November 4, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs Request for Information

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our response to the Centers for Medicare and Medicaid Services' (CMS) Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs Request for Information (RFI). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 160,000 internal medicine physicians, 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.

ACP greatly appreciates the opportunity to inform CMS' efforts to identify potential opportunities for improvement and increased efficiencies across CMS policies, programs, and practices. The College was supportive of President Biden's Executive Order 13985 on *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, and remains committed to advancing efficient, equitable, and quality health care. We recognize, however, that disparities in health and health care persist despite decades of research and widespread efforts to improve health outcomes in the United States. In speaking to these complexities, the College has laid out a framework that addresses social drivers of health and community-level burdens that contribute to the exacerbation of health disparities.

There are also factors that result in chronic maldistribution of physicians in the United States, both in terms of specialty and geography. Studies demonstrate that primary care physician supply is associated with lower mortality and better patient outcomes. But as of 2022, the Health Resources and Services Administration estimates 98 million people live in primary care Health Professional Shortage Areas (HPSAs), 70 million live in dental HPSAs, and 157 million people live in mental health HPSAs. Coupled with accelerating rates of physician burnout, there is an urgent need to strengthen our infrastructure, create synergies across the healthcare system to drive structural change, and identify and collaborate to eliminate barriers to service and coverage.

To offer feedback in a concise manner, we have provided specific comments on the following topics.

Topic 1: Accessing Healthcare and Related Challenges

ACP has long advocated for universal access to high-quality health care in the United States. The College's vision, outlined in an accompanying call to action, includes ten vision statements with a series of position papers addressing access, coverage, cost of care, social drivers of health, and reducing barriers to care. While there are many barriers to accessing health care, there are several key elements that should inform future policymaking: expanding access and coverage; bringing greater value for the costs; reducing the administrative burden on physicians and patients; leveraging technology to improve patient care; supporting a well-trained physician workforce; reducing barriers to care for patients who struggle accessing care; and supporting scientific research and policies to improve public health. Resolving the access and coverage crisis will necessitate collaborative work that addresses each of these elements, and the forthcoming issue areas within the RFI should serve as a triaged approach to doing so.

While addressing delivery and payment systems is necessary to resolving access issues, ACP does not believe there is a one-size-fits-all approach. The College strongly encourages CMS to work with the physician community in constructing a robust network of care innovations that can be layered to meet a wide range of unique patient types and needs while being cognizant of the potential for adverse consequences on patient access. These conversations should be underscored by the realization that CMS' programs must meet patients where they are. Decades of data has evidenced that capitation struggles to connect patients with appropriate services, accompanied by administrative hurdles that are unsustainable. ACP recognizes, however, that poorly designed value-based payment models have the potential to exacerbate health inequities, particularly those that feature cost-sharing, and the College welcomes the opportunity to work with CMS to revise current and develop future models and arrangements that more adequately and appropriately facilitate access to coordinated clinical care.

In addressing access to health care, the College has developed a series of recommendations that may be beneficial to CMS' inquiry. ACP encourages CMS to review these recommendations in full, but in this limited context, the College specifically notes the following:

- Recommending that Medicare and other payers progressively adopt population-based, prospective payment models for primary and comprehensive care that are structured and sufficient to ensure access to needed care and address the needs of individuals who are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health; and
- Modifying Medicare law to establish a mechanism for savings to be calculated across all aspects of the program.

Topic 2: Understanding "Provider" Experiences

At the outset, the College emphasizes that while "provider" may have longstanding, legal origins as defined by federal law, its use is non-specific and greatly simplifies the role of the *physician*. The distinction lies in the fact that physicians do not simply "provide" in the commercial or commoditizing sense. The "physician" designation appropriately references the professional values, roles, expertise, professionalism, and values the unique relationship with patients.

It is no revelation that general internal medicine specialists and other primary care physicians deliver high-quality care, reduce mortality, provide continuity of care, and reduce overall health care costs. The

positive impacts of internal medicine physicians have been documented for over two decades, and these principles were further evidenced by the 2021 National Academies of Sciences, Engineering and Medicine (NASEM) report on *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. It is also no secret, however, that the United States' healthcare system has long undervalued primary care, and we need changes that better support primary care physicians and recognize the value they bring to patients and our health system.

Similar recommendations to those published in the NASEM report can be found in ACP's policy, namely our Vision for the U.S. Health Care System; Aligning GME Policy with the Nation's Health Care Workforce Needs; Addressing Social Determinants to Improve Patient Care and Promote Equity; Reforming Physician Payments to Achieve Greater Equity and Value in Health Care; and Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration.

Through our Physician Well-being and Professional Fulfillment initiative, ACP sought to provide guidance and resources that foster communities of well-being for internal medicine physicians to best serve patients and optimize professional fulfillment. In the face of the unprecedented challenges created by the COVID-19 pandemic, the College cannot emphasize enough that coupled with maldistribution, compassion fatigue and burnout is straining our primary care community – and thereby patient care. To address these concerns, ACP encourages CMS to engage with the healthcare community on the following:

- Raising the visibility of physician anxiety, burnout, depression, stress, and suicide;
- Improving the baseline understanding of challenges to physician well-being; and
- Advancing evidence-based, multidisciplinary solutions to improve patient care by care for the physician-led clinical team.

Topic 3: Advancing Health Equity

Many populations, including racial and ethnic minorities, members of federally recognized Native American tribes, people with disabilities, patients seeking substance use and mental health services, individuals dually eligible for Medicare and Medicaid, and those living in rural and underserved areas are more likely to experience challenges accessing healthcare services, lower quality of care, and below-average health outcomes when compared to the general population. Through continued collaborations with the physician community, patient advocacy networks, and community-based organizations, CMS' programs must better understand individual and community-level burdens, health-related social needs, and opportunities for improvement. This increased understanding and engagement will be critical to promoting efficiency in CMS' programs, as well as driving innovation and reducing disparities. It follows, then, that it would be a great disappointment to see the benefits of telephone services extinguished by CMS' expired coverage.

There are several challenges an individual may face when accessing care, and the provision of services via telephone are but one lever in mitigating these barriers. A few of these challenges include understanding coverage options and benefits; receiving culturally and linguistically appropriate care; accessing oral health services; and accessing comprehensive and timely health care services and medication. To address health outcomes associated with social drivers of health, ACP recommends CMS work with various agencies and Congress to address downstream environmental, geographical, occupational, educational, and nutritional social drivers to reduce disparities and better inform areas of

improvement in its programs. Truly addressing health inequities will require a robust agenda that should include, but not be limited to, the following:

- Social drivers of health and underlying individual, community, and systemic issues related to health inequities should be integrated into medical education at all levels, including dissemination of education from CMS on screening and identifying social drivers and approaches to treating patients whose health is affected by social drivers;
- Interprofessional communication and collaborative models should encourage a team-based approach to treating patients at risk to be negatively affected by social drivers;
- Federal, state, tribal, and local agencies should be adequately and efficiently funded to address social drivers, including investments in programs and social services shown to reduce health disparities or costs, as well as collaborating with CMS to reduce or eliminate redundancies;
- Research into the causes, effects, prevention, and dissemination of information about social drivers should be a priority of CMS. This research agenda should include short- and long-term analysis of how social drivers affect health outcomes and increased effort to recruit disadvantaged and underserved populations into large-scale studies and community-based participatory studies;
- Electronic health records should be leveraged to capture social drivers and coordinate appropriate care to address social drivers; and
- CMS should better provide for coverage and reimbursement schemes that encourage increased screening and collection of social drivers of health data to aid in health impact assessments and supports evidence-driven decision making from the Agency.

Though the College recommends the increased collection of and utilization of social drivers of health data, ACP cautions against the frivolous and unauthorized use of such data. The confidentiality of these data will be critical to establishing and maintaining the confidence of populations that have been historically marginalized and have some of the most pervasive health disparities.

Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

The impact of CMS-authorized waivers and flexibilities issued during the COVID-19 PHE cannot be understated. There exists no 'good' version of a global health crisis, but the COVID-19 pandemic shed considerable light on a public health infrastructure that was fraught with misalignment, unsustainable costs, and a lagging sense of collaboration. Decades of deep cuts to social welfare programs, the systematic underfunding and privatization of key infrastructure, and ongoing constriction of physician reimbursement and coverage for E/M and other primary care-related services has hamstrung the U.S. healthcare system, leaving behind a fragile foundation.

While our physician community has maintained its resiliency by providing care and facilitating access despite being under-resourced and underfunded, industry must now lean on our partners at CMS to ensure continued access to COVID-related flexibilities and waivers.

To this end, the College strongly recommends that CMS permanently support the COVID-era rule revisions and Medicare benefits interpretations that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non-in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care. The College is currently engaging

in a data collection effort amongst our 160,000 internal medicine physician members regarding the benefit, importance, and appropriate utilization of telephone visits. As we continue this effort, ACP welcomes the opportunity to discuss with CMS the implications of not extending coverage and ways we can facilitate continued access while dually guarding against fraud, waste, and abuse.

In assessing its coverage and reimbursement options for telehealth, including telephone visits, the College encourages CMS to be mindful of the September 2022 report from the Office of the Inspector General (OIG). Recognizing that Medicare beneficiaries used telehealth services 88 times more during the first year of the pandemic than they did in the prior year, OIG conducted a review of the use of telehealth to determine whether physicians were billing appropriately. This report evidenced that of approximately 742,000 "providers," only 1,714 were identified as being 'high-risk' based on their billing practices. These findings represent a small proportion of the whole; in fact, 99.8% of physician and other "providers" showed no evidence of worrisome billing practices. Though ongoing conversations to protect the integrity of the Medicare trust fund should heed this information, ACP strongly believes these incidents of misconduct are not representative of the group and CMS would be in err to remove access to and reimbursement for appropriately furnished telehealth services, including telephone visits.

The College also encourages CMS to work with Congress to inform and pass H.R. 4040, the Advancing Telehealth Beyond COVID-19 Act of 2021, which ACP has endorsed. As noted below, this legislation would extend current-law telehealth flexibilities beyond the PHE through 2024.

- Removes geographic requirements and expands originating sites for telehealth services.
- Extends telehealth services for FQHCs and RHCs.
- Delays the in-person requirements under Medicare for mental health services furnished through telehealth and telecommunications technology.
- Allows for the furnishing of audio-only telehealth services for E/M services.

ACP asks CMS to work with Congress, as well as the physician community, to realize these extensions until 2024, at which time additional research can be had and evidenced gathered.

Conclusion

ACP greatly appreciates this opportunity to share our views and provide requested information on accessing healthcare and related challenges, understanding physician experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 PHE. The College continues to welcome partnership with CMS to revise regulatory policies and inform future rulemaking or legislation.

Sincerely,

William Fox, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians