



December 10, 2020

Dear President-Elect Biden,

The American College of Physicians (ACP) congratulates you on your election as the 46th President of the United States of America. ACP is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. Our membership includes 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The task before you and your administration is daunting, including stabilizing the economy, eliminating racial inequity, reducing rising uninsured rates, and addressing climate change. In the best of times, the American health care system is fragmented and inefficient and now it is further strained because of the COVID-19 pandemic. Despite these challenges, ACP believes better is possible. In January 2020, we released a **new vision for America's health care system**, one where everyone has coverage for and access to the care they need, at a cost they and the country can afford; where stakeholders take action to address racial and ethnic health disparities and invest in public health; and where patients have access to physicians who emphasize high-quality, evidence-based, coordinated care.

The policy priorities of ACP and the Biden-Harris transition team are aligned in many areas, including developing an evidence-based, science-focused response to COVID-19, addressing racial equity and health care disparities related to race, ethnicity and cultural identities; implementing a comprehensive plan to mitigate and adapt to climate change and other environmental health issues, improving the Affordable Care Act (ACA) and rolling back current policies that create barriers to care; reforming immigration policies that create barriers to health, and implementing policies to reduce injuries and deaths from firearms. ACP offers our commitment to work with your administration to tackle other challenges, including developing health care payment and delivery system reforms that support the importance of primary, preventive, and comprehensive care.

We also believe that there are initiatives and policies from the administration of President Trump that should be continued and even expanded upon by your administration, including reducing paperwork and other regulatory burdens on physicians and patients, expanding access to telehealth, and improving Medicare payments for evaluation and management services.

The attached document provides in-depth recommendations on immediate and high priority changes that can begin to be addressed through the regulatory or executive order process, as

well as additional policies that we believe should be a priority for your administration's first 100 days, many of which may require Congressional action.

ACP Recommendations for Action on Federal Regulations, Executive Actions, and Legislation

The following list of recommendations includes immediate actions that the Administration can take to rollback policies harmful to health and to redirect federal efforts to policies that will improve the health of individuals and populations. We also recommend the Administration work with Congress and through federal agencies in the first 100 days and beyond to build on these immediate steps to expand access to affordable and comprehensive health insurance coverage, lower prescription drug costs, reform health care payment and delivery systems, advance policies to address racism and disparities, address social drivers of health, and support and fund our nation's public health infrastructure. More details on our recommendations, including references to Executive Orders and federal rules, can be found in the appendix.

Ending the COVID-19 Pandemic

ACP recommends your administration take immediate action to:

- Restore prominence of science in the federal government and protect federal career scientists. We greatly appreciate that you have nominated several internal medicine specialists and ACP members to help lead the national response to end this pandemic, including Dr. Vivek Murthy as Surgeon General, Dr. Anthony S. Fauci as your chief medical adviser, and Dr. Rochelle Walensky as director of the Centers for Disease Control and Prevention (CDC).
- Implement approval, distribution, and funding of a safe and effective COVID-19 vaccine based on recommendations from the Advisory Committee on Immunization Practices (ACIP) informed by ethical considerations as outlined in ACP's Policy Statement on the Ethical Allocation of Vaccines During Pandemics Including COVID-19 which supports and modifies the National Academies of Sciences, Engineering and Medicine report, Framework for Equitable Allocation of COVID-19 Vaccine. The latter report says, "mitigating health inequities is 'a moral imperative of an equitable vaccine allocation framework.'"
- Promote the wearing of masks and encourage social distancing, including supporting mask mandates based on recommendations from public health authorities, to reduce transmission and save lives until enough people are vaccinated to end the pandemic.
- Provide support to physicians and other frontline health care workers, including ensuring access and distribution of personal protective equipment (PPE) to health care workers, invoking the Defense Production Act to require manufacturers to make PPE for physicians and other health care workers, and increasing financial support to practices that are struggling to keep their doors open because of the loss of revenue associated with COVID-19.
- Continue and expand Medicare payment for telemedicine and audio-only consultations.

- Improve COVID-19 testing capacity and public health data infrastructure capabilities to better transfer data among the health care and public health sectors and enable systems to effectively and securely contact trace.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Enact a comprehensive COVID-19 relief package.
- Fund COVID-19 testing and contact tracing efforts.
- Increase funding for the public health infrastructure to address population health needs related to COVID-19.
- Support equitable distribution of safe and effective COVID-19 vaccines; provide funding to states, localities and clinicians to make the vaccines widely available; and fund and implement a trusted public education campaign to increase vaccine acceptance and boost inoculation rates, with particular attention to building confidence in the vaccine among Black persons and others that are distrustful because of legacy of, and continued presence of racism and discrimination in the health care system.
- Support front-line physicians and other health care professionals by providing an adequate supply of personal protective equipment, and economic relief to physicians and their practices from losses of revenue from COVID-19, prioritized to frontline primary and comprehensive care physicians, practices in underserved communities, and smaller independent practices.

Building and improving on the Affordable Care Act (ACA)

ACP recommends your administration take immediate action to:

- Initiate rulemaking to reverse regulations that allow the sale of extended short-term, limited duration plans, association health plans, and other products that do not comply with the ACA's requirements for essential benefits and protections for pre-existing conditions.
- Designate a special enrollment period related to the COVID-19 public health emergency, provide enhanced subsidies for marketplace-based coverage, and increase funding for Navigator programs and open enrollment outreach and education efforts.
- Expand the Healthcare.gov Open Enrollment Period beyond the current span of 45 days.
- Strengthen network adequacy requirements for Qualified Health Plans to ensure patients can access their preferred physician.
- Prohibit policies that would allow states to replace existing health insurance exchanges with Exchange Direct Enrollment mechanisms.
- Rescind the 2018 guidance on statutory guardrail requirements for 1332 State Innovation waivers, which loosens existing safeguards and encourages health plans that do not comply with the ACA's patient protections.

- Explore ways promote a health insurance marketplace-based public option, including through the Section 1332 waiver process.
- Take regulatory and legislative action to defend the ACA from any litigation, including California v. Texas, that would undermine coverage and patient protections. ACP participated in an [amicus brief](#) supporting the petitioners in California v. Texas.

As recommended in **Improving the Patient Protection and Affordable Care Act's Insurance Coverage Provisions: A Position Paper From the American College of Physicians**, and in **Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care**, ACP recommends that your administration build on these immediate steps to improve the ACA and close coverage gaps:

- Expand premium tax credits and cost-sharing reductions.
- Create a permanent reinsurance mechanism.
- Establish a federal public option to inject competition into the health insurance marketplace, and allow any person, including people with employer-sponsored coverage, to enroll in the public option plan or keep private insurance if it meets comparable benefit and cost-sharing standards.
- Implement auto-enrollment or other mechanisms to enroll people who otherwise do not have access to affordable coverage (uninsured and underinsured) in Medicaid or a new public option, as important steps toward universal coverage.
- Fix the “family glitch” through legislation or regulation to expand eligibility for subsidized comprehensive health coverage.
- Mandate coverage of a high-value essential benefit package that includes primary care, prescription drugs, and behavioral health services, and other categories.
- Eliminate patient cost sharing for high value care including primary and comprehensive care and for patients with certain chronic conditions. If cost-sharing is required for any services, it should be adjusted and scaled based on income.

Expanding and Improving Medicaid

ACP recommends your administration take immediate action to:

- Rescind agency guidance promoting work/community participation requirements and per-capita or block grant financing.
- Support waivers that allow reimbursement of behavioral health treatment services provided in Institutions for Mental Diseases.
- Eliminate waivers that condition Medicaid enrollment on whether an eligible individual is working, volunteering, attending school, performing a job search, or other requirements that are inconsistent with the purpose of Medicaid and create barriers to eligibility.

- Eliminate waivers that include high premiums and cost sharing on beneficiaries, or seek to eliminate or pare back retroactive coverage, non-emergency medical transportation, and other crucial benefits.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Work with Congress and state officials to expand Medicaid eligibility and oppose expansion waivers that limit benefits and apply high cost sharing.
- Amend recent Medicaid managed care regulations regarding “provider” networks, provider directories, and beneficiary information.
- Permanently increase payment for Medicaid primary care services to the level of Medicare.
- Increase the federal matching payment (FMAP) to states during the duration of the public health emergency and continuing at least through the end of the 2021 calendar year.

Supporting the value of, and increasing the supply of, physicians providing primary and comprehensive care

ACP recommends your administration take immediate action to:

- Issue an Executive Order to prioritize support for primary and comprehensive care in all federal agencies by requiring that they develop plans to increase funding and investment in primary care under all federal health programs and in plans offered through the Federal Employee Health Benefit Program, re-align workforce and Graduate Medical Education funding to support the training and retention of physicians providing primary and comprehensive care, and implement and expand on payment and delivery system reforms to support primary care physicians and their clinical care teams.
- Create a comprehensive national health care workforce policy to guide the training, supply, and distribution of physicians and other clinicians, including internal medicine specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.
- Pursue executive actions to address the barriers to physicians, including internal medicine specialists, from entering and remaining in the primary care workforce and practicing in underserved communities. Such measures should include: reducing administrative burdens; reforming payment policies to support high-value primary care; relief from high levels of student debt; and increasing the number of Medicare-funded GME positions to address the shortages in primary care and other specialties.

Improving the Health of Immigrants and Supporting International Medical Graduates (IMGs)

ACP recommends your administration take immediate action to:

- Repeal the current administration's ban on travel from certain Muslim-majority countries and amend existing caps on the number of refugees permitted to enter the United States.
- Amend restrictions on IMG physicians and their dependents with J-1, H-1B, and other visas.
- Restore the Deferred Action for Childhood Arrivals, consistent with a recent ruling from a federal judge, and identify executive actions that can be taken to ensure that it is not vulnerable to being eliminated in the future.
- Rescind the "public charge" rule, a regulation that could be used to deny entry for those seeking to immigrate to the U.S. or result in deportation for individuals seeking basic federally funded health care services for themselves and their families.
- Permanently ban the practice of separation of children from parents at the border and detention centers, ensure appropriate health care and access to other resources to improve the health of detainees, ensure compliance with the Flores consent agreement, and reunite children and parents who have been separated.

Supporting Women's Health

ACP recommends your administration take immediate action to:

- Pursue executive actions to preserve the principles of patient autonomy regarding reproductive decision-making rights.
- Direct the Attorney General to enter into litigation to defend reproductive rights and oppose state laws and regulations that infringe upon these rights.
- Initiate rulemaking to eliminate employer exemptions to providing contraceptive coverage.
- Reverse the Title X gag rule and restore funding to family planning clinics.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Codify legal and existing constitutional protections that center on principles of autonomy on matters affecting patients' individual health, including about types of contraceptive methods they use and whether or not to continue a pregnancy as defined by existing constitutional law.
- Establish universal access to at least six weeks of paid family and medical leave that is flexible to accommodate care for a diverse array of family structures, including updating the Family Medical and Leave Act to include grandparents or in-laws.
- Implement policies to eliminate maternal mortality disparities and improve maternal outcomes through expanding access to affordable, comprehensive, and

nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman's lifespan and covers resources like doulas.

Ending Discrimination, Racism, and Disparities in Health Care; Addressing Social Drivers and Other Barriers

ACP recommends your administration take immediate action to:

- Implement a “health in all policies” approach by using health impact assessments to anticipate and prevent negative social drivers of health in government policies and community planning decisions.
- Promote cross-agency collaboration through the Federal Interagency Health Equity Team to ensure resources are being used efficiently and effectively to address social drivers of health.
- Direct the National Institutes of Health (NIH) and other federal agencies to conduct research on how social drivers affect health outcomes and to recruit disadvantaged and underserved populations into large-scale research studies and community-based participatory studies.
- Ensure that alternative payment models and value-based interventions reflect the increased risk associated with caring for disadvantaged patient populations and provide support to clinicians and their practices who track, address, and partner with the community to address social drivers of health.
- Issue an Executive Order permitting the consideration of race in admission decisions in medical schools receiving federal funding.
- Clarify that discrimination on the basis of sex stereotypes and gender identity constitutes sex discrimination under federal law and rescind any executive orders or regulations that interpret otherwise.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Adequately fund federal, state, tribal, and local agencies in their efforts to address social drivers of health.
- Prioritize funding and policy interventions on critical public health objectives including reducing smoking and tobacco-related preventable illnesses, reducing and treating substance use disorders, and improving access to the availability of high-quality nutritional food.
- Reform biased and inequitable education funding mechanisms that rely on underlying socioeconomic factors and perpetuate in disparities in resources, opportunities, and outcomes.
- Provide government and institutional support in removing the financial and non-financial barriers of practicing medicine for those of underrepresented backgrounds.

- Support programs and initiatives that recruit and retain physicians from underrepresented minorities and to practice in underserved areas.
- Reimburse clinicians for translation services needed to provide care for those with limited English proficiency or who are deaf.

Implementing Innovative Law Enforcement Practices and Criminal Justice Reforms to Improve Health

ACP recommends your administration take immediate action to:

- Rescind federal prohibitions on implicit bias and racial sensitivity trainings.
- Initiate an Executive Order to include creation of a national police oversight commission, funding for community policing initiatives, supporting training of mental health clinicians to be first responders, and development of a national database on law enforcement misconduct.
- Reduce militarization of civilian law enforcement encounters by signing an executive order banning the inappropriate acquisition and use of certain surplus military-grade weapons and equipment by local police departments from the Department of Defense through the Law Enforcement Support Office (LESO) 1033 Program.
- Require federal law enforcement authorities to incorporate best practices to eliminate excessive use of force and use technology like body cameras to assist in monitoring and enforcing use of force protocols.
- Prohibit federal law enforcement agencies from using dangerous and deadly force, including the use of tear gas and rubber bullets, against peaceful protestors.
- Support officer wellness and safety by requiring federal law enforcement agencies to adopt best practices on recruitment, training, retention, and support programs.
- Remove barriers to transparency and accountability of federal law enforcement agencies in cases of misconduct.
- Direct DOJ to conduct an extensive review of criminal justice law, policies, and practices for racial impact and overhaul those that contribute to racial and ethnic disparities in rates of law enforcement interactions, incarceration, and severity in sentencing and result in unnecessary or disproportionate harm.
- Utilize clemency powers and authority granted by the CARES Act to order the Bureau of Prisons to grant compassionate release and home confinement requests for those who are non-violent offenders and are not likely to pose a substantial public safety risk.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Re-introduce and pass the George Floyd Act and other legislation focused on eliminating racism and police violence.
- Provide funding to study and implement alternative emergency first response models that deploy social workers and other mental health professionals for instances of mental

health crises, homelessness, violence interruption, and mediation in appropriate circumstances.

- Research and adopt policy alternatives to pre-trial incarceration practices that result in inequities, such as cash bail, that ensure appropriate protection from harm for those who may be dangerous to themselves or others.
- Take steps to eliminate racial and ethnic disparities and other inequities in capital punishment sentencing.
- Ensure adequate resources are allocated for public defender programs so that all individuals have access high-quality legal representation.
- Study and implement safe alternatives to incarceration and other criminal penalties for nonviolent drug offenses.

Addressing Climate Change and Environmental Health

ACP recommends your administration take immediate action

to:

- Rejoin the Paris Agreement.
- Ensure that federal agencies communicate apolitical, science-based information regarding climate change and greenhouse gas emissions, and eliminate any restrictions and agency guidances that interfere with the ability of career scientists to provide such information.
- Protect career scientists and other federal employees engaged in this area.
- Rollback regulations that would increase carbon emissions and associated respiratory diseases and other health outcomes, including the Affordable Clean Energy and methane emissions rules.
- Lay policy and regulatory groundwork for rapid shift from use of fossil fuels to clean, renewable energy and support efforts to reduce greenhouse gas emissions in the health care sector.
- Prevent contamination of the U.S. water supply and ensure everyone has access to clean, affordable drinking water.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Implement strong, comprehensive climate change mitigation and adaptation policies, including an accelerated transition from fossil fuels to clean energy and energy efficiency.
- Develop policies to address the needs of communities disproportionately impacted by climate change, including people with low-incomes, communities of color, outdoor workers, and the aged and disabled.
- Support the health care sector in building resilience to the impacts of climate change.

Reducing Injuries and Deaths from Firearms

ACP recommends your administration take immediate action to:

- Issue an Executive Order to create a task force to develop a comprehensive, coordinated plan to reduce injuries and deaths from firearms.
- Appoint senior level officials dedicated to treating injuries and deaths from firearms as a public health crisis.
- Create a federal office of violence prevention in the Department of Health and Human Services.
- Direct federal agencies to support and fund community-based gun violence victim services and violence intervention programs and programs that collect public health-based information on gun deaths and injuries.

Improving the Transition to Value-Based Payment

ACP recommends your administration take immediate action to:

- Continue testing new, innovative Alternative Payment Models (APM) that are flexible in design to meet a wide range of patient and practice-specific needs.
- Incorporate feedback from patients, physicians, and stakeholders to continuously improve existing Medicare APMs, including CMS' new Primary Care First (PCF) and Direct Contracting (DC) Models set to start in 2021 and 2022. More specifically, for PCF, consider increasing the flat visit fee, adding additional utilization indicators beyond acute hospital utilization and total per capita cost, further refining risk adjustment methodologies to account for comorbidities, and removing the current 50-clinician cap. For the DC Model, consider including new cohorts, allowing smaller, more variable discounts, and improving risk adjustment to account for co-morbidities and social drivers of health.
- Pilot ACP's Medical Neighborhood Model, as recently recommended by the Physician-focused Payment Model Technical Advisory Committee (PTAC).
- Look to collaborate with Medicaid, Medicare Advantage, and private payers on new models and performance metrics to align incentives and minimize burden on practices.
- Implement broad COVID-19 pandemic-related flexibilities for all Advanced APM participants.
- Push Congress to extend the 5% Advanced APM bonus and give the Secretary more discretion in setting Qualified APM Participant (QP) thresholds in the future to reflect the current availability of APMs in the market.
- Continue working with stakeholders to improve MIPS to reduce administrative burden on practices while driving more impactful change in patient outcomes.
- Continue working with ACP to implement our preventive care and chronic disease management MVPs.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Ensure payment rates are sufficient and appropriately risk adjusted to ensure access to care for all and existing health disparities are not further exasperated in any way.
- Design physician payment policies that appropriately value primary care and cognitive services, including primary care, preventive health services, and comprehensive care provided by internal medicine physician specialists.
- Eliminate “check-the-box” reporting of measures and improve performance measures to ensure all metrics used for payment and public reporting purposes are reliable, meaningfully improve patient outcomes, and actionable by clinicians.
- Provide patients with the information they need to make educated decisions about which services, physicians, care teams, and treatments are right for them, in a way that a wide range of patients with varying cultural and educational backgrounds can understand.
- Continue exploring opportunities to eliminate unnecessary or inefficient administrative requirements, particularly for clinicians in value-based payment arrangements that hold clinicians accountable for cost and utilization outcomes.

Making Prescription Drugs Affordable

ACP recommends your administration take immediate action to:

- Direct the Centers for Medicare and Medicaid Innovation to implement a reference pricing demonstration project.
- Modify the Medicare Part D low-income subsidy (LIS) program by eliminating beneficiary cost-sharing for generic or biosimilar drugs to increase medication adherence and promote utilization of lower-cost generic drugs.
- Institute rigorous price transparency standards for prescription drugs that are developed using National Institutes of Health (NIH) and other federally funded research.
- Implement payment models to study approaches to Medicare Part B reimbursement for physician-administered prescription drugs that reduce incentives to prescribe higher-priced drugs when a lower-cost and similarly effective option is available.
- Amend existing regulations to allow all states to import prescription drugs from Canada.
- Evaluate ways to ensure that cost savings from rebates derived from pharmacy benefit managers are directed to patients.

Building on these immediate steps, ACP recommends that your administration prioritize and advance the following policies through legislative and executive action:

- Enable Medicare to negotiate for lower prescription drug prices.
- Implement caps on annual out-of-pocket spending on prescription drugs for Medicare Part D beneficiaries who reach the catastrophic phase of coverage.

- Urge Congress to grant the legal authorities to CMS necessary to ensure compliance with the Medicaid Drug Rebate Program (MDRP) to minimize the financial impact to the federal government of prescription drug misclassification.
- Reform the Orphan Drug Act to better align incentives to reward true innovation and drug discovery for rare diseases.
- Federal agencies should be empowered through guidance and congressional action to address anti-competitive behaviors and gaming in the pharmaceutical market, such as “pay-for-delay” arrangements.
- Reduce data and market exclusivity period for biologic drugs from 12 years to 7 years; and
- Eliminate tax deductions for direct-to-consumer product claim advertisements.

Expanding and Enhancing Telehealth and other Health Information Technology (IT)

ACP recommends your administration take immediate action to:

- Where necessary, make certain telehealth provisions established under the COVID-19 public health emergency permanent, including permanently lifting the geographical and originating site restrictions.
- Prioritize the CMS commissioned study on the telehealth flexibilities provided during the COVID-19 PHE to assess the experiences and learnings of both patients and physicians utilizing these revised policies.
- Delay information blocking applicability and enforcement deadlines beyond the current April 2021 date until the COVID-19 pandemic is under control.
- Support federal legislation to provide expanded health data privacy, protection, and use principles outside of HIPAA.
- Remove ban on federal funding to research best practices for patient matching and identification to improve patient safety and interoperability efforts.

Thank you considering our recommendations. The nation’s internal medicine physicians stand ready to work with you and your administration to find solutions to the challenges facing our health care system. We would welcome the opportunity to meet with the transition team to discuss these and their priorities. Please contact Bob Doherty, Senior Vice President for Governmental Affairs at rdoherty@acponline.org to schedule a meeting.

Sincerely,



Jacqueline W. Fincher, MD, MACP
President, American College of Physicians

Appendix: ACP's detailed recommendations to President-elect Biden and his transition team

Ending the COVID-19 Pandemic

Desired Action

Implement an evidence-based approach to the COVID-19 pandemic, address economic needs resulting from the virus, support public health interventions, and support fair and equitable vaccine distribution effort. Work with Congress to enact a comprehensive COVID-19 relief package, fund COVID-19 testing and contact tracing efforts, increase funding for the public health infrastructure to address population health needs related to COVID-19; provide funding to states, localities and clinicians to make the vaccines widely available and effectively distributed, and fund and implement a trusted public education campaign to increase vaccine acceptance and boost inoculation rates. Particular attention should be directed to building confidence in the vaccine among Black persons and others who may be hesitant to get vaccinated due to continued discrimination and a historical legacy of being subjected to harmful treatment and research practices. Support front-line physicians and other health care professionals by providing an adequate supply of personal protective equipment, and economic relief to physicians and their practices from losses of revenue from COVID-19, prioritized to frontline primary and comprehensive care physicians, practices in underserved communities, and smaller independent practices.

Background

The COVID-19 pandemic continues to test our nation. As of December 2020, nearly 290,000 people have lost their lives to the virus and millions have been infected. Communities of color, the elderly, long-term care residents, and Indigenous populations are disproportionately affected. Millions have lost or are on the verge of losing their jobs and the health coverage that comes with it. The health care system is stretched to the brink: physicians and other health care professionals desperately need Personal Protective Equipment (PPE) and many physician offices are struggling financially. The current administration's response on mask wearing, social distancing, contact tracing and other interventions has often confused the public and led to a less effective response. As a result, many people face long wait times to get tests and contact tracing efforts are sporadic and underfunded. The pandemic response is complicated by rising vaccine hesitancy, misinformation about the virus, and legitimate mistrust by some communities of color of the health care system. ACP is greatly encouraged by the Biden administration's commitment to have science and scientists lead the response to COVID-19 as evidenced by naming several internal medicine specialists as well as ACP members to key roles, including Vivek Murthy, MD, as Surgeon General, and Anthony S. Fauci, MD, as chief medical adviser on COVID-19; and Rochelle P. Walensky, MD, as director of the Centers for Disease Control and Prevention (CDC).

Recommendations

1. Partner with ACP and other organizations representing clinicians to prioritize sending clear, evidence-based messaging to the public about mask wearing, limiting travel, and other interventions.

2. Work with Congress to pass comprehensive COVID-19 response legislation that includes financial support for physician practices and funding for state and local public health entities to increase testing and contact tracing capabilities.
3. Invoke the Defense Production Act to require manufacturers to make masks, gowns and other supplies for physicians and other frontline health care workers.
4. Implement approval, distribution, and funding of a safe and effective COVID-19 vaccine based on recommendations from the Advisory Committee on Immunization Practices (ACIP) informed by ethical considerations as outlined in ACP's Policy Statement on the Ethical Allocation of Vaccines During Pandemics Including COVID-19 which supports and modifies the National Academies of Sciences, Engineering and Medicine report, Framework for Equitable Allocation of COVID-19 Vaccine. The latter report says, "mitigating health inequities is 'a moral imperative of an equitable vaccine allocation framework.'"

Building and Improving on the Affordable Care Act (ACA)

Desired Action

Build on the ACA to expand coverage, close coverage gaps, offer more choice of coverage including a public option, ensure access to essential benefits, and reverse policies from the current administration that create barriers to coverage.

Background

The ACA has expanded access to coverage for millions of Americans and ensured that no person is denied affordable coverage due to a pre-existing condition. However, there are gaps in coverage that should be closed. In addition, regulations and other policies from the current administration that have created barriers to coverage should be reversed. Prior to the 2018 rule, short-term limited duration (STLD) plans were intended to be temporary insurance for people who were between jobs. The current administration changed the definition of short-term, limited duration plans to allow them to remain in effect for nearly 12 months, with an opportunity to renew. These plans are not obligated to comply with the ACA's regulations, raising concern that healthier individuals would purchase STLD plans instead of comprehensive coverage. The current administration also finalized a regulation amending rules for Association Health Plans that do not comply with the ACA's regulations.

Over the last few years, funding for Healthcare.gov Navigator programs and open enrollment education and outreach activities has been cut, potentially reducing awareness of open enrollment periods. The open enrollment period for Healthcare.gov has been shortened to 45 days, although many states with state-based exchanges have expanded open enrollment periods to provide more time to shop for and select a plan. ACP is also concerned about the proliferation of plans with narrow "provider" networks and has recommended that the Centers for Medicare and Medicaid Services (CMS) establish quantitative network adequacy measures and additional oversight to ensure patients have access to their preferred physician. Further, ACP is concerned about recent 1332 waivers and proposed rulemaking that would allow states to reject the well-established and effective health insurance exchange in favor of private direct enrollment mechanisms. ACP supports establishing a federal public option in health insurance marketplace. The 1332 State Innovation Waiver process could be a vehicle for state-based public option plans.

More needs to be done to expand access to affordable, comprehensive coverage, particularly during the COVID-19 pandemic and resulting economic instability. Health coverage costs are rising and many middle-income individuals find coverage to be unaffordable. Premium and cost-sharing subsidies for marketplace-based coverage are phased out at 400% of the federal poverty level, making coverage unaffordable for many. A mechanism to ensure coverage enrollment, such as automatic enrollment should be considered to encourage enrollment, particularly among those who do not qualify for subsidized coverage and reside in states that have not expanded Medicaid. Some areas, particularly rural counties, continue to see limited competition among marketplace-based health insurers. Policies to expand choice of coverage, including the public option, could address this issue and broaden access to lower-cost insurance in underserved areas.

Recommendations

1. Initiate rulemaking to reverse the Short-Term, Limited-Duration Insurance final rule (83 FR 38212) and Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans (83 FR 28912).
2. Restore (and consider increasing) funding for Healthcare.gov Navigators, in-person assisters, and open enrollment outreach and promotion activities.
3. Create a special enrollment period related to the COVID-19 public health emergency.
4. Expand the Healthcare.gov Open Enrollment Period beyond the current span of 45 days.
5. Strengthen network adequacy requirements for Qualified Health Plans to ensure patients can access their preferred physician.
6. Prohibit policies that would allow states to replace existing health insurance exchanges with Exchange Direct Enrollment mechanisms.
7. Fix the “family glitch” through legislation or regulation to expand eligibility for subsidized comprehensive health coverage.
8. Rescind the 2018 guidance on statutory guardrail requirements for 1332 State Innovation waivers, which loosens existing safeguards and encourages health plans that do not comply with the ACA’s patient protections.
9. Explore ways promote a health insurance marketplace-based public option, including through the Section 1332 waiver process.
10. Take regulatory and legislative action to defend the ACA from any litigation, including California v. Texas, that would undermine coverage and patient protections. ACP participated in an [amicus brief](#) supporting the petitioners in California v. Texas.
11. Expand premium tax credits and cost-sharing reductions.
12. Create a permanent reinsurance mechanism.
13. Implement auto-enrollment or other mechanisms to enroll people who otherwise do not have access to affordable coverage (uninsured and underinsured) in Medicaid or a new public option, as important steps toward universal coverage.
14. Mandate coverage of a high-value essential benefit package that includes primary care, prescription drugs, behavioral health services, and other categories.
15. Eliminate patient cost sharing for high value care including primary and comprehensive care and for patients with certain chronic conditions. If cost-sharing is required for any services, it should be adjusted and scaled based on income.

Expanding and Improving Medicaid

Desired Action

Reverse policies and waivers that create barriers to Medicaid eligibility, increase out-of-pocket costs, and restrict benefits. Expand access to Medicaid coverage.

Background

A number of states have requested Medicaid waivers that condition enrollment on whether an individual is working, volunteering, or taking part in other “community engagement” activities. Evidence shows that work requirements have led to reduced enrollment and have not increased employment among the Medicaid-eligible population. ACP has opposed mandatory work requirements and joined amicus briefs to block these requirements. As a result of judicial decisions and other policies, work requirements are currently on hold, but if such decisions are reversed or altered, then work requirements could go forward, leading to reduced enrollment. The U.S. Supreme Court is scheduled to consider whether a lower court decision that blocked work requirements should be overturned.

The current administration issued guidance to State Medicaid Directors on developing waivers to test block grant or per-capita cap financing. ACP is opposed to these financing arrangements because they will put Medicaid enrollees at risk of losing essential coverage, benefits and eligibility, especially if block grants or per-capita financing do not keep pace with rising costs. The current administration also approved regulations providing flexibility to managed care organizations and state Medicaid programs that could reduce “provider” network adequacy and patient information requirements. Medicaid payment rates are far below those of Medicaid and commercial payers, creating barriers to care. To address this, ACP supported making the ACA provision requiring Medicaid-Medicare pay parity permanent.

The United States continues to face an opioid use disorder crisis. The current administration has built on efforts to enable states to reimburse for substance use disorder treatment furnished in Institutes of Mental Diseases (IMD), which ACP supports.

Steps should be taken to expand Medicaid eligibility and coverage throughout the United States.

Recommendations

1. Reject any Medicaid waivers that would impose work requirements, restrict benefits, or create other barriers to eligibility inconsistent with the program’s purpose to ensure access to health care. Repeal the Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries (SMD:18-002) guidance.
2. Repeal the Healthy Adult Opportunity (SMD: 20-001) guidance and reject pending waiver requests.
3. Amend regulations in Medicaid & Children’s Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2408-F) on managed care “provider” directories, network adequacy requirements, including restoring time and distance standards.
4. Work with Congress to make Medicare-Medicaid pay parity permanent, particularly for primary care.

5. Support waivers to expand access to behavioral health services, including those that facilitate substance use disorder treatment in IMDs and other settings as well as primary care-behavioral health integration.

Supporting the value of, and increasing the supply of, physicians providing primary and comprehensive care

Desired Action

Initiate policies to strengthen and expand the primary care physician workforce, increase access to primary and comprehensive care, address growing shortages, and ensure an adequate supply of internal medicine physician specialists.

Background

An adequate physician workforce is essential to ensuring access to care. Particular attention should be directed at recruiting and retaining ambulatory-based internal medicine specialists in recognition of their unique training, skills, and contributions in providing high-value primary, preventive, and comprehensive care to adolescents and adults throughout their lifetimes, particularly for patients with more complex medical problems. A comprehensive approach to address shortages and maldistribution of clinicians is urgently needed. This should include increasing graduate medical education training slots for specialties facing shortages, including internal medicine; reducing administrative burdens; easing medical student debt; reforming payment policies to support high-value primary care; and improving and expanding on programs that support primary care physicians who choose to practice in underserved areas.

Recommendations

1. Issue an Executive Order to prioritize support for primary care in all federal agencies and mandate greater investment in primary care under all federal health programs.
2. Create a comprehensive national health care workforce policy to guide the training, supply and distribution of physicians and other clinicians, including internal medicine specialists.
3. Pursue executive actions to address the barriers to physicians, including internal medicine specialists, from entering and remaining in the primary care workforce and practicing in underserved communities:
 - a. Reduce administrative burdens
 - b. Reform payment policies to support high-value primary and comprehensive care
 - c. Provide relief from high levels of student debt.
4. Increase the number of Medicare-funded GME positions to address the shortages in primary care and other specialties.
5. Initiate and support efforts to increase diversity, equity, and inclusion in the physician workforce.

Improving the Health of Immigrants and Supporting International Medical Graduates (IMGs)

Desired Action

Change immigration policies that adversely affect health and inappropriately limit legal immigration of physicians and health care professionals.

Background

The current administration has issued several Executive Orders and taken other actions limiting or banning the number of immigrants from various countries, reducing the number of refugees allowed into the country each year, and changing the qualifications to become a permanent resident (public charge rule). Policies have been implemented that have been harmful to immigrants and refugees seeking to enter the United States, including family detention, separation of children from their families, and poor conditions in Immigration and Customs Enforcement (ICE) facilities. The current administration has banned travel from 7 majority-Muslim countries and limited the numbers of refugees admitted to the US. It has also sought to discontinue the Deferred Action Childhood Arrivals (DACA) program, although a federal judge recently re-instated the program. Backlogs and greater restrictions on visas have adversely affected IMGs who seek to enter the US for education, research or patient care, and for IMGs who have been legally admitted to the US, have made it harder and longer to obtain permanent residency status. All of these policies are potentially harmful to the health and well-being of immigrants, and/or deny the US the talents of persons from other countries, including physicians, who seek to legally enter the United States.

Recommendations

1. Amend restrictions on IMG physicians and their dependents with J-1, H-1B, and other visas.
2. Reverse the Inadmissibility on Public Charge Grounds proposed rule (DHS Docket No. USCIS-2010-0012).
3. Fully restore the DACA program and work with Congress to develop a permanent pathway to citizenship for “Dreamers.”
4. Direct U.S. Immigration and Customs Enforcement (ICE) to release children and families/caregivers from Family Residential Centers.
5. Increase caps on refugee admissions.
6. Direct ICE to change procedures at the border, including no longer detaining/separating families and improving conditions in detention centers, and ensuring access to vaccines and other medical care.
7. Repeal the Trump Administration’s ban on travel from certain Muslim-majority countries.

Supporting Women’s Health

Desired Action

Support women’s health by reducing barriers to accessing needed health care services, enact legislation to create paid family and medical leave, and lower maternal mortality particularly for people of color. Pursue executive actions to preserve the principles of patient autonomy regarding reproductive decision-making rights. Ensure access to contraception by eliminating inappropriate employer exemptions to providing contraceptive coverage. Reverse the Title X gag rule and restore funding to family planning clinics.

Background

ACP's 2018 [position paper](#), *Women's Health Policy in the United States*, examined the challenges women face in the U.S. health care system across their lifespans, including access to care; sex-and gender-specific health issues; variation in health outcomes compared with men; underrepresentation in research studies; and public policies that affect women, their families, and societies. Stakeholders must consider how to integrate women's health needs into policy discussion and capitalize on opportunities to improve the health of women, their families, and society.

Women face unique challenges throughout their life regarding their physical health, health care system interactions, and societal roles. Barriers exist in accessing reproductive health care for women, which have substantially grown under actions taken by the Trump administration. In 2018, the Trump Administration issued final rules that expanded exemptions from the requirement for employer-sponsored plans to cover preventive services and screenings for women, including contraceptives, to additional employers that object on religious or moral grounds. As a result, there is no guaranteed coverage of contraceptive services for female employees or their dependents. Another final rule placed several requirements on family planning clinics that receive federal funding through the Title X program that interfere with the patient-physician relationship and reduce access to medically appropriate care. This rule prevents clinics receiving federal funds from offering abortion services and prevents them from referring pregnant patients to abortion providers, among other measures. As funding for family planning services and access to comprehensive reproductive health care are regularly disputed by state and federal legislatures, creating uncertainties and potential disparities around access to reproductive care, ACP believes bold policy actions are needed to restore and stabilize this access.

The U.S. has the highest maternal mortality rate of developed countries and is the only developed country with maternal mortality rates that continue to rise, but the causes of this disparity are mostly unknown. Of the 700 pregnancy-related deaths in the U.S. each year, roughly 60% of them are preventable. Women of color are disproportionately impacted by high maternal mortality, with Black, American Indian and Alaska Native women 3 times more likely to die of pregnancy-related causes than White women. Efforts are needed to improve health factors that impact maternal outcomes, like preconception health, health through pregnancy, and postpartum care, as well as the social drivers of health such as income, education, and employment that contribute to disparities.

The U.S. is one of only two countries that does not guarantee some degree of paid family or maternity leave to its citizens. As a result, only 13% of private sector employees had access to paid family leave and the rate at which new mothers have used maternity leave has been stagnant for the past several decades. The lack of paid family leave particularly affects women given that as many as 75% of all caregivers are women and female caregivers report spending as much as 50% more time providing care than men. Caregiving can take a toll on one's health and is associated with a higher risk for poor health due to physical and emotional stress associated with the caregiver role. Hence, paid leave policies can improve health outcomes for women and their families. ACP believes that paid leave policies should be flexible in scope and allow for the care of children (biological or adopted), spouses, partners, parents, parents-in-law, or grandparents.

Recommendations

1. Initiate rulemaking to eliminate inappropriate employer exemptions to providing contraceptive coverage as specified in the Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act.
2. Reverse the Title X gag rule in the Compliance With Statutory Program Integrity Requirements (84 FR 7741) final rule and restore funding to family planning clinics.
3. Pursue executive actions to preserve the principles of patient autonomy regarding reproductive decision-making rights.
4. Direct the Attorney General to enter into litigation to defend reproductive rights and oppose state laws and regulations that infringe upon these rights.
5. Codify legal and existing constitutional protections that center on principles of autonomy on matters affecting patients' individual health, including about types of contraceptive methods they use and whether or not to continue a pregnancy as defined by constitutional law in the cases of *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.
6. Establish universal access to at least six weeks of paid family and medical leave that is flexible to accommodate care for a diverse array of family structures, including updating the Family Medical and Leave Act to include grandparents or in-laws.
7. Implement policies to eliminate maternal mortality disparities and improve maternal outcomes through expanding access to affordable, comprehensive, and nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman's lifespan and covers resources like doulas, as well as promoting and supporting the establishment of maternal mortality review committees.

Ending Discrimination, Racism, and Disparities in Health Care; Address Social Drivers and Other Barriers

Desired Action

Address and seek to end discrimination and racism in health and health care; initiative policies to understand, address and end health care disparities associated with a person's race, ethnicity and cultural identity; seek to understand, address, and overcome social drivers that contribute to poorer health. Support consideration of race in admission decisions at institutions of higher education.

Background

The United States' experience with the COVID-19 pandemic has laid bare the impact of social drivers of health on individual and community well-being and the inadequacies of the current health care system in dealing with them. Social drivers of health (also known as social determinants of health) are the nonmedical factors and conditions under which people are born, grow, live, work, and age in that contribute to health status.

These factors may have short- or long-term effects on health outcomes and are associated with negative health outcomes. Drivers like housing, socioeconomic status, access to health care, environment, neighborhood/geographical location, employment, education, social support networks, language, transportation, racism, and others have a far-reaching influence on nearly all areas of physical and mental health. For example, education and employment status provide the knowledge and resources

necessary to create health while access to a healthy and adequate supply of food is necessary to living a healthy and productive life. People are more likely to have better health outcomes if they have the resources to obtain a good education, stable housing, safe environments, and health care coverage. Programs and efforts that address social drivers of health, such as the provision of social services, recruitment of a diverse physician workforce, and strategic placement of physicians to address access issues should be supported by governments. These investments are associated with overall cost savings and improved health and should be included in health care funding packages. Investment in the general public health infrastructure and programs is needed to address the underlying conditions that comprise social drivers of health. Policymakers must take into effect the impact public policies and decisions in all realms have on creating and exacerbating negative social drivers of health.

Historically, racial and ethnic minorities and those from disadvantaged backgrounds have faced various financial and societal barriers to studying at institutions of higher education. Black, Latinx, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander students are underrepresented in higher education and particularly in medical schools. Disparities in education quality and opportunities and wealth, segregation, exclusion, social influences, and other factors contribute to this underrepresentation. Many institutions of higher education have affirmative action policies that consider race as a factor in admission decisions in order to promote student body diversity, which has been upheld on numerous occasions by the Supreme Court. Federal policy should promote the consideration of race in admission decisions for institutions of higher education as a means to correct historical injustices that have contributed to the underrepresentation of students of color.

Recommendations

1. Issue an Executive Order directing agencies to use health impact assessments to prevent government implemented policies and community planning decisions from creating or exacerbating negative social drivers of health (SDOH); direct the Federal Interagency Health Equity Team to improve federal coordination agency to address SDOH; and direct federal research agencies to conduct research on SDOH.
2. Establish through Executive Order policy that supports consideration of race in admission decisions as a factor of federal funding.
3. Clarify that discrimination on the basis of sex stereotypes and gender identity constitutes sex discrimination under federal law and rescind any Executive Orders or regulations that interpret otherwise.
4. Implement a “health in all policies” approach by using health impact assessments to anticipate and prevent negative social drivers of health in government policies and community planning decisions.
5. Promote cross-agency collaboration through the Federal Interagency Health Equity Team to ensure resources are being used efficiently and effectively to address social drivers of health.
6. Direct the National Institutes of Health (NIH) and other federal agencies to conduct research on how social drivers affect health outcomes and to recruit disadvantaged and underserved populations into large-scale research studies and community-based participatory studies.
7. Ensure that alternative payment models and value-based interventions reflect the increased risk associated with caring for disadvantaged patient populations and provide support to clinicians and their practices who track, address, and partner with the community to address social drivers of health.

8. Adequately fund federal, state, tribal, and local agencies in their efforts to address social drivers of health.
9. Prioritize funding and policy interventions on critical public health objectives including reducing smoking and tobacco-related preventable illnesses, reducing and treating substance use disorders, and improving access to the availability of high-quality nutritional food.
10. Reform biased and inequitable education funding mechanisms that rely on underlying socioeconomic factors and perpetuate in disparities in resources, opportunities, and outcomes.
11. Provide government and institutional support in removing the financial and non-financial barriers of practicing medicine for those of underrepresented backgrounds.
12. Support programs and initiatives that recruit and retain physicians from underrepresented minorities and to practice in underserved areas.
13. Reimburse clinicians for translation services needed to provide care for those with limited English proficiency or who are deaf.

Implementing Innovative Law Enforcement Practices and Criminal Justice Reforms to Improve Health

Desired Action

Permit federal agencies to conduct implicit bias and racial sensitivity trainings, implement broad law enforcement and criminal justice reforms including community policing models, de-militarization of law enforcement, and law enforcement wellness. Direct federal agencies to review how criminal justice law and policies impact racial and ethnic disparities in sentencing severity, incarceration rates and other measures.

Background

In response to the 2015 fatal shooting of Michael Brown by law enforcement in Ferguson, Missouri, President Barack Obama established the President's Task Force on 21st Century Policing to examine best practices for building community trust between law enforcement and the communities they serve. This task force produced 59 recommendations that touched on issues including use of force policies, recruitment and hiring practices, and department culture, among others. Additional executive action on this issue is needed. Continual discriminatory law enforcement practices and fatal law enforcement encounters involving unarmed people of color have culminated in a national reckoning with racism. Discrimination, racism, and violence in criminal justice and law enforcement policies can negatively impact the health and well-being of racial and ethnic minorities and result in the loss of life. ACP asserts that addressing biases in criminal justice and law enforcement is integral to a comprehensive public policy approach to reduce and eliminate health and health care disparities.

In recent months, the deaths of George Floyd in Minneapolis, Minnesota and Breonna Taylor in Louisville, Kentucky at the hands of law enforcement have ignited renewed calls for sweeping action addressing racism in society and specifically violent and discriminatory law enforcement and criminal justice policies. ACP contends that disparities and discrimination in criminal justice and law enforcement must be addressed as part of a comprehensive and interconnected approach to eliminating disparities in health and health care for racial and ethnic minorities. Innovative policies that reduce unnecessary interactions with law enforcement and the criminal justice system, and hence reduce the harms associated with them, while balancing public safety are needed. Criminal justice law, policies, and

practices must be examined and studied for racial impact and overhauled if they result in unnecessary or disproportionate harm.

Recommendations

1. Rescind Executive Order on Combating Race and Sex Stereotyping, which seeks to prohibit implicit bias and racial sensitivity trainings.
2. Initiate an Executive Order to include creation of a national police oversight commission, funding for community policing initiatives, supporting training of mental health clinicians to be first responders, and development of a national database on law enforcement misconduct.
3. Sign an Executive Order banning the inappropriate acquisition and use of certain surplus military-grade weapons and equipment by local police departments from the Department of Defense through the Law Enforcement Support Office (LESO) 1033 Program.
4. Require federal law enforcement authorities to incorporate best practices to eliminate excessive use of force and use technology like body cameras to assist in monitoring and enforcing use of force protocols.
5. Prohibit federal law enforcement agencies from using dangerous and deadly force, including the use of tear gas and rubber bullets, against peaceful protestors.
6. Support officer wellness and safety by requiring federal law enforcement agencies to adopt best practices on recruitment, training, retention, and support programs.
7. Remove barriers to transparency and accountability of federal law enforcement agencies in cases of misconduct.
8. Direct DOJ to conduct an extensive review of criminal justice law, policies, and practices for racial impact and overhaul those that contribute to racial and ethnic disparities in rates of law enforcement interactions, incarceration, and severity in sentencing and result in unnecessary or disproportionate harm.
9. Utilize clemency powers and authority granted by the CARES Act to order the Bureau of Prisons to grant compassionate release and home confinement requests for those who are non-violent offenders and are not likely to pose a substantial public safety risk.
10. Re-introduce and pass the George Floyd Act and other legislation focused on eliminating racism and police violence.
11. Provide funding to study and implement alternative emergency first response models that deploy social workers and other mental health professionals for instances of mental health crises, homelessness, violence interruption, and mediation in appropriate circumstances.
12. Research and adopt policy alternatives to pre-trial incarceration practices that result in inequities, such as cash bail, while ensuring appropriate protection from harm for those who may be dangerous to themselves or others.
13. Eliminate racial and ethnic disparities and other inequities in capital punishment sentencing.
14. Ensure adequate resources are allocated for public defender programs so that all individuals have access high-quality legal representation.
15. Study and implement safe alternatives to incarceration and other criminal penalties for nonviolent drug offenses.

Addressing Climate Change and Environmental Health

Desired Action

Rejoin the Paris Agreement, implement broad climate change emission mitigation and adaptation policies, including accelerating transition away from fossil fuels to carbon neutral energy and energy conservation. Address the health impacts of climate change. Facilitate environmental sustainability and energy efficiency in the health care sector.

Background

In 2016, ACP released a [policy paper](#) on climate change and human health calling for immediate action to mitigate and adapt to global climate change. The paper outlined the impact that climate change has on human health, including increased risk of heat-related illness, respiratory diseases, and behavioral health issues. These health effects have a disproportionate impact on certain communities, including the elderly and outdoor workers. ACP recommended public health interventions, environmental sustainability in the health care sector, and aggressive mitigation and adaptation initiatives like promoting active transportation. Since then, ACP has signed the U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda. This [framework](#) maintains “Climate change is one of the greatest threats to health America has ever faced—it is a true public health emergency” and recommends that policymakers transition from fossil fuels to clean, safe, renewable energy; encourage active transportation; promote healthy, sustainable agriculture; aid workers affected by climate change mitigation and adaptation policies; incorporate climate solutions into health care and public health systems; and build resilient communities. The call underscores that “equity must be central to climate action.”

The United States joined the Paris Agreement in 2015. Under the Paris Agreement, nations committed to reducing greenhouse gas emissions by up to 28% of 2005 levels by 2025. The current administration directed the U.S. to leave the agreement in November 2020. It also repealed federal efforts to address greenhouse gas emissions. In an effort to meet the Paris Agreement goals, the Obama Administration implemented the Clean Power Plan (CPP) that sought to regulate power plant emissions to reduce air pollution and mitigate greenhouse gas emissions. The current administration replaced the CPP with the Affordable Clean Energy program that curtails the EPA's ability to regulate emissions. ACP opposed this program.

Recommendations

1. Rejoin the Paris Agreement.
2. Ensure that federal agencies communicate apolitical, science-based information regarding climate change and greenhouse gas emissions and eliminate any restrictions and agency guidance that interfere with the ability of career scientists to provide such information.
3. Protect career scientists and other federal employees engaged in this area.
4. Rollback regulations that would increase carbon emissions and associated respiratory diseases and other health outcomes, including the Affordable Clean Energy final rule (84 FR 32584) and methane emissions rules.
5. Lay policy and regulatory groundwork for rapid shift from use of fossil fuels to clean, renewable energy and support efforts to reduce greenhouse gas emissions in the health care sector.
6. Prevent contamination of the U.S. water supply and ensure everyone has access to clean, affordable drinking water.

7. Implement strong, comprehensive climate change mitigation and adaptation policies, including an accelerated transition from fossil fuels to clean energy and energy efficiency. The U.S. Call to Action on Climate, Health, and Equity provides a health-centered policy framework.
8. Develop policies to address the needs of communities disproportionately impacted by climate change, including people with low-incomes, communities of color, outdoor workers, and the aged and disabled.
9. Support the health care sector in building resilience to the impacts of climate change.

Reducing Injuries and Deaths from Firearms

Desired Action

Take immediate action to reduce injuries and deaths from firearms and direct federal government to treat it as a public health crisis.

Background

For more than 20 years, ACP has advocated for the need to address firearm-related injuries and deaths in the United States. Yet, firearm violence continues to be a public health crisis that requires the nation's immediate and sustained intervention. Firearms-related injuries and deaths are a significant public health threat, with over 40,000 fatalities every year in the U.S. (suicides, homicides and other intentional shootings, and negligent/accidental shootings combined) and 81,000 non-fatal injuries to survivors of shootings. In 2018, ACP released a [policy paper](#) with a series of recommendations based on an analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence. The available data support the need for a multifaceted and comprehensive approach to reducing firearm violence that is consistent with the Second Amendment.

Recommendations

1. Issue an Executive Order to create a task force to develop a comprehensive, coordinated plan to reduce injuries and deaths from firearms.
2. Appoint senior level officials dedicated to treating injuries and deaths from firearms as a public health crisis.
3. Direct federal agencies to support and fund community-based gun violence victim services and violence intervention programs and programs that collect public health-based information on gun deaths and injuries.
4. Make prevention of firearms-related injuries and deaths a priority by
 - a. Creating an Interagency Task Force or Hub on Gun Violence Prevention responsible for developing and implementing a coordinated, comprehensive plan to address all aspects of gun violence across all federal agencies.
 - b. Appointing a senior-level White House official to coordinate federal efforts to address gun violence; Nominate a Director of the Bureau of Alcohol, Tobacco, Firearms and Explosives and a Secretary of the Department of Health and Human Services who will promote gun violence prevention values.
 - c. Declaring gun violence to be a public health emergency.

5. Work with Congress to enact legislation in line with recommendations from ACP's 2018 policy paper including:
 - a. Banning sales of assault weapons and requiring universal background checks.
 - b. New policies on extreme risk protection orders, domestic violence, child access prevention, and others that are found to be effective in reducing gun-related injuries and deaths.
 - c. Several key bills were introduced in the 116th Congress with ACP's support that would strengthen the accuracy and reporting of the National Instant Criminal Background Check System (NICS), as well as expand Brady background checks to cover all firearm sales, including unlicensed firearms sellers currently not required to use background checks. Continued and increased funding for research will also be a priority.

Improving the Transition to Value-Based Payment

Desired Action

Appropriately value primary and cognitive care services, test a variety of alternative payment models (APMs) to meet diverse patient and practice needs, continually improve Medicare APMs and the Merit-based Incentive Payment System (MIPS) with physician and other stakeholder input, minimize administrative burden, continue to encourage APM participation by extending bonuses and maintaining current thresholds, and improve performance metrics and risk adjustment to account for social drivers and other factors.

Background

ACP supports the goals of aligning physician payments with the efficient delivery of high-quality care to patients and believes value-based payment presents an opportunity to do away with unnecessary administrative burden. However, current value-based payment efforts have been fragmented and rely on burdensome, flawed performance metrics. For the transition to work, performance measures must be evidence-based, clinically relevant, and appropriate and internists must be given ample opportunity to participate in a range of diverse APMs that can accommodate a wide range of specialties, practice sizes, and unique patient populations.

Several new Medicare APMs will be implemented in 2021 and 2022, including Primary Care First (PCF) and new Direct Contracting Models. ACP staff had multiple productive interactions with CMS PCF team staff, which lead to critical model design improvements that made the model more workable for physician practices]. We hope to continue to work with CMS to continuously improve existing and future CMS payment models.

ACP worked with the National Committee for Quality Assurance (NCQA) to develop its own APM called the Medical Neighborhood Model (MNM) designed to encourage specialty clinicians to coordinate care with primary care clinicians engaged in CMS' Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) models. The MNM offers small "care coordination payments" in exchange for meeting a robust set of clinical transformation and care coordination criteria. It also offers the potential for performance-based incentive payments and the option to elect reduced FFS payments in exchange for prospective, lump sum quarterly payments. At its April 2020 meeting, the Physician Focused Payment

Model Technical Advisory Committee (PTAC) voted that the MNM met all ten of the Secretary's criteria and recommended the model for pilot testing. The PTAC released its [full report](#) to the HHS Secretary in November 2020.

Despite these promising new developments, Advanced APM bonuses are set to expire at the end of the 2022 performance year and Qualified APM Participant (QP) bonuses are set to increase drastically Jan. 1, 2020, which ACP fears may significantly reduce physician willingness to participate in new APMs.

In the 2021 Physician Fee Schedule (PFS)/Quality Payment Program (QPP) final rule, CMS recently finalized several changes that will impact the future of value-based payment. CMS finalized changes to its approach for distributing Advanced APM bonuses that will prioritize payment year Taxpayer Identification Numbers (TIN), even if that TIN has no relationship to an APM and impose a new cutoff for claiming those bonuses. ACP is concerned these changes run counter to the clinical care team model that the College strongly supports and may undercut physician confidence in APMs. CMS also replaced the MIPS APM scoring standard with the new APM Performance Pathway (APP), which requires all clinicians to report the same six quality measures regardless of APM. ACP worries this may inadvertently increase administrative burden. We also have technical concerns with the measures proposed for inclusion and do not support a change of this magnitude as practices recover from the COVID-19 PHE. In the rule, CMS delays implementation of the first "MIPS Value Pathways" until 2022 due to COVID. ACP proposed two MVP bundles in 2020; one focused on preventive care and the other on chronic disease management. Throughout 2020, ACP engaged with several meetings focused on MVP implementation with CMS and several other stakeholders, yet several outstanding differences remain. ACP makes the following recommendations to help reaffirm physician confidence in the transition to value-based reimbursement and willingness to participate in APMs:

Recommendations

1. Continue testing new innovative APMs that are flexible in design to meet a wide range of patient and practice-specific needs.
2. Incorporate feedback from patients, physicians, and stakeholders to continuously improve existing Medicare APMs, including CMS' new Primary Care First and Direct Contracting Models set to start in 2021 and 2022. More specifically, for PCF, consider increasing the flat visit fee, adding additional utilization indicators beyond acute hospital utilization and total per capita cost, further refining risk adjustment methodologies to account for comorbidities, and removing the current 50-clinician cap. For the DC Model, consider including new cohorts, allowing smaller, more variable discounts, and improving risk adjustment to account for co-morbidities and SDOH.
3. Pilot ACP's Medical Neighborhood Model, as recently recommended by the PTAC.
4. Look to collaborate with Medicaid, Medicare Advantage, and private payers on new models and performance metrics to align incentives and minimize burden on practices.
5. Implement broad COVID-19 pandemic-related flexibilities for all Advanced APM participants.
6. Push Congress to extend the 5% Advanced APM bonus and give the Secretary more discretion in setting Qualified APM Participant (QP) thresholds in the future to reflect the current availability of APMs in the market.
7. Continue working with stakeholders to improve MIPS to reduce administrative burden on practices while driving more impactful change in patient outcomes.

8. Continue working with ACP to implement our preventive care and chronic disease management MVPs.
9. Ensure payment rates are sufficient and appropriately risk adjusted to ensure access to care for all and existing health disparities are not further exasperated in any way.
10. Design physician payment policies that appropriately value primary care and cognitive services, including primary care, preventive health services, and comprehensive care provided by internal medicine physician specialists.
11. Eliminate “check-the-box” reporting of measures and improve performance measures to ensure all metrics used for payment and public reporting purposes are reliable, meaningfully improve patient outcomes, and actionable by clinicians.
12. Provide patients with the information they need to make educated decisions about which services, physicians, care teams, and treatments are right for them, in a way that a wide range of patients with varying cultural and educational backgrounds can understand.
13. Continue exploring opportunities to eliminate unnecessary or inefficient administrative requirements, particularly for clinicians in value-based payment arrangements that hold clinicians accountable for cost and utilization outcomes.

Making Prescription Drugs Affordable

Desired Action

Implement a Reference Pricing Demonstration Project, allow more states to import prescription drugs from Canada, enable Medicare to negotiate for lower-price drugs, expand drug subsidies for low-income Medicare beneficiaries, amend market exclusivity policy, and address anti-competitive practices in the pharmaceutical industry.

Background

Prescription drugs are a critical component of a physician’s toolkit and play an important part in treating and preventing disease. A majority of Americans use prescription drugs and many report facing financial barriers to accessing these drugs. The United States pays higher prices for the same prescription drugs than other countries do and is one of the few industrialized countries not to have some degree of prescription drug pricing oversight and regulation. Prescription drug misadherence as a result of rising costs and other access barriers threatens individual health and can result in increased costs for the health system at large. Although manufacturers are solely responsible for setting their price, it is important to keep in mind that other factors (i.e., PBMs, payers, physicians, regulations, patents, etc.) play a role in how manufacturers set them, regardless of other motivations. Any solution addressing the many issues surrounding prescription drug pricing will require commitment by all stakeholders. ACP has issued extensive recommendations on stemming prescription drug prices specific to private health plans, public health plans, pharmacy benefit managers, and promoting competition.

As Medicare is statutorily prohibited from directly negotiating pricing with manufacturers, private plans administer the Part D benefit negotiate prices. Discounts negotiated by these plans, known as direct and indirect remuneration (DIR), often take the form of rebates paid by the manufacturer to the plan after the point of sale. While these rebates can lower the price of drugs for the Medicare program, the costs are often shifted to beneficiaries as their cost-sharing is determined by the point-of-sale price. Payments by CMS to plans are supposed to be based on costs actually incurred by plans, including DIR-like rebates.

Further, the Centers for Medicare and Medicaid Innovation has the ability to waive the provision banning Medicare from directly negotiating pricing, potentially allowing the federal government to test reference pricing approaches to lowering drug costs.

Under existing law, HHS is able to permit pharmacists and wholesalers to import certain drugs under certain conditions, so long as the Secretary of HHS certifies that the rules will “pose no additional risk to the public’s health and safety” and “result in a significant reduction in the cost of covered products to the American consumer.” The current administration issued a final rule that establishes a mechanism for allowing states to import drugs from Canada.

Recommendations

1. Direct the Centers for Medicare and Medicaid Innovation to implement a reference pricing demonstration project. The project should establish a single price for a group of drugs with similar characteristics or tie the price of drugs to some benchmark, such as the price paid by other countries.
2. Modify the Medicare Part D Low-Income Subsidy program by eliminating beneficiary cost-sharing for generic or biosimilar drugs to increase medication adherence and promote utilization of lower-cost generic drugs.
3. Institute rigorous price transparency standards for prescription drugs that are developed using National Institutes of Health (NIH) and other federally funded research,
4. Implement payment models to study approaches to Medicare Part B reimbursement for physician-administered prescription drugs that reduce incentives to prescribe higher-priced drugs when a lower-cost and similarly effective option is available.
5. Amend existing regulations to allow all states to import prescription drugs from Canada.
6. Evaluate ways to ensure that cost savings from rebates derived from pharmacy benefit managers are directed to patients. CMS should evaluate ways to better ensure savings negotiated by plans are better captured and passed along to the Medicare program and its beneficiaries.
7. Enable Medicare to negotiate for lower prescription drug prices.
8. Implement caps on annual out-of-pocket spending on prescription drugs for Medicare Part D beneficiaries who reach the catastrophic phase of coverage.
9. Urge Congress to grant the legal authorities to CMS necessary to ensure compliance with the Medicaid Drug Rebate Program (MDRP) to minimize the financial impact to the federal government of prescription drug misclassification.
10. Reform the Orphan Drug Act to better align incentives to reward true innovation and drug discovery for rare diseases.
11. Federal agencies should be empowered through guidance and congressional action to address anti-competitive behaviors and gaming in the pharmaceutical market, such as “pay-for-delay” arrangements.
12. Reduce data and market exclusivity period for biologic drugs from 12 years to 7 years.

Expanding and Enhancing Telehealth and other Health Information Technology (IT)

Desired Action

Maintain certain telehealth expansions implemented during COVID-19 public health emergency (PHE), direct CMS to study impact of COVID-19 PHE telehealth flexibilities, delay information blocking applicability and enforcement deadlines, support federal privacy legislation for the expanding digital health ecosystem, and support patient matching research.

Background

Over the course of COVID-19, CMS has allowed for numerous waivers and flexibilities that have demonstrated strong successes in practice with respect to physician workflow, workload, and burden, as well as patient access to care and quality of care. ACP's goal is to work with CMS, HHS, and Congress (where necessary) to extend, and in some cases make permanent, the following: (1) Waiver of the geographical and originating-site restrictions; (2) creation of a third category of criteria for adding services to the Medicare telehealth services list, and remove the requirement for the use of two-way, audio/video telecommunications technology; (3) continuation of providing flexibility in the Medicare and Medicaid programs to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service; (4) allow direct supervision by physicians in teaching hospitals to be provided using real-time interactive audio and video technology; (5) maintain pay parity between telephone E/M claims and in-person E/M visits and between all telehealth and in-person visits; (6) flexibilities that allow physicians to provide telehealth services across state lines, so long as specific licensure requirements and conditions are met.

The Office of the National Coordinator for Health Information Technology (ONC) has been in the process of implementing the Cures Act that focuses on promoting interoperability, improving patient access to data, and prohibiting information blocking. The College is supportive of the Cures Act's purpose to increase information sharing, improve patient care, and ensure a patient's health information follows the patient across the health care continuum. We also agree that the PHE has substantiated even greater the urgency of these goals. ONC recently delayed compliance to information blocking provisions to April 5, 2021; however, ACP thinks this deadline is still not feasible for physicians given the ongoing, and currently surging COVID-19 pandemic. ACP recommends ONC further delay the information blocking deadlines to either align with the health IT certification deadlines or until the COVID-19 pandemic is under control.

When participating in the digital health ecosystem, it is important for individuals to feel confident that they can receive needed health care without the inappropriate disclosure or use of their information. Absent this trust, there could result in downstream potentially negative clinical consequences. Advancements in tech and the expansion of digital interactions has increased the amount of patient digital health information that falls outside the scope of HIPAA.

As the sharing of electronic health information continues to expand, patient misidentification is a real and growing safety problem. There remains a provision in the federal appropriations bill prohibiting use of funds to promulgate or adopt any final standard providing for a unique health identifier until legislation is enacted specifically approving the standard. ACP supports the efforts to improve patient matching and identification and believes removing the federal funding ban will allow industry to research the best methods for patient identification.

Recommendations

1. Where necessary, make certain telehealth provisions established under the COVID-19 public health emergency permanent, including permanently lifting the geographical and originating site restrictions. Pay parity for telehealth services should extend through at least the end of 2021.
2. Prioritize the CMS commissioned study on the telehealth flexibilities provided during the COVID-19 PHE to assess the experiences and learnings of both patients and physicians utilizing these revised policies.
3. Delay information blocking applicability and enforcement deadlines beyond the current April 2021 date until the COVID-19 pandemic is under control through additional rulemaking and/or enforcement discretion announcement.
4. Support federal legislation to provide expanded health data privacy, protection, and use principles outside of HIPAA to account for advancements in technology and the expansion of digital health interactions.
5. Remove ban on federal funding to research best practices for patient matching and identification to improve patient safety and interoperability efforts.