Leadership Day 2014
By Greg Kane, MD, FACP

On May 21 and 22, the PA-ACP sent a strong contingent of students, residents and physician members to Washington to get our lawmakers attention on key issues facing Internists in our local communities. During this two-day event, we focused on four (4) priority issues:

• Preserving GME Funds for our Teaching Hospitals
• Achieving a permanent SGR fix to avoid potential cuts to reimbursements
• Promoting alternatives to our flawed medical liability system and
• Preventing Cuts to Medicaid that affect the most vulnerable in our midst

This year’s attendees were led by Drs. Jeff Jaeger and Evan Pollack and included Drs. Dan Kimball, Larry Jones, Darilyn Moyer, Chuck Cutler, and Greg Kane. We were excited to have resident attendees from Drexel, Jefferson, Penn, and Temple (Drs. Danielle Krol, Arpan Patel, Fatima Syed, Natalya Klebanov, and Jonathan Gottfried); as well as students from Penn State and Drexel (Christine Prifti, Sravanthi Koduri, and Katherine Greco).

1. Fixing the Broken SGR Payment System Imagine, you are running a business and each year you face the uncertainty of a 24% per cent cut in revenue. Imagine the stress that could create? Imagine how that would impact growing the business? Since that is what we all face each year on reimbursements for E & M codes, it is not at all hard to imagine because we have faced this threat every year for more than the past decade. 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. We believe it is still possible for Congress to reach agreement, this year, on full SGR repeal. 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.

2. Working to Promote Innovative Safe Harbor Legislation. 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. 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." With ACP’s support, bipartisan legislation has emerged as a new pathway forward that will provide safe harbors 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). We look forward to working with these members to advance this legislation through Congress. More detailed information about H.R. 4106 can be found on the ACP website.

3. Preserving GME to meet the Nation’s Workforce Needs

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. If we are to address the physician workforce crisis, sufficient funding for graduate medical education (GME), coupled with a more strategic approach to using that funding, is critical. In addition, funding for federal programs aligned to improving the primary care workforce and ensuring access to primary care physicians must be preserved. In the meantime, we urge IOM to include the following in its study: an accurate assessment of current training costs, establish a mechanism for monitoring this in the future, seek to minimize inequalities across the system, and encourage training programs in underserved areas and regions, structure GME funding to help address physician workforce needs, and evaluate changes in direct medical education costs, which are heavily influenced by new accreditation requirements. So what are we working to achieve in the area of GME funding:

a. Strategically Lifting the Caps on GME: The existing caps on the number of Medicare-funded GME positions available makes it impossible to fund GME training positions in the numbers needed to slow or reverse growing shortages of physicians in primary care and other fields. The caps should be strategically lifted to align spending with the nation’s healthcare workforce policy needs. New primary care slots should also be added in underserved geographic areas. We support legislation that has been introduced in both the House and Senate that would increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. The Resident Physician Shortage Reduction Act, S. 577, H.R. 1180, introduced by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY) and the Resident Physician Shortage Reduction Act, H.R. 1201, introduced by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), would provide for approximately 15,000 additional GME positions for medical residents and require at least 50 percent of the new positions to be allocated to specialties, such as primary care, that face a shortage.

b. Establish an All-Payer GME System: ACP and AAIM, along with many other medical associations, have long-supported an all-payer GME system. The all-payer system should be linked to the nation’s health care workforce needs to ensure an adequate supply of physicians with an appropriate specialty mix and distribution.

c. Supporting other federal programs important for ensuring an adequate physician workforce: Without a robust primary care physician workforce, the nation’s health care system will become increasingly fragmented and inefficient. Hundreds of studies show that the numbers and percent of physicians in primary care disciplines practicing in a region, state or country is positively associated with better health outcomes and lower costs. See the policy paper for more details.

Unless changes to the U.S. health care system are met by adequately funded GME programs as well as an adequate supply of well-trained primary care physicians, increasing access to high quality and affordable health care will not be possible. Congress should fund the following programs at the levels indicated:

Section 747, Primary Care Training and Enhancement/Title VII, at $71 million, is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine and promote
interdisciplinary training that helps prepare physicians to work with other health professionals, such as physician assistants, patient educators and psychologists.

National Health Service Corps (NHSC), at $810 million, funds training for thousands of primary care clinicians who provide care to tens of millions of persons in underserved communities by providing scholarships and loan forgiveness to primary care physicians who serve in underserved communities.

National Health Care Workforce Commission, at $3 million, is a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy, analyzing and making recommendations for eliminating barriers to entering and staying in careers in primary care. However, to date, Congress had not provided the necessary funding for the Commission to be convened, preventing this advisory body from embarking on its vital mission.

**What are we asking Congress to do in the area of GME?**

- Preserve funding for Graduate Medical Education in FY2015; stop the 2 percent cut to GME under sequestration; and protect IME from cuts.

- Cosponsor and urge enactment of 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.577, H.R. 1180 and H.R. 1201.

- Introduce legislation to support GME financing reform by introducing more transparency and accountability and requiring that all payers contribute to GME funding.

- Ensure full funding for other vital federal physician workforce programs including Title VII, and the NHSC.

4. Fully fund the National Health Care Workforce Commission, which has yet to become operational because Congress has not provided the necessary funding. Advocating to Avoid Medicaid Payment Cuts: The Medicaid program currently provides coverage for more than 62 million low-income Americans, including more than 20 million nonelderly adults. Primary care physicians and related subspecialists are not required to participate in the Medicaid program, and many practices traditionally have not been able to accept significant numbers of Medicaid patients because reimbursements do not keep pace with their costs of providing services. In all but a few states, Medicaid payment rates are much lower—as much as 60 percent less—than the amounts allowed by Medicare. This differential, studies show, is a major reason why Medicaid patients have trouble accessing physicians. In 2010, the federal government enacted into law the Medicaid Pay Comparability program, which is designed to increase Medicaid payment for designated primary care services and immunizations to 100 percent of Medicare rates in years 2013 and 2014. Unless Congress intervenes, the Medicaid Pay Comparability program will expire at the end of this year. In some states, this could mean a cut of 60 cents on the dollar for primary care services, which is simply not sustainable. 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 indicated they had enrolled in the Medicaid Pay Comparability program via their State Medicaid program and 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. We asked our Congressional leaders not to let this happen by extending the current Medicaid Comparability Program through at least 2016.

I know this is a lot of material for a single message, but I wanted to be sure you had a chance to hear about our advocacy efforts first hand.
If you have questions or comments, I would love to hear from you or see you at a regional event. Please watch for future announcements.

I want you to know that we will be fighting for Pennsylvania’s Internists, not just on the Hill, but back here in Pennsylvania as well. To learn more about our issues, please visit the ACP website.