ACOFP 2021
Principles of Health Care System Reform

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Protect Patients During the COVID-19 Pandemic

Over 374,000 Americans have died from COVID-19 with public health officials warning that cases and deaths will continue to rise. The COVID-19 pandemic is the public health crisis of our generation, and family physicians are on the frontlines protecting patients across the country from the deadly virus.

In the face of this once-in-a-lifetime crisis, family physicians have prioritized patients and changed their practices to address the unique challenges of delivering care during the pandemic. Family physicians have quickly adopted telehealth to ensure patients can maintain their care, invested in personal protective equipment (PPE) and established safety protocols to protect patients and their staff. The response from family physicians and their staff has been heroic, but more must be done to ensure they can continue to serve patients.

In many areas, family physicians are the primary source of care, and even before the pandemic, small, independent and solo practices faced barriers, including physician shortages, low reimbursement and overly burdensome regulations. It is critical that Congress and the federal government support family medicine during the pandemic, or patients and seniors across the country will lose access to care.

Congress acted swiftly in passing various coronavirus relief legislation, including the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA); and the Consolidated Appropriations Act, 2021 (CAA). The CARES Act appropriated $100 billion to the Public Health and Social Services Emergency Fund (Provider Relief Fund) to support our nation's health care providers. The PPPHCEA replenished the Provider Relief Fund and other important programs (e.g., the Paycheck Protection Program), adding $75 billion to the Provider Relief Fund. The CAA provided an additional $3 billion, while also making key policy changes to provider greater flexibility for Provider Relief Fund recipients to appropriately use these funds. However, more work needs to be done to ensure funds are reaching family physicians and that financial support does not come with overly burdensome requirements.

The Centers for Medicare & Medicaid Services (CMS) also acted quickly to support providers. There are many regulatory actions that have been helpful, including hardship exceptions for Quality Payment Program reporting requirements and relaxing physician supervision requirements. However, the COVID-19 telehealth flexibilities have been the most impactful and critical for many family physicians and patients.

As the 117th Congress convenes, the pandemic will continue to disrupt our daily lives. Congress and the U.S. Department of Health and Human Services (HHS) must continue to provide resources and regulatory flexibilities for providers in order to beat the virus. Below, we provide our advocacy positions that build and expand upon the existing COVID-19 relief policies.

Advocacy Positions

- Provide financial support for family physicians through the Provider Relief Fund during the COVID-19 pandemic.
- Provide clear and consistent requirements for funding from the Provider Relief Fund that do not overly burden physicians or discourage them from accepting the funds.
- Advance appropriate, yet fiscally responsible, COVID-19 relief legislation that stimulates the economy and supports providers.
- Continue to promulgate appropriate administrative flexibilities to ensure physicians can respond to the COVID-19 pandemic.
- Ensure that reimbursement for COVID-related treatments and vaccines are appropriate to ensure patients and seniors have access to care.
- Provide family physicians with adequate PPE and other resources to protect their staff and patients.

Encourage the Appropriate Use of Telehealth

In response to the COVID-19 public health emergency, CMS loosened its telehealth rules and expanded the types of telehealth services that are reimbursable by Medicare. According to the HHS, telehealth utilization increased by 350 percent during April 2020,[1] largely due to CMS' telehealth changes. The new flexibilities have been critical for seniors, especially during the early months of the outbreak when in-person visits dropped dramatically.

Congress continues to recognize the importance of telehealth, most recently in the CAA, which permanently expanded the use of telehealth to provide mental health services. This expansion is noteworthy both due to its permanence and because it does not subject these services to geographic restrictions, while also maintaining certain protections to guard against fraudulent activity (i.e., requirements that the clinician must have furnished an item or service within the past six months prior to the first telehealth service).

Although telehealth utilization is beginning to level off as in-person visits rebound, there is a paradigm shift in care delivery that relies more on telehealth. Telehealth has the potential to improve access to care for countless Americans.

However, telehealth is particularly vulnerable to fraud and abuse and could lead to higher costs for patients. There is also limited data on the quality of telehealth.[2] Additionally, there are concerns that telehealth could increase physician burden, which should be avoided as much as possible, especially during the COVID-19 pandemic.[3] We firmly believe that in-person care is the gold standard for care and telehealth is a tool available to improve care delivery when in-person care is not possible—not a silver bullet.

We are also concerned that the growth of telehealth could inadvertently disrupt existing physician-patient relationships and care coordination. There is a growing trend of telehealth-only providers as opposed to traditional brick and mortar physician practices. We fear these telehealth-only providers may not effectively coordinate with family physicians, which could result in poor health outcomes.[4] We believe telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth.

Telehealth can be a powerful tool for care delivery, but it must also have appropriate guardrails to ensure its effectiveness and to prevent fraud and abuse. Below are our recommendations to achieve such a framework.

Advocacy Positions

- Prioritize telehealth services for the patient's primary care physician.
- Ensure care is properly coordinated with the primary care physician, and Congress should provide resources for physicians to effectively coordinate care with other providers.
- Continue to allow reimbursement for audio-only telehealth services in a manner that protects program integrity.
- Reduce administrative burden associated with telehealth, including burdensome state licensing requirements.
- Establish appropriate rules to curb fraud and abuse and protect patients from unnecessary charges.
- Use data and evidence to develop telehealth coverage policy that ensures patients are receiving the highest quality care possible.
- Allow patients to use telehealth from their home by reforming or eliminating site origination requirements.
- Establish payment rates that reflect the resources and expertise necessary to deliver high-quality care via telehealth.
- Ensure that family physicians have sufficient resources to invest in new technologies to provide effective telehealth services.

[1]Issue Brief. Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic. July 28, 2020. Accessible here: https://aspe.hhs.gov/system/files/pdf/263866/HP_IssueBrief_MedicareTelehealth_final7.29.20.pdf

[2]Castellucci, Maria. Telehealth explosion points to need for more research on quality of care provided. June 18, 2020. Accessible here: https://www.modernhealthcare.com/safety-quality/telehealth-explosion-points-need-more-research-quality-care-provided

[3]Based on a 2020 ACOFP member survey, 26 percent of respondents reported administrative burden associated with obtaining state licensures for using telehealth across state lines.

[4]Counsell R., Steven MD, Callahan M., Christopher, MD, et al. Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial. December 12, 2007. Accessible here https://jamanetwork.com/journals/jama/fullarticle/209717 (Finding that effective care management can reduce emergency department visits and hospital admission rates for high risk patients).

Address the Family Physician Shortage

Currently, the United States faces shortages between 21,400 and 55,200 of primary care physicians by 2033.[5] As more family physicians are reaching retirement age, it is critical that the primary care physician pipeline is ready to address the shortage.

More needs to be done to increase the number of residents choosing family medicine. Medical students are financially incentivized to choose specialty training (e.g., cardiology, pulmonary medicine, etc.) over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing and procedures.

Incentives for medical students to choose family medicine include:

- Equalizing reimbursement between various settings of care (e.g., office, outpatient clinic, emergency department) and between family medicine and other specialty medical services;
- Enhancing reimbursement by rewarding care provided by family physicians that are proven to ensure high-quality patient outcomes and patient satisfaction; and
- Providing financial support in the form of loans, loan forgiveness and loan deferment.

More training opportunities also are needed for medical students choosing family medicine. Medical education funding and programs must be preserved and expanded, such as Medicare Graduate Medical Education, Teaching Health Centers Graduate Medical Education and Title VII.

Advocacy Positions

- Support policies that equalize reimbursement for primary care and specialty care.
- Reward care provided by family medicine through reimbursement policies that are proven to ensure high-quality patient outcomes and patient satisfaction.
- Expand access to loans for medical students and deferment and forgiveness of loans for medical students choosing family medicine.
- Increase financial support to hospitals, especially those in rural areas, to establish residency programs in family medicine.
- Protect and expand medical education funding, including Direct and Indirect Graduate Medical Education funding, and preserve existing alternative Graduate Medical Education programs, such as the Teaching Health Centers Graduate Medical Education program, Title VII and other medical education programs.

[5]Stuart Heiser. "New AAMC Report Confirms Growing Physician Shortage." Association of American Medical Colleges. June 26, 2020. Available at https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage

Reduce Unnecessary Paperwork Requirements

Cumbersome electronic health record (EHR) systems, utilization management policies (e.g., prior authorization) and continuously changing regulatory rules are forcing doctors to spend more time on administrative tasks rather than treating patients.

According to recent studies measuring the impact of administrative requirements, doctors spend approximately half of their time on EHRs and desk work.[6] Many physicians are also spending time after hours completing paperwork. For every hour a physician spends on face-to-face clinical time, nearly two hours are spent on EHR and administrative tasks every day.[7]

Burdensome paperwork requirements are contributing to the physician shortage and inhibiting appropriate patient care. Many physicians are burned out by the paperwork requirements and decide to retire early or leave medical practice for another profession. The issue is especially acute in small, rural and solo practices—as they do not have the resources to manage all the paperwork requirements. As more small, rural and solo practices are forced to close or relocate, health care shortage areas widen, and more communities lose access to care.

While federal programs like the Quality Payment Program (QPP) are intended to improve health outcomes and reduce spending, these well-intentioned initiatives have significantly increased administrative burdens for physicians. CMS has taken steps to reduce paperwork requirements through the Patients Over Paperwork Initiative and has worked to develop outcome measures that are clinically appropriate through the Meaningful Measures Framework. While we appreciate CMS, commitment to cut red tape so more time can be devoted to providing care, more must be done to reduce administrative burdens.

Advocacy Positions

- Reduce burdensome paperwork requirements across federal programs so physicians can spend more time treating patients.
- Maintain and expand the Patients Over Paperwork principles and goals.
- Promote EHR interoperability and standardize reporting requirements to reduce time spent on EHRs.
- Develop meaningful EHR reporting requirements to replace unnecessary requirements that do not contribute to patient outcomes.
- Allow physicians to be reimbursed for time spent preparing for patient visits and time spent logging medical information into the electronic medical record beyond the day of the patient visit.
- Streamline utilization management policies across payers in a way that all stakeholders can quickly and efficiently address patient needs.
- Thoughtfully implement any major regulatory changes to Medicare to increase program certainty and to ensure that physicians have time to familiarize themselves with new program rules and update their practice accordingly.

[6]Christine Sinsky, et al. "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties." Annals of Internal Medicine. Website Accessed November 12, 2020 at https://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties?doi=10.7326%2fM16-0961

[7]Id.

Improve Outcomes and Reduce Costs Through Primary Care and Support for Family Physicians

The goal of any health care system is to improve the overall health of the patients it serves. To achieve this goal, primary care must play a more prominent role in health care. Many studies show dramatic benefits in geographic areas that have higher primary care provider (PCP) use and PCPs per capita.

For example, a retrospective literature review by Dr. Barbara Starfield found that overall health is better in areas in the United States with more PCPs. Areas with higher ratios of PCPs per capita had better health outcomes, including lower rates of all-cause mortality, mortality from heart disease, cancer, stroke and infant mortality. Also, areas with higher ratios of PCPs per capita had much lower health care costs than did other areas, possibly due to better preventative care and lower hospitalization rates. This contrasts with areas where there are a higher number of specialists—characterized by more spending, but worse health outcomes.[8]

Programs created for primary care—like CMS Transitional Care Management, Chronic Care Management and the Medicare Diabetes Prevention Program—help improve primary care patient outcomes and reduce costs.[9] In addition, these programs provide physician payments for care coordination activities, which normally are not covered. Family physicians devote considerable time to ensuring patient care is efficiently and effectively coordinated among specialists and non-physicians. These activities drive down costs for payers and hospital systems, while improving health outcomes for patients.

While primary care physicians are demonstrated to be a critical asset for high-quality health care delivery, more needs to be done to support family physicians who have upgraded their EHR systems in compliance with federal programs, including the QPP, at great expense. We must ensure that any new EHR requirements take into account investments in IT systems.

Many small, rural and solo practices are unable to change their EHR system as rules shift annually. It is essential that federal policy makers do not implement policies that require physicians to invest additional funds in EHR updates, management and repairs without adequate support.

Advocacy Positions

- Support primary care models that empower and reward PCPs who focus on prevention of chronic illness, manage those who have progressed and appropriately use specialists.
- Educate specialists on the role of PCPs in coordinating care to ensure the patient is receiving high-quality care.
- Support reimbursement policies that reward care provided by family physicians who are proven to ensure high-quality and improved patient outcomes.
- Ensure physicians earn compensation for activities that are under the heading of "care coordination," which are essential for improved outcomes and reduction of health care costs.
- Reimburse family physicians through Medicare Part B—during and beyond the COVID-19 public health emergency—for the administration of medically necessary vaccines (beyond influenza, pneumococcal and hepatitis B) to reduce exposure to COVID-19 and maintain appropriate care coordination.
- Recognize the clinical value and cost-savings from physician-led care coordination and establish appropriate reimbursement policies for such activities.
- Equalize reimbursement across settings of care and between primary care and specialty care so that primary care has the resources to provide the newest technology and to obtain health IT that assists with improving quality and reducing costs.
- Carefully consider how new federal health program policies will affect EHR systems and provide support to physicians for any policy that requires changes to existing EHRs.

[8]Starfield, Barbara. "Contribution of Primary Care to Health Systems and Health." Milbank Quarterly, vol. 83, No. 3. Pgs. 457-502

[9]www.cms.gov. Website Accessed October 7, 2019

Preserve the Family Medicine Model of Care

Family medicine plays a critical role in the provision of primary care, which ensures improved patient outcomes and reduced health care costs. We are concerned about federal policies that incentivize replacing family physician services with those of "non-physician practitioners," such as nurse practitioners and physician assistants. While the use of non-physician clinicians may be appropriate under certain circumstances—with adequate physician supervision—the model is not an equivalent substitute to the use of family physicians.

Furthermore, the number of small and solo family medicine private practices has declined in recent years. We believe it is essential that policy makers support private practices, which are able to tailor how they provide care to best meet the needs of the communities they serve. Small and solo family medicine private practices therefore should have access to federal resources, in order to ensure they remain a critical access point for primary care—especially in rural and underserved areas.

We also believe that Congress and the Administration should support opportunities for medical students to train in private practices and continue to support innovative payment models, like Direct Primary Care (DPC) arrangements.

Advocacy Positions

- Support policies, including reimbursement policies, that do not create incentives to use non-physician clinicians in lieu of family physicians.
- Deliver the highest quality care for patients through physician-led care teams.
- Establish physician supervision and scope of practice requirements through state medical regulatory entities.
- Support small and solo family medicine private practice access to federal resources, as well as administrative flexibility especially during the COVID-19 pandemic.
- Continue to support DPC arrangements through appropriate tax treatment (e.g., allowing DPCs to be paid for using health savings accounts).

Focus on Vulnerable Populations and Address Racial Disparities

Osteopathic family physicians are committed to treating vulnerable populations, such as rural patients, the uninsured and underinsured, and racial/ethnic minorities. We believe there are several ways to improve family physicians' ability to ensure the health and longevity of these populations.

Social determinants of health have been shown to have a major impact on patients' overall health. Even when a physician provides high-quality care, follows evidence-based guidelines and provides access to community resources, the patient may still not achieve the desired health outcomes because of their social determinants of health. Making changes to a patient's social environment is key. This includes utilizing social services to ensure adequate housing, good nutrition, language interpreter services and transportation.

While physicians may be able to direct patients to community resources to assist patients with services and supports to address social determinants of health, it is beyond the capacity of physicians or the health care system alone to completely address these factors. Physicians should not be held accountable for eliminating or mitigating that which is in the social environment nor should they be penalized for failing to fully ameliorate a patient's social determinants of health.

Additionally, ACOFP strongly believes all individuals—regardless of race, color, religion, sex, gender identity, sexual orientation, age or disability—should have access to high-quality health care. As an organization, we have disapproved of federal efforts to restrict or otherwise limit care based on immutable characteristics of an individual. Congress and the federal government must uphold the rights of all individuals and ensure there are no discriminatory laws or regulations that limit care and work to protect minority populations.

The COVID-19 outbreak has highlighted systemic inequities in our country's health care system. Studies have found that COVID-19 death rates of Black, Asian, Native American and Hispanic COVID-19 patients are disproportionately higher than white patients.[10] For example, Black and Asian patients were 37 percent and 53 percent, respectively, more likely to die from COVID-19 than white patients.[11]

Other studies have shown that ethnic minorities are less likely to receive preventative care, and despite improvements in the overall health of the American population, ethnic and racial minorities are not receiving the same quality of care in the United States. These same disparities exist in the maternal mortality context with data showing that African American women have higher rates of pregnancy-related deaths than white women.[12]

As osteopathic physicians, we have been trained to treat the patient holistically and look beyond the disease. We pride ourselves on understanding the social determinants of health for our patients and embrace diversity and inclusion in our profession. Our foundational principles are to treat all patients, regardless of their ethnicity or racial background. We encourage policy makers to make meaningful changes that improve the lives of minority populations in our country and, in turn, all Americans.

Advocacy Positions

- Ensure recognition and inclusion of social determinants of health and their overarching impact on healthcare in policy making.
- Advocate for federal health program policies that assist and support—rather than financially penalize—physicians for unmet patient needs related to social determinants of health.
- Expand physician knowledge of population health and how it relates to the understanding of patient outcomes.
- Develop and advocate for policies ensuring access to equitable and high-quality healthcare.
- Encourage Congress to recognize and act on the racial health disparities in our country to improve health outcomes for minority populations.
- Advocate for healthcare workforce and education programs that increase diversity among family physicians (e.g., programs that recruit students from underserved or diverse communities to practice in their community).
- Preserve and enhance Medicare and Medicaid reimbursement for rural and underserved area physicians, including the facilities where they provide care (e.g., Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs) and Disproportionate Share Hospitals (DSHs)).

[10]Dan Keating, Ariana Eunjung Cha, and Gabriel Florit. "'I just pray God will help me': Racial, ethnic minorities reel from higher covid-19 death rates" Washington Post. November 20, 2020. Accessible here: https://www.washingtonpost.com/graphics/2020/health/covid-race-mortality-rate/

[11]Id.

[12]Howell, Elizabeth. "Reducing Disparities in Severe Maternal Morbidity and Mortality." June 1, 2019. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/

Address the Opioid Crisis

As the United States continues to confront the opioid crisis, attention has been focused on prescribing and dispensing these drugs. Despite the risk for abuse, opioids do play a legitimate role for many patients with chronic pain.

Federal efforts to combat the abuse of opioids should not pose a barrier to access for those who truly need these drugs to treat chronic pain. Failing to do so will result in a crisis of untreated chronic pain.

Primary care physicians are on the frontlines of the opioid epidemic and have been instrumental in treating patients with substance-use disorders and opioid-use disorders (OUDs). Osteopathic family physicians support behavioral health as part of the whole person approach to care and use of community support resources. Osteopathic family physicians support federal actions, including additional funding and access to medication-assisted treatment (MAT), to support the treatment of mental health and substance use disorders.

However, some well-intentioned efforts to improve OUD treatment may push patients away from their family physicians. Specifically, bundled payments for opioid treatment assumes there is a standardized way to treat OUD and substance-use patients.

Family physicians understand that each patient is different and are in the best position to address individual patient needs. After all, OUD patients are members of the physicians' community and have a personal connection with their family physicians.

Family physicians understand the patient's unique clinical needs and social factors that may impact substance use. CMS must carefully consider new payment models to ensure the agency does not drive patients to non-primary care for OUD services.

Advocacy Positions

- Support federal legislative and regulatory actions that combat the opioid crisis, but do not impede access to opioids for legitimate indications and patients.
- Support federal action on behavioral health, including additional funding for mental health facilities and more physicians trained to manage these patients.
- Support additional reimbursement for family physicians to provide high-level, in-office screening and make appropriate referrals to behavioral health specialists.
- Provide parity in reimbursement for behavioral health screening and services.
- Support greater access to MAT by loosening prescribing rules and expanding telehealth services, especially in rural areas.
- Ensure that family physicians are leading care for patients suffering from OUD instead of other types of practitioners.
- Encourage CMS to reassess the value of bundling for payment of OUD services.
- Leverage existing primary care-focused codes that supports family physicians' ability to treat OUD.