



American College of Physicians
Leading Internal Medicine, Improving Lives

Policy Compendium

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HOW TO USE THE ACP POLICY COMPENDIUM

The American College of Physicians (ACP) Policy Compendium is arranged by headings of broad category areas relating to health care. These categories follow those used in the American Medical Association (AMA) Policy Compendium to facilitate cross-referencing between ACP and AMA policies.

All headings are listed in both the table of contents and the text of the manual in bold, underlined, upper-case letters. Headings indicate the general subject being addressed, and are followed by one or more policies. The individual policies indicate the subject being addressed, and appear as bold, lower-case letters below the heading. Subheadings address specific elements of a policy, and are listed in italic, lower-case letters.

CITATION LEGEND

A citation follows each policy in this Compendium. The following table shows the key for abbreviations used in those citations. The citation format is [Paper Title, Approving Body YY], where YY represents the last two digits of the approval year.

ACP	The Board of Regents of the American College of Physicians, pre-merger.
ACP AMA Del Res	A Resolution of the ACP Delegation to the AMA.
BoR	The Board of Regents of the ACP, post-merger.
CMS	The Council of Medical Societies
HoD	The House of Delegates of the ASIM, pre-merger.

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All policies in the Compendium that are approaching their tenth (10) anniversary will be identified and forwarded to the relevant committee for sunset review. The reviewing committee will make recommendations to reinstate or remove the policy due to lack of relevance or because it has been superseded by more recent policy.

The Policy Compendium will be published in paper form once per year, after the Board of Regents meeting at the Annual Session. An interim electronic version of the Compendium will be posted at ACP Online in the Governors' Information Center and the Regents' Information Center.

Policy Compendium Editorial Group

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ACCIDENT PREVENTION

Protective Head Gear for Bicycle and Moped Riders

ACP recommends bicycle helmets for all moped and bicycle riders and encourages state legislatures to pass laws requiring bicycle and moped riders to wear protective head gear (helmets) on all county, state, and national highways. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 16)

ACCIDENT PREVENTION: MOTOR VEHICLES

Drunk Driving

ACP urges Congress and state legislatures to recognize the disease of alcoholism and to require evaluation of those people guilty of driving under the influence (DUI) for the disease of alcoholism and appropriate treatment if the disease is present. However, the presence of the disease of alcoholism should not relieve DUI offenders from being responsible for their actions while under the influence of alcohol. ACP supports stringent enforcement of laws that would curtail motor vehicle injuries related to drunk driving and encourages enactment and enforcement of more effective drunk driving laws. (HoD 82; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Provision of Clean Needles/Syringes to Drug Addicts

Exchange programs for the needles/syringes are warranted as a means of AIDS control. (HoD 95; reaffirmed BoR 04; reaffirmed BoR 16)

Definition of Disability

ACP works with appropriate Federal agencies as well as the insurance industry to include in the definition of disability HIV positive physicians, medical students and physicians-in-training, who although still physically and mentally capable to practice medicine, cease performing evasive procedures either voluntarily or as a result of regulation or statute. (HoD 92; reaffirmed BoR 04)

Mandatory Testing for All Physicians

ACP vigorously opposes mandatory HIV testing of all physicians. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 16)

Physician Responsibilities to Patients

Physicians who are at a significant risk of being or becoming infected with the HIV virus should establish their serostatus and monitor that status at regular intervals. A physician who knows that he or she is seropositive shall not engage in any activity that creates a significant risk of transmission of the infection to patients, based on scientific data. Physicians who perform exposure-prone medical procedures should know their HIV antibody status and monitor that status at regular intervals. Physicians who are infected with HIV should not perform exposure-prone procedures unless they have sought counsel from an expert review panel as described by CDC and been advised under what circumstances, if any, they may continue to perform these procedures*. Physicians who are cognitively impaired by HIV infection, as with other illnesses, shall not engage in any activity which causes significant hazard to their patients. (HoD 91; reaffirmed BoR 04)

* The review panel should include experts who represent a balanced perspective. Such experts might include all of the following: a. the physician's personal physician(s); b. an infectious disease specialist with expertise in the epidemiology of HIV and HBV transmission; c. a health professional with expertise in the procedures performed by the physician, and; d. state or local public health official(s). If the

physician's practice is institutionally based, the expert review panel might also include a member of the infection-control committee, preferably a hospital epidemiologist. Physicians who perform exposure-prone procedures outside the hospital/institutional setting should seek advice from appropriate state and local public officials regarding the review process. Panels must recognize the importance of confidentiality and the privacy rights of infected physicians.

Testing

ACP supports voluntary testing for the HIV antibody, in conjunction with appropriate counseling to high-risk individuals. The cost of the tests should be subsidized for those who cannot afford to pay for it. Voluntary testing for the AIDS virus should be routinely offered to:

- a. Patients at sexually transmitted disease clinics;
- b. Patients in drug abuse and rehabilitation programs;
- c. High-risk pregnant women in the first trimester of pregnancy;
- d. High-risk individuals seeking family planning services; and
- e. High-risk patients requiring surgical or other invasive procedures.

ACP supports voluntary testing for the HIV antibody only after the patient has given consent, with a full understanding of the adequacy of the current test, medical implications of a positive HIV antibody test, and the reporting requirements and confidentiality protections.

ACP supports the use of universal precautions as the primary method to prevent transmission of HIV infection in health care settings. ACP does not support the use of involuntary testing for the purpose of infection control, in part because a person who tests negative for the HIV antibody may nevertheless be infected with HIV.

ACP supports testing of a patient without consent if a health care worker sustains significant percutaneous or mucocutaneous exposure to the body fluids of that patient and the patient refuses voluntary testing. (HoD 91; reaffirmed BoR 04)

ACP supports limiting notification of test results to:

- a. The individual tested;
- b. Health care workers who have a legitimate need to have access to the information in order to assist the patient or to protect the health of others;
- c. Sexual or needle-sharing contacts; and
- d. Blood, semen, and organ banks. ACP supports legislation to provide adequate funds to public health authorities to establish a mechanism to find, test and counsel endangered sexual or needle-sharing partners of infected individuals.

ACP supports mandatory testing for: Donors of blood, semen, ova, tissue and organs, military personnel, and immigrants.

ACP opposes mandatory HIV testing but supports voluntary premarital testing. (HoD 87; revised HoD 91; reaffirmed BoR 04)

Treating and Paying for AIDS Patients

ACP supports legislation to provide sufficient funding for:

- a. Counseling and testing for AIDS patients;
- b. Research to find a cure and develop an effective vaccine (without taking away necessary resources to study other diseases);
- c. Providing care of AIDS patients who cannot afford to pay for their treatment;
- d. The education of the public regarding appropriate prevention measures.

ACP supports legislation that would prohibit health insurers from:

- a. Testing applicants to identify and subsequently exclude persons testing positive for the HIV antibody;
- b. Using other discriminatory tests, such as T-Cell subsets, to determine an applicant's exposure to the HIV antibody; and
- c. Canceling or failing to renew group or individual health insurance policies because an individual has AIDS or tests positive for the HIV antibody.

ACP supports legislation that would extend group health insurance coverage from the current 18 months to 24 months for those employees who leave a firm with 20 or more employees (at a premium of no more than 102 percent of what it would have cost the employer to cover an employee).

ACP supports state subsidization for HIV positive individuals who cannot afford to pay for the high premiums of conversion policies (once their COBRA protection runs out).

ACP supports legislation to allow Medicaid buy-in by the poor and near poor.

ACP endorses the following American Medical Association policy (with modifications):

- a. Physicians are dedicated to providing competent medical service with compassion and respect for human dignity.
- b. A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.
- c. Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide such services.
- d. Physicians are ethically obligated to respect the rights of privacy and of confidentiality of AIDS patients and seropositive individuals.
- e. States that do not already have a contact tracing program should give serious consideration to implementing such a program. Provisions must be made for adequate safeguards to protect confidentiality of seropositive persons and their contacts and for the counseling of parties involved.

Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities, and a physician knows that a seropositive individual is endangering a third party, the physician should: Attempt to persuade the infected patient to cease endangering the third party; If persuasion fails, notify public health authorities in states where there is already a contact tracing program; and If the public health authorities take no action, notify the endangered third party.

- a. In states with strict confidentiality laws which limit the exercise of this duty by reason of severe

penalties for any breach of confidentiality, especially HIV-related information, special legislation is needed to grant a physician legal immunity to act in the following ways: The legal right to notify endangered third parties directly; The choice of not acting at all if, in the physician's judgment, the danger to the third party is seen to fall short of substantial risk.

- b. A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to patients.
- c. A physician who has AIDS or who is seropositive should consult his or her personal physician as to which activities can be pursued without creating a risk to patients.

ACP believes that patients who test HIV positive should be provided full protection against discrimination in employment, housing, medical and dental care and other aspects of life.

ACP continues to encourage members and other physicians to pursue the highest ideals of medical practice by providing care to those individuals suffering from AIDS. The College recognizes such care as a truly compassionate and selfless commitment to patients' well being. (HoD 87; revised HoD 88; revised HoD 91; reaffirmed BoR 04)

HIV Policy - A Joint Position Paper of the American College of Physicians and HIV Medical Association

HIV Prevention

1. States should work to eliminate requirements for a separate informed consent for HIV testing.
2. Public health officials and others in public leadership should promote evidence-based prevention interventions, including ensuring access to comprehensive sex education for youth, wide availability of condoms and education about their proper use, and broad availability of syringe exchange programs and drug treatment interventions, to minimize the risk of HIV transmission.
3. The U.S. government should increase funding for evidence-based HIV prevention activities through the Centers for Disease Control and Prevention to fund community-based programs aimed at populations at high-risk and groups with intermittent access to care, and to enhance surveillance activities.
4. Physicians and other health professionals should educate patients about all behaviors that put them at risk for HIV infection and other sexually transmitted infections (STI). Physicians treating patients with HIV infection should educate their patients about eliminating behaviors that might contribute to transmitting HIV infection to sexual and drug using partners.

Access to Quality HIV Care

5. All people living with HIV/AIDS in the U.S. should have access to HIV care provided by or in consultation with those skilled in providing care for HIV/AIDS. Physicians, hospitals and other health professionals are obligated to provide state-of-the-art and humane care to patients with HIV infection or arrange for referral to an HIV expert. Adequate resources should be dedicated to addressing the unique psychosocial needs of newly identified patients in the health care setting. Funding for HIV care should be adequate to maintain a competent workforce. The Federal government should evaluate the adequacy and capacity of the HIV clinical workforce.

6. The U.S. government should work with states to assure access to care to all patients with HIV/AIDS by establishing a program, as recommended by the Institute of Medicine that would provide comprehensive medical care and prescription drugs to all low income persons with HIV infection. At a minimum, Congress should increase funding for programs funded under the Ryan White CARE Act and enact legislation that would allow state Medicaid programs to expand eligibility to low-income persons with HIV infection before they progress to AIDS.

Patient Protections

7. Confidentiality of HIV positive individuals should be protected to the greatest extent possible, consistent with the duty to protect others and to protect the public health.

HIV Research

8. The U.S. government should continue to support a comprehensive portfolio of research into the causes, prevention and treatment of HIV infection and AIDS, including research aimed at identifying a vaccine; prevention technologies including barrier methods to prevent HIV acquisition; the development of improved antiretroviral therapies; therapeutic and prophylactic regimens for opportunistic infections and malignancies that affect persons with HIV infection. Further research evaluating the behavioral and cultural aspects of prevention and treatment of HIV in the U.S. and the associated co-morbidities should also be well represented in the research agenda.

The Global HIV/AIDS Epidemic

9. The U.S. government should continue to devote substantial resources to respond to the global pandemic with a particular focus on developing countries. Resources should be devoted to evidence-based prevention interventions such as risk-reduction programs for sexual transmission, condom distribution, syringe and needle exchange, drug treatment programs and programs to prevent perinatal transmission; antiretroviral treatment and comprehensive medical care and support services for infants, children and adults; and programs to provide care and services to HIV-related orphans. The U.S. government should also remain a major contributor to the Global Fund to fight HIV, Tuberculosis, and Malaria. U.S. scientists, physicians, and other experts should continue to assist and be supported in the assistance of developing countries to address the operational, scientific and training issues surrounding implementation of new programs.
10. Visitors with HIV should be able to enter the United States and otherwise qualified immigrants with HIV should be able to obtain permanent residency status or citizenship. (BoR 08)

ALLIED HEALTH PROFESSIONS

Physician Assistants

1. AAPA and ACP believe that physicians and PAs working together in a team-oriented practice, such as the patient-centered medical home, is a proven model for delivering high quality, cost-effective

patient care. National and state legal, regulatory and reimbursement policies should recognize that physician assistants function as primary care providers in the patient-centered medical home as part of a multidisciplinary clinical team led by a physician.

2. AAPA and ACP encourage training programs from both professions to promote and support opportunities for internists to precept PA students and participate as faculty at PA programs.
3. AAPA and ACP encourage interdisciplinary education of physicians-in-training and physician assistant students throughout their educational programs.
4. AAPA and ACP should continue to be represented on the accrediting and certification bodies of the PA profession (ARC-PA and NCCPA).
5. AAPA and ACP encourage the creation of an interdisciplinary task force on workforce development. Workforce policies should ensure adequate supplies of primary care physicians and physician assistants to improve access to quality care and to avert anticipated shortages of primary care clinicians for adults. Workforce policies should recognize that training more physicians assistants does not eliminate the need nor substitute for increasing the numbers of general internists and family physicians trained to provide primary care.
6. AAPA and ACP encourage flexibility in federal and state regulation so that each medical practice determines appropriate clinical roles within the medical team, physician-to-PA ratios, and supervision processes, enabling each clinician to work to the fullest extent of his or her license and expertise. (BoR 10)

Nurse Practitioners in Primary Care

1. Physicians and nurse practitioners complete training with different levels of knowledge, skills, and abilities that while not equivalent, are complementary. As trained health care professionals, physicians and nurse practitioners share a commitment to providing high quality care. However, physicians are often the most appropriate health care professional for many patients.
 - a. Whenever possible, the needs and preferences of every patient should be met by the health care professional with the most appropriate skills and training to provide the necessary care.
 - b. Patients with complex problems, multiple diagnoses or difficult management challenges will typically be best served by physicians working with a team of health care professionals that may include nurse practitioners and other non-physician clinicians.
 - c. Patients have the right to be informed of the credentials of the person providing their care to allow them to understand the background, orientation and qualifications of the health care professionals providing their care and to better enable them to distinguish among different health care professionals.
 - d. The College recognizes the important role that nurse practitioners play in meeting the current and growing demand for primary care, especially in underserved areas.
 - e. The College advocates for research to develop effective systems of consultation between physicians and nurse practitioners as clinically indicated.
2. Collaboration is defined as ongoing interdisciplinary communication regarding the care of individuals and populations of patients in order to promote quality and cost-effective care.

Recognizing the importance of coordinated care to improving health outcomes, we offer the following principles on collaboration between physicians and nurse practitioners:

- a. Effective interdisciplinary collaboration is critical to ensuring that all patients receive the highest possible quality of care.
 - b. Members of a health care team should understand their complementary roles in the delivery of care as defined through their respective professional practice acts.
 - c. Collaboration among physicians and nurse practitioners can occur during both face-to-face encounters and electronically through the use of technology, including telephone, e-mail, telehealth, and electronic health records.
 - d. Effective collaboration among nurse practitioners and physicians requires appropriate sharing of information and mutual acknowledgement and respect for each professional's knowledge, skills, and contributions to the provision of care.
 - e. Payment systems should provide sufficient reimbursement for the coordination of care and collaboration between nurse practitioners and physicians.
3. Licensing and certification examinations for nurse practitioners should be developed by the nursing discipline and based on standardized training involved in graduating from advanced practice nursing programs as well as scope of practice statutes and regulations. Certification examinations should be carefully constructed so as to avoid any appearance of equivalency of training/certification with physicians. ACP therefore opposes use of test questions (past or present) developed by the National Board of Medical Examiners (NBME) for Step 3 of the U.S. Medical Licensing Exam in the certifying examination of Doctors of Nursing Practice (DNPs).
4. In the patient-centered medical home (PCMH) model, care for patients is best served by a multidisciplinary team where the clinical team is led by a physician. However, given the call for testing different models of the PCMH, ACP believes that PCMH demonstration projects that include evaluation of physician-led PCMHs could also test the effectiveness of nurse practitioner-led PCMH practices in accord with existing state practice acts and consistent with the following:
 - a. Demonstration projects testing the effectiveness of Nurse Practitioner (NP)-led PCMH practices should meet the same eligibility requirements as those for physician-led practices.
 - b. NP-led PCMH practices should be subject to the same recognition standards to participate in the demonstration project as physician-led practices.
 - c. NP-led PCMH practices should be subject to the same standards of evaluation as physician-led PCMH practices.
 - d. Patients who are selecting a PCMH as their source of regular care should be informed in advance if it is a physician-led or nurse-practitioner led practice and the credentials of the persons providing care within each practice.
 - e. All clinicians within the PCMH are operating within existing state practice acts.
 - f. Payments and evaluation metrics for both physician and nurse-practitioner led PCMH practices must take into account differences in the case-mix of patients seen in the practice.

5. ACP advocates for research efforts to identify and disseminate effective models of collaboration, referral, and co-management of patients between and among nurse practitioners and physicians.
6. Opportunities for professional multidisciplinary training and team development should be incorporated into the education and training of all health professionals.
7. Workforce policies should ensure adequate supplies of primary care physicians and nurse practitioners to improve access to quality care and to avert anticipated shortages of primary care clinicians for adults. Workforce policies should recognize that training more nurse practitioners does not eliminate the need nor substitute for increasing the numbers of general internists and family physicians trained to provide primary care. (BoR 09)

Pharmacist Scope of Practice

Position 1

ACP supports research into the effects of pharmacy automation and the move to the PharmD on pharmacy practice.

Position 2

In an effort to improve patient safety and reduce medical errors, ACP supports physician-directed pharmacist/physician collaborative practice agreements limited to pharmacist involvement in patient education and hospital rounds.

- Expanded roles for pharmacists should not be solely based on cost savings.
- The responsible physician and pharmacist should be compensated for their time spent on collaborative services.
- The physician solely determines if a relationship will be formed with a pharmacist.
- The physician solely and individually refers a patient to a pharmacist.
- Only the physician shall and must diagnose the patient's condition prior to any referral.

Position 3

- ACP opposes independent pharmacist prescriptive privileges and initiation of drug therapy.

Position 4

- ACP supports the use of the pharmacist as immunization information source, host of immunization sites, and immunizer, as appropriate and allowed by state law. ACP will work with pharmacy organizations to increase immunization awareness.

Position 5

- ACP reiterates its support of its 1990 therapeutic substitution position. ACP resolves to work with pharmacists in designing therapeutic substitution policies that ensure the highest level of patient care and safety. (BoR 00, reaffirmed BoR 11)

Promoting the Leadership Role of Physicians in the Health Care Team

ACP affirms policy that physicians and non-physician health professionals are not interchangeable, and that optimal care for patients is provided by physicians and other health professionals working together in team-based model of care delivery under physician leadership and that vigorously promote the leadership role of physicians in the health care team. (BoR 11)

BEHAVIORAL HEALTH

Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Concerns into Primary Care

1. The ACP supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources.
2. The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care.
3. The ACP recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that are barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws.
4. The ACP supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting.
5. The ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting.
6. The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These programs need to address negative perceptions held by the general population and by many physicians and other health care professionals. (BoR 15)

BLOOD

Blood Donations by Donors Over 65 Years of Age

ACP supports and encourages healthy adults of all ages to be active blood donors. (HoD 87; reaffirmed BoR 06; reaffirmed BoR 17)

CHILDREN AND YOUTH

Decisions about Reproduction

If a patient who is a minor requests termination of pregnancy, advice on contraception, or treatment of sexually transmitted diseases without a parent's knowledge or permission, the physician may wish to attempt to persuade the patient of the benefits of having parents involved but should be aware that a conflict may exist between the legal duty to maintain confidentiality and the obligation toward parents or guardians. Information should not be disclosed to others without the patient's permission. In such cases, the physician should be guided by the minor's best interest in light of the physician's conscience and responsibilities under the law. (BoR 04; reaffirmed as amended BoR 11)

Amended Recommendation on Appropriate Patient Age for Internal Medicine

Many internists are qualified by training and/or experience to provide primary or subspecialty care services for patients beginning with the onset of puberty, roughly age 12, and should not be excluded from providing such care. Some internists, however, may choose to select a higher age criterion (usually between 12 and 18) for accepting patients, based on the internist's own level of training, experience, and comfort with adolescent and/or pediatric medicine and the desires of the patient and the patient's family. Other internists with additional training may choose to set an age younger than puberty for accepting patients. (BoR 2-99, reaffirmed BoR 10)

CIVIL AND HUMAN RIGHTS

Relation of the Physician to Government

Physicians must not be a party to and must speak out against torture or other abuses of human rights. Participation by physicians in the execution of prisoners except to certify death is unethical. Under no circumstances is it ethical for a physician to be used as an instrument of government to weaken the physical or mental resistance of a human being, nor should a physician participate in or tolerate cruel or unusual punishment or disciplinary activities beyond those permitted by the United Nations Standard Minimum Rules for the Treatment of Prisoners. Physicians must not conduct, participate in, monitor, or be present at interrogations (defined as a systematic effort to procure information useful to the purposes of the interrogator by direct questioning of a person under the control of the questioner; it is distinct from questioning to assess the medical condition or mental status of an individual) or participate in developing or evaluating interrogation strategies or techniques. A physician who becomes aware of abusive or coercive practices has a duty to report those practices to the appropriate authorities and advocate for necessary medical care. Exploiting, sharing, or using medical information from any source for interrogation purposes is unethical. (BoR 04; reaffirmed as amended BoR 11)

Medicine and the Law

Physicians should remember that the presence of illness does not diminish the right or expectation to be treated equally. Stated another way, illness does not in and of itself change a patient's legal rights or permit a physician to ignore those legal rights.

The law is society's mechanism for establishing boundaries for conduct. Society has a right to expect that those boundaries will not be disregarded. In instances of conflict, the physician must decide whether to violate the law for the sake of what he or she considers to be the dictates of medical ethics. Such a violation may jeopardize the physician's legal position or the legal rights of the patient. It should be remembered that ethical concepts are not always fully reflected in or adopted by the law. Violation of the law for purposes of complying with one's ethical standards may have consequences for the physician and should be undertaken only after thorough consideration and, generally, after obtaining legal counsel. (BoR 04; reaffirmed as amended BoR 11)

Health Professionals and the Health Effects of Economic Sanctions and Embargoes

The ACP supports:

- exempting from sanctions humanitarian goods such as food and health-related materials or medical supplies, which are deemed likely to reduce the morbidity or mortality of civilians;
- empowering qualified and neutral agencies to address publicly and expeditiously humanitarian appeals for exemptions; that these agencies conduct and disseminate impact analysis of the health effects of economic sanctions;

- providing medical and health-related supplies and services to offset any increased morbidity caused by sanctions; and,
- monitoring and reporting the effective delivery of medical and health-related materials. (BoR 2-99, reaffirmed BoR 10)

Equal Opportunity

ACP affirms a policy of not holding or supporting meetings or social gatherings at organizations and clubs that have exclusionary policies based on gender, race, color, religion, national origin or sexual orientation. ACP shall not pay for, or reimburse, the dues of any member, officer, or employee for membership in clubs which have exclusionary policies based on gender, race, color, religion, national origin or sexual orientation. (HoD 90; reaffirmed BoR 04)

CODING AND NOMENCLATURE

Payment for Physician Services

ACP advocates and will take steps to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately codes services unless the actual description of the codes under which bundling is placed clearly states that the bundled service(s) is part and parcel to the service code for which payment is allowed. (HoD 97; reaffirmed BoR 08)

Coding for Lab Services

1. ACP supports a CPT coding change in which the codes for automated, multichannel tests (80002-80019) are replaced by a small, well defined number of organ-, disease-, or condition-oriented panels to which physicians would be encouraged to add or delete specific tests as guided by medical appropriateness. (HoD 95; reaffirmed BoR 17)
2. Some organ-oriented laboratory panels should be maintained in the CPT Code Manual, and should be reconstructed through the use of consultants who have extensive experience utilizing such laboratory studies for the evaluation of disease states. (HoD 92; reaffirmed BoR 17)

Cognitive/Evaluation and Management Services

1. ACP continues to work with the AMA to improve the current Evaluation and Management CPT codes to be clearer for interpretation, clinically relevant, and more easily applicable in the day-to-day medical practice setting. ACP continues to provide an ongoing mechanism to assist its members with CPT coding issues. (HoD 94; reaffirmed BoR 04)
2. ACP promotes uniform interpretation and appropriate consideration of evaluation and management CPT codes by Medicare fiscal intermediaries and other third-party payers. (HoD 89; reaffirmed BoR 04)
3. ACP opposes the compression of codes for cognitive services. (HoD 89; reaffirmed BoR 04)
4. ACP continues to aggressively work with all appropriate parties to achieve adequate recognition and reimbursement for comprehensive evaluations of complex, established patients by internists. ACP works with component societies to ensure that local carriers do not improperly downcode complex services provided by internists to patients with multiple, complex medical problems. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 16)

Provider Based Billing

1. The College does not support provider based billing for care delivered in an outpatient, hospital-system owned practice when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's high value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care.
2. Hospitals and hospital-owned outpatient practices should be transparent about their billing policies with patients prior to providing care, particularly if the patient and/or their health plan will be responsible for both physician service and hospital facility fees.
3. Provider based billing should not be used as a mechanism for hospitals to recoup/stabilize funding or as a means of ensuring access to care. Ensuring adequate hospital funding and patients' access to care can better be addressed and supported through other means, such as increased/improved health insurance coverage, strengthened workforce policies, and delivery system reforms. (BoR 13)

Resolving Payment and Practice Hassles

Recommendations To Reduce Unnecessary Practice Hassles

1. Claims Payment Issues. All payers in all health care payment systems:
 - a. Must pay clean claims promptly within 30 days of receipt of the clean claims and not delay payment for all services if one service on an otherwise clean claim needs additional information.
 - b. Must make "black box" coding edits for code bundling and claims editing available to physicians at no cost, for the purpose of education.
 - c. Should give practicing physicians the opportunity to review coding edits before implementation in claims processing systems.
 - d. Should not require that office visit claims be submitted with copies of the chart, unless there is ample suspicion of fraud.
 - e. Should not down-code services and procedures without appropriate individual medical review.
 - f. Should request for repayment of claims based on audits, not billing profiles. Billing profiles should be used to identify subjects for possible audits, not repayment without further investigation.
 - g. Must make detailed information on compensation arrangements readily available to physicians, including fee schedules; relative values and conversion factors of services; capitation arrangements; percent of premium; and other physician incentive plans, such as withholds and bonuses.
 - h. Must eliminate extending negotiated discounted fee schedules to other payers without the consent of the physician with whom the original agreement was made (e.g., eliminate silent preferred provider organization [PPO] arrangements).
2. All payers in all health care payment systems should eliminate the use of contract "all-products clauses," which force physicians to participate in health insurance plans against their will.
3. All payers in all health care payment systems must maintain a 24- hour-a-day telephone line or

other confidential electronic means of communication to provide information about specific coverage of and benefits available to any patient presenting for medical care or agree to pay for services provided when such a system is unavailable.

4. Paperwork Reduction and Administrative Uniformity:
 - a. One standard physician credentialing and recredentialing form should be used for health care plans and hospitals, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the recredentialing form can be prepopulated with previously submitted data from the physician.
 - b. Physicians should only have to be recredentialed and required to undergo a site visit once every 3 years, unless quality issues indicate more immediate attention. Insurers should be able to share credentialing and site visit information upon approval of the physician.
 - c. The health insurance industry should standardize the fields of information required so that there is a single uniform encounter form, single uniform durable medical equipment approval form, single formulary request form, single uniform referral form, etc. All health insurance industry forms should be uniform, with one form per task rather than a different form from every insurer for the same task. The development of the uniform forms should involve practicing physicians.
5. The health insurance and pharmaceutical industries should develop technology to make formulary databases accessible and easier to utilize and provide these databases in electronic formats that can be imported into practice systems. Practicing physicians should be involved in the design and pretesting of these technologies.
6. Health insurance carve-out entities, such as managed behavioral health organizations (MBHOs), should share their disease management protocols with primary care and other treating physicians. When a patient's health is managed and/or administered by a carve out entity, the primary care and other treating physicians should be immediately notified and kept apprised of the patient's treatment, progress, and medications, so that the primary care and other treating physician can coordinate the patient's health care needs in an optimal fashion.
7. Health insurance plans should allow consulting physicians or primary treating physicians to make referrals for tests, radiologic procedures, and therapy rather than requiring "gatekeeper" physicians to manage all referrals. (BoR 03, reaffirmed BoR 13)

Reimbursing Physicians for Telephone Care

Recommendation 1:

The American College of Physicians (ACP) supports reimbursement by Medicare and other payers for health-related communications, consultations, and other appropriate services by telephone, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communications, consultations, and other appropriate services via the

telephone. The guidelines should include examples of both reimbursable and nonreimbursable telephone-related communications.

Recommendation 3:

Payment for health-related telephone communications should not result in a reduction in separate payments for E/M services. (BoR 03, reaffirmed BoR 13)

ACP Recommendations for Achieving an Interoperable National Healthcare Information System

In developing and implementing a national interoperable healthcare information infrastructure, ACP urges the federal government and all sectors of the healthcare market to ensure the following recommendations are addressed:

1. Interoperable health information networks should be created in the United States to ensure the rapid flow of secure, private and digitized information relevant to all facets of patient care.
2. ACP will take a leadership role among the national and state medical societies advocating for public policies and private sector initiatives to create a national electronic health information infrastructure. The American College of Physicians will support this objective by:
 - a. Advocating for federal legislative and executive branch initiatives to create an electronic health information infrastructure consistent with the policies described in these recommendations.
 - b. Participating in public and private sector initiatives to support the development and implementation of interoperable electronic health information systems.
 - c. Facilitating participation by internists in demonstration projects on interoperable electronic health information systems.
 - d. Providing practice management assistance to internists to help them make informed decisions on acquiring components compatible with interoperable electronic health information systems.
 - e. Providing clinical decision support tools, such as the Physicians' Information and Education Resource (PIER), which can be integrated into office-based electronic health information systems.
 - f. Providing physician and technical input into the development and implementation of voluntary quality performance measures and health information systems industry standards.
3. The creation of interoperable healthcare information networks, electronic health records, electronic prescribing, and other e-health technologies must not become another un-funded regulatory mandate on physician practices.
4. Federal policy should support voluntary standards setting, rather than federal mandates on specific e-health technologies or products.
5. Demonstration projects, which contain usability requirements, should be conducted to test the new e-health technologies to ensure the technology is practical and worthwhile in the clinical setting prior to being implemented nationally.
6. Sufficient time must be allowed for development, implementation, and testing of interoperable

healthcare information networks, electronic health records, electronic prescribing, and other e-health technologies, with direct involvement of physicians and other stakeholders in all stages of the design and implementation of the networks.

7. Physicians and other caregivers must be given adequate time and financial resources to acquire the necessary technology, training and skills to incorporate interoperable healthcare information networks, electronic health records, electronic prescribing, and other e-health technologies into their practices. Consideration must be given to the increased personnel costs that will be incurred as a result of these increased technological skill requirements.
8. The physician's responsibility to make patient care decisions and prescribe medications, based on his or her clinical expertise and experience, must be preserved. Electronic health record (EHR), e-prescribing, and other e-health technology must be designed to facilitate access to unbiased and evidence-based decision support tools.
9. Clinicians, researchers, and patients should have access to complete health records available on the interoperable healthcare information network consistent with Health Insurance Portability and Accountability Act (HIPAA) regulations.
10. EHR and e-prescribing systems must dynamically/bi-directionally link to the physician office medical management system, reducing the need for double entry of information such as insurance and demographic information.
11. Insurance companies must place clear formulary codes on insurance cards and e-prescribing systems so that formulary checking can be seamless and accurate.
12. Although EHRs may include certain functions for the collection of data or as reminders, physicians should not be mandated to use each EHR function. For example, physicians should not be required to screen every patient for a disease condition, such as Lyme disease or all drug/diet interactions, simply because a reminder function for this disease is embedded in the EHR. Ultimately, a clinical encounter should be managed based upon a patient's presenting condition and the physician's training and expertise.
13. E-prescribing systems:
 - a. Must provide a patient medication profile that includes prescriptions from all pharmacy sources in a single unified view. The system would provide a list of every individual prescription filled for a given patient by any pharmacy within a specified time frame from most recent to least recent and indicate which prescriptions have been discontinued.
 - b. Must be dynamically updated with the most current health plan formularies.
 - c. Must interact with the final HIPAA Security standards, due to be implemented in 2005, address issues such as what physical safeguards are necessary to guard data integrity, personal authentication, encryption, and patient confidentiality, and address the impact of e-prescribing on access to DEA-controlled drugs, which in many states can only be provided through a triplicate (or other special paper) prescription order.
 - d. Must not be used as a means for payers and pharmacy benefits managers to pressure physicians to prescribe a different therapy or medication than what the physician concludes is best for a particular patient based upon scientific evidence and knowledge

of the patient's medical history. (BoR 04)

e-Prescribing

1. The College broadly supports the development and implementation of e- prescribing technology within the healthcare system. It recognizes the potential for benefits in care quality, patient safety, administrative efficiencies and lower costs associated with the introduction of this technology.
2. The College has specifically supported the Centers for Medicare and Medicaid Services (CMS) efforts to develop foundation standards for the primary e-prescribing functions, the creation of safe harbors to the Medicare Anti-kickback Act and exceptions to the Stark laws promoting donation of e-prescribing technology to practices, and efforts at the federal, state and private sector level to provide increased payment, loans and grants to facilitate e-prescribing adoption at the practice level.
3. The College recognizes that efforts to facilitate e-prescribing adoption at the practice level must address significant barriers. These barriers, which effect all practices, but have the greatest effect on small and medium size practices and rural practices, include:
 - a. The significant software, hardware, implementation and maintenance costs to the practice.
 - b. The substantial practice workflow changes that are required to effectively implement e-prescribing into the practice.
 - c. The limited evidence for a "business case" to implement e-prescribing technology at the practice level. Most benefits and costs savings are received by the patient, the pharmacy benefit manager, the pharmacy and the payer.
 - d. The significant technical difficulties being encountered in implementing current e-prescribing products in the market place being reported by our members and in the literature.
 - e. The lack of a system to certify and ensure that the e-prescribing products available in the market place are functionally effective (BoR 07)

Electronic Prescribing of Controlled Substances

ACP supports an amendment to the Controlled Substance Act to permit electronic transmission of prescriptions of controlled substances using appropriate and reasonable security standards and audit capabilities; and will encourage the Centers of Medicare/Medicaid Services (CMS) and the Drug Enforcement Agency (DEA) to work together to modify the regulation. If this is not feasible, legislation should be passed to allow for a statutory change in the law. (BoR 09)

Downcoding

ACP continues to assign high priority to monitoring downcoding and documentation problems and continue working with the Health Care Financing Administration, Congress, the Physician Payment Review Commission (PPRC) and others to alleviate these difficulties. ACP believes that component societies should monitor downcoding issues, comment on carrier policy changes and meet regularly with

their carriers to resolve difficulties members are experiencing with them. This should include components monitoring with the appeals process and forwarding this information to ACP to enhance ACP's abilities to conduct more meaningful discussions with CMS. ACP believes that a useful and meaningful definition of codes including guidelines for appropriate documentation of services performed should be established. ACP opposes the practice of arbitrary or automatic downcoding of comprehensive hospital admission services and will work with CMS towards this end. ACP believes that the apparently different requirements (in complexity and documentation) for acceptably complete hospital admission history and physical examinations as defined by state licensing authorities, JCAHO and Medicare carriers, particularly as to how these may change with subsequent hospital admissions should be clarified. ACP believes that a simplified, uniform and expeditious process for development and appeals of coding disputes with Medicare carriers should be developed and promoted. (HoD 90; reaffirmed BoR 04)

Coding

ACP opposes burdensome coding and record-keeping requirements unless patient care benefits result from their implementation. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 16)

Support for AMA/CPT

ACP approves of the AMA Current Procedural Terminology (CPT) coding and nomenclature, recognizing it will be expanded as medical practice advances. (HoD 70; reaffirmed HoD 87; reaffirmed BoR 04)

ACP supports the Editorial Board of CPT and the AMA Board of Trustees in their effort to implement the nationwide use of CPT by the medical profession, and recognizes that responsibility for formalized nomenclature of professional services and procedures is the clear prerogative of organized medicine. (HoD 73; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Third-Party Manipulation of Terminology

ACP opposes the modification of procedural descriptions or conversions to different terminologies by third-party employees without appropriate professional medical consultation. The use of any terminology system containing modified data shall be considered invalid and inappropriate for the purposes of reimbursement, measures of practice patterns, peer review, utilization review, or any other related uses. (HoD 76; revised HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Timely Release of New CPT/CMS Common Procedural Coding System Codes

ACP believes that the appropriate agencies to release CPT/HCPCS codes on newly accepted medical treatments, procedures and medications immediately following their acceptance should be petitioned. ACP believes that CMS should fairly and promptly reimburse these newly accepted treatments, procedures and medications. ACP will urge CMS to provide carriers and physicians with timely, clear and uniformly applied conditions if there are limitations on service or special requirements for documentation. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Reimbursement to Assure Fair Reimbursement for Physician Care Rendered Online

1. ACP supports reimbursement by Medicare and other payers for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.
2. Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communication, consultations, and other appropriate services

via the Internet. The guidelines should include examples of both reimbursable and non-reimbursable Internet-related communication.

3. Payment for health-related Internet communication should not result in a reduction in separate payments for evaluation and management (E/M) services. Such reimbursement should also not be subject to budget-neutrality offsets under the Medicare fee schedule. (BoR 03, reaffirmed BoR 13)

Controlling Health Care Costs: Options for Controlling Administrative Costs

1. Congress should request that the Institute of Medicine or another appropriate entity conduct a comprehensive assessment of administrative, paperwork, documentation, and medical review requirements imposed on physicians by federal regulatory agencies, public and private health plans and state governments. This study should determine the amount of time typically required by physicians to meet such requirements and identify specific strategies to reduce the time required. Particular attention should be given to the administrative burdens imposed on primary care physicians, such as micromanagement of E&M documentation.
2. Congress should enact legislation to:
 - a. Require that any new regulatory requirements that would create added costs to physician practices be accompanied with funding to offset such costs and establish a moratorium on any new regulations that would create additional unfunded costs to physician practices.
 - b. Simplify and shorten the physician enrollment process under Medicare by allowing physicians to use external databases to submit demographic and credentialing information required to establish and maintain Medicare participating physician status.
 - c. Study "real-time" adjudication of claims for physician services
 - d. Study opportunities to collaborate with private sector relief and simplification efforts.
 - e. Test models that eliminate documentation requirements for E/M services, pre-authorizations, retrospective medical utilization review, and other regulatory and paperwork requirements for physician practices that qualify as PCMHs or that participate in other designed programs where the performance of such practices are measured based on quality, efficiency, and patient satisfaction metrics.
3. Health insurance forms should be uniform across insurers, (e.g., a single durable medical equipment approval form, a single referral form).
4. An online platform should be established in which all benefit information, forms, formularies, and prior approval information could be accessed and completed online with as little disruption to medical practices as possible.
5. A standard physician credentialing and re-credentialing form should be used, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the re-credentialing form can be prepopulated with previously submitted data from the physician.
6. Health insurance companies should be required to disclose fully and uniformly the portion of health care premiums that is spent on administration, including the percentage of premium dollars allocated to marketing, claims processing, other administrative expenses, profits, and reserves as well as the payment for covered benefits. (BoR 10)

Solutions to the Challenges Facing Primary Care Medicine: Quality of Practice Life: Provide Relief from Administrative Burdens

1. Congress should request that the Institute of Medicine or other appropriate entity conduct a comprehensive assessment of administrative, paperwork and medical review requirements imposed on primary care physicians by federal regulatory agencies, public and private health plans and state governments. This study should determine the amount of time typically required by primary care physicians to meet such requirements, and identify specific strategies to reduce the time required.
 - a. Based on results of such a study, the federal government should implement reforms to reduce the amount of time required to complete administrative tasks, especially tasks required by the Medicare program, leading to an overall improvement in the practice conditions for primary care physicians and practices and allowing them to better serve patients.
 - b. Private payers that participate in programs subsidized, directly or indirectly, with public dollars should be required to implement comparable strategies as a condition of qualifying for such subsidies.
 - c. Other private payers should be encouraged to implement comparable strategies. (BoR 09)

Efficiency Benchmarks for Health Insurance Companies

ACP work with the AMA to establish performance, e.g. business practice, benchmarks for health insurance companies and furnish this information to providers, purchasers, patients, and policymakers. (BoR 08)

COLLECTIVE BARGAINING

Physicians and Joint Negotiations

Physicians should have the right to negotiate jointly with health insurance plans over issues that affect the quality of, and access to, patient care, including payment policies that because they are unrealistic or unfair are likely to affect adversely access and quality. ACP opposes joint actions by any physicians that would 1) deny or limit services to patients (including strikes, slow-downs, boycotts, and administrative or other organized actions that would harm patients), or 2) result in price fixing or other anticompetitive behavior. Physicians-in-training should have means available to communicate with their program directors and supervisors to address and resolve concerns about patient care, stipends, hours, and other working conditions. Educational content should remain the purview of the appropriate Residency Review Committee (RRC) and program directors, and not subject to negotiations. A process must be established for the determination of negotiating units for physicians and for the selection of representation for joint negotiations. Bargaining units for physicians should not include nonphysician providers but should include representatives of patients in meaningful advisory roles. Conflict-resolution mechanisms must be available for resolving impasses in joint negotiations on behalf of physicians. For residents and fellows, a mutually agreed upon third-party mediator from within academic or organized medicine should be available in the event that agreement cannot be achieved through these mechanisms. Membership in an organization that negotiates for physicians should be voluntary. Physicians should have the right to join or not join organizations that represent them for joint negotiations and should not be penalized or discriminated against based on their membership status in such organizations. (BoR 7-99, reaffirm BoR 10)

COMPARATIVE EFFECTIVENESS

Comparative Effectiveness

Position 1: The American College of Physicians (ACP) strongly supports efforts to improve access to information comparing clinical management strategies.

Position 2: The College strongly supports the establishment of an adequately funded, independent entity to sponsor and/or produce trusted research on the comparative effectiveness of healthcare services.

Position 3: The College believes that the federal government should have a significant role in the funding, implementation and maintenance of this comparative effectiveness entity, but takes no formal position on its organizational structure (e.g. government or joint public/private).

Position 4: The College recommends that the newly proposed comparative effectiveness entity should:

- have a structure and adopt operating procedures that encourage trust in its impartiality and adherence to the strictest scientific standards, by ensuring its independence from both undue governmental and private sector influence.
- be responsible for the development of evidence concerning comparative effectiveness necessary for clinical practice, coverage or pricing decisions, but have no direct involvement in the making of these healthcare decisions.
- conduct proceedings and present results in a transparent manner.
- involve all relevant stakeholders, including beneficiaries, payers, scientists, providers, and industry representatives, at all levels of the evidence development process.
- implement a prioritization process informed by input from the stakeholder groups that ensures that the comparative effective evidence developed will have the greatest positive effect on improving the quality and efficiency of the overall health care provided in the country.
- support the development of evidence at all levels from review and synthesis of existing evidence to initiation of new research in priority areas when essential evidence does not already exist.
- include in its analyses relevant clinical information that is available from federal agencies as well as private and academic settings.
- ensure that the comparative effectiveness findings developed are accessible in a timely manner and in a comprehensible form to all stakeholders.

Position 5: The College recommends that the proposed comparative effectiveness entity be charged with systematically developing both comparative clinical and cost-effectiveness evidence for competing clinical management strategies.

Position 6: The College recommends that as part of the implementation of the proposed comparative effectiveness entity, a panel of stakeholders and additional scientific experts including those specifically in the area of cost-effectiveness analyses be formed and charged with:

- Updating and expanding upon the recommendations of the 1993 Panel on Cost-effectiveness and Health and developing related procedures to ensure that the proposed entity produces high quality cost-effectiveness information.
- Developing a framework and related procedures to reconcile apparently disparate estimates of cost effectiveness regarding specific clinical management comparisons.
- Developing recommendations including suggested model procedures for potential use by stakeholders who plan to consider this cost-effectiveness information in coverage, purchasing and pricing decisions. These recommendations should:
 - recognize that cost-effectiveness analysis is only a tool to be used in coverage and pricing decisions. It cannot be the sole basis for making resource allocation decisions.
 - help to ensure that the use of cost-effectiveness information as part of the decision making process takes into account the unique needs and values of each patient (is patient-centered) and the clinical opinion of the treating physician, while also recognizing the limited nature of healthcare resources available to society in general (the Medical Commons).
- Developing recommendations to establish a mechanism to educate the general public and promote discussion on the use of comparative clinical and cost effectiveness information to both meet the needs of the individual and help ensure the equitable distribution of finite health care resources throughout society.

Position 7a: The College recommends that all healthcare payers including Medicare, other government programs, private sector entities and the individual healthcare consumer employ both comparative clinical and cost-effectiveness information as factors to be explicitly considered in their evaluation of a clinical intervention.

Position 7b: The College recommends that cost should never be used as the sole criterion for evaluating a clinical intervention. Cost should only be considered along with the explicit, transparent consideration of the comparative effectiveness of the intervention. (Improved Availability of Comparative Effectiveness Information: An Essential Feature for a High Quality and Efficient United States Healthcare System, BoR 08)

Controlling Health Care Costs: Comparative Effectiveness Research

1. Efforts should be made to improve access to information comparing clinical management strategies.
2. An adequately funded, trusted national entity should be charged with systematically developing both comparative clinical and comparative cost-effectiveness evidence for competing clinical

management strategies. It should prioritize, sponsor, or produce comparative information on the relative clinical effectiveness, safety, and cost-effectiveness of medical services, drugs, devices, therapies, and procedures.

3. The federal government should have a significant role in funding, implementing, and maintaining this comparative effectiveness entity.
4. Cost should never be used as the sole criterion for evaluating a clinical intervention, but it should be considered alongside the explicit, transparent consideration of the comparative effectiveness of the intervention.
5. Health care payers, physicians and other health professionals, and patients should consider both comparative clinical and cost-effectiveness information in evaluating a clinical intervention.

Employers and health plans should consider adopting value-based benefit design programs that use comparative research on clinical outcomes and cost effectiveness developed by an independent entity that does not have an economic interest in the benefit determinations. (BoR 09)

CORRECTIONAL HEALTH CARE

Correctional Medicine

I. *Corrections and Public Health*: ACP supports maximizing the collaborative efforts of correctional entities with state, county, and local health offices to best ensure the effective delivery of public health care. This should include direct involvement by health departments in the strategic planning, assessment, and the provision of clinical services when appropriate. The epidemiologic approach and management of infectious diseases, violence, and chronic diseases should be jointly addressed.

Efforts should be made to assure timely and accurate disease reporting for epidemiological purposes and to assure the continuity of care for these conditions upon an inmate's release from a correctional facility.

II. *Tuberculosis*: ACP supports the aggressive identification and assurance of treatment completion for actively identified tuberculosis (TB) cases and tuberculin reactors in correctional settings. CDC guidelines and collaboration with public health departments for testing and treatment are appropriate for this setting.

III. *Human Immunodeficiency Virus (HIV)*: ACP supports aggressive testing programs to identify all HIV-infected inmates to allow for early intervention, treatment, and education. Up-to-date therapy must be utilized. Experienced clinicians familiar with the treatment of HIV and its complications must oversee and direct patient care. Following discharge from the correctional setting, continuity of care should be maintained through appropriate community referrals.

IV. *Hepatitis C (HCV)*: ACP supports aggressive testing programs to identify HCV-infected inmates and ensure appropriate counseling concerning necessary lifestyle changes related to both disease progression and spread. Recognizing that clinical outcomes and predictors of response are still in the evaluation phase, and that local community standards may vary substantially, ACP supports the development of correctional policies that reflect the prevailing clinical approach and standards of the communities served.

V. *Qualifications of Practitioners in Correctional Settings*: ACP strongly opposes licensure provisions that enable physicians otherwise deemed unqualified to practice in the community for practice privileges in correctional settings. Prisoners by virtue of their incarceration do not forfeit their right to community standards of care that must be adhered to by those rendering care to this population.

VI. *Medical Schools Involvement in Prisons, Prisoners as Experimental Subjects, and Health Services Research*: ACP supports medical and academic institutional involvement in the delivery of correctional health services. The quality and level of care should be consistent with that provided to other segments of the populations served by these providers. All consideration for access to experimental treatments and involvement in medical research must be reviewed and controlled by Institutional Review Board oversight. Informed consent and right of refusal must be rigorously respected and assured. No laxity of standards applied to research projects with prison subjects is acceptable. Ethics committees must provide input and oversight to ensure appropriate protocol implementation.

ACP strongly supports health services research in the field of correctional health care. The same scientific rigor applied in academic centers, HMOs, and community-based clinics must be utilized in the prison populations. Opportunities for health interventions and priorities for health expenditures must be based upon sound scientific knowledge and evidence-based medicine.

VII. *Private Prisons and Private Medical Vendors*: ACP advocates that all aspects of medical care, inclusive of level and quality, provided by private, for-profit prisons or by private medical vendors, must be at least equivalent to that provided in public facilities. States contracting for these services must provide the necessary oversight and maintain the technical ability to ensure the appropriate delivery of services in terms of type and quality.

VIII. *Special Prison Populations: Women, the Elderly, Special Needs, and the Terminally Ill*: ACP advocates that corrections systems address the specific needs of the special populations they incarcerate. Screening and prevention guidelines should follow nationally accepted parameters. Provision of special services to inmates should be determined by medical necessity. Hospice programs should be provided in the correctional setting within the security constraints of the environment.

X. *Substance Abuse and Mental Illness*: ACP supports identification and voluntary treatment of inmates with substance abuse problems. Specifically, prisons should identify and offer services to addicted inmates at a minimum of six months prior to their discharge into the community. Continuity of such treatment begun in prison should occur upon discharge. Mentally ill inmates must receive care consistent with the community standard of care and protection including specialized units as needed within the prison environment.

XI. *Accreditation of Correctional Health Care*: ACP supports the accreditation of medical care provided in correctional settings. Specifically, the College encourages acceptance of medical care consistent with community standards. Accreditation entities uniquely focused on corrections, such as the National Commission on Correctional Health Care (NCCHC), are best qualified to ensure these standards (23). The standards for accreditation should reflect those of the community, and use evidence-based medicine as the standard against which to measure outcomes assessment. (BoR 07, reaffirmed 11)

XI. *Opiate Replacement Therapy*: ACP endorses the medical treatment model of employing Opiate Replacement Therapy (ORT) in conjunction with the provision of appropriate medical services and counseling as effective therapy in treating incarcerated opiate addicted persons. (BoR 01-07)

COST CONTROL

Controlling Health Care Costs: Ensure Accurate Pricing of Services

1. The Federal government should take action to reduce the high cost of prescription drugs in the United States by using its purchasing power to obtain the best prices from pharmaceutical manufacturers covered by publically funded plans, including Medicare, similar to the

prescription drug purchasing process used by the Veterans Administration. However, ensuring high quality and patient safety and support for continued innovation and research on drugs that can advance medical care must remain the top priority of any program to address the price of prescription drugs. Prescription drug importation is not a long-term solution to the high cost of prescription drugs. Efforts to reduce prescription drug prices should include:

- a. Encouraging increased competition among brand-name manufacturers
- b. Studying the effectiveness of prescription drug substitutes, such as lower-cost, therapeutically equivalent medications and expediting approval of generic drugs and encouraging their use
- c. Negotiating volume discounts on prescription drug prices and pursuing prescription drug bulk purchasing agreements under the Medicare program
- d. Encouraging pharmaceutical manufacturers to expand their patient assistance and drug discount programs and increase patient education for these programs.

Controlling Health Care Costs: Options for Ensuring an Appropriate Physician Workforce Specialty Mix

1. Congress should charge a federal agency to convene an advisory group of experts on physician workforce. The advisory group should include representatives of national membership societies representing primary care physicians, nursing, physician assistants, and consumer and patient advocacy groups. It should also develop specific and measurable goals regarding numbers and proportions of primary care physicians and other clinicians needed to meet current and future demands for primary care, including those associated with expansions of coverage.
2. Congress should strategically lift restrictions on the number of residency training positions that Medicare can reimburse for the direct and indirect costs of graduate medical education to encourage increased opportunities for the training of physicians in primary care.
3. The federal government should design and implement policies to produce immediate, measurable increases in primary care workforce capacity and to improve the training environment for the primary health care professions.
4. Appropriations should be increased for scholarship and loan repayment programs under Title VII and the National Health Services Corps to increase the number of positions available to physicians who agree to train in a primary care specialty and complete a reasonable primary care service obligation. New pathways to eliminate debt should be created for internists, family physicians, and pediatricians who meet a service obligation in a critical shortage area or facility. (BoR 09)

Controlling Health Care Costs: Certificate of Need Laws and Health Planning

1. Local, state, and regional health planning should be done to identify health care needs and to appropriately allocate resources to meet those needs. This planning should be conducted in a way that promotes public engagement in the development of the plans and subsequent adherence to them.
2. Research is needed on the effectiveness of Certificate of Need (CON) programs for reviewing proposed capital expenditures, acquisitions of major medical equipment, and new institutional facilities to reduce maldistribution and redundancy and to ensure that health care resources are best allocated in accord with health care needs. This research should include exploration of the characteristics of CON programs that have had the greatest or least beneficial impact on reducing unnecessary capacity with sufficient public support to be accepted. (BoR 09)

Controlling Health Care Costs: Encourage Cost-Consciousness and Patient Involvement in Shared Decision-Making

1. Health insurance benefits should be designed to encourage patient cost-consciousness and responsibility without deterring patients from receiving needed and appropriate services or participating in their care.
2. Physicians and other health care providers, including medical technology and pharmaceutical manufacturers and suppliers of medical equipment, should provide price transparency on the goods and services they provide.
3. Physicians should engage patients in shared decision-making and provide patients with sufficient information about all clinically appropriate treatment options and risk and risk/benefits, so that patients can make informed choices.
4. All payers should encourage shared decision-making and pay physicians for the additional time and resources involved, including the cost of providing patient-shared decision-making tools and maintaining a shared decision-making process.
5. Medicare should undertake demonstration projects to develop implementation models for shared decision-making and for the development and testing of decision aids.
6. Physicians and patients should engage in advance planning to help ensure that treatment decisions, including surrogate decision-making, are in accord with the patient's values and wishes. Medically appropriate care should never be withheld solely because of costs.
7. Research should seek to enhance the quality of life for terminally ill patients and their caregivers, and incentives should be provided for palliative care programs and hospice services in all settings. (BoR 09)

Controlling Health Care Costs: Enhance and Coordinate Technology Assessments

1. A coordinated, independent, and evidence-based assessment process should be created to analyze the costs and clinical benefits of new medical technology before it enters the market, including comparisons with existing technologies. Such information should be incorporated into approval, coverage, payment, and plan benefit decisions. The assessment process should balance the need to inform decisions on coverage and resource planning and allocation with the need to ensure that such research does not limit the development and diffusion of new technology of value to patients and clinicians or stifle innovation by making it too difficult for new technologies to gain approval.
2. Coverage of tests and procedures should not be denied solely on the basis of cost-effectiveness ratios; coverage decisions should reflect evidence of appropriate utilization and clinical effectiveness.
3. Useful information about the effectiveness and outcomes of technology and public education should be widely disseminated to reduce patient and physician demand for technologies of unproven benefit. (BoR 09)

Controlling Health Care Costs: Pay Appropriately for Health Care Services, and Encourage Adoption of the Patient-Centered Medical Home and Other Innovative Models of Health Care Delivery

1. Congress should provide the Secretary of the Department of Health and Human Services with authority and funding to conduct voluntary pilots of innovative models to better align physician payment with desired outcomes pertaining to quality, cost-effectiveness, and efficient patient-

centered care and create a fast-track process and timeline for widespread adoption of the models that are shown to have the greatest positive impact on these desired outcomes.

2. Medicare and other payers should accelerate adoption of the PCMH model by transitioning to a coverage and payment structure for qualifying practices. Payments to qualified PCMHs should include severity-adjusted monthly bundled care coordination payments, prospective payments per eligible patient, fee-for-service payments for visits, and performance-based payments based on evidence-based quality, patient satisfaction, and efficiency measures. The monthly bundled care coordination payment should cover the practice overhead costs of a PCMH linked to the costs of providing services that are not currently paid under the present system. It should also cover the work value of physician and nonphysician clinical and administrative care coordination activities of the PCMH that take place outside of face-to-face visits. Other payment models to support care provided through a PCMH could also be pilot-tested.
3. Physicians and multidisciplinary teams should be paid for care management and care coordination services provided on a fee-for-service basis.
4. Fee-for-service payments to primary care physicians should be increased to be competitive with payments for other fields and specialties in medicine to ensure a sufficient supply of primary care physicians that will help save costs in the long run. (BoR 09)

Controlling Health Care Costs: Wellness, Prevention, and Chronic Disease Management

1. Encourage individuals to take responsibility for their own health through exercise, preventive care, healthy diets and nutrition, and other health-promotion activities. ACP supports efforts to evaluate the effectiveness of wellness programs and to encourage employers to purchase benefit packages that include cost-effective wellness care. ACP also advocates that Medicare should provide coverage for preventive care, including appropriate screening services.
2. Federal and state funding for health promotion, public health activities, and support of the public health infrastructure should increase.
3. Public policy should support steps to increase the health and wellness of the population, promote changes in unhealthy behaviors, and reduce the burden of chronic disease, such as obesity, diabetes, and smoking-related illnesses. Steps should include ending agricultural subsidies for products harmful to health, such as tobacco, increasing taxes on tobacco products, and strengthening regulation of the marketing and labeling of tobacco products. Revenue from such measures should be used to promote healthy nutrition, smoking cessation, and obesity prevention as well as to promote healthy nutrition and physical education in our schools and communities. Policies should promote community planning that supports walking, bicycling, and other physical activities for healthy lifestyles.
4. Public and private health insurers should encourage preventive health care by providing full coverage, with no cost-sharing, for preventive services recommended by an expert advisory group, such as the U.S. Preventive Services Task Force.
5. Employers and health plans should fund programs proven to be effective in reducing obesity, stopping smoking, deterring alcohol abuse, and promoting wellness and providing coverage or subsidies for individuals to participate in such programs. (BoR 09)

Controlling Health Care Costs: Options for Controlling Costs from Medical Malpractice and Defensive Medicine

1. Further studies should be done on the value of professional liability insurance reforms, including no-fault systems, enterprise liability, the bifurcation of jury trials, raising the burden of proof, shorter statutes of limitation on claims, and elimination of joint and several liability claims.
2. Professional liability reforms should be considered at both the state and federal levels including allowing periodic payments of future damages over \$50,000, establishing sliding scales for attorneys' fees, and giving states flexibility to develop Alternative Dispute Resolution programs, including health courts.
3. Legislation should be enacted to establish \$250,000 caps on noneconomic damages for professional liability cases.
4. Offsets for collateral source payments should be allowed in professional liability cases.
5. Physicians should be immune from patient malpractice claims of "failure-to-inform" for appropriately administered treatments provided by physicians in conjunction with documented patient-shared decision-making. (BoR 09)

Controlling Health Care Costs: Options for Controlling Administrative Costs

1. Congress should request that the Institute of Medicine or another appropriate entity conduct a comprehensive assessment of administrative, paperwork, documentation, and medical review requirements imposed on physicians by federal regulatory agencies, public and private health plans and state governments. This study should determine the amount of time typically required by physicians to meet such requirements and identify specific strategies to reduce the time required. Particular attention should be given to the administrative burdens imposed on primary care physicians, such as micromanagement of E&M documentation.
2. Congress should enact legislation to:
 - a. Require that any new regulatory requirements that would create added costs to physician practices be accompanied with funding to offset such costs and establish a moratorium on any new regulations that would create additional unfunded costs to physician practices.
 - b. Simplify and shorten the physician enrollment process under Medicare by allowing physicians to use external databases to submit demographic and credentialing information required to establish and maintain Medicare participating physician status.
 - c. Study "real-time" adjudication of claims for physician services
 - d. Study opportunities to collaborate with private sector relief and simplification efforts.
 - e. Test models that eliminate documentation requirements for E/M services, pre-authorizations, retrospective medical utilization review, and other regulatory and paperwork requirements for physician practices that qualify as PCMHs or that participate in other designed programs where the performance of such practices are measured based on quality, efficiency, and patient satisfaction metrics.
3. Health insurance forms should be uniform across insurers, (e.g., a single durable medical equipment approval form, a single referral form).
4. An online platform should be established in which all benefit information, forms, formularies, and prior approval information could be accessed and completed online with as little disruption to medical practices as possible.
5. A standard physician credentialing and re-credentialing form should be used, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the re-credentialing form can be prepopulated with previously submitted data from the physician.

6. Health insurance companies should be required to disclose fully and uniformly the portion of health care premiums that is spent on administration, including the percentage of premium dollars allocated to marketing, claims processing, other administrative expenses, profits, and reserves as well as the payment for covered benefits. (BoR 09)

Controlling Health Care Costs: Comparative Effectiveness Research

1. Efforts should be made to improve access to information comparing clinical management strategies.
2. An adequately funded, trusted national entity should be charged with systematically developing both comparative clinical and comparative cost-effectiveness evidence for competing clinical management strategies. It should prioritize, sponsor, or produce comparative information on the relative clinical effectiveness, safety, and cost-effectiveness of medical services, drugs, devices, therapies, and procedures.
3. The federal government should have a significant role in funding, implementing, and maintaining this comparative effectiveness entity.
4. Cost should never be used as the sole criterion for evaluating a clinical intervention, but it should be considered alongside the explicit, transparent consideration of the comparative effectiveness of the intervention.
5. Health care payers, physicians and other health professionals, and patients should consider both comparative clinical and cost-effectiveness information in evaluating a clinical intervention.
6. Employers and health plans should consider adopting value-based benefit design programs that use comparative research on clinical outcomes and cost effectiveness developed by an independent entity that does not have an economic interest in the benefit determinations. (BoR 09)

DEATH

Autopsies

ACP recognizes the need to encourage the performance of autopsies while respecting cultural differences in values and health practices. ACP does not support financial remuneration for those individuals acquiring informed consent for the performance of an autopsy. (HoD 89; reaffirmed BoR 04; revised BoR 16)

DISPARITIES

Core Principles on Health Disparities and Disease Prevention

1. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities. (ACP 90; reaffirmed BoR 11)
2. Health reform should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation, and demographic differences:
 - a. Health reform proposals should be designed to address barriers to care in inner city, rural and other underserved communities.
 - b. Health reform proposals should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients. (BoR 00, reaffirmed BoR 11)

Eliminating Racial and Ethnic Disparities in Health Care

1. Providing all legal residents with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.
2. All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high quality health care.
3. As our society increasingly becomes racially and ethnically diverse, physicians and other health care professionals need to acknowledge the cultural, informational, and linguistic needs of their patients. Health literacy among racial and ethnic minorities must be strengthened in a culturally and linguistically sensitive manner.
4. Physicians and other health care professionals must be sensitive to cultural diversity among patients and recognize that preconceived perceptions of minority patients may play a role in their treatment and contribute to disparities in health care among racial and ethnic minorities. Initiatives such as cultural competency training should be incorporated into medical school curricula to improve cultural awareness and sensitivity.
5. The health care delivery system must be reformed to ensure that patient-centered medical care is easily accessible to racial and ethnic minorities and physicians are enabled with the resources to deliver quality care.
6. A diverse health care workforce that is more representative of those they serve is crucial to promote understanding among physicians and other health care professionals and patients, facilitate quality care, and promote equity in the health care system.
 - a. Education of minority students at all educational levels, especially in the fields of math and science, needs to be strengthened and enhanced to create a larger pool of qualified minority applicants for medical school.
 - b. Medical and other health professional schools should revitalize efforts to improve matriculation and graduation rates of minority students. ACP supports policies that allow institutions of higher education to consider a person's race and ethnicity as one factor in determining admissions in order to counter the impact of current discriminatory practices and the legacy of past discrimination practices. Programs that provide outreach to encourage minority enrollment in medical and health professional schools should be maintained, reinstated, and expanded.
 - c. Medical schools need to increase efforts to recruit and retain minority faculty.
 - d. Efforts should be made to hire and promote minorities in leadership positions in all arenas of the health care workforce.
 - e. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals in minority communities.
7. Social determinants of health are a significant source of health disparities among racial and ethnic minorities. Inequities in education, housing, job security, and environmental health must be erased if health disparities are to be effectively addressed.

8. Efforts must be made to reduce the effect of environmental stressors that disproportionately threaten to harm the health and well-being of racial and ethnic communities.
9. More research and data collection related to racial and ethnic health disparities is needed to empower stakeholders to better understand and address the problem of disparities. (BoR 10)

LGBT Health Disparities

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.
2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.
3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.
4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.
5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.
6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.
7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.
8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.
10. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation. (BoR 15)

DRUG ABUSE

Illegal Drug Abuse and National Drug Policy

This position paper addresses key issues pertaining to the problem of illegal substance abuse in today's society. The paper presents background information on the drug problem and ways in which the

government has sought to fix it. The costs of drug abuse are astounding, but the criminal justice approach focusing on interdiction and incarceration has been unsatisfactory. ACP believes that the time is right to enlist a medical model to treat this crisis. ACP supports all appropriate and effective efforts to reduce illegal substance abuse. As physicians dealing with the health effects of this condition, we support medical research on addiction, its causes and treatment therapies. We believe that there needs to be a greater emphasis on prevention, education, aftercare and treatment. The College advocates development of treatment guidelines to provide the best quality treatment for all who need it. ACP recognizes substance abuse as a chronic condition that must be treated continuously through the life of the abuser. Aftercare and other support are crucial to keeping people off drugs. Adequate funding must be provided for research and to ensure that treatment is available. Public perceptions of the drug user must be changed. As internists, ACP seeks to educate our members to ensure that they recognize the signs of substance abuse and are prepared to appropriately counsel and treat their patients. (BoR 10-98, reaffirm BoR 10)

Prescription Drug Abuse

1. ACP supports appropriate and effective efforts to reduce all substance abuse. These include educational, prevention, diagnostic, treatment, and aftercare efforts. As physicians dealing with the health effects of this condition, we also support medical research on addiction, its causes and treatment.
2. ACP supports a comprehensive national policy on prescription drug abuse containing education, monitoring, proper disposal, and enforcement elements.
3. ACP supports the consideration by physicians of the full array of treatments available for the effective treatment and management of pain.
4. ACP supports the establishment of a national Prescription Drug Monitoring Program (PDMP). Until such a program is implemented, ACP supports efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting (NASPER) program. Prescribers and dispensers should check PDMPs in their own and neighboring states prior to writing prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to assure confidentiality and privacy.
5. ACP supports efforts to educate physicians, patients, and the public on the appropriate medical uses of controlled drugs and the dangers of both medical and non-medical use of prescription drugs.
6. ACP favors a balanced approach to permit safe and effective medical treatment utilizing controlled substances and efforts to reduce prescription drug abuse. However, educational, documentation, and treatment requirements towards this goal should not impose excessive administrative burdens on prescribers or dispensers.
7. ACP recognizes that defined maximum dosage (i.e., morphine equivalent) and duration of therapy limitations are not applicable to every clinical encounter. ACP favors establishment of unbiased evidence-based, non-binding guidelines regarding recommended maximum dosage and duration of therapy that a patient taking controlled substance medications may receive.
8. Patients identified by Medicare, Medicaid, private insurance plans, or law enforcement authorities as being at risk of prescription drug abuse may be required to participate in a drug monitoring program and undergo random drug testing. Physicians may be required to report

suspected cases of drug abuse, but should not be mandated to conduct random drug testing without the patient's prior consent. The financial cost of mandatory drug testing should be borne by the authority requiring the testing; neither the patient, nor the physician should bear the financial cost of random drug testing mandated by a third-party authority.

9. ACP recommends the consideration of treatment contracts (agreements) between physician and patients as a tool for the treatment of pain.
10. ACP recommends the passage of legislation by all 50 states permitting the electronic prescription of all scheduled controlled substances. (BoR 13)

Prevention and Treatment of Substance Use Disorders

Recommendations from 2017 paper affirmed:

Recommendation 1: Substance use disorder is a chronic medical condition and should be managed as such.

Substance use disorders are treatable chronic medical conditions that should be addressed through expansion of evidence-based public and individual health initiatives to prevent, treat, and promote recovery. ACP supports appropriate and effective efforts to reduce all substance use including: educational, prevention, diagnostic, and treatment efforts. In addition, the ACP supports medical research on substance use disorders including causes and treatment. ACP emphasizes the importance of addressing the stigma surrounding substance use disorder among the health care community and the general public.

Recommendation 2: ACP supports the implementation of treatment-focused programs as an alternate to incarceration or other criminal penalties for persons with substance use disorders found guilty of the sale or possession of illicit substances.

Treatment for substance use disorders should be made available in a timely manner, including making them available for those in the criminal justice system as an alternative to incarceration and other criminal penalties.

Recommendation 3: Stakeholders should assess the risks and benefits of removing or reducing criminal penalties for non-violent offenses involving illicit drugs.

ACP calls for policymakers and researchers to carefully assess the arguments and evidence for amending criminal justice laws to remove or reduce criminal penalties (decriminalization, legalization, or offer treatment as an alternative to criminal justice penalties) for non-violent users of drugs including assessing:

- The relative risk of such drugs on the individual health of the users, the potential for misuse, and the potential impact on the overall health of the population that might result from decriminalization or legalization;
- Whether criminalization acts as a barrier to preventing and treating substance use disorders and recurrence of such disorders;
- The consequences of criminalization on the person suffering from a substance use disorder, including disproportionate adverse impacts on persons based on racial, socioeconomic and ethnic characteristics; and

- Whether decriminalization or legalization leads to more or fewer substance use disorders and the health consequences associated with them
- ACP also calls for research on the individual and public health impacts in states that have legalized or decriminalized the use of marijuana and the effectiveness of regulatory structures in those states that may minimize any adverse health impacts especially on children and adolescents.

Recommendation 4: Multiple stakeholders should cooperate to address the epidemic of prescription drug misuse including the following strategies: implementation of evidence-based guidelines for pain management; expansion of access to naloxone to opioid users, law enforcement, and emergency medical personnel; expansion of access to medication-assisted treatment of opioid use disorders; Improved training in the treatment of substance use disorders including buprenorphine-based treatment; establishment of a national Prescription Drug Monitoring Program and improvement of existing monitoring programs.

ACP believes that physicians should work with other stakeholders, including medical and behavioral health care professionals, public health officials, government programs, patient advocacy groups, insurance plans, and law enforcement to address the prescription drug use disorder epidemic.

To help address the prescription drug use epidemic, the College makes the following recommendations:

- Physicians are obligated by the standards of medical ethics and professionalism to practice evidence-based, conscientious pain management that prevents illness, reduces patient risk, and promotes health. The College strongly believes that physicians must become familiar with and follow as appropriate clinical guidelines related to pain management and controlled substances such as prescription opioids as well as nonopioid pharmacologics and nonpharmacologic interventions.
- Lift barriers that impede access to medications to treat opioid use disorder (methadone, buprenorphine and naltrexone) and to medications for overdose prevention (naloxone). The federal government should consider lifting the cap on the number of patients that can receive buprenorphine if a physician has been trained in proper prescribing practices. Public and private insurers should remove onerous limits on medications for overdose prevention and medication-assisted treatment, including burdensome prior authorization rules or lifetime limits on buprenorphine that prevent medically-necessary care. Oversight and enforcement efforts should be strengthened to protect against misuse, diversion, and illegal sale of buprenorphine and other opioid treatment drugs. Policymakers should evaluate and consider removing restrictions on office-based methadone treatment provided by trained physicians or other health care professionals.
- Funding should be allocated to distribute naloxone to individuals with opioid use disorder to prevent overdose deaths and train law enforcement and emergency medical personnel in its use. Legal protections (i.e., Good Samaritan laws) should be established to encourage use of naloxone and the reporting of opioid overdoses in instances where an individual's life is in

danger. Physician standing orders to permit pharmacies to provide naloxone to eligible individuals without a prescription should be explored. Insurance and cost-related barriers that limit access to naloxone should be addressed.

- Pre-and post-buprenorphine training support and education tools and resources should be made available and widely disseminated to assist physicians in their treatment efforts. Physicians support initiatives, such as mentor programs, shadowing experienced providers, and telemedicine can help improve education and support efforts around substance-use treatment.
- ACP reiterates its support for the establishment of a national Prescription Drug Monitoring Program (PDMP). Until such a program is implemented, ACP supports efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting (NASPER) program. The College strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) prior to writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to assure confidentiality and privacy. Efforts should be made to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health care team to consult PDMPs.

Recommendation 5: Health insurance should be required to cover mental health conditions including the evidence-based treatment of substance use disorder and abide parity rules.

The American College of Physicians strongly supports mental health and substance use disorder parity and the coverage of comprehensive evidence-based substance use disorder treatment. Strong oversight must be applied to ensure adequate coverage of medication-assisted treatment components, counseling, and other items and services. Components of comprehensive drug addiction treatment should also be extended to those in need, including medical services, mental health services, educational services, HIV/AIDS services, legal services, family services, and vocational services.

Recommendation 6: Training in the treatment of substance use disorder should be embedded throughout the continuum of medical education.

The American College of Physicians supports policies to increase the substance use disorder treatment professional workforce. Loan forgiveness programs, mentoring initiatives, and increased payment may encourage more individuals to train and practice as behavioral health professionals.

Recommendation 7: The workforce of professionals qualified to treat substance use disorders should be expanded.

Training in screening and treatment of substance use disorders should be embedded in the continuum of medical education. Continuing medical education providers should offer courses to train physicians in addiction medicine, medication-assisted therapy, evidence-based prescribing and the identification and treatment of substance use disorders.

Recommendation 8: The effectiveness of public health interventions to combat substance use disorders and associated health problems should be studied.

Public health-based substance use disorder interventions, such as syringe exchange programs and safe injection sites, that connect the user with effective treatment programs should be explored and tested. (Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs, BoR 17).

DRUGS

Medicare Prescription Drug Coverage

1. Medicare Part D should be financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas. Given the anticipated high cost of a prescription drug benefit, Congress must assure that revenues for financing the benefit do not depend on overly optimistic assumptions about tax revenues resulting from growth in the economy or under-estimates of the costs of the benefit. A predictable and stable source of financing, which will assure that revenues keep pace with the costs of the benefit without requiring cuts in other benefits, should be identified. If it turns out that costs in future years exceed anticipated revenues, Congress will need to consider making adjustments in the benefit and/or financing mechanism to assure that prescription drug coverage can be sustained without requiring cuts in other benefits.
2. ACP believes that the highest priority should go toward providing prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans. Funding of programs to assist low-income Medicare beneficiaries in paying their Part D costs, such as the low-income subsidy, should be provided and adjusted as needed. The federal government should improve its efforts to alert qualified beneficiaries of their eligibility to receive financial assistance related to Part D cost-sharing.
3. While ACP strongly prefers that the Government not require the use of formularies for covered prescription drugs, existing Medicare Part D-formularies should operate in a way consistent with ACP policies on drug formularies.
4. A method of pricing Medicare payments for prescription drugs should be included that will balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products. Rigid price controls that will discourage innovation should be rejected.
5. Physicians should continue to be able to prescribe covered drugs for accepted off-label uses.
6. The prescription drug benefit should not require an expansion of prescribing privileges for non-physician health professionals beyond what can be supported based on their level of training.
7. Issues of generic and therapeutic substitution under the Medicare program should be addressed in a way that is consistent with existing ACP policies on those issues. (BoR7-99, revised BoR 10)

Methadone Regulation

The American College of Physicians (ACP), recommends that Methadone be considered no differently than any other DEA Schedule II agent. (BoR 4-99, reaffirmed BoR 10)

Improving FDA Regulation of Prescription Drugs

1. Improve the FDA's ability to approve and monitor prescription drugs through increased funding.
2. Increase the FDA's capacity to regulate drugs manufactured outside the U.S. through both appropriations and user fees.
3. The FDA's regulatory authority should be expanded and more clearly exercised in the design of preapproval trials and studies. Design of preapproval trials should include at least the following:
 - A sample size large enough to reflect an appropriate distribution of age and comorbidity among subjects.
 - Similar priority given to evaluating both drug safety and efficacy
 - Use of scientific and technological tools (such as pharmacogenetics and computer simulations) to provide earlier warnings about drug toxicities and potential harm.
 - Mandatory registration and public reporting of all clinical trial results.
4. Bundling of drugs to limit marketability and availability should be prohibited.
5. Improve the adverse events reporting system.
6. Grant the FDA the authority to require that newly approved drugs have a special symbol on their labels to help increase public awareness that they are new, and limit direct-to-consumer (DTC) advertising for the first 2 years after approval. (BoR 10)

FDA Regulation of Drugs and Medical Devices

ACP opposes any efforts to weaken FDA authority to demand rigorous evaluations of drugs and medical devices for both safety and effectiveness based on sound scientific and medical evidence and opposes legislative attempts to curtail FDA authority to establish and maintain standards of safety and effectiveness for approval of drugs and medical devices. (ACP AMA Del A-95; reaffirmed BoR 08)

Removal of Drugs by the Food and Drug Administration (FDA)

ACP recommends that the FDA inform the medical profession of the evidence for the need to withdraw drugs of long standing use prior to implementation of such an order and there shall be opportunity and time for a response by the medical profession except in instances of immediate threat to life and well being. Consideration should be given to the experiences, views and opinions of physicians in the clinical practice of medicine before condemning or removing drugs from the market. (HoD 71; revised HoD 73; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Office Compounding of Allergen Extracts and Other Drugs

RESOLVED, that the Board of Regents support the current 2008 USP Ch. <797> sterile compounding rules as they apply to allergen extracts; and be it further

RESOLVED, that on behalf of allergy and immunology, a subspecialty of internal medicine, the Board of Regents contact the FDA to encourage that regulations that incorporate USP-established standards prioritize patient safety, but within a balanced approach that includes patient access to well-established,

evidence based specialty care that relies upon individualized treatments provided through in-office compounding. (BoR 16)

Statement of the American Pharmaceutical Association (APA) and ASIM on Prescriptions

Introduction

Historically, the pharmaceutical and medical professions have devoted considerable time and effort to the development and rational utilization of safe and effective drugs for the treatment and prevention of illness. Today, that successful effort continues, helping to achieve the highest standards of health in the world for the American people. But in order to gain maximum benefit from the use of drugs while minimizing their adverse side effects, prescribers and pharmacists must maintain effective communications not only among themselves, but with their patients as well. The directions for drug use and other information which prescribers indicate on prescription orders and which pharmacists transfer to prescription labels are critical to safe and effective drug therapy. In order to assure that this information is conveyed clearly and effectively to patients, the following guidelines have been developed by the APA and ASIM.

Guidelines for Prescribers

The following guidelines are recommended for prescribers when writing directions for drug use on their prescription orders: The name and strength of the drug dispensed will be recorded on the prescription label by the pharmacist unless otherwise directed by the prescriber. Whenever possible, specific times of the day for drug administration should be indicated. (For example, "Take one capsule at 8:00 am, 12:00 noon, and 8:00 pm" is preferable to "Take one capsule three times daily." Likewise, "Take one tablet two hours after meals" is preferable to, "Take one tablet after meals.") The use of potentially confusing abbreviations, i.e., quid, qod, qd, etc., is discouraged. Vague instructions such as, "Take as necessary," or, "Take as directed," which may be confusing to the patient, are to be avoided. If dosing at specific intervals around-the-clock is therapeutically important, this should specifically be stated on the prescription by indicating appropriate times for drug administration. The symptom, indication or intended effect for which the drug is being used should be included in the instructions whenever possible. (For example, "Take one tablet at 8:00 am and 8:00 pm for high blood pressure," or, "Take one teaspoonful at 8:00 am, 3:00 pm and 6:00 pm for cough.") The metric system of weights and measures should be used. The prescription order should indicate whether or not the prescription should be renewed and, if so, the number of times or the period of time such renewal is authorized. Statements such as "Refill prn" or "Refill ad lib" are discouraged. Either single or multi-drug prescription forms may be used when appropriately designed, and pursuant to the desires of local medical and pharmaceutical societies. (reaffirmed HoD 87; reaffirmed BoR 04) When institutional prescription blanks are used, the prescriber should print his or her name, telephone number, and registration number on the prescription blank.

Guidelines for Pharmacists

Pharmacists should include the following information on the prescription label: name, address and telephone number of pharmacy; name of prescriber; name, strength and quantity of drug dispensed (unless otherwise directed by the prescriber); directions for use; prescription number; date on which prescription is dispensed; full name of patient; any other information required by law. Instructions to the patient regarding directions for use of medication should be concise and precise, but readily understandable to the patient. Where the pharmacist feels that the prescription order does not meet these criteria, he or she should attempt to clarify the order with the prescriber in order to prevent confusion. Verbal reinforcement and/or clarification on instructions should be given to the patient by the pharmacist when appropriate. For those dosage forms where confusion may develop as to how the

medication is to be administered (for example, oral drops which may be mistakenly instilled in the ear, or suppositories which may be mistakenly administered orally), the pharmacist should clearly indicate the intended route of administration on the prescription label. The pharmacist should include an expiration date on the prescription label when appropriate. Where special storage conditions are required, the pharmacist should indicate appropriate instructions for storage on the prescription label.

Conclusions

Communicating effective dosage instructions to patients clearly and succinctly is a responsibility of both the medical and pharmaceutical professions. Recent studies documenting the low order of compliance with prescription instructions indicate that inadequate communication between the medical and pharmaceutical professions and poor comprehension by the public may be causative factors. The APA and ASIM believe that the guidelines as stated above will serve as an initial step toward patients achieving a better understanding of their medication and dosage instructions. The two organizations urge state and local societies representing pharmacists and prescribers to appoint joint committees for the purpose of refining these guidelines further as local desires and conditions warrant. Cooperative efforts between the professions are essential to good patient care and significant progress can be made in other areas by initiating discussions between the two professions concerning common interests and goals. (HoD 74; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Stemming the Escalating Cost of Prescription Drugs

1. ACP supports transparency in the pricing, cost, and comparative value of all pharmaceutical products:
 - a. Pharmaceutical companies should disclose:
 - i. Actual material and production costs to regulators;
 - ii. Research and development costs contributing to a drug's pricing, including those drugs which were previously licensed by another company.
 - b. Rigorous price transparency standards should be instituted for drugs developed from taxpayer-funded basic research.
2. ACP supports elimination of restrictions of using quality-adjusted life-years (QALYs) in research funded by the Patient-Centered Outcomes Research Institute (PCORI).
3. ACP supports the following approaches to address the rapidly increasing cost of medications:
 - a. Allow greater flexibility by Medicare and other publicly funded health programs to negotiate volume discounts on prescription drug prices and pursue prescription drug bulk purchasing agreements;
 - b. Consider legislative or regulatory measures to develop a process to reimport certain drugs manufactured in the United States, provided that the safety of the source of the reimported drug can be reasonably assured by regulators;
 - c. Establish policies or programs that may increase competition for brand-name and generic sole-source drugs.
4. ACP opposes extending market or data exclusivity periods beyond the current exclusivities granted to small-molecule, generic, orphan, and biologic drugs. ACP supports robust oversight and enforcement of restrictions on product-hopping, evergreening, and pay-for-delay practices as a way to increase marketability and availability of competitor products.
5. ACP supports research into novel approaches to encourage value-based decision making, including consideration of the following options:
 - a. Value frameworks;
 - b. Bundled payments;

- c. Indication-specific pricing;
 - d. Evidence-based benefit designs that include explicit consideration of the pricing, cost, value, and comparative effectiveness of prescription medications included in a health plan's benefit package.
6. ACP believes payers that use tiered or restrictive formularies must ensure that patient cost-sharing for specialty drugs is not set at a level that imposes a substantial economic barrier to enrollees obtaining needed medications, especially for enrollees with lower incomes. Health plans should operate in a way consistent with ACP policy on formularies and pharmacy benefit management.
 7. ACP believes that biosimilar drug policy should aim to limit patient confusion between originator and biosimilar products and ensure safe use of the biosimilar product in order to promote the integration of biosimilar use into clinical practice. (BoR 16)

DRUGS: ADVERTISING

Direct-to-Consumer Prescription Drug Advertising

Position 1: ACP believes that direct-to-consumer advertising of prescription drugs is an inappropriate practice that undermines the patient-physician relationship and often leaves patients confused and misinformed about medications.

Position 2: In the absence of legislation or regulation to ban DTC advertising, the FDA should play a stronger role in ensuring that complete, valid, and clear information is provided to the public and in making determinations about whether the commercial information in a DTC ad actually will educate and enhance the health of the public. ACP calls on the federal government to expeditiously strengthen regulations governing DTC ads in the following ways:

- Congress should give the FDA the authority to issue regulations that require review and approval of the content of any DTC advertisement prior to it being released to the public.
- Congress should provide additional resources for the FDA to carry out enhanced oversight and enforcement duties and to study the effectiveness of DTC advertising.
- Congress should give the FDA the authority to regulate “reminder” and “help-seeking” ads.
- The FDA should require at least a two-year moratorium on DTC advertising for newly launched prescription drugs to allow for appropriate monitoring and regulation of drug safety and efficacy.
- Federal regulations should require manufacturers to run corrective ads after receiving both “untitled” and “warning” letters.
- The FDA should take steps toward regulating image selection in ads.
- The FDA should require that information about a drug’s effectiveness, side effects, and contraindications, as well as references to where more comprehensive information can be obtained, be prominently displayed in ads and on labeling and be in a language that is clear and understandable to the general public.
- The FDA should require that ads provide key information to consumers on alternative treatments, such as lifestyle changes.

- DTC ads should be required to contain a statement directing patients to report all adverse reactions to a physician and the FDA at MedWatch, and give the toll-free telephone number and Web address of MedWatch.
- The FDA should require that ads for those drugs approved on the condition of further studies publicly identify that safety concerns have been identified and are being investigated.
- The federal government should sponsor public service ads that do not mention particular treatments, but instead are aimed at increasing the public's awareness of various under-treated diseases.
- Federal regulations should prohibit the use of DTC ads to promote controlled substances.

Position 3: ACP recognizes the value of patient education and supports public and private efforts to make patients—particularly older patients— aware of diseases/conditions, treatment options, indications, and contraindications. The FDA, in cooperation with the medical profession, the pharmaceutical industry, and the pharmacy industry, must further evaluate, define, and measure the impact of DTC ads on patients and physicians and identify ways to ensure that patients and physicians are provided with complete, truthful, and non-confusing health information. (BoR 04-06)

DRUGS: IMPORTATION

Reimportation

ACP supports legislative and/or regulatory measures to develop a process to ascertain and certify the safety of reimported prescription drugs. (revised BoR 05)

Recommendation 1: Action is needed, including consideration of drug importation, to reduce the high cost of prescription drugs in the United States. However, assuring high quality and patient safety must remain the top priority of any cost control program.

Recommendation 2: Before legalizing the importation of prescription drugs, Congress should:

- Permit state pilot programs to test the safe implementation of prescription drug importation programs. Trials could initially be aimed at individuals without drug coverage. The results of such pilots should serve as a model for the federal government and individual states.
- Create an independent FDA oversight board to handle drug safety issues, including those related to prescription drug importation, and to communicate more effectively with patients and physicians about the risks and benefits of such medications.
- Study and report on the effectiveness of promising new and emerging anti-counterfeiting technologies, such as radio frequency chips to track drug shipments. Nevertheless, it should be recognized that widespread adoption of authentication technologies is a daunting task that could raise the cost of imported drugs, thereby reducing any expected savings from importation.
- Urge the expansion of accreditation programs. In particular, ACP urges the NABP to consider applying its Internet pharmacy accreditation program on an international level to help consumers identify legitimate Internet pharmacies.
- Enhance resources of the FDA to inspect facilities manufacturing prescription drugs for export to the U.S. and enhance resources of the FDA, the U.S. Customs Service, law enforcement agencies, and other federal agencies involved in assuring that products that are illegal, are counterfeit, or do not meet U.S. safety and quality standards are not allowed into the U.S.

Recommendation 3: ACP believes that any drug importation system that Congress approves should:

- Be a closed system, in which participating pharmacies and Internet sites must meet FDA standards;
- Have a tightly controlled and documented supply chain;
- Not include controlled substances, biologics, or products that are infused/injected or products that are photo reactive or have strict temperature requirements;
- Be limited to countries that meet U.S. standards to assure high quality and patient safety of imported drugs;
- Include adequate resources for inspections of facilities and enforcement of U.S. requirements; and
- Require that only prescriptions written by a U.S.-licensed physician with an established professional relationship with the patient be accepted for importation.

Recommendation 4: Prescription drug importation is not a long-term solution to the high cost of prescription drugs, which is having a detrimental effect on Americans' access to life-saving therapies. ACP urges the federal government to take immediate action to improve access to pharmaceuticals by:

- Assuring there are sufficient incentives for pharmaceutical research and development;
- Encouraging increased competition among brand-name manufacturers;
- Speeding the approval and encouraging the use of generic drugs;
- Negotiating volume discounts on prescription drug prices and pursuing prescription drug bulk purchasing agreements under the Medicare program;
- Expanding the availability of public and private sector health insurance that includes coverage for prescription drugs;
- Encouraging pharmaceutical manufacturers to expand their patient assistance and drug discount programs and increase patient education for these programs;
- Protecting state pharmaceutical programs that may be impacted by the new Medicare law;
- Reviewing recent increases in the cost of pharmaceuticals;
- Studying the effectiveness of prescription drug substitutes, such as lower-cost, therapeutically equivalent medications;
- Encouraging and helping to implement disease management programs;
- Encouraging the use of evidence-based medicine; and
- Considering limits on direct-to-consumer drug advertising. (BoR 05; reaffirmed BoR 16)

Controlling Health Care Costs: Ensure Accurate Pricing of Services

1. The Federal government should take action to reduce the high cost of prescription drugs in the United States by using its purchasing power to obtain the best prices from pharmaceutical manufacturers covered by publically funded plans, including Medicare, similar to the

prescription drug purchasing process used by the Veterans Administration. However, ensuring high quality and patient safety and support for continued innovation and research on drugs that can advance medical care must remain the top priority of any program to address the price of prescription drugs. Prescription drug importation is not a long-term solution to the high cost of prescription drugs. Efforts to reduce prescription drug prices should include:

- a. Encouraging increased competition among brand-name manufacturers
- b. Studying the effectiveness of prescription drug substitutes, such as lower-cost, therapeutically equivalent medications and expediting approval of generic drugs and encouraging their use
- c. Negotiating volume discounts on prescription drug prices and pursuing prescription drug bulk purchasing agreements under the Medicare program
- d. Encouraging pharmaceutical manufacturers to expand their patient assistance and drug discount programs and increase patient education for these programs.

DRUGS: LABELING AND PACKAGING

Pharmacy Labeling

In order to reduce patient confusion and the potential for therapeutic errors, ACP calls upon pharmacy organizations, mail-order pharmacies, national pharmacies to label prescriptions with both the generic drug name and brand name substituted for. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

Quality Assurance and Labeling

ACP believes that appropriate action should be taken to ensure that, through federal regulations or laws, all pharmaceutical manufacturers be required to perform effective and meaningful ongoing quality assurance studies of the biologic efficacy and purity of prescription medications they are marketing. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 16)

DRUGS: PRESCRIBING AND DISPENSING

Drug Formularies and Pharmacy Benefit Management

Formularies

1. ACP opposes any formulary that may operate to the detriment of patient care, such as those developed primarily to control costs.
2. Decisions about which drugs are chosen for formulary inclusion should be based upon the drug's effectiveness, safety, and ease of administration rather than solely based on cost.
3. Evaluation of physician prescribing patterns (i.e., drug utilization review) should give priority to the effectiveness, and safety and ease of administration of the drugs prescribed rather than solely based on costs.
4. ACP recommends that financial incentive arrangements should be linked to cost-effective practices rather than formulary compliance.
5. ACP opposes financial arrangements that place the physician's financial interest in conflict with his or her patient's well-being.
6. ACP recommends that formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically indicated cause) without cumbersome prior authorization requirements.

7. ACP recommends that a patient information program be instituted by Managed care plans to make patients aware of formulary utilization and any associated costs such as co-pays.
8. Patient formulary education should include how the formulary functions, and a discussion of how co-payment and/or deductible requirements may affect their pharmacy benefit.
9. ACP supports prompt prior notification to patients and physicians when formularies are changed or discontinued.
10. ACP recommends such notification be given within a specified time period, not fewer than ninety (90) days prior to change implementation.
11. Formularies should be approved on a regional basis by a professionally qualified body which includes practicing physicians using that formulary.
12. ACP recommends that Pharmacy & Therapeutic (P&T) Committees be representative of, and have the support of, the medical staffs that will utilize the formulary.
13. ACP supports industry moves to develop technology to make formularies more accessible and easier to utilize. ACP recommends physician input in designing, and pre-testing of, these technologies.
14. ACP supports continued government and industry studies of the impact of formularies on patient care. ACP recommends that CMS and states develop annual report-cards on the impact of formularies on beneficiaries enrolled in Medicare managed care plans.
15. Prescribing patterns should be influenced primarily through educating physicians on safety and efficacy. Cost should be a determinant only when safety and efficacy are equal among specific drug choices.

Pharmacy Benefit Management

1. ACP supports government regulation and industry self-regulation of Pharmacy Benefit Managers (PBMs). ACP particularly supports close government oversight of mergers between PBMs and pharmaceutical manufacturers.
2. ACP supports the disclosure to patients, physicians, and insurers of the financial relationships between PBM companies, pharmacists, and pharmaceutical manufacturers.
3. ACP supports requiring that PBM organizations' requests to alter medication regimes should occur only when such requests are based on objective data supported by peer reviewed medical literature and which undergo review and approval of associated Managed care plans'/MBHOs' P & T Committees.
4. ACP supports requiring that, with a patient's consent, PBM organizations be required to provide treating physicians with all available information about the patient's medication history. (BoR 00, reaffirmed BoR 11)

Internet Prescribing

The ACP advocates that a direct physician patient relationship remain inviolate and that the use of the Internet for prescribing should facilitate, not circumvent that relationship, and that Internet prescribing should be used only in the context of an established physician-patient relationship. (BoR 10-99, reaffirmed BoR 10)

Misuse of DEA Numbers

ACP, in order to protect confidentiality and minimize administrative burdens on physicians, supports the AMA policy to eliminate requirements by pharmacies, prescription services and insurance plans to include physicians' DEA numbers on prescriptions written for non-controlled drugs. (HoD 95, reaffirmed BoR 10)

Mail Order Pharmacy Confidentiality

ACP opposes the use of confidential prescribing data by third parties to directly contact patients for any purposes. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

Negative Formularies

Resolved, that the Board of Regents encourage the deletion of drugs from Negative Drug Formularies for which there exist FDA A-rated generic substitutes. (BoR 00, reaffirmed BoR 13)

Proper Use of Accepted Drugs

ACP believes that physicians in clinical practice are best suited to determine the proper usage of accepted drugs, and professional judgment should not be restricted by legislative or administrative fiat. Physicians should be permitted to use already approved drugs in any manner consistent with prudent medical judgment. (HoD 78; revised HoD 89; reaffirmed BoR 04; reaffirmed BoR 16)

Physician Drug Dispensing

ACP believes that patients should be informed that they have the right to have their prescription filled at a pharmacy of their choice. However, physicians should have the option to dispense medication in their offices, especially when it is to the medical or economic advantage of their patients. Under no circumstances should physicians who dispense medication place their own financial interest above the welfare of their patients. (HoD 87; reaffirmed BoR 04)

Behind the Counter Drugs

The College's believes that the current two-drug category system of prescription-only and over-the-counter (O-T-C) drugs formalized by Congress under the Durham-Humphrey's Amendment to the Food, Drug and Cosmetic Act is effective in ensuring safe and accessible medications to the population. The current system allows for the general availability within the O-T-C market of those drugs suitable for self-medication that also require no medical monitoring and have a low potential for significant adverse side-effects, overdose or abuse. Furthermore, it appropriately requires the intervention of a physician, specifically trained in the diagnosis and treatment of medical conditions, to serve as the intermediary prior to having access to medications that don't meet the O-T-C conditions.

The College believes that the B-T-C drug category under consideration offers little evidence of improving the current two-category system and poses increased patient-safety concerns. More specifically, the College opposes the implementation of a B-T-C drug category for the following reasons:

- The pharmacist does not have the necessary training to serve as the intermediary to drugs that fall outside the current O-T-C requirements—Many of the medications being considered for potential inclusion in this B-T-C category (e.g. cholesterol-lowering drugs, drugs for the treatment of asthma) relate to conditions that require the taking of a skilled medical history, a physical exam, and the use of laboratory results to ensure that an accurate diagnosis is made and the most appropriate medication is used. The pharmacist, while skilled in areas of drug

effects and interactions, does not have the adequate training to provide these diagnostic and treatment considerations.

- The pharmacist may not have time in their current schedule of activities to even perform limited counseling or educational expectations—The experience of many of our members is that most pharmacists are already having difficulties meeting their current drug dispensing demands. These increased demands are fueled by current demographics and the implementation of the Medicare Part D benefit. It is unclear whether the typical pharmacist would be able to adequately meet even minimal additional intervention requirements.
- The consideration of a B-T-C drug category raises a number of questions that must be addressed prior to any consideration of implementation—The FDA Notice of Comment includes a large number of questions that currently have no suitable answer regarding the potential implementation of a B-T-C drug category. These include questions pertaining to the criteria for a drug to be treated as a B-T-C, the appropriate role of the pharmacist and the training required, and the type of documentation that would be required. Additional issues not included in the Notice that need to be considered include the process by which the patient’s personal physician would be notified regarding this medication intervention to ensure appropriate subsequent care, the pharmacist’s responsibility to provide follow-up consistent with their intervention, and the extent the pharmacist would be legally liable for their actions during this encounter.
- There is no currently available data supporting the contention that a B-T-C drug category would safely increase access, lower cost, or generally effect improvement to our current two-category system—As you are aware, the most comprehensive study of this issue was a 1995 Government Accounting Office (now the Government Accountability Office) study 1 that examined international (and the limited national) experience with a B-T-C drug category. The results reflected that there was no clear pattern of increased or decreased access, that the counseling conducted by pharmacists was infrequent and incomplete and that any safeguards provided to deter drug abuse were easily circumvented. The study concluded that “the evidence that is available tends to undermine the contention that major benefits are obtained in countries that have such a class.” The College is aware of no evidence in the current literature to refute this conclusion.

The College is not opposed to the FDA’s expanding of the limited number of drug exceptions to the two-category system that were recently implemented for non-medical reasons and require only an administrative intervention on the part of the pharmacist. Examples of this include the recent implementation of a proof-of-age requirement prior to the dispensing of a Plan B emergency contraceptive, which was motivated by social /legislative concerns and the signature requirement and quantity limitations coupled to the dispensing of drug products with pseudoephedrine, which was motivated by concerns related to its use as a key ingredient to the production of methamphetamine.

DRUGS: SUBSTITUTION

Use of "A" Rated Generic Drugs

ACP will petition the FDA or other appropriate agency to develop a national system that would allow

physicians who permit generic substitution to designate substitution by only "A" rated generic drugs; require any prescription medication crossing state lines, such as those as part of a prescription filled by an out-of-state pharmacy, to use only "A" rated generic drugs if brand name is not required by the prescribing physician; and require a national uniform policy regarding a phrase that can be used to denote the need for a brand name drug. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 16)

Drug Product Selection and/or Substitution

ACP opposes therapeutic substitution in an outpatient setting without the prescribing physician's consent. ACP physicians should prescribe generically when therapeutic equivalency, therapeutic safety and bioavailability are established. Physicians should carefully consider the advice of the pharmacist and use his or her knowledge and experience regarding selection of drug product alternatives that could result in cost savings to the patient. When therapeutic equivalency and bioavailability of alternative generic drug products are assured, then the privilege of drug product selection may be delegated to the pharmacist. Any generic drug product selected by the pharmacist must be therapeutically equivalent and bioavailable and should result in cost savings to the patient. The physician, at his or her discretion, must at all times have the authority to specify in some simple manner the source of the drug product to be dispensed. (HoD 79; HoD 88; revised HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

Generic Drug Prescriptions

ACP believes that the Food and Drug Administration and other state regulatory agencies should require that generic drugs be held to the same standards as the trade name drug. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 16)

EMERGENCY MEDICAL SERVICES

Provision of Emergency Medical Services

ACP urges that in the provision of emergency medical services in facilities, all reasonable efforts should be made to contact the patient's personal physician, to refer that patient to the personal physician for follow-up care, and to provide a written report on the visit to the personal physician in a timely manner. (HoD 83; reaffirmed HoD 93; reaffirmed BoR 04)

ACP believes that in the provision of emergency medical services, all reasonable efforts should be made to contact the patient's personal physician, from the field, through the base station, or from the emergency facility. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

ETHICS

*For more information, please see the **ACP Ethics Manual, 6th ed.**, and position statements at https://www.acponline.org/running_practice/ethics/manual/manual6th.htm for additional statements and policies specific to medical ethics.*

Ethics and Time, Time Perception, and the Patient-Physician Relationship

1. Time is an important element of high quality clinical care, and a necessary condition for the development of the patient-physician relationship and trust between patient and physician. Therefore, efforts to improve how care is delivered must focus on preserving the patient-physician relationship, with an emphasis on fostering trust, maintaining fidelity, demonstrating patient advocacy, exhibiting respect for the patient as a person, and carrying out the individual and collective ethical obligations of physicians.
2. Effective communication, especially active listening by the physician, and the provision of information and recommendations to facilitate informed decision-making and patient

education, are critical to the patient-physician relationship and to respect for patient rights. Health care systems, payers, government agencies and others should recognize that these activities require time and be supportive of them.

3. Health plans, institutions and others should support the patient advocacy duty and resource stewardship role of the physician, and minimize barriers to appropriate care, by recognizing the value of time spent by the physician in his or her role as patient advocate in an increasingly complex health care system.
4. Physicians should spend adequate time with patients based on patient need and uphold their ethical obligations in doing so. It should be recognized, however, that measures of “adequate” time for the medical encounter involve dimensions of caring and trust that are not so easily quantifiable, and that it is not just the actual time a patient spends with the physician that affects outcomes, but how the time is used. Research that examines how time is used and that distinguishes between time spent with patients (actual care) versus time spent on patient care (tasks associated with care) should be encouraged. (BoR 03, reaffirmed BoR 13)

Ethics Committees and Consultants

Ethics committees and consultants contribute to achieving patient care and public health goals by facilitating resolution of conflicts in a respectful atmosphere through a fair and inclusive decision-making process, helping institutions to shape policies and practices that conform with the highest ethical standards, and assisting individual persons with handling current and future ethical problems by providing education in ethics.

Accrediting organizations require most health care facilities to provide ethics consultation at the request of patients, nurses, physicians, or others. Physicians should be aware that this resource is available. Consultation should be guided by standards, such as those developed by the American Society for Bioethics and Humanities. Ethics committees should be multidisciplinary and broadly representative to assure the perspectives necessary to address the complex problems with which they are confronted. (BoR 04; reaffirmed as amended BoR 11)

Financial Arrangements

Financial relationships between patients and physicians vary from fee-for-service to government contractual arrangements and prepaid insurance. Financial arrangements and expectations should be clearly established. Fees for physician services should accurately reflect the services provided. Physicians should be aware that a beneficent intention to forgive copayments for patients who are financially stressed may nonetheless be fraud under current law.

Professional courtesy may raise ethical, practical, and legal issues. When physicians offer professional courtesy to a colleague, physician and patient should function without feelings of constraints on time or resources and without shortcut approaches. Colleague-patients who initiate questions in informal settings put the treating physician in a less-than-ideal position to provide optimal care. Both parties should avoid this inappropriate practice.

As professionals dedicated to serving the sick, all physicians should provide services to uninsured and underinsured persons. Physicians who choose to deny care solely on the basis of inability to pay should be aware that by thus limiting their patient populations, they risk compromising their professional obligation to care for the poor and the credibility of medicine's commitment to serving all classes of patients who are in need of medical care. Each individual physician is obliged to do his or her fair share to ensure that all ill persons receive appropriate treatment and to honor the social contract with society,

which is based in part on the substantial societal support of medical education. (BoR 04; Reaffirmed as amended BoR 11)

Financial Conflicts of Interest

The physician must seek to ensure that the medically appropriate level of care takes primacy over financial considerations imposed by the physician's own practice, investments, or financial arrangements. Trust in the profession is undermined when there is even the appearance of impropriety.

Potential influences on clinical judgment cover a wide range and include financial incentives inherent in the practice environment (such as incentives to overutilize in the fee-for-service setting or underutilize under capitation arrangements); drug, device, and other health care company gifts; and business arrangements involving referrals. Physicians must be conscious of all potential influences, and their actions should be guided by patient best interests and appropriate utilization, not by other factors.

Physicians who have potential financial conflicts of interest, whether as researchers, speakers, consultants, investors, partners, employers, or otherwise, must not in any way compromise their objective clinical judgment or the best interests of patients or research subjects. Physicians must disclose their financial interests to patients, including in any medical facilities or office-based research to which they refer or recruit patients. When speaking, teaching, and authoring, physicians with ties to a particular company should disclose their interests in writing. Most journal editors require that authors and peer reviewers disclose any potential conflicts of interest. Editors themselves should be free from conflicts of interest.

Physicians should not refer patients to an outside facility in which they have invested and at which they do not directly provide care. Physicians may, however, invest in or own health care facilities when capital funding and necessary services that would otherwise not be made available are provided. In such situations, in addition to disclosing these interests to patients, physicians must establish safeguards against abuse, impropriety, or the appearance of impropriety.

A fee paid to one physician by another for the referral of a patient, historically known as “fee-splitting,” is unethical. It is also unethical for a physician to receive a commission or a kickback from anyone, including a company that manufactures or sells medical products or medications.

The sale of products from the physician's office might also be considered a form of self-referral and might negatively affect the trust necessary to sustain the patient–physician relationship. Most products should not be sold in the office. The College has taken a position that asks physicians to consider seriously the moral issues involved in a decision to do so. Physicians should not sell products out of the office unless the products are specifically relevant to the patient's care, offer a clear benefit based on adequate clinical evidence and research, and meet an urgent need of the patient. If geographic or time constraints make it difficult or impractical for patients to obtain a medically relevant and urgently needed product otherwise, selling a product in the office would be ethically acceptable. For example, a splint or crutches would be acceptable products, but vitamin supplements and cosmetic items are neither emergent treatments nor unlikely to be available elsewhere, and so the sale of such products is ethically suspect. Physicians should make full disclosure about their financial interests in selling acceptable products and inform patients about alternatives for purchasing the product. Charges for products sold through the office should be limited to the reasonable costs incurred in making them available. The selling of products intended to be free samples is unethical.

Physicians may invest in publicly traded securities. However, care must be taken to avoid investment decisions that may create a conflict of interest or the perception of a conflict of interest.

The acceptance by a physician of gifts, hospitality, trips, and subsidies of all types from the health care industry that might diminish, or appear to others to diminish, the objectivity of professional judgment is strongly discouraged. Even small gifts can affect clinical judgment and heighten the perception and/or reality of a conflict of interest. Physicians must gauge regularly whether any gift relationship is ethically appropriate and evaluate any potential for influence on clinical judgment. In making such evaluations, physicians should consider the following: 1) What would the public or my patients think of this arrangement?; 2) What is the purpose of the industry offer?; 3) What would my colleagues think about this arrangement?; and 4) What would I think if my own physician accepted this offer? In all instances, it is the individual responsibility of each physician to assess any potential relationship with industry to assure that it enhances patient care.

Physicians must critically evaluate all medical information, including that provided by detail persons, advertisements, or industry-sponsored educational programs. While providers of public and private graduate and continuing medical education may accept industry support for educational programs, they should develop and enforce strict policies maintaining complete control of program planning, content, and delivery. They should be aware of, and vigilant against, potential bias and conflicts of interest.

If medical professional societies accept industry support or other external funding, they also “should be aware of potential bias and conflicts of interest and should develop and enforce explicit policies that preserve the independent judgment and professionalism of their members and maintain the ethical standards and credibility of the society.” At a minimum, medical societies should adhere to the Council of Medical Specialty Societies Code for Interactions with Companies. (BoR 04; Reaffirmed as amended BoR 11)

Advertising

Advertising by physicians or health care institutions is unethical when it contains statements that are unsubstantiated, false, deceptive, or misleading, including statements that mislead by omitting necessary information. (BoR 04; Reaffirmed BoR 11)

Selling Products Out of the Office

The sale of products from the physician’s office raises a number of ethical issues and can affect the trust necessary to sustain the patient-physician relationship. When deciding whether or what products to sell out of the office, physicians should carefully consider criteria including the urgency of the patient’s need, the clinical relevance to the patient’s condition, the adequacy of evidence to support use of the product, and geographic and time constraints for the patient in otherwise obtaining the product, and should make full disclosures about the physician’s financial interests in selling the product, and alternatives, where available, to purchasing the product from the physician. Charges for products sold through the office should be limited to the reasonable costs incurred in making them available. (BoR 7-99, reaffirmed BoR 10)

Medical Ethics, Professionalism and the Changing Practice Environment

Systems of health care influence the provision of care. Although this seems an obvious observation to many in the era of managed care, it was less apparent, or at least less discussed, before the arrival of that era. Incentives to physicians within health care delivery approaches are often the means to influence care: incentives to limit care in the managed care setting, or to over test and over treat, in the fee-for-service context. The question is not whether systems and incentives influence care-- they do. Rather, it is whether that influence inappropriately affects physician judgment, patient care, and the patient-physician relationship.

Physicians must practice in world of increasing complexity and cost pressures. To do so appropriately, they must be conscious of all potential influences and must use ethical judgment and scientifically valid clinical decision-making as their guides. Putting patients first and maintaining professionalism should continue to be the goal of every physician. (BoR 4-99, reaffirmed BoR 10)

Physician-Assisted Suicide and Euthanasia

Physician-assisted suicide occurs when a physician provides a medical means for death, usually a prescription for a lethal amount of medication that the patient takes on his or her own. In euthanasia, the physician directly and intentionally administers a substance to cause death. Oregon and Washington have legalized the practice of physician-assisted suicide [\(78, 79\)](#). Many other states have had referenda, legislative proposals, and case law on both sides of the issues.

A decision by a patient or authorized surrogate to refuse life-sustaining treatment or an inadvertent death during an attempt to relieve suffering should be distinguished from physician-assisted suicide and euthanasia. Laws concerning or moral objections to physician-assisted suicide and euthanasia should not deter physicians from honoring a decision to withhold or withdraw medical interventions as appropriate. Fears that unwanted life-sustaining treatment will be imposed continue to motivate some patients to request assisted suicide or euthanasia.

In the clinical setting, all of these acts must be framed within the larger context of good end-of-life care. Some patients who request assisted suicide may be depressed or have uncontrolled pain. In providing comfort to a dying person, most physicians and patients should be able to address these issues. For example, regarding pain control, the physician may appropriately increase medication to relieve pain, even if this action inadvertently shortens life [\(80, 81\)](#). In Oregon, losing autonomy or dignity and inability to engage in enjoyable life activities were each cited as concerns in most cases [\(78\)](#). These concerns are less amenable to the physician's help, although physicians should be sensitive to these aspects of suffering.

The College does not support legalization of physician-assisted suicide or euthanasia [\(82\)](#). After much consideration, the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns and that the practice might undermine patient trust; distract from reform in end-of-life care; and be used in vulnerable patients, including those who are poor, are disabled, or are unable to speak for themselves or minority groups who have experienced discrimination. The major emphasis of the College and its members, including those who lawfully participate in the practice, should be ensuring that all persons can count on good care through to the end of life, with prevention or relief of suffering insofar as possible, an unwavering commitment to human dignity and relief of pain and other symptoms, and support for family and friends. Physicians and patients must continue to search together for answers to the problems posed by the difficulties of living with serious illness before death, neither violating the physician's personal and professional values, nor abandoning the patient to struggle alone. (BoR 00; BoR 2004; Reaffirmed with edits BoR 11)

Physician Participation in Executions

Participation by physicians in the execution of prisoners except to certify death is unethical. (BoR 04; Reaffirmed BoR 11)

Making Decisions Near the End of Life

Informed adults with decision-making capacity have the legal and ethical right to refuse recommended life-sustaining medical treatments (65). This includes any medical intervention, including ventilators, artificial nutrition and hydration, and cardiovascular implantable electronic devices (such as pacemakers and implantable cardioverter-defibrillators) (66). The patient's right is based on the philosophical concept of respect for autonomy, the common-law right of self-determination, and the patient's liberty interest under the U.S. Constitution (67). This right exists, regardless of whether the patient is terminally or irreversibly ill, has dependents, or is pregnant. When a physician disagrees with a patient's treatment decisions, the physician should respond with empathy and thoughtful exploration of all possibilities, including time-limited trials and additional consultation. If the patient's or family's treatment decisions violate the physician's sense of professional integrity, referral to another qualified physician may be considered, but the patient and family should not be abandoned. Consultation with an ethics committee can be of assistance in mediating such disputes.

Patients without decision-making capacity (see the Informed Decision Making and Consent section) have the same rights concerning life-sustaining treatment decisions as mentally competent patients. Treatment should conform to what the patient would want on the basis of written or oral advance care planning. If these preferences are not known, care decisions should be based on the best evidence of what the patient would have chosen based on the patient's values, previous choices, and beliefs (substituted judgments) or, failing that, on the best interests of the patient. However, there may be situations in which best-interest decisions should supersede substituted judgments (26). Physicians should be aware that hospital protocols and state legal requirements affecting end-of-life care vary. Patients with mental illness may pose particular challenges in understanding their wishes regarding end-of-life care. The presence of mental illness is not *prima facie* evidence of decisional incapacity. Psychiatric consultation should be considered to explore the patient's ability to participate in decision making. (BoR 04; Reaffirmed as amended BoR 11)

Care of Patients Near the End of Life

Physicians and the medical community must be committed to the compassionate and competent provision of care to dying patients and their families (58) and effective communication with patients and families (28, 59). Patients rightfully expect their physicians to care for them as they live with eventually fatal illnesses. Good symptom control; ongoing commitment to serve the patient and family; and physical, psychological, and spiritual support are the hallmarks of high-quality end-of-life care. Care of patients near the end of life, however, has a moral, psychological, and interpersonal intensity that distinguishes it from most other clinical encounters. It is the physician's professional obligation to develop and maintain competency in end-of-life care. (BoR 04; Reaffirmed as amended BoR 11)

Palliative Care

Although palliative care goes beyond end-of-life care, palliative care near the end of life entails addressing physical, psychosocial, and spiritual needs and understanding that patients may at times require palliative treatment in an acute care context [\(60–62\)](#). To provide palliative care, the physician must be up to date on the proper use of medications and treatments, including the legality and ethical basis of using whatever doses of opioids are necessary to relieve patient suffering. The physician should seek appropriate palliative care consultation when doing so is in the patient's best interest, know when and how to use home-based and institution-based hospice care, and be aware of the palliative care capabilities of nursing homes to which patients are referred. (BoR 04; Reaffirmed as amended BoR 11)

Advance Care Planning

Advance care planning allows a person with decision-making capacity to develop and indicate preferences for care and choose a surrogate to act on his or her behalf in the event that he or she cannot make health care decisions. It allows the patient's values and circumstances to shape the plan with specific arrangements to ensure implementation of the plan.

Physicians should routinely raise advance planning with adult patients with decision-making capacity and encourage them to review their values and preferences with their surrogates and family members. This is often best done in the outpatient setting before an acute crisis. These discussions let the physician know the patient's views, enable documentation of patient wishes in the medical record, and allow the physician to reassure the patient that he or she is willing to discuss these sensitive issues and will respect patient choices. The Patient Self-Determination Act of 1990 requires hospitals, nursing homes, health maintenance organizations, and hospices that participate in Medicare and Medicaid to ask if the patient has an advance directive, to provide information about them, and to incorporate advance directives into the medical record. It does not require completion of an advance directive as a condition of care.

Written advance directives include living wills and the durable power of attorney for health care (68). The latter enables a patient to appoint a surrogate to make decisions if the patient becomes unable to do so. The surrogate is obligated to act in accordance with the patient's previously expressed preferences or best interests. Some patients want their surrogates to strictly adhere to their expressed wishes. Others, however, want their surrogates to have flexibility in decision making (69–71). Patients should specify what authority and discretion in decision making they are giving their surrogates.

Living wills enable individuals to describe the treatment they would like to receive in the event that decision-making capacity is lost. Uncertainty about a future clinical course complicates the interpretation of living wills and emphasizes the need for physicians, patients, and surrogates to discuss patient preferences before a crisis arises. Some state laws limit the application of advance directives to terminal illness or deem advance directives not applicable for pregnant patients. Requirements for witnessing documents vary.

Advance directives should be readily accessible to health care professionals regardless of the site of care; some states have statewide systems for documenting physician orders on end-of-life care (72). When there is no advance directive and the patient's values and preferences are unknown or unclear, decisions should be based on the patient's best interests whenever possible, as interpreted by a guardian or a person with loving knowledge of the patient, if available. When making the decision to forgo treatment, many people give the most weight to reversibility of disease or dependence on life support, loss of capacity for social interaction, or nearness to death. Family members and clinicians should avoid projecting their own values or views about quality of life onto the incapacitated patient. Quality of life should be assessed according to the patient's perspective (73, 74). (BoR 04; Reaffirmed as amended BoR 11)

Reaffirming ACP Policy to Encourage Advanced Care Planning that Includes Further Details on Patient End-of-Life Choices through Mechanisms such as Physicians' Orders for Life Sustaining Treatment

ACP policy encourages routine advanced care planning, including use of physicians' orders for life sustaining treatment for documenting such discussions; and that such documentation reflects both goals of care and patient preferences regarding specific treatment interventions such as resuscitation, and the use of artificially administered fluids and nutrition, antibiotics and supplemental oxygen. The

College demonstrates support for patient–physician advance planning discussions by advocating for direct Medicare payments to physicians (as in H.R. 1898, the Life Sustaining Treatment Preferences Act of 2009). (BoR 10)

Providing Medical Care to One's Self; Persons With Whom the Physician has a Prior, Nonprofessional Relationship; and VIPs

Physicians may be asked to provide medical care to a variety of people with whom the physician has a prior, nonprofessional relationship. Each of these situations raises clinical and professionalism concerns that should be considered.

Except in emergent circumstances when no other option exists, physicians ought not care for themselves. A physician cannot adequately interview, examine, or counsel herself; without which, ordering diagnostic tests, medications, or other treatments is ill-advised.

Regarding people with whom the physician has a prior, nonprofessional relationship, including family members, friends or acquaintances, colleagues, and employees, the physician's prior emotional or social relationship complicates what would become the professional patient–physician relationship.

A physician asked to provide medical care to a person with whom the physician has a prior social or emotional relationship should first consider alternatives [\(47\)](#). The physician could serve as an advisor or medical translator and suggest questions to ask, explain medical terminology, accompany the patient to appointments, and help advocate for the patient. Alternatively, the physician could use his or her knowledge to refer the person to another physician.

Physicians should usually not enter into the dual relationship of physician–family member or physician–friend for a variety of reasons. The patient may be at risk of receiving inferior care from the physician. Problems may include effects on clinical objectivity, inadequate history-taking or physical examination, overtesting, inappropriate prescribing, incomplete counseling on sensitive issues, or failure to keep appropriate medical records. The needs of the patient may not fall within the physician's area of expertise [\(48\)](#). The physician's emotional proximity may result in difficulties for the patient and/or the physician. On the other hand, the patient may experience substantial benefit from having a physician–friend or physician–family member provide medical care, as may the physician. Access to the physician, the physician's attention to detail, and physician diligence to excellence in care might be superior.

Given the complexity of the dual relationship of physician–family member or physician–friend, physicians ought to weigh such concerns and all possible alternatives and seek counsel from colleagues before taking on the care of such patients. If they do assume the care, they should do so with the same comprehensive diligence and careful documentation as exercised with other patients. Whenever physicians provide medical care, they should do so only within their realm of expertise. Medical records should be kept just as for any other patient.

Taking care of VIPs poses different challenges. The physician ought to avoid the tendency to skip over sensitive portions of the relevant medical history or physical examination [\(49\)](#). Fame or prestige ought not buy patients medical care that is not medically indicated. Patient privacy and confidentiality must be protected, as for all patients (see Confidentiality section). Finally, the social standing of a VIP ought not negatively affect the physician's responsibilities toward other patients. (BoR 04; Reaffirmed as amended BoR 11)

Confidentiality

Confidentiality is a fundamental tenet of medical care. It is increasingly difficult to maintain in this era of electronic health records and electronic data processing, e-mail, faxing of patient information, third-

party payment for medical services, and sharing of patient care among numerous health professionals and institutions. Physicians must follow appropriate security protocols for storage and transfer of patient information to maintain confidentiality, adhering to best practices for electronic communication and use of decision-making tools. Confidentiality is a matter of respecting the privacy of patients, encouraging them to seek medical care and discuss their problems candidly, and preventing discrimination on the basis of their medical conditions. The physician should not release a patient's personal medical information (often termed a "privileged communication") without that patient's consent.

However, confidentiality, like other ethical duties, is not absolute. It may have to be overridden to protect individuals or the public or to disclose or report information when the law requires it. The physician should make every effort to discuss the issues with the patient. If breaching confidentiality is necessary, it should be done in a way that minimizes harm to the patient and heeds applicable federal and state law.

Physicians should be aware of the increased risk for invasion of patient privacy and should help ensure confidentiality. They should be aware of state and federal law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule [\(18\)](#). Within their own institutions, physicians should advocate policies and procedures to secure the confidentiality of patient records. To uphold professionalism and protect patient privacy, clinicians should limit discussion of patients and patient care issues to professional encounters. Discussion of patients by professional staff in public places, such as elevators or cafeterias, violates confidentiality and is unethical. Outside of an educational setting, discussion of patients with or near persons who are not involved in the care of those patients impairs the public's trust and confidence in the medical profession. Physicians of patients who are well-known to the public should remember that they are not free to discuss or disclose information about any patient's health without the explicit consent of the patient.

In the care of the adolescent patient, family support is important. However, this support must be balanced with confidentiality and respect for the adolescent's autonomy in health care decisions and in relationships with clinicians [\(19\)](#). Physicians should be knowledgeable about state laws governing the right of adolescent patients to confidentiality and the adolescent's legal right to consent to treatment.

Occasionally, a physician receives information from a patient's friends or relatives and is asked to withhold the source of that information from the patient [\(20\)](#). The physician is not obliged to keep such secrets from the patient. The informant should be urged to address the patient directly and to encourage the patient to discuss the information with the physician. The physician should use sensitivity and judgment in deciding whether to use the information and whether to reveal its source to the patient. The physician should always act in the best interests of the patient. (BoR 04; Reaffirmed as amended BoR 11)

Disclosure

To make health care decisions and work in partnership with the physician, the patient must be well-informed. Effective patient–physician communication can dispel uncertainty and fear and enhance healing and patient satisfaction. Information should be disclosed to patients and, when appropriate, family caregivers or surrogates, whenever it is considered material to the understanding of the patient's situation, possible treatments, and probable outcomes. This information often includes the costs and burdens of treatment, the experience of the proposed clinician, the nature of the illness, and potential treatments.

However uncomfortable for the clinician, information that is essential to and desired by the patient must be disclosed. How and when to disclose information, and to whom, are important concerns that must be addressed with respect for patient wishes. In general, individuals have the right to full and detailed disclosure. Some patients, however, may make it known that they prefer limited information or disclosure to family members or others they choose [\(21\)](#).

Information should be given in terms that the patient can understand. The physician should be sensitive to the patient's responses in setting the pace of communication, particularly if the illness is very serious. Disclosure and the communication of health information should never be a mechanical or perfunctory process. Upsetting news and information should be presented to the patient in a way that minimizes distress [\(22, 23\)](#). If the patient cannot comprehend his or her condition, it should be fully disclosed to an appropriate surrogate.

Therapeutic nondisclosure, also called “therapeutic privilege,” is the withholding of relevant health information from the patient if disclosure is believed to be medically contraindicated [\(24\)](#). Because this exception could swallow the rule of informed consent, therapeutic privilege should be rarely invoked and only after consultation with a colleague. A thorough review of the benefits and harms to the patient and ethical justification of nondisclosure is required [\(25\)](#).

In addition, physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may. (BoR 04; Reaffirmed as amended BoR 11)

Informed Decision Making and Consent

The patient's consent allows the physician to provide care. The unauthorized touching of a person is battery, even in the medical setting. Consent may be either expressed or implied. Expressed consent most often occurs in the hospital setting, where patients provide written or oral consent for a particular procedure. In many medical encounters, when the patient presents for evaluation and care, consent can be implied. The underlying condition and treatment options are explained to the patient or authorized surrogate and treatment is rendered or refused. In medical emergencies, consent to treatment necessary to maintain life or restore health is usually presumed unless it is known that the patient would refuse the intervention.

The doctrine of informed consent goes beyond the question of whether consent was given. Rather, it focuses on the content and process of consent. The physician must provide enough information for the patient to make an informed judgment about how to proceed. The physician's presentation should include an assessment of the patient's understanding, be balanced, and include the physician's recommendation. The patient's or surrogate's concurrence must be free and uncoerced.

The principle and practice of informed consent rely on patients to ask questions when they are uncertain about the information they receive; to think carefully about their choices; and to be forthright with their physicians about their values, concerns, and reservations about a particular recommendation. Once patients and physicians decide on a course of action, patients should make every reasonable effort to carry out the aspects of care under their control or inform their physicians promptly if it is not possible to do so.

The physician must ensure that the patient or the surrogate is adequately informed about the nature of the patient's medical condition and the objectives of, alternatives to, possible outcomes of, and risks of a proposed treatment.

Competence is a legal determination. All adult patients are considered competent to make decisions about medical care unless a court has declared them incompetent. In clinical practice, however, physicians and family members usually make decisions without a formal competency hearing in the court for patients who lack decision-making capacity (that is, the ability to receive and express information and to make a choice consonant with that information and one's values). This clinical approach can be ethically justified if the physician has assessed decision-making capacity and determined that the patient is incapable of understanding the nature of the proposed treatment; the alternatives to it; and the risks, benefits, and consequences of it. Assessing a patient's understanding can be difficult. Decision-making capacity should be evaluated for a particular decision at a particular point in time. The capacity to express a particular goal or wish can exist without the ability to make more complex decisions. The greater the consequences of the decision, the more important the assessment of decision-making capacity.

When a patient lacks decision-making capacity, an appropriate surrogate should make decisions with the physician. Treatment should conform to what the patient would want on the basis of written or oral advance care planning. If these preferences are not known, care decisions should be based on the best evidence of what the patient would have chosen based on the patient's values, previous choices, and beliefs (substituted judgments) or, failing that, on the best interests of the patient. However, there may be situations in which best-interest decisions should supersede substituted judgments [\(26\)](#).

If the patient has designated a proxy, as through a durable power of attorney for health care, that choice should be respected. Some states have health care consent statutes that specify who and in what order of priority family members or close others can serve as surrogates. When patients have not selected surrogates, a family member—which could be a domestic partner—should serve as surrogate. Physicians should be aware of legal requirements in their states for surrogate appointment and decision making. In some cases, all parties may agree that a close friend is a more appropriate surrogate than a relative.

Surrogate preferences can conflict with the preferences and best interests of a patient. Physicians should take reasonable care to ensure that the surrogate's decisions are consistent with patient preferences and best interests. When possible, these decisions should be reached in the medical setting. Physicians should emphasize to surrogates that decisions should be based on what the patient would want, not what surrogates would choose for themselves. Hospital ethics committees can be valuable resources in difficult situations. Courts should be used when doing so serves the patient, such as to establish guardianship for an unbefriended incompetent patient, to resolve a problem when other processes fail, or to comply with state law.

Physicians should routinely encourage patients to discuss their future wishes with appropriate family and friends and complete a living will and/or durable power of attorney for health care [\(27, 28\)](#). (See also “Advance Care Planning” within the Care of Patients Near the End of Life section.)

Most adult patients can participate in, and thereby share responsibility for, their health care. Physicians cannot properly diagnose and treat conditions without full information about the patient's personal and family medical history, habits, ongoing treatments (medical and otherwise), and symptoms. The physician's obligation of confidentiality exists in part to ensure that patients can be candid without fear of loss of privacy.

Physicians must strive to create an environment in which honesty can thrive and patients feel that concerns and questions are elicited. (BoR 04; Reaffirmed as amended BoR 11)

Decisions about Reproduction

The ethical duty to disclose relevant information about human reproduction to the patient may conflict with the physician's personal moral standards on abortion, sterilization, contraception, or other reproductive services. A physician who objects to these services is not obligated to recommend, perform, or prescribe them. As in any other medical situation, however, the physician has a duty to inform the patient about care options and alternatives, or refer the patient for such information, so that the patient's rights are not constrained. Physicians unable to provide such information should transfer care as long as the health of the patient is not compromised.

If a patient who is a minor requests termination of pregnancy, advice on contraception, or treatment of sexually transmitted diseases without a parent's knowledge or permission, the physician may wish to attempt to persuade the patient of the benefits of having parents involved, but should be aware that a conflict may exist between the legal duty to maintain confidentiality and the obligation toward parents or guardians. Information should not be disclosed to others without the patient's permission [\(19\)](#). In such cases, the physician should be guided by the minor's best interest in light of the physician's conscience and responsibilities under the law. (BoR 04; Reaffirmed as amended BoR 11)

Complementary and Alternative Care

Complementary and alternative medicine (CAM), as defined by the National Center for Complementary and Alternative Medicine, "is a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine" [\(41\)](#). Integrative medicine "combines both conventional and CAM treatments for which there is evidence of safety and effectiveness" [\(41\)](#). Folk healing practices are also common in many cultures [\(42\)](#). In 2007, 38% of U.S. adults reported using CAM in the previous year [\(43\)](#).

Patients may value the differing approaches of Western medicine, with its scientific basis, and CAM. A failure of conventional therapy, or cultural concerns, might lead a patient to alternative approaches to care. Requests by patients for alternative treatment require balancing the medical standard of care with a patient's right to choose care on the basis of his or her values and preferences. Such requests warrant careful physician attention. Before advising a patient, the physician should ascertain the reason for the request. The physician should be sure that the patient understands his or her condition, standard medical treatment options, and expected outcomes. Because most patients do not affirmatively disclose their use of CAM, physicians should ask patients about their current practices [\(44, 45\)](#) as an essential part of a complete history.

The physician should encourage the patient who is using or requesting alternative treatment to seek literature and information from reliable sources [\(46\)](#). The patient should be clearly informed if the option under consideration is likely to delay access to effective treatment or is known to be harmful. The physician should be aware of the potential impact of CAM on the patient's care. The patient's decision to select alternative forms of treatment should not alone because to sever the patient–physician relationship. (BoR 04; Reaffirmed as amended BoR 11)

The Physician's Relationship to Other Clinicians

Physicians share their commitment to care for ill persons with a broad team of health professionals. The team's ability to care effectively for the patient depends on the ability of individuals on the team to treat each other with integrity, honesty, and respect in daily professional interactions regardless of race, religion, ethnicity, nationality, sex, sexual orientation, age, or disability. Particular attention is warranted with regard to certain types of relationships, power imbalances and behaviors that could be abusive or disruptive or lead to harassment, such as those between attending physician and resident, resident and

medical student, or physician and nurse. (BoR 04; Reaffirmed as amended BoR 11)

Consultation and Shared Care

In almost all circumstances, patients should be encouraged to initially seek care from their principal physician. Physicians should in turn obtain competent consultation whenever they and their patients feel the need for assistance with care [\(118\)](#). The purpose, nature, and expectations of the consultation should be clear to all.

The consultant should respect the relationship between the patient and the principal physician, should promptly and effectively communicate recommendations to the principal physician, and should obtain concurrence of the principal physician for major procedures or additional consultants. The consultant should also share his or her findings, diagnostic assessment, and recommendations with the patient. The care of the patient and the proper records should be transferred back to the principal physician when the consultation is completed, unless another arrangement is agreed upon.

Consultants who need to take temporary charge of the patient's care should obtain the principal physician's cooperation and assent. The physician who does not agree with the consultant's recommendations is free to call in another consultant. The interests of the patient should remain paramount in this process.

A complex clinical situation may call for multiple consultations. To assure a coordinated effort that is in the best interest of the patient, the principal physician should remain in charge of overall care, communicating with the patient and coordinating care on the basis of information derived from the consultations. Unless authority has been formally transferred elsewhere, the responsibility for the patient's care lies with the principal physician.

When a hospitalized patient is not receiving care from his or her principal physician, good communication between the treating physician and principal physician is key. The principal physician should supply the inpatient physician with adequate information about current and past clinical history to allow for appropriate decision making and care. The inpatient physician should keep the principal physician informed of the patient's clinical course and supply a timely and complete description of care. Changes in chronic medications and plans for follow-up care should be promptly communicated to the principal physician before discharge.

The patient-centered medical home model promotes whole-person, patient-centered, integrated care across the health care system [\(119\)](#) and has overall responsibility for ensuring the coordination of care by all involved clinicians. Achieving these goals requires the collaboration and mutual respect of subspecialists, specialists, other clinicians, and health care institutions [\(120\)](#) in serving the patient. (BoR 04; Reaffirmed as amended BoR 11)

The Impaired Physician

Physicians who are impaired for any reason must refrain from assuming patient responsibilities that they may not be able to discharge safely and effectively. Whenever there is doubt, they should seek assistance in caring for their patients.

Impairment may result from use of psychoactive agents (alcohol or other substances, including prescription medications) or illness. Impairment may also be caused by a disease or profound fatigue that affects the cognitive or motor skills necessary to provide adequate care. The presence of these disorders or the fact that a physician is being treated for them does not necessarily imply impairment.

Every physician is responsible for protecting patients from an impaired physician and for assisting an impaired colleague. Fear of mistake, embarrassment, or possible litigation should not deter or delay identification of an impaired colleague [\(121\)](#). The identifying physician may find it helpful and prudent to seek counsel from a designated institutional official, the departmental chair, or a senior member of the staff or the community.

Although the legal responsibility to do so varies among states, there is a clear ethical responsibility to report a physician who seems to be impaired to an appropriate authority (such as a chief of service, chief of staff, institutional or medical society assistance program, or state medical board). Physicians and health care institutions should assist impaired colleagues in identifying appropriate sources of help. While undergoing therapy, the impaired physician is entitled to full confidentiality as in any other patient–physician relationship. To protect patients of the impaired physician, someone other than the physician of the impaired physician must monitor the impaired physician's fitness to work. Serious conflicts may occur if the treating physician tries to fill both roles [\(122\)](#). (BoR 04; Reaffirmed as amended BoR 11)

Professionalism

Medicine is not a trade to be learned, but a profession to be entered (1). A profession is characterized by a specialized body of knowledge that its members must teach and expand, by a code of ethics and a duty of service that put patient care above self-interest, and by the privilege of self-regulation granted by society (8). Physicians must individually and collectively fulfill the duties of the profession. While outside influences on medicine and the patient–physician relationship are many, the ethical foundations of the profession must remain in sharp focus (9). (BoR 11)

Care of Patients Near the End of Life

Problems of Life-Sustaining Treatments

Withdrawing or Withholding Treatment

Withdrawing and withholding treatment are equivalent, ethically and legally, although state evidentiary standards for and cultural and religious beliefs about withdrawing or withholding treatment may vary. Treatments should not be withheld because of the mistaken fear that if they are started, they cannot be withdrawn. This would deny patients potentially beneficial therapies. Instead, a time-limited trial of therapy could be used to clarify the patient's prognosis. At the end of the trial, a conference to review and revise the treatment plan should be held. Some family members may be reluctant to withdraw treatments even when they believe that the patient would not have wanted them continued. The physician should try to prevent or resolve these situations by addressing with families feelings of guilt, fear, and concern that the patient may suffer as life support is withdrawn, ensure that all appropriate measures to relieve distress are used, and explain the physician's ethical obligation to follow the patient's wishes. (BoR 04; Reaffirmed as amended BoR 11)

Do-Not-Resuscitate Orders

A do-not-resuscitate order (DNR order)—or do-not-attempt-resuscitation order (DNAR order) or allow natural death order (AND order)—is a physician order to forgo basic cardiac life support in the outpatient setting and advanced cardiac life support in the inpatient setting. Intervention in the case of a cardiopulmonary arrest is inappropriate for some patients, particularly those for whom death is expected, imminent, and unavoidable. Because the onset of cardiopulmonary arrest does not permit deliberative decision making, decisions about resuscitation must be made in advance. Physicians should

especially encourage patients who face serious illness or who are of advanced age (or their surrogates as appropriate) to discuss resuscitation.

A DNR order applies only to cardiopulmonary resuscitation. Discussions about this issue may reflect a revision of the larger goals and means of the care plan, and the extent to which a change is desired in treatment goals or specific interventions must be explicitly addressed for each patient. A DNR order must be written in the medical record along with notes and orders that describe all other changes in the treatment goals or plans, so that the entire health care team understands the care plan. A DNR order does not mean that the patient is necessarily ineligible for other life-prolonging measures, therapeutic and palliative. Because they are deceptive, half-hearted resuscitation efforts (“slow codes”) should not be performed [\(76\)](#).

A patient who is a candidate for intubation but declines will develop respiratory failure and is expected to arrest. For this reason, physicians should not write a do-not-intubate order in the absence of a DNR order. Moreover, it is important to address the patient's or surrogate's wishes regarding intubation and intensive care unit transfer in tandem with discussions about resuscitation.

A DNR order should not be suspended simply because of a change in the venue of care. When a patient with a preexisting DNR order is to undergo, for example, an operative procedure requiring general anesthesia, fiberoptic bronchoscopy, or gastroesophageal endoscopy, the physician should discuss the rationale for continuing or temporarily suspending the DNR order. A change in DNR status requires the consent of the patient or appropriate surrogate decision maker.

In general, any decision about advance care planning, including a decision to forgo attempts at resuscitation, applies in other care settings for that patient, and this should be routinely addressed. Many states and localities have systematic requirements for out-of-hospital implementation of DNR orders [\(77\)](#). Physicians should know how to effectuate the order and try to protect the patient from inappropriate resuscitation efforts. Physicians should ensure that DNR orders transfer with the patient and that the subsequent care team understands the basis for the decision. (BoR 04; Reaffirmed as amended BoR 11)

Determination of Death

The irreversible cessation of all functions of the entire brain is an accepted legal standard for determining death when the use of life support precludes reliance on traditional cardiopulmonary criteria. After a patient has been declared dead by brain-death criteria, medical support should ordinarily be discontinued. In some circumstances, such as the need to preserve organs for transplantation or to counsel or accommodate family beliefs or needs, physicians may temporarily support bodily functions after death has been determined. In the case of a pregnant, brain-dead patient, efforts to perfuse the body in order to maintain the fetus should be undertaken only after careful deliberation about the woman's interests. (BoR 04; Reaffirmed as amended BoR 11)

Solid Organ Transplantation

Ideally, physicians will discuss the option of organ donation with patients during advance care planning as part of a routine office visit, before the need arises [\(85\)](#). All potential donors should communicate their preference for or against donation to their families as well as have it listed on such documents as driver's licenses or organ donor cards.

Organ donation requires consideration of several issues. One set of concerns is the need to avoid even the appearance of conflict between the care of a potential donor and the needs of a potential recipient [\(86\)](#). The care of the potential donor must be kept separate from the care of a recipient. The

potential donor's physician should not be responsible for the care of the recipient or be involved in retrieving the organs or tissue.

Under federal regulations, all families must be presented with the option of organ donation when the death of the patient is imminent. To avoid conflicts of interest, neither physicians who will perform the transplantation nor those caring for the potential recipient should make the request. Physicians caring for the potential donor should ensure that families are treated with sensitivity and compassion. Previously expressed preferences about donation by dying or brain-dead patients should be sought and respected. Only organ procurement representatives who have completed training by an organ procurement organization may initiate the actual request [\(87\)](#).

Another set of issues involves the use of financial incentives to encourage organ donation. While increasing the supply of organs is a noble goal, the use of direct financial incentives raises ethical questions, including about treating humans as commodities and the potential for exploitation of families of limited means. Even the appearance of exploitation may ultimately be counterproductive to the goal of increasing the pool of organs.

In the case of brain-dead donors, once organ donation is authorized, the donor's physician should know how to maintain the viability of organs and tissues in coordination with the procurement team. Before declaration of brain death, treatments proposed to maintain the function of transplantable organs may be used only if they are not expected to harm the potential donor.

A particular set of issues has been raised by the advent of “donation after cardiac death” (previously known as “non–heart-beating cadaveric organ donation”). This approach allows patients who do not meet the criteria for brain death but for whom a decision has been made to discontinue life support to be considered potential organ donors. Life support is discontinued under controlled conditions. Once cardiopulmonary criteria for death are met, and a suitable period of time has elapsed that ensures clinical certitude of death but does not unduly compromise the chances of successful transplantation (generally 2 to 5 minutes), the organs are procured. This generally requires that the still-living patient be moved to the operating room (or nearby suite) in order to procure the organs as quickly after death as possible.

As in organ donation from brain-dead individuals, the care of the potential donor and the request from the family must be separated from the care of the potential recipient. The decision to discontinue life support must be kept separate from the decision to donate, and the actual request can be made only by an organ procurement representative. This process is an important safeguard in distinguishing the act of treatment refusal from organ procurement. Because these potential donors may not always die after the discontinuation of life support, palliative care interventions must be available to respond to patient distress. It is unethical, before the declaration of death, to use any treatments aimed at preserving organs for donation that may harm the still-living patient by causing pain, causing traumatic injury, or shortening the patient's life. As long as the prospective donor is alive, the physician's primary duty is to the donor patient's welfare, not that of the prospective recipient. (BoR 04; Reaffirmed as amended BoR 11)

Tax Deductibility of Travel Expenses and Lost Wages for Living Organ Donors

ACP supports tax deductibility of travel expenses and lost wages for living organ donors who are hospitalized as a result of organ donation. (BoR 01-07)

Disorders of Consciousness

There are a variety of disorders of impaired consciousness with variable prognoses, including coma, persistent and permanent irreversible vegetative states (“wakeful unresponsiveness”), and the

minimally conscious state (83). Diagnostic clarity in determining the patient's brain state by clinicians qualified to make such assessments before making ethical judgments about appropriate care is critical (84). Goals of care as decided by the patient in advance or by an appropriate surrogate should guide decisions about treatment for these patients as for other patients without decision-making capacity. (BoR 04; Reaffirmed as amended BoR 11)

Artificial Nutrition and Hydration

Artificial administration of nutrition and fluids is a medical intervention subject to the same principles of decision making as other treatments. Some states require high levels of proof of the patient's specific wishes regarding nutrition or hydration before previous statements or advance directives can be accepted as firm evidence that a patient would not want these treatments. Physicians should counsel patients desiring to forgo artificial nutrition and hydration under some circumstances to establish advance care directives with careful attention to decisions regarding artificial nutrition and hydration. Despite research to the contrary (75), concerns remain that discontinuing feeding tubes will cause suffering from hunger or thirst. On the other hand, imminently dying patients may develop fluid overload as their kidneys stop functioning, with peripheral and pulmonary edema; continued administration of intravenous fluids exacerbates these symptoms and may cause substantial distress. Physicians should address these issues with patients and loved ones involved in providing care. (BoR 04; Reaffirmed as amended BoR 11)

FIREARMS: SAFETY AND REGULATION

Firearm Injury Prevention

Positions from 1995 paper reaffirmed:

Position 1: The College urges internists to inform patients about the dangers of keeping firearms, particularly handguns, in the home and to advise them on ways to reduce the risk of injury. If a firearm is kept in the home, internists should counsel their patients about the importance of keeping firearms away from children, including recommending that the patient consider voluntary removal of firearms from the home. If patients are unwilling to consider removal of all firearms from the home, internists should refer them to information on best practices to reduce the risk of accidental or intentional injuries or deaths from firearms.

Position 2: The College supports the development of coalitions that bring different perspectives together on the issues of firearm morbidity and mortality. These groups, comprising health professionals, injury prevention experts, parents, teachers, police, and others, should build consensus for bringing about social and legislative change.

Position 3: The College supports efforts to improve and modify firearms to make them as safe as possible, including the incorporation of built-in safety devices (such as trigger locks and signals that indicate a gun is loaded). The College also supports efforts to reduce the destructive power of ammunition.

Position 4: The College encourages further research on firearm violence and on intervention and prevention strategies to reduce injuries caused by firearms. (Firearm Injury Prevention, ACP 95, reaffirmed ACP 96; reaffirmed as amended BoR 13)

Positions from 1996 paper reaffirmed:

Position 1: Firearms-related violence and the prevention of firearm injuries and deaths is a public health issue that demands high priority for public policy.

Position 2: Internists should be involved in firearm injury prevention both within the medical field and as part of the larger community.

- Internists should discuss with their patients the dangers of firearm ownership and the dangers of having a firearm in the home.
- Physicians should obtain training relating to firearms injury prevention, including education concerning adolescent assault, homicide and suicide.
- Physicians should support national, state and local efforts to enact legislation to regulate the sale of legal firearms including waiting periods and universal background checks.
- Violence prevention and prevention of injuries and deaths from firearms is a high priority issue for the American College of Physicians.
- The College must take an active role in providing education and training for internists concerning all aspects of violence prevention, including firearm injury prevention.

Position 3: The American College of Physicians supports the current ban on sales of automatic weapons for civilian use. The College favors enactment of legislation to ban the sale and manufacture for civilian use of all semi-automatic firearms that have specified military style features and are capable of rapid fire and large capacity ammunition magazines. Such legislation should be carefully designed to make it difficult for manufacturers to get a semi-automatic firearm exempted from the ban by making modifications in its design while retaining its semi-automatic functionality. Exceptions to a ban on such semi-automatic firearms for hunting and sporting purposes should be narrowly defined.

Position 4: The American College of Physicians supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings such as serial numbers on weapons, to aid in the identification of weapons used in crimes.

Position 5: The American College of Physicians supports appropriate regulation of the purchase of legal firearms to reduce firearms-related injuries and deaths. The College acknowledges that any such regulations must be consistent with the Supreme Court ruling establishing an individual right to firearms ownership. Sales of firearms should be subject to a waiting period, satisfactory completion of a criminal background check, and proof of satisfactory completion of an appropriate educational program on firearm safety.

- Criminal background checks for firearms sales should be universal to include sales by gun dealers, at gun shows and private sales.
- Firearms should not be sold to minors, persons with criminal records, or persons who are known threats to themselves or others.
- Permits to carry concealed weapons should be issued only to persons with special justifiable needs, such as law enforcement personnel.
- The College supports a ban on plastic guns that cannot be detected by metal detectors or standard security screening devices.
- All firearms should incorporate safety features to make them as child-proof as possible.
- The College favors strong penalties and criminal prosecution for those who sell firearms illegally.

(Firearm Injury Prevention, ACP 96; reaffirmed as amended BoR 13)

Reducing Firearm-Related Injuries and Deaths in the United States

1. The American College of Physicians recommends a public health approach to firearms-related violence and the prevention of firearm injuries and deaths.
 - a. The College supports the development of coalitions that bring different perspectives together on the issues of firearm injury and death. These groups, comprising health professionals, injury prevention experts, parents, teachers, law enforcement professionals, and others should build consensus for bringing about social and legislative change.
2. The medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths, just as physicians have spoken out on other public health issues. Physicians should counsel patients on the risk of having firearms in the home, particularly when children, adolescents, people with dementia, people with mental illnesses, people with substance use disorders, or others who are at increased risk of harming themselves or others are present.
 - a. State and federal authorities should avoid enactment of mandates that interfere with physician free speech and the patient–physician relationship.
 - b. Physicians are encouraged to discuss with their patients the risks that may be associated with having a firearm in the home and recommend ways to mitigate such risks, including best practices to reduce injuries and deaths.
 - c. Physicians should become informed about firearms injury prevention. Medical schools, residency programs, and continuing medical education (CME) programs should incorporate firearm violence prevention into their curricula.
 - d. Physicians are encouraged, individually and through their professional societies, to advocate for national, state, and local efforts to enact legislation to implement evidence-based policies, including those recommended in this paper, to reduce the risk of preventable injuries and deaths from firearms, including but not limited to universal background checks.
3. The American College of Physicians supports appropriate regulation of the purchase of legal firearms to reduce firearms-related injuries and deaths. The College acknowledges that any such regulations must be consistent with the Supreme Court ruling establishing that individual ownership of firearms is a constitutional right under the Second Amendment of the Bill of Rights.
 - a. Sales of firearms should be subject to satisfactory completion of a criminal background check and proof of satisfactory completion of an appropriate educational program on firearms safety. The American College of Physicians supports a universal background check system to keep guns out of the hands of felons, persons with mental illnesses that put them at a greater risk of inflicting harm to themselves or others, persons with substance use disorders, and others who already are prohibited from owning guns. Clear guidance should be issued on what mental and substance use records should be submitted to the National Instant Criminal Background Check System (NICS). This should include guidance on parameters for inclusion, exclusion, removal, and appeal. States should submit mental health records and report persons with substance use disorders to the NICS. The federal government should increase incentives and penalties related to

state compliance. The law requiring federal agencies to submit substance use records should be enforced.

- b. Although there is limited evidence on the effectiveness of waiting periods in reducing homicides, waiting periods may reduce the incidence of death by suicide, which account for nearly two thirds of firearm deaths, and should be considered as part of a comprehensive approach to reducing preventable firearms-related deaths.
 - c. Lawmakers should carefully weigh the risks and benefits of concealed-carry legislation prior to passing laws.
 - d. The College supports a ban on firearms that cannot be detected by metal detectors or standard security screening devices.
 - e. The College favors strong penalties and criminal prosecution for those who sell firearms illegally and those who legally purchase firearms for those who are banned from possessing them (“straw man sales”).
4. The American College of Physicians recommends that guns be subject to consumer product regulations regarding access, safety, and design. In addition, the College supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings, such as serial numbers on weapons, to aid in the identification of weapons used in crimes.
5. Firearm owners should adhere to best practices to reduce the risk of accidental or intentional injuries or deaths from firearms. They should ensure that their firearms cannot be accessed by children, adolescents, people with dementia, people with mental illnesses or substance use disorders who are at increased risk of harming themselves or others, and others who should not have access to firearms. Firearm owners should report the theft or loss of their firearm within 72 hours of becoming aware of its loss.
6. The College cautions against broadly including those with mental illness in a category of dangerous individuals. Instead, the College recommends that every effort be made to reduce the risk of suicide and violence, through prevention and treatment, by the subset of individuals with mental illness who are at risk of harming themselves or others. Diagnosis, access to care, treatment, and appropriate follow-up are essential.
- a. Physicians and other health professionals should be trained to respond to patients with mental illness who might be at risk of injuring themselves or others.
 - b. Ensuring access to mental health services is imperative. Mental health services should be readily available to persons in need throughout their lives or through the duration of their conditions. Ensuring an adequate availability of psychiatric beds and outpatient treatment for at-risk persons seeking immediate treatment for a condition that may pose a risk of violence to themselves or others should be a priority.
 - c. Community understanding of mental illness should be improved to increase awareness and reduce social stigma.
 - d. Laws that require physicians and other health professionals to report those with mental illness who they believe pose an imminent threat to themselves or others should have

safeguards in place to protect confidentiality and not create a disincentive for patients to seek mental health treatment. Such laws should ensure that physicians and other health professionals are able to use their reasonable professional judgment to determine when a patient under their care should be reported and should not hold them liable for their decision to report or not report.

7. The College favors enactment of legislation to ban the sale and manufacture for civilian use of firearms that have features designed to increase their rapid killing capacity (often called “assault weapons” or semiautomatic weapons) and large-capacity ammunition and retaining the current ban on automatic weapons for civilian use. Although evidence on the effectiveness of the Federal Assault Weapons Ban of 1994 is limited, the College believes that there is enough evidence to warrant appropriate legislation and regulation to limit future sales and possession of firearms that have features designed to increase their rapid killing capacity and can, along with a ban on large-capacity ammunition magazines, be effective in reducing casualties in mass shooting situations. Such legislation should be carefully designed to make it difficult for manufacturers to get a semiautomatic firearm exempted from the ban by making modifications in its design while retaining its semiautomatic functionality. Exceptions to a ban on such semiautomatic firearms for hunting and sporting purposes should be narrowly defined.
8. The College supports efforts to improve and modify firearms to make them as safe as possible, including the incorporation of built-in safety devices (such as trigger locks and signals that indicate a gun is loaded). Further research is needed on the development of personalized guns.
9. More research is needed on firearm violence and on intervention and prevention strategies to reduce injuries caused by firearms. The Centers for Disease Control and Prevention, National Institutes of Health, and National Institute of Justice should receive adequate funding to study the impact of gun violence on the public's health and safety. Access to data should not be restricted. (BoR 14)

HEALTH CARE DELIVERY

Concierge and Other Direct Patient Contracting Practices

1. The ACP supports physician and patient choice of practice and delivery models that are accessible, ethical, and viable and that strengthen the patient–physician relationship.
2. Physicians in all types of practices must honor their professional obligation to provide nondiscriminatory care, serve all classes of patients who are in need of medical care, and seek specific opportunities to observe their professional obligation to care for the poor.
3. Policymakers should recognize and address pressures on physicians and patients that are undermining traditional medical practices, contributing to physician burn-out, and fueling physician interest in DPCPs.
4. Physicians in all types of practice arrangements must be transparent with patients and offer details of financial obligations, services available at the practice, and the typical fees charged for services.
5. Physicians in practices that choose to downsize their patient panel for any reason should consider the effect these changes have on the local community, including patients' access to

care from other sources in the community, and help patients who do not stay in the practice find other physicians.

6. Physicians who are in or are considering a practice that charges a retainer fee should consider the effect that such a fee would have on their patients and local community, particularly on lower-income and other vulnerable patients, and ways to reduce barriers to care for lower-income patients that may result from the retainer fee.
7. Physicians participating, or considering participation, in practices that do not accept health insurance should be aware of the potential that not accepting health insurance may create a barrier to care for lower-income and other vulnerable patients. Accordingly, physicians in such practices should consider ways to reduce barriers to care for lower-income patients that may result from not accepting insurance.
8. Physicians should consider the patient-centered medical home as a practice model that has been shown to improve physician and patient satisfaction with care, outcomes, and accessibility; lower costs; and reduce health care disparities when supported by appropriate and adequate payment by payers.
9. The College calls for independent research on DPCPs that addresses the following:
 - a. the number of physicians currently in a DPCP, where DPCPs are located geographically, projections of growth in such DPCPs, and the number of patients receiving care from DPCPs;
 - b. factors that may undermine the patient–physician relationship, contribute to professional burnout, and make practices unsustainable and their effect on physicians choosing to provide care through DPCPs;
 - c. the impact and structure of DPCP models that may affect their ability to provide access to underserved populations;
 - d. the effect of DPCPs on the health care workforce;
 - e. patients' out-of-pocket costs and overall health system costs;
 - f. patients' experience with the care provided, quality of care, and outcomes; and
 - g. the effect of physicians not participating in insurance and therefore not participating in national quality programs, interoperability with other electronic health record systems, and the associated effect on quality and outcomes. (BoR 15)

Principles on Retail Health Clinics

1. Retail health clinics should serve as an episodic alternative to care from an established primary care practice for relatively healthy patients without complex medical histories.
 - a. Ideally, all patients should establish a longitudinal care relationship with a physician. Physicians should discuss circumstances in which the use of a retail health clinic might be appropriate.
 - b. All care settings should develop strategies to provide patients with improved access via flexible scheduling and after-hours business care.

2. Retail health clinics should have a well-defined and limited scope of clinical services that are consistent with state scope-of-practice laws and with the more limited physical space and infrastructure that such a setting permits. These well-defined and limited services should be clearly disclosed to the patient prior to or at the visit.
3. Retail clinics should use standardized medical protocols based on evidence-based practice guidelines.
4. Retail health clinics should have a structured referral system to primary care settings and encourage patients they see to establish a longitudinal relationship with a primary care physician if the patient does not have such an existing relationship. ACP believes that it is not appropriate for retail clinics to refer patients directly to subspecialists without consultation by a primary care clinician in order to ensure continuity of care.
5. ACP believes it is primarily the responsibility of the retail health clinic to promptly communicate information about a retail health clinic visit to a patient's primary care physician, including but not limited to the administration of any vaccination, prescriptions, tests, or postcare instructions.
 - a. Physicians are encouraged to engage patients in a discussion on how to appropriately follow up with the physician or patient-centered medical home after a retail health clinic visit.
 - b. Patients are encouraged to engage the retail health clinic about when and what information will be sent to their primary care physician and discuss their retail health clinic visit with their physician.
6. ACP believes insufficient data exist concerning the provision of chronic disease management in the retail health clinic setting and recommends against chronic and complex disease management in these settings at this time. ACP recommends controlled research into the safety, efficacy, and cost-effectiveness of chronic disease management in the retail health clinic setting. (BoR 15)

Language Services

Physicians encounter patients with limited English proficiency (LEP) on a fairly frequent basis. Yet, medical practices typically do not have a formal process for tracking data on patients' primary language and those that do rely primarily on paper records. These patients have more difficulty understanding basic health information and generally require additional time during office visits. The majority of practices represented by internists that have LEP patients provide language services. And, the majority of these physicians agree that it is difficult to provide patient care to LEP patients when language services are not available. However, language services are limited and are typically provided by a bilingual physician or staff member. Nevertheless, the aggregate costs are not insignificant and are mostly borne by the physician practice. Few practices rely on external sources for language services or provide such services during off hours.

Few physicians perceived a need for tools or training to assist their practices in providing language services. A clearinghouse to provide translated documents and patient education materials would be useful, but providing reimbursement for the added costs of clinical time and language services would be the most effective means of expanding the use of language services.

ACP recommends:

1. Language services should be available to improve the provision of health care services to patients with Limited English Proficiency (LEP).
2. Medicare should directly reimburse clinicians for the added expense of language services and the additional time involved in providing clinical care for patients with LEP.
3. A national clearinghouse should be established to provide translated documents and patient education materials (*Language Services for Patients with Limited English Proficiency* BoR 07)

Prohibit Institutions from Mandating In-House Testing

ACP seeks measures discouraging institutions from mandating only in-house preoperative testing where responsible internists are able to assume this function and provide the necessary documentation before the procedure. (HoD 96; reaffirmed BoR 08)

HEALTH CARE SYSTEM REFORM

State Experimentation with Reforms to Expand Access to Health Care

Position 1. State-based health plans should either achieve universal coverage, or should at a minimum result in measurable and substantial reductions in the number of uninsured within the next five years.

Position 2. State-based health plans should ensure that all individuals participate in the coverage plan, by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.

Position 3. State-based health plans should at a minimum provide coverage for a core package of preventive and primary care services and for catastrophic expenses.

Position 4. States should ensure adequate and stable funding for their state-based health programs by broadly sharing responsibility with the federal government, employers and individuals within the state.

Position 5. State-based health programs should include incentives to assure a better balance of primary care physicians to specialists and an adequate supply of primary care physicians

Position 6. State-based health plans should give individuals the ability to obtain care from a qualified patient centered medical home.

Position 7. State-based health plans should include reimbursement reforms to support the value of patient-centered care managed by a primary or principal care physician.

Position 8. State-based health programs should include incentives for health information exchange and physicians' adoption of Health Information Technology (HIT) to support patient-centered care.

Position 9. State-based health programs should not reduce existing benefits for current Medicaid and S-CHIP recipients.

Position 10. State-based programs should not penalize patients for engaging in unhealthy lifestyles but should include positive incentives for well-being and prevention. (BoR 07)

The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care

Position 1: ACP calls for a comprehensive public policy initiative that would fundamentally change the way that primary care and principal care (whether provided by primary care or specialty care physicians) are delivered to patients by linking patients to a personal physician in a practice that qualifies as an advanced medical home.

Position 2: Fundamental changes should be made in third party financing, reimbursement, coding, and coverage policies to support practices that qualify as advanced medical homes.

Position 3: Fundamental changes should be made in workforce and training policies to assure an adequate supply of physicians who are trained to deliver care consistent with the advanced medical home model, including internists and family physicians.

Position 4: Further research on the advanced medical home model and a revised reimbursement system to support practices structured according to this model should be conducted and should include national pilot testing. (BoR 06; reaffirmed BoR 17)

Solutions to the Challenges Facing Primary Care Medicine: Quality of Practice Life: Develop, Study, and Support New Primary Care Delivery Models

1. Public and private payers should support expansion of the patient-centered medical home models.
2. Public and private payers should invest in other new practice models that support the ability of primary care physicians to deliver comprehensive, preventive, and coordinated care to patients. (BoR 09)

Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists, Updated 2008

ACP believes that Congress should enact legislation to establish a framework of a step-by-step plan to make affordable coverage available to all Americans within seven years:

1. The federal government should provide dedicated funding to states that have requested federal support for their efforts to redesign their health care delivery programs to achieve measurable expansions of health insurance coverage, and to redesign health care financing and delivery systems to emphasize prevention, care coordination, quality and the use of health information technology through the Patient-Centered Medical Home.
2. States should have the option to expand Medicaid coverage to all residents up to 100% of the federal poverty level, with the additional cost of such expansion to be paid for by a dollar-to-dollar increase in the federal matching program. States should also have the option to unify CHIP and Medicaid coverage so that families are covered under a single program.
3. Advance, refundable and sliding scale tax credits should be made available to uninsured working Americans with incomes up to 200% of the federal poverty level. The tax credit should provide a premium subsidy equal to what the federal government now provides to its own employees.
4. Tax credit recipients should have the options of buying coverage through state purchasing group arrangements modeled after the federal employees health benefits program, giving them the same types and variety of health plan options now available only to federal employees, or from qualified non-

group insurers. Plans that participate in the purchasing group would be required to agree to uniform new federal rules on risk-rating and renewability as a condition of participating in the program.

5. Small employers should have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees.

6. Once coverage is affordable and available, national and/or state-based health plans should ensure that all individuals participate in the coverage plan, by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.

7. An expert advisory commission should be created to recommend core set of benefits that participating health plans will be encouraged to offer, as well as ways to expand coverage to those with incomes above 200% of the federal poverty level. (BoR 08)

Achieving A High Performance Health Care System with Universal Access

Recommendation 1a: Provide universal health insurance coverage to ensure that all people within the United States have equitable access to appropriate health care without unreasonable financial barriers. Health insurance coverage and benefits should be continuous and not dependent on place of residence or employment status. ACP further recommends that the federal and state governments consider adopting one or the other of the following pathways to achieving universal coverage:

- Single-payer financing models, in which one governmental entity is the sole third-party payer of health care costs, can achieve universal access to health care without barriers based on ability to pay. Single payer systems generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health care expenditures, high levels of consumer/patient satisfaction, and high performance on measures of quality and access. They may require a higher tax burden to support and maintain, particularly as demographic changes reduce the number of younger workers paying into the system. Such systems typically rely on global budgets and price negotiation to help restrain health care expenditures, which may result in shortages of services and delays in obtaining elective procedures and limit individuals' freedom to make their own health care choices.
- Pluralistic systems, which involve government entities as well as multiple for-profit and/or not-for-profit private organizations, can assure universal access while allowing individuals the freedom to purchase private supplemental coverage, but are more likely to result in inequities in coverage and higher administrative costs (Australia and New Zealand). Pluralistic financing models must provide (1) a legal guarantee that all individuals have access to coverage and (2) sufficient government subsidies and funded coverage for those who cannot afford to purchase coverage through the private sector. (See ACP Proposal for Expanding Access to Health Insurance as an example of how a pluralistic system can achieve universal coverage)

Recommendation 1b: Provide everyone access to affordable coverage, whether provided through a single-payer or pluralistic financing model, that includes coverage for a core package of benefits, including preventive services, primary care services, including but not limited to chronic illness management, and protection from catastrophic health care expenses.

Recommendation 1c: Until there is political consensus for achieving universal coverage at a federal level, Congress should encourage state innovation by providing dedicated federal funds to support state-based programs with an explicit goal of covering all uninsured persons within the state. (See ACP Position Paper on State Experimentation with Reforms to Expand Access to Health Care)

Recommendation 2: Create incentives to encourage patients to be prudent purchasers and to participate in their health care. Patients should have ready access to health information necessary for informed decision making. Cost-sharing provisions should be designed to encourage patient cost-consciousness without deterring patients from receiving needed and appropriate services or participating in their care.

Recommendation 3: Develop a national health care workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs. To meet this goal, the nation's workforce policy must focus on ensuring an adequate supply of primary and principal care physicians trained to manage care for the whole patient. The federal government must intervene to avert the impending catastrophic shortage of primary care physicians. A key element of workforce policy is setting specific targets for producing generalists and specialists and enacting policy to achieve those targets.

Recommendation 4: Redirect federal health care policy toward supporting patient-centered health care that builds upon the relationship between patients and their primary and principal care physicians and financially supports the patient-centered medical home, a practice system that the evidence suggests has the potential to improve health outcomes, achieve more efficient use of resources, and reduce health care disparities.

Recommendation 5: Provide financial incentives for physicians to achieve evidence-based performance standards. The U.S. should consider revising existing volume-based payment systems used by Medicare and most private insurers to (a) better support physician/patient relationships by creating care coordination payments and other incentives for physicians working with health care teams to provide patient care management that includes comprehensive ongoing care and (b) maintain a fee-for-service component for separately-identifiable visits and procedures, such as the bundled and hybrid payment structure used in Denmark and the Netherlands.

Recommendation 6: Reduce the costs of health care administration and the attendant burdens they place on patients and their physicians, including creating uniform billing and credentialing systems across all payers.

Recommendation 7: Support with federal funds an interoperable health information technology (HIT) infrastructure that assists physicians in delivering evidence-based, patient-centered care.

Recommendation 8: Encourage public and private investments in all kinds of medical research—including research on comparative effectiveness of different treatments—to foster continued innovation and improvements in health care (BoR 07)

Insurance of Unemployed and High-Risk

ACP continues to support appropriate legislative and private sector approaches to provide health insurance coverage to patients who have difficulty obtaining such insurance because of unemployment or health status. (HoD 83; reaffirmed 94; reaffirmed BoR 04; reaffirmed BoR 15)

Participation in Managed Care Programs

ACP reaffirms its support for legislation allowing patients access to their physician of choice and

physician due process for application to and retention within any health care plan. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Point-of-Service Legislation

Legislation should be enacted which mandates a point-of-service option for all those insured under health insurance plans. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Support for the Health Care Infrastructure

National legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations, and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. Such legislation should also include sufficient and continuing federal funding for special programs, including the National Health Service Corps, to enhance the recruitment and retention of physicians for practice in underserved areas. (ACP AMA Del A-94; reaffirmed BoR 04; reaffirmed BoR 16)

Prioritization of Health Care

ACP believes that society, policy makers and the health care professions will confront in the near future the need to set priorities for what services will be guaranteed to all citizens and those services to which access may need to be limited. It is extremely important that broad participation of all affected sectors of society be involved in the process of establishing such priorities. In addition, physicians must have a leading role in the creation of this process and a voice in determining the policies deriving from this process because of their professional expertise and their role as patient advocate. ACP continues to evaluate various methods for establishing priorities in the delivery of health care services. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

Self Inflicted Illness

ACP, through the AMA and other physician organizations, supports and will develop health care reform legislation that provides concrete and non-discriminatory incentives to discourage self inflicted avoidable illness and promotes health and cost effective behavior above and beyond preventive measures typically prescribed by physicians. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

ERISA Preemption

ACP supports the enactment of legislation to amend ERISA:

- a. to require self-insured plans to be subject to state-imposed premium taxes which are used to fund state risk pool arrangements;
- b. to require self-insured plans to meet state standards which restrict capricious and unfair changes in benefit packages; and
- c. to require self-insured plans to be subject to state oversight, including penalties, for improper claims processing. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Insurance for Small Employers-Managed Care Programs

ACP supports legislation that provides federal funding for states to establish a program or network that pools small employers to purchase private health insurance at more affordable rates. If small group insurance market reforms are in effect at the time insurance pools are established, employers should not be mandated to purchase insurance solely through these pools. Managed care organizations are an acceptable and viable method of delivering medical care to Medicaid recipients. ACP supports the

development of consistent national standards for an effective quality assurance program for all managed care programs. All managed care programs, including those programs that provide care to Medicare recipients, should be required to meet these nationally developed standards. States should be required to provide sufficient physician oversight of managed care organizations, especially those programs that provide care to Medicaid recipients. (HoD 92; reaffirmed BoR 17)

Negotiations for Physician Payments Under Comprehensive Health Care Reform

This policy is under review by the MSC.

Non-Exemption of Government Employees from Health Care Reforms

ACP urges that any change in our health care delivery system passed by Congress and signed by the President include all federal civilian government employees, including Congress and the Administration, and include all government facilities. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Provider-Specific Taxes

ACP opposes any attempt to levy taxes on professional physician services, whether to fund specific health care programs or as a general revenue fund enhancement. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Cost Containment Measures

ACP supports: legislation requiring insurance carriers to fully and uniformly disclose the portion of health care premiums that is spent on administration, specifically with a breakdown of the percentage of premium dollars that is allocated to marketing, claims processing, other administrative expenses, profits, reserves and payment for covered benefits; continued efforts to develop scientific data that assesses what managed care techniques—including prior authorization, preadmission review, preferred provider arrangements, utilization review, pre-procedure review and capitation plans—are effective in controlling costs and maintaining quality; efforts to reduce health care costs associated with fraud and abuse (such as strengthening the power of state disciplinary boards and providing immunity for physicians who report colleagues who are suspected of violations); appropriate efforts to reduce health care costs associated with incompetent and impaired physicians; efforts to develop and encourage employers to purchase benefit packages that include wellness care, including the development of scientifically valid evidence that wellness programs are cost-effective and; the development of a Medicare PPS for hospital capital costs that promotes efficiency in capital investments and maintains access to high quality hospital care for Medicare beneficiaries. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Managed Care in Health Care Reform

ACP supports legislation to protect an individual's right to choose a non-managed care plan. Additionally, ACP believes that all managed care plans must:

1. have a sufficient number of providers to assure that all appropriate services are available and accessible to each enrollee with reasonable promptness, and immediately available when medically necessary;
2. provide benefits at in-network cost sharing for covered items and services not furnished by participating providers if the services are medically necessary and immediately required because of an unforeseen illness, injury or condition in order to adequately protect access to care and;
3. not have reimbursement mechanisms that penalize primary care physicians who have an increased number of severely ill patients.

ACP supports legislation requiring all insurance carriers who make a managed care plan available to a large employer in the community to also make the managed care plan available to small employers.

ACP supports the pre-emption of state laws or regulations that:

1. prohibit a managed care plan from freely selecting the health care providers in a locale as the participating providers; or
2. limit the ability of a managed care entity to negotiate, enter into contracts, establish alternative rates or forms of payments for participating providers, or to require a provider reasonable incentives that promote the use of participating providers. ACP opposes unfair penalties on subscribers who elect to use out-of-plan physicians in certain circumstances.

ACP opposes any unfair penalty, such as a tax, if an employer fails to enroll in a managed care plan. Such a tax penalty unduly restricts an individual's right to select a health care plan and could place an employer in a position of limiting the types of health care plans offered. (HoD 91; reaffirmed BoR 04; reaffirmed as amended BoR 15)

Payment Issues

ACP opposes legislative proposals that would pressure or require private payers to establish their payment levels for physician services based on the fee schedules used by Medicare, Medicaid and other public programs. ACP opposes legislative proposals that would pressure or require physicians to limit their charges for private patients based on the fee schedules used by Medicare, Medicaid and other public programs, or that otherwise would restrict their right to voluntarily enter into contracts with private individuals or payers to provide services at a mutually agreeable fee. (HoD 91; reaffirmed BoR 04; reaffirmed as amended BoR 15)

Reforming the Small Group Insurance

ACP reaffirms support for the enactment of legislation to require insurance companies to rely on community rating and to prohibit medical underwriting. In the interim, to address the immediate needs of the small group market, ACP supports the enactment of legislation to correct abusive rating practices in the small group market, including the establishment of rating and renewal standards. ACP supports legislation requiring insurance carriers to disclose to small employers and to consumers insurance rating and renewal practices. ACP supports legislation to require small group insurers to maintain records pertaining to rating practices, renewal underwriting practices including actuarial assumptions, and to require insurers to file a report with the Insurance Commissioner to ensure that their actuarial practices are consistent with rating and renewal standards. ACP reaffirms support for legislation requiring states to develop a reinsurance mechanism. States should be given sufficient flexibility to develop a reinsurance mechanism that meets a state's individual needs. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Containing Health Care Costs

(Policy from FILED HoD Report V) ACP supports funding for outcomes research and the development of practice guidelines, appropriate copayments and deductibles, medical liability reform, the elimination of administrative inefficiencies and physician and patient hassles for payment of claims in the public and private insurance markets and the implementation of physician payment reform.

ACP believes that selective contracting for certain high-cost, non-emergency procedures may be an appropriate means of containing costs provided certain protections are built in, including:

1. Travel costs for the patient, as well as family members when appropriate, and distance from the

contracted site should not impede access to services. All travel costs should be reimbursed by the payer.

2. Consumers should be able to select a health care plan that does not require them to obtain certain services at contracted sites. This plan may require a higher premium or higher out-of-pocket expenses than the plan which requires certain procedures to be obtained at designated facilities.
3. Contracts should not automatically be awarded to the lowest bidder. The payer should consider quality of care in terms of mortality rates, lengths of stay, morbidity, willingness to follow accepted practice guidelines, the existence of adequate self-assessment and peer review programs, and critical volume of procedures in addition to costs.
4. Patients should not be restricted from, or penalized for opting out of the contracted site in cases requiring immediate medical attention.

ACP supports appropriate efforts to analyze the costs and benefits of medical technology but opposes the use of technology assessment explicitly to limit the development and diffusion of new technology.

ACP supports varying copayments by type of service, with reasonable copayments on primary care services, diagnostic and surgical services based on the ability to pay.

ACP supports further study of ways of reimbursing physicians based on quality of services provided as opposed to quantity of services performed. (HoD 90; reaffirmed as amended BoR 13)

How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?

1. Sufficient resources should be devoted to developing needed data on clinical and cost-effectiveness of medical interventions for comparative, evidence-based evaluations that should serve as the basis for allocation decisions about the utilization of health care resources.
2. There should be a transparent and publicly acceptable process for making health resource allocation decisions with a focus on medical efficacy, clinical effectiveness, and need, with consideration of cost based on the best available medical evidence.
3. The public, patients, physicians, insurers, payers, and other stakeholders should have opportunities to provide input to health resource allocation decision-making at the policy level.
4. Multiple criteria should be considered in determining priorities for health care resources. Factors that might be considered for high priority, in addition to clinical effectiveness and costs, should include:
 - a. Patient need, preferences, and values
 - b. Potential benefit
 - c. Safety
 - d. Societal priorities that include fiscal responsibility and equitable access
 - e. Quality of life gained, consistent and compliant with the Americans with Disabilities Act
 - f. Public health benefit
 - g. Impact on families and caregivers
 - h. A balance between cost and clinical effectiveness to minimize adverse economic consequences
 - i. on current and future generations.

5. Allocation decisions should be in accord with societal values and reflect moral, ethical, cultural, and professional standards.
6. Allocation decisions should not discriminate against a class or category of patients and should be developed and applied in conformance with established rules without prejudice or favoritism.
7. The allocation process should be flexible enough to address variations in regional and population-based needs that are identified in a scientific way and to accommodate special circumstances.
8. Decisions on allocation of health care resources will have more public support if they incorporate an essential role for individuals to make their own informed decisions and to share in decision-making responsibility, rather than having such decisions imposed on them. Accordingly:
 - a. Patients and physicians should be provided with objective and understandable information about the benefits and costs of different treatments to enable them to make informed choices, in consultation with their physicians (shared decision-making), on the best treatment options.
 - b. To encourage patients to use health care resources wisely, public and private health insurers could vary patient cost-sharing levels so that services with greater value, based on a review of the evidence, have lower cost-sharing levels than those with less value.
 - c. Although everyone should be guaranteed access to affordable, essential and evidence-based benefits, persons should be able to obtain and purchase additional health care services and coverage at their own expense. Physicians and other health care professionals should not be obligated to provide services that are unnecessary, inappropriate, harmful, and/or unproven even if the patient requests to pay for such services out-of-pocket.
9. Medical liability reforms are needed to decrease the practice of defensive medicine.
10. The resource allocation process and priority setting should be periodically reviewed to reflect evolving medical and societal values, changes in evidence, and assess for any cost shifting or other unwanted effects. (BoR 10)

HEALTH FRAUD, ABUSE, AND SELF-REFERRAL

Understanding the Fraud and Abuse Laws: Guidance for Internists

Fraud and abuse laws and their enforcement are an onerous burden on practicing internists. These laws have created an atmosphere in which physicians feel that almost all of their behavior is suspect. In particular, many physicians believe that inadvertent billing and coding errors made in the context of a complex system are being treated as fraud. The College seeks to: 1) reduce unnecessary burdens for physicians who do not engage in illegal activities and 2) prevent and punish fraud. (Understanding the Fraud and Abuse Laws: Guidance for Internists, ACP 98, reaffirmed BoR 10)

Safe Harbors and the Stark Ban

ACP strongly supports the activities of the AMA's Council on Ethical and Judicial Affairs to undertake a proactive approach to educating physicians of their ethical responsibilities regarding the self-referral issue and to aggressively investigate reports of abuse or non-compliance with the Council's opinion. ACP urges state and federal policy makers to closely evaluate the effects of the ban on self-referral to clinical laboratories on access to such services; and the effects of the Safe Harbor Regulations on reducing implicit or explicit inducements to refer, before placing additional restrictions on physician referrals to

health care entities with which physicians have a financial relationship. ACP shall continue to monitor legislative and regulatory initiatives that would further restrict physician referrals to health care entities with which physicians have a financial relationship and develop sound policy as needed. ACP shall establish priorities on protecting those health care services that are critical to the practice of internal medicine. (HoD 91; reaffirmed BoR 04)

Referrals to Facilities in Which Physicians Have a Financial Interest

ACP believes that potential conflicts of interest are an inherent and inevitable part of medical practice. Physicians must at all times make decisions on referrals and other matters based on what offers the best possible care to their patients.

Although the vast majority of physicians meet this responsibility appropriately, ACP abhors and condemns any physician who engages in activities for financial gain that do not result in the best possible care for their patients.

ACP strongly endorses the opinion of the AMA Council on Ethical and Judicial Affairs on physician referrals to entities in which they have a financial interest.

ACP supports appropriate legislation or regulation to prevent and when necessary, prosecute and impose sanctions on behavior that is contrary to the principles established in the judicial council opinion. Specifically, ACP believes that new legislation should:

1. Clearly specify instances that are unethical and illegal, including: any financial arrangement that links income generation explicitly or implicitly to the volume or revenues generated by the investor-physicians; referrals if there is no valid medical need for the referral; any arrangement that involves an explicit or implicit inducement or encouragement of physicians by the management of the entity to increase the volume of referrals to the facility; and referrals to any entity (except those specifically exempted by law) unless disclosure has been made to patients of the physician's financial interest in the facility and, to the extent practicable, a list of alternative facilities from which the goods or services can be obtained.
2. Specify certain arrangements that should be exempt from regulation under anti-kickback statutes, including: such services as those provided by physicians (or physicians in the same group) principally to their own patients (e.g. in-office laboratories and x-ray facilities); other professional and incidental services provided by physicians and their employees in the same group practice as the referring physician; ownership limited to publicly traded investment securities; sole rural providers; and physicians who are part owners of hospitals, ambulatory surgical centers and renal dialysis facilities.
3. Describe certain criteria that must be met for arrangements that are not specifically prohibited or exempted (see above) to be considered lawful under anti-kickback statutes, including: investment interests in entities, such as limited partnerships, where a bona fide opportunity to invest is made on an equal basis to people not in a position to make referrals, where disclosure has been made to a referred patient, and where payments are not related to referrals; and managing partnership interests where there is disclosure to a referred patient and where payments are not related to referrals. (HoD 88; reaffirmed BoR 04; reaffirmed BoR 15)

The In-Office Ancillary Services Exception

ACP supports the continuation of the In-Office Ancillary Services (IOAS) exception under the Stark Self-Referral laws with appropriate safeguards to address concerns over physician ownership interests

potentially contributing to unnecessary utilization. ACP recognizes that this exception enables physicians to provide convenient, onsite access to designated healthcare services (DHS) to their patients and better ensures patient adherence to recommended treatments. The exception also provides a structure that allows for increased quality oversight by the ordering physician, better care-coordination, and the potential for the provision of lower cost care compared to alternative settings (e.g. hospitals). On-site availability of laboratory, diagnostic and other services is consistent with the principles underlying Patient-Centered Medical Homes, which call for “enhanced access to care” that is “facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it.”ⁱ

The College also is aware of substantial correlational data associating physician ownership interests in referred to DHS facilities with higher, unnecessary utilization, although this does not necessarily mean that overutilization occurs in all or most physician-owned DHS facilities. ^{ii iii iv v} The large number of studies reflecting this association provides adequate support for the College to update policy to support efforts to minimize the likelihood of ownership interests contributing to inappropriate and /or unnecessary referrals. Inappropriate or unnecessary utilization have also been associated with diagnostic facilities owned by hospitals--contributing to what some have called a competitive “arms race” between hospitals trying to gain a competitive advantage by offering ever more advanced imaging services.^{vi vii viii} The preeminent public policy goal should be to make services as accessible and convenient to patients as possible, while having safeguards to ensure appropriateness of the services offered—regardless of the setting or ownership arrangement.

Therefore, ACP supports efforts by the Secretary to engage in the following specific and related processes to minimize the likelihood of ownership interests contributing to inappropriate and /or unnecessary referrals:

1. monitor utilization of high cost/high frequency diagnostic tests and procedures in practices where physicians own their own facilities,
2. provide timely educational feedback to such practices regarding utilization of defined high cost/high frequency diagnostic tests or procedures compared to practices that do not have an ownership interest in such facilities.
3. Develop procedures with input from all relevant stakeholders and through use of the Notice of Proposed Rulemaking (NPRM) process to address those practices that remain outliers after receiving educational feedback for a suitable amount of time. Such procedures may include use of appropriate use criteria, prior authorization requirements or similar processes. Any procedures used should include an appeal and exception process for those practices who believe their specific patient population or other circumstances supports their continued outlier pattern of use.

In all efforts by the Secretary to minimize the likelihood of ownership interests contributing to inappropriate and /or unnecessary referrals, the administrative burden on practices should be taken into consideration. In addition, efforts should be made to ensure that any administrative burden placed on practices does not interfere with delivering high quality, efficient patient care.

In addition, the College supports further development by national medical societies of appropriate use criteria to help ensure that diagnostic testing and other procedures are necessary and appropriate for an

individual patient's clinical condition, under all ownership arrangements. Initial emphasis for this effort should be placed on high cost elective services. Physicians should be encouraged by their professional associations to consult such appropriate use criteria when available.

The College further reaffirms its support for a transition from the current system that pays physicians mostly based on how many procedures or visits performed (traditional Fee-For-Service), to models that align payments with the value of the care provided (e.g. shared savings programs, bundled payments, patient-centered medical home, capitation). These models may remove the incentive for overutilization by placing the practice at financial risk for the services offered (although under-utilization may be a concern in such arrangements). Practices providing services within such at-risk payment models should be excluded from the monitoring procedures described above. (Approved by BOR, November, 2014)

HEALTH INFORMATION TECHNOLOGY

Electronic Health Information Exchange

1. The American College of Physicians supports the concept of safe and secure electronic HIE and advocates that clinical enterprises/entities/physicians wishing to share health information, should develop principles, procedures, and policies appropriate for electronic HIE.
2. In addition, clinical enterprises/entities/physicians should develop clear guidelines regarding the handling of shared information, as well as the potential legal, financial and workflow implications that may result from participating in such efforts.

The College anticipates that more of its members will participate in this activity and proposes the following statements to guide HIE efforts.

Technical:

A key component for health information sharing is the need to obtain consensus on the appropriate technical specifications to facilitate data exchange. Clinical entities should recognize the activities of the Health Information Technology Standards Panel (HITSP) and the American Health Information Community (AHIC) when considering the technical specifications for health information exchange. Specifically:

- Clinical entities/physicians should adopt the appropriate health information technology (HIT) standards to facilitate the transmission, receipt, and utilization of data.
- Clinical entities / physicians should use standardized terminology (controlled vocabulary, value sets) and coding standards e.g., LOINC, SNOMED, to facilitate the transmission, receipt, and utilization of data.
- Mechanisms should be in place to ensure the integrity of data during their transmission, so that data sent from one clinical entity / physician to the next is not changed en route.
- Clinical entities should develop the necessary infrastructure to support both clinical and administrative functions to improve quality and lower the costs of health care delivery.

Legal:

The electronic exchange and sharing of data should conform to appropriate Federal, state, and local legislation. Furthermore, entities engaging in HIE should have in place the necessary legal infrastructure that will guide their exchange of information. Specifically clinical entities/ physicians should:

- Advocate for the adoption of uniform Federal legislation. Until this are present, clinical entities / physicians should adhere to state regulations and licensing requirements when sending health information electronically across state lines.
- Determine their responsibilities and limitations under the physician Self-Referral, Anti- kickback, and Anti-trust laws.
- Determine whether there are any additional duties / liabilities that physicians and/or clinical entities engaging in HIE may incur by exchanging clinical information, and/or participating in HIE initiatives.
- Develop clear policies (and if necessary contracts) that specify ownership and control of data, and how to manage the data-sharing relationship. Further policies should document a process for providing appropriate access to clinical data when entities choose to terminate their data-sharing relationships.

Practice Redesign:

The ability to exchange health information has the potential to enhance coordination of care as envisioned in the patient-centered medical home model of care and of quality care measurement. Specifically:

- Clinical entities / physicians that wish to exchange and share information should encourage the development of the essential infrastructure necessary to facilitate information management and information sharing with other stakeholders in health care, where one element of the infrastructure is the electronic health record (EHR).
- Clinical entities should develop clear policies that relate to the aggregation of data and their use and release for purposes other than direct care of the patient e.g.: performance aggregation and reporting, research. Further, the collection and aggregation of relevant clinical data should be based on accepted clinical information standards and should leverage existing investments in, and use of HIT.
- Clinical entities / providers should have in place the necessary infrastructure to provide consumers with the necessary information to make more fully informed choices in their own health care.
- Attempts should be made to ensure HIE ensures the availability of clinical information at the point of care for all providers and patients.

Security & Privacy:

To facilitate HIE, administrative, technical, and physical safeguards must be in place to ensure the security, confidentiality, integrity, and availability of information, consistent with the provisions of the Health Information Portability and Accountability Act of 1996 (HIPAA) and any applicable state laws. Specifically:

- To facilitate HIE, particular attention should be paid to the following areas of security:
 1. User identification and authentication
 2. User authorization
 3. Role-based access control
 4. Transmission security
 5. Transmission of the minimum information necessary

6. Audit trail and information system activity review
7. Data encryption
- Clinical entities / physicians that share information electronically should publish:
 1. Their management plan for security incidents including reporting, sanctions, and litigation.
 2. Their policies and procedures for sharing patient data and ensuring privacy.
 3. Adhere to all relevant federal, state, local legislation and community best practices, and, where necessary, work with the appropriate legislative bodies to effect necessary changes.
- In keeping with HIPAA, patients should know what information exists about them, its purpose, who can access and use it, and where it resides. (BoR 10-06)

E-Health

General Recommendations:

1. ACP supports e-Health activities that enhance patient-physician collaborations. Potential benefits from e-Health include:
 - a. Increasing patient access to high quality healthcare through established relationships with a physician and his or her clinical team by making healthcare guidance and specific preventive, acute and chronic care available without requiring a face-to-face visit;
 - b. Improving patient-physician communication by broadening communication beyond office visits and telephone care to include other effective and convenient strategies using technology;
 - c. Improving patient satisfaction by enhancing access to high quality healthcare with his/her physicians and healthcare team;
 - d. Improving efficiency of healthcare for patients, physicians and employers through more appropriate use of resources and lowering the cost for payers;
 - e. Facilitating patient participation in healthcare decision-making and self-management.
 - f. Enabling virtual teams to contribute to enhanced patient-care processes.
2. ACP recommends that the prioritization of any e-Health activities should consider the following:
 - a. Evidence that the e-Health activity contributes to the effectiveness (“doing the right things”) and efficiency (“doing things right”) of physician workflows;
 - b. The readiness of healthcare sub-systems, e.g., hospitals and home health, to participate in those work flows;
 - c. The availability of the current infrastructure, e.g., the sophistication and usability of applications for patients and physicians, and the availability of reliable high-speed connectivity to support wide-spread adoption of the e-Health activity;
 - d. The existing and varied sets of federal and local laws and regulations that govern medical licensure and practice, and patient privacy and confidentiality with a focus on the re-evaluation and harmonization of current HIPAA regulations and local privacy regulations.
3. ACP recommends that e-Health activities address the needs of all patients without disenfranchising financially disadvantaged populations or those with low-literacy or low computer literacy. Specifically, e-Health activities need to consider the:

- a. Literacy level of all materials (including written, printed, and spoken words) provided to patients and/or families;
 - b. Affordability and availability of computer hardware and Internet access
 - c. Ease of use which includes accessible interface design and language.
- 4. ACP supports the prioritization of e-Health activities through the American Health Information Community (AHIC) and its on-going support of the development of standards that address interoperability, functionality, security, data aggregation, privacy, content, and legal liability by multi-stakeholder groups such as the Healthcare Information Technology Standards Panel, the Certification Commission for Health Information Technology and the Health Information Security
- 5. ACP recommends the reform of payment policy to appropriately compensate physicians for their investment in and ongoing use of e-Health services which can positively affect access, care coordination, patient satisfaction, value, and process and clinical outcomes.

Telemedicine and e-Visits

- 1. ACP supports the expanded use of telemedicine for those patients with an established physician relationship, to achieve fully integrated, location-independent care processes supported by care teams that are not necessarily all present at a single location at the time of a patient encounter.
- 2. ACP recommends the commitment of federal funds to promote research regarding the safety, effectiveness, and costs of telemedicine strategies, such as those currently sponsored by AHRQ.
- 3. ACP recommends the use of secure Web messaging infrastructure rather than standard email to ensure the highest levels of privacy and confidentiality that are currently available for electronic communications between physicians and their patients.
- 4. ACP recommends that physicians who use Web-messaging adopt guidelines as recommended by the American Medical Informatics Association; these guidelines provide a strategic process for email-based communications that assures privacy and confidentiality for patients and appropriate use of physicians' time.
- 5. ACP supports reimbursement for appropriately structured online communications, whether synchronous or asynchronous and whether solely text-based, or supplemented with voice, video, and/or device feeds, as this form of communication may be a clinically appropriate comparable service alternative to a face-to-face encounter.

Patient Use of Online Healthcare Information

- 1. ACP supports the development of a national process to certify for trustworthiness of content for websites that offer consumer health information.
- 2. ACP encourages physicians to assist their patients who use the Internet for health information to identify reputable sources.

3. ACP recommends that public and private payers consider reimbursement for the time and effort required to review and manage the increasing frequency and volume of patient-provided health information generated through Internet queries.

Patient Use of Patient Portals/PHRs and Access to Provider EHRs

1. ACP believes that patient portals or PHR applications provide the greatest benefit to patients when used collaboratively with physicians.
2. ACP believes that there may be value in physician review and analysis of summarized information in a patient's connected or free-standing PHR, and that an emerging responsibility may be one of periodic review, analysis, and a resulting set of actions by the physician.
3. ACP believes that payers should compensate physicians for the additional work of accepting, reviewing and validating data from a PHR, as well as the additional work of responding to this information, which may include deleting, modifying, or adding medications or other treatments (E-Health and Its Impact on Medical Practice, BoR 08)

Recommendations to Guide the Use of Telemedicine

1. 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.
 - a. ACP believes that telemedicine can be most efficient and beneficial between a patient and physician with an established, ongoing relationship.
 - b. ACP believes that telemedicine is a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area.
 - c. ACP believes that episodic, direct-to-patient telemedicine services should be used only as an intermittent alternative to a patient's primary care physician when necessary to meet the patient's immediate acute care needs.
2. ACP believes that a valid patient–physician relationship must be established for a professionally responsible telemedicine service to take place. A telemedicine encounter itself can establish a patient–physician relationship through real-time audiovisual technology. A physician using telemedicine who has no direct previous contact or existing relationship with a patient must do the following:
 - a. Take appropriate steps to establish a relationship based on the standard of care required for an in-person visit, or
 - b. Consult with another physician who does have a relationship with the patient and oversees his or her care.
3. ACP recommends that telehealth activities address the needs of all patients without disenfranchising financially disadvantaged populations or those with low literacy or low technologic literacy. In particular, telehealth activities need to consider the following:

- a. The literacy level of all materials (including written, printed, and spoken words) provided to patients or families.
 - b. Affordability and availability of hardware and Internet access.
 - c. Ease of use, which includes accessible interface design and language.
4. ACP supports the ongoing commitment of federal funds to support the broadband infrastructure needed to support telehealth activities.
5. ACP believes that physicians should use their professional judgment about whether the use of telemedicine is appropriate for a patient. Physicians should not compromise their ethical obligation to deliver clinically appropriate care for the sake of new technology adoption.
 - a. If an in-person physical examination or other direct face-to-face encounter is essential to privacy or maintaining the continuity of care between the patient's physician or medical home, telemedicine may not be appropriate.
6. ACP recommends that physicians ensure that their use of telemedicine is secure and compliant with federal and state security and privacy regulations.
7. ACP recommends that telemedicine be held to the same standards of practice as if the physician were seeing the patient in person.
 - a. ACP believes that there is a need to develop evidence-based guidelines and clinical guidance for physicians and other clinicians on appropriate use of telemedicine to improve patient outcomes.
8. ACP recommends that physicians who use telemedicine should be proactive in protecting themselves against liabilities and ensure that their medical liability coverage includes provision of telemedicine services.
9. ACP supports the ongoing commitment of federal funds to establish an evidence base on the safety, efficacy, and cost of telemedicine technologies.
10. ACP supports a streamlined process to obtaining several medical licenses that would facilitate the ability of physicians and other clinicians to provide telemedicine services across state lines while allowing states to retain individual licensing and regulatory authority.
11. ACP supports the ability of hospitals and critical access hospitals to “privilege by proxy” in accordance with the 2011 Centers for Medicare & Medicaid Services final rule allowing a hospital receiving telemedicine services (distant site) to rely on information from hospitals facilitating telemedicine services (originating site) in providing medical credentialing and privileging to medical professionals providing those services.
12. ACP 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 health professional shortage areas.
13. ACP supports reimbursement for appropriately structured telemedicine communications, whether synchronous or asynchronous and whether solely text-based or supplemented with voice, video, or device feeds in public and private health plans, because this form of communication may be a clinically appropriate service similar to a face-to-face encounter. (BoR 15)

HEALTH INSURANCE

Availability of Insurance Coverage Information to Patients

The American College of Physicians has as policy that health insurance providers and third party administrators must be required to maintain a 24-hour-a-day telephone line or other confidential electronic means of communication to provide information about specific coverage and benefits available to any patient presenting for medical care. (BoR 98, reaffirmed BoR 10)

Consumer-Directed Health Care and Health Savings Accounts (HSAs)

Recommendation #1: ACP believes that HSAs alone will not achieve the goal of universal health care access nor are they likely to have a dramatic impact on either costs or access to health care. Additional and comprehensive reforms will still be needed. HSAs should be considered as one alternative within an array of reforms intended to increase access to health care services, improve quality, and reduce costs.

Recommendation #2: ACP supports increasing the portability of health insurance, including approaches that combine new options for employees to obtain health insurance coverage that is not tied to their place of employment. However, proposals to expand coverage should not erode coverage already available in the workplace. Therefore, ACP supports making HSAs and other consumer-directed plans more available and attractive to small employers if such reforms are linked to other measures to encourage employers to maintain or expand coverage, including offering more traditional low-deductible insurance products along with HSAs. HSAs should not create new gaps in coverage by encouraging employers to terminate existing employee health benefits.

Recommendation #3: Because HSAs must be linked to high-deductible health insurance plans, protective measures should be put in place to ensure that low income patients are not forced to cut back on needed care or suffer severe financial and/or medical hardships. Safe harbor provisions for low-cost preventive and primary care services in HSA-linked high deductible plans should be expanded, as should safe harbors for prescription drugs. At the same time, safety net programs for low-income patients should be preserved and expanded, since enrollment in Medicaid, S-CHIP and other public programs would provide the greatest level of protection for those with incomes below the poverty level without the risks associated with relying on HSAs.

Recommendation #4: The federal government and other groups should continue to monitor the use of HSAs and other consumer-directed health plans on access to health insurance for people with existing health problems and people with low and moderate incomes. The effect such plans have on the ability of vulnerable populations to obtain health insurance and access to health care services should also be monitored to ensure that such groups are not indirectly harmed. Further demonstrations should be required to test the adequacy of adjustments made to the original MSA law. Elements to be especially monitored include: the problem of adverse selection; access to basic, preventive services; affordability of premiums; consumer and employer awareness and understanding of these savings options; and potential for consumers to save for future health care expenses.

Recommendation #5: ACP supports changes to increase health insurance, including, but not limited to, making HSAs more available. The College calls on Congress to continue to explore ways to enhance health insurance portability, including approaches that combine new options for employees to obtain health insurance coverage that is not tied to their place of employment. Such new options should be carefully designed to expand and improve upon existing employer-based coverage, not to erode coverage that is already available through the workplace.

Recommendation #6: Because the tax advantages of HSAs provide greater financial incentives for those

who already can best afford to purchase individual health insurance and fewer financial benefits to lower-income consumers ACP recommends that greater use of HSAs be combined with advance refundable tax credits for lower-income uninsured Americans and expansion of existing public safety net programs for the poor.

Recommendation #7: HSAs should not create a further strain on state budgets. Studies should be commissioned to study the effect of tax-sheltered HSAs on federal and state revenues.

Recommendation #8: Enrollment in an HSA should not limit a person's ability to access affordable prescription drugs. ACP should urge Congress to take action to further exempt prescription drugs from the high deductible requirements of HSAs. Establishing an HSA should not confine an account holder to limited, specific prescription drug benefits. Similarly, access to a prescription drug benefit program that is subject to a separate lower deductible than other benefits should not preclude an individual from being eligible for an HSA. This is particularly important for those most in need of prescription drug benefits, such as older individuals and those with chronic conditions.

Recommendation #9: HSAs should provide patients with incentives to select more cost-effective and higher-quality options. Employers and health insurers should provide first-dollar coverage for preventive care to encourage healthy choices and to deter people from forgoing medical care to build savings.

Recommendation #10: Since HSAs put consumers in control of the limited resources that are available for their health care, it is essential that consumers be provided with the understandable information necessary for such decision-making:

Employers, health insurers and regulators should make sure that valid and reliable information and appropriate decision-support tools are made available to facilitate informed consumer decision-making and ensure consumer protections in the marketplace;

Both public policy and private sector responses are needed to guide the development of standardized measurement, data collection, and dissemination, as well as decision support tools to assist diverse consumers to navigate an increasingly consumer-oriented health care system;

Information and decision-support tools must be accurate, accessible and understandable for consumers to use. This can include simply reducing the amount of information presented.

Recommendation #11: Consumer-directed health care proposals will require changes in the current payment system to reflect the physician's expanded role of informing and educating the patient about health care choices, economic tradeoffs, and risks involved in each decision.

Recommendation #12: HSAs should be aligned with a payment system that includes incentives that reward physicians who meet or exceed performance standards. The College supports demonstration projects to evaluate the use of incentives, including financial incentives. (BoR 04; reaffirmed BoR 15)

Insurance Reform in a Voluntary System: Implications for the Sick, the Well, and Universal Health Care

In the absence of universal coverage, carefully designed insurance reforms can make health insurance in the individual and small-group markets more affordable for those who need it most—the sick—and more secure for all subscribers. The ACP calls for specific strong reforms at both the state and federal levels.

ACP reaffirms its commitment to universal health care coverage. To that end, the College recommends reforms of the private insurance market that 1) harness the benefits of economic principles, including

competition based on price and quality but not risk selection and 2) spread risk, financing, and access broadly across communities. The College's insurance reform recommendations are put forth not as independent goals but as stepping stones along the path towards universal coverage.

The College supports guarantee-issue requirements on all insurers in all markets.

The College supports guaranteed renewal requirements on all insurers in all markets.

The College supports limits on preexisting condition clauses and exclusion waivers in both the individual and small-group markets and for those persons moving between these markets. Exclusion of coverage for a maximum of 1 year for conditions existing as long as 6 months before coverage would serve as a reasonable disincentive to remaining uninsured. As a protection against retrospective underwriting, an exclusion should not be enforceable for a condition unless the condition was actually treated during the applicable period before coverage.

Preexisting condition clauses and exclusion waivers should be prohibited altogether for previously insured persons.

The College supports requirements for standardized benefit plans, including one comprehensive plan. Insurers should make all of the plans they sell available in all markets, including voluntary purchasing pools.

The College recommends limiting premium variation to the following factors: geography, family composition, plan design, age, and group size, which should be phased out over time. Variation in age ratings should follow the Small Employer Health Insurance Availability Model Act developed by the National Association of Insurance Commissioners.

The College supports a federal minimum standard for both Market and rating reforms, based on the recommendations contained in this paper. States wishing to establish stronger standards could do so. (Insurance Reform in a Voluntary System: Implications for the Sick, the Well, and Universal Health Care, ACP 96; reaffirmed BoR 08)

Timely Payment on Claims

ACP supports legislation which requires all payers in all health care payment systems to pay physicians' clean claims promptly within thirty days of receipt of claims. (HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care

This position paper of the ACP discusses how a system of well-designed voluntary purchasing pools can help protect the integrity of health care in the emerging managed care marketplace.

Recommendation 1: Choice of health plans offered through a purchasing pool must be made by individual persons.

Recommendation 2: To provide the broadest possible choice of health plans, purchasing pools should offer all qualified health plans. If that is not done, the authority of purchasing groups to negotiate price should be limited. As an alternative, states should set a minimum threshold for the number of competing plans that must be offered, in the aggregate and by type of plan.

Recommendation 3: Purchasing pools should be as large as possible and as few as possible in a given area.

Recommendation 4: Standardize one or two benefit packages across the entire small group market—in

public state-chartered purchasing pools, in private pools such as MEWAs and employer purchasing coalitions, and outside of all pools.

Recommendation 5: Standardize community rating rules and regions, as well as other market rules, across the entire small group market. Rating factors must exclude health status and claims experience.

Recommendation 6: Allow participants in public purchasing pools to use an agent's or broker's services for enrollment and employee education but require commissions to be line-itemed separately from the pool premium so that consumers know the cost of the extra administrative service and the cost of the plan.

Recommendation 7: In a system of competing public pools, require state certification and monitoring of the pools' adherence to the same market rules to deter competition among pools based on risk selection.

Recommendation 8: Eventually, make public purchasing pools available to low-income and underserved persons. Adopt federal legislation prohibiting states from pooling Medicaid population premium costs with public purchasing pools.

Recommendation 9: Make purchasing groups accountable to the purchasers they serve—employers and consumers. Minimize political appointments to the boards of state-operated purchasing pools. Create incentives for pools to minimize in-house staff and use performance-based contracting for labor-intensive tasks.

While maintaining its commitment to universal coverage, the ACP supports the concept of voluntary purchasing pools as an incremental mechanism for 1) expanding access to small groups and individual persons, 2) reducing administrative costs, and 3) maintaining quality in a marketplace increasingly dominated by corporate managed care. The College supports federal and state initiatives that stimulate the creation of voluntary purchasing pools in every state. (Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care, ACP 95; reaffirmed BoR 06; reaffirmed BoR 17)

Small Business Pooling Arrangements and Association Health Plans (AHPs)

Recommendation #1: ACP supports federal legislation that provides small businesses with the group purchasing advantages enjoyed by larger companies, provided that such "pooling" arrangements:

Do not weaken existing federal and state consumer protection safeguards including, but not limited to, state regulations regarding fiscal soundness, prompt payment, and consumer grievance and appeals rights.

Protect enrollees against under-insurance by requiring or creating incentives for health plans offered under the pooling arrangement to provide a package of essential benefits, including coverage for preventive and primary care services.

Recommendation #2: ACP supports the creation of a federal regulatory structure to assure that all health plans, including association health plans, meet essential consumer protection and benefit requirements. Specifically, legislation to exempt AHPs from state consumer protection and benefit requirements is not desirable until an alternative federal regulatory structure is created that includes:

Enactment of a comprehensive federal patient bill of rights law to be applicable to all health plans, including AHPs.

Creation of a federal process to require or create strong market-based incentives for all health plans, including AHPs, to offer a package of essential health benefits to enrollees as approved by Congress.

Recommendation #3: ACP believes that until an adequate infrastructure to regulate insurance is established at the federal level, these responsibilities are best left to the states, which traditionally hold the authority, expertise and experience needed to regulate insurance.

Recommendation #4: Purchasing pool arrangements should be designed according to criteria likely to encourage broad membership that minimizes risk selection and maximizes choice.

Recommendation #5: In supporting proposals that promote voluntary hybrid state-employer programs, ACP supports proposals that would enable small businesses to buy into Medicaid or CHIP for coverage of their employees.

Recommendation #6: As an alternative to association health plans, ACP believes that Congress should enact legislation that includes the key “pooling” requirements in the HealthCARE Act of 2003, including:

Allowing employers with 100 or fewer employees to join together in state group purchasing arrangements to obtain coverage through a program modeled on the Federal Employee Health Benefit program

Requiring that health plans offered under such pooling arrangements meet existing federal requirements governing plans offered under the FEHBP program.

Requiring that all participating health plans offer benefits equivalent to those provided under the FEHBP.

Establishing a process for congressional approval of an essential benefit package, with requirements that all health plans offered under the pooling arrangements disclose to consumer how their benefits compare with the essential benefits package. (BoR 04; reaffirmed BoR 15)

Concurrent Care

ACP believes that appropriate recognition of all medical subspecialties in the development of concurrent care screens should be assured. ACP believes that the Centers for Medicare and Medicaid Services should instruct its carriers to distinguish (as not equivalent) internal medicine physicians from family practice and general practice physicians on its hospital concurrent care screens. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 16)

Principles on Preadmission Review Programs

ACP endorses the following AMA principles (with modifications) for preadmission review programs: All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be of an urgent and emergency nature. Blanket preadmission review of all or the majority of hospital admissions in and of itself does not improve the quality of care and should not be mandated by government, other payers or hospitals. Policies for review should be established with input from state or local physician review committees and reflect reasonable standards of medical practice. The actual review should be performed by physicians or under the close supervision of physicians with experience in rendering the care under review. Adverse decisions concerning hospital admissions should be finalized only by physician reviewers, and only after the reviewing physician has discussed the case with the attending physician. Physicians should be able to appeal adverse decisions. There should be direct and continuing communications to physicians and patients by the review organization explaining the prior authorization and preadmission review requirements. No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review, or solely on the fact that hospitalization occurred in the face of a

denial for such admissions without consideration of extenuating circumstances. When appreciable amounts of physician time or effort are involved in complying with preadmission review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. Preadmission review programs should train their personnel so they can collect the needed data, communicate any necessary information and make valid medical judgments with minimal disruption of physicians' offices. (HoD 88; reaffirmed BoR 06; reaffirmed BoR 17)

Preadmission Testing

ACP approves and supports the use of acceptable preadmission testing (PAT) and professional services wherever feasible to reduce inpatient hospital costs. Preadmission tests are those radiology and laboratory services performed within a reasonable (physician-determined) period of time preceding admission by a physician or laboratory with acceptable proficiency testing programs. (HoD 87; reaffirmed BoR 04)

ACP encourages the American Hospital Association and third-party insurance carriers to accept and promulgate the concept of preadmission testing by qualified practitioners in an out-of-hospital setting. (HoD 73; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Core Principles on Financing

1. Financing should be adequate to eliminate barriers to care. (ACP 1990; reaffirmed BoR 00)
 - a. The highest priority should go toward assuring adequate and predictable financing for “critical access” institutions and providers with a higher burden of uncompensated care, including rural and inner city hospitals, outpatient care, physicians practicing in underserved areas, community health centers, home care, rehabilitation and skilled nursing facilities, and academic medical centers. Adequate funding of such critical access institutions and providers will be particularly important until such time as affordable health insurance coverage is made available to all Americans. Durable and sustainable mechanisms to improve ease of administration should also be incorporated to enhance the economic viability of such “critical access” institutions. Adequate funding of critical access institutions should not come at the expense of diverting resources from other health care facilities and health professionals, however.
 - b. Reimbursement levels for covered services must be fair and adequate to reduce barriers to care. Mechanisms to improve ease of administration should also be included to enhance participation of physicians and others in providing services to insured populations.
 - c. Financing for public programs that provide health insurance coverage should be progressive. Individuals with higher incomes should contribute more than those with lower incomes. Explicit means-testing of programs- that is, denying access to the program for those in higher income brackets- should be discouraged. (BoR 00, reaffirmed BoR 11)

Core Principles on Patient Rights, System Accountability, and Professionalism

1. Health reform proposals should promote accountability at all levels of the system for quality, cost, access, and patient safety.
 - a. These could include incentives for physicians and other health care professionals to participate in the design of systems of accountability. Non-punitive and educational approaches should be favored over ones that rely on sanctions.

- b. Decisions on medical necessity, coverage, and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.
 - c. Innovation and improvement should be fostered (ACP 90; reaffirmed BoR 00), including innovation in use of health information technologies to improve access, quality, and health care delivery with safeguards to protect the confidentiality of medical information that is transmitted electronically.
 - d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a particular problem or perceived problem should be based on evidence of clinical effectiveness and predetermined benefits.
2. The medical profession must embrace its responsibility to participate in the development of reforms to improve the U.S. health care system.
 1. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.
 2. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation, or demographic differences. (BoR 11)

Individually Owned Health Insurance

1. ACP believes that moving to a system of individually owned insurance merits further consideration as a potential strategy for making coverage affordable for all Americans, but believes that any such approach would need to correct existing flaws in the individual insurance market in order to have a positive impact on reducing the number of uninsured Americans. Expansion of individually owned insurance could be part of an overall sequential plan that would expand coverage in stages to uninsured individuals within a defined period of time. However, expansion of individually owned insurance as part of an overall sequential plan that would increase coverage in stages to uninsured individuals, within a defined period of time, will depend on enactment of legislative reforms to correct flaws in the individual insurance market.
2. ACP believes, however, that a decision to move to a system of individual insurance must be approached very cautiously. Moving from an employer-sponsored system to one that encourages individually owned insurance will be very complex and, if done improperly, could have the unintended consequence of increasing the number of uninsured and under-insured.
3. More study and discussion is needed on how to design such a system to assure that it truly makes coverage affordable and available to all Americans, rather than creating new gaps and inequities in coverage. Federal and state law and regulations will need to be significantly changed to make an individual insurance system a viable alternative to employer-sponsored insurance. Specifically, national rules would need to be established relating to:

- minimum benefits,
- rating and under-writing practices,
- renewability,
- consumer protections and patient rights,
- health plan quality,
- marketing practices, and the
- adequacy and types of tax incentives and direct subsidies that would be made available to individuals to help them purchase insurance.

An infrastructure would need to be created to assist individuals in evaluating the health plan choices that would be available to them. In addition, policies will need to be developed to prohibit or discourage individuals from voluntarily opting out of the insurance market.

4. Until agreement is reached on the necessary changes in federal and state law and regulations that are needed to make individual insurance a viable alternative to employer-sponsored coverage, Congress should not enact abrupt changes--such as eliminating the deductibility of employer-paid health insurance premiums--that would discourage employers from providing health insurance coverage to their employees. (BoR 2001, reaffirmed 2011)

Federally Qualified Health Centers

ACP shall study promotion of further expansion of the number of Federally Qualified Health Centers so as to decrease health care disparities and improve access to and quality of care for the medically underserved. (BoR 08)

Health Insurance Consolidation

The American College of Physicians opposes consolidation of health insurance companies that significantly increase health insurer concentration and result in decreased choice and increased cost for patients and employers, reduced access due to changing and narrowing networks of physicians and hospitals and prevent physicians from negotiating over provision of health services with those insurers. (BoR 15)

HEALTH INSURANCE: BENEFITS AND COVERAGE

Individual Mandate

Recommendation 1: An individual mandate should be established only in connection with reforms to ensure that any legal resident will have access to coverage that is affordable, accessible, portable, and guaranteed, with sufficient federal funding to subsidize purchase of qualified private health insurance plans or for eligible persons to enroll in applicable public programs.

Recommendation 2 –An individual mandate should be linked to requirements that all participating health plans offer a core package of essential benefits, including preventive services. ACP recommends that an expert advisory panel, including primary care physicians, be created to recommend a core set of benefits.

Recommendation 3: Individual mandates will be most effective, and less likely to result in a hidden tax on individuals and families, if combined with a requirement that employers provide health insurance coverage or pay into a fund to provide such coverage.

Recommendation 4: Federal and/or state stakeholders should monitor and enforce an individual mandate through a comprehensive mix of methods such as review of personal income tax records, random audits, data matching, and database review. Fines for noncompliance should be fair and effective to encourage participation but compliance should not be enforced by denying access to care.

Recommendation 5: Reforms to the insurance market, including guaranteed issue and renewability, modified community rate setting, portability safeguards, and no exclusions or limitations of coverage for pre-existing conditions, are needed to ensure access to affordable coverage.

Recommendation 6: In conjunction with efforts to achieve universal health coverage and reform the nation's health care delivery system, efforts to expand and strengthen the long-term viability of the primary care physician workforce must be undertaken to ensure individuals with coverage are able to access health care when needed. (BoR 10)

Public Plan Option

1. ACP could provide conditional support to a public plan option, as part of comprehensive health care reform in the United States, based on the extent to which the plan is consistent with the following criteria:
 - a. The public plan should be required to meet the same rules and obligations as private plans within the insurance exchange.
 - b. Insurance reforms, including guaranteed issue with prohibitions against risk selection based on pre-existing conditions and modified community rating, should apply to all qualified plans offered through a health insurance exchange, public and private.
 - c. Income-related premium subsidies are provided for those who cannot afford coverage.
 - d. Both the public and private plans should adopt delivery system reforms that put primary care at the center of a patient's health care plan and establishes a reimbursement structure that incentivizes care coordination, rewards positive health outcomes, and promotes use of best practices and effective drugs and devices.
 - e. Core benefits should include coverage of evidence-based preventive services.
 - f. Safeguards are included to ensure that physician payments under a public plan are competitive with those of qualified private plans, to ensure adequate physician participation in all specialties and locations, and to ensure that flaws associated with existing Medicare payments to physicians are not carried over into a new public plan.
 - g. The public plan should be managed in a way to reduce conflicts of interest.
 - h. Participation by individual persons, physicians, and other providers in the public plan and private insurance options offered in a health insurance exchange should be voluntary. Physicians and other providers who participate in Medicare, Medicaid or other currently operating public insurance programs should not be required to participate in any other public or private insurance plan offered in a health insurance exchange.
 - i. The public plan should be required to maintain financial reserve funds similar to the those required of private insurance plans.
2. An expert advisory commission, including primary care physicians, should be created to recommend core benefits that would be required for all plans in a health insurance exchange. Plans could offer additional benefits to those covered.

3. Payment rates in a public plan should reflect efforts to improve quality, health outcomes, and cost-effectiveness using innovative models such as the patient-centered medical home. Plan payments should be consistent with the following policies:
 - a. Payments have incentives for appropriate, high-quality, efficient, coordinated, and patient-centered care, informed by pilot tests of models that have shown to be effective in improving the quality and effectiveness of care provided. Specifically, such models should:
 - i) Improve the accuracy, predictability, and appropriate valuation of primary care services and pay primary care physicians competitively with other specialties;
 - ii) Promote value and appropriate expenditures on physician services;
 - iii) Support patient-centered care and shared decision-making;
 - iv) Align incentives across the health care system;
 - v) Encourage optimal number and distribution of physicians in practice and sufficient member access to physicians in all specialties and regions;
 - vi) Support use of health information technology;
 - vii) Recognize differences in physician practice characteristics;
 - viii) Reduce existing and avoid imposing new administrative burdens on physicians except as needed to ensure program integrity.
 - ix) Not carry over the flaws in existing Medicare payment methodologies including the sustainable growth rate formula and undervaluation of primary care.
 - b. Physician payment rates by private and public insurers operating in an insurance exchange should be regularly reviewed by an advisory group, including adequate representation of primary care physicians, to the organization operating the exchange.
 - i) The group should issue an annual report with comparative data on how payment rates under the public plan compare to those from private insurers and with recommendations on updates in public plan payments to ensure that the payment rates to physicians are competitive and to ensure maximum physician participation in the public plan.
 - ii) The group should report on physician participation in the public plan by specialty, geographic locale, and other criteria as needed to ensure that enrollees in the public plan will have sufficient access to primary and specialty care.
 - iii) The group should also compare payment rates of primary care physicians with those of other specialists and recommend payment adjustments as needed to ensure that payments to primary care are competitive with other specialty choices.
 - iv) The administrator of the public plan should have the authority to change payments as needed to increase physician participation based on the recommendations of the advisory group.
4. Recommendation 4 – To mitigate conflict of interest, the health care connector and the public plan option should be managed by independent entities. (BoR 10)

Reforming the Tax Exclusion for Health Insurance

Recommendation 1: A cap on the existing income tax exclusion for employer-sponsored health insurance should be established as part of overall health care reform that provides guaranteed, affordable, sufficient and portable coverage to all Americans, without regard to health status, employment and location.

Recommendation 2: A cap on the existing income tax exclusion for health insurance should be implemented in a way that will not create incentives for employers to drop coverage.

Recommendation 3: A cap on the income tax exclusion should be set at an initial level, and updated annually, to balance several priorities: providing fair treatment to low- and moderate- income workers, creating incentives for individuals to be prudent purchasers in selection of health insurance plans, providing for reasonable growth in level of the cap—such as to reflect increases in health insurance premiums—while creating incentives for cost-effectiveness, reducing incentives for downward pressure on health benefits that could lead to under-insurance, and generating sufficient revenue to help pay for affordable health insurance coverage for all Americans.

Recommendation 4: Changes to the current income tax exclusion for ESI should recognize variations in the health status of covered individuals and regional variations in the costs of providing medical care, health insurance benefits related to collective bargaining contracts, and the experience rating of employers offering coverage. (BoR 10)

Community Rating for Health Insurance

ACP supports community rating for health insurance as the most appropriate model for commercial health insurance and opposes experience-rating in selling health insurance. The College advocates for community insurance rating in both national and state legislative forums, and encourages other medical organizations to join ACP in promoting legislation that requires community rating of health insurance policies. (BoR 09)

Coverage of Preventive Services

ACP supports and to the extent feasible, will initiate efforts to ensure that all insurers cover an appropriate range and frequency of preventive services supported by evidence-based medicine including: comprehensive examinations; clinical laboratory tests; and screening procedures, such as colonoscopy, sigmoidoscopy, and mammography. (HoD 97; reaffirmed BoR 08)

Employer Opt-Out of Benefit Requirements

1. The American College of Physician reaffirms its support for requiring all insurance plans and products—whether purchased by an individual, through a fully-insured group plan, or a self-insurance arrangement—to cover an evidence-based essential health benefit package.
 - a. All public and private health insurance plans and products should be required to encourage preventive health care by providing full coverage, with no cost-sharing, for evidence-based preventive and screening services recommended by expert advisory groups. This should include preventive services that have an A or B rating from the U.S. Preventive Services Task Force; vaccines recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by Health Resources and Services Administration (HRSA); and women’s health services based on HRSA’s guidelines for preventive care and screening related to women’s health.
2. Allowing employers to selectively opt-out of providing such evidence-based preventive and screening services would undermine essential consumer protections established by the Affordable Care Act, leading to under-insurance, poorer health outcomes and potentially discriminatory health benefit packages based on gender, socioeconomics, health status, religion, sexual orientation, or other factors.

- a. Under-insurance (insurance that lacks coverage of essential evidence-based services) is associated with poorer health outcomes.
 - b. Allowing employers to selectively opt-out of coverage would have a disproportionately adverse effect on low-income persons, because they will be less likely to have the financial resources needed to purchase such services on their own. This would exacerbate racial, ethnic and socioeconomic disparities.
 - c. Allowing employers to selectively opt-out of providing evidence-based benefits could threaten public health. For example, some employers could decide not to offer coverage of adult or childhood vaccinations, adversely affecting the health not only of individuals who would go unprotected against preventable infectious diseases, but also adversely affecting population based health outcomes (e.g. measles or influenza outbreaks).
 - d. Allowing employers to selectively opt-out of providing evidence-based benefits could result in discrimination against patients with chronic or acute diseases, contrary to the intent of the ACA. For example, a decision by an employer not to cover medications for HIV/AIDS could have a discriminatory impact on patients who have these conditions.
 - e. The College acknowledges that it does not have expertise in the constitutional questions brought by some for-profit employers that are challenging the ACA's requirement that all qualified health plans must include coverage of evidence-based preventive services. Solely from a health policy standpoint, which is within the College's expertise, the courts' rulings could have major (and potentially adverse) impact on health outcomes, if the courts rule in a way that allows employers to selectively opt-out of providing essential, evidence-based benefits, including preventive and screening services, or a positive impact on health outcomes, if the courts rule in a way that maintains the essential benefits requirements established by the ACA.
3. The American College of Physician reaffirms its support for requiring all insurance plans and products—whether purchased by an individual, through a fully-insured group plan, or a self-insurance arrangement—to cover an evidence-based essential health benefit package.
- b. All public and private health insurance plans and products should be required to encourage preventive health care by providing full coverage, with no cost-sharing, for evidence-based preventive and screening services recommended by expert advisory groups. This should include preventive services that have an A or B rating from the U.S. Preventive Services Task Force; vaccines recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by Health Resources and Services Administration (HRSA); and women's health services based on HRSA's guidelines for preventive care and screening related to women's health.

4. Allowing employers to selectively opt-out of providing such evidence-based preventive and screening services would undermine essential consumer protections established by the Affordable Care Act, leading to under-insurance, poorer health outcomes and potentially discriminatory health benefit packages based on gender, socioeconomics, health status, religion, sexual orientation, or other factors.
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 - e. The College acknowledges that it does not have expertise in the constitutional questions brought by some for-profit employers that are challenging the ACA's requirement that all qualified health plans must include coverage of evidence-based preventive services. Solely from a health policy standpoint, which is within the College's expertise, the courts' rulings could have major (and potentially adverse) impact on health outcomes, if the courts rule in a way that allows employers to selectively opt-out of providing essential, evidence-based benefits, including preventive and screening services, or a positive impact on health outcomes, if the courts rule in a way that maintains the essential benefits requirements established by the ACA. (BoR 14)

Insurers to Cover Hepatitis B Immunization

ACP supports federal legislation mandating insurance coverage for medically appropriate Hepatitis B immunization. (HoD 97; reaffirmed BoR 08)

Parity of Benefits for Physician Services for Mental and Medical Illness in All Insurance Plans

ACP opposes limitations on benefits and higher copayment/deductible payment for physician services for evaluation and management services (the 99000 CPT codes series) that are submitted with 1997 ICD-9 codes 290-320. ACP will seek legislative and/or regulatory means to require that Medicare restore its payment to physicians for evaluation and management services submitted with diagnosis codes 1997 ICD-9 codes 290-320 to the same level for evaluation and management codes for medical diagnoses.

ACP supports the ultimate parity of reimbursement for physician services for medical and psychiatric diagnoses (1997 ICD-9 codes 290-320) by all payers. (HoD 97; reaffirmed BoR 08)

Number of Medical Opinions

Managed care and other insurance benefit programs should not arbitrarily restrict the number of medical opinions a patient may obtain to address a medical problem, but that coverage or authorization of opinion should reflect criteria of medical necessity and appropriateness judged on a case by case basis. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Deductibles and Copayments

Some appropriate form of deductible and/or copayment by the patient should be a feature of any health insurance plans. (HoD 77; revised HoD 80; revised HoD 93; reaffirmed BoR 04)

Insurance Coverage of Clinical Preventive Services

ACP promotes the inclusion of clinically effective preventive services among the benefits to be provided by all private and public health insurance programs. ACP seeks appropriate reimbursement for physicians providing clinical preventive services according to the CPT-4 preventive medicine codes by all private and public health insurers. (HoD 92; reaffirmed BoR 04)

Emergency Circumstance Fee

ACP believes that all third-party carriers and the Centers for Medicare & Medicaid Services should be aware of the need to recognize and include benefits for medical services at hours which are not usual or customary and are under emergency circumstances. (HoD 73; revised HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Core Principles on Health Insurance Coverage

1. Proposals to expand access to health insurance coverage should have an explicit goal of all Americans being covered by an adequate health insurance plan by a specified date.

Sequential reforms that expand coverage to targeted groups should be considered, but such proposals should:

- a. identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage;
 - b. include a defined target date for achieving affordable coverage of all Americans; and
 - c. include an ongoing plan of evaluation. The evaluation plan should provide for an ongoing assessment by health policy experts, physicians, patients, and others of the effectiveness of the sequential reforms in expanding coverage to the targeted groups and in achieving the goal of making affordable coverage available to all Americans by the defined target date. The evaluation plan should include a process for proposing to Congress and the President further recommendations for reforms to achieve the goal of making coverage available to all Americans.
2. Achieving affordable coverage for all Americans will require that mechanisms be established to encourage individuals who otherwise might voluntarily choose not to obtain coverage to participate in the insurance pool. This implies that strong incentives will need to be created for participation or strong disincentives be created to discourage nonparticipation.
 3. Flexibility should be provided for states to investigate different approaches to expanding coverage, controlling costs, implementing insurance reforms (such as premium rating rules,

guaranteed issue/renewal, etc.), identifying funding sources, and reducing barriers to access and quality, provided that such state-based approaches contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to assure portability and access to the basic benefits package. State initiatives, while encouraged, are not a substitute for federal action when state initiatives are lacking or ineffective.

4. Mechanisms should be created to make prescription drugs more affordable. Formularies that act as a barrier to patients obtaining the best drugs available to treat their medical conditions should not be permitted. Other barriers to access to affordable prescription drugs should be identified and addressed by public policy initiatives. (BoR 00, reaffirmed 11)

Establishing Benchmarks for Reasonable Health Insurance Administrative Costs

ACP shall establish benchmarks for reasonable health insurance administrative costs and explore means for reducing and controlling such costs as well as establish guidelines on the appropriate percentage of premium that needs to be spent on patient care delivery. (BoR 09)

Requirement that Requires Healthcare Bills to be Uniform and Written so that Patients with Average Health Literacy Can Understand Them

ACP seeks federal and/or state regulation and/or legislation to require that bills for healthcare provider services and products, as well as insurance explanation of benefits, be uniform and written so that patients with average health literacy can understand them. (BoR 09)

HEALTH INSURANCE: CLAIM FORMS AND CLAIMS PROCESSING

Disclosure of Denials

ACP will seek at the national level, to require health plans or the entities which perform preauthorization review, to track and regularly publish, in a form accessible to the public and physicians, and of worth to health services researchers, information about the numbers and rates of denials of health care services, rates of denial of payment for services and of rates of reversal of denials on appeal. (HoD 97; reaffirmed BoR 10)

Evaluating the Impact of Preauthorization Programs for "Advanced Medical Imaging"

ACP will advocate for a careful and scientific evaluation of the impact of "Advanced Medical Imaging" preauthorization programs for cost savings, patient satisfaction and work of the physician office in the short and long time frame and the College encourages health plans to compensate, in the form of payment or other recognition, clinicians for the cost of preauthorization for "Advanced Medical Imaging." (BoR 08)

Evaluating the Impact of Pharmaceutical Preauthorization Programs

ACP advocates for a careful and scientific evaluation of the impact of pharmaceutical preauthorization programs for cost savings—including the cost incurred by the physician, patient satisfaction, medical outcomes, and work of the physician office in the short and long time frame and the College shall lobby Congress to mandate a non-partisan entity to conduct an evaluation of the impact on patient care and the potential for adverse medical outcomes for patients who are unable to purchase medications prescribed by their physicians and refused by their PBMs. (BoR 08)

Advocating for Compensation for Completion of Preauthorization Program Applications for Pharmaceuticals

ACP shall advocate that health plans fairly compensate, in the form of payment or other recognition, providers for the costs associated with completing preauthorizations for pharmaceuticals.(BoR 08)

Publicizing Misleading or Fraudulent Representation by Health Insurers

The College will publicize to ACP members the potential dangers of signing ambiguous forms from health insurers and highlight documented cases of misleading or fraudulent insurance practices along with the specifics of the misrepresentation; and work with the AMA and other appropriate medical societies to be certain that unclear or fraudulent representation by health insurers is brought to the attention of regulating organizations. (BoR 09)

Payment for Providing Information to Third Party Payers

ACP seeks regulations that would require third-party payers to pay costs of providing information beyond standard billing information (services provided, CPT/RVS codes, diagnosis codes, date and place of service, patient and physician identifying information). This applies to information provided on paper, by fax, or by telephone. ACP encourages national regulations for interstate payers and payers who are currently exempt from state regulation. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Medical Paperwork

ACP encourages third-party payers whenever they wish to initiate a new policy which results in a significant increase in the work-load of the physician provider (reimbursement information, disability forms, other information from medical records) to explain the reasons for such new policy in writing to representatives of practicing physicians, such as the state medical society and appropriate specialty societies such as the respective state society of internal medicine, and solicit comments from same before the institution of the policy; and to reimburse the provider for such additional information. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Standard Prescription and Procedure Forms

ACP will work with each state's legislature to require that insurers who do business in each state develop a standard prescription request form and procedure request form acceptable to all by January 2011, and that any insurance company who has not accepted these forms be banned from conducting business in the state.(BoR 10)

Adopting a Single Definition of Medical Necessity

ACP adopts the AMA's single definition of medical necessity and recommends that the AMA use appropriate administrative, legal and legislative influence, including the sponsoring of legislation, to ensure that all health plans doing business in the United States use the AMA definition of medical necessity. (BoR 10)

HEALTH WORKFORCE

Using Market Reform to Encourage Physician Primary Care

ACP supports physician workforce policy based on sound documented studies. ACP discourages arbitrary and inflexible targets. ACP continues to support adequate payment to primary care physicians to encourage needed adjustment in the physician primary care workforce. Any physician workforce policy should only affect funding and not accreditation. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 16)

Physician Workforce Legislation

ACP supports the goal of increasing the number and proportion of physicians in general internal

medicine and other generalist programs oriented towards primary care, to be achieved within a reasonable time frame.

ACP supports enactment of federal legislation to develop a national workforce policy that is consistent with the goal of increasing the number and proportion of physicians who are trained to provide primary care. Such legislation should result in the development of a workforce policy that includes recommendations on the number and mix of positions in each accredited graduate medical education (GME) program, as well as changes in payments from Medicare and other payers to assure or encourage conformity with the proposed number and mix of physicians.

In addition, such legislation should be consistent with the following principles:

A national commission (or council or board) should be appointed to develop a proposed workforce policy.

1. Physicians should be adequately represented on the commission. In particular, internists in primary care and subspecialty practice should be represented on the commission.
2. The commission should solicit the views of practicing physicians, educators, residents, medical students, accrediting bodies, and others in developing its proposed workforce policy. It should consider the quality of different training programs and the need to maintain programs with demonstrated success in recruiting, retaining, and promoting minority practitioners; and consider the need to assure the provision of primary care and other health care services to medically underserved communities.
3. The commission should publish its proposed workforce policy in draft form for public comment, prior to submitting it to the Department of Health and Human Services and/or Congress for approval and implementation.
4. The commission's workforce policy should review the number and mix of positions in each geographic region (state or other appropriate geographic area, as determined by the commission) in each accredited graduate medical education program. Mechanisms should be developed to assure or encourage conformity with the national policy. The proposed policy should explain how payments from Medicare and other payers would be eliminated or phased out for programs that are not in conformity with the national workforce policy. The commission should consider patient access, travel and availability of technological support services in each region.
5. The commission should have the flexibility to recommend a realistic timetable for achieving its workforce goals and to deviate from the 50:50 goal of generalists to other specialists, if it determines that this goal cannot or should not be achieved within the recommended timetable, provided that the policy would still result in a substantial increase in the number and proportion of physicians trained to provide primary care.
6. The commission should include recommendations to assure that a substantial number of the physicians trained to provide primary care are trained as internists.
7. The commission must assure appropriate distribution of the physician workforce. This would likely require significant increase in rural and inner-city areas.
8. The commission should develop policies that are intended to minimize disruption or interruption in the training of physicians who are already in a specialty or subspecialty training

program that may be determined to be in "excess" supply.

9. The commission should consider the contributions of internal medicine subspecialists in providing primary care and in providing services within their own subspecialty in developing its proposed workforce policy.
10. The commission should include recommendations on increasing the exposure of physicians in training to ambulatory care, including recommendations for funding training in physician offices, Area Health Education Centers, and other non-hospital settings.
11. The commission's recommendations should be submitted to Congress and/or HHS and acted upon prior to implementation. If the commission is to report only to HHS, any rule to implement the workforce policy should first be published as a proposed rule for public comment, not as a final rule.
12. The national workforce policy should be implemented by linking the amount of funding from Medicare and other payers for individual training programs to their willingness to comply with the national workforce policy.

ACP supports requiring all payers, including Medicare, to pay into a fund to support GME programs that are in compliance with the national workforce policy.

ACP strongly supports improving the economic and regulatory environment for primary care as an essential part of any effort to increase the number and proportion of physicians in primary care. Changes in funding for GME programs cannot, by themselves, produce physicians who are motivated to go into--and remain in--primary care nor locate in underserved areas if the economic and regulatory environment is in conflict with this goal.

ACP supports the development and implementation of medical school curricula which increases the exposure of students to quality ambulatory primary care training incorporating continuity of care experiences and mentoring by primary care practitioners. This can be effected via funding mechanisms that allow for education of internal medicine students and residents in primary care private practice settings. (HoD 93; reaffirmed BoR 04; revised BoR 16)

Generating More Generalists: An Agenda of Renewal for Internal Medicine

The Federated Council for Internal Medicine (FCIM) prepared this paper as part of a series designed to address specific actions that the internal medicine community must take to produce more practicing general internists in order to meet the nation's health care needs. The ACP BoR voted to approve this statement at the July 16-18, 1993 BoR meeting. Specific actions suggested for achieving the goal of generating more generalists, include:

Recommendation 1: Enhance the medical school curriculum to promote careers in general medicine. Medical school staff must take explicit steps to recognize the value of generalism by promoting professionalism and collegiality among generalists and subspecialists, by identifying and eliminating institutional bias that encourages subspecialization over generalism, and by ensuring that students have educational opportunities with practicing internists in the community. Medical schools and their departments of medicine must place a high priority on educating generalist physicians by: (1) revising the admissions process to promote the selection of students interested in general medicine; (2) revising medical school administration to recognize excellence among the general medicine faculty, investing in the professional development of the general medicine faculty, and establishing mentoring programs for interested generalist students, residents, and fellows; and (3) modifying the curriculum to make

students aware of the shortage of primary care physicians, expanding opportunities for students to experience medicine as practiced in ambulatory care settings, increasing the number of practicing internists involved in teaching medical students and collaborate with other specialty departments to enhance the primary care experiences of students.

Recommendation 2: Redesign residency training to promote a career in generalist medicine. Graduate medical education should be redirected toward the production of more general internists by: (1) enhancing the Ambulatory Care Experience so that students experience the continuity of care of patients; (2) exposing students to medical problems encountered in the practice of general internal medicine; (3) modifying the curriculum to prepare residents for practice as generalists and basing the number of internal medicine residency positions on the national or regional physician workforce needs; (4) promoting financial incentives and reimbursement policies that facilitate a career in general medicine; (5) investing resources in the creation of faculty programs to develop generalism; and (6) offering advanced training, beyond the minimum 3-year requirement, to acquire advanced clinical and research skills.

Recommendation 3: The internal medicine community should encourage the NIH and VA to fund research training in generalist medicine. (reaffirmed as amended BoR 17)

Recommendation 4: Improve the practice environment for the generalist by providing adequate reimbursement and by eliminating administrative burdens in order to encourage physicians, both in training and in active practice, to remain in internal medicine. The internal medicine community should: (1) encourage the Federal Government to decrease regulatory and administrative burdens and to provide equitable payment for internal medicine and other primary care services; and (2) promote long-term changes in government and private sector policies to provide incentives to maintain appropriate rewards for generalists and encourage the development of administrative management and clinical support systems for general internists within the practice environment. (reaffirmed as amended BoR 06; reaffirmed as amended BoR 17)

Recommendation 5: Explore the use of physician extenders as a way to foster more efficient delivery of patient care by general internists. In order to maximize the contribution of physician extenders, their function, in concert with generalists, must be precisely defined in order to assure patients access to primary care.

Recommendation 6: Provide new training opportunities and incentives for certain subspecialists to become up-to-date generalists and promote life-long learning and continuing medical education. (Federated Council for Internal Medicine, ACP 1993; reaffirmed BoR 04; reaffirmed as amended BoR 17)

Workforce Policies re: Underserved Areas

1. Leverage all appropriate government and institutional resources to produce an adequate number of primary care physicians and other clinicians who are willing to practice in underserved areas.
2. Create incentives to change medical school recruitment and education and residency training. Medical school recruitment policies, curricula, and clerkship programs must be retooled to address the health needs of medically underserved residents. Medical schools must accelerate recruitment of qualified members of minority groups, especially black and Hispanic persons, and must make changes in curricula that expose students to delivery of health care in underserved areas.

3. Provide substantial fiscal incentives to attract individual physicians and other clinicians to underserved locations.
4. Deploy financial incentives and technical assistance to safety net physicians and other clinicians who are being squeezed by reductions in public funding and competition for insured patients that have been brought on by the changing health care marketplace.
5. During a transitional period, require managed care organizations to contract with essential community physicians and other clinicians (for example, those who serve low-income populations, such as community health centers) if the managed care organizations are serving persons in underserved locations and are financed in whole or in part with federal funds.
6. Carefully scrutinize in advance all mergers, buy-outs, and conversions involving nonprofit hospitals and insurance plans by an objective representative of the public (for example, the state attorney general or an insurance commissioner) to evaluate potential effect on the communities served by these nonprofit organizations. Community participation and vigilance are necessary to ensure that charitable resources remain dedicated to maintaining the well-being of the community. (Inner-City Health Care, ACP 96; reaffirmed BoR 06; reaffirmed as amended BoR 17)

Controlling Health Care Costs: Options for Ensuring an Appropriate Physician Workforce Specialty Mix

1. Congress should charge a federal agency to convene an advisory group of experts on physician workforce. The advisory group should include representatives of national membership societies representing primary care physicians, nursing, physician assistants, and consumer and patient advocacy groups. It should also develop specific and measurable goals regarding numbers and proportions of primary care physicians and other clinicians needed to meet current and future demands for primary care, including those associated with expansions of coverage.
2. Congress should strategically lift restrictions on the number of residency training positions that Medicare can reimburse for the direct and indirect costs of graduate medical education to encourage increased opportunities for the training of physicians in primary care.
3. The federal government should design and implement policies to produce immediate, measurable increases in primary care workforce capacity and to improve the training environment for the primary health care professions.
4. Appropriations should be increased for scholarship and loan repayment programs under Title VII and the National Health Services Corps to increase the number of positions available to physicians who agree to train in a primary care specialty and complete a reasonable primary care service obligation. New pathways to eliminate debt should be created for internists, family physicians, and pediatricians who meet a service obligation in a critical shortage area or facility. (BoR 09)

Solutions to the Challenges Facing Primary Care Medicine

Establish a National Health Care Workforce Policy

1. The federal government should develop a national health care workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs and specifically to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient. General Internists, who provide long-

term, longitudinal, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly, are essential to a high functioning primary care system.

2. The federal government should establish a permanent national commission on the health care workforce to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity, including training and retaining more primary care physicians whose training is appropriate for the present and anticipated health care needs of the nation. The Commission should also recommend policies, including changes in graduate medical education funding, to achieve those targets and metrics to evaluate the success of each policy intervention.
 - a. As a preliminary target, ACP recommends that the number of Medicare-funded graduate medical education positions available each year in adult primary care specialties be increased in order to graduate 3000 additional primary care physicians each year for the next 15 years to meet the nation's anticipated health care needs (This estimate is presented as a placeholder but is not intended to substitute for a more rigorous evaluation by the commission.

Improve Training, Recruitment and Retention of Primary Care Physicians

1. The federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation with greatest need by developing or expanding programs that eliminate student debt for physicians choosing primary care linked to a reasonable service obligation in the field and creating incentives for these physicians to remain in underserved areas after completing their service obligation. This should include:
 - a. New loan repayment and medical school scholarship programs in exchange for primary care service in critical shortage health facilities with funding for 1000 awards each year for the next 15 years.
 - b. Increase funding for scholarships and loan repayment programs under Title VII for an additional 500 awards annually for the next 15 years.
 - c. Increase funding for National Health Service Corps (NHSC) scholarships and loan repayment programs for an additional 1500 awards annually for the next 15 years for primary care medicine.
 - d. New practice-entry bonus for scholarship or loan repayment award recipients who remain in underserved communities after completion of service obligation.
2. Congress should enact legislation to allow deferment of educational loans throughout the duration of training in primary care residency programs.
3. The federal government should support education and training reform in primary care by:
 - a. Providing funding to encourage medical schools and post-graduate residency training programs to improve primary care education and training through grants for:
 - i. mentorship programs
 - ii. curriculum development for primary care models
 - iii. development of materials to promote careers in primary care
 - b. Eliminating barriers to increased training time in ambulatory care settings for primary care trainees.
 - c. Increasing funding for primary care training programs under Title VII.

4. The federal government should develop public policies that support the retention of senior physicians in primary care practice, including appropriate expense reduction in medical liability insurance and other financial or administrative barriers to reduced practice load for senior physicians choosing part-time practice, and other incentives for senior physicians to stay in practice. (BoR 09)

Policy on Physician Reentry to the Workforce

1. The College supports pathways to make it easier for physicians to reenter the workforce.
2. The College supports federal funding for physicians participating in physician reentry programs in exchange for a service obligation as long as such funding does not divert funds from Graduate Medical Education or Title VII funding.

Principles on Dynamic Clinical Care Teams

Professionalism

1. Assignment of specific clinical and coordination responsibilities for a patient's care within a collaborative and multi-disciplinary clinical care team should be based on what is in the best interest of that patient,¹ matching the patient with the member(s) of the team most qualified and available at that time to personally deliver particular aspects of care and maintain overall responsibility to ensure that the clinical needs and preferences of the patient are met.
2. ACP reaffirms the importance of patients having access to a personal physician, trained in the care of the “whole person,” who has leadership responsibilities for a team of health professionals, consistent with the PCMH joint principles.
3. Dynamic teams must have the flexibility “to determine the roles and responsibilities expected of them based on shared goals and needs of the patient.”
4. Although physicians have extensive education, skills, and training that make them uniquely qualified to exercise advanced clinical responsibilities within teams, well-functioning teams will assign responsibilities to advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals for specific dimensions of care commensurate with their training and skills to most effectively serve the needs of the patient.
5. A cooperative approach including physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals in collaborative team models will be needed to address physician shortages.
6. A unique strength of multidisciplinary teams is that clinicians from different disciplines and specialties bring distinct training, skills, knowledge base, competencies, and patient care experiences to the team, which can then respond to the needs of each patient and the population it collectively serves in a patient- and family-centered manner. ,
7. The creation and sustainability of highly functioning care teams require essential competencies and skills in their members.
8. The team member who has taken on primary responsibility for the patient must accept an appropriate level of liability associated with such responsibility.

Licensure

1. The purpose of licensure must be to ensure public health and safety.
2. Licensure should ensure a level of consistency (minimum standards) in the credentialing of clinicians who provide health care services.

3. Licensing bodies should recognize that the skills, training, clinical experience, and demonstrated competencies of physicians, nurses, physician assistants, and other health professionals are not equal and not interchangeable.
4. Although one-size-fits-all standard for licensure of each clinical discipline should not be imposed on states, state legislatures should conduct an evidence-based review of their licensure laws to ensure that they are consistent with ACP policies.
5. State regulation of each clinician's respective role within a team must be approached cautiously, recognizing that teams should have the flexibility to organize themselves consistent with the principles of professionalism described previously.

Reimbursement

1. Reimbursement systems should encourage and appropriately incentivize , the organization of clinical care teams, including but not limited to Patient-Centered Medical Homes and Patient-Centered Medical Home Neighbor practices. Reimbursement and compensation should appropriately reflect the complexity of the care provided.
2. Payment systems that require the clinical care team to accept financial risk must account for differences in the risk and complexity of the patient population being treated, including adequate risk adjustment.

Research

- a. Optimal formulation, functioning, and coordination in team-based care to achieve the best outcomes for patients should be evidence-based.
- b. Efforts should be made to address the “deficiency in the availability of validated measures with strong theoretical underpinnings for team-based health care.” (BoR 13)

Reducing Administrative Tasks in Health Care

Positions from 2017 paper affirmed:

Recommendation 1: The ACP calls on stakeholders external to the physician practice or health care clinician environment who develop or implement administrative tasks (such as payers, governmental and other oversight organizations, vendors and suppliers, and others) to provide financial, time, and quality-of-care impact statements for public review and comment. This activity should occur for existing and new administrative tasks. Tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely.

Recommendation 2: Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.

Recommendation 3: Stakeholders, including public and private payers, must collaborate with professional societies, frontline clinicians, patients, and electronic health record vendors to aim for performance measures that minimize unnecessary clinician burden, maximize patient and family centeredness, and integrate the measurement of and reporting on performance with quality improvement and care delivery.

Recommendation 4: To facilitate the elimination, reduction, alignment, and streamlining of administrative tasks, all key stakeholders should collaborate in making better use of existing health information technologies, as well as developing more innovative approaches.

Recommendation 5: As the U.S. health care system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative requirements.

Recommendation 6: The ACP calls for rigorous research on the effect of administrative tasks on our health care system in terms of quality, time, and cost; physicians, other clinicians, their staff, and health care provider organizations; patient and family experience; and, most important, patient outcomes.

Recommendation 7: The ACP calls for research on best practices to help physicians and other clinicians reduce administrative burden within their practices and organizations. All key stakeholders, including clinician societies, payers, oversight entities, vendors and suppliers, and others, should actively be involved in the dissemination of these evidence-based best practices. (Putting Patients First by Reducing Administrative Tasks in Health Care, BoR 17)

HOME HEALTH SERVICES

Physician Ordering of Durable Medical Equipment and Home Health Services

1. ACP reaffirms its support for the copayment and deductible for DME and reaffirm its support for its existing policy favoring appropriate cost sharing for home health services. ACP opposes the establishment of additional cost sharing requirements for skilled nursing services that could hinder access to medically necessary services and/or encourage use of more costly inpatient care. ACP supports the federal government's efforts to prevent, investigate, and eliminate fraud and abuse associated with the supply of DME and the provision of home health and skilled nursing services, provided that such increased enforcement activities do not result in increased hassles for internists and/or result in internists unfairly being targeted for investigation for authorizing medically appropriate DME, home health, and skilled nursing services. ACP recommends that home health providers and DME suppliers document and attest to the need identified in the home for recommended DME and home health services. This documentation should be provided to the physician at the time the physician attests to the need for DME and home health services and should be made part of the permanent medical record and attached to the forms submitted to the appropriate local or regional carrier. (HoD 97; reaffirmed BoR 06)
2. ACP urges the Centers for Medicare & Medicaid Services (CMS) to require that Durable Medical Equipment and services to be provided by home health agencies and skilled nursing facilities must be ordered by the attending physician after appropriate documentation of medical necessity before such services are offered to the patient or family. Suppliers should provide to the physician the charge for all DME and home health services prior to the time the physician is required to sign the order. (HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Home-Bound Care

ACP believes that payment should be allowed for physicians' charges for his or her allied health personnel and that a physician should be reasonably reimbursed for the care and supervision of his or her home-bound patients. (HoD 82; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Unnecessary Recertification Forms

ACP urges CMS to modify its policy regarding Home Health Certification and Plan of Treatment so that recertification by the physician is not necessary for permanent or terminal conditions as judged by the physician. ACP urges CMS to examine and modify recertification requirements in other areas to accomplish the same purpose. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

HOSPITALISTS

Voluntary Choice of Inpatient Physicians (Hospitalists)

Patients along with their outpatient physicians have the right to choose their inpatient physicians within the limitations of availability and the policies of the hospital's medical staff. (BoR 98, reaffirmed BoR 10; reaffirmed BoR 12)

HOSPITALS

Hospitals to Provide All Services on a Seven Day a Week Basis

ACP encourages hospitals to provide, in collaboration with its medical staff and related healthcare professionals, the services required to meet patient needs on a 24-hour/7 –day- a- week basis. This will help ensure timely evaluation, treatment and safe discharge of patients. (HoD 96; reaffirmed BoR 06; reaffirmed BoR 12)

Controlling Health Care Costs: Certificate of Need Laws and Health Planning

1. Local, state, and regional health planning should be done to identify health care needs and to appropriately allocate resources to meet those needs. This planning should be conducted in a way that promotes public engagement in the development of the plans and subsequent adherence to them.
2. Research is needed on the effectiveness of Certificate of Need (CON) programs for reviewing proposed capital expenditures, acquisitions of major medical equipment, and new institutional facilities to reduce maldistribution and redundancy and to ensure that health care resources are best allocated in accord with health care needs. This research should include exploration of the characteristics of CON programs that have had the greatest or least beneficial impact on reducing unnecessary capacity with sufficient public support to be accepted. (BoR 09)

Inpatient Admission Criteria

The College supports the position that the decision to admit a patient into an inpatient hospital setting is a complex medical judgment which can be made only after the physician has considered a number of factors. In light of this position, the College recommends that:

1. Inpatient admission review criteria used by all payers, including Medicare, should be clear and transparent.
2. Whenever possible, these criteria should be evidence-based.
3. A physician's decision to admit a patient to an inpatient hospital setting should only be denied by a payer through a process which includes a review and confirmation by a physician and is supported by clearly documented, evidenced-based reasons.
4. All payers should have easily accessible and clearly stated reconsideration/appeal processes to review denied inpatient admissions. (BoR 12)

HOSPITALS: MEDICAL STAFF

Internist Hospital Privileges

Hospital privileges and the scope of practice in hospitals for internists, as for other physicians, should be based primarily on training and demonstrated competence.

ACP reaffirms that the delineation of privileges in any clinical department of a hospital should be a professional function of the physicians in that department and of the entire medical staff. The role of

the governing board of the hospital is to act on the recommendations for privileging by the medical staff.

ACP reaffirms its belief that all physicians supervising or participating in patient care in a hospital, including employed physicians, should be members of the organized medical staff and subject to the provisions of the hospital medical staff bylaws. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Admission to a Hospital Medical Staff

Admission to a hospital medical staff should be by an impartial review of an applicant physician's relevant qualifications. Mere membership in a closed panel HMO or other group shall not substitute for such review of the individual's qualifications. ACP members are urged to assure that their own hospital bylaws include this policy. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

HOSPITALS: MEDICAL STAFF-CREDENTIALING AND PRIVILEGES

Limitation or Cancellation of Hospital Privileges Based on Age

ACP favors delineating the professional privileges of physicians when the determination of competency is properly done by peers, and is based upon individual evaluation, without regard to chronological age.

ACP is opposed to any arbitrary rules that would cancel or limit the hospital privileges of physicians based on the chronological age of 65 or more.

Medical staff policy should include formal processes to conduct individual staff competency evaluations on a regular basis. (HoD 76; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed 12)

Privileges in Clinical Departments of Hospitals

ACP believes that the delineation of privileges in any clinical department of a hospital is a professional function of the physicians in that department and of the entire medical staff. The role of the governing board of the hospital is to affirm the existence and implementation of an effective method for delineation of privileges. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

HOSPITALS: MEDICAL STAFF-ORGANIZATION

Establishment of Separate Subspecialty Departments Distinct from Departments of Medicine

ACP believes that the integrity of departments of internal medicine should be maintained and that the establishment of separate subspecialty departments, distinct from the department of medicine, should be discouraged. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Hospital-Employed Physicians on Hospital Medical Staffs

ACP believes that all physicians supervising or participating in patient care in a hospital, including teaching positions and employed physicians, shall be members of the organized medical staff and shall be subject to the provisions of the hospital medical staff bylaws. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Hospital Governing Boards

ACP believes that the election of practicing physicians by and from the medical staff as voting members of the hospital governing board should be made a requirement for accreditation. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Opposing the Requirement that Hospitals Screen Patients for Methicillin-resistant Staphylococcus aureus (MRSA)

ACP opposes legislative requirements that hospitals screen patients for Methicillin-resistant

Staphylococcus aureus (MRSA). (BoR 10)

IMMIGRATION

Immigration

1. ACP supports expanding U.S legal residency status to refugees who are vulnerable to health consequences, including death, illness, starvation and persecution, with appropriate vetting. ACP opposes denying refugee status from persons in designated countries of origin who otherwise would meet refugee status law requirements in the United States.
2. ACP opposes policies that would broadly deny entry or re-entry to the United States for persons who currently have legal visas, including permanent residence status (green card) and student visas, based on their country of origin and/or religion. ACP is particularly concerned about the impact on medical students and foreign-born non-citizen physicians who have or will seek to have legal visas to study or provide medical care within the U.S. as authorized by current law.
3. ACP strongly opposes discrimination based on religion, race, gender or gender identity, or sexual orientation in decisions on who shall be legally admitted to the United States as a gross violation of human rights. The College reaffirms its view that practicing physicians, residents, fellows and medical students, including those of the Muslim faith, should not be subjected to discrimination and/or travel restrictions, based on their religious beliefs, and believes that this principle should broadly apply to all persons seeking legal admission to the United States.
4. ACP is concerned about the health consequences of policies that would split up families, including separating parents and children from each other. We oppose policies that would deny permanent or temporary entry to the United States to persons who otherwise would meet current law requirements for admission. Priority should be given to supporting families in all policies relating to immigration and lawful admission to the United States to live, study, or work.
5. ACP opposes deportation of undocumented medical students, residents, fellows, practicing physicians, and others who came to the United States as children due to the actions of their parents (“Dreamers”) and have or are eligible for Deferred Action for Childhood Arrivals (DACA) status. We urge the administration to preserve the DACA action taken by the previous administration until such time that Congress approves a permanent fix. The College also urges Congress to promptly enact legislation to establish a path to legal immigration status for these individuals to ensure that “Dreamers” are permanently protected from deportation. These individuals should also have access to federal student loans and other appropriate opportunities.
6. ACP supports the establishment of a path to legal immigration status for undocumented children who came to the United States due to the actions of their parents.
7. The College reaffirms its call for a national immigration policy consistent with the recommendations in its 2011 paper, National Immigration Policy and Access to Health Care. (ECBoR 17)

National Immigration Policy and Access to Health Care

Access to Care

1. Access to health care for immigrants is a national issue and needs to be addressed with a national policy. Individual state laws will not be adequate to address this national problem and will result in a patchwork solution.
2. Access to health care should not be restricted based on immigration status, and people should not be prevented from paying out-of-pocket for health insurance coverage.
3. U.S.-born children of parents who lack legal residency should have the same access to health coverage and government-subsidized health care as any other U.S. citizen.

Delivery of Care

4. National immigration policy should recognize the public health risks associated with undocumented persons not receiving medical care because of concerns about criminal or civil prosecution or deportation
 - a. Increased access to comprehensive primary care, prenatal care, injury prevention initiatives, toxic exposure prevention, and chronic disease management may make better use of the public health dollar by improving the health status of this population and alleviating the need for costly emergency care.
 - b. National immigration policy should encourage all residents to obtain clinically effective vaccinations and screening for prevalent infectious diseases.
5. The federal government should develop new and innovative strategies to support safety-net health care facilities, such as community health centers, federally qualified health centers, public health agencies, and hospitals that provide a disproportionate share of care for patients who are uninsured, covered by Medicaid, or indigent. The federal government should also continue to help offset the costs of uncompensated care provided by these facilities and continue to support the provision of emergency services. All patients should have access to appropriate outpatient care, inpatient care, and emergency services, and the primary care workforce should be strengthened to meet the nation's health care needs.

Eliminating discrimination in health care and professionalism

6. Physicians and other health care professionals have an ethical and professional obligation to care for the sick. Immigration policy should not interfere with the ethical obligation to provide care for all.
7. Immigration policies should not foster discrimination against a class or category of patients in the provision of health care.

Call for Action

ACP is calling for a national immigration policy on health care that balances:

- A. The need for a country to have control over whom it admits within its borders and to enact and implement laws designed to reduce unlawful entry.
- B. The need for the U.S. to differentiate its treatment of persons who fully comply with the law in establishing legal residency from that of persons who break the law in the determination of access to subsidized health coverage and treatment.
- C. The concern that unlawful residents may not pay state or federal income taxes but could receive care that is subsidized by legal residents who lawfully pay their income taxes.
- D. Recognition that residents who lack legal documentation are still likely to access health care services when ill, especially in emergency situations, and that hospitals have an ethical and legal obligation under Emergency Medical Treatment and Active Labor Act (EMTALA) to treat such persons, and physicians are ethically responsible to take care of them
- E. Recognition that society has a public health interest in ensuring that all residents have access to health care, particularly for communicable diseases, and that delayed treatment for both

communicable and noncommunicable diseases may be costly and can endanger the rest of the population.

- F. Recognition that persons who delay obtaining care because they cannot document legal residency are likely to generate higher health care costs that are passed onto legal residents and taxpayers, through higher premiums and higher taxes. (BoR 11)

INTERNAL MEDICINE

The Evolving Role of the Internal Medicine Specialist

ACP envisions the role of the Internal Medicine Specialist as a comprehensive provider for the health needs of adults across the delivery spectrum of health care and reaffirms several fundamental characteristics of general internists. Although several of these are features of other generalist disciplines, others distinguish the Internal Medicine Specialist from other physicians who provide comprehensive care to adults. Not every general internist actively partakes in every feature, but potential responsibilities for the evolving role of the Internal Medicine Specialist will include one or more of the following:

1. A primary care physician: the patient's first contact and a provider of comprehensive continuing evidence-based care that involves the development and maintenance of a sustained and trusting patient-physician relationship.
2. A physician who evaluates and manages all aspects of illness-biomedical and psychosocial-in the whole patient.
3. An expert in evidence-based disease prevention and management, early detection of disease, and health promotion.
4. The patient's guide and advocate in a complex health care environment.
5. An expert diagnostician who treats and manages chronically ill patients with one or multiple complex and interactive illnesses across the delivery spectrum of health care.
6. A consultant when patients have difficult, undifferentiated problems or when the general internist has special expertise to apply to their problems.
7. A resource manager and administrator of health care who is familiar with the science of clinical epidemiology and evidence-based medicine and can bring a thoughtful, cost-effective practice style to evaluation and management.
8. A clinical information manager who can take full advantage of health information technology.
9. A generalist in outlook and team leader in the healthcare environment who also possesses special skills that respond to the needs of a particular care environment.
10. An administrator, researcher, and educator who expands the medical knowledge base.
11. A leader in the area of quality improvement. (BoR 05; revised BoR 16)

Resolution Recognizing Geriatrics as a Primary Care Discipline

ACP adopted a resolution of the American Geriatric Society that had been adopted by the AMA House of Delegates. ACP recommends that:

Geriatric medicine be recognized as a primary care discipline and supports the inclusion of geriatric medicine in the AMA definition of primary care, as a means to increase training opportunities in geriatric

medicine and enhance physician education and participation in the delivery of primary care services to older adults. (American Geriatrics Society, AMA House of Delegates Resolution, ACP, 1994; reaffirmed BoR 04; reaffirmed BoR 16)

Promoting Internal Medicine

ACP encourages individual internists to participate in activities in their communities which promote the specialty of internal medicine, particularly primary care internal medicine. Such activities include providing ambulatory, office-based mentorships for medical students; offering to counsel and/or provide on-the-job experience to bright, young high school and college students with an interest in becoming physicians (such as in one's office or at high school career days or job fairs); and being a spokesperson to promote the specialty whenever possible. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 16)

Definition of Internist

Internists are physicians that specialize in the prevention, detection and treatment of illness in adults. Internal medicine physicians include specialists and subspecialists with advanced training who possess a wide variety of clinical knowledge and skills, and who are able to deliver comprehensive and consultative care to patients with various chronic and acute conditions. ACP will incorporate this definition of internists in the ACP Vision for 2015 statement and, as appropriate, in its communications and publications with interested parties, including the U.S. Congress, the American public and other advocacy organizations. (BoR 10)

LABORATORIES

Physician Office Laboratories

ACP supports and promotes the physician office laboratory that delivers laboratory testing to patients in a timely, efficient, accurate and cost-effective manner. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 08)

Proficiency Testing in Physician Office

ACP encourages its members to use appropriate quality control measures and proficiency testing in their laboratories to ensure accurate and reproducible laboratory results. (HoD 84; reinstated HoD 95; reaffirmed BoR 08)

Reimbursement for Lab Services

ACP, to avoid unnecessary burdensome documentation requirements on physicians, urges CMS to use the new coding methods as a basis for limited test-site of performance-specific, focused medical review.

ACP urges the AMA and specialty societies to pursue regulatory and legislative changes in Medicare's laboratory fee schedule to a resource-based system. (HoD 95; reaffirmed BoR 08)

Laboratory Personnel Certification Under CLIA

ACP continues to work to recategorize certain high complexity tests it believes belong in the moderate complexity category or the physician performed microscopy procedures (PPMP) category. ACP supports the recommendations made by the Clinical Laboratory Improvement Advisory Committee (CLIAC) that testing personnel who performed high complexity testing prior to September 1, 1992, should be granted a permanent "grandfather" clause and not be required to obtain an associate's degree. This grandfather clause would apply to high complexity testing personnel who worked in the field prior to the date this recommendation becomes effective in final regulations. (HoD 94; BoR 04; reaffirmed BoR 15)

Self-Referral Legislation

ACP supports an exception from the Stark II ban on self-referrals for facilities to allow physicians, who are not members of the same group practice but whose practices are in the same building, to share clinical laboratories and other in-office diagnostic facility services such as x-rays and EKGs. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Physician Office Labs in Medicare Risk Products

ACP opposes the awarding of regional contracts to reference labs for all Medicare Part B lab services. If the government pursues competitive bidding contracting, it should not be done without the guidance of a CMS-established body with adequate physician representation to provide guidelines and other standards as necessary for the implementation of such a contract program. (HoD 94; reaffirmed BoR 04)

ACP will work with the Centers for Medicare & Medicaid Services to preserve the physician office lab by ensuring that appropriate reimbursement be paid to physician office labs providing services to Medicare patients enrolled in Medicare risk products. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Shared Office Labs

ACP supports an exception from the Stark II ban on self-referral that would allow a shared office lab to be housed in a building separate from a physician's office and to bill Medicare so long as any other restrictions are met. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

CLIA Regulations

The waived category under the Clinical Laboratory Improvement Amendments (CLIA) should include simple, basic microscopic and non-microscopic tests. (ACP AMA Del A-93; reaffirmed BoR 04; reaffirmed BoR 15)

Elimination of Fee for CLIA Certificate of Waiver

ACP continues to work with the U.S. Department of Health and Human Services to ensure that the fee for the CLIA Certificate of Waiver is limited to the actual cost of issuing the certificate. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Payment for Handling or Conveyance of Specimen

Third party reimbursement for specimen collection should be sufficient to cover physician resource costs, including those costs involved in handling and conveyance of specimens and complying with increased regulatory burdens such as the OSHA regulations. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Physicians Performing Radiographs and Electrocardiograms in Offices

ACP believes that internists with competence in interpreting laboratory tests and procedures, including, but not limited to certain x-rays and electrocardiograms, should be permitted to perform such tests in their own offices, and be reimbursed fairly for doing so. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 15)

LICENSURE AND DISCIPLINE

Licensure, Relicensure

ACP opposes any legislation and/or regulation that continuing medical education as a condition of licensure or relicensure to practice medicine. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04)

Relicensure--State Legislation

Physician relicensure procedures must recognize that only physicians themselves possess the capability

to evaluate physician competence. Physician relicensure should be accomplished by utilization of appropriate medical societies to draft and supervise physician competence regulations as they deem proper in consultation and cooperation with appropriate state authorities. Efforts to develop methodologies to evaluate the quality of care provided in the physician's office will continue to be explored to replace the use of continuing medical education and didactic examinations as determinants for physician relicensure. (HoD 80; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

LONG TERM CARE

Long Term Care

ACP supports efforts to promote integration of acute and home/community-based long term care services for the elderly and disabled. Such efforts should include expansion of current federal demonstration projects and removal of administrative barriers to state experimentation in delivering long term care through integrated health systems. (HoD 96; reaffirmed BoR 08)

Regulatory Oversight of Boarding Care Facilities

ACP will monitor and support the efforts of groups, such as the Institute of Medicine, to improve the regulatory oversight of boarding care facilities in the United States and disseminate information to component sections on their recommendations. (HoD 96; reaffirmed BoR 08)

Supervision of Care of Patients in Extended Care Facilities

All care of patients in extended care facilities, including Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Residential Facilities (RF) shall be carried out only on the orders of an attending physician, or his or her designee. (HoD 95; reaffirmed BoR 08)

Physician Visits to Nursing Home Patients

ACP believes that medical necessity alone should dictate the frequency of physician visits to nursing home patients. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

"Swing Bed" Concept

ACP endorses the "swing bed" concept, where appropriate, as one solution to the shortage of skilled nursing facility beds. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Financing Long Term Care Benefits

ACP supports minimizing the impact of out-of-pocket expenses on low-income beneficiaries for new Medicare long-term care benefits. ACP believes that to enable low-income beneficiaries to purchase long-term care insurance, a sliding scale subsidy for low-income beneficiaries with incomes above the poverty level should be provided (for example, between 100-200 percent of the poverty level) to purchase long-term care insurance.

Additional funding mechanisms should be established that spread the responsibility for financing new Medicare long-term care benefits beyond the beneficiary community, such as: increasing the excise tax on alcohol and tobacco and dedicating at least a portion of the revenue for long-term care under Medicare; and imposing the Medicare payroll tax on currently exempt state and local government employees. To protect individuals from further spending down their assets, encourage private sector long-term care asset protection insurance and establish an asset protection program that waives the consideration of protected assets in determining Medicaid eligibility. Other mechanisms, such as health IRAs, may provide viable options for protecting individuals from spending down their assets. (HoD 89; reaffirmed BoR 04)

Long Term Care

ACP supports a public and private sector approach for financing long-term care that would expand Medicare coverage to include nursing home benefits after an individual either expends a "reasonable" dollar amount or stays in a nursing home for one year. To offset the increased costs to the Medicare program a copayment should be established for people with longer lengths of stay in nursing homes. ACP supports the following changes in the tax code to encourage the development and purchase of long-term care insurance: apply the same tax status to long-term care products as now exists for accidental and health insurance; allow the deductibility of insurance reserves and related investment earnings; allow the inclusion of long-term care benefits in cafeteria plans; offer tax credits for the purchase of long-term care coverage; eliminate the restrictions on the prefunding of retiree health benefits and long-term care insurance. ACP supports federal and state regulations that enhance consumer protections in the long-term care market. These regulations should assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of renewal and cancellation, requirements for sufficient reserves, and development of benefit/premium ratios. ACP supports expansion of the Medicare program to cover "reasonable" amounts of medical care in the home, adult day care and respite care to relieve a family member who is the primary caregiver. (HoD 88; reaffirmed BoR 04)

Nursing Homes

1. It is clear from CMS analysis that nursing homes must continue to receive the additional financial support provided to keep the industry stabilized and avoid the financial chaos triggered by implementation of the PPS system. ACP urges Congress to maintain adequate funding levels until a more methodical and rational approach to nursing home reimbursement can be developed that permits industry stability and avoids forcing staffing cutbacks that undermine patients' well-being.
2. ACP urges CMS to implement its retracted April 2000 proposal to "create new, higher payment categories for nursing home residents with multiple, serious health problems that require intensive care and treatment".
3. ACP urges Congress to take immediate legislative measures to address and remedy the impending crisis in skilled nursing care by addressing its root causes: inadequate reimbursement, an undersupply of qualified nursing personnel, and rapidly increasing demand created by the baby-boomer population. (BoR 02, reaffirmed as amended BoR 13)

Supporting Legislation that Requires Nationwide Criminal Background Checks for Health Care Workers

ACP supports the provisions in the federal Patient Protection and Affordable Care Act of 2010 that requires a nationwide criminal background check on applicants before hiring them into a position where they may be caring for vulnerable patients, which is referred to as a "direct patient access employee" in the law. (BoR 10)

MANAGED CARE

Physician Privileging

The ACP supports that one standard credentialing and re-credentialing form be used for healthcare plans and hospitals, and that practicing physicians should be involved in the development of the form. (BoR 00, reaffirmed 11)

Patient Protection Legislation

ACP believes that any effective patient protection legislation must:

- Apply to all insured Americans, not just those in ERISA plans.
- Require that physicians, rather than health plans, make determinations regarding the medical necessity and appropriateness of treatments. ACP supports language that defines medical necessity in terms of generally accepted principles of professional medical practice, as supported by evidence on the effectiveness of different treatments when available.
- Provide enrollees with timely access to a review process with an opportunity for independent review by an independent physician when a service is denied.
- Offer all enrollees in managed care plans a point-of-service option that will enable them to obtain care from physicians outside the health plan's network of participating health professionals, and
- Hold all health plans, including those exempt from state regulation under ERISA, accountable in a court of law for medical decisions that result in death or injury to a patient. (BoR 2-99, reaffirmed BoR 10)

Medical/Surgical and Psychiatric Service Integration and Reimbursement

The American College of Physicians (ACP) advocates for health care policies that insure access to and reimbursement for integrated medical and psychiatric care regardless of the clinical setting.

ACP advocates for standards that encourage medically necessary treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. (BoR 99, reaffirmed 11)

Appealing Managed Care Plans' Denials of Medical Care

The American College of Physicians takes an active role in encouraging the enactment of Federal laws and regulations that mandate:

1. That decisions regarding coverage that cannot be resolved by the managed care plan on the first telephone call from a physician's office must be decided promptly by an managed care plan physician, and that to do this, Managed care plans be required to have 24 hours telephone access for physician-to-physician dialogue with the ability to resolve any clinical or medical necessity issues;
2. That the managed care plan physician ultimately denying medical necessity decisions needs to be licensed in the state in which the patient is being treated and needs to be in a specialty relevant to the medical problem;
3. That an appeal of the managed care plan physician's decision needs to be heard by the managed care plan Medical Director in a time frame as determined by the urgency of the medical condition;
4. That a managed care plan will be prevented from retrospectively denying payment for services if prior approval had been obtained and the information provided by the physician was accurate. (BoR 98, revised BoR 10)

Patient Choice of Health Plans and Physicians

1. Patients must have a choice of health plans and the opportunity to voluntarily choose plans that best meet their health needs.
2. Patients should not be “locked-in” to receiving care from any one physician for an indefinite period of time but allowed the freedom to select another physician as their patient care manager if and when they choose.
3. Patients must be clearly informed in advance of any restrictions on their access to specialists that may result from their choice of alternative delivery systems. (HoD 86; reaffirmed BoR 04; reaffirmed BoR 15)

Internists’ Role in a Managed Care Setting

1. ACP supports the role of internists in providing services to patients in a managed care setting. Managed care policy and reimbursement methods should promote proper recognition of both primary care services and consultative services. (HoD 93; reaffirmed BoR 04)
2. Physicians are best suited for the role of patient care manager. The internist is an important and highly qualified component of the patient care manager system. Internists are physicians that specialize in the prevention, detection and treatment of illness in adults. Internal medicine physicians include specialists and subspecialists with advanced training who possess a wide variety of clinical knowledge and skills, and who are able to deliver comprehensive and consultative care to patients with various chronic and acute conditions. Physicians who assume the case manager function must possess broad clinical competence and appropriate training in primary care. The physicians providing case management services should be appropriately reimbursed for performing the additional management/administrative functions associated with this role. (HoD 86; reaffirmed BoR 04; reaffirmed as amended BoR 15)
3. ACP supports scope of practice legislation or designation by managed care organizations that are consistent with ACP policy that focuses on physicians’ training and expertise rather than legislative mandates or managed care policies that specifically name medical specialties as primary care physicians. (HoD 95; reaffirmed BoR 08)

Expanding Access to Internists and Internal Medicine Subspecialists

Managed care plans should permit expanded patient access to internists and internal medicine subspecialists by:

1. Giving internal medicine subspecialists and generalists the same opportunities to participate as primary care physicians for any enrolled patient who wishes to choose them, provided that they meet the same or equivalent credentialing criteria--such as demonstrated competence in all aspects of primary care.
2. Permitting internal medicine subspecialists to participate with managed care plans as primary care physicians, principal care physicians and/or consultants based on their preference if they meet the requisite credentialing criteria for each role.
3. Allowing internal medicine subspecialists listed as consultants with a health plan to act as principal care physicians for patients with conditions in their area of expertise. Health plans should consult with representatives of the internal medicine subspecialties on specific disease conditions that would qualify for principal care. Plans should not require patients to obtain authorization from a gatekeeper physician to receive services from their principal care physician

4. Health plans should evaluate the cost of subspecialist and primary care physicians by using severity-adjusted economic profiles and other measures of physician performance, rather than arbitrarily limiting subspecialists' scope of practice because of cost-effectiveness concerns. (Reinventing Managed Care: Patient Access to Internist-Subspecialists in Gatekeeper Health Plans, ASIM 95; reaffirmed BoR 08)

Definition of Principal Care Services

Principal care, that is, the predominant source of care for a patient based on his or her needs, can be provided by a primary care physician or medical specialist. In most cases, primary care physicians, with their office care team, are ideally suited to provide principal care and be a patient's care coordinator – a personal physician, in the advanced medical home model. However, a medical specialist with his or her office care team can fulfill the role of personal physician as defined in this paper if he or she so chooses. (The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care BoR 06; reaffirmed BoR 17)

Definition of Primary Care Services

ACP supports the Institute of Medicine definition of primary care as revised: the provision of integrated, accessible health care services by physicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. ACP defines the minimum set of medical services a physician must provide to be designated as a primary care physician as follows:

1. Provision of comprehensive care that is not organ- or disease-specific;
2. Periodic health maintenance exams;
3. Health counseling;
4. Ability to provide preventive services, such as immunizations and cancer screening;
5. Ability to provide terminal care;
6. Comprehensive disease management;
7. Coordination of continuum of care for acute and chronic illnesses;
8. Arrangement of consultations when appropriate;
9. Ability to provide emergent care as it presents itself in the office setting, and arrange for definitive care in a separate designated urgent care facility as necessary. (HoD 96; reaffirmed BoR 08)

Physician Credentialing

1. In consultation with practicing physicians, Managed care plans should develop a uniform, standardized credentialing process for collecting and verifying documents—including applications and credentialing questionnaires—for managed care products. Managed care and other entities should adopt these standardized credentialing materials and a uniform credentialing process.
2. Each managed care plan should evaluate the professional competence of physician applicants and panel members in a manner that is comprehensive, but not cumbersome or inordinately time consuming.
3. Managed care plans should assess physicians on the basis of education, training, experience and

demonstrated competence.

4. Managed care plans should use nationally recognized guidelines for procedural competence in assessing physicians.
5. Managed care plans should provide a fair hearing and an appeals process for applicants or panel members who have been denied participation or retention for reasons related to professional competency.
6. Each physician should have to complete the credentialing document collection process only once; other Managed care plans or contractors can share the results, with the physician's consent. Similarly, physicians should complete recredentialing documents only once every two years; other Managed care plans or contractors can share the results, with the physician's consent.
7. Physicians should have to fill out the uniform credentialing application only once. Recredentialing applications should contain a summary of the information in the credentialing file for the physician to review, verify and change as necessary.
8. Physicians who change practice location or affiliation should not have to undergo automatic recredentialing.
9. Managed care plans should recognize the services provided by any qualified *locum tenens* physician covering for physicians already on the health plan's panel, for a specified, reasonable maximum number of days per year (determined on a case-specific basis). The health plan should base payment to the covering physician on its accepted schedules or arrangements. (Reinventing Managed Care: Reducing the Managed Care Hassle Factor, ASIM 98, reaffirmed BoR 10)

Board Certification

Internal medicine board certification, by itself, should not be used to exclude or include physicians from participation in health care plans, employment opportunities, or hospital privileges. Objective criteria other than board certification should be considered to obtain a more accurate assessment of an internist's clinical judgment and competence. These criteria should include:

1. Meeting the training requirements necessary to sit for the certification examination of the American Board of Internal Medicine or American Osteopathic Association Board.
2. Completion of an ACGME or AOA approved internal medicine residency.
3. Faculty appointment in a medical school or participation in teaching residents and medical students.
4. Evidence of extensive continuing medical education (CME).
5. Appointments to peer review or quality assurance committees.
6. Evidence of a large, busy practice of satisfied patients.
7. Documentation of good standing in the medical community.
8. Clinical privileges granted by a hospital medical staff.
9. Outcome measures.

ACP continues to vigorously promote these and other criteria of clinical experience in providing quality

patient care to medical associations, managed care entities, employer groups, and accrediting organizations. (HoD 95; reaffirmed BoR 08)

Recertification

1. ACP reaffirms its commitment to lifelong learning and professional accountability through the process of recertification.
2. All pathways for recertification must meet the following criteria: relevance to a variety of practice settings, elimination of redundancy, accommodation to different learning styles and sensitivity to cost and time.
3. Whatever methods of recertification are chosen must be subject to continuous testing and validation.
4. It is the position of the ACP to encourage the maintenance of certification of subspecialists in both general internal medicine and their subspecialties and therefore continue to work with the ABIM to eliminate barriers and facilitate the process of dual recertification in both general internal medicine and the subspecialties. (BoR 02)

Physician Contracting

ACP supports federal preemption of state laws that unfairly interfere with the ability of health plans to establish the contractual conditions of participation by physicians and other providers in the plan, provided that the health plans are required to comply with federal standards to protect the interests of patients in those plans, including the requirements specified below:

1. Health plans that contract with selected physicians to furnish care should utilize selection criteria based on professional competence and quality of care and appropriate economic considerations.
2. Health plans that contract with selected providers should have an established mechanism by which any provider willing to abide by the terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan.
3. Health plans or networks should provide public notice within their geographic service areas when physician applications for participation are being accepted.
4. Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have the application judged on the basis of objective criteria that are available to both applicants and enrollees.
5. Selective contracting decisions made by any health care delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriate utilization and resources. In general, no single criterion should provide the sole basis for selecting, training, or excluding a physician from a health delivery or financing system. The projected staffing needs of the contracting entity to serve its patient population is a valid criterion that may be used for provider selection.
6. Plans should provide for review by a credentialing committee with appropriate representation of the applicant's medical specialty of all applications to participate in the plan. Any economic profiling of physicians should be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher than or lower than expected costs.

7. Plans should be prohibited from excluding practitioners with practices containing a substantial number of patients with expensive medical conditions.
8. All decisions should be on the record and the physician applicant should be provided with all reasons used if the application is denied or the contract not renewed.
9. After an initial probationary period, plans should not be allowed to include clauses in physician contracts that allow for the plan to terminate the contract “without cause.”
10. Prior to initiation of actions leading to termination of a physician’s participation contract “for cause,” the physician should be given notice specifying the grounds for termination. Physician contracts should provide for an appeal process and remedies if applicable. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Prohibition on Gag Clauses

ACP believes that no contract between a health care payer and a physician should contain any provision restricting the physician's ability to communicate information to the physician’s patient regarding medical care or treatment options for the patient when the physician deems knowledge of such information by the patient to be in the best medical interest of the patient. (HoD 96; reaffirmed BoR 08)

Availability of Physician Payment Information

1. All health insurance plans should be required to make detailed information on compensation arrangements readily available to physicians, including fee schedules, relative values and conversion factors of services, capitation arrangements, percent of premium and other physician incentive plans such as withholds and bonuses.
2. General information regarding the type of payment methodology (e.g. salary, fee-for-service, withhold/bonus, percent of premium, or capitation) from insurers to physicians for the delivery of medical services should be made available to patients upon request to the health insurance plan. (HoD 97; reaffirmed BoR 08)

Assuring Physician Reimbursement, Incentives, and Financial Risk Sharing Do Not Compromise Patient Care

1. All health plans must assume responsibility to assure that financial risk-sharing methods do not lead to compromised patient care, which capitation and other risk-sharing methods may do. The plans need to be open to proposals from physicians to restructure their capitation arrangements to reduce any potential adverse impact on patients. It is not sufficient for health plans to argue that the responsibility for assuring that appropriate care is given falls solely on the physician, when it is the health plan that determines the financial arrangement under which medical care is provided.
2. All health plans should offer stop-loss coverage to all physicians. Physicians should be required to obtain stop-loss coverage if their capitation contains risk provisions beyond the services that the physician provides (for example, sharing risk for hospital care).
3. Risk-bearing capitation payments should be based on a minimum enrolled patient population of 250 or more patients per physician. If an internist has fewer than a group average of 250 patients per plan, the internist should be compensated under a fee-for-service or a primary-care capitation payment mechanism.
4. Managed care plans that use a "gatekeeper" model should require either that patients select a primary care physician within 30 days of enrollment, or the plan will select a primary care

physician for the patient. If, for some reason, a primary care physician is not selected within this time frame, health plans that use a capitation payment mechanism must pay the primary care physician who first sees the patient a capitation payment for that patient retroactive to the enrollment date.

5. Health plans should modify the methods they use to determine capitation payments to include several factors, in addition to age and gender, that can predict use of medical care resources. Specifically, ACP recommends that health plans incorporate measures of health status and prior-year utilization.
6. Patients should be informed, at the time of enrollment, of any financial arrangements—including capitation—that place physicians at risk for the services that they provide to patients.
7. Health plans that capitate physicians should provide a fee-for-service, point-of-service option.
8. Health plans should use the most current work relative value units as found in the Medicare fee schedule methodology in determining their reimbursement mechanisms.
9. Most importantly, internists have a responsibility to do everything they can to assure that patient care is not compromised when they accept financial risk for clinical decisions.
10. Managed care contracts should include provisions to protect physicians from adverse selection when certain high-cost patients with preexisting conditions sign up with the primary care physician, (e.g., patients with active AIDS, organ transplants or end-stage renal disease). Specified high-cost patients with pre-existing conditions should be excluded from the individual capitation rate and handled on a fee-for-service or capitation carve-out basis. (Reinventing Managed Care: Assuring Appropriate Patient Care Under Capitation Arrangements, ASIM 95; reaffirmed BoR 08)
11. ACP supports changes in regulation and/or legislation so that managed care plans' financial incentives to physicians include valid outcomes measures in determining the provision of these incentives. (HoD 96; reaffirmed BoR 08)
12. ACP supports legislation requiring that physicians in capitated arrangements receive notification of insurance status of the names of eligible enrollees and non-eligible disenrollees within thirty days of such changes. Payment for eligible enrollees from all payers should be made within 30 days of enrollment, with appropriate penalties for lack of compliance in payments for all capitated patients. (HoD 96; reaffirmed BoR 08)

Physician and Health Plan Liability

1. Managed care organizations should be held responsible for assuring quality health care and be held liable for any negligence on the part of the health plan resulting in patient injury.
2. ACP will work to modify ERISA laws which prevent personal injury and wrongful death actions being brought against health plans in state courts. Deserving claimants should be allowed to bring personal injury and wrongful death cases in state courts against health plans and managed care organizations if the utilization review or preauthorization protocols influenced the provider's care and the care was a contributory cause of the injury or death. (HoD 97; reaffirmed BoR 08)
3. ACP opposes physician and physician-in-training liability in cases where they have been restricted in their treatment and referral decisions by managed care plans. (HoD 96; reaffirmed

BoR 08)

Health Plan Marketing Standards

1. ACP encourages the U.S. Congress and through the ACP component societies the legislative bodies of the respective states to enact appropriate legislation designed to prevent the use of fraudulent, deceptive and high-pressure sales tactics to enroll patients in health insurance plans, and to penalize those individuals and organizations which promote such activity. (HoD 96; reaffirmed BoR 08)
2. State and Federal standards for marketing health benefits plans must ensure that: marketing materials must not include false or materially misleading information; and sales agents do not partake in abusive enrollment procedures such as not showing potential beneficiaries the listing of covered insurance benefits. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

For-Profit Conversion of Health Care Organizations

In order to protect the general public in regard to for-profit conversion of health care organizations, ACP recommends the following:

1. Representatives of state government (e.g. state attorney general, state insurance commissioner) should oversee all for-profit conversions of health organizations.
2. Public notice and subsequent public hearings should be required prior to the approval of a for-profit conversion.
3. The health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance commissioner) overseeing the for-profit conversion.
4. For-profit conversions should be structured to prohibit private inurement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals.
5. If the establishment of a charitable foundation is required as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion.
6. The mission of a charitable foundation resulting from a for-profit conversion should reflect closely the original mission of the non-profit health care organization.
7. A designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation.
8. The level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations. Representatives of state government (e.g., state attorney general, state insurance commissioner) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions.
9. Once a charitable foundation has been established as a result of a for-profit conversion, ongoing community liaison with the foundation should occur on a regular basis (e.g., community

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advisory committees, periodic public reports).

10. There should be meaningful physician presence on the board of directors of any charitable foundation formed as a result of the conversion of a non-profit health care organization to a for-profit organization. (BoR 98, reaffirmed BoR 10)

Accountability of Medical Director

In order to ensure fairness to physicians providing care and patients receiving care through managed care plans, and to ensure that managed care medical directors are held accountable for their actions, ACP believes that the final determination of a managed care plan's denial of services or benefits based on lack of medical necessity or appropriateness must be made or reviewed by the plan's medical director, who must be fully licensed to practice medicine in the state in which the claim arose. Clear instances of poor clinical judgment on the part of the medical director, causing potential harm to a patient, should be reported to the state licensing board. (HoD 95; reaffirmed BoR 08)

Utilization Review (UR) and Utilization Management (UM)

1. UR/UM policies must never place physician financial incentives in conflict with patient welfare.
2. Physicians' adherence to evidence-based, scientifically supported practice guidelines should result in payment without excessive demands for documentation and without filing appeals. If the patient care does not comply with these guidelines, the physician should provide information to justify the claim.
3. UR/UM appeals should provide physicians with due process, including the right to review the material used to make the claims denial with the actual personnel responsible for the review.
4. Managed care plans should reveal UR/UM criteria--such as computer algorithms, screening criteria, and weighting elements--to physicians and their patients, on request.
5. Managed care plans should require preauthorization only for services for a specified procedure if there is clear evidence that: (1) Routine use of preauthorization substantially reduces the number of medically unnecessary services; and (2) The costs of conducting the preauthorization--including costs incurred by the physician's office in complying with the preauthorization requirements--do not exceed the potential savings.
6. Managed care plans should require that UR/UM personnel and processes focus on medical procedures that have a consistent pattern of overutilization, pose significant medical or financial risk to the patient, or for which there are no clear medical indications for use.
7. Managed care plans should apply uniformly the UR/UM criteria established or endorsed by a UR/UM organization or the medical community, based on sound scientific principles and the most recent medical evidence
8. Managed care plans should ensure that the UR/UM process is educational. Instead of punishing physicians or preventing appropriate care, the process should alert physicians to practices that may not be cost-effective and efficient. UR/UM should encourage physicians to examine methods for altering practices and procedures while viewing high quality patient care as their priority.
9. Managed care plans should not exclude physicians who have served as patient advocates in appealing UR/UM decisions.
10. Managed care plans should not initiate UR/UM contracts intended to deny medically necessary

services.

11. Managed care plans should not base the compensation of individuals who conduct UR/UM on the number or monetary value of care denials.
12. Managed care plans should accept a prudent layperson's assessment of an emergency condition in determining when to pay for initial screening and stabilization in the emergency room. Managed care plans should base the determination on what the patient knows at the time of seeking the emergency care, rather than on what the emergency department visit reveals.
13. With input from practicing physicians, the managed care plan industry should standardize utilization review authorization processes. (Reinventing Managed Care: Reducing the Managed Care Hassle Factor, ASIM 98)
14. All insurers requiring pre-approval for the provision of medical services (Diagnostic and/or therapeutic) must provide an approval mechanism 24 hours a day; and a physician must be available on-call 24 hours a day to review and adjudicate any denials. All insurers rejecting the provision of medical services (diagnostic and/or therapeutic) must provide the specific reason for said action at the time of rejection). (HoD 95; reaffirmed BoR 08)

Concurrent Review of Inpatient Care

ACP supports the following principles regarding utilization review entities involved in Concurrent Review of Inpatient Care provided by Managed care plans:

1. Third-party reviewers who are on site in hospitals evaluating inpatient management must submit their credentials for identification and must obtain clinical data in the hospital only under the supervision of hospital-based utilization review/quality assurance programs.
2. Medical protocols and other relevant medical review processes used in a health plan's concurrent review program should be established with appropriate involvement from physicians.
3. Professionally accepted pre-established review criteria, that is evaluated and updated periodically, should be used for concurrent review. These criteria should be evidence-based and take into account community standards.
4. The UR entity should inform, upon request, designated hospital personnel and/or the attending physician of the UR requirements. However, the UR firm should collect only that information which is necessary to certify the admission, procedure or treatment and length of stay. Copies of medical records should only be required when problems occur in certifying the medical necessity of admission or extension of stay and only pertinent sections of the medical record should be required.
5. UR organizations should make available to hospitals, physicians and other health care professionals the general contact procedures to be followed in verifying the identity of the review personnel requesting information, in calling for review and appeals information, and in registering concerns about any element of the review process. UR staff should be available through a toll free telephone number to answer such inquiries during normal business hours of the provider's time zone.
6. After hours contact procedures should be specified, as well as a means for expedited review.
7. Initial concurrent review should be conducted by trained individuals using medical and/or

benefit screening criteria established or endorsed by the UR entity in consultation with the medical community.

8. Concurrent review should be done on a targeted basis.
9. When necessary, concurrent review conducted by telephone should be supplemented by reviewer and provider examination of the patient's medical record.
10. Concurrent review should be initiated after a reasonable period of time following admission and conducted at reasonable intervals thereafter. Routine daily review of all patients should not be conducted by the UR firm. Frequency of review should be based on the patient's medical condition.
11. The attending physician and/or hospital should be informed of the length of stay certified and the next anticipated review time. Generally, routine concurrent review should not be conducted earlier than 24 hours prior to the end of the certified length of stay.
12. All review organizations must have a medical advisor, preferably licensed in the state in which the review is conducted. Decisions by the reviewer to certify additional services or continued stay should be conveyed to the attending physician by telephone or in writing within one working day of receipt of information needed to complete the review. Decisions not to certify continued stay for reasons of medical necessity should be reviewed by a physician advisor of the reviewing entity. This advisor should be available by telephone for consultation with the attending physician.
13. The attending physician should be notified as soon as possible of a denial of continued stay and given the opportunity to appeal the decision on an expedited basis. Reconsideration of the denial may also be handled through the standard appeals process.
14. A decision by the reviewing entity to uphold the denial or continued stay should be conveyed to the attending physician and/or hospital by telephone the same working day. A written confirmation of the denial should follow and include an explanation of the primary reasons for the denial and procedures to initiate further appeal, if the patient so chooses.
15. If the initial appeal is still denied after reconsideration, the attending physician should have the right to ask for additional review by another physician advisor or medical consultant of the appropriate medical specialty.
16. On-site third party reviewers should communicate all suggestions regarding patient management directly to the attending physician and should document all such actions in accord with medical staff policy. (HoD 92; reaffirmed BoR 04; reaffirmed with amendments BoR 15)

Physician Run Health Plans, Professional Accountability, and Anti-Trust Considerations

1. ACP encourages physician-led integration as the surest way to retain professional values at the core of the health care system. A physician organization should be bound first and foremost to professional values, while commercial organizations are bound to stockholders. Additionally, both evidence and logic suggests that integrated practice and professional collaboration may improve quality of life.
2. In all forms of integration, physicians should have a commitment to and a central role in accountability processes. This necessitates the involvement of physicians at the highest levels of organizational leadership, particularly in the areas of quality and utilization management, and

the collaborative involvement of all physicians in these processes. Legislation and licensing of health care delivery organizations should require physician leadership of utilization and quality management in all organizations.

3. Highly integrated practices with established quality and utilization systems are better positioned to deliver quality, cost-effective care than are loosely-knit networks or individual practices, which do not have the necessary tools.
4. In choosing any type of practice organization, physicians have the responsibility to evaluate and place a high priority on physician development and leadership of collaborative quality improvement and clinical activities and on overall physician leadership in the organization. ACP supports the right of physicians to choose any type of practice arrangement.
5. Patients have the right to full disclosure of all methods of reimbursement, quality management, and utilization review in any health care delivery organization. Legislation and licensing should require such disclosure.
6. No delivery organization, accountability process, or reimbursement structure can fully resolve the conflicts posed between economic self-interest and professional commitment to the patient's best interest. Neither purchaser demand nor regulatory oversight can stimulate the type of quality that comes from professional commitment to altruism, research, and self-improvement.
7. Professional societies have a responsibility to support physicians attempting to form integrated organizations by providing information, guidance, and referrals; by arranging support networks; and by sponsoring or financing educational programs.
8. Medical schools should include instruction on health care economics, business issues, cost-efficient practice patterns, epidemiology, population-based medicine, and evidence-based practice. Alternatively, medical schools, like the profession itself, are called on to impart a milieu that supports collaborative practice.
9. ACP, other professional organizations, universities, and government should support vigorous research of the effects of various types of integration and reimbursement structures on clinical outcomes, population-based health status measures, patient satisfaction data, and functional health status measures. (Physician-Driven Integration: A Response to the Corporatization of Medicine, ACP 96; reaffirmed BoR 08)

Establishing Strategy that Uses Anti-Trust Laws to Prevent Insurance Market Domination by One or Few Carriers

The American College of Physicians advocates that anti-trust laws be changed to prevent market domination by one or very few insurers which harm patients' freedom to choose insurers, unfairly increase costs of health care for consumers and employers, and prevent physicians from negotiating over provision of health services with those insurers. (BoR 04; reaffirmed BoR 15)

Establishing Strategy to Allow Physicians to Collectively Negotiate with Insurers

The American College of Physicians supports federal and state legislation which expressly grants physicians the ability to jointly negotiate with insurers. (BoR 04; reaffirmed BoR 16)

Supporting the Use of Physician Office Labs (POLs) in a Managed Care Setting

1. Managed care plans should reach agreement with their participating physicians on the types of laboratory tests that should be routinely made available in the physician's office--based on the

specialty of the Physician running the lab--so the appropriate tests that contribute to prompt diagnoses are available to the patient.

2. Managed care plans should not require patients to travel to a reference lab to get their tests done. Physicians should be reimbursed an adequate fee for the in-office drawing and handling of tests that are sent to a reference lab for testing.
3. Managed care plans should survey enrollees on their satisfaction with access to laboratory services and make changes in their laboratory arrangements--such as expanding access to POLs--if such surveys support a conclusion that patients prefer to have their tests done in their doctor's office.
4. Managed care plans should be willing to negotiate with individual doctors and medical group practices to expand the menu of laboratory tests that may be provided in the physicians individual POL beyond the minimum testing set necessary.
5. Managed care plans should compare the costs of tests sent to outside reference labs to POLs and allow POLs to provide laboratory tests at a competitive rate.
6. Managed care plans should address concerns about potential over-utilization of laboratory tests in POLs by using severity-adjusted and specialty-specific profiling, or by negotiating arrangements that include placing physicians at financial risk for lab tests, rather than prohibiting physicians from providing in-office tests.
7. To address quality concerns, Managed care plans should consider requiring all labs--POLs and reference labs--to participate in proficiency testing and to obtain accreditation from COLA or other accrediting organizations. (Reinventing Managed Care: Assuring Appropriate Access to Laboratory Testing for Patients in Managed Health Care Plan, ASIM 96; reaffirmed BoR 08)

Statement on Arbitrary Classifications that Restrict the Practice of Internal Medicine

The College opposes arbitrary categorizations that restrict internists from providing health care services for which they are trained and qualified to deliver. Patient access should not be limited based solely on the specialty designation of the physician. Physicians should be permitted to practice in areas for which they are appropriately trained and can demonstrate that they are currently knowledgeable and clinically competent.

The ACP maintains that physicians should be permitted to practice in areas for which they are appropriately trained and can demonstrate that they are currently knowledgeable and clinically competent. Accordingly, requirements by insurers and other third-party payers that physicians must choose between being a primary care physician and a specialist are inappropriate. (Statement on Arbitrary Classifications that Restrict the Practice of Internal Medicine, ACP 96; reaffirmed BoR 11)

Use of Board Certification

Board certification, by itself, should not be used to exclude or include physicians from participation in health care plans, employment opportunities, or hospital privileges. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Managed Behavioral Health Organizations (MBHOs)

1. Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care physicians.
2. When a patient's mental health care is managed and/or administered by an MBHO, with the

patient's permission, the primary care physician should be immediately notified and kept apprised of the patient's treatment and progress, so that the primary care physician can coordinate the patient's health care needs in optimal fashion. (BoR 00; reaffirmed BoR 11)

MANAGED CARE: MEDICAID

Monitoring

ACP supports uniform criteria for monitoring the transformation of Medicaid into state programs providing coverage through managed care plans and the impact of such changes on access and quality. Suggested criteria for monitoring and review include (1) adequacy of public notification of pending charges, (2) phased implementation allowing sufficient time for a managed care infrastructure to develop and for a smooth transition for both patients and providers, (3) sound financial underpinnings with capitated payments actuarially based on analysis of expected utilization and enrollment of the covered population, and (4) uniform standards of quality.

Medicaid Waivers for Managed Care Demonstration Projects

Criteria for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act should be that the proposed projects assist in promoting the Medicaid Act's objective of improving access to quality medical care. (ACP AMA Del I-94; reaffirmed BoR 04) ACP supports the 1115 waiver process, but urges that renewal requirements for waivers be flexible enough to provide for long-range planning with predictable and sufficient funding. (BoR 00; reaffirmed BoR 11; reaffirmed with amendments BoR 15)

State Medicaid Managed Care Programs

ACP supports:

1. State governments should demonstrate to the federal government the organizational capacity and structure sufficient to operate a Medicaid managed care program.
2. States should conduct appropriate education and outreach programs to their Medicaid populations to familiarize them with the rules of managed care. To avoid confusion on the part of recipients and providers created by automatic enrollment policies, states should be required to notify enrollees concerning any health plans to which they may be assigned and the need to use a health plan's network of providers.
3. States should establish a statewide grievance system for their Medicaid managed care program for use by enrollees and providers to report instances of fraud and abuse or unreasonable denials of care.
4. States should have the authority to impose fines, terminate enrollment and cut off payments to health care plans violating the standards of the Medicaid managed care program.
5. States should be encouraged to adopt independent enrollment brokers for their Medicaid managed care plans to remove incentives for marketing abuses.
6. State contracts with Medicaid managed care plans should include standards for accountability and management of the health plan and should include review of a health plan's medical necessity standards and preauthorization rules to ensure that the health plan's standards of care are consistent with those in the medical community.
7. Similar regulatory standards should be applied to Medicaid plans as those applied to commercial managed care plans, including accreditation by an established third party accrediting body and

licensing by a state insurance department or equivalent licensing body.

8. Rules on marketing by Medicaid managed care plans should be strengthened, including prohibitions on door-to-door canvassing in low-income areas, marketing at food stamp offices and offering gifts as incentives to join a plan.
9. Background checks should be conducted by the state on health plan owners and managers, with prohibitions against granting of an HMO license to anyone with a criminal background or deemed lacking in managed care expertise.
10. Health plans should be required to report to the appropriate state agency the salaries of plan executives and to spend at least 80 percent of their Medicaid payments on health care services and medical care.
11. Health plans should be prohibited from considering an individual's health status during the enrollment or reenrollment process or for purposes related to underwriting.
12. To alleviate problems associated with rotating enrollment, beneficiaries who join a managed care plan should be required to remain in the plan for the remainder of the plan year, after an initial 60 day trial period. (HoD 96; reaffirmed BoR 08)

MANAGED CARE: MEDICARE

Physician Contacts with Medicare-HMO Intermediaries

The American College of Physicians endorses the principle that it is inappropriate for Medicare Advantage intermediary contracts with physicians to contain any clause that would proscribe the capacity of the physician to bill another government or commercial insurance carrier such as State or Federal worker's compensation, automobile, medical, no-fault, or liability insurance – including a self insured plan. (BoR 98, reaffirmed BoR 10)

Disclosure of Information to Beneficiaries/Enrollees

ACP believes that the information described below should be disclosed to enrollees and potential enrollees prior to enrollment, at least once annually thereafter, and at any time that the managed care plan substantially modifies its established rules or policies. Managed care plans should be required to provide this information to beneficiaries written and formatted in the most easily understandable manner possible:

1. Require Managed care plans to provide beneficiaries with information written and formatted in the most easily understandable manner possible that explains:
 - a. Written rules and policies regarding benefits;
 - b. How and where to obtain services from or through the managed care plan;
 - c. Restrictions on coverage for services furnished outside the managed care plan, including the extent to which enrollees may select the providers of their choice (from within or outside the plan's network of providers if applicable), and the restrictions (if any) on payment for services furnished to the enrollees by providers other than those participating in the plan;
 - d. The obligation of the managed care plan to assume financial responsibility and to provide reasonable reimbursement for emergency services and urgently needed services;

- e. Any services other than emergency or urgently needed services that the managed care plan chooses to provide;
 - f. Premium information;
 - g. Grievance and appeal procedures including the right to address grievances to the Secretary of Health and Human Services (HHS) or the applicable review entity;
 - h. Disenrollment rights;
 - i. Any restrictions that limit coverage to prescription drugs approved by the managed care plan (i.e., drug formularies);
 - j. Any prior authorization requirements for inpatient admissions, elective procedures or referrals;
 - k. Any rules that require beneficiaries to obtain authorization from a primary care physician (PCP) to cover referrals for tests, elective procedures and specialty care; and
 - l. Any rules that limit access to clinical laboratory tests performed in participating physicians' offices.
2. Require Managed care plans to inform beneficiaries of their right to be informed about various treatment options including:
- a. The right to discuss with their physician the advisability of seeking treatment options that may not be available through the managed care plan or for which the managed care plan will not authorize coverage; and
 - b. The right to decline treatment.
3. Require managed care plans to disclose their:
- 1. Disenrollment rates for Medicare enrollees for the previous two years (excluding disenrollment due to death or moving outside of the plan's Medicare service area);
 - 2. The number and percentage of claims for payment of services for the previous two years that were denied by the plan and appealed to the Secretary of HHS, an administrative law judge, or federal court under the appeals procedures that are available to beneficiaries; and disclose the number and percentage of such denials that were reversed upon appeal.
 - 3. The number and percentage of participating providers for the prior three years whose contracts with the managed care plan were not renewed by action of the managed care plan or the provider.
 - 4. Their medical expense ratio, using a standard reporting format as required by the Secretary. A medical expense ratio represents the proportion of total revenue spent on medical services, as opposed to the proportion spent on administrative expenses, retained or distributed to owners.

Any restrictions placed on the information that participating providers are allowed to discuss with or otherwise communicate to beneficiaries.

- 1. Using a standard reporting format as required by the Secretary of HHS, require that the managed care plan provide a report card on the satisfaction of enrolled beneficiaries

and participating physicians with the plan. As a basis for preparing such report cards, require managed care plans to use a standard survey instrument (as specified by the Secretary) to survey beneficiaries and their participating physicians at least once annually on their satisfaction with the managed care plan-- including assessments by enrolled beneficiaries and by participating providers of the quality of care provided, and the ease by which beneficiaries can access needed services and obtain care from physicians who are most qualified to treat them.

2. Require managed care plans that have physician incentive plans (as defined by current regulations), provide a written disclosure--based on standard definitions and explanations as established by the Secretary of HHS--of the impact that such arrangements can have on patient care, including the financial incentives that are created for providers to provide fewer services to beneficiaries. The recently released physician incentive plan regulations need to be improved by standardizing the information that must be provided to patients, rather than leaving it to the plans to decide on the wording and content of the disclosure statements. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Congress should direct the Secretary of HHS to develop a comparative information packet on the competing managed care plans. CMS would provide the packet--upon request--to any Medicare beneficiary who is considering enrolling in a managed care plan. The types of information should include:

1. Enrollment and disenrollment rates;
2. Comparative performance on clinical, structural, and satisfaction benchmarks;
3. Access measures, including the percentage of referrals denied or unavailable;
4. Physician turnover rates;
5. Satisfaction measures (specifying those with chronic conditions) including disenrollment information;
6. Appeals and grievance procedures, including the numbers, reasons, and resolutions of grievances and appeals per managed care plan;
7. Access and quality findings from CMS monitoring surveys;
8. Information on how referrals are made, including who makes the referrals and on what basis;
9. Financial and contractual arrangements between plans and providers that may influence their decisions regarding services, in the judgment of the federal government. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96, reaffirmed BoR 08)

Choice of Physicians in Medicare Managed Care Plans

In order to assure beneficiaries' freedom to choose the physician who is best qualified to treat them, Medicare Managed care plans should meet the following standards concerning enrollee choice of physician:

- a. Enrollees should be able to select a personal physician from among all participating plan physicians.

- b. If a plan limits benefits to items and services furnished only by providers in a network of providers which have entered into a contract with the sponsor, the sponsor must also offer at the time of enrollment a Point-of-Service (POS) rider to cover items and services furnished by health professionals who are not participating providers. A supplemental premium could be charged for such a rider and cost-sharing rules imposed by the managed care plan for out-of-plan services.
- c. For the POS option, the HHS Secretary should establish an actuarially sound schedule of limits on cost sharing for out-of-plan items and services. These cost-sharing limits must be applied uniformly to all POS offerings. Cost-sharing for such items and services for lower-income enrollees should be appropriately lower than limits established by the Secretary for other enrollees and should be set at a level that would not pose an unacceptably large financial burden to obtaining out-of-network services. For purposes of cost-sharing, lower income enrollees are defined as individuals who have adjusted gross income below 250% of poverty level. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Provision of Care to Enrollees with Chronic Conditions and Special Needs

In order to assure beneficiaries--especially those with chronic conditions and special needs--have timely and convenient access to the full range of needed physician services, Medicare Managed care plans should be required to:

1. Develop and implement standards for accessibility to hospital-based services and to primary and specialty care physician services. These accessibility standards shall ensure the plan establishes and maintains adequate arrangements with a sufficient number, mix and distribution of health professionals and providers to assure that items and services are available to each enrollee in the service area of the plan; in a variety of sites of service; with reasonable promptness (including reasonable hours of operation and after-hours services); with reasonable proximity to the residence and workplace of enrollees; and in a manner that takes into account the diverse needs of enrollees and that reasonably assures continuity of care.
2. Develop and implement standards to allow for the addition of providers to meet patient needs based on increases in the number of enrollees, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.
3. Develop and implement standards to ensure that processes for coordination of care and control of costs do not create undue burdens for enrollees with special health care needs or chronic conditions. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Enrollees' Access to Urgent and Emergency Care Services

In order to assure beneficiaries have immediate access to urgent and emergency care, Medicare Managed care plans should:

1. Use a prudent layperson's assessment of what constitutes an emergency condition as one of the factors in determining when it should pay for initial screening and stabilization in the emergency room. The determination should be based on what is known by the patient at the time the emergency care is sought, rather than what is later learned as a result of the emergency department visit. Additional evaluation and treatment services should be provided consequent to a medical professional's screening, so a different standard would apply to coverage of such services.

2. Make timely decisions on requests for preauthorization of emergency and urgent care services. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Enrollees' Grievance and Appeals Rights and Procedures

Medicare Managed care plans should be required to meet the following appeals and grievance criteria:

1. As required under existing standards, the managed care plan should ensure that all enrollees receive written information about the appeals and grievance procedures at the time of enrollment. Given the findings by GAO and OIG that some Managed care plans have been violating this requirement without being sanctioned by CMS, CMS should strictly enforce this requirement and impose sanctions on plans that are not in compliance.
2. The managed care plan should review an adverse preauthorization determination upon request of the enrollee, enrollee's family or enrollee's physician--within specified time frames that would allow for a rapid determination of denials for urgent and emergency care. CMS's current standards do not include any specific requirements for timely review of emergency and urgent care. ACP proposes the following time frames:
 - a. For urgent care services, within one hour after the time of the request for such review;
 - b. For services other than emergency and urgent care, within 24 hours after the time of a request for such review.
3. The managed care plan should review an initial determination on payment of claims within 45 days after the date of a request for such review by the enrollee, enrollee's family or recipient of payment (provider), instead of the 60 days allowed under the existing standards.
4. The managed care plan should review a grievance regarding inadequate access to any physician specialist by an enrollee, the enrollee's family, or the enrollee's physician, within five business days. The current standards do not include any specific requirements on timely reviews of complaints concerning inadequate access.
5. The managed care plan should inform the parties involved with the complaint of its decision in writing. The notice should state the specific reasons for the determination and inform the enrollee and enrollee's physician of his/her right to reconsideration.
6. The managed care plan preauthorization/claims payment reviewer described in this section should be of the same or similar medical specialty as the provider of the service in question.
7. A request for a second reconsideration should be made in writing by the enrollee, enrollee's family or enrollee's physician and filed with the managed care plan or the Social Security Administration office within 60 days of the organization determination. The enrollee should request an extension if "good cause" is shown. The managed care plan should make a second reconsideration within 30 days, instead of the 60 days now allowed, and for access complaints, within five days. If the managed care plan does not reconsider in the beneficiary's favor, it should prepare a written explanation for all parties involved with the dispute and send the entire case to CMS for a determination.
8. The managed care plan should be granted an extension from the above time requirements only if the appropriate providers have not forwarded them patient records for review.
9. If the managed care plan does not act within the prescribed time period, the case should be

automatically decided in favor of the enrollee. Currently, beneficiaries are still subjected to the managed care plan's original denial of their request for payment of medical services, even when the managed care plan has failed to comply within the time frames for review in the existing standards. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Handling of Reconsidered Appeals Determinations

When a case is turned over to CMS (or its contractor) for a reconsidered determination, CMS should:

1. As required under current regulations, notify the enrollee, the enrollee's family, the enrollee's physician and the managed care plan of:
 - a. The reasons for the reconsidered determination;
 - b. The enrollee and enrollee's physician's right to a hearing if the amount in controversy is \$100 or more;
 - c. The procedure that the enrollee or enrollee's physician must follow to obtain a hearing.
2. Make a reconsidered determination within 30 days for denials of covered services, as currently required, and within five days for access complaints.
3. As required under existing standards, inform the parties involved with the complaint of its decision in writing. The notice should state the specific reasons for the determination and inform the enrollee of his/her right to a hearing for reconsideration.
4. Establish that the reconsidered determination is final and binding unless a request for a hearing is filed within 60 days of the date of the notice of reconsidered determination by the enrollee, the enrollee's family or the enrollee's physician.
5. Decide the case in favor of the enrollee if CMS or its contractor does not act within the prescribed time period (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Quality Improvement Organizations (QIOs) Review of Disputed Inpatient Lengths of Stay

Medicare should maintain its current standard requiring QIOs to immediately review disputes between the managed care plan and the patient over the length of inpatient stays (stated below):

1. A Medicare enrollee, enrollee's family or enrollee's physician who disagrees with a determination made by the managed care plan that inpatient care is no longer necessary may request immediate QIO review of the determination.
2. The enrollee may stay in the hospital until the QIO makes a determination.
3. The PRO must make a determination and notify the enrollee, the enrollee's physician, the hospital and the managed care plan by the close of business the first working day after it receives the information from the parties involved necessary to make a determination. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Standards for CMS Appeals Contractors

Any contractor used by CMS to review appeals of an managed care plan's decision to deny payment for otherwise covered services and to review beneficiary grievances should be required to meet performance standards that are comparable to those required of Medicare Part B FFS carriers, including:

1. The contractor should be required to establish state or regional advisory committees of practicing physicians that reflect various medical specialties, practice settings and geographic areas. The advisory committees should:
 - a. Review the contractor's performance on reviewing and adjudicating claims disputes;
 - b. Review newly proposed Medicare policies and policy changes as required by CMS;
 - c. Address generic managed care problems raised by CMS, the contractor, QIOs, carriers, Managed care plans, physicians or beneficiaries. However, the committee will not involve itself with individual physician disputes with an managed care plan or the contractor;
 - d. Meet with the contractor on a quarterly basis;
 - e. Make quarterly, formal reports to local and state medical associations and specialty societies.
2. The contractor should provide for timely notification and adequate opportunity for review by state medical societies and specialty societies of changes in criteria, protocols or other standards used by the contractor in making determinations about disputed claims.
3. The contractor should disclose to physicians and beneficiaries, upon request, all coding edits, medical necessity criteria, algorithms and practice guidelines used to review denials by Managed care plans. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Utilization Review (UR) Requirements for Medicare managed care plans

1. Medicare Managed care plans should establish utilization review (UR) programs with the involvement of participating physicians and release to affected health providers and enrollees the screening criteria, weighting elements and computer algorithms used in reviews and a description of the method by which these were developed.
2. Medicare Managed care plans should uniformly apply UR criteria that are based on sound scientific principles and the most recent medical evidence
3. Medicare Managed care plans should use licensed, certified or otherwise credentialed health professionals in making review determinations and, subject to safeguards outlined by the Secretary of HHS, make available upon request the names and credentials of those conducting UR.
4. Medicare Managed care plans should be explicitly prohibited from compensating individuals conducting UR based on numbers of denials.
5. Medicare Managed care plans should treat favorable preauthorization reviews as final for payment purposes unless the determination was based on fraudulent information supplied by the person requesting the determination.
6. Medicare Managed care plans should provide timely access to review personnel and, if such personnel are unavailable, waive any preauthorization that would otherwise be required. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Assuring Quality of Care--Managed Care Plan Responsibilities

In order to assure that internal and external reviews of the Quality of Care Provided by managed care plans are sufficient for beneficiaries to obtain necessary and beneficial care, Medicare managed care plans should be required to:

1. Establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians and providers that improve quality of care into:
 - a. Medical policies of the plan (such as policies relating to coverage of new technologies, treatments and procedures;
 - b. Quality and credentialing criteria of the plan;
 - c. Medical management procedures of the plan.
2. Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions.
3. Evaluate the continuity and coordination of care that enrollees receive.
4. Have mechanisms to detect both underutilization and overutilization of services.
5. Use systematic data collection of performance and patient results, provide interpretation of these data to its practitioners, and make needed changes.
6. Make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate). (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Assuring Quality of Care--CMS Responsibilities

In order to assure that internal and external reviews of the quality of care provided by Managed care plans are sufficient for beneficiaries to obtain necessary and beneficial care, CMS should:

- a. Require managed care plans to regularly report patterns of utilization of services, availability of such services and other information to track utilization, access and satisfaction of enrollees.
- b. Routinely publish comparative data collected on HMOs such as complaint rates, disenrollment rates, rates of outcomes and appeals as well as the results of its investigations or any findings of noncompliance by HMOs.
- c. Check the effectiveness of a plan's quality assurance and utilization management processes and, using trained clinical evaluators, include in that examination a systematic consideration of any QIO findings concerning the quality of the plan.
- d. Impose an appropriate level of sanctions when a significant quality deficiency is detected--until such deficiencies are rectified--such as freezing enrollment in the plan by stopping payment for new Medicare enrollees.
- e. Provide for private sector accreditation as an alternative to federal review and certification of Managed care plans, provided that a deemed accrediting body's standards are equal to or stronger than the standards outlined for managed care plans by CMS.
- f. Provide for external monitoring--by an independent, publicly accountable group--of the effectiveness of the managed care plan's internal quality improvement processes, emphasizing collaborative

efforts to improve quality rather than micromanagement. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

CMS Application of Statutory Sanctions for Sub-Standard Quality of Care

CMS should be more willing to exercise its existing statutory authority to impose sanctions uniformly against managed care plans for contractual violations that can substantially impair beneficiaries access to quality medical care. CMS should specifically use its existing authority to apply graduated levels of sanctions that would impose increasingly higher levels of sanctions on repeat violators. The types of violations that should result in imposition of sanctions include:

1. Failure to provide medically necessary services required by a beneficiary;
2. Requiring enrollees to pay excess premiums;
3. Inappropriately expelling or excluding a beneficiary from participation;
4. Denying or discouraging enrollment;
5. Falsifying information;
6. Not promptly paying claims;
7. Inappropriately terminating participating physicians. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Use of Quality Indicators Specific to a Medicare Population

1. A new set of quality indicators--developed specifically for the Medicare population--should be used to determine whether a plan is providing appropriate continuity and coordination of care.
2. An managed care plan's internal quality review criteria should ensure that the plan's quality assurance system makes appropriate use of best practices and outcomes information--both processes of care and health status measures--for older persons.
3. Medicare Managed care plans should be required to provide CMS with the clinically relevant data from which valid quality indicators can be produced.
4. Funding should be provided for research on outcomes and to develop quality measures. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Assuring Managed Care Plans are Responsive to the Needs of the Medicare Population

1. Managed care plans not currently serving older persons should be required to modify their existing policies and structure before enrolling Medicare beneficiaries.
2. Medicare Managed care plans should be required to provide ongoing training in geriatrics to their physicians and staff. In particular, plans should train their physicians in concepts of coordinated care using a multidisciplinary team with a focus on geriatric syndromes and diseases with a high prevalence in the elderly. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Measuring Patient and Physician Satisfaction

Managed care plans should be required to regularly perform surveys to determine patient and physician satisfaction. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Ongoing Medicare managed care plan Internal Monitoring System

Case-by-case review should be eliminated and replaced with a system of ongoing monitoring of practice patterns, quality improvement, and outcomes. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Physician Reimbursement, Financial Incentives, Risk-Sharing, and Avoidance of Adverse Selection

1. CMS should require M\managed care plans that pay physicians on an individual or group capitation basis must adjust their provider capitation payments to reflect the risk selection of the patients assigned to an individual participating provider, using risk adjustment methodologies as approved by the Secretary of HHS for this purpose.
2. To assure that Medicare payments to managed care plans do not create incentives for Managed care plans to discriminate against sicker patients with more complex--and costly--illnesses, the Secretary of HHS should be required to develop a methodology for adjusting Medicare and Medicaid capitation payments to managed care plans to reflect risk selection, paying less to plans attracting favorable selection and more to plans with adverse selection. In developing the methodology, the Secretary shall consider factors such as prior utilization and current health status of beneficiaries. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

CMS should require managed care plans that have financial incentive arrangements with physicians to provide adequate stop-loss coverage for physicians who are at substantial financial risk for services provided to Medicare and Medicaid enrollees. CMS's interim final rule on physician incentive plans should be improved by:

1. Reviewing the definition of "risk threshold." A 25 percent risk threshold may be too high for physicians in solo or small group practice. CMS should consider developing a graduated risk threshold based upon the size of the physician group or based upon the number of patients in the physician's or physician group's patient panel. Using a graduated risk threshold that is lower on smaller patient panels--for example, 10 percent on a solo physician or patient panels of less than 100 patients--will provide greater protection for enrollees than a 25 percent risk threshold. For larger physician groups and larger patient panels, a 25 per-cent risk threshold is more appropriate.
2. Broadening the regulatory requirement for stop-loss coverage. The initial \$10,000 stop-loss limit for patient panels less than 1,000 patients is too high to protect a solo practice or small group of physicians and their patients from unusually high medical expenses. Similarly, the higher stop-loss limits for patient panel sizes greater than 1,000 patients are too high to adequately protect physicians and their patients from random risk of unusually high medical expenses.
3. Increasing the 90 percent protection above the stop-loss limit to 100 percent; 90 percent stop-loss protection is not an adequate safeguard for patients. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Medicare Risk Contracting

ACP supports the following statements favoring improvements in the current Medicare risk contracting program:

1. revising the method of designating payment in Medicare risk contracts.

2. use of risk adjustments such as history of serious illnesses in setting payments to risk contracting plans.
3. offering beneficiaries a choice of point-of-service HMOs and POPS in addition to staff model HMOs.
4. requiring that beneficiaries be provided comparative information about all health plan choices available to them.
5. requiring that beneficiaries stay with a health plan until the next annual enrollment period (after an initial 60 day trial enrollment), thereby discontinuing the current policy that allows them to enroll or disenroll on a monthly basis.
6. requiring reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain in the traditional Medicare fee-for-service system.

requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Assessing Physician Performance in a Medicare Managed Care Plan Setting

In order to assure that the methods used by Managed care plans to assess physician performance are designed and implemented in a manner that will not compromise access and quality, Medicare Managed care plans should:

1. Involve affiliated doctors in network management, and set up--with participating provider input--provider performance evaluation measures.
2. Establish procedures for selection of health professionals based on objective standards of quality that would take into consideration suggestions by professional associations, health professionals and providers.
3. Provide for review of applicants by committees with appropriate provider representation, and written notification to provider applicants of any information indicating that the applying provider fails to meet the standards of the plan, along with an opportunity for the applicant to submit additional or corrected information.
4. Use objective criteria when taking into account economic considerations in the selection process, and make such criteria available to those professionals applying to participate.
5. Adjust economic profiling by taking into account a physician's or health professional's patient characteristics (such as severity of illness) that may lead to unusual utilization of services, and make the results of such profiling available to plan providers involved.
6. Provide potential participating providers with the plan's contracting standards and criteria.
7. Involve participating physicians in developing written policies for disciplinary action and sanctions.
8. Unless the physician poses an imminent harm to enrollees, provide:
 - a. A 90-day notice of a determination to terminate a physician contract "for cause";
 - b. An opportunity to review and discuss all the information on which the determination is based;

- c. An opportunity to submit supplemental and corrected information;
 - d. An opportunity to enter into a corrective action plan.
9. Not include in its contracts with participating physicians a provision permitting the managed care plan to terminate a contract "without cause." (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Medicare Managed Care Plan Reimbursement for Medical Education, Training, and Research

Medicare payments to capitated medical plans should accurately reflect expenses for medical education, training and research. (The Impact of Managed Care on Medical Education and Physician Workforce, ACP 96; revised BoR 08)

MEDICAID

Dual Eligibles

1. ACP supports changes in the “clawback” provisions of the Medicare Modernization Act to relieve short- and long-term financial pressures under state Medicaid programs that may occur due to the shift in dual-eligible drug coverage from state Medicaid programs to Medicare.
2. ACP believes that physicians must be provided with clearly communicated information that is detailed but user-friendly from prescription drug plans in Medicare Part D concerning what drugs will be available to Qualified Medicare Beneficiaries and at what cost.
3. ACP advocates that current minimum dollar thresholds for appealing prescription reimbursement decisions should be revised—or eliminated—and patient advocates should be permitted to help guide patients through the appeals process.
4. ACP advocates that co-payments under the Part D benefit for Qualified Medicare Beneficiaries be modified so that these co-payments are no higher than those under state Medicaid programs—with reasonable adjustments for inflation, etc.—and that QMBs not be denied prescription drug coverage when they cannot afford the co-payment. (BoR 05; reaffirmed BoR 16)

Medicaid and Health Reform

1. The Medicaid program should serve as the coverage foundation for low-income children, adults, and families regardless of categorical eligibility. Medicaid minimum eligibility standards should be uniform on a national basis and federally mandated Medicaid coverage expansions should be fully subsidized by the federal government. Further, policymakers should refrain from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.
2. Medicaid payment rates must be adequate to reimburse physicians and health care facilities for the cost of providing services, to enhance physician and other provider participation, and to assure access to Medicaid covered services. Policymakers must permanently increase payment for Medicaid primary care and other specialists’ services to at least the level of Medicare reimbursement.
3. Medicaid resources must be allocated in a prudent manner that emphasizes evidence-based care mitigates inefficiencies, waste, and fraud. Efforts to reduce fraud, abuse and waste under the Medicaid program should not create unnecessary burdens for physicians who do not engage in illegal activities.
4. In the case of long-term care, Medicaid beneficiaries should be offered more flexibility to choose among alternatives to nursing home care, such as community or home health care, since

these services could be less costly and more suitable to the individual's needs. States and the federal government should collaborate to ensure access to home and community-based long-term care services. Individuals with long-term care needs should be able to supplement their Medicaid coverage with long-term care insurance products.

5. States' efforts to reform their Medicaid programs should not result in reduced access to care for patients. Consumer-driven health care reforms established in Medicaid should be implemented with caution and consider the vulnerable nature of the patients typically served by Medicaid. A core set of comprehensive, evidence-based benefits must be provided to enrollees.
6. Federal and state stakeholders must work together to streamline and improve the Medicaid waiver process, ensuring timely approval or rejection of waiver requests and sufficient transparency to allow for public consideration and comment.
7. Medicaid should be held accountable for adopting policies and projects that improve quality of care and health status, including reducing racial and ethnic disparities and effectively managing chronic disease and mental health.
8. Congress should establish a counter-cyclical funding mechanism for Medicaid, similar to the funding mechanism for unemployment insurance, to increase the amount of federal dollars to the program during economic downturns. Substantial structural changes to Medicaid are necessary if states are to meet the needs of the nation's most vulnerable populations.
9. States and the federal government should reduce barriers to enrollment for Medicaid coverage. Efforts should be made to ease enrollment for all eligible persons, including automatic enrollment based on income. Implementation of citizenship documentation requirements should not impede access to Medicaid and CHIP for those lawfully eligible. States and the federal government should provide culturally- and linguistically-competent outreach and education to ensure understanding and enrollment of Medicaid-eligible individuals.
10. States should work to improve the physician and patient experience in dealing with the Medicaid program. Solutions should include reducing administrative barriers, and facilitating better communication and prompt pay standards between payers and physicians. Financial assistance should be provided to Medicaid-participating physicians to purchase and implement health information technology.
11. Medicaid programs should 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.
12. Medicaid program stakeholders should consider alternative financing structures to ensure solvency, high quality of care, and uninterrupted access for beneficiaries, while alleviating the program's financial pressure on states. Particularly, financing and delivery of care for dual eligible beneficiaries must be reformed.
 - a. A physician – particularly a primary care physician – should be included among the membership of the Medicaid and CHIP Access Commission. (BoR 10)

Medicaid Standards for State Waivers

ACP believes that managed care has the potential to improve quality and reduce costs of Medicaid coverage, but only if the standards that we outline below are met by states.

1. States must allow a sufficient time period so that meaningful public comments on significant aspects of Section 1115 waiver applications can be considered by the state before they are submitted to CMS.

2. Implementation must be paced to allow sufficient time for managed care infrastructure to develop and for a smooth transition for both patients, physicians, and other clinicians. (reaffirmed as amended BoR 17)
3. There must be thorough and verifiable compliance with the “Terms and Conditions” by CMS.
4. Sound financial underpinnings must be demonstrated before waiver approval. Capitated payments should be actuarially based on analysis of utilization and enrollment expectations of the covered population.
5. Uniform quality of care standards for existing Medicaid beneficiaries and newly covered insured must be a mandatory part of statewide demonstrations.
6. The ACP recommends that CMS require that utilization review criteria be disclosed to physicians and patients, that the criteria be based on reasonable, timely medical evidence, and that they be consistently applied. In addition, physicians should supervise the review decisions, including determinations of the medical appropriateness of any denial, as well as an appeals process. Finally, mechanisms should be established to evaluate the effects of the utilization review program—including provider and patient satisfaction data. (Reforming Medicaid: Essential Standards for State Waivers, ACP 95; reaffirmed BoR 06; reaffirmed BoR 17)

Medicaid Expansion: Premium Assistance and Other Options

1. Medicaid programs must develop and widely disseminate information to enrollees (and potential enrollees) that clearly explains in plain language health insurance concepts, plan rewards and penalties, provider and hospital network, and other pertinent information. Materials should be made available to meet the needs of the Medicaid population, including those with disabilities and/or limited English proficiency and literacy. States should work with independent enrollment brokers and community-based organizations, and other assistance entities to provide enrollee outreach and education and, when applicable, act as a liaison between the enrollee, insurer, and state program. State programs should work with such stakeholders to provide toll-free help lines, face to-face counseling, electronic communication and other ways to access Medicaid information, education materials, and enrollment assistance.
2. At a minimum, Medicaid expansion waivers should provide coverage of the essential health benefit package, nonemergency transportation, Early and Periodic Screening and Diagnostic and Treatment benefits, mental health parity, and other benefits required of Alternative Benefit Plans.
3. Medicaid premiums and cost-sharing should be structured in a way that does not discourage enrollment or cause enrollees to disenroll or delay or forgo care due to cost, especially those with chronic disease. If costsharing is applied it should be done in a manner that encourages enrollees to seek high-value services and health care physicians and other health care professionals. Medicaid enrollees should not be restricted from reenrolling in coverage (i.e., locked-out). Medicaid out-of-pocket costs should remain nominal and be subject to a cap (such as no higher than 5% of family income) for those with incomes above the poverty line.
4. Work-related or job search activities should not be a condition of eligibility for Medicaid. Assistance in obtaining employment, such as through voluntary enrollment in skills- and interview-training programs, can appropriately be made available provided that is not a requirement for Medicaid eligibility.

5. Medicaid wellness programs should be structured in a manner that monitors health status and encourages healthy behavior through positive incentive-based programs. Punitive approaches that penalize enrollees for not achieving better health status, or for not changing unhealthy behaviors, should be avoided. Applicable programs should adhere to the recommendations established in the ACP policy paper “Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond.” (BoR 16)

MEDICAL EDUCATION

Fellowship Start Date

The American College of Physicians supports a one week separation between residency completion and fellowship initiation. (BoR 04; reaffirmed BoR 16)

United States Medical Licensure Exam Step II Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensure Exam Part II Clinical Skills Exam

The American College of Physicians encourages all medical schools to adjust their student financial aid budgets to reflect all relevant costs incurred by the student to complete the United States Medical Licensure Exam (USMLE) Step II Clinical Skills Exam and/or Comprehensive Osteopathic Medical Licensure Exam (COMPLEX) Part II Clinical Skills Exam. (BoR 04; reaffirmed BoR 16)

Women’s Health Training

ACP supports efforts to improve formal training in women’s health issues in internal medicine training programs in the United States. ACP actively promotes internal medicine as ideally suited to providing comprehensive women’s health care. (HoD 97; reaffirmed BoR 08)

Geriatrics

ACP believes that the treatment of the elderly is an integral part of the practice of internal medicine. ACP endorses recognition of geriatrics and clinical gerontology as part of the academic discipline of internal medicine. ACP supports additional emphasis on the unique aspects of the geriatric patient at all levels of teaching, research and patient management. (HoD 81; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

Clinical Faculty of Medical Schools

ACP encourages departments of medicine to provide leadership to non-salaried members of the clinical faculty of medical schools in their involvement in educational and research programs. Departments of medicine are encouraged to involve clinical faculty of medical schools in the educational and administrative policies dealing with curriculum development. (HoD 72; revised HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

MEDICAL EDUCATION: FINANCING AND SUPPORT

Financing

ACP favors cooperative ventures to engage representatives of all parties involved in the financing of health care and/or graduate medical education to develop mutually acceptable recommendations for mechanisms by which all third-party payers will equitably share in the financing of graduate medical education. (ACP AMA Del I-95; reaffirmed BoR 08)

Elimination of Federal Financial Assistance to Those Attending Unaccredited Medical Schools

ACP supports the elimination of federal financial assistance (guaranteed student loans) to US students attending unaccredited medical schools. (HoD 86; reaffirmed HoD 97; reaffirmed BoR 08)

Fair Contribution by Payers for Medical Education, Research and Indigent Care

ACP supports an all-payer approach to appropriately subsidize medical education, postgraduate training, and clinical research (including practice guidelines, medical outcomes and cost-effectiveness studies). ACP continues to support appropriate alternatives for subsidizing indigent care. (HoD 96; reaffirmed BoR 08)

Student Debt

1. ACP advocates both increased financing and measures to improve both the effectiveness of primary care service obligation components and the ease of the application process for scholarships, loan-forgiveness programs, and low-interest loan programs that require primary care service in return for financial aid.
2. ACP calls for expanded funding and eligibility for federal loan programs targeted to support primary care, such as Title VII's Primary Care Loan Program, allowing the deferment of interest and principal payments on medical student loans until after completion of postgraduate training and the tax-deductibility of interest and principal payments for such loans, if repayment occurs during residency training.
3. Financial aid and debt counseling, as well as counseling in budget management, should be available for all medical students, beginning before admission and available throughout attendance at medical school and residency. Opportunities for military and other scholarships and information about loan-forgiveness programs need to be better publicized. (BoR 03 reaffirmed BoR 13)

MEDICAL EDUCATION: GRADUATE

Affiliation with LCME Approved Medical Schools

ACP believes that teaching hospitals should be encouraged to affiliate with LCME-approved medical schools. (HoD 86; reaffirmed HoD 97; reaffirmed BoR 08)

The Case for Graduate Medical Education as a Public Good

Graduate medical education is a unique public good that benefits all of society and must be financially supported by all who pay for health care services. Graduate medical education provides intense educational experiences and supervised, hands-on training required to prepare physicians for clinical practice.

Unless there is continued, broad-based funding to support graduate medical education, with all-payers sharing in funding the costs of graduate medical education, access to the medical profession will increasingly be available only to families of the very affluent and the fortunate few who are able to obtain financial support from private foundations. Efforts to maintain opportunities for students from lower and middle income families and to increase ethnic and racial diversity will be thwarted. Further, without adequate financial support, teaching facilities will be unable to continue to perform their missions and new physicians will be forced by financial necessity into fields with the greatest income potential rather than those specialties and areas where there are shortages.

All patients and all members of society should be concerned that the nation's system of graduate medical education is preserved, that the high standards of quality required for patient care services provided by resident physicians are maintained, and that opportunities for entry to the medical profession are available to the best qualified candidates. (The Case for Graduate Medical Education as a Public Good, ACP 97, reaffirmed BoR 10)

Internal Medicine Training

Traditional Broad-Based Training

All internists should be trained initially as traditional broad-based internists. Subspecialists in internal medicine provide a high proportion of primary care. Internal medicine training produces physicians who are highly skilled in primary care as well as who possess the capacity to deal with complex problems. Physicians who are adequately trained in the skills of the internist do not lose that expertise in the process of developing subspecialty skills.

Reduction of Internal Medicine Training for Other Primary Care Training

ACP objects to the reduction of internal medicine training programs and preferential funding of other primary care training. Internal medicine is the backbone of all primary care and furthermore, is an integral part of training programs for other disciplines (such as anesthesiology, family medicine, psychiatry, neurology and others).

The Internist as Role Model for Primary Care and Other Training Programs

The internist provides a logical role model for primary care and other training programs. Because of the high proportion of internists serving as clinical investigators and teachers in other residency training programs, curtailment of internal medicine programs would adversely affect all postgraduate training and research. (HoD 82; reaffirmed HoD 86; revised HoD 97; reaffirmed BoR 08)

Graduate Medical Education (GME) Funding/Physician Workforce Policy

The United States should continue to provide GME opportunities for non-US citizens who have graduated from non-U.S. medical schools. These physicians should participate in GME under the J-1 Exchange Visitor Program.

To increase the likelihood that U.S. medical school graduates will establish practices in underserved communities, federal funds should be provided to encourage and support medical schools' efforts to expand the opportunities students have to gain experience in underserved communities. This should include efforts to increase the diversity of student bodies and to encourage students to pursue careers as generalist physicians and establish practices in these communities.

A national all-payer fund should be established to provide a stable source of funding for the direct costs of GME (resident stipends and benefits, faculty supervision and program administration, and allowable institutional costs). Payments should be made from this fund to entities that incur the costs of GME, whether they be hospital-based or not, or to other entities, such as consortia, that have been designated to receive funds on behalf of the entities incurring the costs. However, further study is needed to determine how and to whom these payments should be appropriately distributed.

A national physician workforce advisory body should be established to monitor and periodically assess the adequacy of the size and specialty composition of the physician workforce in the context of the changing needs of the evolving health care delivery system and evolving patterns of professional practice by non-physician health professionals. This body should be legislatively mandated, but staffed independently of existing government agencies.

ACP should further evaluate the use of consortia as described by COGME and/or the use of a voucher system as outlined by the AMA as approaches for implementing workforce policy goals and for controlling/dispersing GME funds to all appropriate training sites.

ACP should reaffirm that training programs should have strict anti-discrimination policies in place so that

all graduate medical education trainees who are admitted to any program have equal supervision and are not exploited for their services.

ACP supports policy that training of all internists should provide an optimal balance of ambulatory and inpatient experiences and skills. ACP supports the unification of primary care and categorical internal medicine residency in the initial part of training. (HoD 97; reaffirmed as amended BoR 06; (reaffirmed as amended BoR 17)

Aligning GME Policy with the Nation's Healthcare Workforce Needs

1. Payment of Medicare GME funds to hospitals and training programs should be tied to the nation's health care workforce needs. Payments should be used to meet policy goals to ensure an adequate supply, specialty mix, and site of training.
2. There should be a substantially greater differential in the weighted formula for determining direct GME payments for residents in primary care fields, including internal medicine. Training programs should receive enough funding to develop the most robust training programs and meet the requirements stipulated by their Residency Review Committees (RRCs).
3. GME caps should be lifted as needed to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages. Opportunities for GME should exist for both international medical graduates and U.S. medical graduates.
4. Internal medicine residents should receive exposure to primary care in well-functioning ambulatory settings that are financially supported for their training roles. The Accreditation Council for Graduate Medical Education (ACGME) and RRCs should establish specific goals for increased time spent by residents in ambulatory settings. Mentorship programs should be encouraged. Additional Medicare funding should be provided to facilitate training in all ambulatory settings that provide residency education.
5. Medical educators, not governments, should take the lead in improving GME curricula, but governments should provide competitive funding and support to encourage and facilitate such innovation.
6. The concept of a performance based GME payment system is an idea that is worth exploring. Such a system should be thoughtfully developed and considered in a deliberate way to ensure that goals are achieved without destabilizing the system of physician training. ACP recommends the following:
 - Measures should be developed by appropriate stakeholders, including physicians involved in GME, especially those involved in primary care training.
 - All measures must be carefully developed and thoroughly evaluated before they are implemented.
 - Any curriculum related measures should be linked to the well-established ACGME competencies and competency based educational reforms already underway.
 - Training programs must be allowed adequate time to make necessary changes to their programs before financial incentives are introduced so that they do not risk losing funding at a time when they may need additional resources to meet performance standards.

- Measures must be developed and implemented in a manner that does not systematically advantage or disadvantage certain types of hospitals and training programs, for example large programs, rural programs, community based programs.
 - A provision must be in place to evaluate the operation of any performance based FME payment system at certain intervals to avoid adverse unintended consequences, ensure that the goals of implementing such a system are achieved, and that the measures are still relevant over time. It should not be assumed that simply instituting performance metrics will result in improved medical education and/or progress toward workforce goals.
7. The ACGME and RRCs should provide greater flexibility to training programs to experiment with innovative methods and techniques to improve their training programs and provide residents with the skills and experiences necessary to meet the nation's health care needs.
 8. Pilot projects should be introduced to promote innovation in GME and provide training programs with the resources necessary to experiment with innovative training models and incorporate models of care, such as the patient-centered medical home. Congress should consider creating a Center for Medical Education Innovation and Research, parallel to the Center for Medicare and Medicaid Innovation, with dedicated dollars to fund pilots and multisite educational outcomes research and have them more widely accepted if successful.
 9. GME financing should be transparent, and accountability is needed to ensure that funds are appropriately designated toward activities related to the educational mission of teaching and training residents.
 10. All payers should be required to contribute to a financing pool to support residencies that meet policy goals related to supply, specialty mix, and site of training.
 11. Incentives are needed to attract medical students, especially U.S. medical graduates, to residencies in primary care fields, including internal medicine.
 12. A significant commitment to robust and stable Title VII health professions funding is needed. (BoR 11)

Core Principles on Physician Workforce and Graduate Medical Education

1. Undergraduate medical school class size and the total number of students graduating from U.S. allopathic and osteopathic medical schools should reflect national needs and requirements for physicians. Action should be instituted promptly due to the long medical education pipeline that takes up to twelve years or more from the start of undergraduate medical education until the completion of residency training.
2. All members of society benefit from having well-trained physicians and appropriately funded academic medical centers. Consequently, all health care payers should share in the costs of graduate medical education.
3. Physicians should be educated and trained in sufficient proportion to meet the nation's need for a balanced mix of physicians among generalists and specialists.

4. The expanding roles and increasing numbers of non-physician health care professionals must be taken into consideration in workforce planning, and the supply of these health care professionals should also be adjusted to reflect national needs and requirements.
5. Workforce policy should seek to improve the geographic distribution of physicians. Existing incentives should be expanded and/or new incentives should be developed to encourage all health care professionals to help meet the health care service needs of underserved populations, particularly in urban and rural areas.
6. There should be no discrimination based on age, sex, national origin, religion, sexual orientation, or political affiliation for career opportunities in medicine.
7. Funding for Graduate Medical Education should be sufficient, predictable and stable to support the academic, patient care, and research missions of teaching hospitals and ambulatory training sites. Financing must be sufficient to support teaching hospitals that provide a disproportionate share of care to indigent and medically under-insured patients. (BoR 00; reaffirmed as amended BoR 13)

Financing U.S. Graduate Medical Education

1. The federal government should maintain its commitment to GME. Payment of Medicare GME funds should be linked to the ability of the GME system to meet the nation's health care workforce needs. Payments should be used to meet policy goals to ensure adequate supply, specialty mix, and training sites.
2. All payers should be required to contribute to a financing pool to support residencies that meet the nation's policy goals related to supply, specialty mix, and training sites.
3. A thorough evaluation of the true cost of training physicians is required before any decisions are made about how GME funds are distributed.
4. Direct GME and IME should be combined into a single, more functional payment program that is designed to meet the needs of patients and populations.
5. Graduate medical education funding should be transparently allocated to ensure that funds are appropriately designated toward activities related to the educational mission of teaching and training residents and fellows. Graduate medical education funds should follow trainees into all training settings, rather than being linked to the location of service relative to the sponsoring institutions.
6. Graduate medical education caps should be lifted as needed to permit training an adequate number of primary care physicians, including internal medicine specialists, and physicians in other specialties facing shortages, including internal medicine–pediatrics and many internal medicine subspecialties.
7. The concept of a performance-based GME payment system is worth exploring. Such a system should be thoughtfully developed and considered in a deliberate way to ensure that goals are achieved without destabilizing the system of physician training. We recommend the following:
 - a. Measures should be developed by appropriate stakeholders, including physicians involved in GME training.
 - b. All measures must be carefully developed and thoroughly evaluated before they are implemented.

- c. Institutions must be allowed adequate time to make necessary changes to their training programs before financial incentives are introduced.
 - d. Revised GME funding should account for the costs of transitioning into a performance-based GME system, and once done, clear-cut financial transparency and incentives must be delineated.
 - e. The performance measures should be evidence-based and align with the Accreditation Council for Graduate Medical Education (ACGME) requirements. The core mission of individual programs should be considered. Producing a certain number of physicians trained in a certain specialty or subspecialty should not be a specific performance metric.
 - f. A careful study of unintended consequences should be done to ensure that programs are not unfairly disadvantaged.
 - g. Regular evaluations of the measures should be implemented to avoid adverse unintended consequences, ensure that the goals of implementing such a system are achieved, and confirm that the measures remain relevant over time.
8. Pilot projects should be introduced to evaluate potential changes to GME funding, including a performance-based GME payment system, and to promote innovation in GME by providing training programs with the resources necessary to experiment with innovative training models. Pilot projects should not be funded using existing GME funding.
 9. Internal medicine and internal medicine–pediatrics residents should receive primary care training in well-functioning ambulatory settings that are financially supported for their training roles. Barriers should be removed to encourage programs to train residents in nonhospital settings, promote innovation in training, and facilitate clinical learning experiences that promote primary care. (BoR 16)

Implementing Universal State and Federal J-1 Visa Application Processes

ACP will work towards the implementation of universal and simplified state and federal J-1 visa application processes.

The College will act for changes to the Conrad 30 program that provide a fair distribution of J-1 visa physicians in the most medically underserved areas based on the total population of the state instead of the current set number of 30 physicians per state regardless of need and population.

The College will act on behalf of the Conrad 30 J-1 physicians to allow them to change sponsors among medically underserved areas without restriction within the Conrad 30 system.

ACP will act to permit Conrad 30 J-1 visa physicians a grace period of 120 days in order to find another Conrad 30 position if relieved of their duties. (BoR 09)

The Role of International Medical Graduates in the U.S. Physician Workforce

ACP recognizes the potential for “brain drain” from less developed countries, but opposes enactment of measures that would prevent international medical graduates—who otherwise meet all U.S. immigration requirements for admittance and residency in the United States-- from emigrating to the United States.

ACP supports streamlining the process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire postgraduate medical training and/or medical practice in the U.S.

ACP supports the expansion of J-1 visa waiver programs such as Conrad 30 to help alleviate physician shortages in underserved urban and rural areas. This program should also be made permanent.

ACP supports the exemption of physicians trained in specialties that are facing shortages in the United States from the annual H-1B visa cap.

ACP supports Schedule A status for physicians trained in internal medicine and other specialties that are facing shortages in the United States. Schedule A status is a designation under federal law that these physicians will not adversely affect the wages and working conditions of U.S. workers similarly employed and will exempt them from the annual immigration visa (green card) cap.

ACP encourages collaboration between medical schools and teaching hospitals in the U.S. and those in less developed countries to improve medical education and training in those countries.

ACP supports the development of a Global Health Corps or other entity that would facilitate opportunities for physicians and other health care providers in the United States to serve in less developed countries. (BoR 08)

Investigating Possible Work-Related Abuses for Physicians Working Under the Conrad-30 Program

ACP will work collaboratively with other medical organizations, including the AMA, to develop a mechanism by which members encountering job-related abuses (e.g., intimidation, loss of benefits, limitations to changes in employment and lack of salary equity) may report this information without fear of retribution for purposes of data collection for advocacy support. (BoR 12)

Outpatient Residency Training

ACP supports changes in the Centers for Medicare & Medicaid Services rules and regulations that would facilitate training of hospital-funded residents in non-hospital outpatient facilities. (HoD 96; reaffirmed BoR 08)

Physician Workforce and Residency Training

ACP reaffirms its support of maintaining a diversity of backgrounds of residents in training. ACP will promote the development of objective measures of quality which should be used for the evaluation of teaching programs. ACP supports the need for diversity in types of training programs (e.g. university-based, community-based) in order to prepare residents for the varied practice environments of internal medicine. (HoD 96; reaffirmed BoR 08)

Funding for Combined Residency Training Programs

Medicare payments for the direct costs of graduate medical education of residents in combined primary care training programs should be for the minimum number of years of formal training required to satisfy the requirements for initial board eligibility for the longest of the individual programs plus one additional year. (ACP AMA Del I-96; reaffirmed BoR 08)

Attending Physicians and Physicians in Training

The very title doctor, from the Latin docere, "to teach," implies that physicians have a responsibility to

share knowledge and information with colleagues and patients. This sharing includes teaching clinical skills and reporting results of scientific research to colleagues, medical students, resident physicians, and other health care providers.

The physician has a responsibility to teach the science, art, and ethics of medicine to medical students, resident physicians, and others and to supervise physicians in training. Attending physicians must treat trainees with the same respect and compassion accorded to other colleagues. In the teaching environment, graduated authority for patient management can be delegated to residents, with adequate supervision. All trainees should inform patients of their training status and role in the medical team. Attending physicians, chiefs of service, or consultants should encourage residents to acknowledge their limitations and ask for help or supervision when concerns arise about patient care or the ability of others to perform their duties.

It is unethical to delegate authority for patient care to anyone, including another physician, who is not appropriately qualified and experienced. On a teaching service, the ultimate responsibility for patient welfare and quality of care remains with the patient's attending physician of record. (BoR 04; reaffirmed BoR 16)

Recommendations on Reform of Residency Training

This paper discusses a series of recommendations on graduate medical education, specifically, residency training. ACP recommendations include:

Recommendation 1: Medical schools and residencies should stress community and public service as a normal and valued activity of physicians. Public service should be broadly defined to encompass volunteer activities, including cultural and civic affairs, community health events, and educational programs. Residency faculty should include physician role models involved in such activities.

Recommendation 2: Residency programs should emphasize the necessity for provision of preventive medical care. The ambulatory care curriculum should include preventive medicine, including mental health screening and treatment at the primary care level, and should expose residents to patient populations deficient in preventive medical intervention. Residency programs should offer formal instruction in prevention medicine and offer elective rotations in public health programs. Career information should be provided concerning health services research and public health organizations.

Recommendation 3: Residency programs should strive to create a humanistic environment, where humanistic attitudes and behaviors are rewarded. Humanism in medicine may be defined as integrity, respect, and compassion for patients. Residents should be provided guidance in dealing with patients and families on issues of death and dying. Humanism should be among the criteria by which residents and faculty are evaluated. To ensure that the residents' basic physical needs are satisfied while on duty, residency programs should provide better scheduling and availability of meals to residents.

Recommendation 4: Residency programs should have a formal process for identification of the impaired resident and a mechanism for their re-entry into the residency program following treatment. A non-threatening and confidential counselor should be available for residents. Residents should be informed of available resources for assistance. Residency programs should encourage support systems and programs designed to reduce the isolation and stress of residency.

Recommendation 5: Residency programs should strive towards a balance of ambulatory and in-patient care experiences. Private practitioners, experienced in ambulatory care, should be included on the residency training staff. Instruction in preventive medicine, should be included in the ambulatory clinic. Didactic teaching sessions in the ambulatory clinic should be dedicated and uninterrupted time for

learning. Residents should receive instruction on telephone management and chart review of patients and continuity of patient care should be provided by the resident in the ambulatory and in-patient settings.

Recommendation 6: Resident programs should strive to broaden resident exposure to patient populations, including rural, inner city, and geriatric populations, all of which experience a wide variety of diseases and demographic characteristics. Residency curricula should stress skills development in problem solving, clinical decision-making, and doctor-patient communication. The disciplines of neurology, dermatology, gynecology, geriatrics, psychiatry, adolescent medicine, office orthopedics, otolaryngology, ophthalmology, quality control and management, utilization, credentialing, and practice management should be integrated into the formal curriculum of general internal medicine. Curriculum content should be evaluated and discussed by faculty and residents on an on-going basis.

Recommendation 7: All residency programs should formally teach residents how to perform all procedures required for certification and for general practice. An appropriate level of supervision should be provided when residents are doing procedures. Evaluation of history and physical examination skills should be done early in the internship and repeated bi-annually throughout residency.

Recommendation 8: Programs should strive to provide faculty role models, mentors, and elective time for residents to pursue an understanding of and interest in scholarly activity. Resources, specifically technical and secretarial services, should be provided to residents conducting research. Various types of research should be supported and various models for providing a core understanding of research design and critical evaluation of literature must be developed. Residency programs should provide opportunities for residents to learn computer skills, especially literature searching.

Recommendation 9: Residency programs should, at a minimum, provide the same benefits that hospital employees receive, including comprehensive disability, medical and life insurance. Accessible, flexible and affordable day care should be available. Residency programs should provide flexible work hours for residents with dependents. Support groups where residents can openly discuss the conflicts between the role of parent and role of physician should be provided. (Council of Associates, ACP 1994; reaffirmed BoR 04)

Universal Hepatitis B Vaccination

ACP recommends that medical schools and residency programs offer hepatitis B vaccine free of charge to its physicians-in-training and medical students. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 16)

Residency Work Hours and Compensation

ACP believes that reductions in resident compensation as a mechanism to fund any changes in graduate medical education is inappropriate. (HoD 88; reaffirmed BoR 04; reaffirmed BoR 16)

Private Patients in the Teaching Setting

ACP encourages individual teaching hospitals to develop and clearly state their policies or procedures which permit house officers to provide care for patients under the supervision of the attending physician. There should be direct, adequate representation of private attending physicians on hospital governing boards formulating and approving guidelines relative to the responsibilities of the physicians involved in patient care where applicable. Such guidelines should reflect that the ultimate legal, moral, and ethical responsibility for the medical care of a patient rests with the personal attending physician. In a teaching setting, the attending physician should recognize the need for optimal communication between the physician and the house staff regarding the patients care. (HoD 72; revised HoD 87; reaffirmed BoR 04)

Teaching of Socioeconomics in Medical Schools and Residency Programs

ACP believes that medical socioeconomic should be recognized as an integral part of the preparation of all physicians for the practice of medicine and strongly recommends the inclusion of such courses at both the undergraduate and postgraduate levels as essential to the education pattern of the future. (HoD 76; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Underprivileged Students

ACP believes that each of its members, as a practitioner of medicine concerned with social responsibilities, should help, advise, direct and counsel underprivileged students from the earliest stages of pre-medical training through graduate training and placement in practice, which is important to eligibility. (revised HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

MEDICAL RECORDS

The Medical Record

Physician entries in the medical record, paper and electronic, should contain accurate and complete information about all communications, including those done in-person and by telephone, letter, or electronic means. Ethically and legally, patients have the right to know what is in their medical records. Legally, the actual chart is the property of the physician or institution, although the information in the chart is the property of the patient. Most states have laws that guarantee the patient personal access to the medical record, as does the federal HIPAA privacy rule. The physician must release information to the patient or to a third party at the request of the patient. Information may not be withheld, including because of nonpayment of medical bills. Physicians should retain the original of the medical record and respond to a patient's request with copies or summaries as appropriate unless the original record is required. To protect confidentiality, protected health information should be released only with the written permission of the patient or the patient's legally authorized representative, or as required by law.

If a physician leaves a group practice or dies, patients must be notified and records forwarded according to patient instructions. (BoR 04; Reaffirmed as amended BoR 11)

Health Information Technology and Privacy

1. ACP believes that protection of confidential data is important for the safe delivery of health care. Privacy policies should accommodate patient preference/choice as long as those preferences/choices do not negatively impact clinical care, public health, or safety.
2. ACP believes that under a revised privacy rule, permitted activities not requiring consent should include well-defined socially valuable activities involving public health reporting, population health management, quality measurement, education, and certain types of clinical research. Further, ACP supports the following principles on the use of Protected Health Information (PHI) and Individually Identifiable Health Information (IIHI):
 - a. The sale of any IIHI without the patient's permission should be expressly prohibited.
 - b. Whenever possible and appropriate, de-identified, anonymized, or pseudonomized data should be used. The method used to remove identifiers should be publically disclosed.
 - c. IIHI should only be supplied in cases where such information is necessary for proper performance of a specific function. For example, if the goal is to count incidence of a

disease or count the number of patients receiving an intervention, there is no need to include IIHI. Determination of the need for identifiable information should be made by appropriate publicly accountable decision-making bodies (e.g., Department of Health and Human Services, regional or local Institutional Review Boards [IRBs])

- d. ACP recognizes that certain activities may not require individual authorization for the use of PHI and IIHI and recommends that whenever possible, all attempts should be made to de-identify PHI and IIHI in the context of educating current and future clinicians. Use of PHI and IIHI in educational and training activities, such as grand rounds and teaching conferences, should be minimized, although access to information in the clinical setting should be permitted as appropriate.
 - e. The public must be educated about the benefits to society that result from the availability of appropriately de-identified health information.
 - f. There should be tighter controls against improper re-identification of de-identified patient data.
 - g. Appropriately de-identified patient data should be available for socially important activities, such as population health efforts and retrospective research, with appropriate IRB approval and adherence to standards for de-identification. (See: *Standards for privacy of individually identifiable health information final rule*. 67. *Federal Register*. 2002;53181–53273; Malin B, Benitez K, Masys D. *Never too old for anonymity: a statistical standard for demographic data sharing via the HIPAA Privacy Rule*. *J AM Med Inform Assoc* 2011;18:3-10.)
 - h. ACP believes that information may be disclosed without authorization to public health authorities as required by law in order to prevent or control disease, injury, or disability.
3. ACP believes that whenever a health care provider discloses PHI for any purpose other than for treatment, that disclosure should be limited to the minimum data necessary for the purpose based on the judgment of the provider.
- a. While we agree conceptually that there could be benefits from application of “minimum necessary” criteria to activities involving payment and operations, current science and technology are not up to the task. It is not possible or appropriate to disentangle a clinical encounter note into relevant and nonrelevant elements.
 - b. As long as health plans require submission of complete notes from the patient record before approving payment, providers have no choice but to provide complete notes.
 - c. Health information technology (HIT) should incorporate audit trails to help detect inappropriate access to PHI.
 - d. Health care providers should be required to notify patients whenever their records are lost or used for an unauthorized purpose.
 - e. Health care providers should not be penalized for failure to comply with requests for PHI that, in their judgment, are inappropriate under disclosure rules after notifying the requester that the request is being denied.
 - f. Health care providers should not be held responsible for actions taken by another entity with regard to PHI that the provider supplied to that entity in accordance with privacy regulations.
4. Regarding research, a revised privacy rule should maximize appropriate uses of information to achieve scientific advances without compromising ethical obligations to protect individual welfare and privacy.

- a. Participation in prospective clinical research requires fully informed and transparent consent that discloses all potential uses of PHI and IIHI, and an explanation of any limitations on withdrawing consent for use of data, including biological materials.
- b. ACP recognizes that further study is needed to resolve informed consent issues related to future research use of PHI and IIHI associated with existing data, including biologic materials.
 - i. Proposed informed consent models include: specific consent (reconsent required for new use of data); tiered or layered consent (menu of options to indicate whether reconsent is required); general permission or open-ended consent (all future uses permitted with IRB review); and blanket consent (no restrictions on future use). The 2009 Institute of Medicine (IOM) report, *Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research*, recommends allowing future use of existing materials for research if the following conditions are met: “(1) the individual’s authorization describes the types or categories of research that may be conducted with the PHI stored in the database or biobank; and (2) an IRB determines that the proposed new research is not incompatible with the initial consent and authorization, and poses no more than a minimal risk.”
- c. Informed consent documents should clearly disclose whether law enforcement agencies would have access to biobank data without a warrant.
- d. ACP recommends that regulations governing IRB review be expanded to include consideration of the preferences of research subjects whose tissue has been stored.
- 5. ACP believes that privacy laws and regulations must apply to all individuals, organizations, and other entities that have any contact with IIHI.
 - a. Privacy protections that apply to all holders of IIHI, including services that store IIHI, should be addressed through new and comprehensive legislation.
 - b. The College supports approaches that ensure that all holders of IIHI are held appropriately accountable for their actions.
- 6. ACP believes that there must be agreement on a basic privacy model and on definitions for all terms used. There must be a single, comprehensive taxonomy for consent provisions as well as a standard structure for consent documents. Therefore, ACP recommends that the National Committee on Vital and Health Statistics (NCVHS) convene an expert panel to address these issues.
 - a. The privacy model must be unambiguous regarding which activities are permitted and which require consent.
 - b. Increasingly narrowly defined consent requirements cause unacceptable burdens on people and systems, and may increase health risks and legal liability. For example, rules that allow the withholding of consent for disclosure of individual prescriptions, laboratory results, or diagnoses pose unacceptable barriers to delivery of health care.
 - c. If consent is to operate effectively in a networked environment, the forms and content of consent artifacts must be at least as interoperable as the patient data to which they apply.
- 7. ACP agrees that individuals should be able to access their health and medical data conveniently, reliably, and affordably. Further, individuals should be able to review which entities and providers have accessed their IIHI and when access occurred according to the following principles:

- a. Full access to medical records and disclosure records will not be possible until electronic health record (EHR) systems and health information exchanges (HIEs) are capable of exchanging such information in electronic form. While we support patient rights to their information, we cannot support requirements to provide the information until systems are capable of providing it in a transparent, efficient manner.
 - b. Patients should have the right to request their information from every holder of information about them. Providers should be permitted a reasonable period to comply and to charge the patient a fee that is based on the cost of providing the information. Electronic medical records systems should be required to facilitate the provision of a patient's information in electronic formats. EHR and personal health record (PHR) vendors should be encouraged to ensure that their systems are interoperable.
 - c. Patients should have the right to request from any provider information about disclosures of their IIHI, other than disclosures made in the normal course of treatment, payment, and operations. Appropriate data would include the nature of the information, to whom it was disclosed, and when it was disclosed.
 - d. Electronic medical records systems should facilitate provision of information regarding all disclosures of patient data to users outside of the practice, other than disclosures made in the normal course of treatment, payment, and operations.
8. Patients should have specific, defined rights to request that their IIHI not be accessed through a health information exchange (HIE).
9. ACP believes that patients should have complete flexibility in making disclosure choices with regard to information stored in their PHR. However, any information that originated in a PHR or that passed through a patient's control must indicate this fact as the information travels through the health care system.
 - a. It is crucial for the safety and health of the patient, as well as for protecting the liability of a provider's actions, that the source of all data in a medical record be clearly identified and maintained as the information moves from system to system because of the risk that such data could be altered and therefore not retain its accuracy and/or relevance for clinical care decisions.
 - b. It is equally important that the dates and times of all creation and modification activities associated with the data be maintained with the data.
 - c. If at any time patient data, which may have originated in a provider's EHR, is supplied from a PHR or other external patient-controlled systems, this fact should be assigned to the data.
10. ACP believes that the nature of every agreement between entities that involves sharing of PHI should be made public.
11. ACP believes that enforcement of penalties for intentional or negligent breaches of privacy should be strictly enforced and that state attorneys general should be empowered to enforce privacy rules.
 - a. Recent calls for increased penalties fail to acknowledge the near-total lack of enforcement of existing penalties. See "Nationwide Review of the Centers for Medicare & Medicaid Services Health Insurance Portability and Accountability Act of 1996 Oversight [A-04-07~05064]" (<http://www.oig.hhs.gov/oas/reports/region4/40705064.pdf>).

- b. It is critical that rules and enforcement efforts distinguish between inadvertent and intentional activities.
 - c. Breach rules must not hold any parties responsible for the actions of other parties over whom they do not have direct control.
- 12. ACP believes that new approaches to privacy measures should be tested before implementation.
 - a. Once implemented, federal agencies and other stakeholders need to monitor the impact of new privacy measures, watch for unintended consequences, and adopt a flexible approach to implementation.
- 13. ACP believes that use of a Voluntary Universal Unique Healthcare Identifier could provide privacy benefits and that its potential use should be studied. (BoR 7-11)

Confidentiality of Electronic Medical Records

- 1. Patients have a basic right to privacy that includes the information contained in patient medical records. Medical personnel who collect health information have a responsibility to protect patients from invasion of their privacy.
- 2. The primary purpose of patient medical records is to document the patient's case and communicate information about care to health professionals involved in the treatment and care of that patient.
- 3. Access to information in medical records should be restricted to persons with legitimate needs for the information.
- 4. Patients have a right to review information in their medical records and to propose corrections.
- 5. Informed consent must be obtained from patients before their medical information is disclosed for any purpose, the only exception being for appropriately structured medical research (see positions 7-9) or as required by law.
- 6. Disclosures other than for health care-related needs, including for law enforcement, should occur only as required by a court order.
- 7. "De-identified" patient data should always be used in medical research and quality improvement processes, unless the nature of the research necessitates identification because coded data would be impracticable.
- 8. If "de-identified" data is to be used for purposes other than those for which it was originally intended, patients must give additional consent.
- 9. Disclosure of health information should be permitted only for research that is approved by an IRB and is in accord with federal policy for the protection of human subjects. (BoR 4-99; reaffirmed BoR 04; revised BoR 07)

Data Needs of Medical Research

Any forthcoming federal standards or legislation concerning the protection or privacy of medical records, including electronic transmissions thereof, should include sufficient safeguards to prevent breaches of patient confidentiality without imposing unduly restrictive barriers that would impede or prevent access to data needed for medical or public health research. (ACP AMA Del A-97; revised BoR 08)

EHR-Based Quality Measurement and Reporting - Critical for Meaningful Use and Health Care Improvement

Position 1: The primary purpose of EHR-based quality measurement and reporting should be to facilitate higher-quality, cost-effective health care.

Position 2: In order for an EHR-based quality measurement and reporting program to engage all health care stakeholders, it must use clinically relevant measures and be accurate and trusted by a full range of stakeholders, particularly patients, physicians, and other health care providers.

Position 3: Data to support EHR-based quality measurement and reporting should rely upon information routinely collected during the course of providing clinical care, including relevant data supplied by patients.

Position 4: EHR-based quality measurement should begin with the goal of facilitating the real-time collection of data that support the effective use of point-of-care clinical decision support algorithms.

Position 5: EHR-based quality measurement and reporting must not increase administrative work and/or impose uncompensated financial costs upon physicians and other health care providers, health care organizations, or patients.

Position 6: Data elements that comprise quality measure data sets should be defined in a standard way to enable health IT developers to implement them effectively.

Position 7: ACP supports the commitment of the HIT Standards Committee, the National Quality Forum (NQF), the NQF Health Information Technology Expert Panel (HITEP), Health Information Technology Standards Panel (HITSP), and others to develop unified standards for structured, codified data elements, calculation logic, measure structure, and reporting structure for quality measures. The development of these standards requires concerted and consistent input from all health care stakeholders. (BoR 10)

Clinical Documentation

1. The primary purpose of clinical documentation should be to support patient care and improve clinical outcomes through enhanced communication.
2. Physicians working with their care delivery organizations, medical societies, and others, should define professional standards regarding clinical documentation practices throughout their organizations. Further, clinical usefulness of health information exchange (HIE) will be facilitated by appropriate re-design of clinical documentation based on consensus-driven professional standards unique to individual specialties as a result of collaboration with standards setting organizations.
 - a. The clinical record should include the patient's story in as much detail as is required to retell the story.
 - b. Patient access to progress notes, as well as the rest of their medical records may offer a way to improve both patient engagement and quality of care.
 - c. The EHR should facilitate thoughtful review of previously documented clinical information.

- d. Copy/paste (note cloning), macros, and templates may be valuable in improving the accuracy and efficiency of documentation. However they can also be misused – to the detriment of accuracy, high quality care, and patient safety.
 - e. Structured data should be captured only where they are useful in care delivery, quality assessment, or reporting.
 - f. Effective and ongoing electronic health record (EHR) documentation training of clinical personnel should be an ongoing process.
- 3. As value-based care and accountable care models grow, the primary purpose of the EHR should remain the facilitation of seamless patient care to improve outcomes while contributing to data collection that supports necessary analyses.
- 4. Physicians should not be required to code data elements for third parties that are not required for patient care or quality assessment.
- 5. Prior authorizations, as well as all other documents required by other entities must no longer be unique in their data content and format requirements.
- 6. The College calls for further research to:
 - a. Identify best practices for systems and clinicians to improve accuracy of information recorded and the value of information presented to other users.
 - b. Study the authoring process and encourage the development of automated tools that enhance documentation quality without facilitating improper behaviors.
 - c. Understand the best way to improve medical education to prepare new and practicing clinicians for the growing uses of health information technology in the care of patients and populations and to recognize the importance of their responsibility to document their observations completely, concisely, accurately, and in a way that support their reuse.
 - d. Determine the most effective methods of disseminating professional standards of clinical documentation and best practices. (BoR 2014)

EHR System Design to Support 21st Century Clinical Documentation:

- 1. EHR developers need to optimize EHR systems to facilitate care delivery that involves teams of clinicians and patients that are managed over time.
- 2. Clinical documentation in EHR systems must support clinicians' cognitive processes during the documentation process
- 3. EHRs must support "write once – reuse many times" and embed tags to identify the original source of information when used subsequent to its first creation.
- 4. Wherever possible, EHR systems should not require users to check a box or otherwise indicate that an observation has been made or an action has been taken if the data documented in the patient record already substantiate the action(s).
- 5. EHR systems must facilitate the integration of patient generated data, and must maintain the identity of the source. (BoR 2014)

MEDICAL REVIEW

Application of Utilization Review Standards

ACP believes that any basic quality standards set by the state or federal government should apply across the board to all entities in a marketplace holding contracts to provide care to health plan enrollees. This

includes IPAs, medical groups and other physician and/or hospital-directed organizations that hold health plan contracts and that contract with physicians for professional services. (HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Medical Appropriateness

ACP believes that a test, procedure, or investigation is medically appropriate if documentation supports that the results of the test procedure, investigation or intervention would influence the diagnosis, course of treatment, or prognosis of the patient's illness, disease or disability. (HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Medical Necessity and Insurance Coverage

Appropriateness cannot be fairly judged by third parties except against standards based on scientifically acceptable data, or professional consensus as described in published documents, and that such data and standards should be publicly available, explicitly referenced by the reviewer, and a rationale for providing a procedure if the practitioner's judgment is contradicted in post payment review. (HoD 94; reaffirmed HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Independent Review of Third Party Payers

ACP supports the concept of an independent review entity with binding authority to adjudicate claims disputes. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Disclosure and Claims Review Requirements

ACP supports efforts to standardize, regulate and make public: The training standards of those performing UR under contract or employed by health plans and pros; The criteria and parameters utilized by private UR firms and the mechanisms by which they function; Access to inquiries and appeals mechanisms offered by private UR firms. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Utilization Review Committees

ACP believes that its members should help control use of beds, diagnostic agents, and therapeutic measures by serving on society and hospital utilization committees. (HoD 66; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

MEDICALLY UNDERSERVED HEALTH CARE

Medicaid Improvements for the Underserved

1. Require managed care organizations to provide special services that are essential in inner-city environments, such as primary care services that are geographically accessible (providing transportation when necessary), after-hours availability of primary and urgent care, outreach services, and self-care education. Managed care organizations must have linguistic and cultural competence and must be able to coordinate interaction with other social services, such as nutrition programs. Capitation rates would reflect the additional cost of providing specialized services and the savings from reduced emergency department and other hospital costs.
2. Restrict direct marketing and encourage enrollment and education through independent brokers to eliminate "cherrypicking" and to provide objective information, thereby enabling enrollees to choose the health plans that meet their health care needs.
3. Provide case management for persons with any serious illnesses.
4. Include risk-adjustment mechanisms to protect plans with a higher-than-expected number of patients who have HIV infection, AIDS, or other costly diseases and conditions. (reaffirmed BoR

06; reaffirmed as amended BoR 17)

MEDICARE

Medicare Buy-in Program

1. A Medicare Buy-in Program must include a financing structure separate from the trust funds for the other Medicare parts (separate from financing for Medicare Part A, Part B, Medicare Advantage, and Part D).
2. A Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate.
3. Eligibility for a Medicare Buy-in Program should include those aged 55-64 regardless of their insurance status.
4. Enrollment in a Medicare Buy-in Program should be optional for eligible beneficiaries, and – for those who do voluntarily enroll – should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D). (BoR 05; reaffirmed BoR 16)

Medicare Premium Support

1. Medicare premium support plans must include risk adjustments that both are analyzed regularly to ensure accuracy and include health-status, geographic, and other relevant demographic issues that affect Medicare beneficiary health so that beneficiaries have chronic care options in both Fee-For-Service and Medicare Advantage.
2. In attracting patients, those plans competing in a Medicare premium support system must base their marketing and recruitment efforts on providing quality initiatives that adequately address the needs of all Medicare population members – not just the most healthy Medicare beneficiaries.
3. Efforts to implement a Medicare premium support system must include methods for making choices understandable for the Medicare population including those with vision, hearing, language, cognitive or other health-related or demographic-related issues.

Medicare Reform and Modernization

ACP supports reimbursement for physician-directed geriatric assessments and disease and case management under Medicare, provided that coordinating care is not limited to primary care physicians. Internal medicine subspecialists should be allowed to managed care for patients, when appropriate, based on their skills and training.

- a. Covered services should be adequately funded, not by re-direction of current funds, but through new funding streams.
- b. Coverage of disease and case management should not lead to more over-burdensome paper work requirements for physicians. (HPPC 2002, reaffirmed as amended BoR13)

Medicare Prescription Drug Coverage

Position 1: Medicare Part D should be financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas. Congress must assure that revenues for financing the benefit do not depend on overly optimistic

assumptions about tax revenues resulting from growth in the economy or under-estimates of the costs of the benefit. A predictable and stable source of financing, which will assure that revenues keep pace with the costs of the benefit without requiring cuts in other benefits, should be identified. If it turns out that costs in future years exceed anticipated revenues, Congress will need to consider making adjustments in the benefit and/or financing mechanism to assure that prescription drug coverage can be sustained without requiring cuts in other benefits.

Position 2: The maximum allowable Medicare reimbursement for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products.

- a. Rigid price controls that will discourage innovation and threaten drug supply should be rejected.
- b. ACP supports using prudent-purchasing tools in Medicare Part D. Like the VA, Medicare should investigate average wholesale drug prices and directly negotiate with manufacturers or wholesalers.

Position 3: Recognizing that many of our patients find the increasing cost of prescription drugs unaffordable, ACP supports legislative and/or regulatory measures to develop a process to ascertain and certify the safety of reimported prescription drugs.

Position 4: Generic drugs should be used, as available, for beneficiaries of Medicare Part D, providing therapeutic safety and equivalency are established. . In order to eliminate delays for generic entry into the market and discourage financial arrangements between generic and name brand manufacturers, ACP supports closing loopholes in patent protection legislation.

Position 5: ACP supports research into the use of evidence-based formularies with a tiered co-payment system and a national drug information system, as a means to safely and effectively reduce the cost of a Medicare prescription drug benefit, while assuring access to needed medications.

- a. ACP opposes a Medicare Part D formulary that may operate to the detriment of patients, such as those developed primarily to control costs. Decisions about which drugs are chosen for formulary inclusion should be based on effectiveness, safety, and ease of administration rather than solely based on cost.
- b. ACP recommends that formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically-indicated cause) without cumbersome prior authorization requirements.
- c. ACP opposes Medicare Part D proposals that limit-coverage to certain therapeutic categories of drugs, or drugs for certain diseases.
- d. To counterbalance pharmaceutical manufacturers' direct-to-consumer advertising, ACP recommends that insurers, patients and physicians have access to unit price and course of treatment costs for medically equivalent prescription drugs.

Position 6: ACP supports the following consumer protections:

- a. Government regulation and industry self-regulation of PBMs. ACP particularly supports close government oversight of mergers between PBMs and pharmaceutical manufacturers.

- b. The disclosure to patients, physicians, and insurers of the financial relationships between PBMs, pharmacists, and pharmaceutical manufacturers.
- c. Requiring that PBM requests to alter medication regimes should occur only when such requests are based on objective data supported by peer reviewed medical literature, and undergo review and approval by associated managed care plan/MBHO Pharmacy and Therapeutics Committees.
- d. Requiring that, with a patient's consent, PBMs be required to provide treating physicians with all available information about the patient's medication history.

Position 7: ACP believes that switching prescription medications to over-the-counter status should be based on clear clinical evidence that an OTC switch would not harm patient safety, through inaccurate self-diagnosis and self-medication, or lead to reduced access to "switched" drugs because they would no longer be covered under a prescription drug benefit. Manufacturers and other interested parties should be allowed to request such a reclassification.

Position 8: ACP opposes proposals to convert the entire Medicare program to a defined contribution program., ACP supports uniform coverage, rules, eligibility and co-payments across plans providing prescription drug coverage under Medicare Part D.

Position 9: A Medicare prescription drug benefit should minimize administrative hassles, including excessive documentation requirements and overly burdensome rules, for physicians. (BoR 01; reaffirmed BoR 11)

ACP Support of Private Contracting Under Medicare

The American College of Physicians supports the primacy of the relationship between a patient and his/her physician, and the right of those parties to privately contract for care, without risk of penalty beyond that relationship.

Such statutes should include the following patient protections: (1) a requirement that physicians disclose their specific fee for professional services covered by the private contract in advance of rendering such services, with beneficiaries being held harmless for any subsequent charge per service in excess of the agreed upon amount; (2) a prohibition on private contracting in cases where a physician is the "sole community provider" for those professional services that would be covered by a private contract; (3) a prohibition on private contracts in other cases where the patient is not able to exercise free choice of physician; (4) a prohibition on private contracting for dual Medicare-Medicaid eligible patients; (5) a requirement that private contracts cannot reduce patient access to care in cases of emergency or life-threatening illness; and (6) a requirement that the Centers for Medicare & Medicaid Services and the Medicare Payment Advisory Commission monitor Medicare beneficiary access to health care and report to Congress and the public if access problems develop as a result of private contracting. (BoR 98, reaffirmed BoR 10)

Outpatient Intravenous Antibiotic Therapy

This policy is under review by the MSC.

Documentation of Evaluation & Management Visits

1. ACP will continue its efforts to reduce excessive documentation requirements for evaluation and management services. (HoD 97; reaffirmed BoR 08)
2. ACP continues to study and address the problems concerning post payment utilization review for medical necessity and downcoding by Medicare and other third party payers that are the

result of Medicare's documentation guidelines of evaluation and management services. ACP provides its members with ways to facilitate compliance with Medicare's documentation guidelines, such as by the development of electronic or paper templates. (HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Solutions to the Challenges Facing Primary Care Medicine: Reimbursement: Provide Payment That Is Commensurate with the Value of Primary Care

1. The federal government should provide immediate, sufficient, and sustained increases in Medicare fee-for-service payments for services provided by primary care physicians by:
 - a. Raising absolute and relative compensation of general internists and other primary care physicians to achieve market competitiveness in choice of specialty and to sustain and increase the practice viability of general internists and other primary care physicians already in practice.
 - b. Improving the accuracy of work and practice expense relative value units, to increase payments for evaluation and management services, and provide for separate payment for care coordination services provided principally by primary care physicians.
2. Congress should provide a dedicated source of federal funding to support such immediate, sufficient, and sustained increases in Medicare payments for services provided by primary care physicians, not limited to budget-neutral redistribution within Medicare physician payments.
3. Congress should eliminate the linking of physician reimbursement by Centers for Medicare & Medicaid Services (CMS) to the sustainable growth rate (SGR). The instability of the SGR formula and its role in restraining payment updates below the rate of medical inflation are especially harmful to primary care practices, which typically run on low margins and have limited ability to increase the volume of services they provide. Any replacement for the SGR should allow for continued improvements in Medicare payments for primary care.
4. Public and private payers should continue to design, implement, evaluate, and expand payment and delivery system reforms to support care provided through the patient-centered medical home (PCMH) and other innovative models.
5. Public and private payers should support development, implementation and evaluation of other new payment models to support the provision of primary care linked to accountability for quality, patient satisfaction, efficiency, and effectiveness of the care rendered. (BoR 09)

Advocating for Medicare Payment Rates for Internal Medicine Subspecialists Providing Primary Care

ACP will continue to advocate for appropriate recognition of the value of services provided by primary care internal medicine specialists and internal medicine subspecialists, including recognition of the contributions of subspecialists to care coordination through a PCMH (medical home neighborhood), allowing IM subspecialists who accept responsibility for comprehensive and longitudinal care of the whole person to qualify for recognition as PCMHs, and developing, pilot-testing and promoting broad adoption of payment reforms that are applicable to different IM subspecialties and types of practice based on established ACP policies and that ACP will also continue to advocate for targeted payment reforms that are specifically designed to address inequities in payments for primary care, including increasing Medicare payments for designated services by general internists, family physicians, pediatricians, and geriatricians (e.g., the Medicare primary care incentive program).(BoR 11)

Reforming Medicare: Adapting a Successful Program to Meet New Challenges

Capitated or Risk-Sharing Approaches

Direct Contracting with Physician-Run Delivery Systems

CMS should contract directly with physicians who demonstrate the ability and willingness to provide a coordinated and comprehensive set of benefits for chronically ill Medicare beneficiaries.

Case Management

CMS should develop demonstration programs that use case management to coordinate services for patients with complex conditions. Providing capitated payments for primary care services to physicians leading an interdisciplinary team is a worthwhile approach.

Bundled Payment

The "bundled payment" demonstration program for heart bypass surgery—which creates a risk-sharing arrangement among physicians and other clinicians by combining fee-for-service payments for specific services—should be expanded, either by CMS or through the enactment of legislation.

Coordinated Care in Fee-for-Service Systems

Targeted Conditions

Medicare should reimburse physicians for providing comprehensive, coordinated care for beneficiaries suffering from chronic illnesses to facilitate delivery system changes.

Case Management

CMS should reimburse care management services under its fee schedule and develop demonstration programs to test various case management models in all payment. (BoR approved as amended 04-06)

"Medicaring": Coordinated Care for the Terminally Ill

Medicare should provide for hospice-type services, including palliative care, pain relief, family counseling, and other psychosocial services, for terminally ill beneficiaries outside of a hospice.

Preventive Care

Medicare should provide for preventive care, including appropriate screening services, for beneficiaries.

Private Sector Management Approaches

Purchasing Supplies and Equipment

CMS should consider competitive bidding, negotiation, and other methods of purchasing supplies and scrutinizing payments. Legislation should be enacted to provide CMS with the management authority to implement these cost-saving techniques.

Reducing Variations in Care

The College recommends increased funding for outcomes research, the development of clinical practice guidelines, and the creation of Quality Improvement Foundations to help identify successful clinical practices and disseminate information to physicians and their patients.

Medicare Coverage Decisions for New Technology

Cost Effectiveness

Medicare should use cost effectiveness as an explicit criterion in its decisions regarding coverage for a new technology.

Conditional and Interim Coverage

Medicare should increase its use of conditional or interim coverage rulings.

Reimbursement and Pricing Policy

Medicare should adopt more flexible pricing policies that cover the cost of the efficient use of technologies and provide incentives for the efficient use of resources.

Assuring Quality

Federal quality standards should be developed to ensure that Medicare beneficiaries receive high-quality care in managed care environments. These standards should guarantee that health plans adopt policies and procedures specifically designed for the elderly and require health plans to disclose all relevant information to beneficiaries regarding access to care, cost-sharing requirements, and other issues.

Enrollees should have access to performance measures that rate the quality of care provided by the plan on issues specific to Medicare beneficiaries, such as functional status or treatment of chronic conditions.

"Gag rules" or other actions designed to improperly intrude on the doctor-patient relationship should be prohibited.

Legislation should be enacted that authorizes CMS to contract directly with provider-sponsored organizations (PSOs) to provide Medicare beneficiaries with the Medicare benefits package for a capitated payment.

Revising the Payment Rate for Medicare HMOs

CMS should evaluate different approaches to fix the HMO payment methodology. Competitive bidding, adding new risk stratifiers, and establishing multi-county rates and payment thresholds all have the potential to improve the current system. In addition, payments for graduate medical education should be recaptured.

CMS should evaluate different approaches to fix the payment methodology. Competitive bidding, adding new risk stratifiers, and establishing multi-county rates and payment thresholds all have the potential to improve the current system. (Reforming Medicare: Adapting a Successful Program to Meet New Challenges, ACP 96; reaffirmed as amended BoR 06; reaffirmed as amended BoR 17)

Flu Vaccine

ACP will petition CMS to reimburse for the flu vaccine as clinically indicated or medically appropriate rather than only every 12 months starting from the last flu vaccine. (HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Medicare Carrier Contracts with CMS

ACP and its component societies will work to change future Medicare carrier contracts with the Centers for Medicare & Medicaid Services to delete provisions holding the individual carriers harmless from actions taken by the carrier. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Timely Notification of Medicare Changes

ACP, directly and through the AMA, urges CMS to establish appropriate notice and comment periods for both federal and local carrier proposed regulations and policies; and establish appropriate notification to practitioners before policy changes are implemented, particularly when these policies potentially carry an adverse impact on coverage or payment. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Carrier Screens and Denial of Payment for Medically Necessary Visits

ACP urges CMS to re-instruct all Medicare carriers that screens should be used to flag cases for further review, and not as a mechanism to automatically deny payments for covered services. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Durable Goods Fraud

ACP supports certification of all Medicare/Medicaid durable medical equipment providers, and ACP supports the existence of a mechanism in the Medicare/Medicaid system whereby potential abuses in the marketing of durable medical goods can be reported. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Medicare Physician Time Survey

ACP urges CMS to modify the process of evaluation of time spent by physicians employed by health care facilities in Medicare Part A funded activities to be less time and labor intensive in order to maximize the time spent in patient care, while still providing rational and reliable data to CMS and its intermediaries. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Equity in Post-Payment Utilization Reviews

ACP supports the development of review procedures which provide the audited physician with due process and the right to review the audit sample with the actual personnel responsible for the review. ACP supports the written publication of all regulations being enforced by the post-payment review personnel employed by the Medicare carriers. ACP supports federal legislation to prohibit the carrier from seeking repayment until the physician has exhausted all appeals and an accurate overpayment amount has been established. ACP supports limitations on the annual interest rate being charged against physicians and furthermore, the carrier be obligated to pay interest at the same level to physicians for any repayment amounts recouped in error. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Medicare Payment for Injectables

ACP supports a fair and reasonable Medicare reimbursement policy for injectables. This should include actual physician cost plus a reasonable overhead expense as well as a reasonable administration fee. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

ACP advocates that interpretation of the BIPA 2000 provision for Medicare coverage "including drugs

and biologicals which are not usually self-administered by the patient" is inclusive of Low Molecular Weight Heparins used in the short-term outpatient treatment of venous thrombosis. (BoR 02)

Medicare Reimbursement for Oximetry

Resolved, that the Board of Regents continue to urge CMS to reinstate Medicare coverage for pulse oximetry testing done in physician offices. (BoR 00; reaffirmed BoR 11)

Prohibit States from Tampering with Federally Funded Health Programs in Which States Have Not Contributed

ACP supports Congressional legislation that would prohibit states from mandating Medicare assignment, and to reverse all existing state mandatory assignment laws. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Explanation of Benefits

ACP urges that Medicare carriers be required to publish accurate and updated lists of participating physicians at least annually. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 15)

Separation of Physician Services from Other Part B Medicare Services

ACP supports and works for a policy of separation of physician services from other Part B expenditures for Medicare accounting purposes. (HoD 89; reaffirmed BoR 04)

Medical Review Programs

ACP supports targeted medical review programs that will improve the overall effectiveness of such review while decreasing inappropriate and unnecessary intrusion into the practice of medicine. Specifically, ACP supports placing increased emphasis on medical review of those services provided in physicians' offices that exhibit a pattern of care that appears to be aberrant, based on utilization screens and guidelines developed with input by the medical profession, as an alternative to more intrusive (and less effective) random review of services in physicians' offices; supports increased outpatient medical review that is targeted to high-cost and/or high-volume services provided in organized outpatient settings; supports revision of existing utilization and quality review screens based on substantial input by the medical profession that can be used to detect aberrant patterns of medical care that are not either necessary or of good quality. These screens should be disseminated within the medical community; supports enhanced coordination and consistency between Medicare carriers and PROs on medical review; advocates increased participation by the medical community in designing and conducting medical review; advocates improved medical review criteria that provides appropriate guidelines that reflect a broad medical consensus for proper care, as well as sufficient room for independent medical judgment. (HoD 88; reaffirmed BoR 04; reaffirmed BoR 15)

Medicare Assignment

ACP vigorously opposes any attempt by law, amendment or directive, to change the Medicare regulations which permit the practicing physician a free choice, on an individual patient basis, of accepting assignment on Medicare patients. (HoD 71; reaffirmed HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Physician Diagnostic Related Groups (DRGs)

ACP reaffirms its strong belief that a physician DRG system for paying for physician service to hospitalized patients, even if limited to radiologists, anesthesiologists, and pathologists, is a largely untested system that potentially could: undermine the quality of care provided to Medicare patients; create undesirable conflicts in the hospital medical staff; create an adversarial relationship between physicians and the hospital in which they treat their patients; and result in mandatory assignment for

some or all physicians. ACP strongly opposes legislation to authorize implementation of an MD-DRG system of payment for some or all physician services. ACP continues to strongly favor development of a resource cost relative value scale (RVS) as an alternative way of establishing, on a prospective basis, an appropriate price for all physician services, and strongly opposes the development and implementation of separate fee schedules for subsets of physician services that may undermine the integrity of a unified resource cost RVS for all physician services under Medicare. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Quality Care

The concept of Medicare as an entitlement program for the elderly, the disabled, and individuals with end-stage renal disease should be preserved, with a primary goal being the provision of cost-effective, quality health care. (HPA 87; reaffirmed BoR 04; reaffirmed BoR 15)

Update of Geographic Practice Cost Index

ACP will work with other interested parties to sponsor legislation that will effectively update the Medicare Geographic Practice Cost Index (GPCI) and allow for future updates to occur on a regularly scheduled basis. (BoR 09)

Legislate Coverage for Preventive Benefits

ACP shall:

1. Promote further improvement to the “Welcome to Medicare” examination benefit;
2. Promote separate payment for Medicare-covered preventive services when furnished during the Welcome to Medicare visit or a “medically necessary” visit;
3. Clarify current Medicare rules pertaining to the role that counseling/coordinating care related to patient receipt of Medicare covered-preventive services can play in determining the appropriate level of evaluation and management service to bill for a “medically necessary” visit;
4. Explore whether Centers for Medicare and Medicaid Services would make separate payment for counseling provided by a physician related to beneficiary receipt of Medicare-covered preventive services furnished by other physicians; and
5. Clarify how Medicare “incident-to” rules impact the ability of non-physician professional staff employed by a practice, i.e. nurse practitioners and physician assistants, to provide counseling.

Legislation shall allow beneficiaries to use a preventive health benefit in conjunction with an evaluation and management visit on the same day; and mandate a reimbursement level which recognizes the amount of time and effort needed to advise a patient on appropriate preventive benefits and Medicare coverage.(BoR 09)

Reforming Medicare in the Age of Deficit Reduction

1. To ensure solvency and maintain access to affordable care for beneficiaries, the Medicare program must lead a paradigm shift in the nation’s health care system by testing and accelerating adoption of new care models that improve population health, enhance the patient experience, and reduce per-beneficiary cost. Medicare must encourage patient-centered, coordinated, cost-conscious care (including access to a patient's primary care physician and specialists/subspecialists based on their health care needs); health information technology; collaboration across health care sectors; comparative effectiveness research; and other reforms

that result in improved care for beneficiaries. Changes to the Medicare benefit structure should not increase the administrative burden on physicians and other health care professionals.

2. To improve the way health care is delivered and ensure the future of primary care, the College recommends that Medicare accelerate adoption of the patient-centered medical home model and provide severity-adjusted monthly bundled care coordination payments, prospective payments per eligible patient, fee-for-service payments for visits, and performance assessment-based payments tied to quality, patient satisfaction, and efficiency measures. Additionally, new payment models should avoid the volume-oriented fee-for-service system in favor of approaches that are aligned with quality and efficiency, such as episode of care payments and accountable care organizations.
3. ACP does not support conversion of the existing Medicare defined benefits program to a premium support model. However, ACP could support pilot-testing of a defined benefit premium support option, on a demonstration project basis, with strong protections to ensure that costs are not shifted to enrollees to the extent that it hinders their access to care. Such a demonstration project would offer beneficiaries a choice between traditional Medicare and qualified premium support plans offered through the private sector, subject to Medicare requirements relating to benefits, cost-sharing, access to services, and premiums, while providing financial support to cover the Medicare benefit package. Such a demonstration project should:
 - a. Utilize risk-adjustment mechanisms to protect against adverse selection.
 - b. Provide a minimum benefit package equal to that of fee-for-service Medicare that includes preventive and primary care services without cost-sharing. Cost-sharing levels may vary but should reflect the actuarial value of traditional Medicare.
 - c. Apply network adequacy standards that ensure beneficiaries have access to a sufficient network of physicians and other providers, including a means for beneficiaries to access out-of-network physicians and other providers at no additional cost if they are unable to receive medically necessary care through their existing network.
 - d. Promote innovative delivery system models, such as the patient-centered medical home, among the participating fee-for-service Medicare and private plans.
 - e. Provide stringent oversight of health plan marketing activities to prevent cherry-picking and risk selection. A government entity or nonprofit organization should be authorized to provide outreach and objective educational assistance to beneficiaries.
 - f. The initial per capita federal contribution should be based on the average bid in a geographic area for a coordinated care plan providing the Medicare benefit package. The per capita Medicare expenditure level for that area may represent the fee-for-service bid. Subsequent federal contribution levels should rise with the average coordinated care plan premium (providing at least the Medicare benefit package) for that geographic area.
 - g. Dual-eligible beneficiaries should be exempt from participating in the demonstration project.
4. ACP supports policies to ensure that Medicare Advantage plans are funded at the level of the traditional Medicare program.

5. The Medicare eligibility age should only be increased to correspond with the Social Security eligibility age if affordable, comprehensive insurance is made available to those made ineligible for Medicare. Potential adverse impacts of prospectively increasing the age of eligibility could be mitigated by including a Medicare buy-in option (with income-based subsidies) for persons aged 55 to the age when they would become eligible for Medicare, by providing access and public income-based subsidies to buy coverage from qualified health plans offered through health exchanges, by providing access to Medicaid for persons up to 133% of the federal poverty level, and by reinsurance programs to encourage employer-based coverage.
6. ACP supports continuing to gradually increase Medicare premiums for wealthier beneficiaries as well as modest increases in the payroll tax to fund the Medicare program.
7. Congress should consider giving Medicare authority to redesign benefits, coverage, and cost-sharing to include consideration of the value of the care being provided based on evidence of clinical effectiveness and cost considerations.
 - a. ACP supports the concept of “value-based” insurance plans that vary the degree of patient cost-sharing based on the results of research on comparative effectiveness. Under such a proposal, patients would be encouraged to use health care resources wisely by varying patient cost-sharing levels so that services with greater value, based on a review of the evidence, have lower cost-sharing levels than those with less value. Although everyone should be guaranteed access to affordable, essential, and evidence-based benefits, persons should be able to obtain and purchase additional health care services and coverage at their own expense. However, physicians and other health care professionals should not be obligated to provide services that are unnecessary, inappropriate, harmful, and/or unproven even if the patient requests to pay for such services out-of-pocket.
 - 1) For such a program to be successful, stakeholders must work to educate physicians and other health professionals and their patients about high-value services, and encourage shared decision-making and use of patient decision aids to promote utilization of such services. Further, comparative effectiveness research should be pursued and given priority for federal funding to provide stakeholders with objective information on procedures and products of high or limited value.
 - b. A coordinated, independent, and evidence-based assessment process should be created to analyze the costs and clinical benefits of new medical technology before it enters the market, including comparisons with existing technologies. Such information should be incorporated into approval, coverage, payment, and plan benefit decisions by Medicare and other payers. The assessment process should balance the need to inform decisions on coverage and resource planning and allocation with the need to ensure that such research does not limit the development and diffusion of new technology of value to patients and clinicians or stifle innovation by making it too difficult for new technologies to gain approval. Coverage of tests and procedures should not be denied solely on the basis of cost-effectiveness ratios; coverage decisions should reflect evidence of appropriate utilization and clinical effectiveness. Useful information about the effectiveness and outcomes of technology and public education should be widely

disseminated to reduce patient and physician demand for technologies of unproven benefit.x

- c. Medicare should explore and pilot-test new ways to establish the pricing of physician services as part of new value-based payment models established with clear policy goals in mind, such as basing payment on evidence of value, so that high-value services would be paid more and lower-value services would be paid less.xi
8. ACP supports combining Medicare Parts A and B with a single deductible under the following circumstances:
- a. Specified primary care, preventive and screening procedures of high value based on evidence are not subject to the deductible, and no co-insurance or co-payments would apply;
 - b. A limit is placed on total out-of-pocket expenses that a beneficiary may incur in a calendar year (i.e., stop-loss coverage);
 - c. The deductible is set at an actuarially appropriate level that does not cause an undue financial burden on beneficiaries, especially lower-income beneficiaries; and
 - d. Medicare payment levels to physicians for covered primary care and preventive benefits are adequate to ensure that beneficiaries have access to such services, the payment rates cover physicians' resource costs (including annual increases in the costs of providing services due to inflation), and adequate annual updates are issued that are fair and predictable.
9. Supplemental Medicare coverage—Medigap plans—should only be altered in a manner that encourages use of high-quality, evidence-based care and does not lead Medicare beneficiaries to reduce use of such care because of cost. Preventive procedures, such as those rated an A or B by the United States Preventive Services Task Force, should be exempt from cost-sharing. Any changes made to the structure of Medigap plans should be made prospectively and not affect existing beneficiaries.
10. Medicare should provide for palliative and hospice services, including pain relief, patient and family counseling, and other psychosocial services for patients living with terminal illness.
- a. Voluntary advanced care planning should be covered and reimbursed by Medicare to encourage patient-physician engagement and ensure that patients are informed of their palliative and hospice care options. Medicare should permit subsequent counseling sessions so patients and their physicians may adjust their advance care plans as needed to reflect changes in care preferences. Physicians and their patients should not be required to conduct such counseling.
 - b. Palliative and hospice care services should be integrated across the health care spectrum, including such innovative delivery models as the patient-centered medical home.
 - c. The federal government and other stakeholders must improve consumer knowledge about advanced care planning, palliative, and hospice care options.
 - d. Racial and ethnic disparities related to palliative and hospice care must be addressed.

11. The costs of the Medicare Part D prescription drug program should be reduced by the federal government acting as a prudent purchaser of prescription drugs.
 - a. Drug manufacturers should be required to provide a rebate to low-income Medicare patients enrolled in Part D.
 - b. Congress should give Medicare the authority to negotiate the price of drugs offered under Part D, similar to the authority that the Veterans Administration has to negotiate the price of drugs for veterans.
12. Congress should amend the authority for an Independent Payment Advisory Board (IPAB) to:
 - a. Allow Congress to override IPAB recommendations with a majority rather than a supermajority vote before they go into effect.
 - b. Require that the IPAB include among its membership a physician who provides comprehensive and primary care services. The existing prohibition on members of the Commission having outside employment should be modified to create an exception for physicians involved in direct patient care.
 - c. Eliminate the requirement that IPAB must produce recommendations for a specified level of savings if a target rate of allowable growth is exceeded. The board should have the discretion to recommend higher or lower savings targets based on its judgment of the best approach to reducing spending while ensuring continued access to care.
 - d. Ensure that savings obtained through IPAB recommendations and implementation either improve or at least maintain the quality of care provided. Budgetary savings founded on reduced quality is short-sighted and inappropriate.
 - e. Authorize that the IPAB consider all Medicare providers and suppliers when developing payment delivery and expenditures change proposals. The existing prohibition on IPAB making recommendations relating to certain providers (e.g., hospitals) through the end of this decade should be lifted. Payment delivery and reduction changes should not be the burden of a restricted number of Medicare clinicians, providers, and suppliers.
 - f. Broaden IPAB's scope of potential policy recommendations to include changes in benefits, cost-sharing, revenue, and payment and delivery system reforms, not limited to physicians. (BoR 12)

MEDICARE: CARRIER REVIEW

Extrapolation Technique in Postpayment Review

ACP continues to urge CMS and Congress to require that Medicare carriers provide data which justify the statistical validity of their extrapolation findings prior to any request for return or monies paid to a physician. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Medicare Contractor Reviews of Medical Necessity for Hospital Inpatient Admissions Supported by Evidence-Based Medicine

ACP requests that Medicare Contractor reviews of medical necessity for hospital inpatient admissions be supported by evidenced-based medicine and physician judgment, review and input; and that the College urges transparency in the processes, policies and procedures that Medicare Contractors use to make determinations and/or denials of medical necessity for hospital inpatient admissions and that the use of review criteria and/or processes that are not grounded in evidence-based medicine and/or physician judgment, review and input be precluded; and that if Medicare Contractors deny an inpatient hospital

admission based upon commercially accepted inpatient screening criteria, the said admission shall undergo a physician review to determine if it meets medical necessity for inpatient hospital admission as defined by statute, regulation, CMS Rulings and guidance grounded upon evidence-based medicine and sound physician judgment, review and input. (BoR 10)

MEDICARE: QUALITY IMPROVEMENT ORGANIZATIONS

Peer Review and Expunging Remote Peer Citations

ACP requests that CMS require QIOs to establish uniform policies and procedures to allow physicians to have quality citations over five years old expunged when no subsequent quality citations have occurred. (HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Physician Involvement in Quality Improvement Organizations (QIOs)

ACP encourages internists to become actively involved with QIOs. ACP encourages the Centers for Medicare & Medicaid Services to continue to allow and encourage physician-directed QIOs. (HoD 84; reinstated HoD 95; reaffirmed as amended BoR 06; reaffirmed BoR 17)

Quality Improvement Organization (QIO) Accountability

ACP believes that state by state review costs and results should be a matter of public record and disclosure. ACP seeks changes in laws and/or regulations to require that CMS document ongoing QIO effectiveness prior to additional budget funding. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Quality Improvement Organization (QIO) Intervention to be Educational

ACP advocates changes in enabling legislation to require that case-review quality sanctions consist first of educational intervention, with referral to state licensing boards or fiscal sanctions permissible when the educational intervention is not followed or does not result in improved clinical conduct. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Quality Improvement Organization (QIO) Demerit Program

ACP believes that QIOs should be required to notify the treating physician and provide an opportunity to respond to each and every determination that a quality problem exists. ACP advocates that PROs disseminate general information regarding QIO defined quality problems maintaining patient and physician confidentiality to all hospital medical staffs in the state in either a monthly bulletin or a similar regular communication. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Quality Improvement Organization (QIO) Guidelines

ACP believes that any adverse decision from the QIO should be based on objective evidence which may include references to standard medical and surgical literature where appropriate. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 15)

Quality Improvement Organization (QIO) Reimbursement for Physicians

ACP recommends that, under QIO reimbursement principles, physicians should be adequately compensated for medical review and administrative services. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

NATIONAL PRACTITIONER DATA BANK

National Practitioner Data Bank

ACP supports legislation requiring an action by a court or a medical licensing jurisdiction before a physician-in-training may be reported to the National Practitioner Data Bank. (HoD 96; reaffirmed BoR

08)

ACP:

- Works with the representatives of the AMA to propose legislation insuring that physicians are notified prior to inclusion in their file of any material reportable to the National Practitioner Data Bank.
- Supports efforts to obtain federal legislation making it illegal for unauthorized agencies to require physicians to turn over their Data Bank reports.
- Continues efforts to place a reasonable minimum level of threshold on the reporting floor for settlements or liability awards against physicians.
- Supports the AMA's efforts to have the Department of Health and Human Services evaluate via independent consultant the Data Bank's effectiveness and confidentiality of data.

ACP opposes efforts to impose any additional data reporting requirements to the Data Bank. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

National Data Bank Reporting

ACP continues to support the AMA's proposed \$30,000 minimum floor for reporting medical malpractice settlements to the National Practitioner Data Bank. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Public Access to the National Practitioner Data Bank

ACP:

- Opposes opening malpractice claims information contained in the National Practitioner Data Bank to the public.
- Supports access to information contained in the National Practitioner Data Bank concerning finalized adverse state licensure actions regarding a physician's or other health professional's licensing privileges.
- Will evaluate further how information about physicians contained in the National Practitioner Data Bank or in other repositories such as the AMA's proposed Health Care Consumer Information Clearinghouse should be released to the public to protect consumers from unquestionably poor care givers without unfairly damaging the reputation of practitioners who provide appropriate, quality care.
- Supports enactment of meaningful tort reform legislation as a necessary component of any legislation to expand access to the National Practitioner Data Bank. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

PATIENT – PHYSICIAN RELATIONSHIP

Sexual Contact between Physician and Patient

Issues of dependency, trust, and transference and inequalities of power lead to increased vulnerability on the part of the patient and require that a physician not engage in a sexual relationship with a patient. It is unethical for a physician to become sexually involved with a current patient even if the patient initiates or consents to the contact.

Sexual involvement between physicians and former patients raises concern. The impact of the patient-physician relationship may be viewed very differently by physicians and former patients, and either

party may underestimate the influence of the past professional relationship. Many former patients continue to feel dependency and transference toward their physicians long after the professional relationship has ended. The intense trust often established between physician and patient may amplify the patient's vulnerability in a subsequent sexual relationship. A sexual relationship with a former patient is unethical if the physician "uses or exploits the trust, knowledge, emotions or influence derived from the previous professional relationship". Because it may be difficult to judge the impact of this influence, the physician should consult with a colleague or other professional before becoming sexually involved with a former patient. (BoR 04; Reaffirmed as amended BoR 11)

Medical Risk to Physician and Patient

Physicians take an oath to serve the sick. Traditionally, the ethical imperative for physicians to provide care has overridden the risk to the treating physician, even during epidemics. In recent decades, with better control of such risks, physicians have practiced medicine in the absence of risk as a prominent concern. However, potential occupational exposures such as HIV, multidrug-resistant tuberculosis, and viral hepatitis necessitate reaffirmation of the ethical imperative.

Physicians should evaluate their risk for becoming infected with pathogens, both in their personal lives and in the workplace, and implement appropriate precautions, including following guidelines for hygiene, protective garb, and constraints for exposure, designed to decrease spread of infection. Physicians who may have been exposed to pathogens have an ethical obligation to be tested and should do so voluntarily. Infected physicians should place themselves under the guidance of their personal physician or the review of local experts to determine in a confidential manner whether practice restrictions are appropriate on the basis of the physician's specialty, compliance with infection control precautions and physical and mental fitness to work. Infection does not in itself justify restrictions on the practice of an otherwise competent clinician. Physicians are expected to comply with public health and institutional policies.

Because the diseases mentioned above may be transmitted from patient to physician and pose risks to physicians' health,, some physicians may be tempted to avoid the care of infected patients. Physicians and health care organizations are obligated to provide competent and humane care to all patients, regardless of their illness. Physicians can and should expect their workplace to provide appropriate means to limit occupational exposure through rigorous infection control methods. The denial of appropriate care to a class of patients for any reason, including disease state, is unethical.

Whether infected physicians should disclose their condition depends on the likelihood of risk to the patient and relevant law or regulations. Physicians should remove themselves from care if it becomes clear that the risk associated with contact or with a procedure is high despite appropriate preventive measures. Physicians are obligated to disclose their condition after the fact if a clinically significant exposure has taken place.

Physicians have several obligations concerning nosocomial risk of infection. They should help the public understand the low level of this risk and put it in the perspective of other medical risks while acknowledging public concern. Physicians provide medical care to health care workers, and part of this care is discussing with health care them the duty to know their risk for such diseases as HIV or viral hepatitis, to voluntarily seek testing if they are at risk, and to take reasonable steps to protect patients. The physician who provides care for a potentially infectious health care worker must determine that worker's fitness to work. In some cases, potentially infectious health care workers cannot be persuaded to comply with accepted infection control guidelines. In such exceptional cases, the treating physician may need to breach confidentiality and report the situation to the appropriate authorities in order to

protect patients and maintain public trust in the profession, even though such actions may have legal consequences. (BoR 04; Reaffirmed as amended BoR 11)

The Physician and the Patient

The patient–physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess, the confidential nature of the relationship, and the imbalance of power between patient and physician. Physicians publicly profess that they will use their skills for the benefit of patients, not their own benefit [\(10\)](#). Physicians must uphold this declaration, as should their professional associations as communities of physicians that put patient welfare first [\(10\)](#).

The physician's primary commitment must always be to the patient's welfare and best interests, whether in preventing or treating illness or helping patients to cope with illness, disability, and death. The physician must respect the dignity of all persons and respect their uniqueness. The interests of the patient should always be promoted regardless of financial arrangements; the health care setting; or patient characteristics, such as decision-making capacity, behavior, or social status. Although the physician should be fairly compensated for services rendered, a sense of duty to the patient should take precedence over concern about compensation. (BoR 04; Reaffirmed as amended BoR 11)

Initiating and Discontinuing the Patient-Physician Relationship

At the beginning of and throughout the patient–physician relationship, the physician must work toward an understanding of the patient's health problems, concerns, goals, and expectations. After patient and physician agree on the problem and the goals of therapy, the physician presents one or more courses of action. The patient may authorize the physician to initiate a course of action; the physician can then accept that responsibility. The relationship has mutual obligations. The physician must be professionally competent, act responsibly, seek consultation when necessary, and treat the patient with compassion and respect, and the patient should participate responsibly in the care, including giving informed consent or refusal to care as the case might be.

Effective communication is critical to a strong patient–physician relationship. The physician has a duty to promote patient understanding and should be aware of barriers, including health literacy issues for the patient. Communication through e-mail or other electronic means can supplement face-to-face encounters; however, it must be done under appropriate guidelines [\(11\)](#). “Issuance of a prescription or other forms of treatment, based only on an online questionnaire or phone-based consultation, does not constitute an acceptable standard of care” [\(12\)](#). Exceptions to this may include on-call situations in which the patient has an established relationship with another clinician in the practice and certain urgent public health situations, such as the diagnosis and treatment of communicable infectious diseases. An example is the Centers for Disease Control and Prevention–endorsed practice of expedited partner therapy for certain sexually transmitted infections. However, aspects of a patient–physician relationship, such as the physician's responsibilities to the patient, attach even in the absence of interpersonal contact between the physician and patient [\(12\)](#).

Care and respect should guide the performance of the physical examination. The location and degree of privacy should be appropriate for the examination being performed, with chaperone services as an option. An appropriate setting and sufficient time should be allocated to encourage exploration of aspects of the patient's life pertinent to health, including habits, relationships, sexuality, vocation, culture, religion, and spirituality.

By history, tradition, and professional oath, physicians have a moral obligation to provide care for ill persons. Although this obligation is collective, each individual physician is obliged to do his or her fair share to ensure that all ill persons receive appropriate treatment [\(13\)](#). A physician may not discriminate against a class or category of patients.

An individual patient–physician relationship is formed on the basis of mutual agreement. In the absence of a preexisting relationship, the physician is not ethically obliged to provide care to an individual person unless no other physician is available, as is the case in some isolated communities, or when emergency treatment is required. Under these circumstances, the physician is morally bound to provide care and, if necessary, to arrange for proper follow-up. Physicians may also be bound by contract to provide care to beneficiaries of health plans in which they participate.

Physicians and patients may have different concepts of or cultural beliefs about the meaning and resolution of medical problems. The care of the patient and satisfaction of both parties are best served if physician and patient discuss their expectations and concerns. Although the physician must address the patient's concerns, he or she is not required to violate fundamental personal values, standards of medical care or ethical practice, or the law. When the patient's beliefs—religious, cultural, or otherwise—run counter to medical recommendations, the physician is obliged to try to understand clearly the beliefs and the viewpoints of the patient. If the physician cannot carry out the patient's wishes after seriously attempting to resolve differences, the physician should discuss with the patient his or her option to seek care from another physician.

Under rare circumstances, the physician may elect to discontinue the professional relationship, provided that adequate care is available elsewhere and the patient's health is not jeopardized in the process [\(14, 15\)](#). The physician should notify the patient in writing and obtain patient approval to transfer the medical records to another physician and comply with applicable laws. Continuity of care must be assured. Abandonment is unethical and a cause of action under the law. Physician-initiated termination is a serious event, especially if the patient is acutely ill, and should be undertaken only after genuine attempts to understand and resolve differences. The physician's responsibility is to serve the best interests of the patient. A patient is free to change physicians at any time and is entitled to the information contained in the medical records. (BoR 04; Reaffirmed as amended BoR 11)

Patient-Physician Covenant

Medicine is, at its center, a moral enterprise grounded in a covenant of trust.

ACP endorses the Patient-Physician Covenant which obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

The medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. (Ralph Crawshaw, MD of Portland Oregon, et. al, ACP 1995; reaffirmed BoR 06; reaffirmed BoR 17)

Controlling Health Care Costs: Encourage Cost-Consciousness and Patient Involvement in Shared Decision-Making

1. Health insurance benefits should be designed to encourage patient cost-consciousness and responsibility without deterring patients from receiving needed and appropriate services or participating in their care.
2. Physicians and other health care providers, including medical technology and pharmaceutical manufacturers and suppliers of medical equipment, should provide price transparency on the goods and services they provide.
3. Physicians should engage patients in shared decision-making and provide patients with sufficient information about all clinically appropriate treatment options and risk and risk/benefits, so that patients can make informed choices.
4. All payers should encourage shared decision-making and pay physicians for the additional time and resources involved, including the cost of providing patient-shared decision-making tools and maintaining a shared decision-making process.
5. Medicare should undertake demonstration projects to develop implementation models for shared decision-making and for the development and testing of decision aids.
6. Physicians and patients should engage in advance planning to help ensure that treatment decisions, including surrogate decision-making, are in accord with the patient's values and wishes. Medically appropriate care should never be withheld solely because of costs.
7. Research should seek to enhance the quality of life for terminally ill patients and their caregivers, and incentives should be provided for palliative care programs and hospice services in all settings. (BoR 09)

Unsolicited Communications

ACP opposes unsolicited communications (“cold calling”) of pharmaceuticals, durable medical equipment, supplies, and healthcare services that target patients and/or physicians and/or other prescribing clinicians including via direct mail, telecommunications, or facsimile. ACP believes this practice can lead to inappropriate treatment, interferes with the patient-clinician relationship, adds unnecessary costs to the health care system, and raises legal issues. (BoR 16)

PEER REVIEW

Second Opinions

ACP supports and encourages the concept of internists being considered as one of the consultants in any second opinion program, medical or surgical. (HoD 78; revised HoD 84; reinstated HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Voluntary Physician-Directed Peer Review

ACP continues to strongly support voluntary, physician-directed peer review programs that are dedicated to upholding quality medical care, and encourages internists' involvement in such programs. ACP supports the coordination of quality assurance programs. *National Goals:* Any peer review program's national goals should be stated in general terms that do not compromise the local autonomy of a peer review program nor become rigid criteria against which peer review programs will be evaluated. Any peer review program should be locally maintained and physician-directed. As such, they should control organization, function, and analytic procedures. *High Quality vs. Cost Considerations:* The high quality of medical care deserves precedence over considerations of cost in any peer review program. ACP encourages emphasis on the quality assurance activities and professional education aspects of any peer review program as methods of achieving high quality, cost effective medical care.

Those interested in the program must recognize its limited ability as a program devised as a quality assurance mechanism to contain costs. Evaluation of the program should focus on its impact in assuring high quality, cost effective care, and much less on its impact in containing costs. Judgments concerning differences of opinion regarding the utilization of a physician are best made by a peer review mechanism managed by impartial physicians. (HoD 80; revised HoD 81; revised HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

PERFORMANCE ASSESSMENT

The Use of Incentives to Promote Care

ACP supports payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending. Assessment of the value of the care provided may include reporting on evidence-based measures of outcomes, patient experience, population health, safety and effectiveness, and cost of the care provided. Such measures should be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. To the extent that such reforms include linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences. Specifically, ACP believes that payment and delivery system reform to promote high-value care should:

- Be integrated into innovative delivery system reforms such as the patient-centered medical home and other payment reform efforts that promote systems-based collaboration and health care delivery;
- Demonstrate improved quality patient care that is safer and more effective as the result of program implementation;
- Support an environment where all physicians—in both primary care and specialty practices—are supported in their efforts to perform better, continually raising the bar on quality;
- Develop, or link closely to, technical assistance efforts and learning collaboratives so that physicians and other health professionals are motivated and helped to improve their performance;
- Engage physicians in all aspects of program development including determination of standard measure sets, attribution methods, and incentive formulas; and
- Reflect national priorities for strengthened preventive health care, quality improvement, quality measurement, and reducing health disparities.

Position 2: To the extent that payment and delivery reforms include financial rewards and/or penalties linked to performance, the reward framework (i.e., type and magnitude of incentives) should be incorporated into systems-based payment reforms designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;

- Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards;
- Timely and followed closely upon the achievement of performance;
- Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and
- Adjusted as the complexity of performance measure requirements change.

The Need to Fundamentally Redesign the Physician Payment System

Programs to link payments to performance assessment must not exist in isolation and must be coordinated with concurrent efforts to improve evidence-based primary and specialty care. Programs should be integrated into other innovative delivery system reform initiatives that seek to promote care coordination across the health care sector and emphasize preventive rather than reactive care, reduce geographic disparities in quality of care, and nurture the patient–physician relationship, such as through a patient-centered medical home.

Public and private payers should work with the medical profession on a fundamental redesign of physician payment methodologies that include the following reforms:

- Physician reimbursement should encourage system-based care, promoting collaboration among payers, physicians, and other health care practitioners, and be structured to achieve the goals of improved population health, patient experience, physician and other health care clinician coordination, and reduced costs.
- The physician payment system should fairly compensate physicians for work and practice expenses, and payment updates should fairly reflect inflation.

Transparency and Oversight

Physicians should have a key role in determining methods used to develop and select measures (including the measurement evidence and any evidence grading methods used), collect data from physicians, aggregate and score performance, and report performance data internally and publicly. These processes should be transparent so that physicians, consumers, and payers know that methods, expectations, rationale, and results are valid and reliable. Sponsors of programs that link payment to assessment of performance should collaborate with physicians who are potential participants regarding program implementation, educate physicians about the potential risks and rewards inherent in program participation, and immediately inform physicians of any changes in program requirements and evaluation methods and newly identified risks and rewards. Payers should inform patients at time of enrollment of such efforts, potential risks, and physician participation.

Position 5: Programs that link payment to assessment of performance should incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate their effects on achieving improvements in quality, including any unintended consequences. The programs and, where appropriate, their performance thresholds should be readjusted only when there is compelling evidence and a justifiable reason to do so.

Selection of Measures

Position 6: The College reaffirms and expands upon the qualities of a good performance measure as reported in the ACP policy paper, *Linking Physician Payment to Quality Care*, and the position paper, *Healthcare Transparency—Focus on Price and Clinical Performance*:

Performance measures used to evaluate physician performance should be:

- Reliable, valid, and based on sound scientific evidence
- Clearly defined
- Based on up-to date, accurate data
- Adjusted for variations in case mix, severity, and risk
- Based on adequate sample size to be representative
- Selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance
- Reflective of processes of care that physicians and other clinicians can influence or impact
- Constructed to result in minimal or no unintended harmful consequences (e.g., adversely affect access to care)
- As least burdensome as possible
- Related to clinical conditions prioritized to have the greatest impact on improving patient health
- Developed, selected, and implemented through a transparent process easily understood by patients/consumers and other users

Position 7: ACP supports the use of structure, process, and outcome measures in programs that link payment to assessment of performance as long as they meet ACP's criteria for measures used to evaluate physician performance.

Position 8: Measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency—or “value-of-care” measures—must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value-of-care measures must appreciate the nuances of physician care and must not compromise the patient–physician relationship. Stakeholders must also work to develop population health measures designed for specific populations.

Position 9: The development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and has broad inclusiveness and consensus among stakeholders in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested prior to adoption to ensure their viability in the medical setting. Once in use, performance measures that have not been shown to improve value to include higher quality, better

outcomes, and reduced costs (and higher patient and physician satisfaction) should be removed from performance-based payment programs.

Position 10: ACP supports a national strategy for quality improvement that will establish national goals, attend to high-leverage priority areas that will lead to significant gains in quality and value of care (such as care coordination), fill gaps where few performance measures exist, develop universal terminology for measurement developers, and harmonize measure sets to improve coordination and reduce duplication and confusion. Such a strategy should also lead to determination of a single core measure set to provide data for benchmarking and ongoing quality improvement. The strategy should be updated as performance measures and programs to link payments to assessments of performance evolve. The College supports directing adequate financial resources to this and other related activities outlined in the Affordable Care Act.

Data Collection and Minimizing Physicians Burdens

Position 11: To alleviate the administrative burden of performance assessment-based payment programs, measurement sets, payment models, and data collection should be standardized across programs; HIT and EHR systems should be enabled to recognize and report performance assessment-based payment data; and audit and validation processes should be facilitated. Data collection and physician reporting required to support programs to assess performance should be administratively feasible, reliable, practical, and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- Prospective data collection should be encouraged whenever possible to minimize burdens and to reduce measurement error.
- Data collection methodology should be consensually determined by national health care stakeholders and standardized across P4P programs.
- Data collection and analysis must not violate patient privacy.
- Physicians should not be required to purchase or lease proprietary models of data collection.
- Programs must consider the unique practice challenges faced by safety-net providers, physicians in small practices, and physicians who are just entering practice, among others.

Position 12: Information technology tools should be used whenever possible to facilitate data acquisition for performance measures and to minimize any manual data extraction to support such measurement. Incentives and best practices for incorporation of electronic health records should be developed, pilot-tested, provided, and disseminated to improve data collection on clinical outcomes.

Data Accuracy, Data Aggregation, and Scoring

Position 13: Analysis and reporting of physician and system performance should include the application of statistical methods that provide valid and reliable comparative assessments across populations.

- Data should be fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, severity of illness, number of comorbid conditions, patient compliance, patient health insurance status, panel size/patient load, and other features of a physician's practice and patient population that may influence the results).

- To the extent possible, data analysis should accurately reflect all units of delivery that are accountable in whole or in part for the performance measured.
- Scores should relate care delivered (numerator) to a statistically valid population of patients in the denominator.

Position 14: Performance measure developers must incorporate socioeconomic status adjustments or other variables to ensure vulnerable patients receive the care they need. Programs that link payment to assessment of performance must monitor participants to identify and address unintended consequences, such as exacerbation of racial and ethnic health disparities. This may be achieved by including incentives to care for underserved or complex-needs patients in such programs.

- a. Measuring, scoring, and incentivizing physician and system performance should result in better patient care. It must not compromise patient access to care through such mechanisms as “deselection” or lead to increased attention to or manipulation of documentation.

Public Reporting and Other Appropriate Uses of Analytical Data

Position 15: The College reaffirms the importance of physicians and other health care professionals having timely access to performance information prior to public reporting and the availability of a fair and accurate appeals process to examine potential inaccuracies as reflected in the ACP policy paper,

Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of Their Rating.

Position 16: Educational feedback should be provided to physicians, other stakeholders in the system, and consumers on a timely, routine basis. Educational feedback should include a discussion of the physician’s individual performance, as well as his or her performance relative to other physicians. Reports should be user-friendly, easily accessible, standardized, and based on recommendations of relevant health care stakeholders. Physicians and other health care clinicians in the system should have the opportunity to review prior years’ performance data at any time.

Position 17: The results of programs to link payments to assessment of performance should not be used against physicians in health plan credentialing, licensure, or certification. Such programs must have defined security measures to prevent unauthorized release of physician ratings and patient data.

Program Implementation

Position 18: As physicians and other health care clinicians, payers, and affiliated community health organizations begin to establish a more collaborative infrastructure, stakeholders must work together to:

- Maintain a cooperative vision to achieve a team-based practice to reach the goals of improved patient experience, better population health outcomes, and reduced costs;
- Harmonize performance measures and data collection through a transparent, collaborative process;
- Improve access to health information technology and electronic medical records;
- Maintain timely and clear feedback to providers and other health care providers in the system;

- Provide ample incentives that at a minimum reflect the financial and practice costs of participation;
- Recognize the complex needs of small practices and physicians serving highly vulnerable populations, such as patients with multiple chronic conditions and the elderly; and
- Strengthen patient-centered primary care.

Position 19: It is crucial that any programs that link payments to performance assessment be subjected to ongoing research and monitoring to ensure that they support the patient–physician relationship, contribute positively to adoption of best practices, and do not unintentionally undermine patient care, such as by contributing to ethnic and racial disparities by penalizing or denying resources to clinicians, hospitals, and other providers who care for poorer and sicker patients. There must be timely reconfiguration of performance-based payment programs if such adverse effects are recognized. A Medicare value-based purchasing program and other initiatives to pay physicians based on performance assessment should meet the principles outlined in this paper. (BoR 11)

PHYSICIAN PAYMENT

A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care

Position 1: The College recommends that Medicare and other health care payers implement changes to support a new model of service delivery with related risk-adjusted prospective payments for ambulatory care that uses systems that promote patient-centered, longitudinal, coordinated care. This new model would apply to physicians in practices that have demonstrated key attributes necessary to manage care consistent with this approach, and would take into account the increased work and resources associated with providing this model of care.

Position 2: The College recommends that this new payment and delivery model be based on the principles of the Advanced Medical Home (AMH), which offers the benefits of a personal physician with a whole-person orientation and provides enhanced access to care, coordinated and integrated care, and increased efforts to ensure safety and quality. This model would improve the care for all patients and address current unmet needs of the chronically ill.

Position 3: The College recommends that a multi-component, bundled payment structure be implemented that results in a substantial increase in payments to primary and principal care physicians who accept responsibility for care management and coordination in recognized AMH practices. The payment structure should have a prospective component and be risk adjusted to reflect differences in the case mix of patients being treated. The increased reimbursement resulting from this payment structure must be sufficient to support the initial and sustained practice redesign and clinical work associated with effective management of patients in a variety of practice settings; particularly in smaller practices that provide the majority of care to Medicare beneficiaries. The payment model should specifically include a:

- Prospective, bundled structural practice component that covers practice expenses linked to the delivery of services under the AMH model not covered by the Medicare Resource-Based Relative Value Scale (RBRVS) system.
- Prospective, bundled care coordination component to cover physician and non-physician clinical and administrative staff work linked to the delivery of services under the AMH model not covered by the Medicare RBRVS system.

- Visit-based fee component for services delivered as part of a face-to-face visit and already recognized by the Medicare RBRVS system.
- Performance-based component based on the achievement of defined quality and cost-effectiveness goals as reflected on evidence-based quality, cost of care, and patient experience measures.

Position 4: The College recommends that Congress enact legislation to direct the Secretary of the Department of Health and Human Services (HHS) to implement a large-scale Medicare pilot project of the AMH model. The pilot would include a bundled payment structure that supports practices, including smaller practices that are recognized as AMHs; authority to institute incentives, such as reduced deductibles and co-insurance, for beneficiaries to select a physician within a recognized AMH as their personal physician; and non-financial incentives, such as reductions in documentation requirements, for practices that qualify as AMHs. The proposed pilot should also include representation from practices of varying sizes (with substantial representation from small practice settings), in different geographic settings and of varying levels of professional maturity. Upon completion of the pilot program, the Secretary should be authorized to implement changes in Medicare payment policies, including changes that will allow physicians in an AMH to share in program-wide savings attributable to them, to provide sustained and ongoing support to practices nationwide that meet the qualifications as an AMH.

Position 5: The College recommends that Centers for Medicare and Medicaid Services (CMS) provide separate Medicare payments under the RBRVS system for services that facilitate patient-centered, longitudinal, coordinated care to be used by physicians in practices that cannot provide all of the attributes necessary to qualify as an Advanced Medical Home in order to encourage improved and more efficient delivery of services.

Position 6: The College recommends that CMS implement procedures within the RBRVS system that:

- Improve the accuracy of work and practice expense relative values,
- Provide an incentive for the adoption of health information technology linked to quality improvement efforts,
- Provide incentives for physicians to participate in programs to continuously improve, measure and report on the quality and cost of the care provided.

Position 7: The College recommends that alternative volume or budget controls be considered by Congress only as a backup mechanism and only to the extent that other reforms in payment methodologies to improve quality and introduce greater efficiency are found to be insufficient. These other reforms include aligning Medicare payments with quality improvement, promoting adoption of HIT in support of quality improvement, promoting physician-guided care management and the Advanced Medical Home, encouraging evidence-based medicine, supporting the value of primary care, and addressing mispricing of services. (BoR 10-06; reaffirmed as amended BoR 17)

Advocating for Medicare Payment Rates for Internal Medicine Subspecialists Providing Primary Care

ACP will continue to advocate for appropriate recognition of the value of services provided by primary care internal medicine specialists and internal medicine subspecialists, including recognition of the contributions of subspecialists to care coordination through a PCMH (medical home neighborhood), allowing IM subspecialists who accept responsibility for comprehensive and longitudinal care of the whole person to qualify for recognition as PCMHs, and developing, pilot-testing and promoting broad adoption of payment reforms that are applicable to different IM subspecialties and types of practice

based on established ACP policies and that ACP will also continue to advocate for targeted payment reforms that are specifically designed to address inequities in payments for primary care, including increasing Medicare payments for designated services by general internists, family physicians, pediatricians, and geriatricians (e.g., the Medicare primary care incentive program).(BoR 11)

Reform of the Dysfunctional Healthcare Payment and Delivery System

I. Recommendations to Ensure the Accurate Valuation of Physician Services

The College calls on policymakers to make immediate reforms in the way that Medicare determines the value of physician services under the Medicare Resource Based Relative Value Schedule (RBRVS).

Position 1: The Centers for Medicare and Medicaid Services (CMS) should substantially increase the work relative value units (RVUs) for evaluation and management (E/M) services based on evidence showing increased physician work.

Position 2: CMS should re-examine its methodologies for determining practice expense RVUs to ensure that the practice expenses assigned to specific services reflect true resource costs.

- CMS should implement a “bottom-up” methodology for using practice expense inputs to determine practice expense RVUs.
- CMS should facilitate a survey of all physician specialties to identify practice costs to include in the practice expense methodology.
- CMS should review its assumptions on the utilization and depreciation of service/procedure-specific equipment.

Position 3: CMS should establish a better process for identifying potentially mis-valued RVUs and redistributing any savings into the budget neutral RVU pool.

- The Secretary should establish a group of independent experts to advise CMS in its process of reviewing RVUs.
- The Secretary should automatically review services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may reflect on the amount of physician work.
- The Secretary should automatically review the work RVU for recently introduced services after a specified period of time or based on other evidence that the work has changed over time.
- The Secretary should establish a process by which every service is reviewed periodically.

Position 4: CMS should request that the RVS Update Committee (RUC) examine its composition to assure that it is reflective of each specialty’s relative contribution to providing services to Medicare patients.

Position 5: The College recommends that MedPAC examine modifying the RBRVS definition of work to more adequately reflect those processes related to the improving of clinical quality, efficiency and patient experience.

II. Recommendations to Provide Separate Medicare Payments for Services that Facilitate Accessible and Coordinated Care

The College calls on policymakers to make immediate reforms so that Medicare can pay physicians for providing patient-focused, longitudinal, coordinated care.

Position 6: CMS should provide separate payment for services employing e-mail, telephonic, and related technology that could facilitate timely communications between physicians and patients and reduce the need for face-to-face visits for non-urgent care.

Position 7: CMS should provide Medicare payment to physicians for the overall provision of defined care coordination/care management services, and/or provide specific codes for those activities that facilitate care coordination/care management services (e.g. care coordination across treatment settings, intensive care follow-up, use of patient registries and population-based treatment protocols, patient disease management training.)

Position 8: CMS should provide an add-on to Medicare payments for office visits that are facilitated by the use of HIT, such as electronic health records, electronic prescribing and clinical decision support tools, and reimburse accordingly. Furthermore, to ensure that the use of this technology is primarily to facilitate improved healthcare quality/safety, payment should be contingent on participation by physicians in reporting related data to approved quality improvement and measurement programs.

III. Recommendations to Add a Quality Component to the Medicare Payment System

Position 9: Congress and CMS should provide sustained and sufficient financial incentives for physicians to participate in programs to continuously improve, measure and report on the quality and efficiency of care provided to patients.

- The current payment system should be modified to allow new methods of reimbursement that reward those who follow evidence-based standards.
- Rewards should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.
- Pay for performance (P4P) systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.
- The value of health information technology (e.g. electronic health records, decision-support tools) should be financially recognized for its ability to assist physicians to do well on quality measures and report their progress.
- Potential P4P rewards should be significant enough to support continuous quality improvement, directed at positive rewards, not negative penalties, and be balanced between rewarding high performance and substantial improvement over time.
- Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement. (BoR 06; reaffirmed as amended 17)

Controlling Health Care Costs: Ensure Accurate Pricing of Services

The accuracy of relative value determinations under Medicare should be ensured through improvements in the processes for identifying potentially undervalued and overvalued services, for recommending new and revised physician work relative value units, and for determination of practice expenses. (BoR 09)

Composition of the Relative Value Update Committee

The membership of the Relative Value Update Committee (RUC) should better reflect concerns of those physicians who primarily provide cognitive services (reaffirmed BoR 08)

CMS Contracts with Professional Review Organizations

The American College of Physicians (ACP) opposes performance-based contract requirements that create inappropriate incentives for identification of payment errors. (BoR 4-99, revised BoR 10)

Billing for Contracted Diagnostic Services

ACP supports the concept that billing for contracted diagnostic services should be limited to the amount charged by the contracted service plus a reasonable fee for professional and administrative services provided. (HoD 86; reaffirmed HoD 97, reaffirmed BoR 10)

Principles on Payment for Physician Services

Development of Valid Utilization Guidelines on the Frequency of Services

ACP favors the development by the medical profession of valid utilization guidelines on the frequency for which certain services are provided for patients with given diagnoses, as well as the development of valid physician specific utilization data that could be used as a basis of comparison with accepted community norms, as ways to address "overutilization" of services. Use of such professionally developed utilization guidelines is preferable to the alternative of including payment for all ancillary services in a global fee for an "ambulatory visit package" or diagnosis related group.

Peer Review of In-Office Care

ACP endorses the concept that if quality improvement organizations (QIOs) review in-office care, such review should be limited to those physicians identified as potentially aberrant through professionally developed utilization guidelines.

Development of Valid Data on Variations in Practice Patterns

ACP encourages the development of data systems that can generate adequate and statistically valid data on variations in practice patterns in different parts of the country, for dissemination to physicians by their professional organizations. ACP supports the concept that data collection and anonymous (not physician specific) publication is the key to educating internists and other physicians on practice patterns. Such educational measures are preferable to punitive approaches.

Discussion of Fees

ACP encourages members to discuss with patients the fees charged for their services (in advance of rendering services, whenever possible) with the qualification that the fee charged for an office visit or other service does not necessarily predict the total cost of care. (HoD 86; reaffirmed HoD 97; reaffirmed BoR 08)

Financial relationships between patients and physicians vary from fee-for-service to government contractual arrangements and prepaid insurance. Financial arrangements and expectations should be clearly established. Fees for physician services should accurately reflect the services provided. Physicians should be aware that a beneficent intention to forgive copayments for patients who are financially stressed may nonetheless be fraud under current law.

When physicians elect to offer professional courtesy to a colleague, physicians and patients should function without feelings of constraints on time or resources and without shortcut approaches. Colleague-patients who initiate questions in informal settings put the treating physician in a less than ideal position to provide optimal care. Both parties should avoid this inappropriate practice.

As professionals dedicated to serving the sick, all physicians should do their fair share to provide services to uninsured and underinsured persons. Physicians who participate in retainer fee practices ("boutique" or "concierge" medicine) should be aware that by thus limiting their patient populations, they risk compromising their professional obligation to care for the poor and the credibility of medicine's commitment to serving all classes of patients who are in need of medical care. (Ethics Manual Fifth Edition, 2005)

Resource Costs

ACP believes that payment systems should recognize that the complexity, time, and resources involved in providing physician services to an individual patient may vary according to the patient's condition, the skill and training of the physician, and other factors. Although specialty profiling is one acceptable method to recognize legitimate differences among physicians in the complexity, time and resources involved in providing services, other payment methodologies may be developed that are consistent with this objective. ACP's support for the principle that third party payers should recognize appropriate differences in the time, liability risk, complexity, and resources required to provide services to individual patients is more important than endorsement of any particular methodology, such as specialty profiling, intended to accomplish that objective. (HoD 85; revised HoD 86; reaffirmed HoD 97; reaffirmed BoR 08)

Pluralistic System

ACP affirms that maintaining a pluralistic approach to the organization, delivery and financing of medical care continues to be of highest priority. Such a pluralistic system will preserve the ability of patients, physicians, and third party payers to participate and experiment with a wide variety of acceptable methods of payment for physician services, including fee-for-service, capitation, salary, and fee schedules. Under a true pluralistic system, the federal government should not favor any particular methods of organization, delivery and financing of medical care over another. ACP works to assure appropriate compensation for internists' services under each type of payment system. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Excessive or Exorbitant Fees/Ordering Inappropriate Services

ACP believes that the small minority of physicians, including some in internal medicine, who charge excessive or exorbitant fees (i.e., fees in excess of any reasonable standard of compensation based on the resources involved in providing the service) or who receive remuneration by ordering services not clearly medically appropriate are providing a disservice both to patients and the medical profession. ACP and other medical organizations should investigate legally acceptable mechanisms to strengthen the ability of the profession to exert influence over those physicians who charge exorbitant fees or who order services not clearly medically appropriate. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Opposition to Payment for Physician Services Via Hospitals

ACP affirms its strong opposition to proposals that would mandate that payment for physician services be funneled through the hospital administration or medical staff for distribution. Internists may, however, voluntarily elect to bill for services through the hospital administration or medical staff or voluntarily participate in integrated care payment models (e.g. bundled payment, Accountable Care Organizations (ACO)) in which payment is provided through the hospital for distribution to the participating professionals. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 06; reaffirmed BoR 12)

Appropriate Compensation for Internist Services

ACP continues to devote resources to developing policy and recommendations to assure appropriate compensation for internists' services under arrangements other than fee-for-service, such as capitation and salaries. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Patient Cost Sharing

ACP continues to encourage patient cost sharing under all private and governmental insurance plans. (HoD 85; reaffirmed HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

Physician Billing for Services Related to Lab Work

ACP continues to promote improvements to ensure adequate and fair compensation for work associated with professional and technical services related to lab test, including: increasing reimbursement for work associated with specimen collection and handling to reflect true overhead costs; seeking fair reimbursement for interpretation of tests independent of office visits or other evaluation and management services; and improving the relative values for evaluation and management services, including office visits, to reflect the true resource costs of test interpretation. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Principles of Payment for Physicians Services

Physicians should continue to volunteer fee information to patients, to discuss fees in advance of services where feasible, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. If a physician does not participate in a patient's health insurance plan, the patient should be informed of this fact prior to the time when an 'elective' medical/surgical service is provided. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Principles on Which Reimbursement Plans Should be Based

ACP believes that the acceptability and desirability of any existing or proposed reimbursement plan depends on its consistency with the following principles: Physicians should have the right to set their own fees at a level that appropriately reflects the resource costs (such as overhead, training, and time) involved in providing the service and the value of their cognitive judgment, independent of the amount of third party reimbursement available for each service. Peer review should be used (to the extent legally permissible) to resolve disputes between patients and physicians over the appropriateness of the fee charged. Physicians should have the right to participate or decline participation in a particular insurance plan, to accept or decline to accept a particular method of payment (such as capitation, global fees, salary, or fee-for-service), and to accept or decline to accept the third party payers' allowance as "payment in full" (except for coinsurance and deductible requirements) for a particular service. Physicians may voluntarily sign contractual agreements that require them (for a period of time) to accept a particular method of payment and/or to accept third party allowances as "payment in full." Third party allowances should provide for improved recognition of the value of physicians' cognitive services in comparison to procedural services, regardless of the method of payment or means for determining allowances. Third party payers should consider basing allowances at least in part on the resource costs (such as time, complexity, training, skill, and overhead) incurred by physicians in providing the services. To the extent legally permissible, participating physicians (i.e., those physicians who voluntarily choose to enroll in a particular insurance plan) should be consulted in the development of fee allowances for those third party plans that require enrolled physicians to accept the plan's allowances as payment in full. Fee allowances for such plans should be regularly updated to appropriately reflect changes in the costs and value of each covered service. Internists and other primary care physicians should be appropriately represented on the physician negotiating team for any insurance plan that pays on the basis of negotiated fee schedules. (HoD 83; reaffirmed HoD 94;

reaffirmed BoR 04; reaffirmed BoR 15)

Resource Costs as the Basis for Determining Charges and Allowances

ACP believes that allowances for all cognitive, procedural, and technical services should be based on the resource costs of providing the service (such as overhead costs, investment in professional training, time, and complexity). (HoD 83; reaffirmed HoD 94; reaffirmed BoR 04; reaffirmed BoR 16)

Increasing RVU for E/M Codes

ACP will press third party payers to allow separate recognition and reimbursement for medical services provided after hours and on weekends to account for increased physician resource costs necessary to provide those services. (HoD 93; reaffirmed BoR 04; reaffirmed BoR 16)

Technical Procedures--Third Party Coverage

Third party coverage for a technical procedure performed by a physician competent by training and experience in the procedure should not be excluded because of differences in the setting in which the procedure is performed (as long as the setting is medically appropriate) nor because of differences in the specialty designation of the physician performing the procedure. Reimbursement for technical procedures performed in the ambulatory or outpatient setting should be at a level at least equal to the level of payment in the inpatient setting. (HoD 82; reaffirmed HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

Monthly Capitated Payment for Dialysis Services

ACP encourages CMS and Congress to update the MCP to reflect the true cost of providing these dialysis services. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Smoking Cessation Counseling

ACP petitions CMS and other third party payers to recognize the diagnostic code for tobacco abuse as a medically necessary diagnosis and to pay appropriately for smoking cessation counseling and monitoring as they would for any other physician's office visit. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

ACP urges third-party payers to reimburse physicians for their efforts in helping patients to stop smoking. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Guidelines on Appropriate Use of the Telephone for Diagnosis and Treatment of Patients

Many professional services can be provided with high quality and efficiency via telephone. Telephone services which are reasonable, properly documented, and of high quality are billable services which merit reimbursement by patients and third parties, including Medicare, Medicaid and private insurers. Coding and billing for telephone services should not be dependent on the reimbursement policy of any third-party payer involved, and should be applied uniformly to Medicare, Medicaid, privately-insured and uninsured patients.

Reasons for Telephone Care

1. Many health care decisions can be made safely over the phone.
2. Telephone care, when properly rendered, saves the patient and the health care system both time and money.
3. Immediate availability during the day, night, weekend and holidays.
4. The physician will be much more willing to provide thorough and appropriate medical service via telephone if properly reimbursed for the time and effort spent.

5. Many patients with chronic diseases require multiple physician contact. Each contact does not require a face-to-face encounter, but physicians will not be willing to provide such care over the telephone unless they are properly reimbursed.
6. Immediate transmission of medical information via fax or any other electronic means.

Reimbursement

These guidelines were drafted to indicate the situations in which ACP believes that medically necessary telephone services involve sufficient resource use and complexity to warrant separate recognition and reimbursement. The appropriate CPT-4 case management telephone service code should be determined according to the level of service rendered. The charge should be based on time, intensity and complexity of the call. Patients should be informed of policy or guidelines adopted by the physician concerning telephone service charges, including what types of services merit a charge, general or specific details of the charge amounts, as well as an explanation that charges are made without regard to a patient's specific insurance benefits and may not be reimbursed by the third party. In addition, physicians should negotiate with third-party payers which have not yet established acceptable policy, guidelines or documentation requirements related to these services.

Documentation

All telephone services which are billed should be documented on the patient's chart. These should include the date of the call, reason for the call, diagnosis, treatment given, involved parties (if other than the patient) and follow-up instructions. (HoD 91; reaffirmed BoR 04)

Reimbursing Physicians for Computer-Based Care

Recommendation 1:

ACP supports reimbursement by Medicare and other payers for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communication, consultations, and other appropriate services via the Internet. The guidelines should include examples of both reimbursable and nonreimbursable Internet-related communication.

Recommendation 3:

Payment for health-related Internet communication should not result in a reduction in separate payments for evaluation and management (E/M) services. Such reimbursement should also not be subject to budget neutrality offsets under the Medicare fee schedule. (BoR 03, reaffirmed BoR13)

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Reimbursement for Two Procedures Performed on the Same Day

ACP believes that a medical evaluation and other diagnostic or therapeutic services performed on the same day as the medical evaluation are not linked services and should be reimbursed separately (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Case Management Services

ACP believes that Congress, the Centers for Medicare & Medicaid Services (CMS) and the insurance industry should recognize and reimburse physicians for case management services. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Prayer Fees Reimbursed as a Medical Expense

ACP believes that prayer as therapy which delays access to traditional medical care is inappropriate. ACP believes that reimbursement by any third party entity for prayer as a medical therapy is inappropriate. ACP believes that therapy should not be considered as a medically deductible expense. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Computerized Electrocardiograms (EKGs)

The physician interpreting a computerized EKG, which cannot be successfully interpreted by a computer, should make the same charge as he or she would customarily make for reading a non-computerized EKG. Such a charge should be commensurate with the physician's skills and should in general be the usual charge for such service within his or her community. In regards to the charge that a physician should make for a review of an EKG interpreted as normal or abnormal by computer, that portion of interpretation of a computer-analyzed EKG that requires the skills and knowledge of the physician should be charged for by the physician. The ultimate responsibility for the use of a computer on non-computer electrocardiographic interpretation remains with the physician responsible for patient care at the time. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Disability Determination Reports

The internist is receiving an increasing number of demands for reports on the physical status of patients to be used in disability determination by various governmental agencies. Furnishing of these reports constitutes a significant expense to the physician. ACP believes that the physician may, at his or her discretion, make an appropriate charge to the patient when payment cannot be received from the agency requesting a report on the patient's physical status. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Patient Counseling

ACP supports greater recognition and adequate reimbursement for extended and complex counseling. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Patient Education

ACP recognizes that appropriate patient education is integral to quality medical care. Successful management of many illnesses cannot be achieved without patient behavioral change. Although the physician is the primary patient educator, other educational methods are available to supplement his or her efforts. Those patients who can benefit from such education should be identified and appropriate programs of patient education developed. Patient education exposures should be recorded in the medical record. Under certain circumstances, patient education can be identified as a separate, compensable component of physicians' services. The appropriateness of such charges, when questioned, should be referred for local peer review. (HoD 87; reaffirmed BoR 04)

Payment for Services Not Requested by Attending Physician

Physicians, including hospital-based specialists, should not bill patients for consultative or other medical services not requested by the attending physician. (HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Solo Practitioners--Payment Schedules

ACP strongly urges all insurance carriers and the Centers for Medicare & Medicaid Services not to discriminate against the solo practitioner in any payment schedule. (HoD 73; revised HoD 87; reaffirmed BoR 04; reaffirmed BoR 15)

Controlling Health Care Costs: Pay Appropriately for Health Care Services, and Encourage Adoption of the Patient-Centered Medical Home and Other Innovative Models of Health Care Delivery

1. Congress should provide the Secretary of the Department of Health and Human Services with authority and funding to conduct voluntary pilots of innovative models to better align physician payment with desired outcomes pertaining to quality, cost-effectiveness, and efficient patient-centered care and create a fast-track process and timeline for widespread adoption of the models that are shown to have the greatest positive impact on these desired outcomes.
2. Medicare and other payers should accelerate adoption of the PCMH model by transitioning to a coverage and payment structure for qualifying practices. Payments to qualified PCMHs should include severity-adjusted monthly bundled care coordination payments, prospective payments per eligible patient, fee-for-service payments for visits, and performance-based payments based on evidence-based quality, patient satisfaction, and efficiency measures. The monthly bundled care coordination payment should cover the practice overhead costs of a PCMH linked to the costs of providing services that are not currently paid under the present system. It should also cover the work value of physician and nonphysician clinical and administrative care coordination activities of the PCMH that take place outside of face-to-face visits. Other payment models to support care provided through a PCMH could also be pilot-tested.
3. Physicians and multidisciplinary teams should be paid for care management and care coordination services provided on a fee-for-service basis.
4. Fee-for-service payments to primary care physicians should be increased to be competitive with payments for other fields and specialties in medicine to ensure a sufficient supply of primary care physicians that will help save costs in the long run. (BoR 09)

Comprehensive Payment Reform: Reforming Physician Payments to Achieve Greater Value in Health Care Spending

New Payment Models Are Needed to Increase Value in Health Care Spending

1. ACP strongly supports the need to develop new payment models that align physician incentives with effective and efficient care instead of paying on the basis of the volume of services.

Recommended Elements for New Physician Payment Models

1. New payment models should support specific policy objectives to ensure accuracy, predictability, and the appropriate valuation of physician services
 - a. Recognize the value of primary care physicians and services
 - b. Provide immediate/short-term payment increases to signal that primary care is valued
 - c. Recognize services provided outside of face-to-face encounters with the patient
 - d. Improve accuracy in the valuation of physician services
 - e. Recognize the value of patient-centered, longitudinal, coordinated care services and the cost of providing these services
 - f. Recognize the value of critical elements of chronic care delivery, such as disease self-management and follow-up, and the cost of providing these services
 - g. Recognize the value of quality improvement and performance measurement on the basis of evidence-based quality, cost efficiency, and patient experience of care, and recognizing the cost of obtaining these data
 - h. Provide, at a minimum, a transition to a unit of payment that diminishes the incentive to increase volume, ensures appropriateness, and promotes greater accountability
 - i. Recognize and appropriately value the complexity, time, and costs associated with sicker-than-average patients, avoiding a potential disincentive for physicians to treat patients with more complex conditions
 - j. Recognize quality and efficiency and reward appropriate stewardship of resources while promoting and maintaining high quality
2. New payment models should increase value to the health care system
 - b. Promote comparative/cost-effectiveness research
 - c. Foster coverage policies that reflect clinical evidence related to treatments
 - d. Promote transparency in reporting on the quality and cost of care in a manner fair to physicians
 - e. Promote increased transparency for all stakeholders and health care sectors
3. New payment models should support patient-centered care and patient engagement in shared decision-making
 - c. Engage and empower patients; promote shared decision-making
 - d. Ensure that patient financial liability in obtaining evidence-based treatments is reasonable
 - e. Include the expectation that patients assume some degree of responsibility for their health
 - f. Encourage team-based care in which a physician directs and/or collaborates with other health care professionals, as well as office-based staff and other personnel, to meet the needs of patients
 - g. Structure payments to reward physicians for providing care that reflects the needs and preferences of the patient (patient-centered care), with emphasis on activities that satisfy requirements for the practice to be recognized as a Patient-Centered Medical Home

- h. Provide incentives that support care to all patients on a physician panel—avoiding patient segmentation by condition and/or type of care that requires multiple delivery models overly disruptive to practice
 - i. Provide for on-going input from patients and organizations representing them
4. New payment models should encourage appropriate expenditures on physician services
- a. Provide, at a minimum, a pathway to eliminate the Sustainable Growth Rate formula system and do so in a way that is sustainable and politically viable
 - b. Provide predictable and stable updates to Medicare physician payments through a mechanism that enables all services to realize positive updates but ensures a positive update for primary care services
 - c. Examine the appropriateness of growth in expenditures on physician services at a sub-aggregate level; for example, by type of service
 - d. Assess the impact of changes in expenditures on physician services, such as Part B spending, in the context of the overall Medicare program, such as Part A or Part D spending
 - e. Assess cross-system physician expenditure impacts at a sub-aggregate level; for example, on Part A spending
 - f. Recognize the value of primary care services and the urgent need for action that can redistribute expenditures toward primary care services
5. New payment models should align incentives across the health care system
- a. Align financial incentives across the health care system—hospitals, physicians and other health care professionals and providers—working toward shared objectives
 - b. Ensure that the data and other informational element needs inherent to a model, such as attributing patients to physicians or identifying an episode of patient care, can be achieved in a manner that is accurate and understandable to stakeholders
 - c. Provide fair policies and/or formulae for distributing money if payments are intertwined—either as a single payment for a bundle of services or through a shared savings fund
 - d. Provide a clear indication of the expected impact of any mechanism aimed at aligning incentives across the health care system by addressing:
 - i) Timing, including whether testing is prudent;
 - ii) Whether the model is predictable in a way that enables essential business planning;
 - iii) Whether the model is sustainable;
 - iv) Whether the model is practical for physicians and other stakeholders; and
 - v) The degree, if any, to which physicians and other stakeholders are at financial risk
6. New payment models should encourage the optimal number and distribution of physicians in the workforce
- a. Have as an explicit payment policy goal that the numbers of physicians who enter primary care and the proportion of those who remain are sufficient to meet the expected increased demand for adult primary care
 - b. Provide a mechanism to assess the extent to which reforms achieve primary care workforce or environment improvement goals

7. New payment models should encourage the use of health information technology that has the capabilities needed to support clinicians' efforts to improve the quality and effectiveness of care
 - a. Provide positive financial incentives to facilitate the adoption and use of Health Information Technology (HIT) that are, at a minimum, of a sufficient amount and duration to ensure physician interest
 - b. Payment penalties for failure to adopt/use HIT should only be applied after a foundation is established that involves appropriate standards, provides reasonable functionality, and ensures interoperability
 - c. Any policy that penalizes failure to adopt or use HIT through payment reductions after a phase-out of payment incentives should include a mechanism to monitor the foundational elements described above. Planned payment reductions should be halted if it is determined that the foundational elements have yet to be realized
 - d. Recognize that the realization of widespread use of interoperable HIT extends beyond acquisition and maintenance costs and addresses the need for appropriate industry standards, technical support, and physician practice workflow changes
8. New payment models should recognize differences in practice characteristics, including the prevalence of small practices
 - a. Recognize the specific challenges of small physician practices—where most patients receive their care
 - b. Recognize challenges patients have in receiving care in rural and other underserved areas, which are typically served by small practices
 - c. The extent to which physician payment is “at risk” should be limited or otherwise clearly defined. A requirement to accept risk as incurred by an insurer would be an insurmountable obstacle for most physician practices
 - d. Provide physicians the ability to participate in a payment approach that best suits the needs of their practice. This element is essential during the testing phase and likely to remain necessary even after successful models are identified and made a permanent part of the Medicare program.
9. New payment models should seek to minimize the imposition of new administrative tasks and costs on physician practices and seek to reduce the cumulative burden of existing requirements that detract from patient care.
 - a. Assess the impact of the new payment model on the administrative tasks and costs required of physicians and physician practices and have an explicit goal to not impose additional tasks that are unnecessary
 - b. Ensure that the cost of any new administrative requirements inherent in new models, such as achieving PCMH recognition, be recognized in the payment structure
 - c. Ensure that inherent new administrative requirements be designed to minimize burden and are facilitated through technology when possible
 - d. Have an explicit goal of reducing existing administrative tasks and costs imposed on physicians and practices under the current, primarily volume-based payment system
 - e. Replace medical review processes that involve Medicare personnel review of medical record documents to assess the necessity of services billed to the program with processes that encourage accountability on the basis of measurement of quality, effectiveness, and efficiency of care

- f. Recognize that primary care and principal care physicians—those with a longitudinal relationship with patients—have an especially heavy administrative workload
- 10. New payment models should recognize the costs to physicians associated with the transition to the new payment structure
 - a. Recognize the costs—in terms of lost productivity, training, and infrastructure—associated with transition to a new payment system.
- 11. New payment models should allow for on-going evaluation and assessment for change
 - a. Provide mechanisms to monitor and assess the impact of reform, including individual elements, and make modifications as appropriate
- 12. Process for Testing Innovative Payment Reform Models to Achieve Maximum Benefit
 - a. Congress should provide the Secretary of the Department of Health and Human Services (HHS) Secretary with the authority and funding to conduct voluntary pilots of innovative models to better align physician payment with desired outcomes pertaining to quality, cost-effectiveness, and efficient patient-centered care and to create a fast-track process and timeline for widespread adoption of the models that are shown to have the greatest positive impact on these desired outcomes. Congress should direct the HHS Secretary to take the specific steps below to guide this effort.
 - i. Direct the HHS Secretary to establish criteria for determining which physician payment reform models should receive priority for fast track funding and implementation. Such criteria should be determined in consultation with physicians, consumers and other stakeholders and specifically include the ACP recommended reform elements articulated in this paper.
 - ii. Direct the HHS Secretary to select payment models, based on the criteria as referenced above, for fast-track funding, implementation and evaluation on a pilot basis, not constrained by the usual requirements for research and development funding, such as the requirement that all pilots be implemented on a budget neutral basis. The Secretary may prioritize and stagger the timeline for implementation but highest priority projects should begin as soon as practicable. Priority should be given to piloting payment models that specifically aim to improve the primary care physician practice environment.
 - iii. Direct the HHS Secretary to establish a technical advisory panel of health policy experts, consumers, physicians (including primary care physicians), and other stakeholders to provide advice to HHS on design, implementation and evaluation metrics for each pilot selected under such fast track authority. Such technical advisory panel shall also assist HHS in ongoing assessment of each pilot as data become available.
 - iv. Direct the HHS Secretary to create processes to allow for voluntary participation by a wide range of physician practices, primary care and non-primary care practices alike, to participate in the projects selected under the fast track authority, recognizing that different models may be more or less applicable to specific types of physician practices and specialties. Direct the Secretary to

make available technical assistance and practice transformation support for practices that elect to participate.

13. Optimizing Benefit Related to the Patient-Centered Medical Home Model

- a. Congress should expand and/or supplement the existing Medicare medical home demonstration with a national pilot project.
- b. Congress direct HHS/the Centers for Medicare and Medicaid Services (CMS) to work with private payer PCMH test projects to include Medicare beneficiaries to ensure that projects include the great majority of patients in a physician's panel.
- c. HHS should establish a PCMH "National Coordinator," who is housed in the Office of the Secretary, to lead an office with the resources to coordinate government involvement pertaining to all PCMH-related activities.

14. Immediate, Sufficient, and Sustained Improvements in Payments to Primary Care in the Current Medicare Fee-for-Service System

- a. As new payment models are developed, pilot-tested, evaluated, and then implemented on a large-scale basis, there also is an urgent need for the federal government and all purchasers and payers of health care to make immediate improvements in existing payment systems based on the principle that compensation to primary care physicians should be competitive with physicians in other specialties.
- b. The federal government should take the lead in working with other purchasers/payers to conduct a price and market sensitivity analysis to determine the level of compensation needed—to which all payers should contribute—to make primary care competitive with specialty and other career choices for physicians.
- c. As an interim step until such a market sensitivity analysis is completed and its results assessed, the federal government and other purchasers/payers should set a target benchmark for annual compensation increases for primary care physicians, based on the best available current data, to close the percentage gap in the average annual compensation for primary care physicians when compared to other specialists.
 - i. As a starting point, the target should be set at 80% of the annual compensation received by the median/average compensation of all non-primary care specialties.
 - ii. Medicare fee-for-service payments to primary care physicians should be increased over a five-year period to account for the program's proportional contribution to achieving the target annual compensation level. This should be implemented as soon as practicable through an adjustment to payments as determined by the existing fee-for-service methodology. The adjustment each year should be no less than one-fifth of the amount needed to reach the 80% threshold over the five-year period.
 - iii. The initial 80% target could be adjusted once the results of the market and price sensitivity analysis are completed. Specifically, Congress should charge the HHS Secretary to determine if the plan to make primary care competitive with other specialties needs to be revised once the market and price sensitivity analysis is complete.
 - iv. HHS should conduct an annual analysis of the impact that each year's payment increase has on primary care workforce to understand if it—and changes in

other factors that determine specialty selection and practice choice—is achieving the intended effect. This analysis should include comparison against benchmarks for the number, proportion, and availability of primary care physicians.

- v. Congress should provide a dedicated source of federal funding to support increases in Medicare payments to primary care physicians. The increase should not be accomplished by redistributing money with the physician payment pool, i.e. in a “budget neutral” manner. This dedicated source should be funded by the decrease in costs in other parts of the Medicare program expected to result from more robust primary care and by other means deemed by the Congress and/or through authority provided to the HHS Secretary.
- d. The federal government should disseminate information pertaining to its efforts to adjust its payment system to make primary care specialties more competitive and viable to private health plans and other purchasers of health care, such as state governments and employers.

15. Other Improvements to the Resource Based Relative Value Scale on which the Fee-for-Service System is Based

- a. *Improving the Accuracy of Relative Value Units Assigned to Physician Services*
 - i. The federal government should improve the methodology for determining practice expense relative value units, including by revising the assumptions that overvalue high-cost equipment. The federal government should establish mutually exclusive equipment categories for all services with each assigned its own percentage utilization rate. Any “savings” that result from these changes should be put back into the physician payment pool of dollars to be redistributed through payments for all other services, which would include primary care services. In addition, the Centers for Medicare and Medicaid Services (CMS) should continue with its plan to update the specialty-specific practice cost data it uses in its practice expense methodology and consider other appropriate actions.
 - ii. The federal government should establish a group of independent experts to advise CMS in its process of reviewing relative value units. It should focus on identifying potentially over-valued services and data sources that can be used to improve the accuracy of relative value units. The group should supplement the advice that is currently provided by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), an entity comprised of representatives appointed by physician specialty organizations that makes relative value recommendations to CMS. Congress can direct CMS to take this action or the agency can use its existing authority.
 - iii. The federal government should study the process by which CMS receives input on the appropriate relative value units for each physician service. The study should assess the degree to which: physician representation is commensurate with contributions toward care of patients, with an emphasis on primary care and treatment of the chronically ill; and how the current statutorily-mandated budget neutrality requirement impact recommendations to CMS.

- b. *RRVS Changes to Facilitate Improved Care Coordination*
 - i. Medicare should make separate payment for services that facilitate care coordination and promote patient-centered care, including:
 - (1) Comprehensive coordination of a patient's care, including care related to transition between settings;
 - (2) Evaluation and management provided to an established patient by phone;
 - (3) Evaluation and management provided to an established patient using internet resources;
 - (4) Collection and review of physiologic data, such as from a remote monitoring device;
 - (5) Education and training for patient self-management;
 - (6) Anticoagulation therapy management services; and
 - (7) Current or future services as determined appropriate by the HHS Secretary.
 - ii. Medicare should make a separate payment for physician counseling related to beneficiary receipt of Medicare-covered preventive services furnished by another physician or entity.
 - iii. Congress should direct the CMS to account for system-wide savings expected to result from payments for physician services that improve care coordination and provide patient-centered care and to use the amount of expected savings to increase the limit by which aggregate expenditures may rise before triggering an offsetting downward adjustment to maintain budget neutrality.
16. Improving the Process by which Medicare Physician Fee Schedule Payments are Updated on an Annual Basis
- a. Congress should replace the unsustainable SGR formula with a system that provides fair, predictable, and stable updates for physician services. This change should provide a permanent solution or, at a minimum, a transition to a more viable system that provides predictable and positive updates for physicians going forward. To facilitate a permanent solution to the SGR:
 - i. CMS should retroactively remove expenditures on Part B drugs from the SGR formula.
 - ii. Congress should rebase Medicare baseline spending to eliminate the accumulated debt created by the SGR since it was implemented in 1998.
 - b. In conjunction with elimination of the SGR, Congress should facilitate and fund the development of alternative physician payment models to introduce incentives for efficient and effective care, rather than paying solely on the basis of volume of services based on input prices.
 - i. Such changes in Medicare payment policies to create incentives for more efficient and effective care at the practice and individual physician level may eliminate the need to replace the SGR with a new Medicare expenditure targets(s).
 - c. Should Congress decide that a national expenditure target(s) is required, it should consider the following adjustments/alternatives.
 - i. New Single National Target for All Services—any national target to replace the SGR should:

1. Separate Medicare payment updates from per capita Gross Domestic Product;
 2. Consider whether the components of the Medicare Economic Index (MEI) still represent an accurate cost of medical inflation;
 3. Refrain from decreasing the MEI for assumed increases in productivity;
 4. Provide a full update that is not lowered by an amount attributed to assumed increased physician productivity;
 5. Establish a realistic floor on payments so that physician payment in any given year would not be subject to drastic cuts;
 6. Allow for expenditure increases resulting from new technologies;
 7. Account for instances when a service/procedure previously performed exclusively in the inpatient setting becomes available in outpatient setting;
 8. Not be cumulative in nature;
 9. Require that HHS more expressly and consistently take into account expenditure growth associated with new and expanded Medicare benefits;
 10. Direct the HHS Secretary to take into account the impact of volume growth within physician services on substituting or reducing expenditures in other categories of Medicare; and
 11. Give the HHS Secretary authority to exempt specific categories of services, such as primary care services, from any payment reductions resulting from the single target, providing flexible to achieve policy objectives.
- ii. Multiple Service Category-specific Targets—any alternative that involves multiple targets by categories of service should:
1. Establish a new spending baseline that eliminates the need to recoup the SGR-accumulated debt;
 2. Ensure that primary care services have a higher expenditure growth allowance than other services;
 3. Make information available on utilization and expenditures for service-specific categories available by geographic regions for informational purposes aimed at fostering local collaboration;
 4. Establish a mechanism to assess how the change in expenditures for physician services impact spending on other categories of physician services and other components of the Medicare program, including Part A expenditures. This information should be used to determine how to best eliminate the artificial divisions between components of the program that are barriers to effective coordination and policy; and
 5. Give the HHS Secretary the authority to adjust a service category target upward should evidence show that increases in volume and expenditures for services included in that category have had a beneficial effect on reducing volume and expenditures in other physician service categories and on other parts of Medicare.
- d. Congress should establish a mechanism to assess how the change in expenditures for physician services impacts spending on other components of the Medicare program.

This information should be used to determine how to best eliminate the artificial divisions between components of the program that are barriers to effective coordination and policy.

17. Administrative Simplification Recommendations Aimed at Supporting an Improved Payment Environment

- a. Physicians who are participating in projects that involve practice-capability requirements, performance measurement, and/or other accountability for the quality and effectiveness of care should be subjected to fewer administrative requirements. (BoR 09)

Mandating Reimbursements for Periodic Health Promotion Visits

ACP supports legislation and regulation that promotes third party payer recognition and payment to physicians for periodic health promotion visits for the purpose of promoting age appropriate screening, prevention and counseling; supports legislation and regulation to ensure that the visit and any testing appropriately ordered at a periodic health promotion visit be covered by third party payers and not be subject to deductibles; and will develop and implement a program to educate members on the appropriate coding for health promotion visits. (BoR 08)

Mandate Adequate Reimbursement for Advisory Committee on Immunization Practices Recommended Vaccines

ACP seeks legislation and/or regulation mandating that health insurance companies provide adequate reimbursement for all vaccines administered according to the guidelines of the Advisory Committee on Immunization Practices (ACIP). (BoR 09)

Patient-Centered Medical Home Certification

ACP shall instruct the business consultants retained to evaluate the Patient Centered Medical Home (PCMH) to analyze the impact of the time and expense necessary for both large and small practices to achieve and maintain recognition as a "certified patient centered medical home." This evaluation would include assessing the time and expense to complete CME-type courses the PCMH requires, to document fulfillment of the various PCMH elements, and to fulfill similar extra work to be PCMH certified; and be it further, utilize data on the cost of achieving and maintaining PCMH recognition to advocate for adequate reimbursement for providing the enhanced level of patient care required, and provide an on-going assessment of the cost associated with complying with payer documentation and other requirements for receiving enhanced payment to assure that these costs are appropriately recognized, especially if the consultant is unable to determine these costs. (BoR 08)

The Patient Centered Medical Home Neighbor

1. The ACP recognizes the importance of collaboration with specialty and subspecialty practices to achieve the goal of improved care integration and coordination within the Patient-Centered Medical Home (PCMH) care delivery model.
2. The ACP approves the following definition of a Patient-Centered Medical Home Neighbor (PCMH-N) as it pertains to specialty and subspecialty practices:

A specialty/subspecialty practice recognized as a PCMH-N engages in processes that:

- Ensure effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care
- Ensure appropriate and timely consultations and referrals that complement the aims of the PCMH practice
- Ensure the efficient, appropriate, and effective flow of necessary patient and care information
- Effectively guides determination of responsibility in co-management situations
- Support patient-centered care, enhanced care access, and high levels of care quality and safety
- Support the PCMH practice as the provider of whole-person primary care to the patient and as having overall responsibility for ensuring the coordination and integration of the care provided by all involved physicians and other health care professionals.

3. The ACP approves the following framework to categorize interactions between PCMH and PCMH-N practices:

The clinical interactions between the PCMH and the PCMH-N can take the following forms:

- Preconsultation exchange—intended to expedite/prioritize care, or clarify need for a referral
- Formal consultation—to deal with a discrete question/procedure
- Co-management
 - Co-management with Shared Management for the disease
 - Co-management with Principal care for the disease
 - Co-management with Principal care of the patient for a consuming illness for a limited period
- Transfer of patient to specialty PCMH for the entirety of care.

4. The ACP approves the following aspirational guiding principles for the development-of-care coordination agreements between PCMH and PCMH-N practices.

- A care coordination agreement will define the types of referral, consultation, and co-management arrangements available.
- The care coordination agreement will specify who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements.
- The care coordination agreement will specify the content of a patient transition record/core data set, which travels with the patient in all referral, consultation, and co-management arrangements.
- The care coordination agreement will define expectations regarding the information content requirements, as well as the frequency and timeliness of information flow within the referral process. This is a bidirectional process reflecting the needs and preferences of both the referring and consulting physician or other health care professional.
- The care coordination agreement will specify how secondary referrals are to be handled.
- The care coordination agreement will maintain a patient-centered approach including consideration of patient/family choices, ensuring explanation/clarification of reasons for

referral, and subsequent diagnostic or treatment plan and responsibilities of each party, including the patient/family.

- The care coordination agreement will address situations of self-referral by the patient to a PCMH-N practice.
- The care coordination agreement will clarify in-patient processes, including notification of admission, secondary referrals, data exchange, and transitions into and out of hospital.
- The care coordination agreement will contain language emphasizing that in the event of emergencies or other circumstances in which contact with the PCMH cannot be practicably performed, the specialty/subspecialty practice may act urgently to secure appropriate medical care for the patient.
- Care coordination agreements will include:
 - A mechanism for regular review of the terms of the care coordination agreement by the PCMH and specialty/subspecialty practice.
 - A mechanism for the PCMH and specialty/subspecialty practices to periodically evaluate each other's cooperation with the terms of the care coordination agreement, and the overall quality of care being provided through their joint efforts.

5. The ACP recognizes the importance of incentives (both nonfinancial and financial) to be aligned with the efforts and contributions of the PCMH-N practice to collaborate with the PCMH practice.

6. The ACP supports the exploration of a PCMH-N recognition process. (BoR 10)

Gender Pay Gap within the Field of Medicine

1. The American College of Physicians believes that physicians regardless of gender should be paid equally and fairly for their work at all stages of their professional careers and in all settings.

2. Sufficient transparency is needed in physician compensation arrangements to ensure that physicians regardless of gender are paid equally and fairly for their work at all stages of their professional careers and in all settings.

3. Further study is needed on the reasons for and the impact of gender pay inequity. (BoR 16)

PHYSICIAN PAYMENT: MEDICARE

Reimbursement for Concurrent Care

Concurrent care provided by a medical subspecialist, as requested by the attending physician should be reimbursed when medically necessary. ACP should interact with CMS to obtain a clear definition of concurrent care and help that organization in the development of appropriate medical-medical concurrent care guidelines. ACP urges CMS to direct its Medicare carriers to follow this nationally uniform reimbursement definition for concurrent care and that the interpretation of concurrent care is not left to the local carrier. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 15)

Reimbursement for New Physicians

ACP opposes any reimbursement that is related to number of years a physician has been in practice. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Reimbursement Policy on Long Term Care Patients

ACP believes that the intensity and level of care rendered to patients residing within long-term care facilities must be judged according to the supporting diagnoses and documentation, rather than by the payment type, number of other visits made to patients in that facility on a given day or any other parameter that does not directly reflect the nature of medical services rendered. ACP believes that the amount of documentation required to substantiate a level of care must not act as a deterrent to delivering sound medical care. ACP believes that reimbursement for medical services rendered within a long-term care facility must reflect resource costs, regardless of where that service is rendered. ACP believes that the intent of Medicare's long-term care medical services reimbursement policy should reflect an intent to increase the level of service to that which is appropriate, while ensuring that the services are medically necessary and of high quality. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Reimbursement for Physicians That Complete All Medicare Claims

ACP promotes appropriate recognition in reimbursement formulas of the administrative costs associated with complying with Medicare regulations, including the mandatory claims submission law. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Payment For Services Provided by Covering Physicians

ACP will attempt to work out with CMS an arrangement that permits physicians to continue to submit a single bill for comparable services by other physicians in coverage situations while maintaining the program's ability to identify the physician who actually renders each service for the purpose of enforcement of fraud and abuse of statutes. ACP will keep its membership informed of how best to comply with CMS requirements on billing in coverage situations. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 15)

CMS Enacted Reduction in DXA Reimbursement

ACP supports a government-commissioned study by the Institute of Medicine, or other respected entity, to determine the effect of the Medicare payment reduction for dual-energy x-ray absorptiometry (DXA) services. (BoR 10)

PHYSICIAN PAYMENT: MEDICARE-RBRVS

Resource Based Relative Value Scale (RBRVS) Use in Productivity and Compensation Systems

ACP, along with other appropriate organizations, requests that the Centers for Medicare & Medicaid Services develop, maintain and publish a separate Resource-Based Relative Value Scale (RBRVS), with the relative values for work, practice expense, and professional liability, which reflects actual resource values and which are not confounded by adjustments, such as those made for purposes of achieving budget neutrality. ACP requests that the Centers for Medicare & Medicaid Services (CMS) publish its conversion factor and separately publish the factor it utilizes to adjust the fee schedule for budget neutrality. (HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

RBRVS Terminology

ACP urges the AMA to seek a means to have published periodically the AMA RUC work RVU recommendations which CMS does not accept.

ACP makes clear a distinction between Medicare reimbursement schedules and the RBRVS. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 16)

Refinement and Implementation of the Medicare Fee Schedule

ACP will work aggressively to obtain necessary legislative changes to prevent distortion of the Relative Values in the Medicare Fee Schedule by application of the existing "Budget Neutrality" provision. (HoD 93; reaffirmed BoR 04)

Preferential Update in RVUs

ACP continues to strongly oppose a preferential update in RVUs for services provided by surgeons to the detriment of the rest of the medical profession and primary care physicians in particular. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 16)

RBRVS and Private Insurers

ACP urges all third-party payers to adopt RBRVS principles, but not CMS's implementation methodology. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 16)

PRACTICE PARAMETERS (GUIDELINES)

Use of New Techniques

Background

New investigative and diagnostic techniques which are useful within the scope of practice of multiple specialties appear with increasing frequency.

Evaluation

Physicians who are proficient in the use of the new diagnostic instruments and techniques provide a valuable service and can widely expand availability of services to patients, improve patient care, and help prevent excessive costs.

Policy

ACP believes that the performance and interpretation of new techniques and procedures should be based upon demonstrated clinical competence and not be restricted by specialty designation. (HoD 87; reaffirmed BoR 08)

Input from Practicing Internists to the Practice Management Center (PMC)

ACP shall devise a formal mechanism to provide input from practicing internists to the Practice Management Center (PMC) regarding issues relevant to practicing physicians on a regular and periodic basis. (BoR 08)

Appropriate Utilization of Endoscopy

ACP support initiatives to: promote the development of practice guidelines as a means of ensuring the quality and appropriate utilization of all endoscopic procedures; link reimbursement for endoscopic procedures to appropriate utilization; limit payment for endoscopic procedures to practitioners who have received appropriate training in the cognitive and technical aspects of endoscopy; create equivalent credentialing for endoscopic procedures for inpatient and outpatient care. The credentialing process should be based not on specialty designation or society membership, but on documented comprehensive training and demonstrated competence; and encourage the developers of endoscopy guidelines to use the ACPNET network to assist in the development of appropriate and clinically relevant guidelines. (HoD 93; reaffirmed BoR 04; reaffirmed with amendments BoR 15)

PREVENTIVE MEDICINE

Medical Screening Programs

ACP endorses medical screening programs that are cost effective and endorses full evaluation of the patient by a qualified physician (preferably the patient's own physician) prior to high-risk procedures involving specific diagnostic modalities performed as screening tests. (HoD 79; reaffirmed HoD 90; reaffirmed BoR 04)

Controlling Health Care Costs: Wellness, Prevention, and Chronic Disease Management

1. Encourage individuals to take responsibility for their own health through exercise, preventive care, healthy diets and nutrition, and other health-promotion activities. ACP supports efforts to evaluate the effectiveness of wellness programs and to encourage employers to purchase benefit packages that include cost-effective wellness care. ACP also advocates that Medicare should provide coverage for preventive care, including appropriate screening services.
2. Federal and state funding for health promotion, public health activities, and support of the public health infrastructure should increase.
3. Public policy should support steps to increase the health and wellness of the population, promote changes in unhealthy behaviors, and reduce the burden of chronic disease, such as obesity, diabetes, and smoking-related illnesses. Steps should include ending agricultural subsidies for products harmful to health, such as tobacco, increasing taxes on tobacco products, and strengthening regulation of the marketing and labeling of tobacco products. Revenue from such measures should be used to promote healthy nutrition, smoking cessation, and obesity prevention as well as to promote healthy nutrition and physical education in our schools and communities. Policies should promote community planning that supports walking, bicycling, and other physical activities for healthy lifestyles.
4. Public and private health insurers should encourage preventive health care by providing full coverage, with no cost-sharing, for preventive services recommended by an expert advisory group, such as the U.S. Preventive Services Task Force.
5. Employers and health plans should fund programs proven to be effective in reducing obesity, stopping smoking, deterring alcohol abuse, and promoting wellness and providing coverage or subsidies for individuals to participate in such programs. (BoR 10)

PROFESSIONAL LIABILITY

Disability Certification

Some patients have chronic, overwhelming, or catastrophic illnesses. In these cases, society permits physicians to justify exemption from work and to legitimize other forms of financial support. As patient advocate, a physician may need to help a medically disabled patient obtain the appropriate disability status. Disability evaluation forms should be completed factually, honestly, and promptly.

Physicians may see a patient whose problems do not fit standard definitions of disability but who nevertheless seems deserving of assistance (for example, the patient may have very limited resources or poor housing). Physicians should not distort medical information or misrepresent the patient's functional status in an attempt to help patients. Doing so jeopardizes the trustworthiness of the physician, as well as his or her ability to advocate for patients who truly meet disability or exemption criteria. (BoR 04; Reaffirmed as amended BoR 11)

Equitable Risk Classification in Medical Liability Premiums

ACP supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category. (HoD 79; reaffirmed HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

Professional Liability Reform Legislation

ACP reaffirms its support for tort reform that:

1. limits awards for noneconomic damages;
2. eliminates punitive damages;
3. eliminates the collateral source rule (eliminates double compensation to plaintiffs for certain items);
4. allows for periodic payment of future damages and structured settlements; and
5. provides for attorney fee regulation in personal injury and medical malpractice cases.

ACP reaffirms its support for testing of alternative solutions such as proposals developed by the AMA/Specialty Society Medical Liability Project, PIAA, and others. ACP supports federal preemptive legislation that would incorporate reforms listed above on the condition that any such initiatives would not undermine effective, already-established reforms. (HoD 90; reaffirmed BoR 13)

Congress should immediately pass medical professional liability insurance reforms similar to those contained in the California Medical Injury Compensation Reform Act (MICRA), particularly caps on noneconomic damages, as necessary changes in a flawed system:

1. The College favors a \$250,000 cap on noneconomic damages. Additionally, the College supports a \$50,000 cap on noneconomic damages for any doctor performing immediate, life-saving care. The College strongly believes that a cap on noneconomic damages is the most effective way to stabilize premiums and should be the centerpiece of any legislative proposal to reform the medical professional liability insurance system. ACP is opposed to limits on economic damages
2. Juries should be aware of collateral source payments and allow offsets for those payments.
3. A reasonable statute of limitation on claims should be required. Lawsuits should be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence that they need to defend themselves. In some circumstances, however, patients should have additional time to file a claim for an injury that could not have been discovered through reasonable diligence.
4. Defendants should remain jointly liable for all economic losses, such as medical bills and lost wages, but should be held liable *only* for their own portion of the noneconomic and punitive damages.
5. Allow the defendant to make periodic payments of future damages over \$50,000, if the court deems appropriate, instead of a single lump sum payment. The plaintiff still would receive full and immediate compensation for all out-of-pocket expenses; noneconomic damages; punitive damages, if awarded; and future damages of \$50,000 or less.
6. Establish a sliding scale for attorneys' fees. This provision would place plaintiff attorneys on the following scale:

- a. Forty percent (40%) of the first \$50,000 recovered
 - b. Thirty-three and one-third percent (33 1/3%) of the next \$50,000 recovered
 - c. Twenty-Five percent (25%) of the next \$500,000 recovered
 - d. Fifteen percent (15%) of any amount recovered in excess of \$600,000
7. Punitive damages should be awarded only if there is “clear and convincing evidence” that the injury meets the standard set by each jurisdiction. In those cases, damages should be limited to \$250,000 or twice compensatory damages (the total of economic damages plus noneconomic losses), whichever is greater.
8. The Secretary of Health and Human Services would be authorized to make grants to states for the development and implementation of Alternative Dispute Resolution (ADR) programs. States would have flexibility in devising their ADR programs as long as federal standards were met. Federal standards should require ADR systems to incorporate some sort of disincentive to proceeding through the court system so that the ADR would not simply be a costly “add-on” rather than a cost-effective and faster way of resolving claims. Additionally, the ADR decision should be admissible in court if the parties proceed to litigation.
9. Nothing that Congress Passes should preempt or supersede any state law:
- a. On any statutory limit on the amount of compensatory or punitive damages that may be awarded in a health care lawsuit;
 - b. On any defense available to a party in a health care lawsuit;
 - c. That imposes greater protections for health care providers and health care organizations from liability, loss, or damages.
10. Any law that Congress passes should preempt state law if it differs with the federal law to the extent that it:
- a. Provides for the greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages;
 - b. Prohibits the introduction of evidence regarding collateral source benefits or mandates or permits subrogation or a lien on collateral source benefits. (BoR 03, reaffirmed BoR 13)

Congress should examine the insurance industry’s financing operations, with a view toward identifying the sources of industry difficulty with predicting loss and setting actuarially appropriate rates. However, an examination of industry practices is not an adequate substitute for MICRA-types reforms. (BoR 03, reaffirmed BoR 13)

The medical community should employ practices designed to reduce the incidence of malpractice, including setting standards of care based on efficacy assessment data, implementing risk management programs in all health care institutions, reviewing current and prospective medical staff members’ malpractice and professional disciplinary records, and restricting or denying clinical privileges to unqualified or incompetent physicians. (BoR 03, reaffirmed BoR 13)

Demonstration projects should be authorized and funded to test no-fault system(s), enterprise liability, and the bifurcation of jury trials and to study raising the burden of proof. (BoR 03, reaffirmed BoR 13)

Liability Coverage for Physician Members of Hospital Committees

ACP believes that all hospitals should hold harmless or provide liability insurance for all physicians who participate in hospital committee work. (HoD 89)

Controlling Health Care Costs: Options for Controlling Costs from Medical Malpractice and Defensive Medicine

1. Further studies should be done on the value of professional liability insurance reforms, including no-fault systems, enterprise liability, the bifurcation of jury trials, raising the burden of proof, shorter statutes of limitation on claims, and elimination of joint and several liability claims.
2. Professional liability reforms should be considered at both the state and federal levels including allowing periodic payments of future damages over \$50,000, establishing sliding scales for attorneys' fees, and giving states flexibility to develop Alternative Dispute Resolution programs, including health courts.
3. Legislation should be enacted to establish \$250,000 caps on noneconomic damages for professional liability cases.
4. Offsets for collateral source payments should be allowed in professional liability cases.
5. Physicians should be immune from patient malpractice claims of "failure-to-inform" for appropriately administered treatments provided by physicians in conjunction with documented patient-shared decision-making. (BoR 10)

Medical Liability Reform

Recommendation 1: Improving patient safety and preventing errors must be at the fore of the medical liability reform discussion. Emphasizing patient safety, promoting a culture of quality improvement and coordinated care, and training physicians in best practices to avoid errors and reduce risk will prevent harm and reduce the waste associated with defensive medicine.

Recommendation 2: Caps on noneconomic damages, similar to those contained in the California Medical Injury Compensation Reform Act (MICRA), should be part of a comprehensive approach to improving the medical liability system. While ACP strongly prefers that such caps and other tort system reforms be enacted by Congress to establish a national framework for addressing medical liability lawsuits, the College also advocates that states lacking such reforms enact legislation modeled after MICRA. The College advocates for caps on noneconomic damages, statute of limitations, a sliding scale for attorney fees, collateral source rule restrictions, fair-share liability, periodic payment of damages, limits on punitive damages.

Recommendation 3: Minimum standards and qualifications for expert witnesses should be established. At minimum, expert witnesses should be board certified, active in full-time practice or experience as an educator at an accredited and relevant medical school, licensed in the state in which the case is filed or another state with similar licensure qualifications, required to disclose expert witness-derived income, and have training similar to that of the defendant.

Recommendation 4: Legislatures should examine the insurance industry's financing operations, with a view toward identifying the sources of industry difficulty with predicting loss and setting actuarially appropriate rates.

Recommendation 5: States and the federal government should continue to pilot-test communication and resolution (also known as early disclosure and apology) programs. Pilot programs should follow the framework described in the position paper.

Recommendation 6: In addition to communication and resolution programs, the Secretary of Health and Human Services should be authorized to make grants to states for the development and implementation of Alternative Dispute Resolution (ADR) models, including mediation.

Recommendation 7: ACP supports the development of safe harbor protections when clinicians provide care consistent with evidence-based guidelines providing the conditions outlined in the position paper are met.

Recommendation 8: ACP supports initiating pilot projects to determine the effectiveness of health courts and administrative compensation models. The pilot projects should follow the recommendations described in the position paper.

Recommendation 9: Additional research is needed to determine the effect of team-based care on medical liability. Physicians and other health care professionals working in dynamic clinical care teams may be compelled to acquire individual liability protection policies. Enterprise liability coverage should be pilot-tested to determine its effectiveness in covering clinical care teams, accountable care organizations (ACOs), patient-centered medical homes (PCMH) and PCMH "neighbors" and other team-based delivery system models. (BoR 14)

PROFESSIONAL LIABILITY: MANAGED CARE

ERISA

ACP supports study of alternatives to traditional tort reforms, including enterprise liability, no fault approaches, and privately contracted mediations and seeks liability reforms in a managed care environment. The College favors legislation to change ERISA so that health care plans bear appropriate legal liability for patient injuries resulting from their involvement in patient treatment decisions. (ACP AMA Del A-96; reaffirmed BoR 06; reaffirmed BoR 17)

PROFESSIONAL RIGHTS AND RESPONSIBILITIES

Principles on the Role of Governments in Regulating the Patient-Physician Relationship

The ACP recommends the following principles for the roles of federal and state governments in health care and the patient-physician relationship.

- 1) 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. The fundamental

ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.¹

- 2) 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. Rules limiting what may or may not be discussed, or the information that may be disclosed, during healthcare encounters undermine the patient-physician relationship and can inappropriately affect patient health. The patient and his or her physician are best positioned to determine what topics to discuss.
- 3) 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:
 - a. Even laws and regulations that mandate a test, procedure, treatment, or provision of specific types of health information or counseling to the patient, when generally consistent with the standard of care and intended to provide benefit to the patient, should be approached cautiously, because they cannot allow for all potential situations in which their application would be unnecessary or even harmful to specific patients. Mandated care may also interfere with the patient-physician relationship and divert clinical time from more immediate clinical concerns.
 - b. Legislation and regulations should not prevent physicians from treating particular types of patients (e.g., based on immigration status, racial or ethnic origin, sexual orientation, religion)
 - c. The following questions may be helpful in providing general guidance for evaluating the appropriateness of proposed laws and regulations regarding the provision of medical care during the patient-physician encounter, *with the presumption being that the government should avoid regulating the content of the clinical encounter without a compelling and evidence-based benefit to the individual patient and/or substantial public health justification that can't be better met through other means*. The list is intended merely to suggest questions that should be raised—it is not meant to be all inclusive. The questions are not mutually exclusive; positive answers to all questions does not imply that a law or regulation is appropriate and is not necessary to support a proposed law or regulation.
 - i. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
 - ii. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, is there any other reasonable way to achieve the same objectives?
 - iii. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
 - iv. d. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting, and means of delivering such information or care?

- v. Is the proposed law or regulation required to achieve a public policy goal –such as protecting public health or encouraging access to needed medical care – without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patients’ own circumstances, and with minimal interference to patient physician relationships?
 - vi. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician’s clinical judgment and the patient’s wishes?
 - vii. Is there a process for appeal to accommodate for specific circumstances or changes in medical standards of care?
- 4) In making decisions about counseling and treatment among evidence-based options, the patient’s values are paramount, although the physician is not required to violate standards of medical care or ethics, fundamental personal values, or the law. Patients should not be required to undergo tests or interventions, especially invasive and potentially harmful interventions, that violate the patient’s values, are not medically necessary, and are not supported by scientific evidence on clinical effectiveness or could expose the patient to unnecessary risk, and physicians should not be required to provide such services.
- 5) Medical practice should reflect current scientific evidence and medical knowledge, which may evolve over time. Physicians should be guided by evidence-based clinical guidelines that allow flexibility to adapt to individual patient circumstances. Statutory and regulatory standards of care may become “set in concrete” and not reflect the latest evidence and applicable medical knowledge.
- 6) Laws governing medical practice must be revised as needed and regulatory rules should offer a process for timely appeal in an interval appropriate to the nature of the condition being treated.
- 7) Regulatory requirements should not create undue burdens that have the consequence of limiting access to needed care or unnecessarily divert from the precious time that physicians have to spend with patients. (BoR 12)

Principles Regarding Professional Accountability

- The Medical Practice and Quality Committee (MPQC) reaffirms the College’s role to facilitate professional accountability through developing and maintaining the domain of standards and values, educating our members about the standards and values, and providing a community that inspires and supports member efforts to abide by these standards and values.
 - The MPQC, after reviewing current College efforts to fulfill these three roles, believes that the College should evaluate methods to further create a community that inspires and supports physicians to abide by these standards and values. Such further efforts may include:
 - The establishment of a College-wide, internet-based, social network dedicated to the discussion of issues pertaining to professionalism by facilitating the

exchange of information and ideas while preserving patient confidentiality and professional confidentiality.

- The inclusion of “open forums” and other events at ACP chapter meetings and the annual meeting allowing all IM physicians to discuss common issues and challenges in medical practice, the value and meaning of doctoring, and ethics and professionalism.
 - The MPQC further recommends that the College increase efforts to counter current trends towards the fragmentation of internal medicine into separate subspecialty communities, and promote activities that emphasize the professional communality among the members.
 - The MPQC also recommends that the College evaluate the establishment of an entity, either by the College or by a trusted third party, that would collate and securely store members' credentials from other entities (licenses, board certification, PCMH recognition, Bridges to Excellence, etc.) as a convenience to members (i.e. serve as the keeper of a members' professional accountability portfolio).
- The MPQC reaffirms that each member of the College should engage in a continual process of self-scrutiny and self-regulation relative to expected professional standards and values. This process should include engaging in an internal assessment and accepting information from legitimate external sources evaluating professional performance.
 - The MPQC recommends that the College engage in additional efforts to further educate and support the membership regarding their professional obligation to provide feedback to their peers about adhering to the highest level of professionalism and when that fails to report instances of colleagues thought to be engaging in unethical or impaired behaviors.
 - The MPQC takes the position that a process of lifelong learning is an essential component of any member of the physician profession. Based on this belief, the MQPC recommends that members participate in a process of continuous learning as a requirement for membership. It is suggested that new members be exempt from this requirement for the first two years. There should be multiple pathways to fulfill this requirement to allow members to focus on learning opportunities most pertinent to their professional activities.
 - The MPQC believes that independent, non-profit certification boards, endorsed and advised by the College, are best positioned to assume the primary role of evaluating and certifying the extent to which College members are abiding by the standards and values of the profession. This recommendation also strongly reaffirms the College's position that its role is to primarily educate members on excellent practice and professionalism and support their life-long learning and professionalism, while the boards' primary role is to evaluate these efforts. Based upon this position, the MQPC further recommends that:
 - Certification boards, based upon a reaffirmation and expansion of current College policies ^{i,ii,iii, iv} should meet the following criteria to be deemed as a certifier of the extent to which physicians are abiding by the professional standards and values of the profession:
 - An “arms length” relationship with the College
 - Strong conflict-of-interest protections
 - Evaluation processes based on professional standards and values defined by the College
 - A non-profit organizational structure.

- A transparent governance structure composed substantially of physician members
- Transparent financial and reporting processes
- Established processes that ensure that the evaluations are:
 - Transparent
 - Relevant to a variety of settings
 - Able to accommodate a variety of different learning styles
 - Non-burdensome as possible while remaining rigorous and robust and balancing cost and time sensitivities.
 - Non-redundant
 - Composed of quality measures to evaluate physician performance that are:
 - Evidence-based or, in the absence of sound scientific evidence, based on expert consensus
 - Relevant to assessing clinical skills expected of a physician in their defined area of practice.
 - Valid and reliable
 - Practical
 - Clearly defined
 - Related to actionable measurement goals
 - Stable over time, unless there is compelling evidence or a justifiablereason to modify them; and
 - Related to clinical conditions prioritized to have the greatest impact
- Has an established quality control process in place that ensures the accuracy and validity of the assessment.
- Contains an appeals process that provides participating physicians with an opportunity to review their evaluations for accuracy and, at the physician's request, affords the opportunity for reconsideration. (BoR 11)

Principles Guiding External Regulatory and Market Accountability

- The MPQC, based on a reaffirmation and expansion of current College policy ^{1,2,3,4}, believes that regulatory or market entities holding physicians accountable should have:
 - A transparent governance structure that has meaningful physician engagement.
 - Transparent financial organizational processes and reporting mechanisms
 - Established processes that ensure that the accountability evaluation is:
 - Transparent
 - Relevant to a variety of settings
 - Able to accommodate a variety of different learning styles
 - Non-burdensome as possible while remaining rigorous and robust and balancing cost and time sensitivities.
 - Non-redundant
 - Composed of quality measures to evaluate physician performance that are:
 - Evidence-based or, in the absence of sound scientific evidence, based on expert consensus;
 - Relevant to assessing clinical skills expected of a physician in their

- defined area of practice;
 - Valid and reliable;
 - Practical;
 - Clearly defined;
 - Related to actionable measurement goals;
 - Stable over time, unless there is compelling evidence or a justifiable reason to modify them; and
 - Related to clinical conditions prioritized to have the greatest impact.
- Has an established quality control process in place that ensures the accuracy and validity of the assessment.
 - Contain an appropriate appeals process that provides participating physicians with an opportunity to review their evaluations for accuracy and, at the physician's request, afford the opportunity for reconsideration.
- When publicly reporting physician performance;
 - The MPQC highlights the importance of “process transparency” in the public reporting of healthcare performance and cost information—the explicit delineation of the methodology and evidence base used to develop the measures being reported.
 - The MPQC holds that the public reporting of physician performance data in a manner that emphasizes differences between physicians should take into account the ability to provide reliable, valid and actionable differences.
 - The MPQC further holds that the entity should employ the most effective means of presenting performance information to patients/consumers, and to educate these information users on the meaning (and limitations) of these differences among providers and on how to effectively use this information to make informed healthcare choices.
- These entities should use a standardized set of performance measures and data collection methodology, consensually agreed upon by relevant nationally recognized healthcare stakeholders.
- The MPQC supports the principles underlying the efforts of the Federation of State Medical Boards (FSMB) to establish a Maintenance of Licensure (MOL) process v focused on the assuring of continuous physician competence. These principles are:
 - Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
 - Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders.
 - The authority for establishing maintenance of licensure requirements should remain within the purview of state medical boards.
 - Maintenance of licensure should not compromise patient care or create barriers to physician practice.
 - The infrastructure to support physician compliance with maintenance of licensure requirements must be flexible and offer a choice of options for meeting requirements.
 - Maintenance of licensure processes should balance transparency with privacy protections.

- The MPQC further recommends that the College advocates that the FSMB MOL processes be relevant to the various types and patterns of physician practices.(BoR 11)

Definition of Internal Medicine Physicians

ACP adopts the following definition of internal medicine physicians for use in ACP communications and other materials:

- 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. (BoR 12)

The Physician and Society

Society has conferred professional prerogatives on physicians with the expectation that they will use their position for the benefit of patients. In turn, physicians are responsible and accountable to society for their professional actions. Society grants each physician the rights, privileges, and duties pertinent to the patient-physician relationship and has the right to require that physicians be competent and knowledgeable and that they practice with consideration for the patient as a person. (BoR 04; Reaffirmed BoR 11)

Obligations of the Physician to Society

Physicians have obligations to society that in many ways parallel their obligations to individual patients. Physicians' conduct as professionals and as individuals should merit the respect of the community.

All physicians must fulfill the profession's collective responsibility to advocate for the health, human rights, and well-being of the public. Physicians should protect public health by reporting disease, injury, domestic violence, abuse, or neglect to the responsible authority as required by law.

Physicians should support community health education and initiatives that provide the public with accurate information about health care and should contribute to keeping the public properly informed by commenting on medical subjects in their areas of expertise. Physicians should provide the news media with accurate information, recognizing this as an obligation to society and an extension of medical practice. However, patient confidentiality must be respected.

Physicians should help the community and policymakers recognize and address the social and environmental causes of disease, including human rights concerns, discrimination, poverty, and violence. They should work toward ensuring access to health care for all persons; act to eliminate discrimination in health care; and help correct deficiencies in the availability, accessibility, and quality of health services, including mental health services, in the community. The denial of appropriate care to a class of patients for any reason is unethical. Importantly, disparities in care as a result of personal characteristics, such as race, have received increased attention and need to be addressed [\(102\)](#). Physicians should also explore how their own attitudes, knowledge, and beliefs may influence their ability to fulfill these obligations.

Health and human rights are interrelated [\(103\)](#). When human rights are promoted, health is promoted. Violation of human rights has harmful consequences for the individual and the community. Physicians have an important role to play in promoting health and human rights and addressing social inequities. This includes caring for vulnerable populations, such as the uninsured and victims of violence or human

rights abuses. Physicians have an opportunity and duty to advocate for the needs of individual patients as well as society.

Physicians should advocate for and participate in patient safety initiatives, including error, sentinel event, and “near-miss” reporting. Human errors in health care are not uncommon [\(104\)](#), and many result from systems problems. Physicians should initiate process improvement and work with their institutions and in all aspects of their practices in an ongoing effort to reduce errors and improve care. (BoR 04; Reaffirmed as amended BoR 11)

Resource Allocation

Medical care is delivered within social and institutional systems that must take overall resources into account. Increasingly, decisions about resource allocations challenge the physician's primary role as patient advocate. There have always been limits to this advocacy role: For example, a physician is not obligated to lie to third-party payers for a patient or to provide all treatments regardless of their effectiveness. Resource allocation pushes these limits further by compelling physicians to consider the best interests of all patients and of each patient. The just allocation of resources and changing reimbursement methods present the physician with ethical problems that cannot be ignored. Two principles are agreed upon:

1. As a physician performs his or her primary role as a patient's trusted advocate, he or she has a responsibility to use all health-related resources in a technically appropriate and efficient manner. He or she should plan workups carefully and avoid unnecessary testing, medications, surgery, and consultations. (BoR 04)
2. Resource allocation decisions are most appropriately made at the policy level rather than entirely in the context of an individual patient-physician encounter. Physicians should participate in decisions at the policy level; should emphasize the value of health to society; and should base allocations on medical need, cost-effectiveness of treatments, and proper distribution of benefits and burdens in society. (BoR 04)

The Changing Practice Environment

Many individuals, groups, and institutions play a role in and are affected by medical decision making. In an environment characterized by increasing demand for accountability and mounting health care costs, tension and conflict are inevitable among patients, clinicians, insurers, purchasers, government, health care institutions, and health care industries. This section of the Manual focuses on the obligations of physicians in this changing context; however, it is essential to note that all of these parties are responsible for recognizing and supporting the intimacy and importance of relationships with patients and the ethical obligations of clinicians to patients. All parties must interact honestly, openly, and fairly [\(88\)](#). Furthermore, concern about the impact of the changing practice environment on physicians and insured patients should not distract physicians or society from attending to the unmet needs of persons who lack insurance or access to care. Questions of quality and access require public dialogue in which all parties should participate. Recent advances in health insurance reform increase the need for continued attention to professional obligations of physicians to their patients and the health care system. Resource allocation decisions should always be made through an open and participatory process.

Physicians have an obligation to promote their patients' welfare in an increasingly complex health care system. This entails forthrightly helping patients to understand clinical recommendations and make informed choices among all appropriate care options. It includes management of the conflicts of interest

and multiple commitments that arise in any practice environment, especially in an era of cost concerns. It also includes stewardship of finite health care resources so that as many health care needs as possible can be met, whether in the physician's office, in the hospital or long-term care facility, or at home.

The patient–physician relationship and the principles that govern it should be central to the delivery of care. These principles include beneficence, honesty, confidentiality, privacy, and advocacy when patient interests may be endangered by arbitrary, unjust, or inadequately individualized programs or procedures. Health care, however, does take place in a broader context beyond the patient–physician relationship. A patient's preferences or interests may conflict with the interests or values of the physician, an institution, a payer, other members of an insurance plan who have equal claim to the same health care resources, or society.

The physician's first and primary duty is to the patient. Physicians must base their counsel on the interests of the individual patient, regardless of the insurance or medical care delivery setting. Whether financial incentives in the fee-for-service system prompt physicians to do more rather than less or capitation arrangements encourage them to do less rather than more, physicians must not allow such considerations to affect their clinical judgment or patient counseling on treatment options, including referrals [\(88\)](#).

The physician's professional role is to make recommendations on the basis of the best available medical evidence and to pursue options that comport with the patient's unique health needs, values, and preferences [\(89\)](#).

Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available. In making recommendations to patients, designing practice guidelines and formularies, and making decisions on medical benefits review boards, physicians' considered judgments should reflect the best available evidence in the biomedical literature, including data on the cost-effectiveness of different clinical approaches. When patients ask, they should be informed of the rationale that underlies the physician's recommendation.

In instances of disagreement between patient and physician for any reason, the physician is obligated to explain the basis for the disagreement, to educate the patient, and to meet the patient's needs for comfort and reassurance. Providers of health insurance are not obliged to underwrite approaches that patients may value but that are not justifiable on clinical or theoretical scientific grounds or that are relatively cost-ineffective compared with other therapies for the same condition or other therapies offered by the health plan for other conditions. However, there must be a fair appeals procedure.

The physician's duty further requires serving as the patient's agent within the health care arena, advocating through the necessary avenues to obtain treatment that is essential to the individual patient's care regardless of the barriers that may discourage the physician from doing so. Moreover, physicians should advocate just as vigorously for the needs of their most vulnerable and disadvantaged patients as for the needs of their most articulate patients [\(88\)](#).

Patients may not understand or may fear conflicts of interests for physicians and the multiple commitments that can arise from cost-containment and other pressures from entities that finance health care. Physicians should disclose their potential conflicts of interest to their patients. While providers of health insurance coverage should hold physicians accountable for the quality, safety, and efficiency of care and not simply for economic performance, they also have duties to foster an ethical

practice environment and should not ask physicians to participate in any arrangements that jeopardize professional and ethical standards. Physicians should enter into agreements with insurers or other organizations only if they can ensure that these agreements do not violate professional and ethical standards.

Pay-for-performance programs can help improve the quality of care, but they must be aligned with the goals of medical professionalism. The main focus of the quality movement in health care should not, however, be on “pay for” or “performance” based on limited measures. Program incentives for a few specific elements of a single disease or condition may neglect the complexity of care for the whole patient, especially patients with multiple chronic conditions. Deselection of patients and “playing to the measures” rather than focusing on the patient are also dangers. Quality programs must put the needs and interests of the patient first [\(90\)](#).

Organizations that provide health insurance coverage should not restrict the information or counsel that physicians may give patients. Physicians must provide information to the patient about all appropriate care and referral options. Providers of health insurance coverage must disclose all relevant information about benefits, including any restrictions, and about financial incentives that might negatively affect patient access to care [\(88\)](#).

When patients enroll in insurance plans, they receive a great deal of information on rules governing benefits and reimbursement. Meaningful disclosure requires explanations that are clear and easily understood. Insured patients and their families bear a responsibility for having a basic understanding of the rules of their insurance [\(88\)](#). Physicians cannot and should not be expected to advise patients on the particulars of individual insurance contracts and arrangements. Patients should, however, expect their physicians to honor the rules of the insurer unless doing so would endanger the patient's health. Physicians should not collaborate with a patient or engage in efforts to deceive the insurer. (BoR 04; Reaffirmed as amended BoR 11)

Expert Witnesses

Physicians have specialized knowledge and expertise that may be needed in judicial or administrative processes. Often, expert testimony is necessary for a court or an administrative agency to understand the patient's condition, treatment, and prognosis. Physicians may be reluctant to become involved in legal proceedings because the process is unfamiliar and time-consuming. Their absence may mean, however, that legal decisions are made without the benefit of all medical facts or opinions. Without the participation of physicians, the mechanisms for dispute resolution may be unsuccessful, patients may suffer, and the public at large may be affected.

Although physicians cannot be compelled to participate as expert witnesses, the profession as a whole has the ethical duty to assist patients and society in resolving disputes [\(114\)](#). In this role, physicians must have the appropriate expertise in the subject matter of the case and honestly and objectively interpret and represent the medical facts. Physicians should accept only noncontingent compensation for reasonable time and expenses incurred as expert witnesses. (BoR 04; Reaffirmed as amended BoR 11)

Strikes and Other Joint Actions by Physicians

Changes in the practice environment sometimes adversely affect the ability of physicians to provide patients with high-quality care and can challenge the physician's autonomy to exercise independent clinical judgment and even the ability to sustain a practice. However, physician efforts to advocate for system change should not include participation in joint actions that adversely affect access to health care or that result in anticompetitive behavior [\(115\)](#). Physicians should not engage in strikes, work

stoppages, slowdowns, boycotts, or other organized actions that are designed, implicitly or explicitly, to limit or deny services to patients that would otherwise be available. In general, physicians should individually and collectively find advocacy alternatives, such as lobbying lawmakers and working to educate the public, patient groups, and policymakers about their concerns. Protests and marches that constitute protected free speech and political activity can be a legitimate means to seek redress, provided that they do not involve joint decisions to engage in actions that may harm patients. (BoR 04; Reaffirmed as amended BoR 11)

The Impaired Physician

Physicians who are impaired for any reason must refrain from assuming patient responsibilities that they may not be able to discharge safely and effectively. Whenever there is doubt, they should seek assistance in caring for their patients.

Impairment may result from use of psychoactive agents (alcohol or other substances, including prescription medications) or illness. Impairment may also be caused by a disease or profound fatigue that affects the cognitive or motor skills necessary to provide adequate care. The presence of these disorders or the fact that a physician is being treated for them does not necessarily imply impairment.

Every physician is responsible for protecting patients from an impaired physician and for assisting an impaired colleague. Fear of mistake, embarrassment, or possible litigation should not deter or delay identification of an impaired colleague (121). The identifying physician may find it helpful and prudent to seek counsel from a designated institutional official, the departmental chair, or a senior member of the staff or the community.

Although the legal responsibility to do so varies among states, there is a clear ethical responsibility to report a physician who seems to be impaired to an appropriate authority (such as a chief of service, chief of staff, institutional or medical society assistance program, or state medical board). Physicians and health care institutions should assist impaired colleagues in identifying appropriate sources of help. While undergoing therapy, the impaired physician is entitled to full confidentiality as in any other patient–physician relationship. To protect patients of the impaired physician, someone other than the physician of the impaired physician must monitor the impaired physician’s fitness to work. Serious conflicts may occur if the treating physician tries to fill both roles (122). (BoR 04; Reaffirmed as amended BoR 11)

Peer Review

Professionalism entails membership in a self-correcting moral community. Professional peer review is critical in assuring fair assessment of physician performance for the benefit of patients. The trust that patients and the public invest in physicians requires disclosure to the appropriate authorities and to patients at risk for immediate harm.

All physicians have a duty to participate in peer review. Fears of retaliation, ostracism by colleagues, loss of referrals, or inconvenience are not adequate reasons for refusing to participate in peer review. Society looks to physicians to establish and enforce professional standards of practice, and this obligation can be met only when all physicians participate in the process. Federal law and most states provide legal protection for physicians who participate in peer review in good faith.

It is unethical for a physician to disparage the professional competence, knowledge, qualifications, or services of another physician to a patient or a third party or to state or imply that a patient has been poorly managed or mistreated by a colleague without substantial evidence. This does not mean that a physician cannot disagree with a plan of management or recommendations made by another physician.

A physician therefore has a duty to patients, the public, and the profession to report to the appropriate authority any well-formed suspicions of fraud, professional misconduct, incompetence, or abandonment of patients by another physician.

In the absence of substantial evidence of professional misconduct, negligence, or incompetence, it is unethical to use the peer review process to exclude another physician from practice, to restrict clinical privileges, or to otherwise harm the physician's practice. (BoR 04; Reaffirmed as amended BoR 11)

Conflicts among Members of a Health Care Team

All health professionals share a commitment to work together to serve the patient's interests. The best patient care is often a team effort, and mutual respect, cooperation, and communication should govern this effort. Each member of the patient care team has equal moral status. When a health professional has important ethical objections to an attending physician's order, both should discuss the matter openly and thoroughly. Mechanisms should be available in hospitals and outpatient settings to resolve differences of opinion among members of the patient care team. Ethics committees or ethics consultants may also be appropriate resources. (BoR 04; Reaffirmed as amended BoR 11)

Physician-Driven Integration: A Response to the Corporatization of Medicine

ACP encourages physician-led integration as the surest way to retain professional values at the core of the health care system. A physician organization should be bound first and foremost to professional values, while commercial organizations are bound to stockholders. Additionally, both evidence and logic suggests that integrated practice and professional collaboration may improve quality of care.

In all forms of integration, physicians should have a commitment to and a central role in accountability processes. This necessitates the involvement of physicians at the highest levels of organizational leadership, particularly in the areas of quality and utilization management, and the collaborative involvement of all physicians in these processes. Legislation and licensing of health-care delivery organizations should require physician leadership of utilization and quality management in all organizations (6, ACP "Quality Standards").

Highly integrated practices with established quality and utilization systems are better positioned to deliver quality, cost-effective care than are loosely-knit networks or individual practices, which do not have the necessary tools.

In choosing any type of practice organization, physicians have the responsibility to evaluate and place a high priority on physician development and leadership of collaborative quality improvement and clinical activities and on overall physician leadership in the organization. The College supports the right of physicians to choose any type of practice arrangement.

Patients have the right to full disclosure of all methods of reimbursement, quality management, and utilization review in any health-care delivery organization. Legislation and licensing should require such disclosure.

No delivery organization, accountability process, or reimbursement structure can fully resolve the conflicts posed between economic self-interest and professional commitment to the patient's best interest. Neither purchaser demand nor regulatory oversight can stimulate the type of quality that comes from professional commitment to altruism, research, and self-improvement.

Professional societies have a responsibility to support physicians attempting to form integrated organizations by providing information, guidance, and referrals; by arranging support networks; and by sponsoring or financing educational programs.

Medical schools should include instruction on health care economics, business issues, precepts of high value care, physician wellness, practice sustainability, epidemiology, population-based medicine, and evidence-based practice. Alternatively, medical schools, like the profession itself, are called on to impart a milieu that supports collaborative practice.

The College, other professional organizations, universities, and government should support vigorous research of the effects of various types of integration and reimbursement structures on clinical outcomes, population-based health status measures, patient satisfaction data, and functional health status measures. (Physician-Driven Integration: A Response to the Corporatization of Medicine, ACP 96; reaffirmed BoR 06; reaffirmed as amended BoR 17)

Promoting the Leadership Role of Physicians in the Health Care Team

ACP affirms policy that physicians and non-physician health professionals are not interchangeable, and that optimal care for patients is provided by physicians and other health professionals working together in team-based model of care delivery under physician leadership and that vigorously promote the leadership role of physicians in the health care team. (BoR 11)

Volunteers in Medicine

ACP supports organized efforts to involve volunteer physicians, nurses and other appropriate clinicians in responding to public health emergencies and in the delivery of health care to the displaced, indigent and uninsured. (HoD 96; reaffirmed BoR 06; reaffirmed as amended BoR 17)

Corporate Medical Practice

ACP believes that a physician who is an employee of a medical practice which is owned by another entity (such as a hospital) should identify that fact professionally. ACP seeks co-adoption of this policy by the AMA. (HoD 93; reaffirmed BoR 04)

PROFESSIONAL RIGHTS AND RESPONSIBILITIES: ANTITRUST

Physician-Run Health Plans and Antitrust

As the health-care system changes and large managed-care entities gain greater control in some markets, proponents of antitrust reform have expressed concern that physicians could lose their autonomy. To respond to this concern, the ACP has consistently argued that physicians should be allowed to establish their own health plans and networks to provide high-quality and cost-effective care. Moreover, the College has advocated utilization review reform and due-process protections to empower physicians in their dealings with insurers.

Physicians already have the legal authority to form their own health plans and networks, and many state medical societies are sponsoring such plans. The law also allows physicians to operate the clinical components of a health plan, regardless of who owns it. Moreover, physicians can share information about quality, utilization, and in some circumstances, fees. In light of market developments, however, the College has urged the federal antitrust agencies to analyze the effect of their current enforcement policies on physician activities and adopt a more flexible approach.

The College will continue to fight for policies that allow physicians to form their own health plans in the belief that plans run by physicians will provide higher-quality care at a lower cost. Moreover, to empower physicians in their dealings with insurers, the College remains committed to its policies that advocate utilization review reform and due-process protections for physicians. The College will monitor the market to ensure that physicians are being treated fairly and will continue to give physicians

information and advice about how to adapt to marketplace changes in their communities. The College will also continue to press the federal enforcement agencies to analyze the effect of their policies on the development of physician networks and develop a more flexible enforcement policy toward them. (Physician-Run Health Plans and Antitrust, ACP 95; reaffirmed BoR 06; reaffirmed BoR 17)

Continuing to Assess and Provide New Information on Non-Traditional Care Models

ACP continues to support internists in all patient-centered practice models that are accessible, ethical, viable and that strengthen the patient-physician relationship. (BoR 7-11)

Supporting Legislation that Requires Nationwide Criminal Background Checks for Health Care Workers

ACP supports the provisions in the federal Patient Protection and Affordable Care Act of 2010 that requires a nationwide criminal background check on applicants before hiring them into a position where they may be caring for vulnerable patients, which is referred to as a “direct patient access employee” in the law. (BoR 10)

PUBLIC HEALTH

The Health Care Response to Pandemic Influenza

I. The Involvement of Physicians in Planning for Pandemic Influenza and Participating in the Health Care Response at all Levels

Position 1: ACP supports strengthening public health emergency preparedness efforts through supporting the development of local task forces that include physicians representing all practice settings.

Position 2: The effective utilization of volunteer physicians and health care providers in public health emergencies should be coordinated by federal or state agencies that are clearly authorized to determine licensing and register volunteers.

II. Effective Surveillance, Monitoring and Reporting During a Pandemic

Position 3: Effective surveillance, monitoring and reporting of patient health status during an influenza pandemic will be best accomplished by insuring that health care providers in every locality have access to two-way communications with public health authorities and health information technology tools.

Position 4: ACP policy recognizes the paramount importance of patient-doctor confidentiality. If breaching confidentiality is necessary, it should be done in a way that minimizes harm to the patient and that heeds applicable federal and state law.

Position 5: ACP believes that infection control measures should be clear, fair and the least restrictive means necessary to protect public health. Physicians should not be penalized for failure to follow emergency orders that are not clear and timely and do not provide for due process to resolve situations outside the physician’s control.

III. The Provision of Vaccines and Antiviral Medications

Position 6: Ending the chronic delays in the delivery of vaccine and achieving vaccination targets for seasonal influenza is a public health prerequisite to developing a successful response to pandemic influenza and other public health emergencies.

Position 7: ACP supports measures to increase pandemic influenza vaccine and antiviral medications in the Strategic National Stockpile. ACP supports the national procurement of vaccine in an amount sufficient to protect the entire U.S. population and national procurement of antiviral medications to cover 25 percent of the U.S. population. ACP believes that additional courses of antiviral medications should be procured for all public safety officers and health care workers with direct patient contact in amounts sufficient to provide prophylaxis. In the event of pandemic influenza, stockpiled vaccine and antivirals should be distributed equitably to all states' public health authorities based on the numbers of people in high-risk and high-priority groups.

IV. The Necessity of Providing Care Outside of Hospital Settings

Position 8: ACP believes that an effective health care response to pandemic influenza will require utilizing all nonhospital-based health care providers to counsel, diagnose, treat and monitor patients outside of hospital settings in order to decrease the likelihood of surges that would overwhelm hospital capacity.

V. Physician Security During a Pandemic

Position 9: The safety of physicians and other health care providers must be provided for during public health emergencies, such as pandemic influenza. Physicians and other health care providers who are storing or administering vaccines, antiviral medications or pandemic-related medical supplies and equipment must be fully informed about preplanned security measures in the event of pandemic influenza. (BoR 04-06)

Recognizing Critical Disaster Preparedness Programs

ACP recognizes the following programs as critical for disaster preparedness: Core Disaster Life Support (CDLS) Course, Basic Disaster Life Support (BDLS) Course and Advanced Disaster Life Support (ADLS) Course; and encourages all internists to avail themselves of these courses to prepare themselves for "all hazard" disasters; and officially communicates its support of these programs to the AMA. (BoR 11)

Drug-Resistant Tuberculosis

ACP seeks appropriate recognition of the seriousness of drug resistant tuberculosis. ACP seeks appropriate regulations to decrease the risks of the exposure of health care workers and non-infected patients by the institution of isolation methods and air quality/control. ACP urges increased support for research and outpatient treatment of drug-resistant tuberculosis and other drug-resistant infections that may pose significant threat to the population. (HoD 92; reaffirmed BoR 04; revised BoR 16)

Supporting Restrictions on Tanning Establishments

ACP supports restrictions that no minor should be permitted to use tanning devices; that a Surgeon General's warning should be placed publicly in all tanning establishments which states at the very least ultraviolet radiation can cause skin cancer; and that no facility should advertise the use of any UV or UVB tanning device using wording such as "safe", "safe tanning"; "no harmful rays"; "no adverse affect"; or similar wording or concepts. (BoR 10)

Working with CMS to Identify Fair and Equitable Compensation for Formulas for Vaccines

ACP will work with the Centers for Medicare and Medicaid Services (CMS) to develop fair and equitable compensation formulas which factor wholesale/retail cost differentials for the acquisition of the vaccine and the administration cost to permit widespread immunization in various practice settings following the guidelines of the Advisory Committee on Immunization Practices. (BoR 10)

Sodium Intake

ACP adopts policy to support efforts to reduce sodium intake by American consumers and supports the efforts of the CDC in its advocacy and public education activities to reduce sodium intake. (BoR 10)

Opposing the Use of Antimicrobials for Agricultural Purposes

ACP opposes use of antimicrobials in agriculture for growth promotion and/or prophylaxis; and advocates the phasing out of antimicrobials in agriculture for these nontherapeutic uses. (BoR 11)

Public Health Infrastructure

1. ACP supports investing in the nation's public health infrastructure. Priority funding should be given to federal, state, tribal, and local agencies that serve to ensure that the health care system is capable of assessing and responding to public health needs. The College is greatly concerned that recent and proposed reductions in funding for agencies responsible for public health are posing a grave risk to the United States' ability to ensure the safety of food and drugs, protect the public from environmental health and infectious risks, prepare for natural disasters and bioterrorism, and provide access to care for underserved populations. Congress must prioritize federal funding to ensure that federal agencies responsible for public health, including the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Agriculture (USDA), the Environmental Protection Agency (EPA), and the Substance Abuse and Mental Health Services Association (SAMHSA), are given sufficient resources to carry out their public health missions. Efforts should be made to ensure better coordination of public health initiatives across federal agencies and to reduce wasteful duplication and inefficiencies resulting from poor coordination of their activities.
2. In the current economic environment, it is particularly important that federal, state, tribal, and local agencies prioritize and appropriately allocate funding to programs that have the greatest need for funding and the greatest potential benefit to the public's health. All programs that receive funding should be required to provide an ongoing assessment of their effectiveness in improving population health. ACP recommends that priority for funding be given to programs based on their effectiveness in improving the health of the public. Specifically, ACP recommends that funding priority should go to programs that a review of the evidence shows have been effective in promoting the following critical public health objectives: (listed in no particular order)
 - a. Support safety net facilities and local health departments
 - b. Reduce health care disparities relating to racial and ethnic characteristics, cultural differences, socioeconomic, and language and literacy barriers
 - c. Encourage healthful diets and exercise to reduce obesity, particularly child obesity
 - d. Reduce smoking and tobacco-related preventable illnesses.
 - e. Reduce illnesses relating to environmental pollution, global climate change, and other environmental risks
 - f. Educate clinicians and the public on disaster preparedness, to ensure sufficient "first-responder" capacity and training, and to ensure that there is sufficient "surge capacity" at hospitals and physician offices to address a public health emergency

- g. Reduce the incidence of food-borne illnesses, including more regulation and inspection of farms and food production facilities, more humane treatment of livestock to reduce preventable exposure to dangerous pathogens, and more effective warning and recall systems
 - h. Provide prevention and treatment of illnesses relating to alcohol, drug, and other substance abuse, including abuse of prescription drugs
 - i. Provide quality care and protection for mentally ill inmates in prison
 - j. Prevent injuries and deaths resulting from all types of violence, including best practices to prevent firearm-related injury and death
3. Having a health care workforce that is appropriately educated and trained in public health–related competencies is essential to meet the nation’s health care needs. The education and training of sufficient numbers of physicians, nurses, allied health personnel, clinical scientists, health services researchers, public health laboratorians, and public health practitioners is an important part of the public health infrastructure. Accordingly, priority funding should be devoted to educational and training programs that prepare physicians, nurses, and allied health personnel that are in short supply and that help meet the health care needs of underserved populations.
 4. The public health workforce should educate the public on new health care delivery models and the importance of primary care. It is also important for the public health sector to promote the need to have a doctor or health center so care can be better coordinated.
 5. To address current and looming pharmaceutical therapies and vaccine shortages, the federal government should work with pharmaceutical companies to ensure that there is an adequate supply of pharmaceutical therapies and vaccines to protect and treat the U.S. population.
 6. Programs to inform the public of the benefit of vaccinations for children, adolescents and adults, to counter misinformation about the risks of vaccinations, and to encourage increased vaccination rates, particularly for vulnerable populations, are especially important for the health of the population. Evidence-based educational strategies should be used to influence behavior and increase vaccination rates. Programs to inform the public on proper use of pharmaceutical therapies and antibiotics are also important for the health of the population. In addition, adequate funding for research and development is also imperative to combat the rise of antibiotic resistance and the emergence of new diseases.
 7. ACP encourages the development and implementation of a comprehensive, nationwide public health informatics infrastructure, sharable by all public health stakeholders. This will require significant investments in new and improved technologies, standards, methodologies, human resources, and education. The result should be a fundamental transformation in the roles and effectiveness of our public health resources. A specific and fundamental requirement is that the public health informatics infrastructure must be capable of seamlessly and automatically exchanging relevant data in a bidirectional manner with any Health Information Exchange (HIE) that is capable of delivering or receiving the required data. This should be the preferred option for collecting data from reporting entities. In cases where a practice does not have access to a suitable HIE, the public health informatics infrastructure must be capable of seamlessly and

automatically exchanging relevant data in a bidirectional manner with any ONC-certified EHR system. (BoR 12)

Elimination of Non-Medical Exemptions from State Immunization Laws

1. The American College of Physicians supports the immunization of all children, adolescents, and adults, according to the recommendations and standards established by the U.S. Advisory Committee on Immunization Practices (ACIP), National Vaccine Advisory Committee (NVAC), and the Centers for Disease Control and Prevention (CDC).
2. The College supports state laws designed to promote all recommended immunizations.
3. The College calls on states to pass legislation to eliminate any existing exemptions, except for medical reasons, from their immunization laws. (BoR 15)

Climate Change and Health

1. A global effort is required to reduce anthropogenic greenhouse emissions and address the health impact of climate change. The United States must commit to taking both a leadership and collaborative role in developing, implementing, and ensuring the success of such a global effort and in reducing its own contributions to greenhouse emissions. Climate change adaptation strategies must be established, and mitigation measures must be adopted.
2. The health care sector, within the United States and globally, must implement environmentally sustainable and energy-efficient practices and prepare for the impacts of climate change to ensure continued operations during periods of elevated patient demand.
3. Physicians, both individually and collectively, are encouraged to advocate for climate change adaptation and mitigation policies and communicate about the health cobenefits of addressing climate change in objective, simple language to their community and policymakers. For its part, the American College of Physicians is committed to working with its international chapters and with other professional membership and public health organizations within the United States and globally to pursue the policies recommended in this paper.
4. Physicians are encouraged to become educated about climate change, its effect on human health, and how to respond to future challenges. Medical schools and continuing medical education providers should incorporate climate change–related coursework into curricula.
5. Governments should commit to providing substantial and sufficient climate change research funding to understand, adapt to, and mitigate the human health effects of climate change. (BoR 16)

QUALITY OF CARE

Criteria for federal legislation concerning how performance measurements are developed, endorsed and implemented

Position 1: Federal legislation should preserve the existing distinctions among developers, endorsers, evaluators and implementers of performance measures:

- a) It should not assign exclusivity in measure development to any one group such as the PCPI.
- b) The PCPI should have *a principal but not exclusive* role as a developer of physician level measures, allowing specialists, the Joint Commission, NCQA, the PCPI, specialty societies and others to propose measures without being required to go through the PCPI.

c) Any group that develops physician-level measures for later implementation by Medicare should be required, by law, to have adequate representatives of physician specialties with practical expertise in the condition or process being measured in the development process, be transparent in its activities including conflict of interest declaration, have a defined and open process to reach consensus, be evidence-based, and make draft measures available for broader public comment before being accepted.

d) NQF should have a defined statutory role in identifying priority areas for measure development, in convening developers to harmonize measures and in endorsing measures.

e) Such legislation should recognize and maintain the critical role played by the AQA and other quality alliances in recommending measures for implementation by CMS and other payers, criteria for selection and prioritization of such measures for implementation, and policies relating to reporting of such measures and data aggregation.

Position 2: ACP supports dedicated federal funding for NQF; however, should such funding be provided, ACP should request that NQF examine its dues structure and consider reducing or eliminating membership dues to assure that its dues are not a barrier to organizational participation in the NQF. Legislation should specify that the NQF, as a condition of receiving federal funding, assure that the work groups it establishes to evaluate measures for endorsement include sufficient representatives of physicians with clinical expertise in the conditions being measured while preserving an “arms length” relationship with the organizations that developed the measures for consideration by the NQF for endorsement.

Position 3: Congress should authorize funding to qualified performance development organizations through the Agency for Healthcare Research and Quality (AHRQ).

Position 4: Funding for measure development should be allocated through a peer-review process of managed by AHRQ. Such funding should be in addition to any current funding for AHRQ so as not to undermine other AHRQ priorities.

Healthcare Transparency—Focus on Price and Clinical Performance Information

Price Transparency:

1. The College supports the goal of price transparency for services and products provided by all healthcare stakeholders to patients/ consumers.
2. The College recommends that any methodology used to publicly report price is also transparent, and contains adequate protections to ensure the reporting of reliable and valid price information.
3. The College recommends that price information provided to patients/consumers should be readily available, presented in a manner that is easily understood and reflective of its limitations.
4. The College recommends that any formal governmental or private sector requirement for price transparency minimize the administrative burden on the participating physicians or other healthcare professionals.

5. The College recommends that price should never be used as the sole criterion for choosing a physician or any other healthcare professional. Price should only be considered along with the explicit consideration of the quality of services delivered and/or the effectiveness of the intervention.

Performance Transparency:

6. The College supports the goal of performance transparency for services and products provided by all healthcare stakeholders to patients/consumers.
7. The College reaffirms and expands upon the qualities of a good performance measure as reported in the ACP policy paper, “Linking Physician Payment to Quality Care.”¹ Quality measures used to evaluate physician performance should be:
 - o reliable, valid and based on sound scientific evidence
 - o clearly defined
 - o based on up-to date, accurate data
 - o adjusted for variations in case mix, severity and risk
 - o based on adequate sample size to be representative
 - o selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance
 - o reflective of processes of care that physicians and other clinicians can influence or impact
 - o constructed so as to result in minimal or no unintended harmful consequences (e.g., adversely impact access to care)
 - o as least burdensome as possible
 - o related to clinical conditions prioritized to have the greatest impact
 - o should be developed, selected and implemented through a transparent process
 - o easily understood by patients/consumers and other users
8. The College highlights the importance of “process transparency” in the public reporting of healthcare performance information— the explicit delineation of the methodology and evidence base used to develop the measures being reported.
9. The College reaffirms the importance of physicians and other healthcare professionals having timely access to assessed performance information prior to public reporting and the availability of a fair and accurate appeals process to examine potential inaccuracies as reflected in the ACP policy paper “Developing a Fair Process through which Physicians Participating in Performance Measurement Programs can Request a Reconsideration of Their Rating.”²
10. The College reaffirms the “ACP Policy Statement Pertaining to Health Plan Programs to Rate Physicians.”³ and recommends that the expansion of public reporting of physician performance differences takes into account the technical capability to report reliable, valid and useful differences.
11. The College supports the use of standardized performance measures and data collection methodology, consensually agreed upon by relevant nationally recognized healthcare

stakeholders, in efforts to publicly report the performance of physician and other healthcare professionals. In addition, the College supports the collection of both public and private data by trusted third party entities so that physician and other clinician's performance can be assessed as comprehensively as possible.

12. The College, while recognizing and supporting the increased patient/consumer interest in obtaining and providing physician performance information, does not support the use of web-based physician rating sites that rely on subjective and invalidated data, and do not meet the College's standards for physician performance measurement.
13. The College supports increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers, and to educate these information users on the meaning of performance differences among providers and on how to effectively use this information to make informed healthcare choices. (BoR 10)

Performance Measurement Appeals

Voluntary payer utilization of the following general guidelines should ensure a fair and accurate process, through which physicians participating in a performance measurement program can request a reconsideration of performance ratings prior to public release:

1. Prior to public release of performance ratings to the public or use of ratings to determine payment, physicians should be given the opportunity to review the ratings for accuracy, and at the physician's request, initiate reconsideration of their individual ratings. The payer should employ all possible means to ensure that no adverse determination regarding physician performance be made without prior review by the rated physician, and, when requested by the physician, ratings should be reconsidered by an appropriate and objective group of reviewers.
2. At the time of enrollment in a performance measurement program, and when ratings are first distributed for internal review, payers should provide physicians with a clear explanation of all program facets, including: the clinical guidelines and evidence that is graded upon which measures are based; the analytical methods used to aggregate, rate, and report data; the physician's right to an objective, timely, and expeditious reconsideration and appeals process; and a clear description of the reconsideration and appeals process, including the grounds for challenging ratings.
3. Payers should have a well-defined and distinct mechanism for responding to physician inquiries and requests for reconsideration. Practical time frames must be established to ensure timely resolution of the contested matters and to minimize the delay of public reporting.
4. In submitting a request for reconsideration, physicians should be given an opportunity to clearly identify the grounds for challenging the ratings. Physicians should be able to challenge the accuracy and fairness of the application of performance measures. Ratings may be challenged on a variety of factors, including: the validity, reliability, appropriateness, and applicability of the measure and its evidence base; the appropriateness of the statistical methods used to aggregate the data, including the size of the sample; the effectiveness of statistical adjustments (or lack of) used to account for confounding factors, including care attributable to the individual physician, case-mix composition, co-morbidities, severity of illness, and patient non-adherence; the suitability of the measure implementation process; and the accuracy of the reporting format.

5. Submitting a request for reconsideration should not create an undue administrative burden on physicians to the extent that it discourages physicians from challenging ratings. Similarly, user fees and penalties should not be imposed on physicians who challenge performance rating decisions.
6. Fairness must be integral to methods used by payers to evaluate requests for reconsideration. Decisions about the appropriateness of ratings should be thorough and responsive to the concerns of the physician. In responding to physicians with the results of a reconsideration appeal, payers should state their findings and the clinical basis for their findings as clearly as possible.
7. The payer should establish unambiguous parameters to determine when a dispute cannot be resolved through an internal review process, and instead warrants consideration by an independent, external review or appeals board. These parameters should be set high enough to minimize the delay of public reporting and to preserve the goals of transparency.
8. If the physician still contests a rating after all mechanisms for reconsideration have been exhausted, the physician should be permitted to include comments adjacent to the disputed rating in the public report.
9. Payers should provide a central source for collecting, monitoring, and analyzing all inquiries and requests for reconsideration in order to enhance accountability, ensure that concerns are adequately addressed, and improve processes through the identification of recurrent issues and concerns. *(Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of Their Ratings BoR 01-07)*

Patient-Centered, Physician-Guided Care for the Chronically Ill

1. Care for Chronically Ill Patients with One or More Co-Morbid Conditions is Fragmented and Unduly Costly Due to Lack of Coordination Under Fee-For-Service, Making Large Scale Testing of a Patient-Centered, Physician-Guided Chronic Care Model Crucial for the Nation's Health and the Health System's Financial Viability.
2. Due to Their Specialized Training and Expertise, Internists Are Particularly Well Suited to Lead and Oversee the Care of Chronically Ill Patients.
3. A Patient-Centered, Physician-Guided Chronic Care Model Should Include a Physician Case Management Fee and Incentives for Physician Performance that are Linked to Improved Quality of Care and Patient Outcomes and Satisfaction.
4. Use of Information Technology, Online Real-Time Clinical Decision Support, and Incentives for Their Adoption and Use Should be an Essential Element of All Patient-Centered, Physician-Guided Models of Chronic Care Improvement. (BoR 04)

Coverage of Obesity Treatment

ACP advocates that any study of obesity programs include an analysis of how individual payment versus insurance coverage influences the short and long term effectiveness in weight loss management. Further, should an analysis demonstrate that insurance coverage of programs to decrease obesity is cost-effective, ACP will advocate for such additional coverage. (BoR 04; reaffirmed BoR 16)

Unbundling of Preventive and Problem Related Office Visits

The American College of Physicians will work with the American Medical Association and other medical

societies to advocate with government and third party payers to have payers pay for preventive and problem related office visits without bundling or rejection of claims containing multiple types of primary care services. (BoR 04)

Alternative Health Care

ACP continues to support the principle that therapies, alternative or mainstream, should be evidence-based. ACP supports the position that doctors of medicine and doctors of osteopathy who also practice alternative medicine should be held to the same standards as the rest of their medical community. (HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Promotion of the Involvement of Practicing Physicians in NCQA Accreditation Mechanisms

ACP promotes the involvement of practicing physicians in the development of accreditation measures. (HoD 94; reaffirmed BoR 04; reaffirmed with amendments BoR 15)

Continuity of Medical Care

ACP encourages its members to assure the continuity of quality medical care of patients, even when home-bound or confined to a nursing home. (HoD 78; reaffirmed HoD 90; reaffirmed BoR 04; reaffirmed BoR 16)

Definition of Medical Care

ACP defines "medical care" as that which connotes a portion of care under the control of the physician, in contrast to "health care," which includes social, economic, and environmental influences beyond the control of medicine. (HoD 87; reaffirmed BoR 04)

Comparative Effectiveness

Position 1: The American College of Physicians (ACP) strongly supports efforts to improve access to information comparing clinical management strategies.

Position 2: The College strongly supports the establishment of an adequately funded, independent entity to sponsor and/or produce trusted research on the comparative effectiveness of healthcare services.

Position 3: The College believes that the federal government should have a significant role in the funding, implementation and maintenance of this comparative effectiveness entity, but takes no formal position on its organizational structure (e.g. government or joint public/private).

Position 4: The College recommends that the newly proposed comparative effectiveness entity should:

- have a structure and adopt operating procedures that encourage trust in its impartiality and adherence to the strictest scientific standards, by ensuring its independence from both undue governmental and private sector influence.
- be responsible for the development of evidence concerning comparative effectiveness necessary for clinical practice, coverage or pricing decisions, but have no direct involvement in the making of these healthcare decisions.
- conduct proceedings and present results in a transparent manner.

- involve all relevant stakeholders, including beneficiaries, payers, scientists, providers, and industry representatives, at all levels of the evidence development process.
- implement a prioritization process informed by input from the stakeholder groups that ensures that the comparative effective evidence developed will have the greatest positive effect on improving the quality and efficiency of the overall health care provided in the country.
- support the development of evidence at all levels from review and synthesis of existing evidence to initiation of new research in priority areas when essential evidence does not already exist.
- include in its analyses relevant clinical information that is available from federal agencies as well as private and academic settings.
- ensure that the comparative effectiveness findings developed are accessible in a timely manner and in a comprehensible form to all stakeholders.

Position 5: The College recommends that the proposed comparative effectiveness entity be charged with systematically developing both comparative clinical and cost-effectiveness evidence for competing clinical management strategies.

Position 6: The College recommends that as part of the implementation of the proposed comparative effectiveness entity, a panel of stakeholders and additional scientific experts including those specifically in the area of cost-effectiveness analyses be formed and charged with:

- Updating and expanding upon the recommendations of the 1993 Panel on Cost-effectiveness and Health and developing related procedures to ensure that the proposed entity produces high quality cost-effectiveness information.
- Developing a framework and related procedures to reconcile apparently disparate estimates of cost effectiveness regarding specific clinical management comparisons.
- Developing recommendations including suggested model procedures for potential use by stakeholders who plan to consider this cost-effectiveness information in coverage, purchasing and pricing decisions. These recommendations should:
 - recognize that cost-effectiveness analysis is only a tool to be used in coverage and pricing decisions. It cannot be the sole basis for making resource allocation decisions.
 - help to ensure that the use of cost-effectiveness information as part of the decision making process takes into account the unique needs and values of each patient (is patient-centered) and the clinical opinion of the treating physician, while also recognizing the limited nature of healthcare resources available to society in general (the Medical Commons).

- Developing recommendations to establish a mechanism to educate the general public and promote discussion on the use of comparative clinical and cost effectiveness information to both meet the needs of the individual and help ensure the equitable distribution of finite health care resources throughout society.

Position 7a: The College recommends that all healthcare payers including Medicare, other government programs, private sector entities and the individual healthcare consumer employ both comparative clinical and cost-effectiveness information as factors to be explicitly considered in their evaluation of a clinical intervention.

Position 7b: The College recommends that cost should never be used as the sole criterion for evaluating a clinical intervention. Cost should only be considered along with the explicit, transparent consideration of the comparative effectiveness of the intervention. (Improved Availability of Comparative Effectiveness Information: An Essential Feature for a High Quality and Efficient United States Healthcare System, BoR 08)

Controlling Health Care Costs: Comparative Effectiveness Research

1. Efforts should be made to improve access to information comparing clinical management strategies.
2. An adequately funded, trusted national entity should be charged with systematically developing both comparative clinical and comparative cost-effectiveness evidence for competing clinical management strategies. It should prioritize, sponsor, or produce comparative information on the relative clinical effectiveness, safety, and cost-effectiveness of medical services, drugs, devices, therapies, and procedures.
3. The federal government should have a significant role in funding, implementing, and maintaining this comparative effectiveness entity.
4. Cost should never be used as the sole criterion for evaluating a clinical intervention, but it should be considered alongside the explicit, transparent consideration of the comparative effectiveness of the intervention.
5. Health care payers, physicians and other health professionals, and patients should consider both comparative clinical and cost-effectiveness information in evaluating a clinical intervention.
6. Employers and health plans should consider adopting value-based benefit design programs that use comparative research on clinical outcomes and cost effectiveness developed by an independent entity that does not have an economic interest in the benefit determinations. (BoR 09)

Controlling Health Care Costs: Ensure Accurate Pricing of Services

1. Congress should charge the Institute of Medicine or another appropriate study group to explore the factors behind regional variations in health care services and issue a report. The report should recommend public policy interventions to improve outcomes and lower the costs of care in areas of the country that have higher per capita expenditures and poorer outcomes, even after correcting for differences in demographics and other characteristics of the population served. (BoR 09)

Primary Care in High Quality-Low Cost Areas

ACP supports federal legislation to fund research that reflects the value and cost-effectiveness of primary care.(BoR 09)

DEVELOPING METHODS AND RESOURCES FOR SMALLPRACTICES TO FAIRLY NEGOTIATE WITH ACCOUNTABLE CARE ORGANIZATIONS

ACP in support of its existing policy statement (Policy Statement Pertaining to the Development of the Accountable Care Organization Model approved by the BOR April 2010), further develops specific methods and resources through which small practices can fairly negotiate with Accountable Care Organizations and advocates for the implementation of these methods with the Centers for Medicare and Medicaid Services and other insurers. (BoR 10)

Joint Principles for Accountable Care Organizations

Structure

1. The core purpose of an Accountable Care Organization is to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population it serves, which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.
2. The Accountable Care Organization should demonstrate strong leadership from among physicians and other healthcare professionals, including significant and equitable representation from primary care and specialty physicians, in its administrative structure, policy development, and decision-making processes; clinical integration in the provision of care; and processes to facilitate operation as a true partnership among physicians and all other participants.
3. Organizational relationships and all relevant clinical, legal, and administrative processes within the Accountable Care Organization should be clearly defined and transparent to physicians, other related healthcare professionals, and the public. This includes methods of payment including the application of any risk adjustment strategies for both pediatric and adult patients, quality management processes, and processes to promote efficiency and value in delivery system performance.
4. Accountable Care Organizations should include processes for patient and/or family panel input in relevant policy development and decision-making.
5. Accountable Care Organizations should include a commitment to improving the health of the population served through programs and services that address needs identified by the community including, for example, interfacing with state Title V programs, early intervention programs, Head Start offices, and public education entities.
6. Accountable Care Organizations should provide incentives for patient and/or family engagement in their health and wellness.
7. Participation by physicians, other healthcare professionals, and patients/families in an ACO should be voluntary. However, if patients are assigned to an ACO, they should be encouraged to select a primary care physician.

8. Nationally-accepted, reliable and validated clinical measures focused on ambulatory and inpatient care should be used by Accountable Care Organizations to measure performance and efficiency and evaluate patient experience. These measurement processes should be transparent, and informed by input from primary and specialty care physicians and other healthcare professionals participating in the Accountable Care Organization.
9. Accountable Care Organizations should implement clinically integrated information systems to provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions and sites of care.
10. The structure and related payment systems of the Accountable Care Organization should be implemented and monitored to prevent "adverse unintended consequences," such as poor access to physicians, denial of needed care, or discrimination against the treatment of the more medically complex or difficult-to-treat patients.
11. Primary care physicians, specialty physicians, and other healthcare professionals should have the option to participate in multiple Accountable Care Organizations.
12. Barriers to small practice participation within the Accountable Care Organization should be addressed and eliminated. These barriers include the small size of their patient panels and their current limited and future access to capital, health information technology infrastructure needs, and care coordination and management resources.
13. Accountable Care Organizations should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
14. Accountable Care Organizations should promote processes to reduce administrative complexities and related unnecessary burdens that affect participating practices and the patients/families to whom they provide service.

Payment

15. Payment models and incentives implemented by Accountable Care Organizations must align mutual accountability at all levels, fostered by transparency and focused on health promotion and healthy development, disease prevention, care management, and care coordination.
16. Payment models and incentives implemented by Accountable Care Organizations should adequately reflect the relative contributions of participating physicians and other healthcare professionals to increased quality and efficiency and demonstrate value in the delivery of care.
17. Payment models should recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.
18. Recognition as an Accountable Care Organization and rewards for its performance should be based on processes that combine achievement relative to set target levels of performance, achievement relative to other participants, and improvement that have been developed with significant input from primary and specialty care physicians and other healthcare professionals.
19. Practices participating within the Accountable Care Organization that achieve recognition as medical homes by NCQA, other nationally accepted certification entities, and/or related processes (e.g. state government recognition) should be provided with additional financial incentives.

20. The structure of the Accountable Care Organization should adequately protect ACO physicians and other healthcare professional participants from “insurance risk,” unless clearly agreed as a requirement for participation.
21. Accountable Care Organizations can employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs including but not limited to blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation. (BoR 10)

Development of the Accountable Care Organization Model

1. ACOs should be structured to provide patient-centered, high quality, efficient, coordinated, seamless, team-oriented care to its defined patient population.
2. ACOs should promote the delivery of services consistent with the principles of the Patient Centered Medical Home (PCMH) and ACP policy on the PCMH – Neighbor and reward practices that achieve this recognition.
3. ACO demonstration and pilot projects should recognize the importance of transitions of care between different sites of service.
4. Physician practice participation within ACO demonstration and pilot projects should be voluntary.
5. Practicing physicians, including representatives of all major specialties, subspecialties and primary care, should have significant representation in the administrative structure, policy development, and decision-making processes of ACOs.
6. ACOs should include processes for patient panel input in policy development and decision-making.
7. ACOs that include hospitals and similar large treatment settings must have processes that protect participating primary care and specialty/subspecialty physician practices from the undue influence of these larger settings in administrative, policy setting and payment distribution decisions.
8. Organizational relationships and all relevant clinical and administrative processes within the ACO should be clearly defined and transparent to physicians, other related health care professionals, and the public. This includes methods of reimbursement, quality management, and assessments of delivery system performance review.
9. ACO structure should recognize the importance of administrative simplification to the participating practices.

10. Performance measures used by ACOs to determine clinical quality, efficiency, and patient experience of care should be nationally recognized and consistent with ACP policy as reflected in the “Linking Physician Payments to Quality Care” and the “Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of their Ratings” policy papers.
11. Priorities for quality improvement should be aligned with a multi-stakeholder national organization such as the National Priorities Partnership.
12. Meaningful use of health information technology (health IT) and health information exchange are integral parts of the ACO model. Therefore, certified EHR technology that supports system integration should be accessible to and used by all practices (including small practices) affiliated with the ACO.
13. ACO payment models should recognize the practice expenses and administrative costs associated with participation in an ACO model including the costs of implementing and maintaining health IT.
14. ACOs should contain a sufficient number of primary care physicians, subspecialists/specialists, and other health care professionals to effectively meet the needs of the patient population served.
15. Barriers to small practice participation within ACO demonstration and pilot projects should be addressed and minimized. These barriers include the small size of their patient panels and their limited capital, health IT and care management resources.
16. ACO demonstration and pilot projects should have processes in effect to help participating practices adjust to the new ACO culture and educate them in the skills necessary to succeed under the model.
17. ACO demonstration and pilot projects should form relationships with the relevant professional societies towards the goals of enlisting participation of physician practices and supporting their functioning within the project.
 - a. Payment models used within the ACO demonstration and pilot projects should recognize and reward performance based on a combination of the meeting of absolute and improvement-based quality and efficiency benchmarks.
 - b. Adequately reflect the participating practice’s contribution to increased quality and efficiency.
 - c. Ensure that a significant portion of any savings attributable to the ACO’s activities be shared by the participating practices.
 - d. Protect ACO participants from “insurance risk” (e.g. degree of illness/severity in the population).

18. ACO demonstration and pilot projects incentive structures should not discriminate against the treatment of the more medically complex or difficult-to-treat patients.

ACO demonstration and pilot projects should align incentives for improving quality while reducing overall costs by testing a wide variety of payment approaches including but not limited to blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation.

20. ACO demonstration and pilot projects should be adequately protected from existing antitrust, gainsharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models. (BoR 10)

REPRODUCTIVE HEALTH

Teenage Pregnancy

The College supports community- and school-based programs that address the growing social and economic consequences of teenage pregnancy, which is a cause for concern both nationally and in underserved areas. Support should be increased for federal, state, and local family-planning grants that provide important educational and clinical services. (Inner-City Health Care, ACP 96; reaffirmed BoR 06; reaffirmed as amended BoR 17)

RESEARCH

Research

Medical progress and improved patient care depend on innovative and vigorous research, on honest communication of study results, and on continued evaluation of patient outcomes following implementation of research findings. Research is defined under the federal “Common Rule” as “a systematic investigation including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge” [\(123\)](#). Honesty and integrity must govern all types and stages of research, from the laboratory to randomized clinical trials, and from the initial design and grant application to publication of results and translation into practice. Institutional review boards (IRBs) must review and approve research involving human subjects to ensure consistency with ethical standards, but use of IRBs does not obviate the investigator's responsibilities to adhere to those standards and uphold the ethical integrity of research. Investigators and their institutions, authors, and editors are individually and jointly responsible for ensuring that the obligations of honesty and integrity are met. Fraud in research must be condemned and punished. Reviewers of grant applications and journal articles must respect the confidentiality of new ideas and information; they must not use what they learn from the review process for their own purposes, and they should not misrepresent the ideas of others as their own.

Scientists have a responsibility to gather data meticulously, to keep impeccable records with appropriate levels of privacy protections, to interpret results objectively and not force them into preconceived molds or models, to submit their work for peer review, and to report knowledge. All clinical trials must be registered and reporting of methodology and outcomes must be clear, complete, and transparent [\(124\)](#).

Contributing to generalizable knowledge that can improve human health should be the main motivation for scientific research. Personal recognition, public acclaim, or financial gain should not be primary motivating factors, and physicians should be aware of conflicting interests when participating in or referring patients to research studies [\(125\)](#). (BoR 04; Reaffirmed as amended BoR 11)

Protection of Human Subjects

The medical profession and individual researchers must assume responsibility for assuring that research is valid, has potentially important value, and is ethically conducted. Research must be thoughtfully planned to ensure a high probability of valid results, to minimize subject risk and maximize subject safety, and to achieve a benefit–risk ratio that is high enough to justify the research effort [\(126\)](#). Benefits and risks of research must be distributed fairly, and particular care must be taken to avoid exploitation of vulnerable populations and those in countries with limited access to health care resources [\(127\)](#). Research projects originating in but conducted outside of the United States must be consistent with ethical principles and practices that govern human subjects research and must adhere to regulatory standards in the United States as well as at international sites.

Functioning as both an investigator and the clinician of a patient-subject can result in conflict between what is best for the research protocol and what is in the patient's best interests. Physician-investigators should disclose this conflict to potential research participants and should maintain patient-subject health and welfare as their primary consideration [\(128\)](#). Patients should be informed that the primary objective of a research protocol is to gain knowledge and that there may or may not be clinical benefit. It should also be clear to patients that participation in research is voluntary and not a requirement for continued clinical care. The right to withdraw consent and discontinue participation at any time must be communicated. Any limitations on withdrawal of data or biological materials must be explained during the consent process.

Each research subject or an authorized representative must be fully informed of the nature and risks of the research so that he or she may give truly informed consent to participate. Physicians have an ethical obligation to ensure that the information shared during the informed consent process is appropriate and understandable to the proposed subject population. Temporary, progressive, or permanent cognitive impairment or a questionable capacity to give consent for participation in research does not preclude participation in research but does necessitate special measures [\(129, 130\)](#). After ensuring that ethical and legal standards of all research are met, institutions and physician-investigators should attempt to obtain the assent of the cognitively impaired individual in addition to obtaining the consent of a legally authorized representative. In some cases, the patient is able to give consent for research participation and designate a proxy in the early stages of disease [\(129\)](#). If there is no advance directive or proxy, the legally appointed surrogate decision maker must first consider whether the patient would have agreed to participate. Once it is determined that the patient would not object, the physician-investigator needs to instruct the surrogate about decision-making standards that are based on the patient's best interests. Research in patients with impaired cognition or capacity still needs to meet the threshold criteria of a high probability of valid results, a benefit–risk ratio that is high enough to justify the research effort, and a fair distribution of research benefits and risks [\(129\)](#). Clinicians who are thinking about participating in or referring patients to research studies should be well-versed about the responsible conduct of research and protection of human subjects.

Research involving special circumstances, such as individuals requiring critical care or emergency care, also requires special measures for the protection of human subjects. While research in these contexts may contribute to improved care, investigators need to be aware that the subject may have an impaired ability to provide informed consent and that the benefits of this research may not flow to the potential subject. Special precautions should be undertaken to ensure the protection of these subjects [\(131\)](#). However, the extent to which precautions, such as community consultation, have actually been protective of subject and community rights and interests is unclear.

Independent review is a fundamental principle of ethical research. All proposed research, regardless of the source of support, must be assessed by an IRB to assure that the research plans are valid and reasonable, human subjects are adequately protected, the benefit–risk ratio is acceptable, the proposed research is sufficiently important and protective of human subjects in light of the local patient population, and the informed consent process and confidentiality protections are both appropriate and adequate. Physician-investigators and physicians referring patients to clinical studies have an independent, professional obligation to satisfy themselves that those studies meet ethical standards.

While the formal, independent review process was designed to protect research subjects, it cannot replace mutual trust and respect between subjects and researchers. Maintaining that trust and respect requires that physician-investigators involved in designing, performing, or referring patients to research studies have primary concern for the potential subjects [\(132\)](#). If the risks of continued participation in a research trial become too great or cannot be justified, the physician-investigator must advise patients to withdraw. Physicians should not abdicate overall responsibility for patients they have referred to research studies and should ensure that data and safety issues are routinely monitored.

Although the responsibility for assuring reasonable protection of human research subjects resides with the investigators and the IRB, the medical profession as a whole also has responsibilities. Clinical investigation is fraught with potential conflicts. Rewards should not be linked to research outcomes and physicians participating in the conduct of clinical studies should avoid such situations. Moreover, physicians who enroll their own patients in office-based research have an ethical obligation to disclose whether they have financial or other ties to sponsors [\(96\)](#). Giving or accepting finder's fees for referring patients to a research study generates an unethical conflict of interest for physicians [\(96\)](#). Compensation for the actual time, effort, and expense involved in research or recruiting patients is acceptable; any compensation above that level represents a profit and constitutes or can be perceived as an unethical conflict of interest.

While the Common Rule [\(123\)](#) and some state laws have provisions regarding privacy and confidentiality requirements for research, the HIPAA Privacy Rule [\(18\)](#) requires subject authorization for use or disclosure of protected health information for research. A privacy board can waive the authorization requirement or information can be used in a “limited data set” with a data use agreement or can be deidentified under HIPAA [\(133\)](#), although the HIPAA deidentification requirements are stricter than those under the Common Rule. Physicians who engage in research studies or who make their patient records available for research purposes should be familiar with the HIPAA requirements and each study's procedures for protecting data confidentiality and security. (BoR 04; Reaffirmed as amended BoR 11)

Innovative Medical Therapies

The use of innovative medical therapies falls along the continuum between established practice and research. Innovative therapies include the use of unconventional dosages of standard medications, a novel combination of currently accepted practices, new applications of standard interventions, and the use of accepted therapy or approved drugs for nonapproved indications. The primary purpose of innovative medical therapies is to benefit the individual patient. While medical innovations can yield important treatment results, they can also produce safety problems. Consequently, medical innovation should always be approached carefully. Medical therapy should be treated as research whenever data are gathered to develop new medical information and for publication. If use of the new therapy, procedure, or intervention becomes routine, it should be investigated in a clinical trial. Adverse events should be carefully monitored and reported to the U.S. Food and Drug Administration and applicable oversight bodies. When considering an innovative therapy that has no precedent, the physician should

consult with peers, an IRB, or other expert group to assess the risks, potential adverse outcomes, potential consequences of forgoing a standard therapy, and whether the innovation is in the patient's best interest [\(138\)](#). Informed consent is particularly important and requires that the patient understand that the recommended therapy is not standard treatment. (BoR 04; Reaffirmed as amended BoR 11)

Scientific Publication

Authors of research reports must be intimately acquainted with the work being reported so that they can take public responsibility for the integrity of the study and the validity of the findings. They must have substantially contributed to the research itself, and they must have been part of the decision to publish. Investigators must disclose project funding sources to potential research collaborators and publishers and must explicitly inform publishers whether they do or do not have a potential conflict of interest (see the Financial Conflicts of Interest section). Physicians should not participate in research if the publication of negative results will be precluded.

Physician-investigators build on the published work of others and can proceed with confidence only if they can rely on the accuracy of the previously reported results on which their work is based.

Registration of clinical trials in a public trials registry before patient enrollment helps address the general public and scientific community's call for transparency in clinical research [\(139\)](#). All researchers have a professional responsibility to be honest in their publications. Biased reporting and selective reporting of study outcomes risks the integrity of the research and may interfere with the ability to derive evidence-based treatment outcomes [\(140\)](#). Researchers must describe methods accurately and in sufficient detail and assure readers that the research was carried out in accordance with ethical principles. They have an obligation to fully report observations actually made, clearly and accurately credit information drawn from the work of others, and assign authorship only to those who merit and accept it. Equally important is acknowledging and revealing the financial associations of authors and other potential conflicts of contributors in the manuscript [\(141\)](#).

In general, subject recruitment alone does not merit authorship. Instead, authorship means substantial contribution to the research along with compliance with current authorship guidelines [\(142\)](#).

Ghostwriting and taking credit or payment for the authorship of another is unethical [\(96\)](#).

Plagiarism is unethical. Incorporating the ideas of others or one's own published ideas, either verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. (BoR 04; Reaffirmed as amended BoR 11)

Public Announcement of Research Discoveries

In this era of rapid communication and intense media and public interest in medical news, clinical investigators or their institutions commonly make public announcements of new research developments. Because media coverage of scientific developments can be fraught with misinterpretation, unjustified extrapolation, and unwarranted conclusions, researchers should approach public pronouncements with extreme caution, using precise and measured language. Researchers should also consider notifying subjects of study findings.

In general, press or media releases should be issued and press conferences held only after the research has been published or presented in proper and complete abstract form so that study details are available to the scientific community for evaluation. Statements of scientists receive great visibility. An announcement of preliminary results, even couched in the most careful terms, is frequently reported by the media as a "breakthrough." Spokespersons must avoid raising false public expectations or providing misleading information, both of which reduce the credibility of the scientific community as a whole. (BoR 04; Reaffirmed as amended BoR 11)

Financial Support of Medical Research

ACP advocates ongoing research with adequate financial support as being in the best interest of the American public. Precipitous changes in such support must be viewed with concern when they threaten to adversely affect the continuity of research efforts. ACP believes that governmental medical research funds should be allocated to categorical areas of need, based on merit and where possible, distributed rather than concentrated on a select number of investigators. (HoD 73; revised HoD 87; reaffirmed BoR 04; reaffirmed BoR 16)

Supporting Research Into the Therapeutic Roles of Marijuana

Position 1: ACP supports programs and funding for rigorous scientific evaluation of the potential therapeutic benefits of medical marijuana and the publication of such findings.

Position 1a: ACP supports increased research for conditions where the efficacy of marijuana has been established to determine optimal dosage and route of delivery.

Position 1b: Medical marijuana research should not only focus on determining drug efficacy and safety but also on determining efficacy in comparison with other available treatments.

Position 2: ACP encourages the use of nonsmoked forms of THC that have proven therapeutic value.

Position 3: ACP supports the current process for obtaining federal research-grade cannabis.

Position 4: ACP urges an evidence-based review of marijuana's status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule. This review should consider the scientific findings regarding marijuana's safety and efficacy in some clinical conditions as well as evidence on the health risks associated with marijuana consumption, particularly in its crude smoked form.[†]

Position 5: ACP strongly supports exemption from federal criminal prosecution; civil liability; or professional sanctioning, such as loss of licensure or credentialing, for physicians who prescribe or dispense medical marijuana in accordance with state law. Similarly, ACP strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws.

Cost Effectiveness Surveys

ACP recommends that any study which purports to compare usage of hospital inpatient facilities by physicians or patients must include the pre- and post-hospital procedures and expenses provided to each patient in determining the cost effectiveness of the treatment and procedures rendered to a specific beneficiary in the hospital. (HoD 94; reaffirmed BoR 04)

[†]In response to questions about the intent of original Position 4, adopted by the ACP Board of Regents in January 2008, the Board of Regents approved a revised position 4 in July 2008. The original position 4 read as follows: "ACP urges review of marijuana status as a Schedule I controlled substance and reclassification into a more appropriate schedule, given the scientific evidence regarding marijuana's safety and efficacy in some clinical conditions." All references to ACP policy should use *only the revised position 4* as stated above.

SPORTS AND PHYSICAL FITNESS

Steroids

ACP opposes the use of anabolic steroids to enhance athletic performance. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 16)

TECHNOLOGY

Genetic Information

GENETIC TESTING

Presymptomatic and diagnostic testing raises issues of education, counseling, confidentiality, and justice. Such testing may allow clinicians to predict diseases or clarify susceptibility at a time when medicine may not have the ability to prevent or cure the conditions that are identified. Both the public and health care professionals often have a limited grasp of the distinction between prediction and susceptibility or risk. Genetic testing presents unique problems by identifying risk for disease that has special meaning for patients and for family members who may not be under the care of the clinician providing the test.

Clinicians should discuss with patients the degree to which a particular genetic risk factor correlates with the likelihood of developing disease. Testing should not be undertaken until these issues are fully explored with the patient and the potential consequences of the test, from its impact on the patient's well-being to implications for other family members and use by insurers or other societal institutions, are fully understood.

Because the number of trained genetic counselors is small and is unlikely to match the exponential growth in genetic testing, the generalist clinician is increasingly responsible for conveying genetic test results. Only physicians who are familiar with the skills necessary for pretest and post-test education and counseling should engage in genetic testing. All primary care physicians should develop these skills.

As more information becomes available on the genetic risk for certain diseases, physicians must be aware of the need for confidentiality concerning results of genetic tests. Many state governments and the federal government are promulgating rules and regulations that cover access of employers and insurers to such information. Additional complex ethical problems exist, such as which family member should be informed of the results of genetic tests. Physicians should be sensitive to these ethical problems, and testing should not be undertaken until issues are fully discussed and their consequences are well understood.

The potential for stigmatization and insurance and job discrimination require that physicians ensure the confidentiality of data. However, the presence of a genetic risk factor or genetic disease in a family member raises the possibility that other blood relatives are at risk. The physician should seek the affected patient's consent in encouraging potentially affected family members to seek genetic counseling if it may affect treatment or major life decisions. (BoR 04)

GENETIC DISCRIMINATION

Position 1: Insurance providers should be prohibited from using an individual's genetic information to deny or limit health coverage or establish eligibility, enrollment or premium contribution requirements.

Position 2: Insurance providers should be prohibited from establishing differential premiums based on an individual's genetic information or request for genetic screening.

Position 3: Employers should be prohibited from using an individual's genetic information in employment decisions, such as hiring, promoting or terminating an employee or establishing the terms, conditions and benefits of employment.

Position 4: Insurers and employers should be prohibited from requiring individuals and families to undergo genetic testing.

Position 5: Insurers and employers should be prohibited from collecting and/or disclosing an individual or families' genetic information. Written and informed consent should be required for each disclosure of genetic information and should include to whom the disclosure is made.

Position 6: Congress should establish comprehensive and uniform federal protection against genetic discrimination that closes the gaps in protection due to varying state laws. Federal protection should also cover ERISA health plan (Establishing Federal Protections Against Genetic Discrimination, BoR 08)

Assessment of Health Care Technology

ACP believes that efforts to assess new and emerging technologies, procedures and pharmaceuticals to ensure their safety and effectiveness are necessary before they become a part of common medical practice. When possible, assessments of cost-effectiveness should be included. ACP supports efforts to create a coordinated, national technology assessment program. All technology assessment programs must pursue several key objectives to ensure credible and fair evaluations based on scientific data, such as the participation of physicians and the utilization of a rigorous methodological review supplemented by clinical judgment of existing scientific evidence. Evaluations must remain totally unassociated from reimbursement decisions. The creation of a coordinated, national technology assessment program should not impede existing technology assessment activities, and all technology assessment programs should be eligible for federal funding for such activities should funds become available. ACP supports the use of credible and fair technology assessment evaluations, based on scientific data, by third-party payers, Medicare and Medicaid to make coverage and reimbursement decisions. When the data are available to ensure accurate measures of benefits to patients, ACP supports an examination of the cost-effectiveness of individual and competing technologies, medical procedures and pharmaceuticals. The cost of a particular technology, medical procedure or pharmaceutical must not be given greater significance than its benefits to patients. (HoD 91; reaffirmed BoR 04; reaffirmed BoR 15)

Controlling Health Care Costs: Enhance and Coordinate Technology Assessments

1. A coordinated, independent, and evidence-based assessment process should be created to analyze the costs and clinical benefits of new medical technology before it enters the market, including comparisons with existing technologies. Such information should be incorporated into approval, coverage, payment, and plan benefit decisions. The assessment process should balance the need to inform decisions on coverage and resource planning and allocation with the need to ensure that such research does not limit the development and diffusion of new technology of value to patients and clinicians or stifle innovation by making it too difficult for new technologies to gain approval.
2. Coverage of tests and procedures should not be denied solely on the basis of cost-effectiveness ratios; coverage decisions should reflect evidence of appropriate utilization and clinical effectiveness.
3. Useful information about the effectiveness and outcomes of technology and public education should be widely disseminated to reduce patient and physician demand for technologies of unproven benefit. (BoR 09)

TOBACCO

Support Food and Drug Administration's (FDA) Attempt to Regulate Tobacco

ACP strongly supports the Commissioner of the FDA in having nicotine declared an addictive substance. (HoD 97; reaffirmed BoR 08)

Inpatient Use of Pharmaceutical Aids of Smoking Cessation

Hospitals should be encouraged to approve pharmaceutical aids to smoking cessation for inpatient use. (HoD 94; reaffirmed BoR 04)

Tobacco-Divestiture

Health related industries should consider divesting themselves of investments in companies which provide major support for the promotion of tobacco use. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Contribution to Death Certificates

ACP encourages state health divisions through its components to add "Did tobacco use contribute to death?" to their current death certificate. ACP encourages the AMA, through its state medical societies to compile and disseminate available data concerning tobacco use as a contributing factor to death. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 15)

Tobacco Control and Prevention

1. All states, with assistance from the federal government, should establish and adequately fund comprehensive tobacco control efforts to prevent smoking and other tobacco product use among young people; provide objective information about the dangers of cigarette, cigar, pipe, smokeless, and other tobacco products; minimize exposure to secondhand smoke; and help tobacco users quit.
2. Public and private insurers, as well as state, community and employer-based entities, should provide all effective comprehensive tobacco cessation and treatment benefits – including counseling and medication - for all qualifying individuals. Physicians should assist tobacco-using patients in their efforts to quit
3. All states should commit to funding tobacco control efforts at CDC-recommended levels. All states should establish requirements that an appropriate portion of tobacco-generated revenue be directed towards tobacco control efforts. Local governments should be permitted to implement tobacco excise taxes beyond state levels.
4. Youth tobacco education and prevention efforts, such as antismoking media campaigns and school-based interventions, must be enhanced and properly funded. Information and interventions related to cigars, pipes, smokeless tobaccos, and other cigarette alternatives should be incorporated into youth antismoking efforts.
5. The Food and Drug Administration should implement a ban on menthol as a flavoring in all tobacco products, as it has done with flavored cigarettes.
6. State and local governments should take necessary action to establish comprehensive smoke-free laws banning smoking in all non-residential indoor areas including all workplaces,

restaurants, and bars. State and local governments should work to control smoking in residential areas such as apartment and condominium buildings.

7. Comprehensive tobacco control efforts should seek to reduce use of cigars and pipes in addition to cigarettes, particularly among young people and cigarette smokers.
8. The FDA should be authorized to regulate electronic cigarettes until convincing evidence develops that they are not addictive.
9. Smoking and tobacco use in movies and television should be discouraged and the media industry should take responsibility to emphasize the dangers of tobacco use, particularly to young people. (BoR 10)

Electronic Nicotine Delivery Systems

6. The American College of Physicians recommends that the Food and Drug Administration extend its regulatory authority granted through the Family Smoking Prevention and Tobacco Control Act to cover electronic nicotine delivery systems (ENDS).
7. The American College of Physicians recommends that characterizing flavors should be banned from all tobacco products, including ENDS.
8. The American College of Physicians reiterates its support for taxing tobacco products, including ENDS devices and nicotine liquids, to discourage use among children and adolescents. Local governments should be permitted to establish higher tax rates for ENDS and related products than state levels.
9. The American College of Physicians supports legislative or regulatory efforts to restrict promotion, advertising, and marketing for ENDS products in the same manner as for combustible cigarettes, including a prohibition on television advertising. Youth tobacco prevention efforts, such as antismoking media campaigns and school-based interventions, should include information about the potential risks of ENDS use.
10. The American College of Physicians recommends that federal, state, and local regulators should take action to extend indoor and public place clean air laws that prohibit smoking in public places, places of employment, commercial aircraft, and other areas to ENDS products.
11. The American College of Physicians recommends that the federal government should authorize and appropriate funding to rigorously research the health effects of ENDS use, chemical content, and toxicity; effects of ENDS vapor exposure; dual-use rates; and effects of ENDS-derived nicotine on human health. An appropriate federal agency, such as the Agency for Healthcare Research and Quality, National Institutes of Health, or Centers for Disease Control and Prevention, should commission an evidence review to evaluate the current research and data related to benefits and harms of ENDS that can be utilized as a basis for a clinical guideline. (BoR 14)

TOBACCO: LABELING AND WARNING

Labeling

ACP supports stronger package labeling on all tobacco products to adequately inform patients of the many health hazards associated with smoking. The labeling should be changed accordingly as new

scientific evidence regarding the health hazards of tobacco products become available. (HoD 82; revised HoD 93; reaffirmed BoR 04; reaffirmed BoR 15)

TOBACCO: MARKETING AND PROMOTION

Tobacco Marketing and Promotion

ACP reaffirms its support of a ban on the marketing and promotion of tobacco with the following guidelines:

1. Youth: Societal and legislative efforts to discourage minors from using tobacco should include education them throughout their school years regarding the hazards of tobacco use, urging adults to refrain from tobacco use in their presence, condemning the targeting of tobacco promotion toward youth, and encouraging their role models in the sports and entertainment industries to refrain from public tobacco use;
2. Minorities and Women: The targeting of tobacco advertisements toward minorities and women is condemned;
3. Subscription Lists: No medical society should sell or provide mailing lists of its members to companies that offer magazines containing tobacco advertising. (HoD 96; reaffirmed BoR 06; reaffirmed BoR 17)

TOBACCO: PROHIBITION ON SALE AND USE

Congress to End Subsidies Related to Tobacco Production and Distribution

ACP believes that Congress should pass legislation ending all subsidies to the tobacco industry. (HoD 97; reaffirmed BoR 08)

Support FDA Regulation

ACP affirms that it supports (a) the efforts of the Food and Drug Administration to regulate tobacco as a drug, including actions to restrict access to tobacco products by underage people, and (b) the elimination of government subsidies for growing, manufacturing, and distributing tobacco products. The College urged the American Medical Association to encourage state medical societies to promote initiatives at the state level, including higher excise taxes, restrictions on smoking in the workplace, and restrictions on access to tobacco products by persons under the age of 21. (ACP AMA Del I-96; reaffirmed BoR 06; reaffirmed BoR 17)

Increasing Federal Excise Taxes on Alcohol and Tobacco

As part of its set of recommendations to restore Medicare solvency, ACP supports increasing the federal excise tax on alcohol and tobacco and earmarking the revenues for promotion of tobacco cessation and alcohol abstinence programs respectively. (HoD 84; reinstated HoD 95; reaffirmed BoR 06; reaffirmed as amended BoR 17)

Smoking

ACP urges all physicians to stop smoking and to prohibit smoking in their offices. (HoD 84; reinstated HoD 95; reaffirmed BoR 06; reaffirmed BoR 17)

Tobacco-Youth

ACP opposes legislation which include clauses which would preclude "sting" operations (intended to identify those who sell cigarettes to minors) by making the child (and the adult who asks him/her to attempt to buy cigarettes) the law-breaker.

Parent-Teacher Associations should be encouraged (both directly and through individual member-physicians) to encourage teachers' unions to help make schools tobacco free. (HoD 94; reaffirmed BoR 04; reaffirmed BoR 15)

Exporting Tobacco Products

1. ACP urges the U.S. government to adopt a trade policy consistent with its health policy and cease to use its trade leverage to promote the export of tobacco and the world smoking epidemic, particularly to Third World nations.
2. ACP supports federal legislation requiring health warning labels in the appropriate native language on all packages of tobacco products exported from the U.S. If the nation importing the products does not have its own health warning requirements, then those packages should contain the health warnings currently required of tobacco products sold in the U.S.
3. ACP supports requiring foreign advertising by U.S. tobacco producers to be at least as restrictive as types of advertising permitted in the U.S.
4. ACP encourages labeling on tobacco products manufactured abroad to be at least as restrictive as labeling on tobacco products produced in the U.S. ACP opposes efforts by the U.S. government to persuade countries to relax regulations concerning tobacco promotion and consumption.
5. ACP opposes the importation and exportation of tobacco products. ACP supports efforts to make U.S. foreign export policy more consistent with domestic health policy, such as policy on the distribution of drugs, the use of pesticides and hazardous waste disposal in other nations. (HoD 90; reaffirmed BoR 04; reaffirmed BoR 15)

VETERANS HEALTH ADMINISTRATION

General Policy Statements

1. ACP recognizes the important healthcare services that VHA provides to this nation's military veterans, supports maintaining the integrity of this system of care, and supports the adequate appropriation of funds to allow the VHA to provide timely and high quality healthcare services.
2. ACP advocate for processes that ensure the timely, bidirectional exchange of patient clinical information necessary for effective patient care between VHA and non-VHA physicians, other healthcare professionals and facilities regarding patients that receive healthcare services from both sources. (BoR 09, Updated BoR 14)
3. ACP advocate for processes that allow non-VA physicians' prescriptions for veterans eligible for non-VHA care to be filled by pharmacy services within the VHA system. Such processes should also allow for coverage of prescriptions filled by pharmacy services outside the VHA system in urgent or emergently needed situations. Non-VA physicians should have ready access to and make use of VHA formularies when providing care to eligible veterans, and access to processes to petition for the use of non-VHA formulary drugs for selected patients. (BoR 04, Updated BoR 14)
4. ACP advocate for processes that allow non-VHA physicians to order laboratory and radiologic testing, and directly seek subspecialty consultations and treatment at VHA facilities for veterans eligible for and receiving non-VHA care. Furthermore, information should be readily available to

these veterans regarding under what circumstances the VHA will cover such services performed outside the VHA system.

5. ACP encourage the Secretary to harmonize clinical performance measures used within the VHA with evidenced-based measures endorsed through a national multi-stakeholder consensus process (e.g. National Quality Forum) and employed by other federal (e.g. Medicare) and private sector healthcare programs. All clinical performance measures and results should be transparent and readily available to the public.
6. ACP encourage the Secretary to address workforce needs within VHA, within the broader context of the nation's healthcare workforce requirements. ACP further requests that the Secretary advocate for the funding and formation of the National Health Care Workforce Commission (approved as part of the Affordable Care Act of 2010) or a similar entity to help inform efforts to address the nation's healthcare needs. (BoR 14)

Supplemental Policy Statements

1. Participation by non-VHA physicians and other healthcare professionals within the Program should be voluntary. Any selection processes for initial or continued Program participation employed by the VHA, other than the minimal qualifications defined in the legislation, should be transparent; be based on measures of professional competency, quality of care,
2. and the appropriate utilization and resources; and include reasonable appeal procedures. Educational resources describing the Program and its related obligations and rights should be developed and provided by the VHA to allow for an informed decision by physicians and other healthcare professionals considering participation.
3. Contracting, enrollment and credentialing procedures for non-VHA physicians to participate in the Program should be non-burdensome and rely on already existing Medicare information and procedures.
4. The fee schedule employed within the Program should be commensurate with the Medicare payment schedule. Claim processes should be clearly defined and similar to those under Medicare (including related appeal procedures), and operate under prompt payment or similar requirements.
5. Procedural infrastructure developed for the Program should allow for the continuation of this expanded private care option beyond the time limitation defined in the legislation if need persists and required funding becomes available.
6. Veterans who qualify for the Program should be provided as early in the care process as possible with information about the private care option. Such information should include estimated wait-list time and estimated costs in comparison to receiving care within VHA, to allow for an informed decision. (BoR 14)

VIOLENCE AND ABUSE

Family Violence

ACP supports the AMA's national campaign against family violence. ACP encourages individual internists to take as many of the following steps as possible to reduce for their patients the prevalence and recurrence of--as well as pain and suffering caused by--family violence; become aware and knowledgeable about the diagnosis and treatment of family violence; become familiar with applicable abuse reporting laws and other legal requirements as well as appropriate procedures for dealing with

and referring suspected cases of abuse; work independently or with local medical societies or other community groups to participate in violence-prevention activities and/or develop resources--such as battered women shelters--in one's community; and encourage and participate in research on family violence. (HoD 92; reaffirmed BoR 04; reaffirmed BoR 16)

Inner-City Health Care

Violence

ACP reaffirms its call for legislative and regulatory measures to reduce injuries and violence related to handguns and other firearms, including support for appropriate regulation of the purchase of legal firearms including universal background checks and waiting periods. The College acknowledges that any such restrictions must be consistent with the Supreme Court ruling establishing an individual right to firearms ownership. The College supports enactment of a ban on the sale, and manufacture for civilian use of all semiautomatic firearms that have specified military style features and are capable of rapid fire. The College encourages its members and other physicians to educate themselves about the clinical signs of domestic and other forms of violence and to educate their patients about the dangers of possessing firearms and about reducing the risk for injury. Coordinated, community-wide efforts on violence prevention should involve hospital emergency departments, local law enforcement agencies, schools, and individual physicians. (Inner-City Health Care, ACP 96; reaffirmed BoR 13)

WAR

Preparation for Chemical and Biological Terrorism

The American College of Physicians (ACP) promotes education of physicians in preparation and clinical care of the effects of biological and chemical weapons.

The ACP, in conjunction with other national and international professional organizations, supports the development of a public health structure to deal with such a disaster. (BoR 98, reaffirmed BoR 13)

Funding

1. Funding to combat a biological or chemical attack should not come at the expense of other essential medical research programs, but should be viewed as part of our defense efforts. (BoR 01, reaffirmed BoR 13)

Public Health Infrastructure

1. Congress should appropriate the necessary funding to support a grant program to local public health departments and hospitals to develop appropriate crisis management structures and plans for dealing with a biological or chemical attack.
2. The Department of Health and Human Services, Centers for Disease Control and Prevention, Office (Department) of Homeland Security, and the Federal Emergency Management Agency should work with representatives of public health departments, hospitals, and physicians to develop model crisis management structures and plans for dealing with biological and chemical attack.
3. Sufficient funding should be available to ensure that every community has the surge capacity to handle a sharp increase in patients, with decontamination units and necessary medical supplies readily available to treat patients from a mass casualty event.
4. Funding should be provided to hospitals and public health departments to conduct drills on responding to a mass casualty event caused by intentional release of chemical or biological

agents.

5. Adequate resources should be provided to departments of public health for staff training, recruitment, and retention; technology improvements; and enhanced communications with local physicians, hospitals, and other health professionals. (BoR 01, reaffirmed BoR 13)

Physician and Hospital Training

1. Congress should provide the necessary funding to support a program of grants to national and local medical societies, hospitals, medical schools, and teaching hospitals for the education and training of individual physicians and hospital communities about the threat of a biological or chemical attack.
2. Congress should provide necessary funding for public health laboratories to enhance training, equipment, and personnel to facilitate identification of a biological or chemical attack as quickly as possible. (BoR 01, reaffirmed BoR 13)

Food and Water Supply

1. Congress should provide increased federal funding to ensure a sufficient supply of food safety inspectors.
2. Overall authority for food safety should be granted to a single federal agency.
3. Congress should provide adequate levels of funding for the federal food and water safety program to include enhanced surveillance systems, better prevention programs, faster outbreak response, enhanced education, and better coordinated and focused research and risk assessment activities. (BoR 01, reaffirmed BoR 13)

Vaccines and Antibiotics

1. Congress should appropriate the funding necessary to ensure that adequate supplies of vaccines and antibiotics are available throughout the country in the event of a biological or chemical attack.
2. If there are shortages of necessary drugs and it becomes necessary in order to protect the general welfare of the public, ACP supports invoking a federal law allowing generic drugmakers to bypass a drug manufacturer's patent to produce a drug for the government.
3. ACP believes that physicians should not prescribe drugs, including antibiotics, without medical indication. Physicians should contribute to the responsible stewardship of health care resources and their recommendations to patients must be based on medical merit. The federal government should increase its activities to educate the public about the dangers of indiscriminate dissemination of antibiotics to people who are not infected and the enhanced antibiotic drug resistance and damaging health consequences that could result from overuse of antibiotics. (BoR 01, reaffirmed BoR 13)

Funding for the Centers for Disease Control and Prevention (CDC)

1. Congress should provide sufficient funding to enhance the CDC's laboratories, equipment, lines of communication, and the training of epidemiological personnel to be able to detect and respond to an attack in a timely and efficient manner.
2. Congress should also provide adequate levels of funding to improve surveillance and security of the CDC's laboratories, offices, and communications to protect them against an attack. (BoR 01,

reaffirmed BoR 13)

Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction

ACP supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction. The College urged that this policy be widely disseminated, including dissemination through the World Health Organization and other forums. (ACP AMA Del I-96; reaffirmed BoR 06; reaffirmed BoR 17)

Resolution on the International Campaign to Ban Antipersonnel Landmines

ACP supports the international campaign to ban the manufacture, stockpiling, use, sale, transfer or export of antipersonnel mines and supports education and advocacy that heightens awareness about the devastating impact landmines have on public health, and medical and social infrastructures. (Health and Public Policy Committee, ACP 1994; reaffirmed BoR 04; reaffirmed BoR 16)

Nuclear Weapons

ACP recognizes the threat of nuclear weapons to the health of the people of the world and supports worldwide diplomatic efforts to limit, reduce and ultimately eliminate these weapons. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 16)

WOMEN

Funding for Women's Health Clinics

The American College of Physicians opposes legislative or regulatory restrictions that would deny or result in discrimination in the awarding of federal grant funds and/or Medicaid funding to women's health clinics that are qualified under existing federal law for the provision of evidence-based services including, but not limited to, provision of contraception, preventive health screenings, sexually transmitted infection testing and treatment, vaccines, counseling, rehabilitation, and referrals. (ECBoR 17)

Principles on Women's Health

ACP endorses the joint principles on women's health issues developed by ACP, ACOG, AAP, and AAFP as follows:

1. Ensure women unencumbered access to affordable, evidence-based health care throughout their lifespan
2. Oppose political interference in the patient-provider relationship
3. Protect and retain current benefits and coverage for women, including preventive care and banning gender rating
4. Protect Medicaid coverage and financing, ensuring consistent treatment of qualified providers. (ECBoR 17)

Women's Health Care

Recommendation 1: Women's health care transcends reproductive care and should address the broad spectrum of health concerns of adult women through their life cycle. Delivering primary care to women is one of the core competencies of internal medicine. Internists should minimize the fragmentation of women's health care and maximize the opportunities for comprehensive primary and preventive care at each clinical encounter.

Recommendation 2: Documented gaps in the education and training of internists in aspects of women's health care should be corrected. Curricular improvements should lead to stronger skills in ambulatory

gynecology; residency tracks and fellowships should include additional expertise in the range of women's health issues. Practicing internists should use continuing medical education to sharpen and deepen the knowledge and skills they need to provide comprehensive care to their female patients.

Recommendation 3: All physicians delivering primary care to women should be competent to diagnose and manage the most common conditions in women presenting in the ambulatory setting. Anything less is antithetical to the concept of primary care. The abilities of all physicians delivering primary care to women should be judged on this basis. (Ad Hoc Committee on Women's Health, ACP 1996; reaffirmed as amended BoR 06; reaffirmed BoR 17)

i NCQA Patient Centered Medical Home (PCMH) Standards and Guidelines

ii GAO. Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer.

<http://www.gao.gov/assets/660/655442.pdf>

iii GAO. Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare

Millions. <http://democrats.energycommerce.house.gov/sites/default/files/documents/GAO-Medicare-Advanced-Imaging-Self-Referrals-2012-9-28.pdf>

iv Mitchell J. Urologists' Use of Intensity-Modulated Radiation Therapy for Prostate Cancer

N Engl J Med 2013; 369:1629-1637 October 24, 2013 DOI: 10.1056/NEJMsa120114.

<http://www.nejm.org/doi/full/10.1056/NEJMsa1201141>

v Lungren M. Amrhein T et al. Physician Self-Referral: Frequency of Negative Findings at MR Imaging of the Knee as a Marker of Appropriate Utilization Radiology, 2013, Vol.269: 810-815, 10.1148/radiol.13130281.

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vi Marketing, Imaging Wars. Media Health Leaders, June 11, 2009.

http://www.healthleadersmedia.com/content/234366/topic/WS_HLM2_MAG/Marketing-Imaging-Wars.html

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viii Time Magazine, The Hospital Wars. <http://kansasheart.com/2006/12/the-hospital-wars/> Accessed 29 of September 2014 at <http://kansasheart.com/2006/12/the-hospital-wars/>

ix American College of Physicians. How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently? Philadelphia: American College of Physicians; 2011: Policy Paper.

x American College of Physicians. Controlling Health Care Costs While Promoting The Best Possible Health Outcomes. Philadelphia: American College of Physicians; 2009.

xi Hood, V. Letter to Joint Select Committee on Deficit Reduction. American College of Physicians. September 12, 2011.