

## **ACOFP 2018 Principles of Health Care System Reform**

*Adopted February 3, 2018 – ACOFP Board of Governors*

### **1. Address the Family Physician Shortage**

Currently, the United States faces shortages of 20,400 primary care physicians by 2020 (cms.gov, Website. Accessed on January 2, 2018). 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, pulmonology, etc.) over primary care because of higher reimbursement for specialty medicine services, such as high cost imaging, testing, and procedures. Incentives for medical students to choose Family Medicine include:

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

More training opportunities are needed for medical students choosing Family Medicine. Preserve and expand medical education programs, such as Medicare Graduate Medical Education, Teaching Health Centers Graduate Medical Education (THC GME), and Title VII.

#### Advocacy Positions:

- Support policies that equalize reimbursement for primary care and specialty care. Family Medicine for America's Health (FMAH) suggests that 10% of the total cost of care should go to the Primary Care Physician (PCP). Currently PCPs receive only 5-6%.
- 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 to establish residency programs in Family Medicine. Expand Graduate Medical Education Funding - both Direct Graduate Medical Education and Indirect Medical Education. Preserve existing alternative Graduate Medical Education programs such as the Teaching Health Centers Graduate Medical Education program, Title VII, and other medical education programs. FMAH has an initiative to increase the percentage of medical school graduates choosing family medicine to 25% by 2030.

### **2. Improving Outcomes and Reducing Costs Through Primary Care**

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. PCPs offer continuity of care to their patients. They know the patient and their history and can use this knowledge to make medical decisions in the acute or chronic setting, or if a referral is needed. Patients appreciate and depend on this continuity of care.

Many studies show dramatic benefits in geographic areas that have higher 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 PCP's 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 and lower health outcomes.<sup>1</sup>

Programs created for primary care like CMS's Transitional Care Management (TCM), Chronic Care Management (CCM), and the Diabetes Prevention Program (DPP) help improve primary care patient outcomes and reduce costs.<sup>2</sup> In addition, these programs provide additional physician payments for care coordination activities that normally are not covered.

We need to reduce federal regulatory burden for Family Physicians. We appreciate the Administration's commitment to cut red tape; however, the Quality Payment Program (QPP) Final Rule for 2018 came out more cumbersome than the QPP for 2017. The recently announced CMS initiative, "Patients Over Paperwork"<sup>3</sup> is strongly supported by ACOFP.

#### 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.
- 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.
- Support reimbursement policies that reward care provided by Family Physicians who are proven to ensure high quality and improved patient outcomes.
- Expand the "Patients Over Paperwork" program initiated by CMS Administrator Seema Verma. The goal is to reduce the burden of paperwork, which detracts from the priority of patient care.
- Physicians should earn compensation for activities that are under the heading of "care coordination." These activities are essential for improved outcomes and reduction of health care costs.
- Expand CMS programs such as TCM and CCM, which compensate eligible clinicians for care coordination.
- Continuity of care should be maintained as patients are discharged from the Emergency Department. Patients should be directed back to their primary care physician to help prevent rehospitalization.

### **3. 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 healthcare costs. We are concerned about federal policies that incentivize replacing Family Physician services with those of "non-physician clinicians," such as nurse practitioners, physician assistants, and most recently, assistant physicians. 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 Medicine physicians.

#### Advocacy Positions:

- Support policies, including reimbursement policies, that create incentives to use non-physician clinicians under the supervision of physicians within a team-based care environment.

#### **4. Focus on Vulnerable Populations**

Osteopathic Family Physicians are committed to treating vulnerable populations, including rural patients, the uninsured, underinsured, and, racial/ethnic minorities. We believe there are a number of ways to improve Family Physicians ability to ensure the health and longevity of these populations.

First, social determinants of health (SDH) have been shown to have a major impact on patients' overall health. Even when a physician provides high quality of care, follows evidence-based guidelines, and provides access to community resources, the patient may still not achieve the desired health outcomes because of their SDH. Making changes to a patient's social environment is key.<sup>4</sup> This includes utilizing social services to ensure adequate housing, healthy food, treatment of dependency, etc.

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

Family Physicians should have sufficient revenues to invest in current technology to be able to care for vulnerable populations. An example of this is telehealth services that are billable for rural physicians. Telehealth helps keep patients from driving hours to an office visit, and for those who are disabled, it is the difference between seeing a doctor and not doing so. Telehealth can also reduce costs by preventing visits to the Emergency Department.

The use of Medicare telehealth services should be expanded to other areas. There are underserved Medicare patients in inner-city and urban areas who could benefit from telehealth as well. Integrating and adopting new billing codes for Medicare telehealth services is an important advancement to improve access to Primary Care physicians. Telemedicine can allow additional touch points with patients with chronic disease and help in chronic care management.

Therefore, ACOFP supports and urges CMS to continue to identify appropriate telehealth codes for a broader range of Medicare patients who comprise vulnerable populations. It is important to preserve the continuity of care between patient and doctor when utilizing telehealth.

Medicare and Medicaid reimbursement must be preserved and enhanced for rural and underserved areas including: RHCs, FQHCs, CAHs, and DSHs.

##### Advocacy Positions:

- Ensure recognition and inclusion of the SDH and their overarching impact on healthcare in policy making.
- Expand physician knowledge of population health and how it relates to the understanding of patient outcomes.
- Expand telehealth access and billable codes for vulnerable populations in rural, inner-city, and urban areas. However, telehealth should not be used as a replacement for visits to the patient's routine Primary Care Physician in areas where patients can easily access them. Continuity of care should not be sacrificed with the use of telehealth.
- Preserve and enhance Medicare and Medicaid reimbursement for rural and underserved area physicians, including the facilities where they provide care (e.g., RHCs, FQHC's, CAH's and DSHs).

## 5. Address the Opioid Crisis

As the United States confronts the opioid crisis, more attention has been focused on the 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 medically need these drugs to treat chronic pain. Failing to do so will result in a crisis of untreated chronic pain.

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, to support the treatment of mental health, including addiction.

PCPs are at the frontlines of care and often are the first to discover the presentation of behavioral health symptoms.

### 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.
- Family physicians should not be blamed for addiction problems – this is a multi-factorial issue. Physicians should be protected in the appropriate treatment of patients suffering from chronic pain.
- Osteopathic physicians can offer Osteopathic Manipulative Treatment (OMT) which should be an option to patients before or in conjunction with opioid therapy. OMT can be conducted in both inpatient and outpatient settings.
- Family physicians who have a DEA number can write a valid prescription for opioids, when appropriate. This should be preserved in the scope of practice for family physicians.
- Family physicians should have parity to pain clinic physicians in the ability to prescribe opioids in appropriate clinical situations.
- Support federal action on behavioral health including: additional funding for mental health facilities, and more physicians trained to manage these patients.
- Medicaid managed care insurers/pharmacies in some states dispense a minimum number of opioid pills for one week and require the patient to pay for the balance of the medication. This is despite the number of pills that the physician originally ordered. The physician’s prescription should be dispensed as written; the insurer or pharmacy should not make determinations on what the patient needs or can afford.
- Support additional reimbursement for PCPs to provide high-level, in-office screening and make appropriate referrals to behavioral health specialists.
- Lobby for parity in reimbursement for behavioral health screening and services.

<sup>1</sup> Starfield, Barbara. “Contribution of Primary Care to Health Systems and Health.” *Milbank Quarterly*, vol. 83, No. 3. Pgs. 457-502

<sup>2</sup> [www.cms.gov](http://www.cms.gov). Website Accessed December 4, 2017

<sup>3</sup> [www.cms.gov](http://www.cms.gov). Website Accessed December 2, 2017

<sup>4</sup> World Health Organization. “Closing a Gap in a Generation: Health Equity Through Actions on Social Determinants of Health.” [www.who.org](http://www.who.org). Website accessed on December 1, 2017