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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Policy statements published in the Policy Compendium are those policy statements of a national scope adopted by the ACP Board of Regents. All ACP policy statements shall be subject to federal, state or local statutes current or future. ACP shall not be responsible in case of any conflict. 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committee will make recommendations to reinstate or remove the policy due to lack of relevance or because it has been superseded by more recent policy.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)

Mandatory Testing for All Physicians

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

ALLIED HEALTH PROFESSIONS

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 definedthrough 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 to avoid any appearance of equivalency of training/certification with physicians.

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, reaffirmed with edits BoR 22)

Pharmacist Scope of Practice

Position 1: ACP supports physician-led physician-pharmacist collaborative practice agreements that reflect ACP's principles supporting dynamic clinical care teams and ensure that team members act in the patient's best interests. Potential benefits of collaborative practice agreements include improved treatment and management of chronic diseases such as diabetes and medication adherence.

a. Collaborative practice agreements should clearly assign responsibilities to clinical pharmacists for specific dimensions of care commensurate with their training and skills to most effectively serve the needs of the patient.

b. Expanded roles for pharmacists should be based on what is in the patient's best interest and not solely on cost savings.

c. The responsible physician and pharmacist should be compensated for their time spent on collaborative services.

d. Only the physician shall and must diagnose the patient's condition prior to any referral.

Position 2: ACP opposes independent pharmacist prescriptive privileges and initiation of drug therapy outside of a collective practice agreement, physician standing order or supervision, or similar arrangement.

Position 3: ACP supports the use of state-licensed pharmacists as sources of immunization information, hosts of immunization sites, and immunizers for adult patients, as appropriate and allowed by state law proving they coordinate, communicate, and collaborate with the patient's primary care team to ensure patient safety and continuity of care. Pharmacists that deliver immunization services must:

a. Meet training and safety requirements.

b. Provide the appropriate immunization paperwork or other documentation to the patient.

c. Refer the patient to their primary care team for any necessary counseling and follow-up care, particularly for patients with complex chronic care management needs.

d. Have a structured referral system to primary care settings and encourage patients they immunize to establish a longitudinal relationship with a primary care team if the patient does not have such an existing relationship.

e. Record immunization administration data within the patient's medical record (if available) and promptly report to the state's immunization information system or other designated CDC system.

During emergency mass vaccination efforts, such as a global pandemic where a national public health emergency has been declared, the federal government may temporarily circumvent state scope of practice laws to allow state-licensed pharmacists and state or board of pharmacy-authorized pharmacy interns under their supervision, to administer vaccinations providing they follow the recommendations stated above, are appropriately trained, and follow safety protocols. It is crucial that pharmacists and primary care teams cooperate and collaborate to educate patients about vaccines, address vaccine hesitancy, ensure patients do not forego medically necessary care, and

ensure vaccines are distributed equitably, especially to communities of color and medically underserved areas.

Position 4: 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, revised BoR 20)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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 characteristics of personal identity including but not limited to gender, gender identity, race, religion, nationality 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, gender identity, race, religion, nationality or sexual orientation. (HoD 90; reaffirmed BoR 04; revised BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)
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; reaffirmed BoR 19)

3. ACP opposes the compression of codes for cognitive services. (HoD 89; reaffirmed BoR 04; reaffirmed BoR 19)

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 that 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 HIPAA Security standards, 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; revised BoR 19)

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; reaffirmed BoR 19)

Electronic Prescribing of Controlled Substances

Where the practice is, in fact, less burdensome for both patients and clinicians, ACP supports the use of electronic prescribing for controlled substances. ACP strongly recommends that a backup system, such as paper or telephone, should be established in order to accommodate for systems going down or other technological barriers. (PFS Proposed Rule Comments 9/21)

Downcoding

ACP continues to assign high priority to monitoring downcoding and documentation problems and continue working with the Centers for Medicare and Medicaid Services, Congress, Medicare Payment Advisory Commission (MedPAC) 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; revised BoR 19)

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; reaffirmed BoR 19)

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 09, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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 may 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, reaffirmed with edits BoR 22)

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 maintaining an adequately funded, independent entity to sponsor and/or produce trusted research on the comparative effectiveness of healthcare services, a role that is currently filled by the Patient-Centered Outcomes Research Institute (PCORI).

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 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 patients and families, payers, scientists, clinicians and clinical care team members, and industry representatives that represent a diversity of gender and racial and ethnic backgrounds, at all levels of the evidence development process.

- include and maintain 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 comparative effectiveness entity systematically develop both comparative clinical and cost-effectiveness evidence for competing clinical management strategies.

Position 6: The College recommends that the comparative effectiveness entity be governed by a panel or panels of stakeholders and scientific and methodological experts, including those specifically in the area of cost-effectiveness analyses. The governance of this entity should be widely representative a diversity of gender and racial and ethnic backgrounds and be charged with:

- Maintaining and regularly updating procedures to ensure that the entity produces high quality cost-effectiveness information.

- Regularly reconciling apparently disparate estimates of cost effectiveness regarding specific clinical management comparisons.

- Maintaining model procedures for use by stakeholders who plan to consider 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 and maintaining 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 clinicians and clinical care teams be fully informed about both comparative clinical and cost-effectiveness information so that this information can be employed as factors to be explicitly considered in their evaluation of a clinical intervention. Patients and families also should be fully informed and empowered, in partnership with their clinical care team, to utilize comparative clinical and cost-effectiveness information in decision-making regarding their course of care.

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; reaffirmed BoR 19; revised BoR 20)

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. Health care payers, physicians and other health professionals, and patients should consider both comparative clinical and cost-effectiveness information in evaluating a clinical intervention.
5. 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, reaffirmed BoR 22)

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. *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.

V. *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.

VI. *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.

VII. *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.

VIII. *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.

IX. *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.

X. *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; revised BoR 19)

COST CONTROL

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. Additional research is necessary to examine the impact of CON programs on costs and competition, particularly in markets with high rates of consolidation. (BoR 09, revised BoR 22)

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, reaffirmed BoR 22)

Controlling Health Care Costs: Enhance and Coordinate Technology Assessments

1. A coordinated, independent, and evidence-based assessment process should be created that incorporates comparative effectiveness research 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, revised BoR 22)

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. 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.
2. Physicians and multidisciplinary teams should be paid for care management and care coordination services provided on a fee for-service basis.
3. 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, revised BoR 22)

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. Policies should promote community planning that supports walking, bicycling, and other physical activities for healthy lifestyles as well as access to and availability high-quality nutritious foods.
4. 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, revised BoR 22)

Controlling Health Care Costs: Options for Controlling Administrative Costs

1. Health insurance forms should be uniform across insurers, (e.g., a single durable medical equipment approval form, a single referral form).
2. 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. (BoR 09, revised BoR 22)

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. The federal government should have a significant role in funding, implementing, and maintaining this comparative effectiveness entity.
3. 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.
4. Health care payers, physicians and other health professionals, and patients should consider both comparative clinical and cost-effectiveness information in evaluating a clinical intervention.
5. 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, revised BoR 22)

Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care – Universal Coverage Reducing Excessive Pricing and Improving Efficiency

9. The American College of Physicians supports efforts to reduce excessive list prices for goods and services, reduce price variation not associated with differences in the cost of providing services, reduce administrative costs at the system level and at the point of care, and improve the efficiency of the health care system.

Overtreatment, Low-Value Care, and Preventable Diseases

10. The American College of Physicians supports greater efforts to reduce low-value care and reduce

costs associated with preventable disease.

Global Budgets and All-Payer Rate Setting

11. The American College of Physicians supports greater adoption of innovative all-payer models, a global budgeting model, or health care growth benchmarks, informed by the experiences of states that have implemented such approaches.
12. The American College of Physicians recommends ongoing study of implemented health system budget reforms that measure the potential effects of the policy changes and identify and mitigate unintended consequences.

Reference Pricing

13. The American College of Physicians supports the adoption of well-designed reference pricing programs for certain elective health care goods and services based on timely, accurate, and accessible local market pricing data supported by all-payer claims databases (APCDs).
14. The American College of Physicians supports the rational stewardship of health care resources through the incorporation of cost-effectiveness analyses (CEAs) into coverage or pricing determinations made by public and private purchasers, as well as the incorporation of value statements into clinical guidelines.

COVID-19

Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care

Due to the recent COVID-19 surge and the availability of safe and effective vaccines, our health care organizations and societies advocate that all health care and long-term care employers require their workers to receive the COVID-19 vaccine. This is the logical fulfillment of the ethical commitment of all health care workers to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being. Because of highly contagious variants, including the Delta variant, and significant numbers of unvaccinated people, COVID-19 cases, hospitalizations and deaths are once again rising throughout the United States.1 Vaccination is the primary way to put the pandemic behind us and avoid the return of stringent public health measures. Unfortunately, many health care and long-term care personnel remain unvaccinated. As we move towards full FDA approval of the currently available vaccines, all health care workers should get vaccinated for their own health, and to protect their colleagues, families, residents of long-term care facilities and patients. This is especially necessary to protect those who are vulnerable, including unvaccinated children and the immunocompromised. Indeed, this is why many health care and longterm care organizations already require vaccinations for influenza, hepatitis B, and pertussis. We call for all health care and long-term care employers to require their employees to be vaccinated against COVID-19. We stand with the growing number of experts and institutions that support the requirement for universal vaccination of health workers.2,3 While we recognize some workers cannot be vaccinated because of identified medical reasons and should be exempted from a mandate, they constitute a small minority of all workers. Employers should consider any applicable state laws on a case-by-case basis. Existing COVID-19 vaccine mandates have proven effective.4,5 Simultaneously, we recognize the historical mistrust of health care institutions, including among many in our own health care workforce. We must continue to address workers' concerns, engage with marginalized populations, and work with trusted messengers to improve vaccine acceptance. As the health care community leads the way in requiring vaccines for our employees,

we hope all other employers across the country will follow our lead and implement effective policies to encourage vaccination. The health and safety of U.S. workers, families, communities, and the nation depends on it. (ECBOR 7/24/2021)

Statement on Global COVID-19 Vaccine Distribution and Allocation: On Being Ethical and Practical

Physicians, as members of a professional community, have individual and collective obligations to advocate for the health and well-being of patients and communities. The ACP Ethics Manual states, "Physicians have an important role to play in promoting health and human rights and addressing social inequities" (1); this applies locally and globally (2). Recognizing the ethical responsibility to assist others in minimizing mortality and morbidity from COVID-19, the American College of Physicians supports immediate ramping up of supply for distribution of COVID-19 vaccines equitably among and within countries in need. This is an ethical imperative, but also aligns with self-interest, as the practical reality is the pandemic will not abate while regions of the world have unchecked viral spread.

Ethical and equitable allocation of vaccine has presented challenges in the US; the rest of the world faces this, too. More than 85% of the world's population lives in low- and middle-income countries, with additional challenges of access to COVID-19 vaccines. At present, for example, the pandemic is severely affecting Brazil and India, where only nine percent and three percent of the populations, respectively, are fully vaccinated (3). The COVID-19 Vaccines Global Access initiative, or COVAX, aims to support procurement and delivery for 2 billion vaccine doses by the end of 2021. The scale and scope of COVAX is unprecedented. However, even with this effort, estimates suggest that it will take years to ensure entire communities are protected against COVID-19 (4)-- a pace that does not meet urgent and ongoing need.

A coordinated global response is required. Otherwise, a continuous cycle of transmission, mutation, and variant strains will continue to threaten health and well-being and vaccine effectiveness. The US experience with the President's Emergency Plan for AIDS Relief (PEPFAR) during the HIV/AIDS epidemic provided practical global solutions that enabled access to lifesaving medical technologies. PEPFAR demonstrates how even one country's leadership, motivated by a sense of ethical responsibility, can make possible the rapid delivery of existing high tech medical solutions, including prevention strategies and treatments, in resource-limited settings (5).

The most urgent need is for rapid scale up of efficient, safe, and effective vaccines, and quality-assured production of approved COVID-19 vaccines. Vaccine manufacturing is a complex process, more complex than small molecule medications, and rapid scale up will require cooperation among national regulatory authorities and vaccine manufacturers globally. In addition, some settings lack the cold chain infrastructure necessary for distributing particular vaccines, limiting their reach. As a result, support for infrastructure development is needed.

There is an ethical obligation to support distribution of vaccines to countries most in need. Some countries have good vaccine supply and good control of the pandemic; some, poor vaccine supply but good control of the pandemic (or they have not been greatly affected); and others have poor vaccine supply and are in the grips of the pandemic with high rates of death and severe illness. It is the third group for which the need is greatest and where our immediate attention and action should be focused.

Ongoing vaccine innovation and pipelines may also be needed for different modes of vaccine administration and techniques of development and manufacture; in response to emerging virus variants;

and with attention to legal and other concerns. Single dose vaccines that are easier to transport and store (ideally without refrigeration) can assist rapid global deployment. People in low- and middle-income countries should have access to high quality, effective vaccines appropriate to their circumstances. Global coordination will require ongoing surveillance of vaccine effectiveness and adverse events to inform future vaccine innovation. Effective strategies are also needed to manage liability and chain of custody concerns to enable countries with vaccine stockpiles to share them with other countries in greater need (prioritized by their rates of COVID-19 deaths and severe illness). Pricing varies among vaccines (6) creating challenges for access and the sustainable financing of initiatives like COVAX that serve a critical role in purchasing vaccines and promoting access for all.

Within countries, ACP supports vaccine distribution plans that are based on medical criteria (i.e., risk of morbidity/mortality and risk of COVID-19 transmission)(7). Plans should be developed through transparent and inclusive processes, consistently applied, and include accountability mechanisms to ensure they are followed. Prioritizing preventive services differs from prioritizing treatments, as ACP noted for vaccine distribution policy for the US. In allocating treatment resources, ACP has said maximizing benefit means prioritizing those most likely to survive. But in allocating preventive services such as vaccines, maximizing benefit means prioritizing those most likely to become severely sick or die (7). Based in principles of nonmaleficence, beneficence, and justice, vaccine allocation should:
1) First, maximize benefit to individuals: save the most lives, care for those most in need and then,
2) maximize benefit to public health: prevent infection and transmission to others.

To promote equity, special efforts may be necessary to deliver vaccines to marginalized and underserved populations (recognizing that how these populations are defined is local context-specific). Discrimination against classes or categories of patients is unethical (1) and measures must be taken to prevent it. Also, reflecting physicians' duties to care for all patients without discrimination, ACP cautions against approaches that systematically disadvantage certain groups of patients, including the "life years" approach, which is biased against older individuals or those living with disabilities, or approaches based on perceived social worth or economic value. The goal should be to maximize lives saved, using a science-based data-driven approach.

In some communities globally, promoting equity may require proactively addressing historical distrust of medicine in general or vaccines in particular and the promotion of informed patient decision-making. Physicians can assist, consistent with their obligation to promote timely and accurate information about health (1), including vaccination.

ACP believes it is critical that the global distribution of COVID-19 vaccines be coordinated in order to rapidly expand vaccine production, to ensure vaccine distribution to countries most in need, and to promote accessibility and affordability. Global distribution of COVID-19 vaccine has been characterized by rapidly changing circumstance and the potential for conflicting values or worldviews. The commitment of the medical profession to the health, wellbeing and equal worth of all individuals, however, is timeless. Distribution of COVID-19 vaccines and other assistance must be immediate and should align with this commitment. (ECBOR 6/8/2021)

Policy Statement on the Provision, Distribution, and Payment of COVID-19 Vaccines

1. Policy Statement on the Ethical Allocation of Vaccines During Pandemics including COVID-19. ACP supports utilizing all appropriately trained, state-licensed clinicians to administer COVID-19 vaccines. Physicians may play a role in advising and counseling patients on COVID-19 vaccines, addressing concerns and vaccine hesitancy, and providing post-vaccine counseling. Vaccines should be used in accordance with the scientific recommendations of the Advisory Committee on Immunization Practices (ACIP) informed by ethical considerations as outlined in ACP's

2. ACP recommends that the Centers for Disease Control and Prevention (CDC), Food and Drug Administration, vaccine manufacturers, state and local health departments, and other stakeholders widely distribute to vaccinators all vaccine-related educational and outreach materials, quality protocols, storage and handing information, documentation, and other requirements specific to COVID-19 vaccines authorized under an Emergency Use Authorization. Vaccinators should be informed of any potential adverse events or contraindications and provided tools to educate and provide outreach to patients about the vaccine in a linguistically and culturally appropriate manner. ACP supports a national campaign to communicate to the public why it is necessary to get vaccinated, where the vaccine can be obtained, and other information.

3. ACP recommends that all vaccinators, including pharmacists, nurses, and health care professionals working in retail health clinics, coordinate, communicate, and collaborate with the patient's primary care team to ensure patient safety and continuity of care. Specifically: a. Vaccinators should provide the appropriate immunization paperwork or other documentation to the patient.

    a. Vaccinators should refer the patient to their primary care team for any necessary counseling and follow-up care, particularly for patients with complex chronic care management needs.

    b. Vaccinators should have a structured referral system to primary care settings and encourage patients they vaccinate to establish a longitudinal relationship with a primary care team if the patient does not have such an existing relationship.

4. ACP recommends that vaccinators record the vaccine administration data within the patient's medical record and promptly report to the state's immunization information system (IIS) or other designated CDC system. Ideally, health IT systems would automate vaccination data sharing with minimal additional effort required, including reporting to state IISs and notifying the patient's primary care team of their vaccination status and other relevant information. Adverse events should be reported to the Vaccine Adverse Event Reporting System. ACP supports funding for a coordinated effort to improve electronic exchange of public health data focused on agreed upon standards that are implemented consistently across vendors and states as well as technical assistance and other resources to states to support IISs and other public health registries.

5. ACP recommends that insurers be required to provide adequate reimbursement for all vaccines, including COVID-19 vaccines, administered according to ACIP scientific guidelines. Private and public payers should inform care teams of all billing, coding, and other information necessary to obtain prompt reimbursement for administering the vaccine and providing related counseling and follow-up care to patients. ACP supports requirements that COVID-19 vaccine be provided at no cost to all patients, regardless of coverage status. ACP supports sufficient funding for the Section 317 Immunization Program; the COVID-19 Claims Reimbursement to Health Care Providers and Facilities

for Testing, Treatment and Vaccine Administration for the Uninsured program; and others that support vaccinations for uninsured adults. (ECBOR 21)

ACP Policy Statement on Wearing Masks in Community Settings

1. The American College of Physicians supports the wearing of surgical or cloth masks by the public in community settings, and believes that federal, state, and local authorities may appropriately require it as a component of a comprehensive public health strategy to prevent and contain the spread of COVID-19 until sufficient population immunity is achieved through vaccination. The strategy should also incorporate physical distancing, education about appropriate mask use (e.g., types of face coverings, application, safe use, and disposal), promotion of preventive hygiene protocols, and widespread diagnostic testing and contact tracing (1, 2). The strategy should take into account local demographics (e.g., high risk populations), epidemiologic data (e.g., reproduction rate, daily case counts, hospitalizations, and deaths), and exposure context (e.g., number of people, indoor vs outdoors, ventilation, etc.). (Modification to Policy Statement as approved by the ECBoR 20).
2. The American College of Physicians supports requiring masks to be worn in interstate public transportation and in facilities run by the federal government as part of a comprehensive prevention strategy.
3. The American College of Physicians supports asking the Occupational Health and Safety Administration to consider requiring that masks be worn in workplaces at high risk of virus transmission and in places where essential services are provided.
4. The American College of Physicians supports creating new federal grants to incentivize states to promptly implement mask requirements as recommended by public health authorities within an appropriate grace period.
5. The American College of Physicians supports an evaluation of conditioning federal grants and assistance to private businesses and organizations related to addressing the COVID-19 pandemic on implementation of a mask requirement for employees and customers.
6. The American College of Physicians urges employers to implement mask requirements within their worksites, as part of a comprehensive prevention strategy, to protect their workers and their customers.
7. The American College of Physicians supports a public education campaign, modeled on programs to discourage smoking and encourage wearing of seat belts, to encourage individuals to wear masks as part of a comprehensive prevention strategy against respiratory virus public health threats.
8. The American College of Physicians supports a public education campaign to educate the general public about appropriate mask use and handling as part of a comprehensive prevention strategy against respiratory virus public health threats.
9. The American College of Physicians urges governors to require the wearing of masks in public facilities run by their respective states, in manufacturing and retail establishments, in schools, in public transportation, and in other workplaces and facilities as part of a comprehensive prevention strategy.
10. The American College of Physicians urges local and state governments to adequately and appropriately enforce mask requirements. Any incentives or penalties should be carefully weighed to ensure against potential negative impact on access and other measures of health equity. Officials should avoid issuing punitive fines and tickets at the individual level for noncompliance.
11. The American College of Physicians supports efforts by federal, state, and local governments to subsidize or directly provide face masks to the public. (ECBOR 1/11/2021)

Policy Statement on the Ethical Allocation of Vaccines During Pandemics Including COVID-19

- ACP supports the conclusions of the National Academies of Sciences, Engineering and Medicine (NASEM) report, Framework for Equitable Allocation of COVID-19 Vaccine (NASEM, October 2020) proposing phased allocation of vaccines, including high-risk health care workers and populations most at risk for death or severe illness in Phase 1. Note: phasing here includes NASEM recommendations and ACP modifications
    - Phase 1a
        - High-risk health care workers in direct patient care, including trainees and workers in nursing homes, home health care and health care facility services
        - First responders
    - Phase1b
        - Persons (all ages) with 2 or more underlying health conditions (as listed by CDC) putting them at significantly higher risk of severe illness or death from COVID-19
        - Older adults and individuals with disabilities of all ages living in congregate settings such as skilled nursing and long-term care facilities, prisons and group homes, and in multigenerational households
        - If availability of vaccine allows for it, individuals age 65 and older not already included
    - Phase 2
        - K-12 teachers and school staff; child care workers
        - Other critical workers in high-risk settings such as public transit and food supply
        - Persons (all ages) with 1 underlying health condition (as listed by CDC) putting them at moderately higher risk
        - Persons and staff in homeless shelters, group homes, prisons, jails and detention centers not included in Phase 1
        - All individuals age 65 and older not in Phase 1
        - If availability of vaccine allows for it, family caregivers of those age 65 and older
    - Phase 3
        - Young adults
        - Children
        - Critical workers at increased risk of exposure not included in Phases 1 and 2
    - Phase 4
        - All other individuals living in the US Equity is a crosscutting consideration
- ACP recommends that the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) adopt the phased allocation of vaccines proposed in the NASEM report with ACP modifications.
- Strategies to reduce transmission—maintaining physical distance, appropriate mask use, self-isolation, quarantine, frequent hand hygiene with soap and water or alcohol-based hand rub, covering cough and sneezes using a bent elbow or paper tissue, refraining from touching the face, and frequent disinfection of frequently touched surfaces—will remain necessary until effective vaccines have been widely administered.

  An explicit framework for the ethical allocation of vaccines during COVID-19 is necessary, especially since initial vaccines supplies will be limited and may have varying levels of effectiveness in different populations. ACP agrees with the NASEM report conclusions (1), which should be implemented in the phases as specified with ACP modifications. ACP differs on some of the report's

assumptions and rationale, however: we broaden and deepen the set of ethical principles and offer additional points on those issues. The application of the framework's principles—but not the principles themselves-- may change as more scientific evidence becomes available. Also, as ACIP identifies, implementation of a vaccine strategy should be "as simple as possible," maximize efficiency while "minimizing the need to apply overly burdensome or restrictive screening policies for eligibility" and be flexible "yet specific enough to provide guidance to health care clinicians and facilities, states, and localities as they develop implementation plans" (2). Being flexible requires an allocation scheme that can adapt as the relevant evidence base evolves over time, as pandemic circumstances change at the local, state and national level, and as vaccines are developed that differ, for example, in effectiveness, storage requirements, and administrative and logistical requirements. ACP believes the NASEM phased approach meets these criteria and that an allocation plan based on risk appropriately addresses the likelihood of limited initial vaccine supplies.

- 1. ACP supports the NASEM's conclusions regarding a phased approach to vaccine allocation (language in quotes is from the NASEM report):
    - Phase 1a (approximately 5 percent of U.S. population)
        - Includes high-risk health workers who are involved in direct patient care, including those providing care in nursing homes and through home health care, as well as those in health care facility services, including transportation and environmental services. First responders are also included." 3
            - ACP agrees. NASEM clarifies in the report's rationale that this includes workers who provide "other health care facility services and who risk exposure to bodily fluids or aerosols." ACP says high-risk health workers, including medical students, residents and other trainees, are those who are at higher risk of COVID-19 infection and transmission based on the current evidence, taking into account local circumstances such as mitigitation strategies in place, work setting (e.g., availability of telehealth), and the current status of the pandemic. Also, this assists physicians and other clinicians to fulfill their duty to limit risk to patients by taking appropriate precautions including immunization (3). Having high-risk health workers "go first" might also help build trust in the health care system and reduce vaccine hesitancy among members of the public.
    - Phase 1b (approximately 10 percent of U.S. population)
        - Includes people of all ages with two or more comorbid or underlying health conditions that put them at significant risk of severe illness or death from COVID-19, defined as having two or more of the conditions listed by CDC as being associated with increased risk of severe COVID-19. Phase 1b also includes all older adults living in congregate settings, including nursing homes, long-term care facilities, prisons and group homes, and multi-generational households."
            - ACP agrees. The CDC's lists (https://www.cdc.gov/coronavirus/2019-ncov/need-extraprecautions/people-with-medical-conditions.html) of 1) conditions that put individuals at increased risk of severe COVID-19 (such as cancer, chronic kidney disease, COPD, certain heart conditions, immunocompromised states, obesity, pregnancy, sickle cell disease, type 2 diabetes mellitus and smoking) and 2) conditions that might put individuals

at increased risk, are evidence-based and updated regularly (4). ACIP includes in its thoughts on initial potential groups for Phase 1b an additional 100 million adults with one or more high-risk medical conditions and all adults age 65 and older. This, however, would bring the total for Phase 1 to 200 million people (2), which does not meet the goal of accomplishing prioritization. The NASEM phasing recommendations do meet that goal and recognize there will be overlap among populations. ACP would also include individuals with disabilities of all ages in congregate settings in Phase 1b . If availability of vaccine allows for it, ACP would include all individuals age 65 and older in Phase 1b.

- "Phase 2 (approximately 30–35 percent of U.S. population)
  - Phase 2 includes K–12 teachers, school staff, and child care workers, a group that includes administrators, environmental services staff, maintenance workers, and school bus drivers. Also included in Phase 2 are critical workers in high-risk settings who cannot avoid a high risk of exposure to COVID-19, such as workers in the food supply system and public transit. In addition, Phase 2 covers people of all ages with comorbid and underlying conditions that put them at moderately higher risk, defined as having one of the conditions listed by CDC as being associated with increased risk of severe COVID-19. This phase also includes people in homeless 4 shelters or group homes for individuals with physical or mental disabilities and all other individuals and staff in prisons, jails, detention centers, and similar facilities who were not included in Phase 1. All older adults not included in Phase 1 are included in this phase."
    - ACP agrees (although if availability of vaccine allows for it, ACP would include all individuals age 65 and older in Phase 1b). If possible, Phase 2 should also include family caregivers of those age 65 and older.
- "Phase 3 (approximately 40–45 percent of U.S. population)
  - Includes all children and young adults in the United States 30 years of age or younger. However, children are not currently included in any major vaccine trials for COVID-19 and would need to be included in these trials before mass vaccination of children could take place. Phase 3 also includes workers in industries and occupations important to the function of society and at increased risk of exposure who are not covered in Phases 1 and 2."
    - ACP agrees. Trials have now begun with children. ACP supports the need to include children and, also, pregnant women, in vaccine trials.
- "Phase 4
  - Includes all other people living in the United States. The United States should ensure that all U.S.-based individuals who did not have access to the vaccine in previous phases (and for whom the vaccine is not medically contraindicated) have access to the vaccine."
    - ACP agrees.
  - "The framework includes four allocation phases of COVID-19 vaccine to the public, outlined above. Detailed discussions of each population group included in the phases, and the rationale behind their inclusion, can be found in Chapter 3 of the full report. The population groups included in each allocation phase overlap to a certain extent, and there are individuals who will fit into multiple categorizations.

Given the current state of the pandemic, the early phases of the committee's proposed framework emphasize prevention of severe illness and death and maintainence [sic] of essential health and emergency services to support this goal, with a shift toward reducing transmission in later phases. Within each phase, all groups have equal priority."

- ACP agrees.

- 2. "Equity is a crosscutting consideration: In each population group, vaccine access should be prioritized for geographic areas identified through CDC's Social Vulnerability Index or another more specific index."
    - ACP agrees although admittedly, this is complex. The recommended phased roll out appropriately addresses the critical crosscutting consideration of equity. NASEM further clarifies that, "The committee does not propose an approach in which, within each phase, all 5 vaccine is first given to people in high-SVI areas. Rather the committee proposes that state, tribal, local, and territorial (STLT) authorities ensure that special efforts are made to deliver vaccine to residents of high-vulnerability areas (defined as 25 percent highest in the state)." The use of the SVI or other more specific indices should direct STLT authorities to engage with the potentially hardest hit communities, some of whom may be more likely to distrust the health care system or be vaccine hesitant, in order to promote trust and vaccine confidence.
- 3. Report Framework: Maximum Benefit, Equal Concern and Mitigation of Health Inequities
    - The NASEM framework's overall goals are stated as "reducing severe morbidity and mortality and negative social impact due to the transmission of SARS-CoV-2." These goals are not in themselves controversial. How to balance ethical tensions in achieving them, however, is more complex. ACP agrees with the ethical concepts stated in the report but sees their definitions and application somewhat differently. The NASEM report seems to adopt the perspective only of public health ethics. ACP would include focus on ethical responsibilities to individual patients, given the ethical principles of nonmaleficence, beneficence, respect for autonomy, and justice, and the duties they entail for physicians and the profession. During public health emergencies, "While the physician's responsibility remains with the health and welfare of individual patients under the physician's care, the well-being of the community as a whole must also be considered at a systems level including in institutional policies and other guidelines… Along with the traditional duty to care, fairness and equality must be promoted and guide health care delivery during health system catastrophes such as pandemic coronavirus" (5).
    - In brief, looking at what the NASEM report calls foundational principles in its framework:
        - A. Maximum benefit
        - The NASEM report states this is "the obligation to protect and promote the public's health and its socioeconomic well-being in the short and long term."
            - ACP frames maximum benefit in vaccine allocation as having two prongs, based in balancing the principles of nonmaleficence, beneficence, and justice:
            - i. Maximize benefit to individuals: save the most lives, care for those most in need first
            - ii. Maximize benefit to public health: prevent infection/transmission to others while maximizing societal good

- In allocating treatment resources, ACP says maximizing benefit means prioritizing those most likely to survive (5). By contrast, in allocating preventive services, ACP says maximizing benefit means prioritizing those most likely to become severely sick or die. Moreover, receiving a vaccine benefits both the individual and the public's health. 6
    - B. Equal concern NASEM report: "The obligation to consider and treat every person as having equal dignity, worth, and value."
        - ACP agrees, based on principles of respect for autonomy, beneficence, and justice, and adds that in implementing equal concern, we must promote equity and nondiscrimination. ACP does not support proposals that discriminate against the elderly, persons with disabilities, or minorities or other groups. Allocation of vaccines must maximize saving those most likely to die without the vaccine, not the number of "lifeyears," which is inherently biased against the elderly and the disabled. The physician's duty to care for all prohibits discrimination against classes or categories of patients (3). In light of the equal concern principle, care must be taken that use of a criterion of "negative societal impact" does not invite discriminatory consideration of social worth (6), even if there is no intent to discriminate. ACP instead focuses on ethical principles and on risk of mortality/severe morbidity and risk of exposure/transmission–medical criteria (5)—and reaches similar conclusions about phasing.
        - An approach based on equal concern aligns with the crosscutting consideration of equity, but may require special outreach and engagement efforts to promote trust in the vaccine and its use among vulnerable or marginalized groups.
    - C. Mitigation of health inequities
        - NASEM says this is "The obligation to explicitly address the higher burden of COVID-19 experienced by the populations affected most heavily, given their exposure and compounding health inequities" and that mitigating health inequities is "a moral imperative of an equitable vaccine allocation framework."
        - ACP agrees, based in principles of justice and beneficence. The elderly and members of minority racial and ethnic groups are disproportionately represented among COVID-19– associated deaths according to the CDC (7) and others (2).
- 4. Fair Process and Open Communication
    - The NASEM report discusses what it calls foundational procedural principles: fairness—that decisions include input from those affected, especially, groups disproportionately impacted by the pandemic; transparency—open communication with the public about the vaccine allocation criteria and framework; and being evidence-based in light of the best available scientific data.
        - ACP agrees and adds that consistency in applying principles and accountability mechanisms (i.e., oversight and documentation that allocation programs work as intended) are also required in resource allocation frameworks (5). Open communication and community engagement about the allocation framework and process will be key. This is especially important as the scientific evidence may change over time and there may be multiple approved vaccines that differ in 7

effectiveness among population subgroups, dosing regimens, storage requirements, and in other characteristics. Humility in the face of uncertainty about vaccine effectiveness in populations, duration of protection and other issues (e.g., whether to vaccinate those previously infected with COVID-19), are also required. This framework is meant to provide fundamental ethical guidance to assist in the equitable allocation of vaccines. (ECBOR 11/23/2020)

MCAT POSITION STATEMENT

The American College of Physicians (ACP), representing 163,000 internal medicine physicians (internists), subspecialists, internal medicine trainees and fellows, and medical students, strongly encourages medical schools to engage in holistic reviews of applicants in their admissions process.

In the midst of the public health emergency due to the COVID-19 pandemic, traditional medical school application processes for pre-medical students have been disrupted. Applicants have experienced disruptions in taking the MCAT examination, whether due to personal health and safety concerns, vendor-initiated scheduling changes, or difficulties in accessing testing centers. Furthermore, applicants of color and those from lower socioeconomic groups are disproportionately impacted by factors such as venue changes to distant testing centers. The ACP is concerned that mandatory MCAT testing in the midst of the current public health emergency will increase disparities in career opportunity among people of color and those of lower socioeconomic status.

We join AAMC in emphasizing the importance of medical schools' optimization of holistic reviews of their applicants and understanding of unique challenges facing current applicants. In light of these challenges, we encourage medical schools to waive MCAT requirements for applicants seeking admission in 2021. (ECBOR 8/3/2020)

Racism and Health: A Position Statement from the American College of Physicians

1. The American College of Physicians (ACP) condemns the injustices and harm that Black and indigenous communities and other people of color experience as a result of pervasive overt and covert systemic institutional racist policies, practices, and discrimination in the United States. ACP commits to being an anti-racist organization that is committed to action and policy to confront and eliminate racism.
2. The ACP condemns and opposes racist policies and actions that perpetuate injustices and inequities in medicine and throughout all aspects of American society. Urgent actions to remedy historical institutional injustices and inequities include eliminating discrimination, bias and racism in the U.S. health care delivery system and in medical education. The ACP commits to developing new policies and expanding existing ones towards these goals.
3. The ACP reaffirms that hate crimes are a public health issue and that all persons, without regard to where they live or work; their race and ethnicity; their sex or sexual orientation; their gender or gender identity; their age; their religion, culture, and beliefs; their national origin, immigration status, and language proficiency; their health literacy level and ability to access health information; their socioeconomic status; whether they are incarcerated; and whether they have intellectual or physical disability must have equitable access to high-quality health care and must not be discriminated against based on such characteristics.

4. The ACP affirms that physical and verbal violence and discrimination, particularly on the basis of race/ethnicity and other perceived characteristics of personal identity, are social determinants of health and, thus, public health issues. Violence and discrimination exacerbate the burden of morbidity and mortality among people of color and other marginalized groups, which may contribute to the disproportionately higher mortality rates from COVID-19 among Black, indigenous, Latinx, and Asian American communities and persons.
5. The ACP affirms that discrimination, racism, and violence in the context of law enforcement and law enforcement policies and practices that target Black individuals and other persons of color harm the physical heath, mental health, and well-being of individuals and the public. Institutional and systemic law enforcement practices that enable, allow and protect racism, discrimination, and violence undermine law enforcement officers who are dedicated to equal treatment under the law, ensuring public safety, and saving lives and undermine public confidence in justice and law enforcement. While solutions to racism and discrimination in law enforcement are complex, ACP supports the following policies as a starting point:
    a. The ACP supports adoption of law enforcement practices that ensure equal treatment under the law of all persons, without regard to race and other personal characteristics, and increase transparency and accountability.
    b. The ACP calls for research on the contributors to law enforcement violence and discrimination and the impact on the health of individuals and communities, particularly for people of color.
    c. The ACP calls for research on and adoption by law enforcement policies that reinforce the importance of community engagement in managing public safety.
    d. The ACP urges research on and adoption of best practices by law enforcement agencies to promote safety and wellness at every level of the organization including support for officer wellness and safety.
    e. The ACP supports greater transparency and accountability and adoption of best practices in law enforcement including:
        i. Creation of a comprehensive national database and reporting mechanism that captures all deaths caused by law enforcement, incidents of excessive use of force, and discriminatory policing practices.
        ii. Requiring local police departments to report the above incidents to state health departments to be made publicly available in a timely manner and at a local level.
        iii. Monitoring and addressing misclassification of causes of death, the underreporting of victims of law enforcement violence, and the prevalence of serial offenders.
        iv. Making investigations, including video evidence, of misconduct and excessive use of force by law officers available to the public.
        v. Identifying and eliminating barriers that hinder the investigation and accountability of officer misconduct.
    f. The ACP believes funding should prioritize research on evidence-based best practices that reduce situations in which use of force is required and promote alternatives to use of force.
    g. ACP believes that law enforcement authorities should be incentivized and required to incorporate best practices to eliminate excessive use of force, to reevaluate use of force policies, to establish parameters around reasonable force, and to delineate

between acceptable and excessive force, with accountability and transparency to elected officials and the public.

h. The ACP supports the use of technology, such as body cameras, to assist in monitoring and enforcing use of force protocols.
i. The ACP calls for the research and implementation of effective law enforcement recruitment, training, and retention programs that encourage safer, less discriminatory, and less forceful policing practices.
j. The ACP believes that the inappropriate militarization of community law enforcement interactions with civilian populations should be eliminated.
k. The ACP urges health care institutions and professionals to review policies and relationships with law enforcement to ensure that they align with the priority of protecting patients and staff.

6. The ACP condemns violations of the fundamental constitutional and human right of persons to peaceably protest against racism and violence and calls on public authorities and law enforcement to protect this right and never subject peaceful protesters to enforcement actions that can harm their health.
7. The ACP is committed to studying, listening, and developing evidence-based solutions to racism and discrimination and acting to implement them in its engagements with its membership, its staff, other organizations, policymakers and society. Issues to be addressed by ACP in further policy development will include impact of racism on the interactions between patients and healthcare professionals, racial violence against clinicians, and impact of racism on health profession training programs. (ECBOR 6/8/2020)

ACP and AMA Joint Statement on Non-Discrimination in Health Care*: A Wake-Up Call for American Health Care: Emerging Ethical Lessons from Covid-19*

As the Covid-19 pandemic evolves it is offering some hard lessons about how American health care fails patients. The pandemic brings into focus inequities that pervade the system, in strategies intended to guide how limited resources are distributed among patients, and in its impact on communities made vulnerable by decades of neglect, disinvestment and marginalization.

The public health crisis of a pandemic challenges medicine's ethical duty to place the care of each individual patient first and foremost. The rapid spread of Covid-19 and the acute needs of patients who have become seriously ill have forced health care professionals and institutions across the country to confront the prospect of rationing and the disproportionate impact of disease across the population.

The goal of crisis standards of care plans (CSC) is to allocate resources fairly. To do so, they must rely on clinically based considerations of medical need, prognosis, and effectiveness, and on fundamental standards of equity and fairness. When CSC focus on process issues such as transparency, consistency, and accountability they can be helpful tools. But when they rely on criteria that discriminate against categories of persons, notably, elderly individuals or individuals with disabilities, CSC are not ethically defensible. The more directly they address clinical decisions such as triage, inappropriately constituting the practice of medicine, the more problematic CSC become. The pandemic has revealed a need for a much more thoughtful, ethically and medically justifiable approach to the clinical aspects of preparedness planning.

Further, significantly higher mortality rates from Covid-19 among residents of long-term care facilities and in Black, Latinx, and Native American populations vividly highlight issues of the pandemic's disproportionate impact and that we must recognize these outcomes as the product of structural barriers to appropriate health care. To be sure, in the midst of a crisis, resource allocation tools that guide decisions for individual patients cannot by themselves redress deep-rooted structural problems, especially structural and social determinants that generate longstanding health inequities. Leveling the playing field will require sustained collective efforts to change not only how society prepares for public health emergencies, but fundamentally how patient care is organized and delivered toward a system that cares for all and directly challenges the taken-for-granted inequities of our current system.

The American College of Physicians and the American Medical Association urge all physicians to heed the hard lessons of Covid-19. We cannot go back to business as usual after this pandemic passes. We must work together to build a society that supports optimal nondiscriminatory health care for all. (ECBOR 6/8/2020)

Partial Resumption of Economic, Health Care and Other Activities While Mitigating COVID-19 Risk and Expanding System Capacity: A Clinical and Public Policy Guidance from the American College of Physicians

Resuming Economic and Social activities in a State or Community: What Is Needed?

Communities Need to Have Sufficient Testing Capacity

1. ACP recommends that in the absence of currently effective vaccine or treatment options available for COVID-19, state and local authorities should prioritize a strategy of case finding, screening, and surveillance to track and reduce further spread.
2. ACP recommends that during this prioritization, special attention needs to be paid to older adults (over 60), those with underlying conditions, those in communities where health care disparities are most pronounced, and others who are at an increased risk for COVID-19.
3. ACP recommends that until an effective vaccine or a treatment is available, active monitoring and voluntary self-isolation based on best available evidence should be recommended for any patient 4 who tests positive for SARS-CoV2. For any individual who has been exposed to a patient who tested positive for SARS-CoV2, active monitoring and self-isolation should continue for at least 14 days from testing positive, based on the estimated incubation period.
4. ACP recommends that communities achieve a minimum threshold to ensure adequate diagnostic testing capabilities and strategies are in place.
5. ACP recommends that for all molecular or serological tests used for COVID-19 or SARS-CoV2, officials should publicly report performance expectations (e.g., sensitivity, specificity) and report community-level utilization and results.
6. ACP recommends the development of a national implementation strategy to ensure adequate healthcare system capacity during periods of surge and availability of personnel protective equipment for all physicians and other clinicians and health care workers.

Communities Need to Have the Capability for Effective Contact Tracing with Privacy Protections

7. ACP recommends ramping up traditional contact tracing measures and capabilities supplemented with complementary technology.

8. ACP recommends that contact tracing and other practices to assist in public health surveillance be fully aligned with civil liberties, due process, non-discrimination, data and health privacy protections, and health ethics.
    a. ACP recommends that any uses of technology in the US in the context of pandemic should be demonstrated to be effective, be temporary and ensure safeguards for privacy and confidentiality are in place.
    b. ACP recommends that physicians and their care teams and patients should be actively involved in the development, testing, and implementation of any public health surveillance technology or application.
    c. ACP recommends that extensive safeguards must proactively be put into place in order to ensure user privacy and responsible data management by any public health surveillance technologies or applications.
    d. ACP recommends that informed consent and opt-in should be required. Users of any public health surveillance technology must be provided with standard, transparent, and easily understandable notices of privacy practices that contain all permitted uses of the data.

<u>Communities Need to Work with Public Health Authorities to Develop Risk-Based Plans for a Phased Resumption of Economic and Social Activities When Cases and Transmission Are Declining Sufficiently</u>

9. In addition to the recommendations above on testing, contacting tracing and health system capacity, ACP recommends that communities consider initiating or continuing a gradual resumption of economic and social activities when the following signals are present:
    a. When new daily case counts demonstrate a consistent and stable decline for at least 14 days.
    b. The reproduction rate is <1. The reproduction rate is the average number of secondary cases that is generated by each case. For example, a reproduction rate of 3 indicates that an infectious person will lead to an average of 3 additional cases (through transmission). A reproduction of <1 means that on an average, an infectious person will transmit to fewer than one other person and is a strong indication that the outbreak has been contained.
10. ACP recommends that public officials and public health authorities work with local public health and state officials to employ a risk-based assessment to prioritize the order in which certain sectors can resume specified activities.
11. ACP recommends that public officials, public health authorities, community leaders, physicians, hospitals, employers, and others be involved in decision-making create and implement an effective communication strategy to ensure community engagement in both mitigation measures taken to prevent the spread of disease and plans for resuming some economic and social activities.
12. ACP recommends utilizing the best available evidence to slow and reduce transmission of COVID-19 even as certain economic and social activities are partially resumed.
13. ACP believes that availability of therapeutics and a vaccine that are effective against COVID-19 is a prerequisite for complete resumption of normal activities.

Resuming In-Person Medical Care Visits and Other Health Care Services: What Is Needed?

1. ACP recommends that the ability of a community to have the capacity needed for COVID-19 mitigation, as recommended by ACP in the preceding guidance on Resuming Economic and Social activities in a State or Community: What Will Be Needed, should also guide decisions on resuming in-person medical care visits and other health care services.

2. ACP recommends that public and private payers provide direct financial support to practices to offset losses of revenue and increased costs, through at least the 2020 calendar year, even as they begin to resume in person visits.
    a. ACP recommends that primary care physician practices, in particular, receive per patient per month prospective payments (PPPM) to make them whole for revenue losses and increased costs.
    b. ACP recommends that support also be prioritized for physicians in smaller practices, internal medicine subspecialty practices, and practices in underserved communities
3. ACP recommends that ambulatory internal medicine practices start planning how they might safely and effectively begin to resume in-person visits that have been temporarily suspended or postponed. R
4. ACP recommends that physicians, practices, and health care facilities consider the use of innovative workflows and schedules designed to minimize contact between patients and staff.

The Federal Government's Role: What Is Needed?

1. ACP recommends that the federal government provide state and local authorities with the resources, funding and effective distribution based on need to 1) ensure sufficient testing capacity, contact tracing and the workforce needed for follow-up, 2) personal protective equipment, 3) health system treatment capacity, and other elements, as described in this guidance (ECBOR 5/6/2020)

Statement on Identifying "Essential Elements" to Ease Social Distancing Protocols, Address White House Guidance to "Re-open" the U.S.

The American College of Physicians (ACP) supports the goal of the Administration's newly released "Guidelines for Opening Up America Again" to make decisions on easing some social distancing protocols in phases based on evidence of disease mitigation, but cautions against reducing social distancing prematurely, and calls for an evidence-based approach to ensure key essential elements are in place and scaled appropriately in communities before easing restrictions.

The American College of Physicians (ACP) agrees with the goals stated in the guidance of a phased approach that is "based on up-to-date data and readiness, mitigates the risk of resurgence, protects the most vulnerable, and is implementable on statewide or county-by-county basis" and that is predicated on downward trajectories in symptoms and cases, and hospitals having a robust testing program in place for at-risk healthcare workers, including emerging antibody testing.

However, ACP cautions that easing social distancing policies prematurely could have grave consequences for the health and well-being of millions of Americans. There is growing evidence that physical/social distancing, especially in states and localities with more robust restrictions and voluntary compliance by millions of Americans and employers, have been effective in reducing person-to-person contacts that can spread the virus. By slowing the virus' spread and building up health system capacity, physical/social distancing is beginning to "flatten the curve." Premature lifting of social distancing protocols can lead to a resurgence of the virus and potentially overwhelm health system capacity, and likely requiring that strict physical/social distancing be re-implemented.
Further, ACP asserts that several elements must be in place, and sufficiently scaled up, before it will be safe to ease social distancing restrictions. These include the availability of:

Population Level

1. Screening and Testing: Widespread administration of a reliable method of testing for COVID-19 and accurate/reliable emerging antibody testing, on a scale to accurately determine that a sustained downward trajectory is being evidenced and sustained. Consent and sufficient privacy protections for patients being tested must be in place.
2. Prevention Measures: An approach to scale up tracing of the contacts of those who test positive (contact tracing) that balances public health needs with confidentiality and privacy protections for patients. Centers for Disease Control and Prevention Director Robert Redfield says contact tracing is "critical" to preventing "multiple community outbreaks that can spiral up into sustained community transmission." [National Public Radio Interview, Morning Edition, April 10, 2020). We agree, but this must be done with great care. Consent and sufficient privacy protections for patients must be in place.
3. Infrastructure Sufficient workforce and supply capacity to do the testing, analysis, and follow up.

Health Care System Level

4. Resources Fully protective Personal Protective Equipment (PPE) for every frontline physician, nurse, or other professional health care worker.
5. Infrastructure Sufficient hospital, physician, and health system capacity to treat patients with the virus.

Currently, the evidence suggests that the 5 necessary elements noted above are not in place in most communities. While the White House guidance gives governor and local officials the authority and sole discretion to determine if the social distancing protocols can be eased based on the guidance, ACP believes that state and local authorities must make decisions based on the best available evidence, and the federal government must do more to ensure that the required tests, workforce capacity, supplies, and PPE are available and distributed based on need. Finally, until an effective vaccine and therapies are available, the United States and the world must be prepared for sustained social distancing protocols, even if eased to some degree in phases as supported by the evidence, as being part of the "new normal. (ECBOR 4/17/2020)

Protecting Patient and Physician Health and Safety During the COVID-19 Pandemic

ACP continues to urge federal, state and local authorities to ensure that there is an adequate supply and distribution of personal protection equipment (PPE) for all clinicians and health care workers. Physicians can and should expect their institutions to provide appropriate means to limit occupational exposure.

Physicians should be allowed to bring their own personal protection equipment (PPE) to protect themselves and others around them when these items are in short supply at their health care systems.

Health care systems should work with physicians to improve care and patient safety ensuring the best interests of patients.

Physicians should not be at risk of having their employment terminated, or be otherwise disciplined, for speaking out in a professional manner, within their health care systems or publicly, on conditions and practices related to care of COVID-19 patients (including lack of personal protection equipment) that the physician has direct knowledge of and believes is in conflict with the health and safety of patients and

clinicians. Physicians may appropriately decide that going public (including to the news media and on social media) with their concerns is their professional responsibility, to achieve needed change for the health and safety of patients and clinicians, both within the health care facility and more broadly. (ECBOR 4/1/2020)

Non-Discrimination in the Stewardship and Allocation of Resources During Health System Catastrophes Including COVID-19

Large-scale health catastrophes, including from infectious causes, can overwhelm health care systems, stressing the norms of health care delivery and the patient–physician relationship. Triage is often needed; stewardship and allocation of resources becomes even more necessary in overwhelmingly high demand circumstances. While the physician's responsibility remains with the health and welfare of individual patients under the physician's care, the well-being of the community as a whole must also be considered at a systems level including in institutional policies and other guidelines. This requires prioritization of resources. But prioritization must not be discrimination. Fairness and other professional responsibilities of physicians require that clinicians, their institutions and health care systems not discriminate against a class or category of patients (e.g., based on age, race, ethnicity, disability, sex, gender identity, social status or other personal characteristics). Treatment decisions must not be based on unjust and prejudicial criteria.

Many clinicians and institutions are going above and beyond the call of duty in these difficult times and we applaud them. Along with the traditional duty to care, fairness and equality must be promoted and guide health care delivery during health system catastrophes such as pandemic coronavirus. When, as in times of health system catastrophe, routine "first come, first served" or "sickest first" approaches are no longer appropriate, resource allocation decisions should be made based on patient need, prognosis (determined by objective scientific measures and informed clinical judgment) and effectiveness (i.e., the likelihood that the therapy will help the patient recover). Allocation of treatments must maximize the number of patients who will recover, not the number of "life-years," which is inherently biased against the elderly and the disabled.

Physicians should also participate in the development of guidelines for the delivery of health care in times of catastrophe with attention to health disparities that may affect populations or regions. Fair process requires transparency, consistency, proportionality and accountability. We must always act and speak as individual clinicians, but also consider our role within the profession of medicine, and within society, in a manner that demonstrates our compassionate commitment to all patients, with equality and fairness. (ECBOR 3/26/2020)

Statement on Nonurgent In-Person Medical Care

Physicians' primary goal is to care for patients, maintaining access to clinical services in environments that are safe for all. While it should be recognized that regular ongoing evaluation of patients with chronic health conditions can prevent deterioration that might lead to unnecessary emergency room or hospital care, during times such as the COVID-19 pandemic, it is appropriate to reassess whether the patient requires an in-person visit. While the need to see a particular patient in person is based on multiple complex factors, physicians should work to transition patients who do not need to be seen in person to a virtual visit (e.g., use telehealth video or telephone services) or else consider delaying thevisit

until such time as the benefits are outweighed by the harms that could occur when timely care is not delivered. Physicians should provide an explanation to the patient for these changes. Physicians should also cancel elective and nonurgent procedures. Internists' comprehensive skills and training uniquely position them to respond to the changing needs of their roles in the healthcare delivery system

Although use of video, online digital, and telephone care may be an option for many patients, many insurers and government programs will only pay for telehealth services that involve smart phones or other devices with video sharing capabilities. Although recent telehealth flexibilities have been introduced by some payers in response to the COVID-19 pandemic, most payers are still not paying for "audio only" phone calls. For patients lacking more advanced technologies, including many of the elderly, traditional "audio only" phone calls may be the only way for physicians to convert in-person visits to virtual ones. Government and all other payers should immediately expand their coverage and payment policies to include both video-enabled and audio-only phone calls, and make that coverage retroactive to the date of the President's declaration of national emergency, allowing physicians to quickly convert routine or preventive visits to a telephone or telehealth visit for as many patients as possible. (ECBOR 3/23/2020)

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)

DISCRIMINATION AND RACISM

A Comprehensive Policy Framework to Understand and Address Disparities and Discrimination in Health and Health Care

1. ACP recommends that U.S. policymakers commit to understanding and addressing disparities in health and health care related to a person's race, ethnicity, religion, and cultural identity [their personal characteristics], as aligned with ACP's mission "to enhance the quality and effectiveness of health care for all."
2. ACP recommends that policymakers comprehensively address the interconnected contributors to health and health care disparities, including the role of racism, discrimination, lack of coverage and access to care, poverty, and other social drivers of health.
3. ACP believes that public policy must support efforts to acknowledge, address, and manage preconceived perceptions and implicit biases by physicians and other clinicians.
4. ACP believes that health care facilities and medical schools and their clinicians and students should be incentivized to use patient-centered and culturally appropriate approaches to create a trusted health care system free of unjust and discriminatory practices.
5. ACP believes that a diverse, equitable, and inclusive physician workforce is crucial to promote equity and understanding among clinicians and patients and to facilitate quality care, and it supports actions to achieve such diversity, equity, and inclusion.
6. ACP believes that policymakers must strengthen U.S. education at all levels to improve health, health literacy, and diversity in medical education and in the physician workforce and must

prioritize policies to address the disproportionate adverse effect of discrimination and inequitable financing in education on specific communities based on their personal characteristics.

7. ACP recommends that policymakers consider discrimination and hate against any person on the basis of personal characteristics as a public health crisis.
8. ACP recommends that policymakers address the effect of social drivers of health, like poverty, on the health and health care of those affected, while addressing disparities associated with personal characteristics independent of, or in addition to, socioeconomic status.
9. ACP believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate effect on those at greatest risk because of their personal characteristics.
10. ACP believes that public policy must acknowledge the long history of racism, discrimination, abuse, forced relocation, and other injustices experienced by Indigenous persons and commit to focused and culturally appropriate policies to address their present reality of injustice, disparities, and inequities.
11. ACP believes that physicians and other clinicians must make it a priority to meet the cultural, informational, and linguistic needs of their patients,with support from policymakers and payers.
12. ACP believes that public policies should reflect the unique effects that country of origin, language, immigration status, workplace, and culture have on health disparities among various distinct communities associated with their personal identities.
13. ACP believes that health care delivery and payment systems should support physician-led, team-based, and patient- and family-centered care that is easily accessible to those affected by discrimination and social drivers of health.
14. ACP believes that policymakers should recognize and address how increases in the frequency and severity of public health crises, including large-scale infectious disease outbreaks, poor environmental health, and climate change, disproportionately contribute to health disparities for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other vulnerable persons.
15. ACP believes that policies must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk.
16. ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.
17. ACP recommends that policymakers understand, address, and implement evidence-based solutions to systemic racism, discrimination, and violence in criminal justice and law enforcement policies and practices because they affect the physical health, mental health, and well-being of those disproportionately affected because of their personal identities. (BOR 20)

Understanding and Addressing Disparities and Discriminations Affecting the Health and Health Care of Persons and Populations at Highest Risk

1. ACP recommends that policymakers consider discrimination and hate against any person on the basis of personal characteristics as a public health crisis.
2. ACP recommends that policymakers address the effect of social drivers of health, like poverty, on the health and health care of those affected, while addressing disparities associated with personal characteristics independent of, or in addition to, socioeconomic status.

3. ACP believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate effect on those at greatest risk because of their personal characteristics.
    a. Universal health coverage, either through single-payer or public choice model as recommended in "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care" (12) is fundamental in addressing the underlying racial and ethnic disparities in comorbidities that increase risk of negative health outcomes.
    b. Medicaid eligibility should be expanded and Children's Health Insurance Program and Medicaid coverage should be unified in all states so that families are covered under a single program.
    c. Insurance marketplace subsidies should be expanded to provide assistance to those in nonexpansion states with incomes too high to qualify for Medicaid and too low to qualify for marketplace premium subsidies.
    d. Approaches should be explored to offer coverage for unauthorized immigrants, including allowing them to obtain coverage in the insurance exchange.
    e. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for racial and ethnic communities historically underserved and disenfranchised.
4. ACP believes that public policy must acknowledge the long history of racism, discrimination, abuse, forced relocation, and other injustices experienced by Indigenous persons and commit to focused and culturally appropriate policies to address their present reality of injustice, disparities, and inequities.
    a. The Indian Health Services (IHS) should become a program with mandatory funding and be equipped with the resources necessary to provide equitable and adequate services to the populations they serve. Funding levels for programs providing health care to Indigenous communities should be at least at parity to other health programs.
    b. The definition of "Indian" in the Affordable Care Act should be revised to match the more expansive definitions used by the IHS and Centers for Medicare and Medicaid Services (CMS) to provide benefit and protection to Indigenous people who are not enrolled in a federally recognized tribe.
    c. Health and wellness promotion, chronic disease prevention, and other public health interventions addressing morbidities with high incidence in Indigenous communities should be evidence-based, culturally appropriate, community accepted, and respectful of traditional practices and customs.
    d. A multidisciplinary approach is necessary to implement culturally appropriate interventions to address the underlying social drivers of health that exacerbate physical, mental, and behavioral health issues and contribute to catastrophic rates of suicide in Indigenous communities. Additional research is needed into the resilience strategies that have bolstered Indigenous communities living in harsh and difficult conditions.
    e. Models that provide comprehensive, integrated, culturally appropriate, affordable, and accessible care operated by tribes and native organizations with federal financial support should be encouraged, supported, and expanded as appropriate, and the practices adopted by them should inform policymaking to better serve the health needs of Indigenous persons.
5. ACP believes that physicians and other clinicians must make it a priority to meet the cultural, informational, and linguistic needs of their patients, with support from policymakers and payers.
    a. Health literacy among those facing disparities on the basis of personal characteristics must be strengthened in a culturally and linguistically sensitive manner. Funding and support should be

made available for clinicians to implement and expand health literacy interventions and adapt their practice to accommodate the cultural, informational, and linguistic needs of their patients.

b. Health care communications must be made in a language the patient understands. Clinicians should be reimbursed by public and private payers for translation services needed in providing care for those with limited English proficiency (LEP) or who are deaf.

c. Patient navigators should be funded and provided to assist patients in navigating the entire spectrum of the health system and to better understand and communicate one's health needs.

6. ACP believes that public policies should reflect the unique effects that country of origin, language, immigration status, workplace, and culture have on health disparities among various distinct communities associated with their personal identities.

7. ACP believes that health care delivery and payment systems should support physician-led, team-based, and patient- and family-centered care that is easily accessible to those affected by discrimination and social drivers of health.

8. ACP believes that policymakers should recognize and address how increases in the frequency and severity of public health crises, including large-scale infectious disease outbreaks, poor environmental health, and climate change, disproportionately contribute to health disparities for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other vulnerable persons.

   a. Racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic should be collected and released in a uniform and timely manner at a local and national level. Data should be shared with local, state, territorial, and tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care.

   b. Testing, treatments, vaccines, and other resources should be equitably distributed in a transparent manner based on need, especially in historically underserved racial and ethnic minority neighborhoods. These services and supplies should be affordable and accessible regardless of socioeconomic status.

   c. The U.S. Department of Labor's (DOL) Occupational Safety and Health Administration (OSHA) should issue appropriate workplace protections to protect the health and well-being of essential workers during a pandemic.

   d. Universal access to family and medical leave that provides a minimum period of 6 weeks of paid leave should be mandated and funded, with flexibility that allows for the caring of family members, as recommended in "Women's Health Policy in the United States" (13). Legislative or regulatory action at the federal, state, or local level are needed to advance this goal.

   e. Environmental factors and other social drivers of health that disproportionately affect racial and ethnic minorities, including the impact on health of large-scale infectious disease outbreaks and climate change, must be addressed as recommended in "Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health" (14), "Addressing Social Determinants to Improve Patient Care and Promote Health Equity" (15), and "Climate Change and Health" (16).

9. ACP believes that policies must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk.

   a. Ensure access to affordable, comprehensive, and nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman's lifespan, including high-

quality and patient-centered preconception, antenatal, delivery, postpartum, and other care and appropriate specialists and subspecialists.

b. Establish maternal mortality review committees (MMRCs) and other state or local programs to collect pertinent data, identify causes of maternal death, and develop and implement strategies with the goals of preventing pregnancy-related or pregnancy associated death and improving maternal outcomes. MMRCs should have access to necessary data across jurisdictions and implement best practice standards for data collection including consistency and comparability of data.
c. Incentivize health care institutions to undertake safety and quality improvement activities that are shown to be effective in improving maternal and other health.
d. Cover resources like doulas and patient navigators by public and private payers. ACP supports ongoing research and evaluation of such services in order to demonstrate which models are most effective.

10. ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns. (BoR 20)

Understanding and Addressing Disparities and Discriminations in Law Enforcement and Criminal Justice Affecting the Health of At-Risk Persons and Populations

1) ACP recommends that policymakers understand, address, and implement evidence-based solutions to systemic racism, discrimination, and violence in criminal justice and law enforcement policies and practices because they affect the physical health, mental health, and well-being of those disproportionately affected because of their personal identities. ACP supports the following policies:
   a) Study, implement, and fund alternative models that deploy social workers and other mental health professionals specially trained in violence interruption, mediation, homelessness outreach, and mental health, who are ancillary to law enforcement, when their intervention would be more appropriate and effective than law enforcement intervention alone.
   b) Additional funding and resources should be directed to and invested in addressing socioeconomic factors that are associated with crime, such as unemployment, homelessness, and poor educational opportunity, to proactively prevent criminal encounters.
   c) Policies should be implemented to address the impact of incarceration on health at the personal, familial, and community levels that disproportionately impact Black, Indigenous, and Latinx persons. Racial and ethnic disparities in rates of law enforcement interactions, incarceration, and severity in sentencing, including capital offenses, should be tracked and reported at the local, federal, and state levels, and steps must be taken to eliminate them. Criminal justice law, policies, and practices should be examined and studied for racial impact and overhauled if they result in unnecessary or disproportionate harm. All persons should have access to high-quality and affordable legal defense and funding should be increased for public defender representation. Priority should be given to reducing the health risks associated with incarceration while ensuring public safety and justice by:
      i) Implementing safe alternatives to incarceration;

ii) researching and adopting alternatives to cash bail that reduce pretrial detention inequities, while ensuring appropriate protection from harm for persons who may be a danger to themselves or others;
iii) ending inequities in sentencing for capital offenses related to structural racism, discrimination, and lack of access to high-quality and affordable legal defense, recognizing the resulting disproportionate harm to Black and Indigenous persons;
iv) re-establishing supervised parole where it has been eliminated;
v) reducing the length of sentences when appropriate, especially for nonviolent offenders;
vi) providing for supervised early release of those shown not likely to pose a substantial public safety risk;
vii) providing for job training and other support in prison and upon release to help inmates re-enter society and find meaningful employment upon release from prison; and
viii) removing financial barriers to accessing and enhancing quality of correctional health care.

Understanding and Addressing Disparities and Discriminations in Education and in the Physician Workforce

1) ACP believes that public policy must support efforts to acknowledge, address, and manage preconceived perceptions and implicit biases by physicians and other clinicians.
2) ACP believes that health care facilities and medical schools and their clinicians and students should be incentivized to use patient centered and culturally appropriate approaches to create a trusted health care system free of unjust and discriminatory practices.
3) ACP believes that a diverse, equitable, and inclusive physician workforce is crucial to promote equity and understanding among clinicians and patients and to facilitate quality care, and it supports actions to achieve such diversity, equity, and inclusion. ACP recommends that the following actions be taken by health institutions and medical schools to achieve such diversity:
    a) Implement policies and practices to eliminate racism and discrimination experienced by health care professionals, especially medical students, residents, and faculty. Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination must be treated with respect and dignity; have opportunities for leadership, mentorship, and advancement; be empowered to report harassment, abuse, and other transgressions; and be ensured action is taken to support them and prevent future abuse.
    b) Be transparent in the policies taken to achieve these goals and be held accountable for failing to create a safe, inclusive, and supportive environment. Federal and state funding should be withheld from those institutions that fail to meet these goals and engage in or permit acts of discrimination. Health care professionals who engage in overt racist and discriminatory behavior must be subject to appropriate professional discipline.
    c) Medical and other health professional schools should revitalize and bolster efforts to improve matriculation and graduation rates of racial and ethnic minority students. Institutions of higher education should appropriately consider a person's race and ethnicity as one factor in determining admission in order to counter the impact of current discriminatory practices and the legacy of past discrimination practices and better reflect the current composition of the population. Programs that provide outreach to encourage racial and ethnic minority enrollment in medical and other health professional schools should be maintained, reinstated, and expanded, including diversity/ minority affairs offices, scholarships, and other financial aid programs.

d) All arenas of the health care workforce should be incentivized to implement evidence-based best practices in the recruitment, retention, and advancement of health professionals of Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination. Institutions should be transparent in their hiring and retention practices and be held accountable for ensuring a culture of nondiscrimination and the elimination of discriminatory practices. Federal and state funding should positively support and incentivize such efforts while holding institutions accountable for failing to make progress in achieving greater diversity, equity and inclusion. Actions to further these goals include:
    i) Developing a hiring diversity strategy to recruit racial and ethnic minority candidates by drafting open job descriptions, broadly advertising open positions outside of traditional venues, better understanding the pathway of diverse talent, and conducting outreach to develop more relationships with diverse candidates.
    ii) Implementing health care career pathway programs to engage and connect Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other students affected by discrimination and expose them to and advance their readiness for careers in medicine.
    iii) Supporting full compliance with Liaison Committee on Medical Education accreditation standards around student and faculty diversity.
    iv) Encouraging mentorship and sponsorship and providing training for faculty on how to be effective mentors and sponsors.
    v) Offering career coaching and leadership development programs for those underrepresented in medicine.
    vi) Requiring the inclusion of Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other physicians affected by discrimination as job candidates and members of search committees when possible. Members of search committees should receive training and educational resources on implicit biases.
    vii) Ensuring diversity on all committees, councils, and boards to achieve inclusion, comprehensiveness, and mechanisms for accountability.

4) ACP believes that policymakers must strengthen U.S. education at all levels to improve health, health literacy, and diversity in medical education and in the physician workforce and must prioritize policies to address the disproportionate adverse effect of discrimination and inequitable financing in education on specific communities based on their personal characteristics. While education reform is a broad and complex issue requiring a multifaceted approach, the American College of Physicians affirms that:
    a) Schools should be sufficiently funded, particularly those serving low-income communities, and be prioritized to support evidence-based practices shown to be effective in strengthening educational quality and results for all students.
    b) Biased and inequitable funding mechanisms built upon underlying structural factors like segregation and racial wealth gaps, which result in discriminatory education resource disparities associated with the racial, ethnic, and cultural identity and characteristics of the communities being served, should be replaced by equitable alternatives.
    c) All students should have equitable access to experienced and qualified teachers, a rigorous evidence-based curriculum, extracurricular activities, and educational materials and opportunities. Instruction should be culturally and linguistically competent for the population served.

Recognizing Hate Crimes as a Public Health Issue

1. ACP opposes prejudice, discrimination, harassment and violence against individuals based on their race, ethnic origin, ancestry, gender, gender identity, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion.
2. Hate crimes directed against individuals based on their race, ethnic origin, ancestry, gender, gender identity, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion are a public health issue.
3. ACP opposes all legislation with discriminatory intent upon individuals based on their race, ethnic origin, ancestry, gender, gender identity, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion.
4. ACP supports the development and implementation of anti- discrimination and hate crime laws.
5. ACP supports the collection and publication of statistics on hate crimes. More research is needed on the impact of hate crimes on public health, understanding and preventing hate crimes, and interventions that address the needs of hate crime survivors and their communities. (BoR 17)

Racism and Health in the United States

1. ACP condemns the injustices and harm that Black and indigenous communities and other people of color experience as a result of pervasive overt and covert systemic institutional racist policies, practices, and discrimination in the United States. ACP commits to being an antiracist organization dedicated to action and policy to confront and eliminate racism.
2. ACP condemns and opposes racist policies and actions that perpetuate injustices and inequities in medicine and throughout all aspects of U.S. society. Urgent actions to remedy historical institutional injustices and inequities include eliminating discrimination, bias, and racism in the U.S. health care delivery system and in medical education. ACP commits to developing new policies and expanding existing ones toward these goals.
3. ACP reaffirms that hate crimes are a public health issue and that all persons, without regard to where they live or work; their race and ethnicity; their sex or sexual orientation; their gender or gender identity; their age; their religion, culture, and beliefs; their national origin, immigration status, and language proficiency; their health literacy level and ability to access health information; their socioeconomic status; whether they are incarcerated; and whether they have intellectual or physical disability must have equitable access to high-quality health care and must not be discriminated against on the basis of such characteristics.
4. ACP affirms that physical and verbal violence and discrimination, particularly based on race/ethnicity and other perceived characteristics of personal identity, are social determinants of health and, thus, public health issues. Violence and discrimination exacerbate the burden of morbidity and mortality among people of color and other marginalized groups, which may contribute to the disproportionately higher mortality rates from coronavirus disease 2019 (COVID-19) among Black, indigenous, Latinx, and Asian American communities and persons.
5. ACP affirms that discrimination, racism, and violence in the context of law enforcement and law enforcement policies and practices that target Black individuals and other persons of color harm the physical heath, mental health, and well-being of individuals and the public. Institutional and systemic law enforcement practices that enable, allow, and protect racism, discrimination, and violence undermine law enforcement officers who are dedicated to equal treatment under the law, ensuring public safety, and saving lives and undermine public confidence in justice and law

enforcement. While solutions to racism and discrimination in law enforcement are complex, ACP supports the following policies as a starting point:

a. ACP supports adoption of law enforcement practices that ensure equal treatment under the law of all persons, without regard to race and other personal characteristics, and increase transparency and accountability.

b. ACP calls for research on the contributors to law enforcement violence and discrimination and the impact on the health of individuals and communities, particularly for people of color.

c. ACP calls for research on and adoption by law enforcement policies that reinforce the importance of community engagement in managing public safety.

d. ACP urges research on and adoption of best practices by law enforcement agencies to promote safety and wellness at every level of the organization, including support for officer wellness and safety.

e. ACP supports greater transparency and accountability and adoption of best practices in law enforcement, including:

    i. Creating a comprehensive national database and reporting mechanism that captures all deaths caused by law enforcement, incidents of excessive use of force, and discriminatory policing practices.

    ii. Requiring local police departments to report these incidents to state health departments, which will be made publicly available in a timely manner and at a local level.

    iii. Monitoring and addressing misclassification of causes of death, the underreporting of victims of law enforcement violence, and the prevalence of serial offenders.

    iv. Making investigations, including video evidence, of misconduct and excessive use of force by law officers available to the public.

    v. Identifying and eliminating barriers that hinder the investigation and accountability of officer misconduct.

f. ACP believes funding should prioritize research on evidence-based best practices that reduce situations in which use of force is required and promote alternatives to use of force.

g. ACP believes that law enforcement authorities should be incentivized and required to incorporate best practices to eliminate excessive use of force, reevaluate use of force policies, establish parameters around reasonable force, and delineate between acceptable and excessive force, with accountability and transparency to elected officials and the public.

h. ACP supports the use of technology, such as body cameras, to assist in monitoring and enforcing use of force protocols.

i. ACP calls for research on and implementation of effective law enforcement recruitment, training, and retention programs that encourage safer, less discriminatory, and less forceful policing practices.

j. ACP believes that the inappropriate militarization of community law enforcement interactions with civilian populations should be eliminated.

k. ACP urges health care institutions and professionals to review policies and relationships with law enforcement to ensure that they align with the priority of protecting patients and staff.

7a. ACP condemns violations of the fundamental constitutional and human right of persons to peaceably protest against racism and violence and calls on public authorities and law enforcement to protect this right and never subject peaceful protesters to enforcement actions

that can harm their health.

7b. ACP commits to studying, listening, and developing evidence-based solutions to racism and discrimination and acting to implement them in its engagements with its membership, its staff, other organizations, policymakers, and society. Issues to be addressed by ACP in further policy development will include impact of racism on the interactions between patients and health care professionals, racial violence against clinicians, and impact of racism on health profession training programs.

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, reaffirmed BoR 22)

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)

Social Determinants of Health

1. The American College of Physicians supports increased efforts to evaluate and implement public policy interventions with the goal of reducing socioeconomic inequalities that have a negative impact on health. Supportive public policies that address downstream environmental, geographical, occupational, educational, and nutritional social determinants of health should be implemented to reduce health disparities and encourage health equity.

2. The American College of Physicians recommends that social determinants of health and the underlying individual, community, and systemic issues related to health inequities be integrated into medical education at all levels. Health care professionals should be knowledgeable about screening and identifying social determinants of health and approaches to treating patients whose health is affected by social determinants throughout their training and medical career.

3. The American College of Physicians supports increased interprofessional communication and collaborative models that encourage a team-based approach to treating patients at risk to be negatively affected by social determinants of health.

4. The American College of Physicians supports the adequate and efficient funding of federal, state, tribal, and local agencies in their efforts to address social determinants of health, including investments in programs and social services shown to reduce health disparities or costs to the health care system and agency collaboration to reduce or eliminate redundancies and maximize potential impact.

5. The American College of Physicians supports increased research into the causes, effects, prevention, and dissemination of information about social determinants of health. A research agenda should include short- and long-term analysis of how social determinants affect health outcomes and increased effort to recruit disadvantaged and underserved populations into large-scale research studies and community-based participatory studies.
6. The American College of Physicians recommends policymakers adopt a "health in all policies" approach and supports the integration of health considerations into community planning

decisions through the use of health impact assessments.

7. The American College of Physicians recommends development of best practices for utilizing electronic health record (EHR) systems as a tool to improve individual and population health without adding to the administrative burden on physicians.

8. The American College of Physicians recommends adjusting quality payment models and performance measurement assessments to reflect the increased risk associated with caring for disadvantaged patient populations.

9. The American College of Physicians recommends increased screening and collection of social determinants of health data to aid in health impact assessments and support evidence-driven decision making. (BoR 18)

Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health

The American College of Physicians believes that all persons, without regard to where they live or work; their race and ethnicity; their sex or sexual orientation; their gender or gender identity; their age; their religion, culture, and beliefs; their national origin, immigration status, and language proficiency; their health literacy level and ability to access health information; their socioeconomic status; whether they are incarcerated; and whether they have intellectual or physical disability must have equitable access to high-quality health care and must not be discriminated against based on such characteristics. (BoR 19)

DRUG ABUSE

Decreasing Barriers to Prescribe Buprenorphine for Opioid Use Disorder

ACP supports eliminating the requirement that physicians obtain a waiver to administer, dispense, and prescribe buprenorphine for the treatment of opioid use disorder. (BoR 22)

Harm Reduction Strategies for Substance Use Disorders including Overdose Prevention Sites and Fentanyl Test Strips

1. The American College of Physicians supports evidence-based harm reduction strategies to prevent overdose, reduce transmission of infectious diseases, encourage safe use protocols, and connect people who use drugs to medical care and substance use disorder treatment.
2. ACP supports federal funding for syringe support programs, including to purchase syringes/needles. Syringe support programs should be enabled to provide a range of services, including testing for infectious diseases and other conditions, drug education materials and checking supplies, naloxone distribution, and referrals to medical, behavioral health, and SUD treatment.
3. ACP recommends the decriminalization of drug checking supplies and syringe support program equipment, including fentanyl test strips and syringes/needles.
4. ACP supports pilot testing of overdose prevention sites (OPS) in high-need areas. OPS should be staffed and supervised by trained, qualified health professionals, and should provide a range of services, including naloxone, health and safety education, sterile supplies, screening, and referrals and/or treatment for infectious diseases, medical, and behavioral health care, including substance use disorders.

a. ACP recommends that legal barriers to OPS implementation be lifted to protect OPS operators from prosecution. Physicians and other health care professionals should be protected from professional sanction, such as loss of license or prescribing privileges, based solely on OPS participation.
b. OPS stakeholders should engage people who use drugs and other members of the community about the potential benefits of OPS to ensure buy-in.
c. Pilot OPS should be evaluated to determine effects on overdose morbidity and mortality, infectious disease control, safe use protocols, and public safety, and other outcomes.

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

Policy Recommendations to Promote Prescription Drug Competition

1. ACP supports legislative reforms to the Orphan Drug Act (ODA) that realign incentives offered through the law to support increased innovation in rare disease drug development.
2. ACP supports reducing the period of data and market exclusivity for biologic drugs from 12 years to 7 years. ACP also supports removing additional barriers to biosimilar market entry, such as modifications to the current patent system that would reduce excessive patenting on brand-name and biologic drugs.
3. ACP opposes anticompetitive pay-for-delay arrangements that curtail access to lower-cost alternative drugs. ACP believes applicable federal agencies should be empowered through guidance, congressional action, or additional resource support to address anticompetitive behaviors and gaming.
4. ACP supports elimination of tax deductions for direct-to-consumer product claim advertisements. (BOR 20)

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. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

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. (BoR 22)

3. 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. ACP supports approaches to addressing the costs of prescription drugs in the Medicare program as outlined in *Policy Recommendations for Public Health Plans to Stem the Escalating Costs of Prescription Drugs* and *Stemming the Escalating Cost of Prescription Drugs*. (BoR 01, reaffirmed BoR 11, revised BoR 22)

4. 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 for Medicare to ascertain and certify the safety of reimported prescription drugs as outlined in *Prescription Drug Importation as a Policy Option to Lower the Cost of Medications in the U.S.* (BoR 01, reaffirmed BoR 11, revised BoR 22)

5. Generic drugs should be used, as available, for beneficiaries of Medicare Part D, providing therapeutic safety and equivalency are established.
    a. ACP supports modification to the Medicare Part D low-income subsidy (LIS) program cost-sharing and copayment structures to encourage the use of lower-cost generic or biosimilar drugs, such as eliminating cost sharing for generic drugs for LIS enrollees.
    b. 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 and other efforts to address anticompetitive behaviors as outlined in *Policy Recommendations to Promote Prescription Drug Competition* and *Stemming the Escalating Cost of Prescription Drugs*. (BoR 01, reaffirmed BoR 11, revised BoR 22)
    c. 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, revised BoR 22)

6. 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. (BoR7-99, revised BoR 10)
    a. 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.
    b. 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.
    c. 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.
    d. ACP opposes Medicare Part D proposals that limit coverage to certain therapeutic categories of drugs, or drugs for certain diseases.
    e. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

7. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

8. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

9. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

10. A Medicare prescription drug benefit should minimize administrative hassles, including excessive documentation requirements and overly burdensome rules, for physicians. (BoR 01, reaffirmed BoR 11, revised BoR 22)

11. Physicians should continue to be able to prescribe covered drugs for accepted off-label uses. (BoR7-99, revised BoR 10, revised BoR 22)

12. 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. (BoR7-99, revised BoR 10, revised BoR 22)

Prescription Drug Recalls

1. In order to adequately protect the health and safety of patients from defective and harmful drugs, a national recall notification network should inform health professionals of all clinically important recalls that have bearing on patient care.
2. Thorough electronic tracking of pharmaceutical products and their components throughout the supply chain is needed to be able to promptly identify and notify those impacted by recalled products.
3. Regulatory agencies should have increased authority to intervene in the production and supply of pharmaceutical products that are known to be defective and cause harm to patients.
4. Health plans and pharmacy benefit managers should provide a process for expedited formulary exceptions in the event of a recall of a generic medication and ensure affordable patient access to the brand medication or alternative treatment options.(BOR 20)

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, reaffirm BoR 22)

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; reaffirmed BoR 19)

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**

Guidelines for Pharmacists

Pharmacists should include the following information on the prescription label: name, address and tele-phone 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)

Prescription Drug Recalls

1. In order to adequately protect the health and safety of patients from defective and harmful drugs, a national recall notification network should inform health professionals of all clinically important recalls that have bearing on patient care.
2. Thorough electronic tracking of pharmaceutical products and their components throughout the supply chain is needed to be able to promptly identify and notify those impacted by recalled products.
3. Regulatory agencies should have increased authority to intervene in the production and supply of pharmaceutical products that are known to be defective and cause harm to patients.
4. Health plans and pharmacy benefit managers should provide a process for expedited formulary exceptions in the event of a recall of a generic medication and ensure affordable patient access to the brand medication or alternative treatment options. (BoR 20)

Policy Recommendations for Pharmacy Benefit Managers to Stem the Escalating Costs of Prescription Drugs

1. ACP supports improved transparency, standards, and regulation for pharmacy benefit managers (PBMs), including a ban on “gag clauses” that prevent pharmacies from sharing pricing information with consumers. ACP supports stringent oversight and regulation of mergers and consolidation within the PBM market.
2. ACP supports the availability of accurate, understandable, and actionable information on the price of prescription medication. ACP urges health plans to make this information available to physicians and patients at the point of prescribing to facilitate informed decision making about clinically appropriate and cost-conscious care.
3. ACP believes health plans, PBMs, and pharmaceutical manufacturers should report the amount paid for prescription drugs, aggregate amount of rebates, and nonproprietary pricing information

to the Department of Health and Human Services and make it publicly available. Any disclosure mandate should be structured in a way that deidentifies negotiated rebates with specific companies and protects confidential information that could be considered trade secrets or could have the effect of increasing prices. (BOR 19)

Policy Recommendations for Public Health Plans to Stem the Escalating Costs of Prescription Drugs:

1. ACP supports modification to the Medicare Part D low-income subsidy (LIS) program cost-sharing and copayment structures to encourage the use of lower-cost generic or biosimilar drugs, such as eliminating cost sharing for generic drugs for LIS enrollees.
2. ACP supports annual out-of-pocket spending caps for Medicare Part D beneficiaries who reach the catastrophic phase of coverage.
3. ACP supports the adoption of Medicare Part D negotiation models that would drive down the price of prescription drugs for beneficiaries.
    a. While ACP reaffirms its support for a full repeal of the noninterference clause, ACP also supports an interim approach, such as allowing the Secretary of Health and Human Services (HHS) to negotiate for a limited set of high-cost or sole-source drugs.
    b. ACP supports a public Medicare Part D plan option that allows the Secretary of HHS to negotiate prices with drug makers. Any Medicare-operated public plan must meet the same requirements as private plans and be consistent with ACP's policy on formularies.
4. ACP supports efforts to minimize the financial impact on the federal government of prescription drug misclassification in the Medicaid Drug Rebate Program (MDRP). The Centers for Medicare & Medicaid Services should identify which legal authorities are necessary to ensure compliance with the MDRP and Congress should pass legislation to grant such authorities.
5. ACP supports further study of payment models in federal health care programs, including methods to align payment for prescription drugs administered in-office in a way that would reduce incentives to prescribe higher-priced drugs when lower-cost and similarly effective drugs are available. (BOR 19)

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; reaffirmed BoR 19)

DRUGS: IMPORTATION

Prescription Drug Importation as a Policy Option to Lower the Cost of Medications in the U.S.

ACP supports legislative and/or regulatory measures to develop a process to ascertain and certify the safety of reimported prescription drugs. (revised BoR 05; reaffirmed BoR 19)

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)

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. (Reaffirmed BoR 22)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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, 7th ed.**, and position statements at https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-seventh-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-seventh-edition for additional statements and policies specific to medical ethics.*

Ethical Allocation of Vaccines During Pandemics Including COVID-19

- ACP supports the conclusions of the National Academies of Sciences, Engineering and Medicine (NASEM) report, Framework for Equitable Allocation of COVID-19 Vaccine (NASEM, October 2020) proposing phased allocation of vaccines, including high-risk health care workers and populations most at risk for death or severe illness in Phase 1.
- ACP recommends that the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) adopt the phased allocation of vaccines proposed in the NASEM report with ACP modifications.
- Strategies to reduce transmission—maintaining physical distance, appropriate mask use, self-isolation, quarantine, frequent hand hygiene with soap and water or alcohol-based hand rub, covering cough and sneezes using a bent elbow or paper tissue, refraining from touching the face, and frequent disinfection of frequently touched surfaces—will remain necessary until effective vaccines have been widely administered. (ECBoR 20)

Ethical Guidance for Electronic Patient-Physician Communication: Aligning Expectations

1. Electronic Communication Can Supplement In-Person Interactions Between Patient and Physician
2. Electronic Communication Should Only Take Place After Discussion with the Patient about Expectations and Appropriate Uses, and with the Patient's Consent
3. E-communications with Patients Should Occur Through a Method that Is Patient-Centered and Secure Such as Patient-Portals
4. All Electronic Communications Should Be Documented in the Medical Record
5. Clinical and Ethical Standards for Relationships Should Be Applied to Electronic Communication Contexts

6. Electronic Communication Between Patients and Their Physicians, if Done with Attention to Ethical and Other Concerns, May Help Improve Patient Care, Patient Satisfaction, and Clinical Outcomes
7. Physicians and Institutions Should Use Electronic Communication to Promote Health Equity and Proactively Address the Socioeconomic and Demographic Factors that May Lead to Disparities in Uptake and Utilization
8. Health Care Institutions Should Have Policies on Electronic Communication Methods. Medical Schools, Training Programs, and Institutions Should Educate Learners and Physicians About Principles of Electronic Patient-Physician Communication
9. Physicians, Institutions, and Patients Should Recognize and Address Increased Workload Associated with Management of Electronic Communication and Implications for Physician Well-being (BoR 20)

Non-Discrimination in the Stewardship and Allocation of Resources During Health System Catastrophes Including COVID-19

Large-scale health catastrophes, including from infectious causes, can overwhelm health care systems, stressing the norms of health care delivery and the patient–physician relationship. Triage is often needed; stewardship and allocation of resources becomes even more necessary in overwhelmingly high demand circumstances. While the physician's responsibility remains with the health and welfare of individual patients under the physician's care, the well-being of the community as a whole must also be considered at a systems level including in institutional policies and other guidelines. This requires prioritization of resources. But prioritization must not be discrimination. Fairness and other professional responsibilities of physicians require that clinicians, their institutions and health care systems not discriminate against a class or category of patients (e.g., based on age, race, ethnicity, disability, sex, gender identity, social status or other personal characteristics). Treatment decisions must not be based on unjust and prejudicial criteria.

Many clinicians and institutions are going above and beyond the call of duty in these difficult times and we applaud them. Along with the traditional duty to care, fairness and equality must be promoted and guide health care delivery during health system catastrophes such as pandemic coronavirus. When, as in times of health system catastrophe, routine "first come, first served" or "sickest first" approaches are no longer appropriate, resource allocation decisions should be made based on patient need, prognosis (determined by objective scientific measures and informed clinical judgment) and effectiveness (i.e., the likelihood that the therapy will help the patient recover). Allocation of treatments must maximize the number of patients who will recover, not the number of "life-years," which is inherently biased against the elderly and the disabled.

Physicians should also participate in the development of guidelines for the delivery of health care in times of catastrophe with attention to health disparities that may affect populations or regions. Fair process requires transparency, consistency, proportionality and accountability. We must always act and speak as individual clinicians, but also consider our role within the profession of medicine, and within society, in a manner that demonstrates our compassionate commitment to all patients, with equality and fairness. (ECBoR 20)

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, reaffirmed BoR 19)

Financial Arrangements

Financial relationships between patients and physicians vary from fee-for-service to government Financial relationships between patients and physicians vary. Financial arrangements and expectations should be clearly established, and 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.

The practice of 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 care should be consistent with care provided to others. 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. (BoR 04; Reaffirmed as amended BoR 11, reaffirmed as amended BoR 19)

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 or rewards for physician implementation of institutional or other quality or population measures); 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 (102). Physicians must disclose their financial interests to patients or research subjects, including interests in any medical facilities or office-based research to which they refer or recruit patients. When speaking, teaching, and authoring, physicians should disclose their interests in writing. Medical journal editors 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 (103). Physicians may, however, invest in or own health care facilities when alternative capital funding is not available and necessary services are provided that would otherwise not be available. 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 or by a physician 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 unless the products are specifically relevant to the patient's care, offer a clear benefit based on adequate clinical evidence, 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 thus the sale of such products is ethically suspect. Physicians should fully disclose their financial interests in selling ethically

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, or 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. Many industry payments and transfers of value to physicians must be reported under the federal Open Payments Program and laws in some states.

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, reaffirmed with edits BoR 19)

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, Reaffirmed BoR 19)

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 of 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. Six states and the District of Columbia have legalized the practice of physician-assisted suicide in the United States. Many other states have had referenda and legislative proposals 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 control pain 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. In Oregon, for example, losing autonomy or dignity and inability to engage in enjoyable life activities have been cited as concerns in most physician-assisted suicide cases (80). 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. After much consideration, the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns. 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. (BoR 00; BoR 2004; Reaffirmed with edits BoR 11, Reaffirmed with edits BoR 19)

Physician Participation in Executions

Participation by physicians in the execution of prisoners except to certify death is unethical. (BoR 04; Reaffirmed BoR 11, reaffirmed BoR 19)

Care of Patients Near the End of Life

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. This includes any medical intervention, including ventilators, artificial nutrition and hydration, and cardiovascular implantable electronic devices (such as pacemakers and implantable cardioverter-defibrillators) (67). The patient's right to refuse treatment is based on the philosophical and ethical concept of respect for autonomy, the common-law right of self-determination, and the patient's liberty interest under the U.S. Constitution (68). 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 appropriate 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 and can make their wishes known through 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 (34). 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, Reaffirmed as amended BoR 19)

Care of Patients Near the End of Life

Physicians and the medical community must be committed to the compassionate, timely, and competent provision of care to dying patients and their families and effective communication with patients and families (35, 61). 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 and hospice 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, Reaffirmed as amended BoR 19)

Palliative Care

Although palliative care may benefit any patient with serious illness, palliative care for dying patients should address physical, psychosocial, and spiritual needs and at times may be required in an acute care context. To provide palliative care, the physician must be up to date on the proper use of medications and treatments, including the ethical and legal basis of the use of opioids as necessary to relieve pain. 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. Physicians should be guided by data on the benefits of early initiation of palliative care and should improve timelier appropriate referrals to hospice. Patients and families often do not know what hospice or palliative care

is but say they want it when informed about this type of care.

Clinicians should prepare the patient and family for the course of illness and care options. Cultural differences at the end of life, including differences in beliefs and values, should be respected by physicians (30). Clinicians should also assist family members and loved ones experiencing grief after the patient's death in receiving bereavement support.

Physicians should partner with colleagues from social work, chaplaincy, and other fields to meet psychosocial, spiritual, and other needs of dying patients and their families. Palliative care chaplains frequently attend medical rounds, assist with goals of care discussions, and aid patients experiencing spiritual distress. (BoR 04; Reaffirmed as amended BoR 11, reaffirmed as amended BoR 19)

Advance Care Planning

Advance care planning allows a person with decision-making capacity to develop and indicate preferences for treatment 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 for 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 whether the patient has an advance directive, to provide information about advance directives, and to incorporate them 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 durable powers of attorney for health care. The latter enables a patient to appoint a surrogate to make treatment 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 adhere strictly to their expressed wishes. Others, however, want their surrogates to have flexibility in decision making. 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, for example 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. 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, as interpreted by a guardian or a person with personal 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. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

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, reaffirmed BoR 22)

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

Physicians may want to provide care for themselves, or from time to time be asked to provide medical care to a family member or others with whom the physician has a close nonprofessional relationship or an employee or supervisor with whom there is a reporting 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 or himself, without which ordering diagnostic tests, medications, or other treatments is ill-advised.

Regarding people with whom the physician has a significant preexisting, nonprofessional relationship, such as family members and close friends, and regarding employees or supervisors, the relationship necessarily adds another layer that may complicate what would become the professional patient–physician relationship. While the patient may feel unduly restrained in making choices, or inhibited in speaking about certain matters or in rejecting physician recommendations, the physician may be unduly impaired in maintaining clinical objectivity; inadequate history-taking or physical examination, overtesting, inappropriate prescribing, incomplete counseling on sensitive issues, or failure to keep appropriate medical records are also potential issues. The needs of the patient may not fall within the physician's area of expertise, and emotional proximity may result in difficulties for the patient and/or the physician. A physician in these circumstances, however, could serve as an advisor or medical interpreter 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 or contacts to refer the person to another physician.

Given the complexity and possible risks, physicians should usually not enter into these dual relationships. If they do assume such care after weighing concerns, all possible alternatives, and seeking counsel from colleagues, they should do so with the same comprehensive diligence and careful documentation as exercised with any other patient. 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 very important persons (VIPs) poses different challenges. The physician should avoid the tendency to skip over sensitive portions of the relevant medical history or physical examination. As with other patients, 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 the Confidentiality section). The social standing of a VIP should not negatively affect the physician's responsibilities toward other patients. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

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, patient portals, e-mail, texting, 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.

Privacy is freedom from unauthorized intrusion. 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. The commitment to confidentiality is based on the duty of nonmaleficence and on respect for persons and autonomy.

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 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) (23, 24). 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, including 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 can impair 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 person's health without his or her explicit consent.

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 (25). Physicians should be knowledgeable about challenges to confidentiality (26), 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 (27). 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, reaffirmed as amended BoR 19)

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 or nontreatment, and probable outcomes. This information often includes the burdens of treatment, the experience of the proposed clinician, the nature of the illness, and potential treatments and costs.

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.

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. 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. 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.

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, Reaffirmed as amended BoR 19)

Informed Decision Making and Consent

Truly informed decision making is patient-centered. 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. Decision aids may be useful supplements. 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 any reservations about a particular recommendation. The question to the patient, “What questions do you have?” may be more respectful and useful than the question, “Do you have any questions?” 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.

If the patient has designated a proxy, as through a durable power of attorney for health care, that choice should be respected. In the absence of a formal appointment of a health care agent, 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 (see also the Advance Care Planning section in Care of Patients Near the End of Life).

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, Reaffirmed as amended BoR 19)

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. 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. 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, Reaffirmed as amended BoR 19)

Complementary and Integrative Care

Complementary and integrative health involves bringing health care approaches developed outside of mainstream Western medicine to conventional approaches to health. Folk healing practices are also common in many cultures. In 2012, 33% of U.S. adults reported using complementary and integrative approaches, and out-of-pocket spending for complementary health approaches represented 9.2% of all out-of-pocket spending on health care and 1.1% of total health care spending.

Patients may value the differing approaches of Western medicine, with its scientific basis, and complementary medicine. 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 complementary approaches, physicians should ask patients about their current practices 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. 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 and patient should be aware of the potential impact of complementary medicine on the patient's care. Interactions between complementary therapies and conventional medications are common and should be discussed with patients. Physicians should not dismiss complementary approaches to medical care because it may impair communication and the therapeutic relationship with patients. The patient's decision to select alternative forms of treatment should not alone be cause to sever the patient–physician relationship. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

The Physician's Relationship to Other Clinicians

Physicians share their commitment to care for ill persons with an interdisciplinary team of health professionals. The team's ability to care effectively for the patient depends on the ability of the individuals on the team to treat each other with integrity, honesty, and respect in daily professional interactions regardless of race, religion, ethnicity, nationality, sex, gender identity, sexual orientation, age, or disability. Particular attention is warranted with regard to certain types of relationships and power imbalances, such as those between attending physician and resident, senior resident and intern, resident and medical student, or physician and nurse, and the potential for abusive or disruptive behavior or harassment (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed with edits BoR 19)

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 additional expertise. 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, while taking the time to answer additional questions. The care of the patient should be transferred back to the principal physician with timely communication and documentation 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 ensure 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.

The patient-centered medical home model promotes whole-person, patient-centered, integrated care across the health care system and has the 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 in serving the patient. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

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 medical or mental health condition, the aging process (134), 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. The identifying physician may find it helpful and prudent to seek counsel from a designated institutional or practice 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 about whom one has a reasonable concern regarding impaired medical judgment or practice 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. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended

BoR 19)

Professionalism

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head," said William Osler. Medicine is not, as Francis Peabody said, "a trade to be learned, but a profession to be entered". 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, in medicine, puts patient care above self-interest; and by the privilege of self-regulation granted by society. Physicians must individually and collectively fulfill the duties of the profession. The ethical foundations of the profession must remain in sharp focus despite outside influences on medicine, individuals. and the patient–physician relationship. (BoR 11, reaffirmed with edits BoR 19)

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 appropriate measures to relieve distress are used, and explain the physician's ethical obligation not to impose unwanted treatment on the patient. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

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 documented in the medical record along with notes and orders that describe all other changes in the treatment goals or plans, enabling the entire health care team to understand and act in accord with that plan. A DNR order does not mean that the patient is ineligible for other potentially life-prolonging

measures, therapeutic and palliative. Because they are deceptive, half-hearted resuscitation efforts ("slow codes") should not be performed.

A patient who is a candidate for intubation but declines will develop respiratory failure and is expected to experience cardiac 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. This 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. 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, Reaffirmed with edits BoR 19)

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, Reaffirmed BoR 19)

Solid Organ Transplantation

All patients should be encouraged to communicate their preference for or against organ donation to their families as well as have it listed on such documents as advance directives, driver's licenses, or organ donor cards. 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.

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. 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.

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 related to treating humans as commodities and the potential for exploitation of vulnerable individuals and families. Even the appearance of exploitation may ultimately be counterproductive to the goal of increasing the pool of organs.

Before declaration of brain death, treatments or interventions proposed to maintain the function of transplantable organs may be used only if they are not expected to harm the potential donor. 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.

A particular set of issues has been raised by the advent of “donation after circulatory 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 after circulatory death 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 or interventions aimed at preserving organs or assessing their suitability 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, Reaffirmed as amended BoR 19)

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; reaffirmed BoR 19)

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 (81). Before making ethical judgments about appropriate care, it is critical that qualified clinicians provide diagnostic clarity in determining the patient's brain state (82). 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, Reaffirmed with edits BoR 19)

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 artificial nutrition or hydration. Physicians should counsel patients desiring to forgo artificial nutrition and hydration under some circumstances to include this in an advance directive. Despite research to the contrary, concerns remain that discontinuing feeding tubes will cause suffering from hunger or thirst (74). 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 the patient's care. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed with edits BoR 19)

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 retainerfee.
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. Section 1557 of the Affordable Care Act added additional requirements to existing federal law that support patients with LEP's legal right to access health care in their preferred language. The ACA requires that physicians that receive federal funds must use qualified medical interpreters when treating LEP patients. 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. Federally-funded insurance programs should reimburse clinicians for the added expense of language services including face-to-face, telephonic and video remote interpreting, 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; revised BoR 19)

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; reaffirmed BoR 19)

Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms

Putting Patients First

1. The American College of Physicians recommends that value must always be defined with patients and families at the center, fully empowered to be active partners in all aspects of their care.

Creating Transparency to Inform Shared Decision Making

2. The American College of Physicians recommends that all patients, families, and caregivers and their clinical care teams be provided with transparent, understandable, actionable, and evidence-based quality, cost, and price information to meaningfully compare medical services, facilities, and products.

HEALTH CARE SYSTEM REFORM

Effect of Financial Profit in Medicine

1. The ACP believes that more research is needed to assess the influence of for-profit companies and corporate influence in the health care market. Research should consider the impact on patients, the patient-physician relationship, universal access to affordable care, and on innovation and market competition and choice. The ACP believes that in the interim, as more research is being conducted, steps should be taken to provide oversight of further conversion of non-profit systems to for-profit ones, require transparency and accountability, and ensure patients' interests are paramount over maximizing profit.
2. The ACP affirms support for policies and actions that foster the patient-physician relationship, including:
    a. Payment and delivery system reforms that allow the physician sufficient time and resources to care for patients, supports physician-led clinical care teams, recognizes and supports the value of primary and comprehensive care, eliminates payment disparities, and aligns incentives with what is best for patients, as proposed in ACP's paper, *Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms (**Error! Bookmark not defined.**)*.
    b. Expansion of evidence-based patient-centered shared decision-making tools to ensure patients receive the right care at the right time;
    c. Mandatory price and quality transparency as proposed in ACP's papers *Envisioning a Better U.S. Health Care System for All: Coverage and Cost (**Error! Bookmark not defined.**)* and in *Improving Health Care Efficacy and Efficiency Through Increased Transparency ([i]).*
    d. Effective policy to end "surprise billing" practices in a way that does not give insurers excessive power to unilaterally set prices;

e. Programs that encourage shared decision-making, effective communication, and clinically appropriate care and referrals;
f. Eliminate or require public transparency of financial conflicts of interest;
g. Providing all Americans with access to comprehensive health care coverage, either through a public choice model or single payer model, as recommended by ACP in *Envisioning a Better U.S. Health Care System for All: Coverage and Cost (**Error! Bookmark not defined.**).*

3. The ACP recommends that non-profit hospitals be required to provide measurable benefits to the community in exchange for their non-profit status, with accountability, transparency and strict enforcement of regulatory standards for non-profit status.
    a. Hospital community benefit spending should be sufficient and in line with the value of its tax exemption.
    b. Non-profit hospitals should consider addressing social determinants of health and population health as part of their community benefit requirement. Hospitals should work with other local health care facilities, health departments, and other relevant stakeholders to identify and coordinate efforts to address social determinants of health and improve population health.
    c. The federal government should enhance transparency by creating a publicly accessible database of hospital community investment data.
    d. Non-profit hospitals that fail to meet requirements for providing measurable benefits to their communities should have their non-profit status revoked. Requirements for providing measurable benefits must be transparent to hospitals, clinicians and the public; be clearly defined in advance; be subject to public comment; be reasonable, actionable and attainable; and provide sufficient opportunity for hospitals to make improvements and correct any substantiated deficiencies before their non-profit status would be subject to potential revocation. Hospitals should have an opportunity to appeal any finding that could lead to revocation and have an opportunity to agree on a plan for necessary changes before revocation would be invoked.
4. The ACP recommends that all Medicare-participating hospitals, regardless of tax-exempt status, should be required to adopt uniform fair pricing, billing, and collection policies. For-profit hospitals should be required to implement comprehensive financial assistance policies.
5. The ACP recommends longitudinal research on the effect of private equity investment on physicians' clinical decision-making, health care prices, access, and patient care, including the characteristics of models that may have adverse impacts on the quality and cost of care and the patient-physician relationship, and the characteristics of models that may have positive impacts on the quality and cost of care and the patient-physician relationship.
    a. ACP supports transparency regarding corporate and private equity investment in the health care industry.
    b. Policymakers and regulators should provide oversight of private equity activity to prevent practices like unwarranted self-referral, overreliance on non-physician health care professionals, or consolidation that results in uncompetitive markets.

6. ACP recommends that lawmakers and regulators carefully scrutinize in advance all mergers, acquisitions, and buy-outs, and involving health care entities, including insurers, pharmacy chains, physician groups and hospitals. The appropriate public representative (for example, federal or state attorney general, trade regulator, insurance commissioner) should evaluate the potential effect on the communities served, competition, health care prices, insurance premiums, innovation, and access to physicians.
7. In order to protect the general public in regard to for–profit conversion of health insurers, ACP reaffirms support for requiring state government officials (including attorneys general and insurance commissioners) oversee all insurer conversions (including conversions to mutual benefit organizations).
    a. Sufficient public notice and public hearings must be provided before the conversion is approved.
    b. There should be a mandatory and independent appraisal of insurer assets prior to conversion approval.
    c. Any charitable foundation established by the converting insurer should be subject to public comment and reflect the original mission of the non-profit organization; requiring that the charitable foundation's board of directors be unaffiliated with the converting entity, have experience related to the mission of the foundation, and include community and physician representatives where applicable. (BoR 21)

Improving the Patient Protection and Affordable Care Act's Insurance Coverage Provisions

1. Immediate efforts are necessary to strengthen the Patient Protection and Affordable Care Act (ACA) and prepare for transformational reform of the nation's health care system that will achieve truly universal health coverage.
2. The eligibility requirements for premium tax credits and cost sharing should be redesigned to enhance individual market insurance affordability. Specifically, the 400% federal poverty level premium tax credit eligibility cap should be eliminated, and the amount of premium tax credits for all income levels should be enhanced.
3. The federal government should stabilize the marketplace by establishing a permanent reinsurance program. The federal government should not prohibit the practice of "silver loading," where insurers raise silver-tier plan premiums to an amount equal to what they would have received if cost-sharing reduction reimbursements were distributed. Also, steps should be taken by federal and state regulators to limit the sale of individual market plans that do not comply with ACA regulations, including extended short-term, limited-duration plans; association health plans; and "grandmothered" off-marketplace plans.
4. Sustained funding is needed for dedicated outreach, consumer assistance, and education to promote open enrollment, provide in-person and virtual enrollment assistance, and respond to inquiries from the community.
5. Federal and/or state governments should ensure that all individuals enroll in coverage by developing an auto-enrollment program, a penalty for failing to enroll upon eligibility, an individual mandate, or some combination of these approaches. Exemptions for financial hardship and residing in a non–Medicaid expansion state, among others, should be applied.
6. The American College of Physicians reaffirms support for Medicaid expansion. All states should fully expand Medicaid eligibility and should not apply financially burdensome premiums or cost-sharing requirements, lock-out periods, benefit cuts, or mandatory work or community engagement policies that have the effect of reducing enrollment among vulnerable individuals.

7. To encourage market competition, Congress should enact legislation to authorize the development of a public insurance plan to ensure enrollees have access to a variety of coverage options in their area. Potentially, the public option could be expanded to serve as a stepping stone to universal coverage. (BoR 18)

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 DeliveryModels

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, reaffirmed BoR 22)

Achieving Affordable Health Insurance Coverage for All

ACP believes that Congress should preserve and improve on policies, many of which are included in the Affordable Care Act, that expand coverage and protections for persons with preexisting conditions. Congress should also consider making improvements to the ACA to make coverage more available and affordable, and consider other approaches to achieve universal coverage.

1. The federal government should continue to 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 continue to have the option to expand Medicaid coverage to all residents up to 138% 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 continue to be made available to uninsured working Americans with incomes up to 400% of the federal poverty level. Congress should also consider

eliminating the 400% cap in current law (ACA) to allow income adjusted subsidies to all persons as well as enhancing the amount of premium tax credits for all income levels.

4. Small employers who offer coverage to their employees should have access to tax credits to aid in the purchase of qualified health insurance designed for small businesses.

5. 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.

6. All health plans should be required to include a core set of evidence-based benefits. (BoR 08; reaffirmed BoR 19)

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. 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.

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: 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,

even as it considers new federal policies to provide universal health insurance coverage to all people within the United States without unreasonable financial barriers, with coverage and benefits that are continuous and not dependent on place of residence or employment.

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. Cost sharing structure should follow the recommendations made in the ACP position paper Addressing the Increasing Burden of Health Insurance Cost Sharing.

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

Recommendation 7: 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; reaffirmed BoR 19)

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 BoR15)

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 BoR17)

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. Potential future and downstream cost savings
    d. Safety
    e. Societal priorities that include fiscal responsibility and equitable access
    f. Quality of life gained, consistent and compliant with the Americans with Disabilities Act
    g. Public health benefit
    h. Impact on families and caregivers
    i. Addressing disparities that disproportionately impact a specific population
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. 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, revised BoR 22)

Improving Health Care Efficacy and Efficiency Through Increased Transparency

1. ACP supports transparency of reliable and valid price information, expected out-of-pocket costs, and quality data that allows consumers, physicians, payers, and other stakeholders to compare and assess medical services and products in a meaningful way. ACP reaffirms the position that “price should

never be used as the sole criterion for choosing a physician, other health care professional, or health care service."

2. Health plans and health care facilities should clearly communicate to a consumer whether a provider or clinician is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer.
3. ACP recommends that payers, plans, and other health care organizations develop patient-targeted health care value decision-making tools that are written for patients at all levels of health literacy that make price, estimated out-of-pocket cost, and quality data available to consumers. This information should be communicated in an easy-to-understand way. Tools should aggregate price, cost, and quality information on health care services and treatments, including prescription drugs. Health care comparison tools should include the following components:
    a. Total estimated price of the medical service or treatment both in-network and out-of-network;
    b. A personalized estimate of the patient's potential out-of pocket cost for the medical service both in-network and out-of-network;
    c. All services provided within the estimate;
    d. Availability to search or compare by CPT code;
    e. Assistance to consumers in identifying potentially unnecessary or avoidable procedures or medical services;
    f. Quality or outcomes data for the medical service or treatment alongside price information;
    g. Data updated in a timely manner.
4. ACP supports legislative action at the state level to require private and public health plans to submit data in a standardized manner to an all payer claims database (APCD).
5. APCDs should be set up for future expansion to other relevant sources of information, such as sources of vital statistics, data contained in regional health information exchanges, or data compiled in quality clinical data repositories (QCDRs).
6. ACP supports legislation at the state level to prohibit "gag clauses" and similar contractual arrangements that interfere in the transparency of relevant healthcare data.
7. ACP supports federal grants or similar incentives to states for the development of APCDs.
8. ACP supports efforts to provide greater protections for patients from unexpected out-of-network health care costs, particularly for costs incurred during an emergency situation or medical situation in which additional services are provided by out-of-network clinicians without the patient's prior knowledge. While the College reaffirms the right of physicians to establish their own fees and to choose whether to participate as an in-network provider, ACP supports establishing processes to reduce the risk for "surprise" bills for out-of-network services for which a patient was unable to obtain estimates for services prior to receipt of care or was not given the option to select an in-network clinician. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care.
9. Efforts to reduce the negative impact of surprise billing should be at the state and federal levels. Legislation aiming to limit surprise billing should, at a minimum, include one or more of the following components:
    a. Support for increased pricing and out-of-pocket cost transparency;
    b. Dispute resolution process;
    c. Assessment of economic impact on patients, providers, and payers. (BoR 17)

Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care –
Universal Coverage

1. The American College of Physicians recommends that the United States transition to asystem that achieves universal coverage with essential benefits and lower administrative costs. -
    a. Coverage should not be dependent on a person's place of residence, employment, health status, or income.
    b. Coverage should ensure sufficient access to clinicians, hospitals, and other sources of care.
    c. Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance.
2. The American College of Physicians recommends that under either a single-payer or public choice model, coverage must include an essential health care benefit package that emphasizes high-value care, preferably based on recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise.

The Role of Cost Sharing and Premiums

3. The American College of Physicians believes that, whether a single-payer or public choice model, cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses. In general, when cost sharing is required for some services, it should be income-adjusted through a subsidy mechanism and subject to annual and lifetime out-of-pocket limits. In a public choice model, premiums should be income adjusted and capped at a percentage of annual income.

Payments and Availability of Health Care Services

4. The American College of Physicians recommends that that in either a single-payer or public choice model, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods.
    a. Current Medicare payment rates generally are insufficient to achieve the objectives of universal coverage.
    b. Physician payment policies must ensure robust participation and not undervalue primary care and cognitive services, including the primary, preventive, and comprehensive care provided by internal medicine physician specialists.

Mandatory Versus Voluntary Coverage

5. The American College of Physicians believes that an automatic and mandatory enrollment mechanism should be developed under either a single-payer or public choice option system. In a public choice system, employers should be required to offer comprehensive coverage to their employees (and families) that is at least as generous as the public insurance option or pay a portion of the cost of their employees' public insurance plan coverage (that is, “pay or play”).

Administrative Requirements and Costs

6. The American College of Physicians believes that relief from health care system administrative requirements should be a priority under either a single-payer or public choice model. Tothe

furthest extent possible, billing and quality measure reporting should be standardized and streamlined.

Financing of Coverage and Treatment of Special Populations

7. The American College of Physicians recommends that a single-payer or public choice model be financed through government spending, employer contributions, progressive taxes on income, tobacco and alcohol excise taxes, value-based cost sharing, reallocation of savings from reduced spending on administration, and system-wide savings and efficiencies described in this paper.
    a. Health care programs that serve special populations, including the Veterans Health Administration, Medicaid long-term services and supports, and Indian Health Service, should continue to operate alongside the new program.

ACP Policy Positions and Recommendations: Investing in Primary and Comprehensive Care

8. The American College of Physicians supports greater investment in primary care and preventive health services, including support for the unique role played by internal medicine specialists in providing high-value primary, preventive, and comprehensive care of adult patients. (BoR 19)

Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms

Building the Bridge to More Complete Value-Based Transformation

3. The American College of Physicians recommends that health care delivery and payment be redesigned to support physician-led, team-based care delivery models in providing effective, patient- and family-centered care.
4. The American College of Physicians believes there is not a one-size-fits-all approach to reforming delivery and payment systems to increase value, and a variety of approaches should be considered, evaluated, and expanded.
5. The American College of Physicians recommends that payers prioritize inclusion of underserved patient populations in all value-based payment models.

Supporting Primary and Comprehensive Care and the Role of Internal Medicine Specialists

6. The American College of Physicians recommends that all payment systems substantially increase relative and absolute payments for primary care commensurate with its value in achieving better outcomes and lower costs. Inappropriate disparities in payment levels between complex cognitive care and preventive services, relative to procedurally oriented services, should be eliminated.

Reducing Administrative Complexity and Burden

7. The American College of Physicians recommends the immediate elimination of unnecessary, inefficient, and ineffective billing and reporting requirements for all health care services, as well as reducing administrative barriers to appropriately paying for and valuing non–face-to-face–based care, such as care management.
8. The American College of Physicians believes that value-based payment reform initiatives should increase flexibility and freedom from billing, reporting, and other administrative burdens in exchange for holding physicians and clinical care teams accountable for quality and cost outcomes.

Improving Quality Measurement Accuracy and Effectiveness

9. The American College of Physicians recommends that performance measures and measurement methodologies, when tied to public reporting and payment, be aligned across payers, models,

and programs whenever possible.

10. The American College of Physicians recommends that value-based payment programs move away from “check the box” performance requirements toward a limited set of patient-centered, actionable, appropriately attributed, and evidence-based measures for public reporting and payment purposes, while also supporting the use of additional clinically meaningful measures for internal quality improvement.
11. The American College of Physicians recommends that all performance targets be provided to physicians and their clinical care teams in a prospective and transparent manner and that all performance feedback be accurate, actionable, and timely.
12. The American College of Physicians calls for a collaborative, multistakeholder measure development and maintenance process that features upfront, ongoing, and transparent input from patients and frontline physicians and their clinical care teams.
13. The American College of Physicians recommends that the performance measurement infrastructure evolve into one that supports, with policy that prioritizes, what is important to measure and evaluates and continually improves upon the science of and methodologies for performance measurement. (BoR 19)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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.”

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. 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. 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 practices
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 polices 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 formal standards and certification criteria as well as the annual directional statements published by the Office of the National Coordinator for Health Information Technology 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; revised BoR 19)

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 development of standards of Health IT that address interoperability, functionality, security, data aggregation, privacy, content, and legal liability by multi-stakeholder groups

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.

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; revised BoR 19)

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)

Controlling Health Care Costs: Enhance Use of Health Information Technology

1. Payment policies should create incentives for physicians and other health professionals and providers to use health information technologies that have the functions and capabilities needed to improve clinical decision-making at the point of care, including functions designed to support care consistent with evidence-based guidelines, care coordination, and preventive and patient-centered care.
2. Technical support, training, and funding should be provided to help primary care practices, especially smaller ones, acquire health information technologies that have the functions needed to become Patient-Centered Medical Homes (PCMHs). **(**BoR 09)

Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms

Redesign Health IT to Enhance the Patient–Physician Relationship and Improve Patient Care

14. The American College of Physicians recommends that improvements to health IT usability should prioritize the needs of patients and frontline physicians and their clinical care teams, strive to remove non–value-added interactions, and support value-based payment reform initiatives.
15. The American College of Physicians calls for interoperability efforts to be focused on the adoption and consistent implementation of health IT standards irrespective of the health IT system or digital technology.
16. The American College of Physicians believes that the testing and subsequent implementation of health IT standards and interoperability rules should be conducted in stages to avoid and/or mitigate adverse effects on patient care, privacy, security, clinical workflow, and data visualization and interpretation.
17. The American College of Physicians recommends that stakeholders support the development, adoption and use of innovative technologies that seamlessly enable enhanced and coordinated patient-centered care. (BoR 19)

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, reaffirmed BoR 22)

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)

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, reaffirmed BoR 22)

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 so that 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, reaffirmed BoR 22)

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.

    a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.

    b. 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 race, ethnic, religious, gender, sexual orientation, cultural identity, or demographic differences. (BoR 11, revised BoR 22)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

Public Plan Option

1. ACP could provide conditional support to a health insurance exchange (or "marketplace") 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 health 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 an essential health benefits package that emphasizes preventive, high-value care, preferably based on recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and other experts.
   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. 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.
   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.

3. Recommendation 4 – To mitigate conflict of interest, the health insurance exchange and the public plan option should be managed by independent entities. (BoR 10, reaffirmed with edits BoR 22)

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, comprehensive, 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, revised BoR 22)

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, reaffirm BoR 22)

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.

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. (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)

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)

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 achieving universal coverage with essential benefits and lower administrative costs. Coverage should not be dependent on a person's place of residence, employment, health status, or income; should ensure sufficient access to clinicians, hospitals, and other sources of care. Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance.
2. Achieving affordable coverage for all Americans will require that an automatic and mandatory enrollment mechanisms be established to enroll individuals who otherwise might voluntarily choose not to obtain coverage to participate in the coverage program. 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, identifying funding sources, and reducing barriers to access and quality, provided that such state-based approaches contribute to the overall goal of providing legal residents with access to affordable coverage, subject to national standards to assure portability and access to the essential 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, revised BoR 22)

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, reaffirmed BoR 22)

Requiring 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 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, revised BoR 22)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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, reaffirmed BoR 22)

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)

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, reaffirmed BoR 22)

Addressing the Increasing Burden of Health Insurance Cost Sharing

1. To help contain health insurance premiums and cost sharing, the health care system must accelerate

its efforts to reduce overall health care spending in ways that do not rely principally on shifting the cost burden onto insured persons who cannot afford to pay more for their medical care. Among the ways that health care spending may be curbed without imposing excessive costs on insured persons include:

a. Reforming the way health care is paid for and delivered and encouraging value-oriented rather than volume-based care;
b. Promoting team-based care that emphasizes prevention as well as cooperation and coordination among physicians, hospitals, and other health care professionals;
c. Enhancing the transparency of price and quality data so that patients, employers, and payers are better informed about the actual costs and quality of health care services;
d. Allocating resources with a focus on medical efficacy, clinical effectiveness, and need, with consideration of cost based on best available medical evidence to ensure that limited health care resources are directed to cost-effective services.

2. To encourage use of high-value health care, employer-sponsored health plans should:
   a. Consider implementing value-based insurance design strategies that reduce or eliminate out-of-pocket contributions for services proven to offer the greatest comparative benefit, with higher cost-sharing for services with less comparative benefit. Such strategies should be based on rigorous comparative effectiveness research by independent and trusted entities that do not have a financial interest in the results of the research. The goal should be to ensure that high-value cost-sharing strategies encourage enrollees to seek items and services proven to be of exceptional quality and effectiveness and not just on the basis of low cost;
   b. Consider implementing income-adjusted cost-sharing approaches that reduce or directly subsidize the expected out-of-pocket contribution of lower-income workers to avoid creating a barrier to their obtaining needed care.
3. Cost-sharing provisions under the Patient Protection and Affordable Care Act should be improved by:
   a. Expanding eligibility for qualified health plan premium tax credits and cost-sharing subsidies for families unable to afford employer sponsored insurance (elimination of the “family glitch”);
   b. Enhancing the affordability of marketplace-based qualified health plans by expanding cost-sharing assistance eligibility, increasing premium tax credits and cost-sharing subsidies, and eliminating the premium cap indexing policy.
4. Stakeholders must work together to enhance health insurance literacy and promote better, more accessible, and objective information about cost-sharing requirements and health insurance plan design.
   a. Federal and state governments, navigators and other assisters, community and health professional organizations, health insurers, and other stakeholders must educate enrollees about the availability of premium tax credits, cost-sharing subsidies, and free or low-cost preventive care and why it is important. Efforts must be made to educate enrollees about value-based cost sharing.
5. A large-scale demonstration should be implemented to test the short- and long-term effects of cost sharing in different populations. (Bor 16)

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.

   The commission must assure appropriate distribution of the physician workforce. This would likely require significant increase in rural and inner-city areas.

7. 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.
8. 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.
9. 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.
10. 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.
11. 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)

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, Reaffirmed BoR 22)

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. (BoR 13, Reaffirmed BoR 19)

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)

Compensation Equity and Transparency in the Field of Medicine

1. The American College of Physicians believes that physician compensation (including pay, benefits, clinical and administrative support, clinical schedules, institutional responsibilities, and where appropriate, lab space and support for researchers, etc), should be equitable; based on comparable work at each stage of their professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on characteristics of personal identity, including, but not limited to, race, gender, religion, nationality, sexual orientation, and gender identity.
2. Transparency is needed in physician compensation arrangements to ensure that physicians regardless of characteristics of personal identity are paid equitably for comparable work.
3. The American College of Physicians supports the study, development, promotion, and implementation of policies and salary reporting practices that reduce pay disparities and bring transparency to physician salaries in a manner that protects the personal privacy of individual physicians.
4. Further research is needed to identify the adverse effects that one's characteristics of personal

identity have on physician pay, with resultant effect on well-being and burnout, and how those affect the strength of the medical workforce. This includes additional collection of data and inclusion of protected personal characteristics as part of collected data. (BoR 17)

Achieving Gender Equity in Physician Compensation and Career Advancement

1. ACP affirms that physician compensation (including pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and support for researchers) should be equitable; based on comparable work at each stage of physicians' professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on characteristics of personal identity, including gender. Physicians should not be penalized for working less than full-time.

2. ACP supports transparency and routine assessment of the equity of physician compensation arrangements by all organizations that employ physicians.

3. ACP supports the goal of universal access to family and medical leave policies that provide a minimum 6 weeks of paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal. Such legislation should include minimum paid leave standards and dedicated funding to help employers provide such leave. Paid leave policies should ensure that all employees have increased flexibility to care for family members, including children, spouses, partners, parents, parents-in-law, and grandparents.

a. ACP opposes discrimination on the basis of reproductive status, for those who choose to have children biologically or via adoption and for those who choose not to have children.

b. Family and medical leave and paid leave policies should be a standard part of physicians' benefit packages, regardless of gender.

c. Residency and fellowship programs, academic medical centers, community hospitals, and physician practices should develop and implement paid leave policies to provide compensation to eligible male and female physicians and trainees for a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

d. Medical schools and residency and fellowship training programs should publish and distribute their family and medical leave policies to all applicants.

e. Accrediting bodies for medical education and training should establish policies regarding family and medical leave for students and trainees, supporting a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

f. Medical specialty boards should be flexible in their requirements for board eligibility in circumstances when trainees took family or medical leave.

4. ACP supports the provision of programs in leadership development, negotiation, and career development for all physicians and physicians-in-training.

5. ACP supports the provision of regular and recurring implicit bias training by all organizations that employ physicians. Organizational policies and procedures should be implemented that address implicit bias.

6. Academic institutions, health care organizations, physician private practice groups, and professional physician membership organizations should take steps to increase the number of women in practice, faculty, and leadership positions and structure equal access to opportunities, including:

a. Encouraging mentorship and sponsorship and providing training for faculty on how to be effective mentors and sponsors.

b. Coaching and development programs.

c. Flexibility in structuring career paths in academic medicine, health systems, and private practice and adopting flexible promotion and advancement criteria, including promotion tracks that reflect the wide range of responsibilities and unique contributions of female physicians.

d. Requiring the inclusion of female physicians as job candidates and members of search committees.

e. Ensuring diversity, including gender diversity, on all committees, councils, and boards through leadership development to ensure inclusion, comprehensiveness, and mechanisms for accountability.

7. Further research is needed on the reasons for and effect of gender pay inequity and barriers to career advancement and the best practices to close these gaps across all practice settings.

8. ACP opposes harassment, discrimination, and retaliation of any form based on characteristics of personal identity, including gender, in the medical profession. (BoR 18)

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; reaffirmed BoR 19)
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, reaffirmed BoR 21)

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. Additional research is necessary to examine the impact of CON programs on costs and competition, particularly in markets with high rates of consolidation. (BoR 09, revised BoR 22)

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)

HOSPITAL: 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, reaffirmed BoR 22)

IMMIGRATION

Increasing Access to Healthcare for Non-Detained Asylum Seekers Living in the United States

1. ACP supports efforts to provide medical care, including primary care, treatment for chronic diseases, vaccinations, and medications, to non-detained asylum seekers, as well as financial support for community health centers, safety-net hospitals, and other settings that serve a disproportionate number of immigrants.
2. ACP recommends that asylum seekers receive health screenings, medical care, and vaccinations upon applying for asylum in the United States. Care for asylum seekers should be trauma-informed, linguistically and culturally appropriate. Translation services should be made available.
3. Immigration officials should be required to return seized prescribed medications and medical equipment to asylum seekers upon release from detention. Medical records of non-detained asylum seekers should be made available to physicians and other health care professionals.
4. ACP supports research into the medical needs of non-detained asylum seekers living in the United States as well as their current access to medical care, the health effects of detention versus non-detention for asylum seekers, and alternatives to detention that connect asylum seekers to health care, legal, and other services. (BoR 22)

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)

The Health Impact of Family Detentions in Immigration Cases

1. The American College of Physicians continues to strongly oppose the separation of children from their families in immigration cases because of the immediate and long-term health impacts on them, and calls for immediate re-unification of those that have been separated.
2. ACP believes that forced family detention—indefinitely holding children and their parents, or children and their other primary adult family caregivers, in government detention centers until the adults' immigration status is resolved—can be expected to result in considerable adverse harm to the detained children and other family members, including physical and mental health, that may follow them through their entire lives, and accordingly should not be implemented by the U.S. government. ACP concurs with the position of the American Academy of Pediatrics that separation of a parent or primary caregiver from his or her children should never occur, unless there are concerns for safety of the child at the hand of a parent, primary family caregiver, or other adults accompanying them; efforts should always be made to ensure that children separated from other relatives are able to maintain contact with them during detention; and community-based alternatives to detention should be implemented to offer opportunities to respond to families' needs in the community as their immigration cases proceed.
3. In every immigration policy decision affecting children and families, government decision-makers should prioritize the best health interests of the child and of the entire family. (ECBOR 18)

Genetic Testing and Reuniting Families

Reuniting families who have been separated at the US border should proceed as expeditiously as possible but if it involves medical testing, testing should be done in the least intrusive manner; safeguard health and other information; and be a last resort means of identification. What testing is being done and why should be understandable to the individual (adult and child).

Government agencies and any other involved entities should not use the individual's samples or information beyond what is needed for prompt family reunification, nor should samples or information be stored in databases or otherwise. As HHS Assistant Secretary for Preparedness and Response Jonathan White has said, test results should be "solely used to accurately connect parents with children."

Genetic testing raises ethical issues and yields health and other results not only about an individual, but about entire families and ancestry. Commercial genetic testing can entail analysis of hundreds of thousands of parts of the human genome. In these circumstances of reuniting families, broad genetic testing is intrusive and likely unnecessary. It also raises significant privacy risks and can take extended time to generate results. If medical testing is needed to assist matching parent and child, rapid DNA fingerprinting paternity/maternity tests that give results in hours and that do not generate additional genetic information beyond paternity/maternity could be utilized. Testing of a broader scope, with safeguards, should only proceed if there are no other reasonable alternatives. When medical tests are used, informed consent and privacy issues must be addressed. (ECBOR 18)

National Immigration Policy and Access to Health Care

Access to Care

4. 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.
5. 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.
6. 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

7. 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.
8. 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

9. 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.
10. 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 ofthem
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, reaffirmed BoR 22)

INDIGENOUS HEALTH

1. ACP believes community-driven public policy, developed under the leadership of Indigenous leaders and built on existing resilience, is necessary to remedy the injustices, disparities, and inequities experienced by Indigenous individuals and communities. Public policy must acknowledge the long history of racism, discrimination, abuse, forced relocation, destruction of elements of social structure, and other injustices experienced by Indigenous people.
2. ACP supports prioritizing health and wellness pro-motion, chronic disease prevention, and other public health interventions addressing morbidities with high incidence in Indigenous communities that are developed by or in collab-oration with Indigenous peoples and medical experts, evidence-based and evidence-informed, culture optimizing, and respectful of traditional values, beliefs, and practices. ACP calls for the collection of high-quality, disaggregated data and research reflecting the unique experiences and conditions of tribes to facilitate targeted and timely action to address disparities and other issues
3. ACP recommends policymakers team with Indigenous leaders to address the full range of underlying social drivers of health associated with disproportionately high rates of poverty experienced by Indigenous people. ACP believes that any such approach should reflect the varying circumstances of Indigenous individuals living on and off tribal lands in both rural and urban environments, account for geographic and tribal differences, and respect cultural values.
4. ACP believes a multidisciplinary approach, developed by Indigenous peoples in collaboration with other experts in the field, is necessary to implement culturally appropriate interventions to address the

underlying drivers that exacerbate physical, mental, and behavioral health issues and contribute to catastrophic rates of suicide in Indigenous communities.

a. ACP recognizes the necessity of pride, honor, respect, and self-determination in the pursuit of self-care, optimal health, and wellness.

b. ACP supports efforts to increase access to mental and behavioral health care for underserved Indigenous communities.

c. ACP supports additional research into the causes of mental health issues and suicide in Indigenous communities, as well as effective individual- and community-level prevention and postvention strategies.

d. ACP supports efforts to understand protective fac-tors such as resilience and cultural, familial, and individual strengths as dimensions of good health and health care to be supported and replicated.

5. ACP believes a collaborative team of Indigenous leaders, substance use disorder experts, and policy experts should develop approaches to reducing risks for alcohol and other substance use disorders facing Indigenous communities. These approaches should support the pursuit of pride, honor, respect, and self-confidence through the implementation of evidence-based, culturally appropriate, and community-driven treatments.

6. ACP urges respectful, community-driven collaboration among relevant governments, agencies, and Indigenous leaders to develop plans to mitigate high rates of violence in Indigenous communities.

a. ACP supports ensuring sufficient funding and access to resources and programs providing health care, legal, housing, and advocacy services to meet the needs of Indigenous peoples and communities affected by violence.

b. ACP supports increased physician and trainee education around issues of violence and the medical needs of Indigenous individuals experiencing violence.

c. ACP supports government efforts to improve the quality of data collection and reporting of instances of violence experienced by Indigenous individuals.

d. ACP supports giving federally recognized tribes special domestic violence criminal jurisdiction for cases of sexual assault, stalking, trafficking, and other domestic violence crimes.

7. ACP recommends policymakers, in partnership and collaboration with Indigenous peoples and appropriate medical experts, should bolster and adequately investing the health infrastructure that serves Indigenous individuals to ensure equitable access to high-quality, modern, and state-of-the-art health care.

a. ACP believes models that provide comprehensive, integrated, culturally appropriate, affordable, and accessible care operated by tribes and Native organizations with federal financial support should be encouraged, supported, and expanded as appropriate. Practices adopted by Indigenous-led care models should inform policymaking to better serve the health needs of Indigenous people.

b. ACP believes funding levels for programs providing health care to Indigenous communities must be at least at parity with other federal health programs and should be increased to reflect the risk and complexity of the communities they serve.

c. ACP believes the Indian Health Service (IHS) should become a program with mandatory funding and be equipped with the resources necessary to provide equitable and adequate services to the populations it serves.

d. ACP supports the development and funding of an evidence-based strategy to address backlogs of care requests and the shortage of qualified physicians and other health professionals in IHS and in tribal and urban health centers.8. ACP supports actions to increase Indigenous representation in medical school student bodies and the medical workforce and recommends that efforts be taken by health care organizations, institutions, and medical schools to achieve these goals. ACP reaffirms the need for enhanced education at all levels, including health care career pathway programs to engage and connect Indigenous students and expose them to and advance their readiness for careers in medicine.

9. ACP supports the goal of achieving universal access to clean, running water for consumption and sanitation. ACP believes that funds must be made available to establish, repair, operate, and maintain water and sanitation services to improve public health.10. ACP calls for focused funding for community-supported policy interventions that improve access to high-quality, nutritious food appropriate to the cultural food traditions of Indigenous populations.

a. ACP believes efforts of Indigenous communities to sustainably provide food in their traditional ways, such as foraging, hunting, and cultivation, should be supported.

b. ACP believes programs providing food to Indigenous individuals residing both on and off tribal lands should be sufficiently and adequately funded.

c. ACP believes policymakers should integrate Indigenous foods into programs providing nutrition services to Indigenous populations.

d. ACP supports innovative models within federal nutrition assistance programs addressing social barriers to obtaining food, such as transportation and location.

11. ACP urges policymakers to center the principles of environmental justice and respect for tribal sovereignty when developing laws, proposing regulations, and considering applications for land use permits.

a. ACP believes public policy must recognize and rectify the negative impact that the loss of control of lands, materials, animal life, and plant life has had on traditional Indigenous ways of life.

b. ACP believes all individuals must receive fair treatment and equal protection from climate change and other environmental hazards impacting health.

c. ACP believes lawmakers must meaningfully consult and involve tribal authorities on decisions impacting tribal lands and natural resources relied on by Indigenous communities.

d. ACP believes government agencies must consider the impact on tribal land and resources, as well as respect closely held cultural and spiritual beliefs, when issuing regulations and permits impacting land and natural resources significant to Indigenous communities.

e. ACP supports the use of federal and state resources to mitigate environmental hazards posing a danger to public health, particularly those impacting the health and safety of Indigenous communities.

12. ACP supports providing financial and technical assistance for deploying and supporting affordable and robust broadband services in areas with limited availability to facilitate the provision of telehealth. (BoR 22)

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)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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

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)

Regulation of Credentialing and Licensure

1. Because a wide variety of attributes contribute to a physician's competence and quality of care, participation in programs for physician accountability such as maintenance of certification should not be an absolute prerequisite for licensure and credentialing. The primary determinants should be demonstrated performance for providing high quality, compassionate care and a commitment to continuous professional development. [Reaffirmation of current policy].
2. If participation in or successful completion in a specialty board's maintenance of certification is to be considered in the credentialing decisions by licensed hospitals/health systems, physician groups and other health care facilities, insurers (including for payment purposes and network participation), medical liability carriers and licensing boards themselves:

    a. it should never be the sole, principal, overriding, or absolute element to be considered,
    b. or be a requirement or prerequisite for such credentialing or reimbursement for medical services provided to patients;
    c. rather, such participation in or successful completion of maintenance of certification should be considered to be only one of a wide variety of attributes that contribute to a physician's competence and quality of care.

3. Enactment of state laws and regulations to regulate how specialty boards' maintenance of certification can be considered in credentialing by licensed hospitals/health systems, physician groups and other health care facilities, insurers, medical liability carriers and licensing boards themselves must be approached with great caution because of their potential for adverse unintended consequences of such regulation, including:

    a. imposing state legislature's judgments on the profession's own standards of

accountability;

b. interfering with the ability of hospitals and physician groups, in particular, to use the criteria they feel is most appropriate in selecting physicians to serve on their staffs or to be granted privileges;
c. lowering the standards of credentialing physicians for hospital medical staff privileges, employment, insurer networks, and medical liability carriers, such as by allowing participation in CME alone to be considered as standard of excellence.

4. To the extent that states choose to enact laws and regulations affecting credentialing and specialty boards, they should be focused on ensuring that maintenance of certification is not used as the sole, principal, overriding, or absolute prerequisite for physicians to be accepted into hospital medical staffs, to have hospital privileges, to be employed by licensed health care facilities, to have access to reimbursement, to participate in insurers' contracts and networks, or to be accepted for medical liability coverage and the premium charged for it. State regulations may appropriately establish appeals and due-process rights, transparency and cause of action to protect physicians from being unfairly discriminated against in such cases. State legislatures should not regulate the content of the profession's own standards of accountability. (BoR 17)

ACP Professional Accountability Principles

Definitions

Accountability refers to the obligation of one party to justify its actions and be held responsible for those actions by another interested party and encompasses three main components:

- The accountable parties—who is responsible to whom?
- The domain of actions (standards) for which the parties are accountable—what is the party responsible for?
- The procedures of accountability—those formal and informal processes to evaluate compliance within the accountable domain and to disseminate the results of the evaluation—how do you know if the party is being responsible?

Professionalism is a proclaimed belief of a defined group (e.g., a professional medical society) in a common set of standards and values

- *Internal Professional Accountability* is a physician's obligation to patients, colleagues and society to accept and meet the clinical and ethical standards and values established and assessed by the professional community, which includes professional societies and certifying boards. It is this obligation that makes a physician a professional.
- *External Professional Accountability* is the expectation that physicians as professionals will accept and meet the clinical and ethical standards and values of entities (constituencies) outside their professional community. These entities traditionally come from the following perspectives:
    - *Public Perspective* refers to the expectations of individual patients and the public at large for physicians to adhere to precepts of the social contract. Although the social contract is an abstract entity, the notion is that the special role and privileges that society bestows upon physicians and the medical profession entail a reciprocal

obligation to service, excellence, and to uphold and exemplify the core values and virtues of the profession.

- *Regulatory Perspective* refers to the expectation of a physician to abide by the domain of standards (requirements, rules, laws, regulations) and values defined by a governmental or healthcare service entity (e.g., a health plan or hospital) to promote and protect the public good. This is typically evaluated through licensing, credentialing or another formal regulatory process.
- *Market Perspective* refers to the expectation of a physician to abide by the domain of standards and values implicitly and explicitly expected within the marketplace by the consumer/patient. This accountability is typically evaluated through the public availability of physician and other healthcare provider price and performance information.

Principles Regarding ACP and Professional Accountability

1. ACP facilitates professional accountability through developing and maintaining the domain of clinical and ethical standards and values, educating members about the standards and values, and providing a community that inspires and supports member efforts to abide by these standards and values.
2. Every ACP member 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 sources evaluating professional performance.
3. Independent, non-profit certification boards assume the primary role of evaluating and certifying the extent to which College members are abiding by the standards and values of the profession through initial certification.
4. ACP recognizes that initial certification, as a single assessment in time, does not in itself demonstrate continual maintenance of clinical and ethical standards and values. ACP members should demonstrate continuing professional accountability through a valid process, such as assessment by a certification body that meets the following criteria:
    a. Strong conflict-of-interest protections
    b. Evaluation processes based on professional standards and values defined by the College
    c. A non-profit organizational structure
    d. A transparent governance structure composed substantially of physician members
    e. Transparent financial and reporting processes
    f. Established processes that ensure that the evaluations are:
        i Transparent
        ii Relevant to a variety of settings
        iii Able to accommodate a variety of different assessment methods
        iv Non-burdensome as possible while retaining utility for the support of the excellence in patient care
        v Considerate of the cost and time required
        vi Non-redundant to other professional requirements
    g. Has an established quality control process in place that ensures the accuracy and content validity of the assessment.
    h. 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.

i. Able to accommodate people with disabilities.

Principles Guiding External Regulatory and Market Accountability

5. Regulatory or market entities holding physicians accountable should have
   a. A transparent governance structure that has meaningful physician engagement
   b. A transparent financial organizational processes and reporting mechanisms
   c. Established processes that ensure that the accountability evaluation is:
      i Transparent
      ii Relevant to a variety of settings
      iii Able to accommodate a variety of different assessment methods
      iv Non-burdensome as possible while remaining rigorous and robust and balancing cost and time sensitivities
      v Non-redundant
   d. An established quality control process in place that ensures the accuracy and validity of the assessment.
   e. An appropriate 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.
6. When publicly reporting physician performance
   a. Transparency is important. The methodology and evidence base used to develop the measures being reported should be explicitly delineated.
   b. Reporting entities should use the most effective means of presenting performance information to patients/consumers
   c. Patients/consumers should be educated on the meaning and limitations of reported differences among providers and on how to effectively use this information to make informed healthcare choices.
   d. Reporting entities should use a standardized set of performance measures and data collection methodology, consensually agreed upon by relevant nationally recognized healthcare stakeholders.
7. Decisions about state licensure and hospital or insurer credentialing should be based on a physician's performance in his or her practice setting and a broad set of criteria for assessing competence, professionalism, commitment to continuous professional development, and quality of care provided. Because a wide variety of attributes contribute to a physician's competence and quality of care, participation in programs for physician accountability such as maintenance of certification should not be an absolute prerequisite for licensure and credentialing. The primary determinants should be demonstrated performance for providing high quality, compassionate care and a commitment to continuous professional development.

Principles underlying the efforts of the Federation of State Medical Boards (FSMB) to establish a Maintenance of Licensure (MOL) process focused on the assuring of continuous physician competence

8. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
9. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders.
10. The authority for establishing maintenance of licensure requirements should remain within the

purview of state medical boards.

11. Maintenance of licensure should not compromise patient care of create barriers to physician practice.
12. The infrastructure to support physician compliance with maintenance of licensure requirements must be flexible and offer a choice of options for meetingrequirements.
13. Maintenance of licensure processes should balance transparency with privacy protections. (Approved BOR 18)

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; reaffirmed BoR 19)

Regulatory Oversight of Boarding Care Facilities

ACP will monitor and support the efforts of groups, such as the National Academy 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; revised BoR 19)

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; reaffirmed BoR 19)

Physicians 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; reaffirmed by BoR 19)

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, reaffirmed BoR 22)

Position Paper on Long Term Supports for Older Adults

1. The ACP recommends a multi-pronged public-private sector approach to reforming LTSS financing. Specifically:
   - ACP supports the creation of a publicly funded, universal catastrophic LTSS insurance program, and,
   - To complement the publicly funded, universal catastrophic LTSS insurance program, ACP supports policies to make front-end private long-term care insurance affordable, accessible, and viable. Policies should include standardizing insurance policies, allowing the optional use of retirement account funds for LTCI, and allowing the sale of hybrid policies that combine LTCI and other products, such as life insurance, and,
   - ACP supports increased funding and policy changes to promote expanded home and community-based services through Medicaid and other programs, and,
   - ACP recommends that public and private entities develop a nationwide information campaign to expand LTSS literacy and educate the public about preparing for future LTSS needs.
2. Policymakers and employers should address shortages in the workforce for the long-term services and supports sector through comprehensive training, pay increases, benefit packages, and opportunities for career advancement and growth. ACP supports policies designed to assist unpaid caregivers through respite care, training, and reimbursement.
3. ACP supports evidence-based interventions to assure and improve the quality of LTSS across settings including:
   - Robust monitoring, enforcement of quality reporting and improvement requirements.
   - Continued development and implementation of evidence-based quality measures and models to improve care coordination, care transitions, health equity, resident and family experience, and discharge planning.
   - Federal minimum nurse staffing levels for nursing homes.
   - Expanded quality and safety information for consumers, including resident and family experience.

- Incentives and support for adoption of interoperable health information technology in LTSS settings.
- Research and implementation of emerging alternatives to institutional care.
- Research and development of delivery and payment models to prevent critical incidents and better integrate medical care and LTSS.

4. ACP supports research into the effect of ownership status on the long-term services and supports sector, including quality of care, staff and patient safety, costs, and staffing ratios. Nursing homes and other LTSS providers should be required to disclose comprehensive ownership and cost information, including private equity investment and related-party payments data. Reports should be publicly available and audited for accuracy.
5. ACP supports funding, assistance, and staff support for nursing homes and other LTSS organizations to develop and implement emergency preparedness plans to ensure the safety of patients and staff.

    - Communication and coordination procedures should be established between LTSS, local, state, and federal government agencies, and emergency management organizations. LTSS facilities should be prepared to conduct effective surveillance, monitoring, and reporting of patient health status during emergencies.
    - Nursing homes and other LTSS facilities should coordinate with public health departments, acute care hospitals, other care settings to prepare for and provide additional medical support during pandemics and other emergencies.
    - Nursing homes and other LTSS organizations should conduct staff training on emergency preparedness, evacuation and shelter-in-place procedures, and resiliency plans.
    - Emergency preparedness plans should consider the behavioral and social well-being of patients and staff and adopt safe visitation policies to prevent unintended consequences, including depression and loneliness. (BoR 22)

MANAGED CARE

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, reaffirmed BoR 22)

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 BoR 11, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)
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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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.
10. 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. (Reinventing Managed Care: Reducing the Managed Care Hassle Factor, ASIM 98, reaffirmed BoR 10, revised BoR 22)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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 and social determinants.
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; revised BoR 19)
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; revised BoR 19)
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; revised BoR 19)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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 inurnment 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 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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

MANAGEDCARE: 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. (Reaffirmed BoR 19)

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 partof 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 85 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; revised BoR 19)

MANAGEDCARE: 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, reaffirmed BoR 22)

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:

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, reaffirmed BoR 22)

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.

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. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96, reaffirmed BoR 08, revised BoR 22 with language from Medicaid Expansion: Premium Assistance and Other Options)

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, reaffirmed BoR 22)

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.

   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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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.

   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.
6. 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.

7. 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.
8. 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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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 inmaking 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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

Assuring Quality of Care--Managed Care Pan 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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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 riskcontracts.
2. Use of risk adjustments such as history of serious illnesses in setting payments to risk contracting plans.
3. Requiring that beneficiaries be provided comparative information about all health plan choices available to them.
4. 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.
5. Requiring reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain in the traditional Medicare fee-for-servicesystem.

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; revised BoR 19)

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; reaffirmed BoR 19)

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 recent efforts to integrate 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, revised BoR 22)

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.

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 outof-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)

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)

MEDICALEDUCATION: FINANCINGANDSUPPORT

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

Revitalization of Internal Medicine: Overview of the Problem and Recommendations on Reducing Medical 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)

MEDICALEDUCATION: GRADUATE

Affiliation with LCME Approved Medical Schools

ACP believes that teaching hospitals should be encouraged to affiliate with LCME-approved medical schools and American Association of Colleges of Osteopathic Medicine (AACOM) schools. (HoD 86; reaffirmed HoD 97; reaffirmed BoR 08; revised BoR 19)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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/disbursing 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, endure 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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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 exemption of physicians on H1B visas seeking permanent resident status and trained in specialties that are facing shortages in the United States from the annual per-country limitation for employment-based immigrants. ACP supports exemption of physicians currently on H1B visas seeking permanent resident status from the annual per-country limitation for employment based immigrants.

ACP encourages collaboration between medical schools and teaching hospitals in the U.S. and those in other countries to improve medical education globally.

ACP supports the development of a Global Health Corps or other entity that would facilitate opportunities for appropriately trained physicians and other clinicians to serve throughout the world. (BoR 08; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

Teaching of Socioeconomics in Medical Schools and Residency Programs

ACP believes that medical socioeconomics 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 medical record is the property of the physician or institution, although the information in the record is the property of the patient. Most states have laws that guarantee the patient personal access to the medical record, as do federal privacy rules. 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. 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.

Electronic health records (EHRs) and computer use facilitate patient care and should align with physician ethical duties in supporting the patient–physician relationship (28). The EHR should assist and enhance clinical reasoning and the development of cognitive and diagnostic skills; for example, copy-and-paste (29) and other features should be used carefully and only if they help reflect the physician's thought processes about the current patient encounter and produce an accurate and complete medical record that meets ethical standards. Electronic health record information retrieval, exchange, and remote access can improve care, but also create risks, including unauthorized disclosure and use of protected health information (28).

If a physician leaves a group practice or dies, patients must be notified and records forwarded according to patient instructions. Physicians should be aware of applicable state laws and regulations with regard to retention of medical records. (BoR 04; Reaffirmed as amended BoR 11, reaffirmed with edits BoR 19)

Health Information Technology and Privacy

1. Transparent privacy policies should accommodate individual preference and choice as long as those preferences and choices do not preclude the delivery of clinically appropriate care, public health, or safety.
2. Within the guardrails of HIPAA and the health care system, permitted information-sharing activities requiring notice but not requiring consent must be narrowly defined, societally valuable activities of public health reporting, population health management, quality improvement, performance measurement, and clinical education. Further, ACP supports the following principles on the use of Protected Health Information (PHI):
    a. The sale or marketing of any PHI without the person's informed consent should be expressly prohibited.
    b. Whenever possible, when disclosing PHI, entities should use deidentified or anonymized data. Best practices for deidentification should be adhered to and reflected in regulations. The method used to remove identifiers should be publicly disclosed.
    c. PHI should only be exchanged 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 PHI. 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 recommends that whenever possible, all attempts should be made to de-identify PHI in the context of educating current and future clinicians. Use of PHI 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. PHI may be disclosed without authorization to public health authorities as required by law to prevent or control disease, injury, or disability.

3. Whenever a physician discloses information for purposes other than treatment or care coordination, it should be limited to the minimum necessary on the basis of the physician's judgment.
    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. Health information technology (HIT) and other digital technologies should incorporate audit trails to help detect inappropriate access to PHI.
    c. All entities that hold PHI should be required to notify persons whenever their information is breached or used for an unauthorized purpose.
    d. When PHI requests are made by entities that are not the individual or an entity authorized by the individual, physicians should not be penalized for not complying with requests that, in their judgment, are inappropriate under disclosure rules after notifying the requester and the individual that the request is being denied.
    e. Physicians and other clinicians should not be held responsible for actions taken by another entity regarding PHI that was shared with that entity in accordance with privacy rules.

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 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 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. There should be a single, comprehensive taxonomy for consent provisions as well as standard structure for consent documents. Such consent models must account for literacy levels and preferred language, be revocable, and be unambiguous about which activities are permitted and which require consent.

6. ACP believes that protecting the privacy and security of PHI collected both within and outside the health care system—while providing individual rights to that information—is essential for fostering trust in the evolving digital health care system, maintaining ethical standards and respect for persons, and promoting the safe delivery of health care. ACP recommends:
   a. Comprehensive federal privacy and security legislation should provide persons the ability to know and control how their PHI is accessed, used, and disclosed, as well as protect PHI from unauthorized, discriminatory, deceptive, or harmful uses, and must apply to all entities not covered under existing legislation and regulation that collect, store, use, or exchange PHI.
   b. Persons should be able to access their PHI conveniently, reliably, and affordably and have complete flexibility in making disclosure choices about their PHI that is stored in their personal devices or health records (for example, mHealth apps and wearable devices).
   c. Efforts to expand privacy and security protections should involve all necessary stakeholders (for example, individuals, physicians and other clinicians, policymakers, payers, vendors, developers, researchers, and performance measurement organizations) and build on existing legislation and regulation to target gaps in health information privacy and security protections.
   d. 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.
   e. Patients should have the right to request from any provider information about disclosures of their PHI, 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.
   f. Health IT and other digital technologies should facilitate the provision of useful and appropriate disclosure notifications to persons when PHI is disclosed and for what purpose, with the ability to customize the types of disclosure notifications received.
      i. Efforts to develop a technical infrastructure allowing for automated and useful disclosure notifications and authorizations should be prioritized.

7. Patients should have specific, defined rights to request that their PHI not be accessed through a health information exchange (HIE).
8. 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. The source of all information, as well as the date and time the information was created or modified, within a medical record should be clearly identified and maintained as the information moves from system to system because of the risk that such information could be altered and therefore not retain its accuracy or relevance for clinical care decisions.
    b. 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.
9. ACP believes that the nature of every agreement between entities that involves sharing of PHI should be made public.
10. ACP supports oversight and enforcement to ensure that all entities not currently subject to HIPAA rules and regulations and that interact with PHI are held accountable for maintaining confidentiality, privacy, and security of that information. ACP recommends:
    a. Penalties for intentional or negligent breaches of privacy should be strictly enforced and state attorneys general should be empowered to enforce privacy rules. If state attorneys general do not pursue enforcement, there should exist a private right of action.
    b. Federal enforcements are needed when reidentification of deidentified PHI occurs.
    c. Increased federal funding is necessary to support federal oversight and enforcement efforts that account for the additional entities engaging in PHI collection exchange and use.
    d. Federal efforts to expand and enforce privacy policies should establish protections from discrimination, bias, stigma, and exploitation resulting from inappropriate use and sharing of PHI.
    e. It is critical that rules and enforcement efforts distinguish between inadvertent and intentional activities.
    f. Breach rules must not hold any parties responsible for the actions of other parties over whom they do not have direct control
11. ACP believes that new approaches to privacy and security measures should be tested before implementation and regularly reevaluated to assess the effect of these measures in real-world health care settings. ACP recommends:
    a. Ongoing research and funding are needed to assess real-world implications of PHI privacy and security policies and to develop strategies to enhance deidentification practices and educational tools and resources to improve public knowledge of PHI privacy rights and responsibilities.
12. 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, revised BoR 22)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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 Advisory Committee, the 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, revised BoR 22)

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 14)

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 14)

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

Developing a 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)

Recommendations on Medicare Modernization Act Premium Support - 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. (BoR 05)

Promoting Transparency and Alignment in Medicare Advantage

1. ACP supports current policies to ensure that MA plans are funded at the level of the traditional Medicare program and that at least 85% of that funding goes to actual beneficiary care.
2. ACP urges Medicare Advantage Organizations (MAOs) to be transparent in their processes, policies, and procedures for how they develop and administer their MA plans and portfolios for all key stakeholders to ensure program integrity. Moreover, MAOs administering MA plans must collaborate with all relevant stakeholders to streamline and align varying policies, procedures, and contracting arrangements with physicians to further promote transparency and reduce excessive and burdensome administrative tasks.
    a. MA plans' administrative processes and contracting arrangements with participating physicians should be transparent and standardized across all MAOs and plans to reduce administrative burden associated with participation in the MA Program.
    b. ACP calls for more research on the effects of excessive administrative tasks on physicians and beneficiaries who participate in MA plans as well as research on best practices to help reduce excessive and burdensome administrative tasks and further align administrative processes within the MAProgram and across traditional Medicare.
    c. The quality measurement systems for both MA plans and traditional Medicare should align to promote high-quality care for all beneficiaries, streamline quality reporting across Medicare programs, encourage administrative simplification, and provide beneficiaries with a clear and understandable means to compare benefits and options across Medicare programs.
    d. All payment models and incentives, including new alternative payment models, implemented by MAOs with participating physicians should be developed in a transparent manner, foster high-value care to all beneficiaries, and aim to engage participating physicians in designing and implementing value-based payment. They should also encourage delivery system reforms that allow them and other members of the clinical care team to share in savings associated with providing high-value, coordinated primary and comprehensive care.
    e. Processes and requirements for risk stratification and capturing severity of illness should be transparent and align across all MA plans. ACP calls on CMS, Office of Inspector General (OIG), and external independent bodies to investigate potentially fraudulent activity and the misuse of risk stratification by MA plans. Further, when any fraudulent activity is identified, the responsible MAO or MA plan should be held liable for that activity and not the physicians participating in the MA plan.

f. MA plans should provide beneficiaries with a clear and understandable means to compare benefits and options when deciding between an MA plan and traditional Medicare; therefore, the process of "seamless conversion" into these plans should be stopped entirely and reevaluated so that newly eligible Medicare beneficiaries are not automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding of the need to opt out.

3. ACP calls for more research on how federal payments to the MA Program are utilized by MAOs. Specifically, ACP calls for further research on the types of payment models used and prices paid by MAOs to contracted physicians, hospitals, and other clinicians compared with the models used and prices paid by traditional Medicare and commercial health insurance plans. (BoR 17)

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 BoR 13)

Medicare Prescription Drug Coverage

5. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

6. 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. (BoR 22)

7. 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. ACP supports approaches to addressing the costs of prescription drugs in the Medicare program as outlined in *Policy Recommendations for*

Public Health Plans to Stem the Escalating Costs of Prescription Drugs and *Stemming the Escalating Cost of Prescription Drugs*. (BoR 01, reaffirmed BoR 11, revised BoR 22)

8. 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 for Medicare to ascertain and certify the safety of reimported prescription drugs as outlined in *Prescription Drug Importation as a Policy Option to Lower the Cost of Medications in the U.S.* (BoR 01, reaffirmed BoR 11, revised BoR 22)

9. Generic drugs should be used, as available, for beneficiaries of Medicare Part D, providing therapeutic safety and equivalency are established.
    a. ACP supports modification to the Medicare Part D low-income subsidy (LIS) program cost-sharing and copayment structures to encourage the use of lower-cost generic or biosimilar drugs, such as eliminating cost sharing for generic drugs for LIS enrollees.
    b. 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 and other efforts to address anticompetitive behaviors as outlined in *Policy Recommendations to Promote Prescription Drug Competition* and *Stemming the Escalating Cost of Prescription Drugs*. (BoR 01, reaffirmed BoR 11, revised BoR 22)
    c. 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, revised BoR 22)

10. 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. (BoR7-99, revised BoR 10, revised BoR 22)
    a. 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.
    b. 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.
    c. 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.
    d. ACP opposes Medicare Part D proposals that limit coverage to certain therapeutic categories of drugs, or drugs for certain diseases.
    e. 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. (BoR 01, reaffirmed BoR 11, revised BoR 22)

11. 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. (BoR 01, reaffirmed BoR 11, reaffirmed BoR 22)

12. 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. (BoR 01, reaffirmed BoR 11, reaffirmed BoR 22)

13. 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. (BoR 01, reaffirmed BoR 11, reaffirmed BoR 22)

14. A Medicare prescription drug benefit should minimize administrative hassles, including excessive documentation requirements and overly burdensome rules, for physicians. (BoR 01, reaffirmed BoR 11, reaffirmed BoR 22)

a. Physicians should continue to be able to prescribe covered drugs for accepted off-label uses. (BoR7-99, revised BoR 10, revised BoR 21)

b. 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. (BoR7-99, revised BoR 10, revised BoR 21)

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, reaffirmed BoR 22)

Outpatient Intravenous Antibiotic Therapy

This policy is under review by the MSC.

Documentation of Evaluation & Management Visits

c. ACP will continue its efforts to reduce excessive documentation requirements for evaluation and management services. (HoD 97; reaffirmed BoR 08)

d. 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. 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.
4. 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, revised BoR 22)

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, reaffirmed BoR 22)

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 stratefiers, 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 stratefiers, 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)

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; reaffirmed BoR 19)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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 though 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.
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.

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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 effectivenessand 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

Statement of 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.
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) 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 beingtreated.
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 2012)

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 also 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, Reaffirmed with edits BoR 19)

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 Ebola virus disease, Zika virus, HIV, multidrug-resistant tuberculosis, and severe acute respiratory syndrome necessitate reaffirmation of the ethical imperative.

Physicians' ethical obligation to the welfare of patients is a fundamental tenet of the medical profession. The social contract between medicine and society also requires physicians to treat all in need of care. 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, immunization, 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 voluntarily quarantine themselves to limit the potential risk to society. 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 for 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 them the duty to know their risk for such diseases as Ebola or HIV, 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, reaffirmed with edits BoR 19)

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, the vulnerability brought on by illness, and the imbalance of expertise and power between patient and physician. Physicians publicly profess that they will use their skills for the benefit of patients, not for other reasons, including their own benefit. Physicians must uphold this declaration, as should their professional associations as communities of physicians that put patient welfare first.

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 medical services, a sense of duty to the patient should take precedence over concern about compensation. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed with edits BoR 19)

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, values, goals, and expectations. After patient and physician agree on the problem and the goals of care, the physician presents one or more courses of action,

with a specific recommendation for the patient. 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 through informed decision making, giving consent to or declining treatment 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 in-person encounters; however, it must be done under appropriate guidelines (14). E-mail or other electronic communications should only be used by physicians in an established patient–physician relationship and with patient consent (15). Documentation about patient care communications should be included in the patient's medical record

Aspects of a patient–physician relationship, such as the physician's responsibilities to the patient, remain operative even in the absence of in-person contact between the physician and patient (16). “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” (16). 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.

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.

In the context of telemedicine, there must be a valid patient–physician relationship for a professionally responsible telemedicine service to take place (17). A telemedicine encounter itself can establish a patient–physician relationship through real-time, technically appropriate audiovisual technology. When there has been no direct previous contact or existing relationship with a patient before a telemedicine encounter, the physician must take appropriate steps to establish a relationship based on the standard of care required for an in-person visit, or consult with another physician who does have a relationship with the patient. The benefits of opportunities for increased access to care through telemedicine “must be balanced according to the nature of the particular encounter and the risks from the loss of the in-person encounter (such as the potential for misdiagnosis; inappropriate testing or prescribing; and the loss of personal interactions that include the therapeutic value of touch, communications with body language, and continuity of care.

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 (18). 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 ethically 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 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.

The physician's responsibility is to serve the best interests of the patient. 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 (19, 20). The physician should notify the patient in writing, offer to transfer the medical records to another physician with patient approval, and comply with applicable laws. Continuity of care must be assured. 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. Abandonment is unethical and a cause of action under the law. 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, Reaffirmed as amended BoR 19)

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, reaffirmed BoR 22)

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 Role of Performance Assessment in a Reformed Health Care System

1. 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.

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.

3. 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.

4. 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.
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.
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

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.

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.

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.

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.

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.

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.

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.

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.

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.*

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.

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.

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.

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 social, economic, 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, revised BoR 22)

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:

20. 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.
21. 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.
22. Visit-based fee component for services delivered as part of a face-to-face visit and already recognized by the Medicare RBRVS system.
23. 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:

24. Improve the accuracy of work and practice expense relative values,
25. Provide an incentive for the adoption of health information technology linked to quality improvement efforts,
26. 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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

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 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. (Ethics Manual Fifth Edition, 2005) (revised BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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)

Reimbursing Physicians for Internet-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)

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; reaffirmed BoR 19)

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. 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.
2. Physicians and multidisciplinary teams should be paid for care management and care coordination services provided on a fee for-service basis.
3. 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, revised BoR 22)

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
    a. Engage and empower patients; promote shared decision-making
    b. Ensure that patient financial liability in obtaining evidence-based treatments is reasonable
    c. Include the expectation that patients assume some degree of responsibility for their health
    d. 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
    e. 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
    f. 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

g. 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. RBRVS 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. Should Congress decide that a national expenditure target(s) is required, it should consider the following adjustments/alternatives.
        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. Ensure that primary care services have a higher expenditure growth allowance than other services;
    2. Make information available on utilization and expenditures for service-specific categories available by geographic regions for informational purposes aimed at fostering local collaboration;
    3. 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
    4. 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.

b. 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, revised BoR 22)

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; reaffirmed BoR 19)

Mandate Adequate Reimbursement for Advisory Committee on Immunization Practices Recommended Vaccines

Refer to ACP Policy Statement on the Provision, Distribution, and Payment of COVID-19 Vaccines - 1/2021.

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, reaffirmed BoR 22)

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)

PHYSICIANPAYMENT: 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.

ACP supports MIPS measure ID# 472: “Appropriate Use of DXA Scans in Women under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture” because implementation will likely result in measurable and meaningful improvements in clinical outcomes and the developers cite clinical recommendations of the United States Preventive Services Task Force (USPSTF) on “Screening for Osteoporosis” to form the basis of the measure.” (BoR 10, revised BoR 22)

PHYSICIANPAYMENT: 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; reaffirmed BoR 19)

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)

Pharmacist Scope of Practice

Position 1: ACP supports physician-led physician-pharmacist collaborative practice agreements that reflect ACP's principles supporting dynamic clinical care teams and ensure that team members act in the patient's best interests. Potential benefits of collaborative practice agreements include improved treatment and management of chronic diseases such as diabetes and medication adherence.

a) Collaborative practice agreements should clearly assign responsibilities to clinical pharmacists for specific dimensions of care commensurate with their training and skills to most effectively serve the needs of the patient.
b) Expanded roles for pharmacists should be based on what is in the patient's best interest and not solely on cost savings.
c) The responsible physician and pharmacist should be compensated for their time spent on collaborative services.
d) Only the physician shall and must diagnose the patient's condition prior to any referral.

Position 2: ACP opposes independent pharmacist prescriptive privileges and initiation of drug therapy outside of a collective practice agreement, physician standing order or supervision, or similar arrangement.

Position 3: ACP supports the use of state-licensed pharmacists as sources of immunization information, hosts of immunization sites, and immunizers for adult patients, as appropriate and allowed by state law proving they coordinate, communicate, and collaborate with the patient's primary care team to ensure patient safety and continuity of care. Pharmacists that deliver immunization services must:

a) Meet training and safety requirements.

b) Provide the appropriate immunization paperwork or other documentation to the patient.
c) Refer the patient to their primary care team for any necessary counseling and follow-up care, particularly for patients with complex chronic care management needs.
d) Have a structured referral system to primary care settings and encourage patients they immunize to establish a longitudinal relationship with a primary care team if the patient does not have such an existing relationship.
e) Record immunization administration data within the patient's medical record (if available) and promptly report to the state's immunization information system or other designated CDC system.

During emergency mass vaccination efforts, such as a global pandemic where a national public health emergency has been declared, the federal government may temporarily circumvent state scope of practice laws to allow state-licensed pharmacists and state or board of pharmacy-authorized pharmacy interns under their supervision, to administer vaccinations providing they follow the recommendations stated above, are appropriately trained, and follow safety protocols. It is crucial that pharmacists and primary care teams cooperate and collaborate to educate patients about vaccines, address vaccine hesitancy, ensure patients do not forego medically necessary care, and ensure vaccines are distributed equitably, especially to communities of color and medically underserved areas.

Position 4: ACP resolves to work with pharmacists in designing therapeutic substitution policies that ensure the highest level of patient care and safety.

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; reaffirmed BoR 19)

Input from Practicing Internists to the Practice Management Center (PMC)

ACP shall devise a formal mechanism to provide input from practicing internists to the Department of Medical Practice (DMP) regarding issues relevant to practicing physicians on a regular and periodic basis. (BoR 08; revised BoR 19)

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; reaffirmed BoR 19)

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. Policies should promote community planning that supports walking, bicycling, and other physical activities for healthy lifestyles as well as access to and availability of high-quality nutritional foods.
4. 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, revised BoR 22)

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 of 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; reaffirmed BoR 19)

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

- ACP facilitates professional accountability through developing and maintaining the domain of clinical and ethical standards and values, educating members about the standards and values, and providing a community that inspires and supports member efforts to abide by these standards and values.
- Every ACP member 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 sources evaluating professional performance.

- Independent, non-profit certification boards assume the primary role of evaluating and certifying the extent to which College members are abiding by the standards and values of the profession through initial certification.
- ACP recognizes that initial certification, as a single assessment in time, does not in itself demonstrate continual maintenance of clinical and ethical standards and values. ACP members should demonstrate continuing professional accountability through a valid process, such as assessment by a certification body that meets the following criteria:
    - 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 assessment methods
        - Non-burdensome as possible while retaining utility for the support of excellence in patient care
        - Considerate of the cost and time required
        - Non-redundant to other professional requirements
    - Has an established quality control process in place that ensures the accuracy and content 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.
    - Able to accommodate people with disabilities. (BoR 18)

Principles Guiding External Regulatory and Market Accountability

- Regulatory or market entities holding physicians accountable should have:
    - A transparent governance structure that has meaningful physician engagement
    - A 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 methods
        - Non-burdensome as possible while remaining rigorous and robust and balancing cost and time sensitivities.
        - Non-redundant
    - An established quality control process in place that ensures the accuracy and validity of the assessment.
    - An appropriate 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.

- When publicly reporting physician performance
    - Transparency is important. The methodology and evidence base used to develop the measures being reported should be explicitly delineated.
    - Reporting entities should use the most effective means of presenting performance information to patients/consumers
    - Patients/consumers should be educated on the meaning and limitations of reported differences among providers and on how to effectively use this information to make informed healthcare choices.
    - Reportingentitiesshouldu seastandardizedsetofperformancemeasuresanddata collection methodology, consensually agreed upon by relevant nationally recognized healthcare stakeholders.
- Decisions about state licensure and hospital or insurer credentialing should be based on a physician's performance in his or her practice setting and a broad set of criteria for assessing competence, professionalism, commitment to continuous professional development, and quality of care provided. Because a wide variety of attributes contribute to a physician's competence and quality of care, participation in programs for physician accountability such as maintenance of certification should not be an absolute prerequisite for licensure and credentialing. The primary determinants should be demonstrated performance for providing high quality, compassionate care and a commitment to continuous professional development. (BoR 18)

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, reaffirmed BoR 19)

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, reaffirmed BoR 22)

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, reaffirmed BoR 19)

Expert Witnesses

Physicians have specialized knowledge and expertise that may be helpful and 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 result, however, in legal decisions that are made without the benefit of all relevant medical opinions and facts. Without the participation of physicians, dispute resolution may be unsuccessful, patients may suffer, and the public at large may be adversely 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. In this role, physicians must have the expertise in the subject matter of the case and honestly and objectively interpret and represent the medical facts. The College lists specific qualifications for serving as an expert witness (121, 122). Physicians should accept only noncontingent compensation for reasonable time and expenses incurred as expert witnesses. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed with edits BoR 19)

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 may challenge the physician's exercise of 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 patient access to health care or that result in anticompetitive behavior. 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. Individually and collectively, physicians should 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 actions that

may harm patients. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed with edits BoR 19)

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 medical or mental health condition, the aging process (134), 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 (135). The identifying physician may find it helpful and prudent to seek counsel from a designated institutional or practice 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 about whom one has a reasonable concern regarding impaired medical judgment or practice 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 (136). (BoR 04; Reaffirmed as amended BoR 11, revised BoR 19)

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 goodfaith.

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, revised BoR 19)

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, Reaffirmed BoR 19)

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, reaffirmed BoR 22)

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; reaffirmed BoR 19)

PROFESSIONAL RIGHTS ANDRESPONSIBILITIES: 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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

Excessive Heat Exposure

1. ACP recognizes that excessive heat exposure and heat-related illnesses are public health threats.

2. ACP encourages physicians to communicate heat-related illness prevention strategies, symptoms, and treatment procedures to at-risk individuals and/or their caregivers.
3. ACP encourages federal and state governments to research, develop and support public health interventions to prevent and address heat-related illnesses.
4. ACP recommends that the Occupational Safety and Health Administration (OSHA) creates occupational standards that protect employees from heat related injuries and illnesses.
5. ACP recommends that employers create procedures to prevent workers from experiencing heat-related injuries and illnesses. (BoR 20)

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)

Position Statement on Immunization of Health Care Workers

1. The American College of Physicians recommends that for the safety of patients and the public, fellow health care workers, and the individual health care worker, all health care workers should be immunized at the intervals recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention against transmissible infectious diseases, unless there is a clear medical contraindication or other exemption under applicable employment law.

2. The American College of Physicians supports requiring all health care workers to be vaccinated as a condition of employment against highly transmissible diseases that pose a substantial risk of transmission resulting in severe illness, hospitalizations and deaths which could be prevented or reduced by requiring safe and effective vaccinations against the disease as recommended by the Advisory Committee on Immunization Practices and the Centers for Disease Control and Prevention. This may include vaccines with emergency use authorization from the Food and Drug Administration. This should be combined with other approaches to increase immunization along with science-based infection control protocols.
    a. The American College of Physicians encourages health care employers to develop mechanisms to facilitate and support staff in becoming vaccinated including education and outreach, and resources to counter vaccine misinformation, such as the *Health Misinformation: The US Surgeon General's Advisory on Building a Healthy Information Environment. ii* Employers should remove barriers to employees getting vaccinated, including offering paid time off to get vaccinated and any additional time off that may be required because of short-term side effects associated with vaccination, without charging that against their usual paid leave benefits.
    b. The American College of Physicians is committed to health equity and recognizes the historical and continued mistrust of health care institutions by individuals, including marginalized populations subject to discrimination and racism, many of whom work in health care. ACP recommends that employers and health care professional societies and organizations commit to ongoing engagement, outreach, education, and provision of resources to all including historically marginalized groups to support informed vaccination decision making.

3. The American College of Physicians recognizes that some health care workers cannot be vaccinated because a clear medical contraindication exists, and these individuals should be exempted from employer vaccine requirements. While ACP believes that allowing exemptions based on non-medical reasons poses a risk to public health and our patients, we acknowledge that applicable federal laws and regulations that recognize religious exemptions as well as other relevant equal opportunity, anti-discriminatory and employment laws need to be considered. (BoR 2021)

Position Statement on Immunization Policies to Protect the Public

1. The American College of Physicians supports immunization of the public 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 American College of Physicians supports state laws designed to promote all recommended immunizations.

3. The American College of Physicians calls on states to pass legislation to eliminate any existing exemptions, except for clear medical contraindications, from their immunization laws.

4. The American College of Physicians believes that employers and schools may appropriately require proof of vaccination for recommended immunizations for highly transmissible diseases that pose a substantial risk of transmission resulting in severe illness, hospitalizations, and deaths which could be prevented or reduced by requiring safe and effective vaccinations. This should be combined with other approaches to increase immunization along with science-based infection control protocols.
    a. The American College of Physicians opposes state laws, regulations or executive orders that prohibit employers and schools from instituting such requirements.
    b. During a pandemic or other public health emergency for highly transmissible diseases that might result in severe illness, hospitalizations, and deaths which could be prevented or reduced by requiring safe and effective vaccinations, the American College of Physicians supports appropriate federal and state regulations to expand vaccination rates, including requiring employers and government agencies to mandate that their employees show proof of age-appropriate vaccination, and requiring organizations that receive government funding to show such proof of vaccination by their employees and contractors.
    c. The American College of Physicians recognizes that some individuals cannot be vaccinated because a clear medical contraindication exists, and these individuals should be exempted from employer vaccine requirements. While ACP believes that allowing exemptions based on non-medical reasons poses a risk to public health and our patients, we acknowledge that applicable federal laws and regulations that recognize religious exemptions as well as other relevant equal opportunity, anti-discriminatory and employment laws need to be considered.
    d. Individuals subject to such requirements should first have meaningful opportunity to voluntarily accept vaccination.
    e. Employers should remove barriers to employees getting vaccinated, including offering paid time off to get vaccinated and any additional time off that may be required because of short-term side effects associated with vaccination, without charging that against their usual paid leave benefits.
    f. The American College of Physicians recognizes the historical and continued mistrust of health care institutions by individuals from marginalized populations subject to discrimination and racism. ACP recommends that employers, working in concert with public health officials and trusted community leaders, commit to ongoing engagement, outreach, education, andodeployment of resources to support all in informed vaccination decision making. (BOR 2021)

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)

Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health

2. The American College of Physicians believes that public policies and efforts should be directed to ensuring an adequate supply and distribution of physicians and other clinicians to meet the nation's health care needs, especially for underserved rural and urban populations. Integrated actions are needed to address the barriers to physicians, including internal medicine specialists, from entering and remaining in the primary care workforce and practicing in underserved communities. Research and policies to address the impact of hospital closures on access and outcomes of care are urgently needed.
3. The American College of Physicians supports greater investment in the nation's public health infrastructure, research, and public policy interventions to address the social determinants of health and other factors that have a negative impact on health.
4. The American College of Physicians believes that greater resources must be devoted to addressing environmental health, and that strategies are needed to address, prevent, mitigate, and adapt to the health consequences of climate change.
5. The American College of Physicians supports focusing funding priority and policy interventions on promoting critical public health objectives, including but not limited to policies and actions to:
    a. Reduce smoking and tobacco-related preventable illnesses, including the health risks associated with the growing use of electronic nicotine delivery systems by teenagers;
    b. Reduce and treat substance use disorders;
    c. Reduce the rate of maternal mortality in the United States, especially for African American women;
    d. Reduce firearm-related injuries and deaths; and
    e. Improve access to and the availability of high-quality nutritional food. (BoR 19)

QUALITY OF CARE

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 publicreporting.
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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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 recommends that any comparative effectiveness entity should:

- Be supported by the federal government through funding, implementation, and maintenance of the comparative effectiveness entity.
- 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 3: 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 4: The College recommends that a panel of stakeholders and additional scientific experts including those specifically in the area of cost-effectiveness analyses be formed and charged with:

- 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 5a: 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 5b: 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; reaffirmed BoR 19)

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, reaffirmed BoR 22)

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, reaffirmed BoR 22)

Patient Safety in the Office-Based Practice Setting

Recommendation 1: ACP believes that physicians and health care organizations have a responsibility to promote a culture of patient safety within their practices and among colleagues with whom they collaborate.

- Patient safety goals must be embedded in the daily activity of the health care team and office staff.Medical error reporting efforts should encourage accuracy, confidentiality, and compliance and ensure that information is useful, actionable, and nonpunitive (just culture) and is focused on actual events and near-misses.
- A culture of safety can be encouraged by adopting liability protections that protect physicians

and the health care team from being penalized for reporting errors and working with patients to address safety issues.

Recommendation 2: ACP recommends that physicians and other health care professionals, payers, government, and other relevant stakeholders should conduct research and work to address physician stress, burnout, and organizational culture that may impact medical errors.

Recommendation 3: Patient and family education, engagement, and health literacy efforts are needed to educate the public about asking the right questions and providing the necessary information to their physician or other health care professional. Materials should reflect the linguistic and cultural characteristics of the audience.

Recommendation 4: ACP supports the continued research into and development of a comprehensive collection of standardized patient safety metrics and strategies, with particular attention to primary care and other ambulatory settings. Domains could include medication safety, diagnosis, transitions, referrals, and testing issues. ACP recommends expanded patient safety research efforts to better understand the ambulatory medical errors and the efficacy of patient safety practices.

Recommendation 5: Team-based care models, such as the patient-centered medical home, should be encouraged and optimized to improve patient safety and facilitate communication, cooperation, and information sharing among team members.

Recommendation 6: Health information technology systems should be tailored to emphasize patient safety improvement.

Recommendation 7: ACP supports the establishment of a national effort to prevent patient harm across the health care sector. A national entity could be charged with coordinating and collaborating with stakeholders, defining the problem, setting national goals, and developing and assisting in the implementation of a patient safety action plan with attention given to the ambulatory setting. (BoR 17)

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, reaffirmed BoR 22)

Developing Methods and Resources for Small Practices To Fairly Negotiate with Accountable Care Organizations

ACP supports the development of 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, revised 22)

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, reaffirmed BoR 22)

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-treatpatients.
    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.
19. 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, reaffirmed BoR22)

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 rigorous research, on honest communication of research 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”. 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 and regulatory standards, but IRB review does not obviate the investigator's responsibilities to uphold the ethical integrity of research. Investigators and their institutions, authors, and journal editors are individually and jointly responsible for ensuring that the obligations of honesty and integrity are met. Research misconduct, which includes fraud, fabrication, falsification, and plagiarism of 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 (for example, with ClinicalTrials.gov), and reporting of methodology and outcomes must be clear, complete, and transparent. Data should be available for sharing.

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. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed with edits

BoR 19)

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 (140). 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 (141). 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 (142). 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 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. Agreement to participate in research should never be coerced, but undertaken freely by a subject (or authorized by a legally appointed representative) who is adequately informed to make the decision. Some groups may be more vulnerable to coercion or undue influence (such as children, prisoners, individuals with impaired decision-making capacity, and economically or educationally disadvantaged persons, as included in the Common Rule [137]). Special efforts must be undertaken to protect such populations and individuals.

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 (143). Research involving individuals with impaired cognition or capacity still needs to meet 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. 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. A patient may be able to give consent for research participation and designate a proxy in the early stages of disease. 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. The physician-investigator must reinforce that surrogate decision-making standards are based on the patient's best interests. If a subject regains decision-making capacity, he or she should be given the opportunity to engage in the consent process (144). 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. Although 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 (145, 146). However, the extent to which some precautions, such as community consultation, have 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. When a single IRB reviews a multisite study, physicians should help ensure the local patient population and local context are considered in study design, review, and conduct

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 (149, 150). 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 (102). Giving or accepting finder's fees for referring patients to a research study generates an unethical conflict of interest for physicians (102). 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 (137) and some state laws have provisions regarding privacy and confidentiality requirements for research, the HIPAA Privacy Rule (23) 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 (151), 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 privacy and data use requirements and each study's procedures for protecting data confidentiality and security. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

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, novel

combinations of currently accepted practices, new applications of standard interventions, and the use of accepted therapies 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. 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, and potential consequences of forgoing a standard therapy, and whether the innovation is in the patient's best interest (156). Informed consent is particularly important and requires that the patient understand that the recommended therapy is not standard treatment. Adverse events should be carefully monitored and reported to the U.S. Food and Drug Administration (FDA) and applicable oversight bodies. If use of the new therapy, procedure, or intervention becomes routine, it should be investigated in a clinical trial (153). Innovative medical therapy should be treated as research whenever data are gathered to develop new medical information and for publication.

FDA-approved expanded access programs for drugs and medical products (157) assess risk versus benefit, provide protections, and maintain necessary oversight in the interest of patients and the public health. Making unapproved products and drugs available to patients with life-threatening illnesses without FDA oversight, as through right-to-try laws, can harm patients, the integrity of science, and the regulatory role and mission of the FDA. (BoR 04; Reaffirmed as amended BoR 11, Reaffirmed as amended BoR 19)

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. Authorship means substantial contribution to the research along with compliance with authorship guidelines. They must also 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 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's and scientific community's call for transparency in clinical research. All researchers have a professional responsibility to be honest in their publications. Biased reporting and selective reporting of study outcomes risk the integrity of the research and may interfere with the ability to derive evidence-based treatment outcomes. 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 disclosing the financial associations of authors and other potential conflicts of contributors in the manuscript.

In general, subject recruitment alone does not merit authorship. Ghostwriting or taking credit or payment for the authorship of another is unethical.

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, Reaffirmed as amended BoR 19)

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." Scientists and 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, Reaffirmed with edits BoR 19)

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 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: Research on the therapeutic benefits of marijuana 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 marijuana in accordance with state law. Similarly, ACP strongly urges protection from criminal or civil penalties for patients who use marijuana as permitted under state laws. (Revised BoR 19)

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

GENETICDISCRIMINATION

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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; reaffirmed BoR 19)

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 electronic nicotine delivery systems, cigars, pipes, smokeless tobaccos, and other cigarette and tobacco product 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. Federal, 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 nicotine delivery systems
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, revised BoR 22)

Electronic Nicotine Delivery Systems

1. 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).
2. The American College of Physicians recommends that characterizing flavors should be banned from all tobacco products, including ENDS.
3. 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.
4. 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.
5. 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.
6. 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)

Minimum Legal Age to Purchase Tobacco

ACP recommends that the minimum legal sale age to purchase all tobacco products, including combustible cigarettes, cigars, smokeless tobacco, and electronic nicotine delivery systems (solutions, devices, or other components) be raised to age 21. (BoR 18)

TOBACCO: LABELINGAND 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; reaffirmed BoR 19)

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 alcogol 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

Position Paper on Health Care for Our Nation's Veterans

Recommendation 1: ACP recognizes the unique, specialized role of the Veterans Health Administration in serving our nation's veterans. ACP supports continuing and improving the VHA's mission to provide integrated health care, medical and other health professions education, research, and emergency preparedness. Lawmakers must ensure adequate funds are appropriated to allow the VHA to provide timely and high-quality healthcare services and to sustain the VHA's health professions education, emergency preparedness, and research programs.

Recommendation 2: ACP affirms that the Veterans Community Care Program should act as a safety-valve to ensure veterans can access the care they need if they are unable to receive timely, local, or appropriate care through the VHA. The Veterans Community Care Program should supplement the VHA, not replace it. ACP recommends that efforts be made to ensure seamless care coordination between non-VHA health

care professionals and the VHA and that enrollees have access to a broad network of physicians and other health care professionals.

Specifically, ACP recommends:

a. Non-VHA physicians should use VHA referral, electronic health record, and care coordination programs, providing they protect patient information.
b. Policymakers and the VHA must enact policies to ensure seamless care coordination between non-VHA clinicians, as well as urgent and retail clinics, and the VHA.
c. Participation by non-VHA physicians and other healthcare professionals within the Veterans Community Care Program (VCCP) should be voluntary. Any selection processes for initial or continued VCCP 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, and the appropriate utilization of resources; and include reasonable appeal procedures.
d. Educational resources describing the VCCP and its related obligations and rights should allow for an informed decision by physicians and other healthcare professionals considering participation.
e. Contracting, enrollment and credentialing procedures for non-VHA physicians to participate in the VCCP should be non-burdensome and rely on already existing Medicare information and procedures. Competency standards for non-VHA physicians treating the unique health care needs of veterans (for example, post-traumatic stress disorder and traumatic brain injury) should reflect those of VHA-based physicians.
f. The fee schedule employed within the VCCP should be commensurate with the Medicare payment schedule. Claim processes should be clearly defined and similar to Medicare (including related appeal procedures) and operate under prompt payment or similar requirements. Clean claims should be processed within 30 days or 14 days for claims submitted electronically.
g. Congress should allow for the continuation of this expanded community care program if need persists.
h. Veterans who qualify for the VCCP should be informed promptly. Information should include estimated wait time and estimated costs to allow for an informed decision.
i. The agency should develop access-to-care measures, including an overall maximum allowable wait time goal, to ensure veterans receive patient-centered care from community-based physicians and other health care professionals in a timely manner.
j. VHA and policymakers should increase administrative and support staff sufficient to meet demand and prevent administrative deficiencies.
k. Clinical resources for treating veterans should be made available to community-based physicians and other health care professionals.

Recommendation 3: ACP recommends that the VHA provide full coverage to higher-income veterans without service-connected disabilities (priority categories 7 and 8). Copayments and other cost-sharing for VHA services should be reduced or eliminating for high-value services, drugs, and devices. Cost-sharing for services provided by urgent care clinics to service-connected veterans should be eliminated or minimal.

Recommendation 4: ACP recommends that the VHA and other stakeholders collaborate with physicians and other health care professionals to identify and eliminate administrative tasks that contribute to burnout. The Secretary and other stakeholders should take action 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. Performance measures should reflect the VHA's goal of delivering person-driven Whole Health care. All clinical performance measures and results should be transparent and readily available to the public.

Recommendation 5: ACP recommends that the VHA be provided resources to implement recruitment and retention best practices for mission-critical physicians and other health care team members, including

gathering workforce data, hiring physician recruiters, instituting competitive salaries and financial incentives, and strengthening oversight of human resources personnel. Congress should allocate adequate funding to achieve full staffing capacity particularly for outpatient primary care. Licensure and scope of practice policies should reflect the recommendations in ACP's Dynamic Clinical Care Teams position paper; specifically, patient care teams should be physician-led and patients should have access to their preferred physicians.

Recommendation 6: ACP supports stable, sufficient funding for Graduate Medical Education (GME), Advanced Fellowships, Professional Development, and non-GME health professions training programs provided through the VHA and encourages the agency to expand and strengthen relations with medical schools to broaden the medical education pipeline.

a. Medical schools and residency programs should provide veteran-specific training to prepare physicians to communicate with and deliver care to veterans in the community and in the VHA.

Recommendation 7: ACP recommends the VHA continue to research and improve the Patient-Aligned Care Team model to deliver patient-centered, coordinated care. The VHA should continue prioritizing models to identify, diagnose, and treat veterans with specific care needs, including women, veterans with suicide risk, depression, military sexual trauma, and substance use disorders.

Recommendation 8: ACP supports sufficient intramural funding for research efforts, including the Health Services Research and Development Service, to foster testing and development of new payment and delivery system models.

a. The VHA should enhance efforts to establish research partnerships with academic affiliates.

The VHA should act to accelerate clinical implementation of research findings into real world settings. (BoR 21)

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

Position Statement on Promoting Policy Standards for Workplace Violence Prevention and Management

1. ACP recognizes the harm of workplace violence against physicians and other health care workers—including physical and verbal violence—and commits to working with all relevant stakeholders to reduce the incidence of workplace violence and uphold a safe and supportive work environment for all.

2. ACP believes physicians and other health care workers have a right to deliver care under conditions that do not impair their health and well-being. ACP believes institutions have a duty to ensure the safety of their employees and must develop and implement policies, plans, and protocols to assess, report, reduce, and prevent workplace hazards and violence.

3. ACP believes physicians and other health care workers should educate themselves on workplace violence policies, plans, and protocols; be aware of potential hazards; report all incidents of workplace violence; participate in workplace violence prevention and response trainings; and commit to upholding a culture of workplace safety.

4. ACP supports legislative efforts to reduce and prevent instances of workplace violence and bolster workplace safety.

5. ACP urges the Occupational Safety and Health Administration and other relevant federal agencies to develop, implement, and enforce a national standard addressing workplace violence in the health care setting.

6. ACP calls for additional research into workplace violence prevention, including the effectiveness and impact of interventions; the prevalence of workplace violence in health care settings and how it impacts various types of health care workers, practice settings, and specialties; the characteristics of perpetrators of workplace violence; and risk factors that increase the likelihood of workplace violence. ACP emphasizes the need for high-quality data and standard definitions in order to better understand the extent of workplace violence against physicians and other health care workers. (BoR 21)

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

6. 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)

Women's Health Policy in the United States

1. The American College of Physicians (ACP) believes internists are well-suited to provide high-quality women's health care and that clinicians in all specialties and fields, including internal medicine, who care for women should receive appropriate training in health issues of particular relevance to the population of women seen in their practice setting. Training should emphasize both primary and comprehensive care of women such as office gynecology as well as the internist's role in team-based care for complex issues.
2. ACP believes it is essential that women have access to affordable, comprehensive, non-discriminatory public or private health care coverage that includes evidence-based care over the course of their lifespan. Health insurers should not be allowed to charge women higher premiums or impose higher cost sharing on women because of their sex or gender.
3. ACP believes in respect for the principle of patient autonomy on matters affecting individual health and reproductive decision-making rights, including about types of contraceptive methods they use and whether or not to continue a pregnancy. ACP believes that individuals have the right to make their own decisions, in partnership with their physician or health care professional, on matters affecting their individual reproductive health and opposes government restrictions that would erode or abrogate one's right to continue or discontinue a pregnancy that may result from the Supreme Court ruling in Dobbs v. Jackson Women's Health Organization. Individuals should have sufficient access to evidence-based family planning and sexual health information and the full range of medically accepted forms of contraception. (BoR 18, revised ECBOR 2022)
4. ACP opposes legislation or regulations that limit access to comprehensive reproductive health care by putting medically unnecessary restrictions on health care professionals or facilities.
5. ACP supports the goal of universal access to family and medical leave policies that provide a minimum period of six weeks paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal.
6. ACP supports increased availability of effective screening tools for physicians or health care professionals treating survivors of intimate partner or sexual violence. ACP supports increased patient education of intimate partner or sexual violence and the availability of resources for those affected by these abuses.
7. ACP supports efforts to improve the representation of women' health in clinical research and close knowledge gaps related to specific women's health issues. (BoR 18)

Maternal Mortality Review Committees

ACP supports the establishment of maternal mortality review committees (MMRCs) and other state or local programs to collect pertinent data, identify causes of maternal death, and develop and implement strategies with the goals of preventing pregnancy-related or pregnancy-associated death and improving maternal outcomes in the United States. ACP believes MMRCs should have access to necessary data across jurisdictions and that MMRCs should implement best practice standards for data collection and analysis with an emphasis on improving the consistency and comparability of data. (BoR 18)

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[i] https://www.acponline.org/acp_policy/policies/improving_health_care_efficacy_and_efficiency_through_increased_transparency_2017.pdf