

**A Two-pronged Strategy to Improve American Health Care:
Make the Health System More Effective
AND
*Remove Barriers to the Patient-Physician Relationship***

**A report from the American College of Physicians on the
State of the Nation's Health Care**

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Like the classic tale of two cities by Charles Dickens, American health care today is a paradox: in some ways it is the best of times, and in other ways, the worst of times, for patients trying to receive high quality, affordable healthcare.

How could it be the best of times?

More People than Ever will Soon Have Access to Coverage

In a little more than 10 months from now, guaranteed and improved health insurance coverage will begin to become available to nearly everyone—for the first time in U.S. history.

When the Affordable Care Act (ACA) becomes fully effective next year, U.S. healthcare will enter an unprecedented era when Americans will *begin* to have access to affordable health insurance coverage without regard to their health status, where they work, how old they are, or how much they earn. Even now, tens of millions of people are benefiting from the law including:

- Young adults who now can stay on their parents' health plans,
- Seniors who now pay less for prescription drugs, and pay nothing out-of-pocket for most preventive care services,
- Children with pre-existing conditions who no longer can be turned down or charged more for coverage, and
- People of all ages, and especially those with expensive illnesses, who no longer have to worry about their benefits being terminated because they exceed an insurance company's lifetime cap.

Beginning in 2014, many millions more will have access to affordable health insurance coverage either from subsidized coverage offered by health exchanges (marketplaces) run by their states or the federal government, or from Medicaid. Also, insurers will be required to provide a defined level of essential benefits, will not be allowed to impose annual limits on benefits, and not be allowed to turn down or over-charge adults with pre-existing conditions.

Health care costs are moderating

The United States is experiencing an unprecedented slowing of health care cost increases:

- In 2012, U.S. health care experienced the, “fourth consecutive year of record-low growth compared to all previous years in the 50-plus years of official health spending data.”
- *Health care prices had the smallest increase in 14 years*, rising in December 2012, “by 1.7 percent compared to December 2011, the lowest year-over-year growth since February 1998.”¹
- Medicare also is experiencing record low cost increases. According to official government numbers, Medicare per capita costs went up by only a fraction of a percent in 2012 (0.4 percent), much less than the rate of growth in the economy (3.4 percent growth per capita). Over the three year period from 2010-2012, Medicare spending per beneficiary grew an average of 1.9 percent annually, or more than 1 percentage point slower than the average annual growth of 3.2 percent in per capita GDP (that is, at GDP-1.3).²

If the slowdown in health care costs can be sustained, it will be extraordinarily good news: less federal health care spending, a smaller deficit, and a smaller public debt. It will mean that families and employers will be less likely to be priced out of good health care. It will also mean a reduced burden on state health care budgets.

Even so, it remains an open question whether the United States has broken the back of health care inflation, or if the recent slowdown is temporary and unsustainable. And even with the slowdown, the Congressional Budget Office (CBO), in its latest forecast, projects that federal budget deficits will remain historically high relative to the economy, in large part because of the pressures of an aging population, rising health care costs, and an expansion of federal subsidies for health insurance.³

How could it be the worst of times?

In too many states, the poor may be left behind from gaining affordable health insurance coverage.

The unwillingness of many states to participate in the ACA's implementation could leave behind millions of the poorest and most vulnerable residents from getting coverage, at least in the near-term.

The Affordable Care Act was designed to be a partnership between the federal government and states: the federal government provides almost all of the funding to expand coverage while the states enroll eligible persons in Medicaid and administer the health insurance exchanges through which their residents will get subsidized coverage. The Supreme Court, by ruling that the ACA's expansion of Medicaid to all persons with incomes up to 133 percent of the Federal Poverty Level (FPL) could not be imposed on the states and offered only as a voluntary choice, means that the ACA's effectiveness is even more dependent on the decisions of each state.

Unfortunately, the continuing political discord over the ACA has resulted in a substantial number of states choosing *not* to accept the offer of federal dollars to expand Medicaid to the poor and near-poor, even though studies show that it is in the economic interests of most of them to do so.⁴ Many of the same states are forgoing the option to set up the exchanges through which private health insurance that meets federal and state requirements would be sold, and through which the premium subsidies for eligible persons will be administered.

- As of February 8, the governors of 11 states have stated that they will not go along with the Medicaid expansion, and at least another five are leaning against it. Twenty-one states and the District of Columbia plan to implement the expansion; the remaining states are undecided.⁵
- At least 26 states have initially decided not to set up health insurance exchanges (marketplaces). In those states, it will become the responsibility of the federal government to set up and run the exchanges, but experts question how effectively it can do so in dozens of states with millions of residents, and whether the federal exchange can even be fully operational by January 1, 2014 as the ACA requires. Federal officials insist that they are on track to have the federally-administered exchanges ready in time.

The unfortunate reality is that the resistance by many states to expanding Medicaid and running the exchanges will result in millions fewer having access to affordable health insurance coverage than originally predicted. ***Left behind in particular will be the poorest residents of states that have chosen not to accept federal funding to expand Medicaid*** because people at or below the poverty level are ineligible for premium subsidies to buy coverage through exchanges. For them, Medicaid is the only option under the ACA to get coverage they can afford—but only if their state goes along.

The result is that the CBO now estimates that five million fewer uninsured people will get health insurance coverage by 2017. Altogether, instead of the 32-34 million uninsured that the CBO

earlier projected would gain coverage under the ACA, the agency now estimates that 27 million will get coverage.⁶

Later in this report, ACP presents recommendations for strengthening the commitment to ensuring access to care, especially for the most vulnerable, at both the national and state levels.

Looming Budget Cuts Threaten Public Health and Safety

Political discord in Washington over the budget may trigger across-the-board federal spending cuts that will devastate public health and safety.

The continued failure of Congress to reach a bipartisan accord on spending and revenue has resulted in the growing probability that across-the-board federal budget cuts—called sequestration—will go into effect on March 1, just nine days from today.

These ill-considered and arbitrary cuts will affect almost every federal program that protects the health and safety of the American people.

- Research to prevent and treat cancer and other life-threatening diseases will be slowed. The National Institutes of Health (NIH) will be subjected to an unprecedented \$2.39 billion budget reduction over the next 10 years starting in 2013.⁷ NIH estimates the cuts would result in 2,100-2,300 fewer research grants also over the next 10 years. Research Proposal Grant (RPG) success rates would drop from 18 percent in FY2011 to 14 percent in FY2013.^{8 9}
- Funding for programs to train more physicians, especially primary care physicians in underserved areas, will be slashed. The Health Resources Services Administration, which supports training of physicians to serve in under-served areas, will be cut by \$29 million over 10 years, starting in 2013.¹⁰ It is estimated that a cut of this magnitude will result in, “295 fewer scholarships for minority and disadvantaged health professions students through Title VII *Scholarships for Disadvantaged Students* program . . . lost funding midway through their training for 14 primary care residents supported by the Title VII Primary Care Residency Expansion Program and 11 physician assistants supported by the Title VII Expansion of Physician Assistant Training Program, 2,315 primary care physician and physician assistant trainees adversely affected by reduced funding for the Title VII Primary Care Training and Enhancement Program, and 14,760 fewer public health professionals trained through the Title VII Public Health Training Center Program”¹¹ among other adverse impacts.

- Patient access will suffer and jobs will be lost as Medicare payments to hospitals, physicians, and physician residency programs are cut. Altogether, Medicare will be cut by \$11 billion in 2013 under sequestration resulting in a loss of nearly 500,000 U.S. jobs.¹² But the biggest impact will be on seniors and disabled persons who rely on Medicare coverage to enable them to access quality health care. Although guaranteed benefits will not be directly reduced by sequestration, cuts in payments to physicians and hospitals will force many of them to lay-off staff, curtail services, and limit how many Medicare patients they can see. Physicians and other clinicians may have to lay off as many as 62,000 employees if sequestration goes into effect.¹³ In the case of physicians, the sequestration cut is a prelude to a much larger scheduled cut on January 1, 2014 as the result of Medicare's flawed Sustainable Growth Rate formula.
- The federal government's ability to prevent and control diseases and to ensure the safety of food and drugs will be compromised. Funding for the Food and Drug Administration will be slashed by \$191 million and for the Centers for Diseases Control and Prevention by \$444 million over 10 years starting in 2013.¹⁴

[Note the projected budget reductions for each program are from an Office of Management and Budget (OMB) analysis that was prepared prior to enactment of legislation to postpone the sequestration cuts from January 2, 2013 to March 1, 2013. Updated estimates are not yet available from OMB.]

Even if a solution is found over the next weeks to avert the immediate sequestration cut, future showdowns over spending and revenue decisions will make these and other programs vulnerable to more cuts. The current "continuing resolution" to fund most federal operations and agencies is set to expire on March 27. A temporary agreement to allow the federal government to borrow money to meet its current obligations (debt ceiling) expires in mid-May.

At each of these junctions, the discord in Washington could cause funding for essential federal programs to protect public health and safety to be interrupted or suspended, at least temporarily.

It simply is unacceptable that the political divisions in Washington have caused a recurring series of wholly unnecessary budget impasses that imperil the health and safety of the American people.

Our recommendations, provided later in this report, propose an alternative approach to the federal budget that preserves funding for essential health programs while reducing unnecessary spending.

Too Many Americans Are Killed or Injured by Firearms

The tragic shooting of schoolchildren and adult teachers and administrators in Newtown, CT reminds us that far too many people each year are hurt or killed by firearms. Yet the United States seems unable to reach agreement on a reasonable set of measures to prevent accidents, suicides and murders at the hands of persons wielding firearms. In 2012, an estimated 30,000 Americans will have been injured or killed from firearms.¹⁵

ACP has made a commitment to conduct a comprehensive review of the evidence on measures that can be taken to reduce injuries and deaths related to firearms. We recognize that any solution will be multi-faceted, addressing culture, mental health, firearms safety, and reasonable regulation to keep firearms out of the hands of persons who will use them to harm themselves and others, as well as measures to reduce mass casualties associated with certain types of firearms.

We believe that the medical profession has a special responsibility to speak out on prevention of firearms-related injuries and deaths, just as physicians have spoken out on other issues that endanger the health and safety of the American people—from smoking to drunk driving. And we believe that physicians have an obligation to counsel patients on the risk of having firearms in the home, particularly when children and adolescents are present.

Our recommendations, presented later in this report, identify steps that can be taken now to reduce firearms-related injuries and deaths.

Medicare's Broken Physician Payment System Endangers Access and Stifles Innovation

Fundamental reform of the Medicare payment system is long overdue, including repeal of Medicare's Sustainable Growth Rate (SGR) formula. For more than a decade, the SGR has caused annual scheduled cuts in payments to physicians, endangering access to care, destabilizing the program, and creating barriers for physicians to develop the practice capabilities to improve clinical quality and effectiveness. Although Congress usually over-rides the scheduled cut with a freeze of current payment rates or a small positive update, such short-term "patches" have not offered the stability needed to ensure stability and access, nor have they provided a roadmap to transitioning to better payment models—while adding hundreds of billions of dollars to the cost of full SGR repeal.

Further, the current Medicare payment system contributes to fragmentation of care and higher costs by undervaluing critically important primary, preventive and care coordination services, by creating payment “silos” between physicians and hospitals and among physicians themselves, and by aligning payments with the volume of services provided rather than the value of those services to patients.

Repeal of the SGR is essential, and it must be achieved this year. But repeal of the SGR alone will not move Medicare to better ways to organize, deliver and pay for care provided to Medicare enrollees. Accordingly, the recommendations later in this report focus on how to get from here to there, from a fundamentally broken physician payment system to one that is based on the value of services to patients, including immediate and longer-term steps that build upon successful physician-led initiatives in the private and public sectors.

A Growing Primary Care Shortage Will Decrease Access and Raise Costs

More than 100 studies show that increased availability of primary care in a community is positively associated with lower costs and better outcomes of care.¹⁶ Yet the United States is facing a growing shortage of primary care physicians for adults—including internal medicine specialists who are the principal source of primary care for millions of Medicare and Medicaid recipients.

Medical students who enter internal medicine residencies are choosing to subspecialize at increasing rates and of those who stay within general internal medicine a significant portion are choosing hospitalist care over office-based practice. With our population aging and chronic conditions increasing, we need to be providing the public with more, not fewer physicians trained to take care of their health care needs. Two years ago the Council on Graduate Medical Education (COGME) told Congress that in order to have an adequate supply of primary care physicians we need to increase their ratio to 40 percent of all physicians, an 8 percent increase over what was at the time 32 percent.¹⁷

A new study published in *The Journal of the American Medical Association (JAMA)* shows that at the rate that medical students and residents are currently choosing general internal medicine there will not be enough internal medicine specialists to care for all of the patients who need them. Only 21.5 percent of graduating residents from internal medicine programs planned to choose general internal medicine. In 1998, this figure was 54 percent. An accompanying editorial in the same issue of *JAMA* pointed to the COGME report from 2010 and noted that even if half of all internal medicine residents were to choose general internal medicine, we would still be falling well short of the recommended increase in primary care.

The solution to this problem must address both attracting medical students into primary care and retaining primary care physicians once they enter the field. GME funding can be a crucial part of both of these aspects. Later in this report, ACP presents its proposals to recruit and retain primary care physicians.

An Unrelenting Assault on the Patient-Physician Relationship

Each and every day, patients and physicians alike encounter barriers imposed on them by others that undermine the patient-physician relationship—the foundation of good medical care:

- ***Lack of time with patients.*** Current payment, coding and relative value systems discourage physicians from spending time with patients. Also, as physicians spend more and more time each day complying with unnecessary administrative tasks and mandates (see below) imposed by payers and government, they have even less time to spend with their patients.
- ***Excessive, Unnecessary and Unproductive Administrative Tasks.*** A recent study found that U.S. physicians spend \$31 billion annually on interactions with health plans. More specifically, physicians reported spending almost a half-hour each day, three hours each week, and three weeks per year, interacting with health plans. Primary care physicians spend significantly more time (3.5 hours weekly) than other medical specialists (2.6 hours) or surgical specialists (2.1 hours). Translated into dollars, the authors estimate that the national time cost to practices of interactions with health plans is a stunning \$23 billion to \$31 billion, or \$68, 274 per physician, per year. Primary care practices spend \$64,859 annually per physician - "nearly one-third of the income plus benefits of the average primary care physician."¹⁸
- ***Electronic Health Records that Do Not Meet Clinicians' and Patients' Needs.*** Electronic health records were intended to improve care but many physicians are frustrated that they lack the capabilities needed while adding more inefficiency to their daily workflow, compounded by well-intended government "meaningful use" standards that might make things even worse.¹⁹
- ***Performance measures that can result in unintended adverse patient care consequences.*** "Quality measurement and pay-for-performance programs can provide strong incentives to improve quality" but also may result in "unintended consequences."²⁰ For instance, "performance measures related to antibiotic timing for patients presenting to hospitals with community-acquired pneumonia" resulted in "physicians trying to choose between the best treatment for patients or following a national performance standard. Concerns arose that the measure was leading to unnecessary and inappropriate prescribing of antibiotics."²¹ Performance measures can be difficult to report on, may measure the wrong things, and they do not always agree with each other. Physicians appropriately ask: who is measuring the value and effectiveness of the measures themselves?

- ***Growing and excessive number of mandates on physicians enforced by penalties.*** Payers and government keep imposing more penalties on physicians: for not e-prescribing, for not converting to a complex ICD-10 diagnosis coding system, for not meaningfully using electronic health records, and for not successfully reporting on measures. Physicians wonder how they can even find the time to track all of these mandates, incentives, rules, and penalties, while keeping their practices open.
- ***The adverse consequences of a dysfunctional medical liability system.*** Physicians feel continually exposed to the risk of medical liability lawsuits, and feel pressured to perform “defensive medicine” to reduce the risk of being sued. At the same time, patients who are truly harmed by medical errors often wait years for a court to decide on their compensation, if they receive compensation at all.
- ***Direct government intrusion into the patient-physician relationship.*** The patient-physician relationship is undermined by laws that tell physicians what they can and cannot say to their patients or what tests or procedures they must compel their patients to obtain, without regard to the physician’s clinical judgment or the patient’s interests.²²

The inevitable result of the unrelenting assault on the patient-physician relationship is physician burnout, causing many physicians to leave their beloved profession. It is especially causing many physicians to view primary care as a less desirable career choice, exacerbating a growing shortage of primary care physicians, because a disproportionate share of the burden of reporting on measures, health insurance transactions, and pressure to spend less time with patients falls directly on primary care physicians and their patients.

System-wide efforts to improve the health care system won’t succeed on their own in improving access and quality if the physicians that the system is counting on to deliver care are over-hassled, over-stressed, harried, hushed, and rushed.

RECOMMENDATIONS TO MAKE THE HEALTH SYSTEM MORE EFFECTIVE

1. **ACP calls for a renewed commitment at both the national and state levels to effectively implement the coverage expansions and related policies under the ACA, with particular attention to ensuring the poorest and most vulnerable patients have access to affordable coverage.**
 - A. Specifically, ACP calls on all states to participate in the Medicaid expansion. Those that have declined should re-consider their decisions.

- B. Physicians in the states that have declined to participate in Medicaid expansion, or who have not yet made up their minds, should join with patient advocacy groups, hospitals, and other stakeholders to make a unified case to their governors and legislators on the benefits to the state, and to patient care, of accepting federal dollars to expand Medicaid to all persons up to 133 percent of the Federal Poverty Level.
- C. The federal government should provide increased flexibility to the states through waivers to implement new models of providing Medicaid benefits more effectively and efficiently.
- D. States should ensure that physicians are not denied access to the Medicaid primary care increases promised by the ACA because of unreasonable and unrealistic attestation requirements and arbitrary deadlines.
- E. All states should move forward with setting up their health exchanges, on their own or in partnership with the federal government.
- F. The federal government must ensure that it will be able to effectively run the federal exchanges in states that have opted-out, so that qualified coverage and subsidies through the exchanges are available without delay. If HHS finds that it may not be able to effectively run the federal exchanges so that they can begin enrolling persons on January 1, 2014, as the law requires, it has a responsibility to act now to develop a contingency plan. Congress should provide sufficient funding for HHS to carry out its exchange responsibilities.
- G. States must partner with the federal government to ensure that sufficient guidance and resources are in place to help people understand and enroll in the new insurance marketplace.

ACP recognizes that the ACA remains controversial. Yet without a renewed commitment at both the state and national levels to providing coverage, the coverage expansions are likely to be slower and more uneven around the country, resulting in tens of millions having to wait longer for coverage.

We especially believe that physicians in the states that have indicated that they are not likely to participate in the Medicaid expansion, or that are undecided, have a responsibility to make the case to their elected officials that accepting federal dollars to include the poor- and near-poor in Medicaid is morally, ethically, and medically the right thing to do. Last September, ACP asked all of its U.S. chapters to make such a case in their own states, using state-specific data on the benefits to the states and to patients. We urge all other state physician associations to do the same. That the governor and/or lawmakers in some states have taken a

firm position against the Medicaid expansion is *not* a reason for physicians to give up the fight to ensure that the poorest residents have access to coverage—quite the opposite, since the need for such advocacy on behalf of patients is greatest in the states that are resistant.

For some patients, the decision their state makes on Medicaid could be the difference between life and death. A recent study found that Medicaid expansions “were associated with a significant reduction in adjusted all-cause mortality (by 19.6 deaths per 100,000 adults, for a relative reduction of 6.1 percent). Mortality reductions were greatest among older adults, nonwhites, and residents of poorer counties.”²³

ACP recognizes, though, that many states are concerned that the federal government does not give the states sufficient flexibility to design and implement ways to deliver Medicaid benefits more effectively and efficiently in a way that does not undermine Medicaid’s benefits and eligibility requirements. **The Medicaid waiver process should be streamlined to facilitate establishment of approved plans, encourage public input, and improve coordination between federal and state agencies.** It should be more transparent and allow for significant public input from stakeholders – including patients, physicians and other health care professionals. To facilitate public interaction, HHS should, at a minimum, widely disseminate waiver notices and other information by publishing in the Federal Register and allow a minimum 30-day comment period before approving or disapproving a waiver. States should also communicate Medicaid waiver intentions through a variety of media and public hearings to ensure that stakeholders are made aware of proposals and have a chance to offer comments. The federal government and state Medicaid programs also should work together to ensure access for Medicaid enrollees to innovative delivery system reforms such as the patient-centered medical home, a team-based care model that emphasizes care coordination, a strong physician-patient relationship, and preventive services.²⁴

States should also ensure that eligible primary care physicians and internal medicine and pediatric subspecialists are not excluded by unrealistic administrative requirements and deadlines from an ACA program that increases Medicaid payments for visits and immunizations to no less than the Medicare rates, beginning on the first of this year and continuing through 2014. This program, which will increase Medicaid primary care payments by 73 percent on average,²⁵ is essential to increasing the numbers of primary care physicians who can afford to take care of existing as well as new Medicaid enrollees. The ACA requires that physicians self-attest that they meet the specialty and/or claims history to begin to receive the higher payments, but states have considerable discretion on how this requirement should be documented and by what date.²⁶ States should not deny participation in the program because a physician has not submitted self-attestation by an arbitrary deadline; should grant extensions and allow for reasonable retroactive self-attestation, and automate its verification of eligibility to the extent feasible.

It also is essential that exchanges be established and ready to enroll eligible persons in qualified health plans by the first of the year, either through a state-run exchange, a state-federal partnership exchange, or a federal exchange. ACP urges states that have not agreed to set up an exchange to reconsider and begin the process to transition to a state-run or partnership exchange.

At the same time, the federal government must ensure that it will be able to effectively run a federal exchange in every state that has decided to opt-out at this time, without resulting in a delay in enrollment or administering of applicable subsidies. Verbal and written assurances from agency officials that they will be ready need to be accompanied by contingency planning to ensure that there will be no delay in coverage.

Finally, a concerted effort will be needed to make residents of each state aware of their new coverage options and responsibilities to obtain coverage, and state participation in such an effort will be critically important.²⁷

2. ACP urges Congress and the administration to reach agreement on a plan to replace across-the-board sequestration cuts and prevent potential future disruptions in funding for critical health care and instead enact fiscally- and socially-responsible alternatives to reduce unnecessary health care spending.

- A. It is especially important to ensure sufficient and uninterrupted funding for health professions training programs (HHS Title VII primary care training), Medicare graduate medical education and physician payments, medical and health services research (including the National Institutes of Health and Agency for Healthcare Research and Quality), ensuring the safety of food and drugs (Food and Drug Administration), and preventing and controlling diseases (Centers for Disease Control and Prevention).
- B. A fiscally and socially-responsible alternative should build on the progress being made in reducing healthcare cost increases and focus on the real cost-drivers behind unnecessary spending.

Across-the-board cuts that do not take into consideration the importance and effectiveness of different health care programs is the wrong way to reduce the deficit. The right way is to enact a balanced package of reforms that focus on changes that can be made to further restrain health care cost increases and eventually reduce per capita health care spending. Such reforms could include:

- Transition to new payment systems aligned with value (discussed in more detail later in this paper).

- Establish a national, multi-stakeholder initiative to reduce marginal and ineffective care and promote high-value care.
- Provide patients and clinicians with information on the comparative effectiveness of different treatments.
- Establish patient incentives and insurance designed to encourage high-value care and reduce use of low-value treatments and tests.
- Reduce the costs of defensive medicine.
- Preserve and broaden financing for Graduate Medical Education and allocate GME funding more strategically, based on an assessment of national workforce priorities and goals.
- Authorize Medicare to negotiate prescription drug prices.
- Enact a cap on the deductibility of employer-sponsored health insurance.
- Create a single shared cost-sharing structure for the different parts of Medicare.

More information on ACP's recommendations to reduce costs, with estimates of potential savings, is available at:

http://www.acponline.org/advocacy/where_we_stand/medicare/super_comm_menu.pdf.

3. Congress must enact legislation to eliminate Medicare's SGR formula and support the medical profession's commitment to transition to new payment models.

- A. Enact legislation to create a clear pathway and timetable to sunset the SGR and transition to new payment models with higher updates for undervalued evaluation and management services.
- B. During such a transitional phase, physicians should also be able to qualify for higher updates for participating in new value-based payment models and designated quality improvement programs.

The current Medicare payment system contributes to fragmentation of care and higher costs by undervaluing critically-important primary, preventive and care coordination services, by creating payment "silos" between physicians and hospitals and among physicians themselves, and by aligning payments with the volume of services provided rather than the value of those services to patients. Repeal of the SGR is essential, and it must be accomplished this year.

But repeal of the SGR alone will not move Medicare to better ways to organize, deliver, and pay for care provided to Medicare enrollees. Accordingly, federal policy should focus on moving from a fundamentally broken physician payment system to one that is based on the value of services to patients, including immediate and longer-term steps that build upon successful physician-led initiatives in the private and public sectors.

ACP believes that steps can be taken over the next five years, while providing physicians and patients with a necessary period of stable payments, to start more physicians on the road to better payment models, and reward “early adopters” who already have taken the leadership and risk of participating in new value-based payment and delivery models.

We have enthusiastically endorsed the bipartisan Medicare Physician Payment Innovation Act, which creates a realistic pathway to evaluate and implement new payment models and to create incentives for physicians to transition to such models. This bill also recognized the importance of providing higher annual updates for undervalued evaluation and management services provided by primary care physicians and other medical specialists.

We also believe that Congress could authorize Medicare to begin making additional value-based payment updates during a transitional period, starting as early as January 2014. During such a transitional period, we propose that physicians receive higher updates for demonstrating that they have successfully participated in an approved transitional quality improvement (QI) or value-based payment program (VBP). We offer the following principles for developing a transitional QI/VBP program, and then we provide an assessment of specific physician-led models that could be incorporated into such a transitional QI/VBP program:

- ACP supports in concept the idea of providing an opportunity for performance based updates based on successful participation in an approved transitional QI/VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.
- Transitional performance based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models. This is important so that physicians and the Medicare program have a clear “destination” and pathway to achieving it, even as physicians begin the journey through the transitional QI/VBP initiative.
- The transitional QI/VBP program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, participation in the Patient Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood (PCMH-N) models, as

determined by practices meeting designated standards through a deemed accreditation body and/or standards to be developed by the Secretary of HHS with input from the medical profession. Participation in other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional QI/VBP program. In addition, physicians who agree to incorporate programs, like ACP's High-Value Care Initiative, into their clinical practice through shared decision-making with patients, might also qualify for a transitional QI/VBP payment.

- Existing QI/VBP payment models—the Medicare PQRS, e-RX, and meaningful use programs—if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all-elements. Efforts should also be made to align them with specialty boards' maintenance of certification programs. Later in this report, we provide specific recommendations on leveraging and improving such programs.
- Transitional performance-based updates could be tiered so that programs that provide coordinated, integrated and patient-centered care get a higher performance update than less robust programs built on the current, fragmented fee-for-service system.
- Performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive/and coordinated care services, not limited by physician specialty, so that any physician who principally provides such undervalued services could qualify for the higher update. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional QI/VBP initiative.
- For a transitional QI/VBP program to be effective in improving quality, CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

ACP is encouraged that a draft proposal from the majority members of the House Ways and Means and Energy and Commerce Committees overall is very consistent with the approach that we have recommended, as well as the framework created by the Medicare Physician Payment Innovation Act of 2013. We are in the process of developing a response to a request from the two committees for our input on the draft framework.

The Congressional Budget Office has just issued a new estimate of the cost of repealing the SGR, reducing the estimated 10-year budget cost by more than half.²⁸ Now is the time for Congress to act, once and for all, to repeal the SGR, and to transition to value-based models of payment and delivery.

4. Implement policies to recruit and retain primary care physicians.

- A. Preserve funding for graduate medical education. As noted above, GME funding is facing a two percent cut, due to the across-the-board sequestration cuts. These cuts need to be stopped, but as importantly, funding should be made more accountable and effective in order to ensure that we are educating and training a supply of health professionals that meets the nation's health care needs.
 - a. The first change that should be considered is a realignment of GME caps. The existing caps on Medicare-funded GME positions need to be strategically aligned so that spending is in line with our workforce goals. Positions should be shifted to general internal medicine and other primary care specialties experiencing shortages.
 - b. The ACA included a provision for the establishment of a national health care workforce commission and while members have been appointed, the commission has been unable to begin its work due to lack of funding. This important commission could determine which specialties are experiencing shortages and direct funding accordingly.
- B. The cost of GME financing should be spread across the health care system. While Medicare and other federal programs should continue to make a significant contribution to the financing, a system where all payers contributed would ease the obligations on the federal government and could provide a more steady and predictable funding stream. GME is a public good; all payers depend on having a well-trained physician workforce to provide care. It is reasonable to expect then, that all payers should share in the costs.
- C. Payment and delivery system reforms need to address disparities that make primary care less attractive than other fields. There is a more than \$100,000-\$135,000 gap between the median annual subspecialist income and that of a primary care physician. This amounts to \$3.5 million over a lifetime. Compensation for primary care specialties must be made competitive in order to truly solve this problem.

- a. Part of the solution can be the development of new care delivery and payment models, like the Patient Centered Medical Home. These models of care better recognize the value of primary care services and focus on making sure that we provide patients with the type of coordinated care that makes a difference.
 - D. Funding for scholarships, loan deferrals and loan repayment programs, such as the National Health Service Corps and Title VII primary care training programs, needs to be preserved and even increased. While student debt alone is not necessarily associated with choice of specialty, the combination of high student debt and lower earnings for primary care specialties is a significant contributor to the primary-care shortage.
 - E. Shifting some primary-care training outside of hospitals could greatly impact the number of residents choosing general internal medicine. Exposing internal medicine residents to primary-care medicine being performed in well-functioning ambulatory settings that are financially supported for their training roles could positively affect their view of office-based general internal medicine. Not only would it expose them to the community that a medical practice can become, it would expose them to a different mix of patients than seen in the hospital setting.
 - F. As explained in more detail later in this report, policies should be enacted to reduce financial and administrative barriers and reduce the expense of medical liability insurance. This is a concern that weighs heavily on the minds of residents as they consider primary care. They believe that the administrative burdens that are associated with office-based practice mean that they will be spending their time on hassles and paperwork and not be able to spend enough time actually with their patients.
- 5. Reduce firearms-related injuries and deaths by improving access to mental health services, supporting research on the causes and prevention of violence, and enacting reasonable controls over access to firearms that do not infringe on constitutionally protected rights including:**
- A. Require background checks on all firearms sales.
 - B. Ban high capacity magazines and certain semi-automatic weapons with military-style features that could be used to increase the lethality and numbers of persons who are at risk of injury or death when such weapons are used by non-law enforcement persons.

- C. Protect police by banning armor-piercing bullets.
- D. End the freeze on firearms violence research and investigate the causes and prevention of violence, including support for the President's executive order to instruct the Centers for Disease Control and Prevention to begin collecting such data.
- E. Preserve the rights of doctors to counsel their patients on preventing deaths and injuries from firearms. In this regard, state governments must also do their parts by not imposing restrictions on engaging in such discussions with their patients, as some state legislatures have attempted to do.
- F. Promote best practices by firearms owners to store guns safely.
- G. Improve access to mental health services, especially for students and young adults.
- H. Ensure coverage of mental health treatment

The evidence suggests that no one policy by itself will be sufficient, but a combination of measures—including the above recommendations—would be effective in beginning to lower the unacceptable toll of persons who lose their lives or are injured by accidents, shootings, and suicide attempts involving firearms.

RECOMMENDATIONS TO REDUCE INTRUSIONS ON THE PATIENT-PHYSICIAN RELATIONSHIP

- 1. Public and private policymakers and payers must ensure that any payment reforms have an explicit goal allowing physicians to spend more appropriate clinical time with their patients.**
 - A. New models of payment should be assessed against the standard of whether they create incentives or disincentives for physicians to spend appropriate clinical time with patients; those that do not create incentives for appropriate clinical time should be rejected or modified.
 - B. Existing relative value, coding and fee-for-service payments models, whether they are stand-alone or integrated into other payment frameworks, should be changed to create incentives for physicians to spend more appropriate clinical time with patients.
- 2. Payment and delivery reforms that hold physicians accountable for the outcomes of care (measurable performance on quality, cost, satisfaction and experience with**

care) should concurrently eliminate the layers of review and second-guessing of the clinical decisions made by physicians.

- A. If the physician achieves good results, the payer should have no need to micro-manage the decision-making that leads to the results.

As policymakers develop new payment and delivery models aligned with “value” to the patient, they must recognize that among the values that patients hold dearest is having enough clinical time with their physicians, and among the values physicians hold dearest is being able to spend appropriate clinical time with their patients. Indeed, allowing physicians to spend appropriate clinical time with their patients—time spent learning about them and their families and home life, listening to them, uncovering the reasons for their symptoms, explaining the clinical issues, developing an appropriate treatment plan, and engaging their patients in shared decision-making—is at the very essence of the patient-physician relationship. Yet discussion of new and improved payment models often appears at best to be indifferent to how their incentives might support or devalue physicians’ and patients’ clinical time together.

Fee-for-service and Relative Value Unit (RVU) payment models have appropriately been criticized for encouraging volume—seeing more patients per hour and providing more procedures to them—than creating incentives for physicians to spend time with patients. Yet the alternatives under consideration could further devalue clinical time if not designed carefully. Some forms of capitation, for instance, can create disincentives for physicians to see patients at all, since they would be paid the same amount per patient no matter how often the patient is seen or how much time is spent with the patient during each encounter. Fee-for-service at least has the virtue of generally requiring a face-to-face encounter for a visit to be reimbursed, even if the incentive is to see more patients per hour than necessarily is appropriate or desirable from a clinical standpoint.

The point is not that fee-for-service is preferable to capitation or other bundled payment models, only that any payment system will create incentives that can affect patient-physician relationships in ways that may be good as well as bad. **The only way to ensure that payment models support the ability of physicians and patients to spend more appropriate clinical time together is to make this an explicit goal of payment reform.**

Accordingly, fee-for-service payment policies and relative value units should be revised to provide higher payments for more time-intensive clinical encounters, especially with patients with more complex diagnostic challenges and clinical conditions. Capitation and bundled payments must ensure that there is an incentive for physicians to spend appropriate clinical time with patients, such as by ensuring that there is good risk-adjustment based on patients’ health status, combining capitation with fee-for-service payments for specific encounters, and

measures of patient experience with the care provided including time spent with the physician.

Similarly, payment systems can detract from patient-physician encounter time by requiring physicians to spend more time reporting on measures, requiring unnecessary documentation of the services provided, and submitting paperwork to justify their clinical decision-making, at the expense of time with patients. There are, after all, only a set number of hours in a day, and an hour spent on paperwork is an hour that is not available for meaningful patient care.

A specific goal of payment reform should be to reduce the time that physicians must spend in administrative tasks that do not improve patient care or outcomes; at a minimum, they should not add to the administrative burden.

As the United States transitions to models where physicians will be held more accountable for the outcomes of care, not the processes they follow to get there, the quid pro quo should be a dramatic reduction in clinical “micro-management” by third-party payers and government. If physicians can show that they can achieve high-quality and cost-effective outcomes and positive patient experiences with the care provided, based on good and readily reportable composite measures, there is little or no justification for pre-authorization requirements, detailed documentation of each code and encounter, and post-payment second-guessing of clinical decision-making.

3. CMS should harmonize (and reduce to the extent possible) the measures used in the different reporting programs, working toward overall composite outcomes measures rather than a laundry-list of process measures.

- A. Currently, there is no true alignment among CMS’s quality reporting programs (meaningful use for EHRs, Physicians Quality Reporting System, and e-prescribing) in their measures, reporting requirements and payment incentives. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both CMS19 and ONC20 on Stage 3 Meaningful Use, we highlighted our support of the government’s vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken.
- B. ACP recommends that measures and measure strategies be thoughtfully aligned with – and where possible, leverage – the regular practice assessment, reporting

and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC).

- C. Efforts need to be undertaken to reduce unintended consequences from performance measures especially when linked to payments. ACP's Performance Measurement Committee has recommended the following steps to reduce potential unintended consequences of performance measurement:

First, it is essential that national performance measures be based on high-quality scientific evidence

Second, measure developers should carefully examine whether the benefits and risks of a test or treatment are homogeneous. Even if studies show that a clinical service is beneficial for an overall study population, the benefit may be large for some subgroups and negligible (or even harmful) for others. If the benefit-risk ratio is minimal or uncertain, use of a therapy should be left to the clinicians' judgment and not be encouraged through performance measurement.

Third, all measures should routinely allow clinicians to report exceptions for not following a recommendation.

Fourth, we must develop more sophisticated measures that can be programmed into flexible, electronic, clinical decision-support rules.

Finally, to mitigate the risk for inducing unnecessary or harmful care, performance measure developers may need to allow multiple pathways to satisfy a measure.²⁹

4. CMS should provide more clinically relevant ways to satisfy the requirement that physicians must transition to using ICD-10 codes for billing and reporting purposes.

- A. Physicians should not be coding with ICD—only a clinical terminology should be used by physicians. Automated crosswalks should be employed to generate codes needed for payment and reporting purposes.
- B. The only criterion should be whether we have the ability to accurately describe the patient's condition with a code. The most specific code does not always offer the most accurate description of the patient's condition.
- C. ICD-11 may eventually work better than 10, but it is still not appropriate. Because it is at least 10 years away from full implementation, ACP cannot yet evaluate ICD-11 because it is too early in the design process.

- D. A move to a clinical terminology would appropriately move billing costs onto the payers. SNOMED, a comprehensive clinical terminology that provides clinical content and expressivity for clinical documentation and reporting, may be considered the obvious choice for clinical terminology, yet any appropriate clinical presentation layer – even a proprietary one such as the one offered by Intelligent Medical Objects, can help physicians to code accurately and efficiently. Clinical systems should be configured with a clinician-facing presentation layer supported by a clinical terminology. On the back-end an automated process that crosswalks to terminologies will be needed for billing and reporting.
- 5. Congress and CMS should work with physicians to encourage participation in quality reporting programs by reducing administrative barriers, improving bonuses to incentivize ongoing quality improvements for all physicians, and broadening hardship exemptions. If necessary, Congress and CMS should consider delaying the penalties for not successfully participating in quality reporting programs, if it appears that the vast majority of physicians will be subject to penalties due to limitations in the programs themselves.**
- A. CMS should consider and study the potential adverse and unintended consequences when making negative payment adjustments. In addition, CMS should assess the impact of negative payment adjustments over time and be prepared to take steps to mitigate potential unintended consequences and/or reconfigure the program if such adverse effects are recognized.
- B. Penalties should be instituted only if there is evidence that CMS has created programs and provided the necessary time, assistance and timely information needed for physicians to successfully participate in them. To, date, CMS has been unable to provide timely feedback to physicians regarding whether they are successfully satisfying program requirements, leading to frustration and distrust.
- C. Programs that would penalize the vast majority of physicians, by definition, are not effective. A new study suggests that as many as 80 percent of physicians could be subject to penalties under CMS’s current reporting programs.³⁰ Preliminary data from ACP’s annual membership survey indicates that about 46 percent of members find the task of submitting their practice’s clinical data to be somewhat or extremely difficult.³¹
- 6. The government, the medical profession, and standard-setting organizations should work with EHR vendors to improve the functional capabilities of their systems, to**

improve the ability of those systems to report on quality measures and to ensure that those systems improve rather than add to workflow inefficiency.

- A. Federal meaningful use requirements should be revised to put more emphasis on improving clinical workflow.

Current EHR definitions focus first on the EHR as a data repository, then as a system for managing the data. This view, while important, does not provide the guidance needed for the design of clinical systems that intimately support patient care processes.

Relying on this data-oriented EHR definition makes it too easy to design systems that provide clinicians the data they need and the required functionality, but that are difficult to learn and use. Workflow and process-aware systems are the key to reducing training times, enhancing productivity, implementing clinical decision support, and other issues. We must revise our definition of what constitutes an EHR system so that it encompasses, in addition to data and functions, awareness of processes and workflows.³²

7. Medicare and private insurers should move toward standardizing claims administration requirements, pre-authorization, and other administrative simplification requirements even in advance of, and in addition to, the simplification rules included in the ACA.

Regulatory actions mandated by the ACA have already made substantial strides toward administrative simplification by providing a framework to support electronic communication and billing between physicians and payers. Standards have been established to help clinicians determine whether a patient is eligible for coverage, determine the status of a health care claim submitted to a health insurer, and facilitate electronic fund transfers. But, more can be done. For example:

- A. Congress can speed up the current timetable for implementing standards and operating rules for electronic claims attachments. This would significantly lessen the current burden on practices of transmitting paper records in support of obtaining prior authorization for needed treatment and decrease the related delay in patients receiving this treatment.
- B. Congress and private payers can reduce the administrative burden and costs to practices from being required to engage in the redundant process of providing separately to each payer the required experience, education and other credentialing information by establishing a single process for submitting and verifying this information to one trusted entity recognized by all parties.

8. Congress should enact meaningful medical liability reforms including health courts, early disclosure of errors, and caps on non-economic damages.

Tort reform and changes in legal standards concerning professional liability are needed to remove a major impediment that interferes with the patient-physician relationship and inhibits physicians from responsibly ordering tests and procedures based primarily on clinical and cost-effectiveness in accord with practice guidelines.

ACP supports proven reforms to reduce the costs of defensive medicine, including caps on non-economic damages and limits on attorneys' contingency fees. We are one of more than 100 physician membership organizations that have endorsed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act." This bill includes caps on non-economic damages and other reforms that have been proven to reduce the costs of defensive medicine.

In addition, ACP believes that health courts offer a promising approach that should be broadly tested nationwide. Under today's judicial system, judges and juries with little or no medical training decide medical malpractice cases. The majority of medical malpractice cases involve very complicated issues of fact, and these untrained individuals must subjectively decide whether a particular provider deviated from the appropriate standard of care. Therefore, it is not at all surprising that juries often decide similar cases resulting in very different outcomes.

The concept of health courts (also called "medical courts") is a specialized administrative process where judges, without juries, experienced in medicine would be guided by independent experts to determine contested cases of medical negligence. The health court model is predicated on a "no-fault" system, which is a term used to describe compensation programs that do not rely on negligence determinations. The central premise behind a no-fault system is that patients need not prove negligence to access compensation. Instead, they must only prove that they have suffered an injury, that it was caused by medical care, and that it meets whatever severity criteria applies; it is not necessary to show that the third party acted in a negligent fashion.

9. State and federal authorities should avoid enactment of mandates that interfere with physician free speech and the patient-physician relationship.

- A. All parties involved in the provision of health care, including government, are responsible for acknowledging and lending support to the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
- B. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information (including

proprietary information on exposure to potentially dangerous chemicals or biological agents) to the patient, which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient, as such rules can undermine the patient-physician relationship and inappropriately affect patient health.

- C. Laws and regulations should not mandate the content of what physicians may or may not say to patients or mandate the provision or withholding of information or care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are not necessary or appropriate for a particular patient at the time of a patient encounter.

Some recent laws and proposed legislation inappropriately infringe on clinical medical practice and patient-physician relationships, crossing traditional boundaries and intruding into the realm of medical professionalism. Several states have proposed or adopted legislation and/or regulations that interfere, or have the potential to interfere, with appropriate clinical practice by (1) prohibiting physicians from discussing with or asking their patients about risk factors that may affect their health or the health of their families; (2) requiring physicians to discuss specific practices that in the physician's best clinical judgment are not individualized to the patient; (3) requiring physicians to provide diagnostic tests or medical interventions that are not supported by evidence or clinical relevance; or (4) limiting information that physicians can disclose to patients. Of particular concern are laws and regulations that require physicians to provide care not supported by evidence-based guidelines and/or not individualized to the needs of the specific patient.

CONCLUSION

In many respects, American health care may be entering the best of times. The United States is on the verge of an unprecedented new era when nearly all legal residents will have access to affordable health insurance coverage. There are promising signs that health care spending increases may continue to moderate, lowering the federal budget deficit and making health care more affordable to individuals, their families, and employers.

But for some Americans seeking access to quality healthcare, it may yet be the worst of times. Resistance in some states to expanding Medicaid may result in the poorest of their poor being denied access to coverage, resulting in unnecessary deaths and suffering. Scheduled across-the-board federal budget cuts, if allowed to go into effect, will lead to massive job losses, reduced access to care, curtailment of medical research to prevent and cure disease, fewer physicians being available to take care of patients, reduced capacity to ensure the safety of our food and drugs, and diminished ability to respond to public health emergencies including pandemic diseases. Medicare's broken payment system, especially its unworkable SGR formula, threatens patient access to care and impedes the movement to better payment and delivery

systems that put the patient first. A growing shortage of primary care physicians for adults will increase costs and reduce access. And it is the worst of times for the tens of thousands of Americans who are injured or killed each year by firearms and for their loved ones.

It's especially concerning that many physicians report that it is the worst of times for the hallowed patient-physician relationship. Excessive and unnecessary paperwork, unneeded micro-management of clinical decision-making, lack of quality clinical time with patients, burdensome and inconsistent reporting programs and measures, less-than-effective electronic health record systems that result in impaired practice efficiency and workflow rather than better patient care, unnecessary testing and distrust between patients and their physicians caused by an adversarial medical liability system, and direct government intrusions into the patient-physician relationship—all of these, and more, represent an unrelenting assault on the patient-physician relationship, the foundation of all good medical care. The result is that too many physicians feel harried, rushed, hushed, distrusted, and second-guessed, causing physician burnout and an exodus from the profession they loved.

In today's report, the American College of Physicians offers specific and achievable proposals to continue to advance the progress being made in expanding affordable coverage, lowering costs, and reforming physician payment systems.

Equally important, we propose actions to stem the assault on the patient-physician relationship, by re-designing payment systems to allow physicians to spend quality clinical time with patients, by reducing unnecessary administrative tasks, by evaluating physicians based on their outcomes rather than micro-managing their clinical decision-making, by harmonizing and improving performance measurement, and by getting governments out of the business of mandating the content of what physicians may or may not say to patients or the provision or withholding of information or care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are not necessary or appropriate for a particular patient at the time of a patient encounter.

Continued improvement in the health care system to expand coverage and reduce unnecessary costs is imperative, but such efforts will not succeed in ensuring patient access to high quality medical care if the current assault on the patient-physician relationship is allowed to continue unabated.

A two-pronged strategy to make the health care system better AND reduce barriers to the patient-physician relationship will be needed to accomplish the only genuine purpose of health reform, which is to put the interests of patients first.

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