ACP Seeks Changes to Health Care Reform Law

BY MARY ELLEN SCHNEIDER

TORONTO — The massive health care reform overhaul passed by Congress this year is here to stay, but officials at the American College of Physicians are hoping that Congress will make some modifications to improve the law for physicians.

At the top of the organization's wish list are changes to the Independent Payment Advisory Board (IPAB) created by the law, making permanent the boost in primary care payment rates under Medicare and Medicaid, and eliminating newly created penalties for failing to report quality data to Medicare.

"Health care reform is an ongoing journey. It's not a destination," Robert B. Doherty, the ACP's senior vice president for governmental affairs and public policy, said at the group's annual meeting in April.

The ACP's plan is to influence how the law is implemented by offering comments as federal regulations are written and as states do their part to roll out provisions in the law. States will have a major role in implementation, Mr. Doherty said, since they are responsible for setting up their own health insurance exchanges in 2014 and awarding competitive grants to fund primary care programs. And as with other large federal programs, it's likely that Congress will pass additional legislation to amend the law as implementation moves along, he said.

The ACP's issue with the IPAB is that it vests too much power in an unelected body. The 15-member board, created by the Affordable Care Act, is charged with presenting proposals to Congress that would slow the growth of Medicare and private health care spending and improve the quality of care. The recommendations of the IPAB would take effect unless Congress votes to reject the proposals and in favor of its own plan for achieving the same level of savings. The IPAB is expected to submit its first recommendation to Congress in 2015.

'Health care reform is an ongoing journey. It's not a destination.'

MR. DOHERTY

The ACP also hopes that Congress will act to make permanent the temporary increases in primary care payments enacted under the law. For example, the health care reform law provides a 10% bonus payment to primary care physicians whose Medicare charges for office, nursing home, and home visits make up at least 60% of their total Medicare charges. Those payments will be available for 5 years, starting in 2011. The law also increases Medicaid payments up to the level of Medicare payments for primary care physicians delivering primary care services in 2013 and 2014.

Mr. Doherty said that although the law's payment provisions are time limited, he thinks it will be difficult for Congress to take this benefit away once it is in effect. ACP officials also plan to lobby Congress to expand the eligibility for these increased payments so that more primary care physicians can qualify.

The ACP's plan is to influence how the law is implemented by offering comments as federal regulations are written and as states do their part to roll out provisions in the law.

The new law also extends the Medicare Physician Quality Reporting Initiative, which offers incentive payments for successful reporting of quality measures. Under the law, physicians can receive 1% bonus payments on Medicare charges in 2011 and 0.5% bonuses in 2012-2014. Starting in 2015, however, physicians who fail to report quality measures will receive a 1.5% cut in their Medicare reimbursement. That penalty will rise to 2% in 2016. Mr. Doherty said the ACP is seeking to eliminate the penalties outlined in the law.

One provision missing from the final health care reform package was a permanent fix to the Medicare physician payment formula, or sustainable growth rate (SGR). At the time, it wasn't politically feasible to get an SGR fix included in the reform legislation. However, Mr. Doherty said he expects that there will be a vote in the Senate on permanent repeal of the SGR this spring.

The challenge, he said, will be to round up 60 votes in the Senate, where fiscal conservatives want to see a method to pay for the $200 billion price tag of an SGR fix. Mr. Doherty argues that the SGR fix would not be a "real cost," because it assumes that Congress would otherwise let the cuts happen each year.

In the meantime, the ACP, the American Medical Association, and other physician organizations have stopped helping lawmakers round up the votes needed for short-term fixes, instead opting to lobby only in favor of a permanent fix to the formula. "The only acceptable option is total repeal," Mr. Doherty said.

The ACP also is launching a "nuts and bolts" educational campaign to help physicians and their patients better understand how the law will actually work. The campaign will include practical information on issues such as the Medicare doughnut hole. ■

'Rational' Use, Not Rationing

ACP *from page 1*

understand the value of different diagnostic and treatment strategies relative to each other and relative to the costs that are incurred," said Dr. Steven E. Weinberger, senior vice president for medical education and publishing at the ACP. "At the same time, patients must have sufficient information to make informed choices in conjunction with their physician's advice."

Cost will be a factor in the ACP's assessment of treatments and diagnostics, but this is not rationing, Dr. Weinberger said. Instead, he called it a "rational" approach. For example, if treatment A is more effective than treatment B, but costs more, the ACP would not recommend limiting access to treatment A, he said.

But the ACP is staying away from thornier situations such as when treatment A is more effective and more costly, but treatment B is less expensive and also a good option for patients. Instead, Dr. Weinberger said the ACP plans to focus specifically on issues of overuse and misuse of ineffective treatments. That approach could yield real savings for the health care system. The Congressional Budget Office estimates that the United States spends as much as $700 billion per year on tests and procedures that do not improve health outcomes.

There are several factors that drive overuse and inappropriate use of treatments and diagnostics, Dr. Weinberger said, including the reflexive practice of medicine, defensive medicine, and patient expectations.

Another part of the problem is that the U.S. health care system has financial and cultural incentives to do more, not less, said Dr. Paul G. Shekelle, chair of the ACP's Clinical Efficacy Assessment Technical Advisory Committee. "All the things in America point toward doing more, and yet as we've found, sometimes doing more isn't necessarily always doing better," he said.

One potential benefit of the initiative is that it could help to better educate patients, according to Dr. Joseph Stubbs, president of the ACP. Dr. Stubbs, who practices internal medicine in Albany, Ga., said he often sees patients spending a lot of time and money on over-the-counter and supplement products whose benefits aren't supported by evidence. While the per-pill cost may not be much, he said he hopes that if these patients stopped taking ineffective OTC remedies they would be more compliant with prescribed treatments that have a proven benefit. "That would be a significant step in the right direction," he said.

As part of the new initiative, the ACP will also make changes to the next edition of its Medical Knowledge Self-Assessment Program (MKSAP). The upcoming MKSAP edition will include a focus on optimal diagnostic and treatment strategies, based on considerations of value, effectiveness, and avoidance of overuse and misuse. The ACP also plans to develop patient education materials and curricula for medical students and residents.

Because the initiative is a high priority for the ACP, the organization will initially fund the effort entirely through its own operating funds. However, Dr. Weinberger said they hope to get outside funding as the initiative is expanded to develop curricula for medical schools and residency programs.

The effort should compliment comparative effectiveness research being conducted by the Agency for Healthcare Research and Quality, according to Dr. Shekelle. Ideally, the AHRQ will develop the evidence base and the ACP will disseminate practical recommendations and guidelines, he said. ■

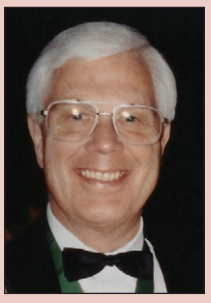
TALK BACK

How do you view the ACP's plan to weed out ineffective diagnostic studies and treatments?

Share your thoughts!
Send e-mail to imnews@elsevier.com;
click on the Talk Back box at
www.internalmedicinenews.com;
or write to Internal Medicine News,
5635 Fishers Lane, Suite 6000,
Rockville, MD 20852.

MY TAKE

Better Data Aid Decision Making



While physicians generally recognize the need to tailor their diagnostic and treatment recommendations to the individual patient, most thoughtful physicians also understand the need to avoid wasteful or ineffective care. A great deal of attention is being properly given to the need for practitioners to consider the value of the services that they recommend, and it is laudable that responsible private sector organizations such as the American College of Physicians are stepping forward to provide physicians with better information to help them make correct decisions consistent with their patients' goals and desires.

ALAN R. NELSON, M.D., *is a member of the* INTERNAL MEDICINE NEWS *Editorial Advisory Board.*