

ACOFP 2020 Principles of Health Care System Reform

1. Address the Family Physician Shortage

Currently, the United States faces shortages of between 21,100 and 55,200 primary care physicians by 2032.¹ As more family physicians are reaching retirement age, it is critical 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 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 (*i.e.*, office, outpatient clinic, emergency department) and between family medicine services and specialty medical services.
- Enhancing reimbursement by rewarding care provided by family medicine physicians that are proven to ensure high quality patient outcomes and patient satisfaction.
- 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, 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 to establish residency programs in family medicine.

¹ Stuart Heiser. "New Findings Confirm Predictions on Physician Shortage." Association of American Medical Colleges. Website Accessed October 9, 2019 at <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>

- Expand Graduate Medical Education Funding - both Direct Graduate Medical Education and Indirect Medical Education including: preserving existing alternative Graduate Medical Education programs such as the Teaching Health Centers Graduate Medical Education program, Title VII, and other medical education programs.

2. 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 their time on EHRs and desk work.² 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.³

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. The Centers for Medicare & Medicaid Services (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, 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.
- Expand the "Patients Over Paperwork" initiative.
- Promote EHR interoperability and standardize reporting requirements to reduce time spent on EHRs.

² 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 October 9, 2019 at <https://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties?doi=10.7326%2fM16-0961>

³ Id.

- Develop meaningful EHR reporting requirements to replace unnecessary requirements that do not contribute to patient outcomes.
- CMS should 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.
- Physicians require program certainty, especially in the QPP, to properly serve Medicare beneficiaries. Any major regulatory changes to Medicare must be thoughtfully implemented to ensure that physicians have time to familiarize themselves with new program rules and update their practice accordingly.

3. Improving Outcomes and Reducing Costs Through Primary Care and Supporting 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 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.⁴

Programs created for primary care like CMS' Transitional Care Management, Chronic Care Management, and the Diabetes Prevention Program help improve primary care patient outcomes and reduce costs.⁵ In addition, these programs provide physician payments for care coordination activities, which normally are not covered.

While primary care physicians are a critical asset for high quality health care delivery, more needs to be done to support family physicians. Family physicians have upgraded their EHR systems in compliance with federal programs, including the QPP. 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

⁴ Starfield, Barbara. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly*, vol. 83, No. 3. Pgs. 457-502

⁵ www.cms.gov. Website Accessed October 7, 2019

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.
- Support reimbursement policies that reward care provided by Family Physicians who are proven to ensure high quality and improved patient outcomes.
- 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.
- 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.
- Federal regulators and legislators should carefully consider how new policies will affect EHR systems and provide support to physicians for any policy that requires changes to existing EHRs.

4. Preserve the Family Practice 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 medicine physician services with those of “non-physician clinicians” 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 medicine physicians.

Advocacy Positions:

- Support policies, including reimbursement policies, that do not create incentives to use non-physician clinicians in lieu of Family Medicine physicians.
- Physician-lead care teams deliver the highest quality care for patients.
- States and state medical regulatory entities are in the best position to establish physician supervision and scope of practice requirements.

5. Focus on Vulnerable Populations

Osteopathic family physicians are committed to treating vulnerable populations, including 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.

First, social determinants of health 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 social determinants of health. Making changes to a patient's social environment is key.⁶ This includes utilizing social services, to ensure adequate housing, healthy food, and transportation.

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 social determinants of health.

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 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 codes for a broader range of Medicare patients who comprise vulnerable populations.

Medicare and Medicaid reimbursement must be preserved and enhanced for rural and underserved areas including: Rural Healthcare Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and Disproportionate Share Hospitals (DSHs).

⁶ World Health Organization. "Closing a Gap in a Generation: Health Equity Through Actions on Social Determinants of Health." www.who.org. Website accessed on December 1, 2017

Advocacy Positions

- Ensure recognition and inclusion of the social determinants of health 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.
- 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 (RHC), Federally Qualified Health Center (FQHC's), Critical Access Hospitals (CAH's) and Disproportionate Share Hospitals (DSH)).

6. Address the Opioid Crisis

As the United States confronts the opioid crisis, more 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 (OUD). 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 primary care physician. Specifically, bundled payments for opioid treatment assumes there is a standardized way to treat OUD and substance use patients. Primary care 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 physician. 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 it 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 PCP's 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.
- Support greater access to MAT by loosening prescribing rules and expanding telehealth services, especially in rural areas.
- Ensure that primary care physicians are leading care for patients suffering from OUD.
- CMS should reassess the value of bundling for payment of OUD services.
- Leverage existing primary care-focused codes that supports family physicians' ability to treat OUD.