

Healthcare and the 114th Congress: A Dynamic Guide to the Top Issues Affecting Internal Medicine Specialists and Their Patients

Summary of ACP's Recommendations to Congress May 11, 2015

<http://www.acponline.org/guideforcongress>

Medicare SGR/Physician Payment Reform

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, which permanently repealed Medicare's Sustainable Growth Rate (SGR) formula. ACP commends Congress and President Obama for enactment of this bipartisan legislation that finally eliminates the flawed SGR formula and puts us on a pathway toward a new value-based payment and delivery system.

Explanation: MACRA repealed the Medicare Sustainable Growth Rate (SGR) formula, which since 1998 had adjusted Medicare's payment updates to physicians based on overall spending on physician services compared to growth in the economy (as measured by per-capita GDP). When spending exceeded per-capita GDP, the SGR reduced the annual inflation update for the Medicare physician fee schedule by the difference. The result had been scheduled cuts to physicians each and every year since 2002. Except for one year, Congress overrode the SGR cut by passing a temporary "patch"—blocking the next scheduled cut but not repealing the SGR itself. This was done 17 times over the past 12 years. Over time, the amount of the scheduled cut grew, mainly because the temporary patches did not fully cover the cost of *future* scheduled cuts from the SGR. Now that MACRA has been signed into law, physicians will never again have to face the uncertainty created by scheduled SGR payment cuts. Equally important, MACRA advances new payment models associated with value—including Patient-Centered Medical Homes (PCMHs).

Medicare Primary Care Incentive Program

Legislation should be introduced in both the House and Senate to continue the current Medicare 10 percent primary care incentive program, followed by action in both chambers to pass the legislation before the program expires on January 1, 2016. This program, which began in 2011, pays eligible internal medicine specialists, family physicians, and geriatricians a 10 percent bonus on designated office visits and other primary care services.

Explanation: If the Medicare Primary Care Incentive Program is not continued, internists, family physicians and geriatricians will experience a 10 percent cut in their Medicare payments for their office visits and other designated primary care services on January 1, 2016. Such a cut will represent a reversal of Congress' long-standing, bipartisan support for policies to ensure that patients enrolled in Medicare have access to a primary care physician, including improving Medicare payments for primary care. Expiration of the program would not only adversely affect established primary care physicians who are on the front lines of providing care to Medicare patients, but also act as a further disincentive for medical students to choose careers in primary care. Hundreds of studies show that access to primary care is associated with better outcomes and lower costs of care. Allowing this program to sunset would also result in deep cuts to primary care physicians in alternative payment models like

Accountable Care Organizations and PCMHs—the very programs that MACRA envisions as the future of Medicare payments—undermining their ability to achieve quality gains and cost-savings.

Medicaid Primary Care Pay Parity

Congress should help improve access to primary care for patients enrolled in Medicaid by enacting legislation to ensure that Medicaid payments for designated services by primary care physicians are reimbursed at no less than what Medicare pays for the same services. ACP urges senators to cosponsor the Ensuring Access to Primary Care for Women & Children Act (S. 737), and House members to cosponsor the House companion version (H.R. 2253), followed by expedited action in both chambers to pass it and enact it into law. The legislation would ensure Medicare-Medicaid pay parity for primary care and immunization services.

Explanation: The Medicaid Primary Care Pay Parity program ensured Medicare-Medicaid payment parity for primary care and immunization services for calendar years 2013-2014. Unfortunately, the program expired in January 2015. Ensuring that Medicaid payments incentivize access to primary care is especially important because Medicaid enrollment is increasing rapidly, regardless of whether a state has opted to accept federal funding to expand Medicaid eligibility or not. Medicaid enrollment increased by over 1.4 million from July-September 2013 to October 2014 in states that have not expanded eligibility, and the Congressional Budget Office estimates (<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAables.pdf>) that 11 million people will enroll in Medicaid in 2015, including those newly-eligible as a result of eligibility expansion in 29 states and the District of Columbia. To meet this increase in demand, physicians will need to accept more Medicaid patients but many are unable to because of low reimbursement. If Congress fails to take action to ensure that Medicaid's primary care payments are no less than the applicable Medicare rates, patients will have more difficulty finding a participating physician and scheduling appointments, as physicians have no choice but to limit participation or leave the Medicaid program altogether due to financial constraints.

Graduate Medical Education

Congress should ensure that overall GME funding for FY2016 is sufficient to train enough physicians, with the skills needed, to meet increased demand. ACP specifically urges members to cosponsor and enact legislation that will strategically increase the number of GME training positions in primary care specialties (including internal medicine) and other specialties facing shortages, such as those included in S.1148/H.R.2124 and H.R. 1117. Funding for Teaching Health Centers should also continue to be supported and expanded. Congress should also broaden the GME financing base by establishing an all-payer system where Medicare, Medicaid and private payers would contribute to GME funding as a public good.

Explanation: ACP strongly believes that Medicare's contribution to GME must be *preserved and prioritized* to ensure that the nation has an adequate supply of physicians in the specialties needed to meet increased demand, that they enter the workforce with the knowledge and skills required to provide the highest quality care, and that all Americans have access to such care, especially primary care. The nation will not be able to expand access, improve health outcomes, and decrease health care expenditures without a *national health care workforce policy* that ensures an appropriate direction of GME funding to achieve these goals. A national health care workforce policy to guide and prioritize GME funding decisions should be based on a thorough assessment of the supply, specialty mix, and distribution of physicians that is needed to meet increased demand. While we agree that some of the costs covered by the IME adjustment have decreased, other costs related to DGME expenditures have increased, primarily due to increased regulatory demands, yet DGME reimbursement amounts were set in 1986 and have been adjusted only for inflation. Data suggests that the increase in DGME costs appear to roughly offset

the decrease in IME costs. In addition, ACP believes that GME is a public good—it benefits all of society, not just those who directly purchase or receive it. All payers depend on well-trained medical graduates, medical research, and technical advances from teaching programs to meet the nation’s demand for high quality and accessible care, and accordingly, all payers should contribute to GME funding.

Funding for Vital Federal Health Care Programs

Congress should ensure necessary funding in fiscal year 2016 for vital federal programs/initiatives designed to support primary care and ensure an adequate physician workforce, including: Title VII Health Professions grants, National Health Service Corps (NHSC), National Health Care Workforce Commission, and Graduate Medical Education (GME).

Explanation: The Title VII Health Professions Program distributes educational grants for primary care physician students, residents, and faculty to enhance primary care provider recruitment. In the 2013-2014 academic year alone, the PCTE program trained over 30,000 students, residents and faculty, with over one-million primary-care patient interactions. Without adequate funding, the program’s capacity to complete its mission of improving the education of primary care providers would suffer. Congress should fund this program at \$71 million for FY2016.

The NHSC provides scholarships and loan forgiveness to enable primary care physicians to be trained to serve underserved communities. The NHSC has a field-strength of over 9,000 clinicians and serves almost 10 million patients in underserved communities at over 15,000 sites. For FY2016, the NHSC’s mandatory funding was set to expire. Fortunately, Congress passed and the President signed into law in April the *Medicare Access and CHIP Reauthorization Act, H.R. 2*, which extends the NHSC’s mandatory funding for two more fiscal years (FY2016, FY2017) at the FY2015 level. Congress should fund the NHSC at \$810 million for FY2016.

The National Health Care Workforce Commission, as authorized by Congress in 2010, was intended to provide Congress with the advice of an independent, expert advisory committee, charged with assessing the nation’s workforce needs including the barriers to primary care. Although appointees were announced, the Commission has not been able to function because Congress has never funded it. Consequently, the federal government and the nation continue to lack an overall and cohesive strategy to addressing the current and future needs of the nation’s health care workforce and to ensure that federal workforce and GME dollars are spent effectively and efficiently. Congress should fund the Commission at \$3 million for FY2016.

Affordable Care Act

Congress should be prepared to act to ensure that people residing in states with health insurance marketplaces operated by the federal government do not lose their premium subsidies, in the event that the Supreme Court rules in favor of the petitioners in the King versus Burwell case. Congress should *not* make changes that would result in more uninsured persons or weaken consumer protections.

Explanation: ACP believes that Congress must be prepared to act to ensure continuation of premium and cost-sharing subsidies for current and future enrollees at the level established in the ACA should the Supreme Court’s decision eliminate subsidies in the 34 states with federally-facilitated marketplaces. We believe Congress should not pass legislation that would increase the number of uninsured or weaken insurance market regulations or consumer protections that ensure essential benefits or prohibit limitations on pre-existing condition coverage. We support greater consumer protections to ensure continuity of care in QHPs offered under the ACA.