



A Prescription for a Forward-Looking Agenda to Improve American Health Care May 23, 2017

Introduction

The continued polarization and partisanship over the future of the Affordable Care Act (ACA) is standing in the way of making progress on a range of issues that are essential to improving our health care system. The American College of Physicians (ACP), the nation's largest specialty society and second-largest physician membership organization, believes that now is the time to move away from the stale, divisive and ultimately unfruitful debate over repealing and replacing the ACA. Instead, we urge Congress and the administration to join with ACP and other clinician and patient advocacy groups to create and implement a forward-looking agenda to improve American health care. Such an agenda should address the following 7 key elements of an effective health care system:

1. Expand access and coverage
2. Bring greater value for the dollars spent
3. Reduce the crushing administrative burden on physicians and patients
4. Leverage technology to improve patient care
5. Support a well-trained physician workforce
6. Reduce barriers to care of patients with chronic diseases
7. Support scientific research and policies to improve public health

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 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.

ACP offers the following recommendations for a forward-looking agenda to improve health care:

Expand Access and Coverage

1. *Sustain gains in coverage from the ACA and close coverage gaps.* Congress should ensure that any legislation sustains and improves on existing coverage programs and consumer protections rather than rolling them back. Action is also needed to stabilize insurance markets and offer individuals more options for coverage.

- a. *Put aside efforts to repeal the ACA and instead work to improve it.*** Congress should drop the effort to repeal and replace the ACA, and more specifically, the American Health Care Act (AHCA). The AHCA would reverse the historic gains in coverage that have occurred under current law, and would have caused 14 million to lose coverage in 2018 and 24 million over the

next 10 years, according to the Congressional Budget Office. Specifically, ACP calls on Congress to reject proposals to cut, cap or block grant the federal contribution to Medicaid; to end the higher federal match for Medicaid expansion; to replace progressive income-based premium and cost-sharing subsidies with regressive age-based tax credits; and to repeal or weaken the ACA's Title I protections, including community-rated premiums, guaranteed issue, and essential benefit requirements by allowing states to obtain waivers to opt-out of such requirements. Read [ACP's letter](#) to the Senate on why the Senate should put aside the AHCA and start over to achieve consensus on needed improvements.

b. *Take immediate action to stabilize the market for insurance sold through the exchanges.*

- i. **The administration and Congress must make a clear, immediate and unambiguous commitment to preserve the ACA's cost-sharing reduction (CSR) payments to insurers at least through 2018, and better yet, for the long-term.** In 2016, about 6 million enrollees relied on CSR payments to help reduce the burden of co-payments, deductibles, and co-insurance. Without a guarantee that the CSR payments will be continued, many insurers will have no choice but to leave the exchanges or to raise premiums by 20 percent or more to make up the shortfall. Many insurers are deciding now whether they will be able to offer insurance through the exchanges for the 2018 enrollment cycle and the proposed premiums should they opt to stay in the exchange markets. Several have already announced substantial premium increases because of the uncertainty over whether the CSR payments will continue. It is imperative that CSR be preserved. Read the [letter](#) to Congress and the administration, signed by over 20 organizations, including ACP, which explains why the CSR payments must be maintained.
- ii. **The administration should take additional actions to reduce uncertainty that could result in more insurers choosing not to offer plans in the 2018 enrollment cycle.** It should commit to actively promote 2018 enrollment especially of younger people; to lengthen the 2018 enrollment period; to enforce existing requirements that people purchase qualified insurance; and to work with insurers, consumers, clinicians, and consumer advocates on additional measures that could be taken to stabilize the markets and encourage more insurers to participate in them. More intensive outreach and enrollment efforts will be vital as the open enrollment period for 2018 has been shortened. In 2017, marketplace enrollment declined after the U.S. Department of Health and Human Services (HHS) prematurely ended its open enrollment publicity and outreach campaign. Evidence [suggests](#) that enhanced television advertising can increase enrollment. Further, many uninsured people remain [unaware](#) of marketplace-based coverage options and subsidies. The administration must expand efforts to promote the marketplace awareness and attract more people to shop and purchase the right coverage for them.
- iii. **Explore options for an effective re-insurance program and other initiatives to stabilize the market.** HHS' March 13, 2017 [letter](#) encouraging states to seek Section 1332 waivers for reinsurance programs was a step in the right direction. Reinsurance can help to ensure patients get to keep the coverage they have while protecting insurers from high costs.

Minnesota has set up its own reinsurance and premium relief program. The administration should cooperate with state officials to stabilize their insurance markets and actively work to attract insurers to enter or maintain activity in underserved states. Such efforts [have been fruitful](#) to encourage insurer participation in underserved regions. Congress can embrace initiatives that have [proven effective](#) in the Medicare Part D program by establishing permanent reinsurance and risk corridor programs as well as emergency fallback protections to provide coverage when no plans are available in an area.

- c. ***Preserve the federal government’s contribution to Medicaid including the higher match for expansion states.*** In the 32 states and the District of Columbia that have agreed to expand Medicaid to persons with incomes up to 138 percent of the federal poverty level (FPL) an estimated 11.2 million [people](#) have gained coverage who otherwise would not have been eligible for coverage prior to expansion. Studies [show](#) that they have gained access to care and financial security as a result, and initial data also show that expansion is associated with improvements in measures of self-reported health status. Yet because 19 states have not yet expanded Medicaid, an [estimated](#) 2.6 million fall in a “coverage gap” because they have incomes at or below 100% of the FPL, making them ineligible for the ACA’s premium and tax credit subsidies to purchase private insurance through the exchanges. For them, Medicaid expansion may be the only option to obtain coverage. States that have not yet expanded Medicaid should do so. Congress should ensure that higher federal match for Medicaid expansion is not eliminated or phased out, and that non-expansion states can continue to join the program at their own option; the AHCA regrettably would sunset the higher federal match for expansion starting in 2020 and prohibit states from joining the program effective on enactment.

2. Consider additional policies to encourage state innovation and bring more choice and competition into insurance markets without rolling back current coverage, benefits and other consumer protections guaranteed by the ACA and other federal laws and regulations.

- a. **Use existing 1332 waiver authority to allow states to adopt their own innovative programs to ensure coverage and access, provided that the coverage and benefits available in the state would be no less than under current law.** Section 1332 waivers offer states the opportunity to test innovative ways to expand insurance coverage while ensuring that patients have access to comprehensive insurance options. As long as a state’s waiver program meets the ACA’s standard of comprehensiveness at the same cost and level of enrollment, it can test a more market-based approach, a single-payer model, or make minor revisions to continue existing state initiatives. States like Alaska, Vermont, and Massachusetts have filed 1332 waiver applications and many more are developing proposals.
- b. **Improve the Medicaid waiver process.** As proposed in a 2011 position paper, [ACP reaffirms](#) its recommendation that the Medicaid waiver process should be improved and streamlined to facilitate the establishment of approved plans, encourage public input, and improve coordination between federal and state agencies.

- c. Encourage states to adopt patient-centered delivery models.** ACP supports continued administrative and financial support to Medicaid programs to develop and implement innovative patient-centered delivery system models like the medical home. [26 states](#) are actively testing Medicaid medical homes to better serve patients with chronic health conditions, integrate behavioral health and primary care, and [address](#) the opioid epidemic.
- d. Improve network adequacy and patients' ability to choose their own physician and hospital.** ACP strongly supports robust provider network adequacy laws that ensure patients have access to their preferred physician. However, in an effort to trim costs, insurers are offering fewer plans with a broad choice of physicians, hospitals, and other providers, potentially restricting patients from seeing the high-quality health care professionals they value most. A [report](#) by the Robert Wood Johnson Foundation found that 41 percent of 2014 silver qualified health plan (QHP) networks were small (they include 10-25 percent of office-based participating providers in the area) or extra small (less than 10 percent included in network). By specialty, 36 percent of primary care networks and 23 percent of internal medicine specialty networks were small or extra small. ACP recommends that CMS and state regulators continue to provide robust oversight of qualified health plan provider networks, use quantitative standards to evaluate network adequacy, approve networks prior to going to market, improve provider directory accuracy, and take other actions to ensure that provider networks provide access to high-quality physicians and not just low-cost providers.
- e. Consider enacting legislation to offer individuals aged 55 through 64 the option to buy into Medicare.** ACP supports the development of a Medicare buy-in option for people age 55-64. By doing so, older adults will have an opportunity to enroll in the popular Medicare program, potentially improving both the Medicare and marketplace risk pools and driving down premiums. Specifically, ACP recommends:
- A Medicare Buy-in Program must include financing that assures that premiums and any subsidies are sufficient to fully cover expenses without further undermining the solvency of the Medicare trust funds;
 - A Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate;
 - Eligibility for a Medicare Buy-in Program should include adults age 55-64 regardless of their insurance status; and
 - Enrollment in a Medicare Buy-in program should be optional for eligible beneficiaries and should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D).
- f. States could use existing law authority to allow sale of insurance across state lines among states that have agreed to enter into a regulatory compact to protect consumers.** The evidence suggests that selling insurance across state lines will not likely result in significant cost-savings and could cause a "race to the bottom," absent a regulatory structure that ensures that

such plans meet existing essential benefit, community-rating, network adequacy standards, prompt claims payment and other consumer protections. Rather than pursuing new statutory authority to sell insurance across state lines absent such a regulatory agreement among the states, the administration should work with states to promote and support the development of interstate health insurance compacts as authorized under Section 1333 of the ACA. This could potentially broaden choice of insurance options while maintaining crucial insurance regulations, benefit requirements, and other protections that characterize marketplace-based QHPs.

3. Adopt and implement policies to address the impact of high-deductible plans on access to services and out-of-pocket costs. Evidence shows that cost sharing, particularly deductibles, may cause patients to forgo or delay care, including medically necessary services. To address this, ACP recommends that high-value health care services, like preventive screening and chronic care management services, be provided without a co-payment and exempt from deductibles. The value-based insurance design concept is embedded in the ACA, since evidence-based preventive care highly-rated by the U.S. Preventive Services Task Force is not subject to cost sharing. We also recommend enhancing the affordability of marketplace-based QHPs by expanding eligibility for CSRs and increasing the generosity of premium tax credits and cost-sharing subsidies. Further, as health insurance becomes more complex, stakeholders must conduct outreach and education efforts to enhance health insurance literacy because many people do not understand health insurance concepts like provider networks, how to calculate out-of-pocket costs or their right to appeal health insurer decisions.

4. Ensure continued access for women's health services. ACP opposes any sort of legislative or regulatory restrictions that prevent patients from obtaining evidence-based services, like contraception, preventative health screenings, vaccines, and sexually transmitted infection testing and treatment, from women's health clinics that are qualified under existing federal law, including providers like Planned Parenthood. Moreover, the College opposes the use of gender rating in insurance pricing which results in women having to pay more for their coverage simply for being a woman. Any reform to the ACA must uphold the coverage of health benefits essential to women's well-being, including the coverage of maternity care and preventative screenings.

5. Reauthorize the Children's Health Insurance Program. The Children's Health Insurance Program is a federal-state financed program that provides health insurance to about 9 million children in families who are ineligible for Medicaid and unable to purchase private coverage. Since signed into law 20 years ago, the [program](#) has played a vital part in reducing the percentage of uninsured kids to an all-time low of just 5% and has [succeeded](#) in alleviating health care-related financial burden and stress related to children's health care. Since CHIP has proven to be an immensely beneficial program, we strongly urge Congress to pass a long-term funding extension before current funding expires in September 2017. Failing to act could endanger coverage for millions of children.

Bring Greater Value for the Dollars Spent

1. Reduce the cost of prescription drugs. [ACP believes](#) that the best way to ease the burden of prescription drug costs is by promoting policies that encourage competition, transparency, assessment of value, and price negotiation. The public is mostly kept in the dark as to the methodology behind how prescription drug prices are set and how much they actually cost to consumers. Policymakers should

support transparency in the pricing, cost, and comparative value of pharmaceutical products including rigorous transparency standards for drugs developed from taxpayer funded basic research. Congress should also leverage the bulk purchasing power of Medicare and other publicly funded health programs and give these programs the flexibility to negotiate prescription drug prices directly with pharmaceutical companies. Such authority can add to potential cost savings. As the prices for drugs, including innovative new drugs and older drugs, rise, patients and policymakers are putting an increased emphasis on the concept of value. Stakeholders should consider novel approaches to value-based decision making including value frameworks, bundled payments, evidence-based benefit design, and eliminating the restriction on the Patient Centered Outcomes Research Institute (PCORI) from considering quality adjusted life years in its research. Finally, Congress and the administration should curb anti-competitive practices that keep lower cost alternative drugs off the market and encourage the biosimilar market. Specifically, Congress should support the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act which aims to stem abuses of risk evaluation and mitigation strategies (REMS) that keep generic competition off the market.

2. Promote high value care assessments to guide clinical decision making. ACP strongly supports the implementation of high-value care principles into day-to-day clinical decision making of physicians. Therefore, we recommend that our clinical practice guidelines, clinical guidance statements, and best practice advice be actively incorporated into decision-support systems. We also recommend the use of our High-Value Care Coordination (HVCC) toolkit as a practical approach that clinicians can take to ensure high-value care—this toolkit includes pertinent data sets for referrals, model out-patient referral request and response checklists, ways to ensure patient- and family-centered discussions with patients regarding their decision process, and care coordination agreements. Further, ACP also offers a toolkit to facilitate the transition of young adults with chronic conditions from pediatric to adult care settings.

3. Promote evidence-based benefit design by applying comparative effectiveness research to coverage decisions and cost-sharing. The College strongly supports evidence-based benefits design and continues to support the role of PCORI and the Agency for Healthcare Research and Quality (AHRQ) in conducting comparative effectiveness research and disseminating evidence-based methods for clinical practice, coverage and pricing decisions, and cost-sharing and benefit design.

4. Continue to implement Medicare’s new Quality Payment Program (QPP), make improvements to make it more meaningful for clinicians and patients, and create more opportunities for physician-led alternative payment models (APM). ACP has been a strong supporter of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and embraces its shift from a volume-based payment and delivery system to one of value, accountability, and patient-centered care. ACP has been active in providing feedback on our MACRA implementation priorities to the Centers for Medicare and Medicaid Services (CMS). In the coming weeks and months, CMS will begin outlining and then implementing policies for the second QPP performance period (2018). The College will be providing a robust set of feedback to the Agency as this rulemaking process progresses—these recommendations will focus on:

- a. Continuing flexibility and a phased-in approach to participation that will allow physicians and other clinicians to be successful;

- b. Simplifying and streamlining the scoring approach and performance categories to enable better understanding and buy-in from clinicians—with an aim of truly improving care for patients and not just meeting the measures and benchmarks;
- c. Allowing multiple pathways for patient-centered medical homes (PCMHs) to qualify as Advanced APMs, including options that do not require physicians to bear more than nominal financial risk; and
- d. Prioritizing the testing of models involving physician specialty/subspecialty categories for which there are no current recognized APM/Advanced APM options.

5. Continue to support the critical role played by the Center on Medicare and Medicaid Innovation (CMMI) in testing and funding value-based payment and delivery models. The College strongly supports CMMI and its essential role in developing, financing, implementing, evaluating, and expanding innovative physician-led Advanced APMs as authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform. ACP encourages CMS to fully use its authority under CMMI and the Physician-Focused Payment Model Technical Advisory Committee (PTAC) process to expand the availability of Advanced APMs and other models. The creation of additional APMs, including those that are specialist/subspecialist-focused, would provide additional pathways for practices to transition from traditional fee-for-service (FFS) to more valued-oriented payment approaches. It is also imperative that CMMI continues to have adequate funding to support its critical role in MACRA/QPP and the movement toward value-based payment.

6. Continue to accelerate the transition from FFS payment systems to bundled and risk-adjusted capitation payments, hybrid FFS + bundled/capitated payments, and other payment systems that incentivize value rather than volume. The College strongly supports the movement from traditional FFS toward a more value-based payment system. This should be achieved by testing a variety of payment models, such as accountable care organizations (ACOs), PCMH and patient-centered specialty practice models, bundled payments, capitated payments, and others. These models should include risk adjustments including adjustments for socioeconomic status, to the extent possible. In recognition that all clinicians are not willing or able to move directly into models with significant payment at risk, there should be pathways to help clinicians transition to models with increasing levels of risk at stake. In order to accelerate the movement toward value-based payments, ACP encourages CMS to develop an expedited process for CMMI to develop, test, and expand APMs. This should include a pathway for testing models recommended by PTAC, as well as models from other payers including Medicaid and private payers. Accelerated implementation of models should prioritize APMs for clinicians who currently lack opportunities, such as specialists/subspecialists and clinicians who are unable to participate in current models such as those in regions where models are not being tested and those who are unable to participate due to limitations in the model design. Additional options for PCMH models and patient-centered specialty practice models should also be prioritized, including models that do not require physicians to bear more than nominal financial risk.

7. Promote greater transparency in pricing and outcomes of care.

- a. ***As the health care system moves towards emphasizing and paying for value and patients are increasingly asked to take responsibility for managing the cost of their care, increasing transparency in the pricing and outcomes of care will be critical.*** Reliable and valid pricing information, expected out-of-pocket costs, and quality data should be made available and communicated to consumers in an easy to understand way, such as through patient-focused targeted decision-making tools.
- b. ***There should be federal grants or other similar incentives that support the development of all-payer claims databases.***
- c. ***Congress should take action to provide greater protection and transparency for patients faced with surprise or unexpected health care bills, particularly for costs incurred during emergency situations, and ensure network adequacy in all fields including emergency care.*** ACP believes physicians have the right to choose whether or not to participate as an in-network provider; however, processes should be established to reduce the risk of financial burden places on patients that are faced with surprise out-of-network bills for which they are unable to obtain out of pocket estimates prior to services or for situations in which the patient is not given an option to select an in-network clinician.

8. Reinvent performance measurement to focus on measures that are clinically relevant, actionable, less burdensome and more meaningful for clinicians, patients, and purchasers. The College believes that the development and implementation of performance measures should evolve and even be reinvented to ensure that the measures are focused on the right things; move toward clinical outcomes and care coordination, become more patient- and family- centered, effectively incorporate population health and prevention; and do not create unintended adverse consequences. We believe that an opportunity has been provided via the new MACRA law, as well as other efforts to implement value-based payment, to build a learning health and health care system. Therefore, it is critically important that these new payment systems truly reflect the learnings from the current and past programs and also effectively allow for ongoing innovation and learning. Also important is the need to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians that care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity).

9. Implement medical liability reforms to reduce the costs of defensive medicine, increase fairness and predictability to those harmed by errors, and promote patient safety. The medical liability crisis continues to have a profound effect on the health care system. While medical liability premiums have leveled off in the past few years, physicians continue to fear litigation, expect lawsuits, and feel the psychological burden of navigating the complex medico-legal system. Patients harmed by medical negligence also suffer under the existing medical liability system. [ACP supports a comprehensive approach](#) to fixing the medical liability problem, including caps on noneconomic damages and other tort system reforms, but also an emphasis on improving patient safety efforts to prevent unintended errors.

We believe that by exploring innovative models like health courts, communications and resolution initiatives, alternative dispute resolution models, and implementing safe harbor protections for physicians who adhere to clinical guidelines, we can improve health outcomes, reduce defensive medicine and health care costs, and result in a fairer and less acrimonious system.

Reduce Administrative Burdens on Clinicians and Patients

1. Implement a framework to formally assess the source, intent, and impact of existing and new administrative tasks imposed by government, private payers, and other external entities and provide recommendations to reduce, streamline, or eliminate excessive and burdensome tasks. ACP is encouraged by the emphasis President Trump’s administration and particularly HHS Secretary Tom Price are placing on easing tasks that interfere with the patient-physician relationship. Excessive administrative tasks divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In fact, the literature has consistently found that time spent by clinicians and their staff on billing and insurance-related activities is about 3 to 5 hours per week, and time spent on quality measurement and reporting activities is potentially up to 15 hours per week. In addition, administrative tasks are keeping physicians from entering or remaining in primary care and may cause them to decline participation in certain insurance plans. They’re also a major contribution to the epidemic of “physician burn-out.”

- a. **Consider incorporating the cohesive framework outlined in ACP’s position paper “[Putting Patients First by Reducing Excessive Administrative Tasks in Health Care](#)” into federal rulemaking to gain a better understanding of any given task as well as the foundation for specific recommendations on revising or eliminating administrative tasks entirely.** Specifically, the College calls on all external sources of administrative tasks to provide impact statements for public review and comment. For those tasks that cannot be eliminated, they must be regularly reviewed and revised or aligned to reduce any associated burden. All key stakeholders must also collaborate on aligning performance measures to minimize burden; collaborate in making better use of existing health IT to facilitate the elimination, reduction, and alignment of administrative tasks; and focus on value over volume of services when reviewing and aligning or eliminating tasks. More research is needed on the impact of administrative tasks on the US health care system and on evidence-based best practices to help physicians reduce administrative burden within their organizations.
- b. **Convene a multi-agency task force to obtain input from clinicians and review evidence to identify tasks that could be streamlined or eliminated, based on the new comprehensive framework for evaluating tasks as proposed by ACP’s policy paper.** Creation of an interagency task force would allow for a coordinated and cross-cutting approach to ease administrative tasks across health care programs regulated by the federal government. Agencies to be included in such a multi-agency task force might include: HHS—and within HHS, the Office of Inspector General and CMS—and specifically, the CMMI; the CMS offices responsible for health information technology like the Office of the National Coordinator for Health Information Technology (ONC), program integrity, Medicare Advantage, Medicaid, and plans offered through

the exchanges; Office of Personnel Management (OPM); U.S. Department of Defense (DoD), and the U.S. Department of Veterans Affairs (VA).

2. Reexamine and replace existing documentation requirements for evaluation and management services billed to Medicare and other payers. The Evaluation and Management (E/M) documentation requirements for billing E/M services have long been an issue for internal medicine physicians as they are counterintuitive to the practice of medicine and overly burdensome. However, it is important that there remain some way of connecting the intensity of work performed by the physician to the level of service provided; therefore, ACP recommends reducing regulatory requirements associated with E/M documentation guidelines through the use of innovative methods, including health IT. The primary goal of electronic health record (EHR)-generated documentation should be concise, history-rich notes that reflect the information gathered and used to develop an impression, a diagnostic and/or treatment plan, and recommended follow-up. Technology should facilitate attainment of these goals in the most efficient manner possible without losing the humanistic elements of the record that support ongoing relationships between patients and their physicians. Wherever possible, EHR systems should not require users to check a box or otherwise indicate that observation has been made or an action has been taken if the data documented in the patient record already substantiate the action(s). Regulations should be clear and should address clinical workflow without adding burden for documentation solely for the purpose of obtaining reimbursement.

Leverage Technology to Improve Patient Care

1. Reduce barriers to use of telemedicine. Telemedicine is reimbursed under Medicare for a narrow number of services in specific areas. Services must originate (where the beneficiary is) in a medical facility located in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA). Medicare will reimburse for telemedicine services that mimic face-to-face interactions between patients and approved health care professionals, but will not cover non-interactive telemedicine, like store-and-forward, except in Hawaii and Alaska. Store-and-forward is asynchronous transmission of a patient's medical information not used in real time.

- a. **ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient-physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care.** [ACP believes](#) that telemedicine can be most efficient and beneficial between a patient and physician with an established, ongoing relationship. Telemedicine is a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area. ACP also supports lifting geographic site restrictions that limit reimbursement of telemedicine and telehealth services by Medicare to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in HPSAs.
- b. **Enact the CONNECT for Health Act, S. 1016. The legislation would substantially expand the use of telemedicine and remote patient monitoring (RPM) services by physicians and other clinicians to improve care of patients enrolled in Medicare.** ACP strongly supports this objective and the Act's creation of a program that would allow Medicare providers (Merit-based

Incentive Payment System (MIPS)-eligible professionals and qualifying APM participants) to furnish telemedicine and RPM services to their Medicare patients not subject to those restrictions under current law. The College also supports the Act requiring that Medicare cover the use of RPM services by Medicare providers for certain Medicare beneficiaries with chronic conditions. ACP believes that the use of RPM services for patients with chronic conditions could help control and manage those conditions and improve the health outcomes for those patients while lowering costs. Lastly, the College supports lifting geographic site restrictions for telestroke evaluation and management sites where the Medicare beneficiary is located. ACP believes that expanding the use of telemedicine for Medicare stroke is an area where evidence supports cost-effectiveness, safety, and positive health outcomes associated with telemedicine.

2. *Improve functionality and usability of EHRs.* The fundamental problem with EHR usability is that systems designed to collect documentation for billing and to satisfy regulatory requirements do not necessarily help clinicians care for patients. Therefore, ACP recommends that the focus of EHRs shift from satisfying billing and regulatory requirements to making care delivery more efficient. A provision of the 21st Century Cures Act (CURES) directs ONC to reexamine and develop new conditions of certification, including listing a number of new transparency requirements for health IT developers, such as not blocking information and restricting communication on usability. This presents an opportunity for ONC to make certification relevant to practicing clinicians by redirecting its focus to usability and useful interoperability. We recommend that Congress conduct hearings among government, clinician stakeholders, EHR vendors and suppliers to foster collaboration between parties requiring everyone to recognize their role and responsibility in reducing administrative burdens associated with health IT. EHR vendors have not had adequate discussions with frontline clinicians to better understand their needs, often leading to workarounds that create additional steps and burden.

3. *Improve the interoperability of electronic health records.* There is growing concern among physicians that the result of improving interoperability will be a flood of data that they will be responsible to read, manage, and act upon. More data does not equal better care; and data without sufficient context may lead to diagnostic or treatment errors. For interoperability to serve the interests of patients, it should be developed and implemented iteratively, so that its effects on patient care are adequately demonstrated and the risks of data overload and data without context are mitigated. On the one hand, we are concerned that physicians could be accused of information blocking if they refuse to purchase and implement every data interface that any other stakeholder wants them to use. On the other hand, physicians are obligated to provide their patients with “all” of their data. Technology vendors and healthcare institutions should not impede the ability of physicians to perform their duty to their patients.

4. *Reduce the burden of health IT-related regulations to better deliver on the promise of EHRs.* After 8 years of ongoing health IT changes, clinicians need a reprieve from the cycle of implementing new reporting requirements and a review and reduction or elimination of complex and ineffective regulations. Therefore, the College recommends that the administration (specifically CMS and ONC) take the following actions to help deliver on the promise of EHRs to streamline and reduce burdens:

- a. Set permanent reporting periods to 90 days (and not moving to a full year);

- b. Relax the upgrade timeline for EHRs to be certified to the 2015 edition requirements, pause both QPP and meaningful use (MU) at current stage for two additional years;
- c. Create cost effective solutions for prior authorizations without creating administrative burdens;
- d. Reduce the burdens of current quality and public health reporting; and
- e. Relax or revisit E/M coding guidelines in order to align with clinical workflow without adding burden for documentation (solely for the purpose of obtaining reimbursement).

Support a Well-Trained Physician Workforce with an Emphasis on High Value Primary Care

1. *Develop a national healthcare workforce policy.* The nation needs workforce policies that include sufficient support to educate and train a supply of health professionals that meets the nation's health care needs and prioritizes physician specialties where millions of patients lack access, including internal medicine specialists trained in comprehensive primary care and have the skills needed to treat an aging population with multiple chronic diseases. The Association of American Medical Colleges projects a shortfall of between 40,800 and 104,900 physicians by 2030. The shortage in the number of primary care physicians is estimated to range between 7,300 and 43,100 by 2030. A report released by HRSA in November 2016 also predicts a shortage of primary care physicians within this range, estimating a shortage of 23,640 primary care physicians for adults by 2025. In certain parts of the country, a shortage of primary care physicians already exists. As of December 2016, HRSA estimates that there are 6,626 designated primary care health professional shortage areas, and it would take approximately 9,376 additional primary care physicians to eliminate them.

2. *Sustain and prioritize graduate medical education funding.* In 2016 ACP and the Alliance for Academic Internal Medicine developed a comprehensive proposal for graduate medical education (GME) innovation and reform. Congress should develop legislation, inclusive of the policies outlined below, to reform GME to prioritize funding toward physician specialties where millions of patients lack access, including internal medicine specialists trained in comprehensive primary care, to improve transparency, to ensure that enough physicians are being trained with the skills needed to treat an aging population with multiple chronic diseases—a hallmark of internal medicine training—and to ensure sustainable and broadly supported funding by all payers going forward.

- a. Congress should increase the number of GME slots by at least 3,000 per year over five years (approximately 15,000 slots) for specialties facing shortages, including internal medicine. Fully fund and support GME, including lifting the GME caps as needed to permit training an adequate number of primary care physicians, including internal medicine specialists, and physicians in other specialties facing shortages. GME funding needs to be sustained and increased on a prioritized basis, to train more physicians in the specialties in greatest need. It is especially important that GME dollars support training of more internal medicine physician specialists. Internal medicine physicians will be especially needed as the population ages and more patients acquire chronic diseases.
- b. Congress should combine DGME and IME into a single, more functional payment program, and broaden the GME financing structure to include all payers. Consolidating direct graduate

medical education (DGME) and indirect medical education (IME) into one payment by using a single per resident amount with a geographic adjustment would increase functionality and improve transparency. All payers—both public and private—should contribute to a financing pool to support residencies that meet the nation’s policy goals related to supply, specialty mix, and site of training. ACP believes that GME is a public good—it benefits all of society, not just those who directly purchase or receive it. All payers, and the patients insured by them, depend on well-trained medical graduates, medical research, and technical advances from teaching programs to meet the nation’s demand for high quality and accessible care, and accordingly, all payers should contribute to GME funding.

- c. Congress should ensure that GME funds are allocated transparently and specifically to activities that further the educational mission of teaching and training residents and fellows. GME funds should follow trainees into all training settings rather than being linked to the location of service relative to the teaching institutions. Medicare GME payment information should be made publicly available in a concise, timely and easily accessible report to ensure that these funds are used for the education and training of residents.

3. Sufficiently fund Title VII, National Health Services Corp (NHSC) and other programs to support the training of primary care physicians. The Title VII Health Professions program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine; the NHSC provides scholarships and loan forgiveness to primary care physicians and certain other clinicians in exchange for service in an underserved area.

Reduce Barriers to Care of an Aging Population with Multiple Chronic Diseases

1. Enact a bipartisan bill to implement recommendations from the Senate Finance Committee. ACP urges the passage of legislation, S. 870, *The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*, which was introduced on April 6, 2017 by Senators Orin Hatch (R-UT), Ron Wyden (D-OR), Johnny Isakson (R-GA) and Mark Warner (D-VA). This legislation would implement reforms to Medicare to improve quality and lower costs of care to patients with multiple chronic illnesses. While developing this legislation, the bill’s sponsors sought the input of multiple stakeholders, including ACP, and we have responded by providing detailed proposals to the Senators on methods to remove barriers to care for seniors with multiple chronic conditions. We are pleased that many of our suggestions have now been incorporated into the CHRONIC Care Act that was introduced in April of this year.

A summary of sections of the CHRONIC Care Act that are consistent with ACP’s policies and recommendations for the bill may be found below:

- **Section 101 – Extending the Independence at Home Model of Care.** Currently, there is a demonstration project under Medicare that uses physicians and nurse practitioner-directed home based primary care teams for Medicare beneficiaries with multiple chronic illnesses. This section would extend this demonstration for an additional two years.

- **Section 303- Increasing Convenience for Medicare Advantage Enrollees through Telehealth.** This section would allow a Medicare Advantage plan to offer appropriate telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B.
- **Section 305- Expanding Use of Telehealth for Individuals with Stroke.** This section would expand the ability of Medicare beneficiaries presenting with stroke symptoms to receive a timely consultation via telehealth to determine the best course of treatment, beginning in 2018.
- **Section 401- Providing Flexibility for Beneficiaries to Be Part of an ACO.** This section would give ACOs in the Medicare Shared Savings Plan the choice to have their beneficiaries assigned prospectively at the beginning of a performance year so that beneficiaries may voluntarily align with their main doctor for ACO assignment.

2. Adopt and implement additional ACP recommendations relating to Chronic Care Management (CCM), other barriers. ACP recommends additional steps to improve care management codes for individuals with chronic conditions and encourage the use of CCM services.

- Eliminate Beneficiary Co-Pay for Chronic Care Management (CCM) Services.** CMS now pays for non-face-to-face chronic CCM services for Medicare beneficiaries who have multiple (two or more) chronic conditions, an effort championed by ACP. However, beneficiaries are responsible for copayments on these services, which can cause undue strain on a doctor-patient relationship because patients are not accustomed to paying for a service when they do not see the doctor face-to-face. It is often difficult to convince patients that their copayment is worth the service. This co-pay should be eliminated by treating CCM services under the preventive services category under Medicare Part B to eliminate any beneficiary cost-sharing associated with the services.
- Require reimbursement and coverage of additional codes for more complex CCM services.** ACP is concerned that Medicare does not adequately value physicians' time spent with patients with multiple chronic conditions. We urge Congress to direct CMS to establish two new codes (perhaps initially as G codes) that would recognize the value of care for clinicians who treat patients with chronic conditions between 20-40 minutes and 40-60 minutes, and authorize payment for CCM codes to allow physicians to spend up to 40 minutes with a patient and an additional code that would allow for 60 minutes of treatment for a patient with multiple chronic illnesses.

3. Continue to promote widespread adoption of the PCMH Model, which incorporates that Chronic Care Model of empowered patients and clinical care teams.

Support Medical and Health Services Research and Public Health

1. Ensure necessary and sufficient funding for the National Institutes of Health (NIH). NIH is the nation's medical research agency, making important discoveries that improve health and save lives. The NIH received \$34 billion in FY2017, \$2 billion more than the FY2016 enacted level. Congress should fund NIH for FY2018 at \$34 billion so that the crown jewel of the country's biomedical research efforts can

continue to fund cures for disease and maintain the United States' standing as the world leader in medical and biomedical research.

2. *Ensure necessary and sufficient funding for programs authorized by the CURES Act.* The CURES Act included funding to fight the opioid crisis and provide more resources to NIH, initiatives that the College strongly supports.

3. *Ensure necessary and sufficient funding for programs authorized by the Comprehensive Addiction and Recovery Act of 2016 (CARA).* The federal government took a major stride forward in confronting this crisis last year when, with the strong support of ACP, the 114th Congress passed and President Barack Obama signed into law CARA, P.L. 114-198. CARA included several provisions that ACP supported, such as:

- a. Developing a federal interagency task force to review, modify, and update, as appropriate, best practices for pain management and prescribing pain medication;
- b. Expanding through grants awareness and education of physicians, patients, health care providers regarding the risks associated with the misuse of opioids;
- c. Improving state-based Prescription Drug Monitoring Program (PDMP) to track dispensing of controlled substances;
- d. Increasing availability of opioid overdose reversal drugs;
- e. Providing alternatives to incarceration to individuals who misuse opioid drugs and other substances to manage their pain; and
- f. Expanding the use of “partial fills” to allow patients to receive a portion of an opioid prescription and increasing the availability of entities to dispose of unwanted medications.

4. *Ensure necessary and sufficient funding for the AHRQ.* ACP strongly believes that AHRQ's activities and related outcomes research provides incomparable and invaluable data that neither can be replicated nor replaced elsewhere in the federal government or the private sector. The College is dedicated to ensuring AHRQ's vital role in improving the quality of our nation's health and over the years in written testimony has consistently requested that the necessary resources be provided for its activities.

5. *Ensure necessary and sufficient funding for the Centers for Disease Control and Prevention (CDC) including funding the Prevention and Public Health Fund created by the ACA.* CDC's mission is to collaborate to create the expertise, information, and tools needed to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. A substantial portion of its funding comes from the fund.

6. *Continue to support PCORI.* ACP strongly supports PCORI and its mission of helping patients and those who care for them make the best care decisions based on reliable information about the potential benefits and harm of various treatment options. Eliminating the Patient Centered Outcomes Research Trust Fund—as Congress has threatened to do in the recent past—would cripple the ability of PCORI, an

independent non-profit entity, to continue important unbiased medical and healthcare system research regarding the delivery of effective care in an efficient manner—with an emphasis from the perspective of the patient. ACP believes PCORI’s research is invaluable and Congress should not reduce or eliminate its funding.

7. Support research on the causes and prevention of firearms-related injuries and deaths and effective policies to reduce such impacts. As data-driven decision makers, ACP advocates for robust research about the causes and consequences of firearm violence and unintentional injuries and for strategies to reduce firearm-related injuries. CDC, NIH, and the National Institute of Justice should receive adequate funding to study the effect of gun violence and unintentional gun-related injury on public health and safety. Access to data should not be restricted, so researchers can do studies that enable the development of evidence-based policies to reduce the rate of firearm injuries and deaths in this nation. Therefore, the College strongly opposes any provision, such as the one included in the FY2017 appropriations bills, which prohibits the use of funds for federal agencies to carry out gun violence research or the gathering of data for future research.

8. Support research on climate change and its adverse consequences for human health and policies to prevent and mitigate such consequences. Climate change is real, it is affecting human health, and it must be addressed now. Climate change potentially increases the threat of heat-related illness, respiratory illnesses like asthma, vector and water-borne diseases like West Nile virus, and behavioral health problems. Tackling climate change is a “win-win” situation – benefiting not only our planet, but also the health of our patients and community. ACP strongly encourages a commitment to substantial and sufficient climate change research funding to understand, adapt to, and mitigate the human health effects of climate change.

9. Support research into the impact of social determinants of health. Research into social determinants of health should include basic scientific research into the underlying mechanisms driving social determinants; increased recruitment of racial and ethnic minorities and those in underserved populations into research studies; and assessments of how the current research environment can better support research on the social determinants of health.

Conclusion

ACP acknowledges that the agenda proposed above is a challenging one, requiring Congress and the administration to put aside partisanship and the seven year (and counting) conflict over the ACA to instead embrace a forward-thinking, patient-centered agenda to expand access and coverage, bring greater value for the dollar spent, reduce administrative burdens, leverage technology, support a well-trained physician workforce, and support research and public health initiatives. Our proposals include ideas that have long had bipartisan support in Congress, from supporting state innovation in health care delivery to bringing greater transparency and value to expanding coverage to funding life-saving medical research and public health programs.

We believe that it is time for Congress and the administration to move on from re-litigating the ACA to embracing true reforms that put patients first. We stand ready to assist in such an endeavor.