera (D-CA) introduced the *Saving Lives, Saving Costs Act*, H.R. 4106. Rep. Bera is a physician in general internal medicine and is an ACP Fellow. As of May 1, the legislation has 11 cosponsors. The bill includes the following key elements designed to provide safe harbor protections from medical liability lawsuits for physicians who document adherence to clinical practice guidelines:

General Purposes

(1) To offer physicians who document adherence to certain evidence based clinical practice guidelines a safe harbor from medical-malpractice litigation
(2) To reduce the practice of defensive medicine
(3) To increase adherence to evidence based clinical practice guidelines to reduce clinical variation in health care practice
(4) To improve the quality of care and patient safety

(5) To permit organizations with relevant expertise to participate in the selection of evidence based guidelines
(6) To permit professionals with relevant expertise to participate and benefit from liability reform

Selection of Guidelines

All eligible professional organizations that have established, maintained, and updated clinical guidelines on a regular basis, shall submit those guidelines to the Secretary not later than 6 months after the date of enactment of this legislation. The Secretary shall designate one or more of those eligible organizations to provide and maintain such clinical practice guidelines on behalf of the Secretary.

Development of Guidelines

The development of clinical guidelines should be based on standards established by the Institute of Medicine and should –

(1) Be developed through a transparent process that minimizes conflicts of interest
(2) Be developed by knowledgeable multidisciplinary panel of experts and representatives from key affected groups
(3) Take into consideration important patient subgroups and patient preferences as appropriate
(4) Be based on a systematic review of the existing evidence
(5) Provide a clear explanation of the relationship between care options and health outcomes

Mandatory review by Independent Medical Panel
This section will 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 will determine if defendant physicians complied with the guidelines, which are to be recognized as the standard of care. The panel should use their medical expertise to determine when departing from recommendations in the guidelines is appropriate for individual patients. The findings, opinions, and conclusions of the review panel shall be admissible as evidence in any and all subsequent proceedings before the court, including for purposes motions for summary judgment at trial. If the panel made a finding that there was an applicable practice guideline that the physician adhered to, the court shall issue summary judgment in favor of the physician unless the claimant is able to show otherwise by clear and convincing evidence.

ACP Advocacy on H.R. 4106 and Health Courts

Since last fall when the initial drafting of this legislation began, ACP has been very pleased and supportive of Reps. Barr and Bera in their efforts to actively address medical liability reforms in this Congress. ACP continually provided feedback to the sponsors of H.R. 4106 throughout the process and even urged them to include a provision to pilot test health courts, as another innovative and promising alternative to traditional 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. Health courts would provide fair compensation for injuries caused by medical care, reduce costly and time-consuming litigation, reduce malpractice 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.

During the initial drafting phase of H.R. 4106, ACP was pleased to see that the sponsors included a provision that would authorize grants to states for the development, implementation, and evaluation of health trials or tribunals. Unfortunately, in later drafts as the bill became more refined, the sponsors decided to remove the health courts provision. The staff of Representatives Barr and Bera remarked that the provision on health courts was removed because the Representatives wanted to – in the end -- keep the focus of the bill on safe harbors only.

While ACP will continue to try to advance the concept of health courts going forward, it will not be a focal point at Leadership Day this year. We continue to meet with lawmakers interested in health courts, specifically about introducing legislation to pilot test the health courts model, but we have to be discerning in an election year and having a viable bipartisan bill, like H.R. 4106, has a greater chance for advancement at this time. Therefore, we will work with the sponsors of H.R. 4106 to get it enacted, including advocating for cosponsors at Leadership Day.

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/.

Frequently Asked Questions (FAQs)

Additional Policy Issues of Interest for Leadership Day 2014

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This legislation would permit, among other things, Medicare beneficiaries and health care professionals the right to contract for items and services outside of the Medicare system and not be penalized. Medicare beneficiaries would still retain their Medicare benefits even if they enter into a private contract with a physician. The bill also prohibits contracting

with beneficiaries who are dually eligible for both Medicare and Medicaid, and when a beneficiary is in an urgent medical care situation. The legislation applies to a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, physical or occupational therapist or a qualified speech-language pathologist, or a qualified audiologist.

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

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

The College has long-standing policy that supports the primacy of the relationship between a patient and his/her physician, and the right of those parties to privately contract for care, without risk of penalty beyond that relationship. ACP policy goes on to state that certain patient protections are essential under any Medicare private contracting agreement. From an ethical standpoint, ACP believes that the physician's first and primary duty is to the patient. Physicians should be cognizant of their professional obligation to care for the poor and of medicine's commitment to serving all classes of patients who are in need of medical care.

While H.R. 1310 contains many provisions that are consistent with ACP policy, including: (1) a requirement that physicians disclose their specific fee for professional services covered by the private contract in advance of rendering such services, with beneficiaries being held harmless for any subsequent charge per service in excess of the agreed upon amount; (2) a prohibition on private contracting for dual Medicare-Medicaid eligible patients; and (3) a requirement that private contracts cannot be entered into at a time when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation. However, there are other important protections absent from H.R. 1310 that are critical to ensuring adequate patient access to care, such as: (1) a prohibition on private contracting in cases where a physician is the "sole community provider" for those professional services that would be covered by a private contract; (2) a prohibition on private contracts in other cases where the patient is not able to exercise free choice of physician; (3) clarification that private contracting arrangements should not apply at a time when emergency or urgent care is being rendered, even if the treating physician and patient had previously entered into a private contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Act also:

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

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

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

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

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

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