PHYSICIAN ADVISORY COMMITTEE ON HEALTH CARE REFORM

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EXECUTIVE SUMMARY

The Physician Advisory Committee on Health Care Reform is a group of seven physicians in active clinical practice and two clinical practice executives. Committee members come from diverse specialty and geographic backgrounds, from family medicine to pediatric heart surgery, from Boston, Massachusetts, to Portland, Oregon, from urban academic health centers to rural single-physician practices. This group started as an advisory committee on healthcare reform to a US Congressional office, but developed an independent voice as meetings progressed over six months. Addressed in this 29-page document are a wide range of topics. It is impossible to limit our executive summary to a "top ten" list; the Committee agreed that the following items deserved particular attention:

1. Federal oversight of commercial insurance plans is critical, including:
    a. A Federal insurance regulatory oversight committee must be created to set standards and audit health insurance companies.
    b. A common universal claims form and a single definition of a "clean claim" is essential, with standards for prompt payment.
    c. Private insurance plan overhead costs (1/medical loss ratio) must not exceed twice the overhead of Medicare and/or other Federal health plans, such as TriCare.
    d. Physician quality metrics and cost performance metrics and data should be disconnected and presented separately, and the basis and logic of each must be transparent.
    e. Along with the need for universal coverage protection, there must be a prohibition against rescission of coverage, pre-existing condition exclusions, and non-payment for covered care, and there must be portability.

2. Reimbursement reform should be used to incentivize and reward high-quality cost-effective medicine. Elements to consider for additional reimbursement include:
    a. Participation in specialty specific quality of care databases and quality improvement programs, and participation in assessment of appropriate use of high-cost healthcare (e.g., pharmaceuticals, procedures, imaging, consultation, etc.).
    b. Current and predicted physician workforce shortages must be addressed by substantially increasing reimbursement for specialties with shortages (currently, e.g., primary care and general surgery, etc., and projected, e.g., cardiothoracic surgery) and for geographically underserved (e.g., rural and underserved urban) regions. Resources for this must come from the total healthcare budget, not just from the 17% currently paid to physicians.
    c. Effective implementation of "interoperable" health information technology.

3. Patient centered medical homes should be created for patients that serve the primary and chronic care needs of most Americans. Elements to consider include:
    a. Annual risk-adjusted capitation payment should be provided for patient centered medical homes that include patient education, disease prevention, and other

overarching practice based health related services. Care obtained outside of the medical home (consultations, pharmaceuticals, imaging, surgical procedures, etc.) should be paid separately and audited periodically for appropriateness, as will care within the medical home, to avoid stinting of indicated care.

   b. There should be patient incentives for maintaining good health (e.g., reimbursement for maintaining healthy weight, blood pressure, blood sugar, etc.)

4. The overall physician workforce should be expanded by increasing support of existing medical schools to increase class size, and funding for additional residency training opportunities properly sized and focused to address the primary care and specialty needs of America. Loan forgiveness is considered a very effective and cost-effective approach for addressing workforce shortages, along with appropriately increased reimbursement (e.g., for primary care).

5. Academic health center viability has been jeopardized by state budget shortfalls and endowment losses in the recent past. Their health should be a high priority and can be best maintained by:
   a. Maintaining a commitment to federally funded (e.g., NIH, AHRQ, CDC, DOD) health research.
   b. Providing "per capita" payments to medical schools that increase class size to meet the 90,000 physician deficit predicted by 2020.
   c. Providing GME funding directly to the medical schools (not hospitals), which are held responsible by the ACGME for the quality and quantity of resident education. This should be a responsibility of all payers, not just Medicare and Medicaid.

6. There should be a formal and major role of Professional Societies in improving the quality and value of medical care through promoting education, research, clinical guidelines and quality improvement tools and programs, and promoting professionalism.

7. Accountable care organizations are not a clear answer to cost containment in medical care because:
   a. Providing a financial incentive to physicians to withhold care creates moral hazard based on a financial conflict of interest whereby withholding medical care brings financial reward.
   b. Previous "experiments" with capitated care have failed.
   c. It may force physicians into hospital employment potentially transferring the practice of medicine from physician-driven to hospital-driven medical practice.

8. Health information technology, and electronic health records (EHRs) in particular, must incorporate:
   a. Interoperability: All physicians caring for patients should have access to all necessary electronic records, upon patient consent, regardless of insurance plan,

health system, or geography. There must be an operationally single national health record source.

b. Clinical quality metrics, as defined by professional societies, must be able to be incorporated into the EHR as well as exported to specialty and other quality improvement programs to report to national databases.
c. Decision support software
d. Capacity for supporting clinical and comparative effectiveness research
e. Financial incentives for use by physicians and healthcare systems, supported by the Federal government and private insurance.

9. An alternative medical liability system has the opportunity to reduce physician ordered health expenses by 10% by changing practice from “defensive medicine” to the highest quality medicine by adherence to standards of care as defined by professional societies and other trusted sources.

INTRODUCTION

In Fall, 2008 a half dozen physicians, a physician practice executive, and a practice manager were called together by a senior staff member of a Congressional office, including medical and surgical specialists and generalists, family physicians, representing academic medical centers, large group practices in metropolitan areas, and solo practices in rural settings, in eastern, western, northern, and southern parts of our country. We were asked to serve as a “brain trust” for developing sound payment health care reform policies. Our assignment was ambitious: we were asked 1) to flesh out core concepts around payment reform in the inpatient, outpatient settings, and 2) to strategize how we can make sure that the physician community supports these concepts. The only rules were that we 1) keep an open mind; 2) be willing to think outside our individual silos for the sake of getting something good done; and 3) use discretion regarding the details of group discussions outside of the group.

In keeping with the determined efforts in Congress to generate a comprehensive health care reform plan by the end of May, 2009, the timeline was aggressive; weekly conference calls and visits to Washington to meet were piled on top of already too-busy schedules. However, the group engaged in this work without reservation, to have the rare opportunity to have input and impact on something that means so much to each and every American - their health care.

Six months later, after much discussion, reading, meeting, and writing, we have recommendations that we hope will serve the purpose of health care reform that will ultimately benefit patients and the health care system itself, long overdue in this nation. The following sections represent a series of “bullet point” recommendations that represent the group’s consensus on key aspects for the evolution of health care reform, including Introduction, Biographies of Advisory Committee Members, Insurance Market Code of Conduct Proposal, Physician Reimbursement, Patient Centered Medical Home, Work Force Issues, Role of Professional Societies, Supporting Academic Medicine Missions in Health Care Reform, Accountable Care Organizations (ACO’s), Health Information Technology, and Alternative Medical Liability System: Federally Mandated.

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James T. Dove, M.D., M.A.C.C.
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Dr. Dove graduated from Case-Western Reserve in Cleveland, Ohio. He completed a residency in Internal Medicine and a fourth year as Chief Resident at Mt. Sinai Hospital School of Medicine in New York City. Cardiology training was completed at the University of Rochester in Rochester, New York. He spent two years in Public Health Services assigned to Washington, D.C. in Georgetown University, Washington, D.C. VA Hospital, and the National Institutes of Health. In 1973 he began practice in Springfield, Illinois and has been affiliated with the Southern Illinois University School of Medicine. Currently he is Clinical Professor of Medicine, Division of Cardiology, SIU School of Medicine. He served as Chief of the Division of Cardiology from 1990 – 1999. He is a founding partner of Prairie Cardiovascular Consultants, Ltd., which is a 45 member group of cardiologists. He has been actively involved in clinical research and served on the Board of Directors of the Prairie Education and Research Cooperative (PERC). His interests have been in coronary artery disease, quality initiatives, and more recently in the use of an electronic medical record to facilitate quality performance.

Heidi J. Foley, M.D.
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Heidi j. Foley, M.D. was born and raised in Georgia, just south of Atlanta. She attended Earlham College in Richmond, Indiana and then spent time as both a research chemist and high school special needs teacher. After completing her residency from The Medical Center of Central Georgia and becoming a board certified Family Physician where she served as Chief Resident, she was employed as a primary care physician in McDonough, Georgia. Dr. Foley moved to Central Massachusetts in 2004 because her husband, Dennis, is from the area and they had an opportunity to open their own practice. Dr. Foley and Dennis are avid Red Sox and Patriots fans, love the scenery New England provides and are the proud parents of their three year old son, Timothy. She practices as a Family Doctor in Athol, Massachusetts and sits on the Massachusetts Academy of Family Physicians' Committee on Governmental Relations.

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Since August 2002, Dr. Grover has been Professor and Chair of the Department of Surgery at the University of Colorado Denver. From 1991 to 2003, Dr. Grover was Professor and Head of the Division of Cardiothoracic Surgery at the University of Colorado Denver and Chief of Surgical Services at the Denver Veterans Affairs Medical Center. He is a graduate of Duke University and Duke University School of Medicine. He obtained his residency training at Duke University and the University of Colorado. Following two years of military service in the U.S. Navy in San Diego, Dr. Grover spent nineteen years of his career at the University of Texas Health Sciences Center in San Antonio in the Division of Cardiothoracic Surgery. He chaired the Society of Thoracic

Surgeons Workforce on National Databases from 1995 to 2004. In addition, he chairs the National Cardiac Surgery Consultants Board for the Department of Veterans Affairs and in that capacity, has helped to organize the VA Cardiac Surgery Database. He also chaired the United Network for Organ Sharing Thoracic Committee, and served on the UNOS Board of Directors, and the American College of Cardiology NCDR Board. He is the Co-Principal Investigator of a large VA multicenter clinical trial comparing off pump to on pump coronary artery bypass. Dr. Grover was the President of the Society of Thoracic Surgeons from 2006-2007. He is currently on the National Quality Forum Board of Directors. He has authored or co-authored over 260 scientific papers, many of which are in the area of utilizing surgical databases for quality improvement. Dr. Grover is a recipient of the Duke Medical Center Distinguished Alumnus Award.

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Fred Grover Jr. M.D. is a solo board certified family physician who has been practicing in Denver since 1994. He has a diverse background including work experience at Kaiser, University of Colorado, and recently private practice for the last 4 years. This has given him the opportunity to work in the big HMO setting, academia, and the real world of running a private practice. He is an Assistant Clinical Professor of Family Medicine at the University of Colorado, is on the board of the Colorado Clinical Guidelines Collaborative, and past board member of the Colorado Academy of Family Physicians. He received an NIH grant in 2003 to promote colon cancer screening using a patient education module on a tablet pc. He has been active locally in promoting the patient centered medical home, evidence based guidelines, and the use of technology for improving health outcomes.

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Dr. John G. Hunter has specialized training in all aspects of advanced and innovative upper GI tract surgery, with special clinical interests in the management of diseases of the esophagus and stomach, and biliary system. He has specific interest and expertise in esophageal cancer, gastroesophageal reflux diseases (GERD), and achalasia. Dr. Hunter spent 11 years at the University of Utah (1981 – 1992), nine years at Emory University School of Medicine in Atlanta (1992 – 2001), where he was Clinical Vice Chairman of the Department of Surgery, and came to Oregon in 2001 to become the Mackenzie Professor and Chair, Department of Surgery at OHSU. His is co-director of the OHSU Digestive Health Center, and vice-president of the OHSU Medical Group. he serves on the Nominating Committee of the American College of Surgeons, the Membership Committee of the American Surgical Association, is the past president of SAGES and is secretary of the SSAT. As well, he is the Editor-in-Chief of the World Journal of Surgery.

Lilly Marks
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Lilly Marks is Senior Associate Dean of Administration and Finance at the University of Colorado School of Medicine and Executive Director of University Physicians, Inc. She has spent over 25 years in academic medicine in a variety of administrative and leadership positions. A graduate of the University of Colorado, in 1989 she was appointed Senior Associate Dean for Administration and Finance at the University of Colorado School of Medicine. In 1991, Ms. Marks took on the additional and concurrent role of Executive Director of University Physicians, Inc., a 501(c) (3) that operates as the centralized faculty practice plan at the University of Colorado School of Medicine. Ms. Marks is past chair of the AAMC Group on Faculty Practice and also serves on the steering committee of the University Health Systems Consortium Group Practice Council. She has also served as chair of the Academic Practice Assembly of the MGMA and as a member of the MCMA national board of directors. Ms. Marks is a frequent speaker on topics related to medical school administration and finance, clinical practice management and compliance issues.

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Dr. Mayer is a Senior Associate in Cardiac Surgery at the Children's Hospital, Boston and Professor of Surgery at Harvard Medical School. His academic interests have encompassed several areas of cardiovascular surgery, including the short- and long-term outcome of the Fontan operation, cardiac transplantation, and tissue engineering of cardiac structures. Dr. Mayer received his BA and MD degree from Yale University. He completed an internship, general surgery residency, and cardiothoracic surgery fellowship at the University of Minnesota Hospital & Clinics from 1972-1981. From 1981 to 1984, he was a US Air Force cardiothoracic surgeon on active duty at the Keesler USAF Medical Center in Biloxi, MS. In 1984, he joined the staff at Children's Hospital, Boston, MA where he specializes in Pediatric Cardiac Surgery. He is currently a member of the board of directors of the American Board of Thoracic Surgery. Since 2002, he has chaired the Council on Health Policy and Relationships in the Society of Thoracic Surgeons and is Past President of the Society (2007-2008).

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Dr. Selker is Dean of Tufts University Clinical and Translational Science Institute, Executive Director for the Institute for Clinical Research and Health Policy Studies at Tufts Medical Center, and Director of the Center for Cardiovascular Health Services Research at Tufts Medical Center. He is also Professor of Medicine at Tufts University School of Medicine and Director of its Graduate Program in Clinical Research at the Tufts Sackler School of Graduate Biomedical Sciences. His clinical practice in general internal medicine is in the Pratt Diagnostic Clinic at Tufts Medical Center. In his

research, Dr. Selker studies the factors that affect clinical care and its outcomes, and develops treatment strategies, decision aids, and computer-based systems for improving care. He is known for a series of studies of the factors influencing emergency cardiac care, including clinical, socioeconomic and gender issues, and is particularly known for the development of cardiac “clinical predictive instruments” to improve emergency cardiac care. He also is known for the development of information systems that provide feedback to improve clinical care. Dr. Selker’s research also includes work on fundamental issues of clinical study design, clinical effectiveness research, data analysis, combination of clinical data, and computer-based mathematical models that predict clinical outcomes. Dr. Selker has served as President, Board member, and in other leadership roles for a number of professional organizations, and has served as an advisor to academic and medical organizations and to government on health care, medical research, and health policy.

INSURANCE MARKET CODE OF CONDUCT PROPOSAL

For a host of complex reasons, an unregulated free market approach to health insurance is far from rational and has contributed substantially to the rise in health care costs, while reducing coverage and insurability. It is estimated that up to 30% of physician's time or $31 billion per year is spent by physicians per year on insurance plan interaction. Many private insurers are estimated to have excessive overhead and profits of at least 18-21% and lack transparency. True health care reform is impossible without insurance market reform. An intelligent regulatory scheme would serve to organize the enormous resources spent on health care into a more transparent and cost efficient model capable of delivering more dollars to health care coverage rather than health care administration.

The following insurance reform proposals include both structural improvements to the current system of defining health care coverage transactions and regulatory requirements for insurance companies. It is intended that these recommendations apply to all public and private insurance payors as appropriate (including Medicare, Medicaid, Tricare, SChip).

Systematic Health Insurance Reform Recommendations, Principles, and Structural Redesign Recommendations:

1. Creation of a Federal regulatory oversight body to set standards and audit health insurance companies to ensure compliance with all requirements. The regulatory agency should be federal for the following reasons:
    a. Current inconsistencies and ineffectiveness of various state regulatory bodies and departments of insurance suggest that effective and consistent enforcement can only be achieved on a national level.
    b. The majority of health care insurance is provided today by a handful of large national or regional companies that sell centrally designed and/or administered insurance products in multiple states which make variable enforcement on a state level ineffective.
    c. Large corporate employers are headquartered in a single state but provide insurance benefits in multiple states.

2. The agency's authority would include the following:
    a. Development of clear accounting standards and review metrics.
    b. Audit of insurers to ensure compliance with accounting standards and metrics and with regulations proposed below.
    c. Power to impose monetary penalties and to suspend or debar a carrier from participating in federal or state insurance programs if they violate any provision cited herein.
    d. Define standards for computing and reporting "medical loss ratio" and create thresholds for allowable "medical loss ratio." Administration and profit should not exceed two times that of Medicare administrative costs.
    e. Develop public utility like rate review for approval of rate hikes or reductions in medical loss ratio standard.

3. On the assumption that universal coverage will be achieved via coverage mandates, define required standards for insurance underwriting practices to include:
    a. Prohibition against rescission of coverage.
    b. Prohibition of pre-existing condition exclusions.
    c. Carriers may not “opt out” or “no bid” specific groups.
    d. Underwriting would be based on large group experience/community blended rating.
    e. Portability.

Targeted Regulatory Requirements on Insurance Companies

1. Common universal claims form and a common clean claim definition that is standardized across all insurance sectors (federal, state, and commercial).

2. Full adoption of the standardized correct coding initiative as the means for coding and reimbursement of services rendered.

3. Straight forward and transparent contracting process between payor and provider. New contracting regulations would stipulate that payors are required to do the following:
    a. Clearly and completely disclose to a provider the terms of reimbursement including all payment policies and all administrative requirements in a concise and readily understandable manner.
    b. Contracts must disclose parties that have access to provider contractual rates to include self insured groups, rental PPOs (silent PPOs) and other affiliated entities.
    c. Carriers shall be required to mail providers written notices of any material change impacting contracts and receive affirmative consent.
    d. Develop credible mechanisms giving providers the right to grieve contracting process violations first to the payor and, if unresolved on a timely basis, to federal insurance oversight board. Federal insurance board would review grievance and if found in violation of contracting process requirements, carrier could be fined, suspended, or disbarred from public health plan participation based on pattern of consistent violations.

4. Prompt payment and administrative regulations to require:
    a. Timely payment of claims.
    b. Permissible and reasonable documentation requests.
    c. Stipulated timeframes for review and resolution of denied payments.
    d. Strict time limits on retroactive claims payment adjustments.
    e. Prohibition against recoupment actions against future claims payments.
    f. Rapid phone access for physicians and patients seeking authorizations and claim resolution.
    g. Prior approval requirements should not be a barrier to reimbursement for services that would otherwise have been approved and paid.
    h. The cost/benefit relation between the pre-authorization process and savings is questionable. Pre-authorization requirements should not be imposed on services for which accepted appropriate use criteria are in place.

i. Understandable, transparent explanation of benefit forms (EOB's) clearly reporting the reason for denial for claim.
j. Reporting process requiring payors to regularly provide performance data on the above.

5. Adoption of a universal provider credentialing form.

6. Development of a process that consolidates all credentialing requirements (NCQA, URAC, JCAHO, etc.).

7. Development of a central credentialing registry to eliminate redundant administrative costs due to duplicative credentialing and re-credentialing processes. (e.g., CAQH in Massachusetts).

8. Require all carriers to have electronic claims payment capabilities consistent with HIPAA transaction standards.

9. Universal authorization requirements and forms (to include all prospective review programs) that are defined by central body based on singular set of criteria reflecting evidence based medicine appropriateness criteria.

10. Payor based quality and efficiency rating systems currently exhibit tremendous variations in ratings demonstrating fundamental flaws in either the criteria, implementation, or both.
    The following changes are proposed:
    a. Disconnect quality and efficiency ratings into separate processes.
    b. Charge professional societies and hospital associations with developing criteria and methods to review and report outcomes for their respective specialties.
    c. Allocate funds to assist professional societies in developing databases and registries.
    d. Allow payors to substitute their own quality metrics only when there is a void in specialty society developed and other widely accepted objective evidence based metrics.

PHYSICIAN REIMBURSEMENT

1. Increase payment for high or improving quality of care, appropriateness of care, efficiency and coordination of care, and for preventative medicine, using a modified fee for service for specialties and medical home for primary care.

2. Incentivize for participation in national or regional databases evaluating outcomes and processes of care.

3. Increase payment to specialties that have or are predicted to have significant workforce shortages; currently, primary care, general surgery, and cardiothoracic surgery.

4. Increase payment to physicians going to underserved geographic areas.

5. Increase payments to physicians who have implemented electronic health records and e-prescribing, and other HIT that improves care quality and efficiency.

6. The cost of these payments (incentives) must come from overall health expenditures, not just from the physician reimbursement pool since only 17-19% of total healthcare expenditures are to physicians; there are not enough resources in that pool to finance the above incentives in a significant way and there have been significant reductions during the past decade. A more appropriately composed physician workforce would lead to more cost-effective use of the large amount of healthcare directed by physicians, leading to savings that would offset the costs for these incentives.

7. Fund pilot studies where physician specialties gain share and bundle payments with hospitals in a joint effort to improve quality, efficiency, control costs and increase patient satisfaction, but with limitations on incentives that could become perverse incentives to stint on care.

8. Financial support for the development of databases by specialty societies to enable physicians to monitor and improve quality, appropriateness and cost of care.

9. Disconnect work RVUs and payments from practice costs. Reimburse physicians practice costs via a cost reporting system akin to hospitals with predefined limits on the practice expenses that could be " passed through."

10. Recognize and correct the dramatic cuts imposed on physician reimbursement over the past decade (combination of inflation, Conversion Factor, RVU reductions, SGR & budget neutrality factor) resulting in 40-50% reduction in inflation adjusted payments over a decade. (Reductions in payment per unit of service results in patient churning and inappropriate utilization, up-coding, etc.).

11. Develop adjustments/enhancements to CPT codes for certain complexity indicators (e.g.: multiple co-morbidities, add a modifier to a CPT code for an MD who mentors a student in an outpatient setting).

12. Increase/enhance payments to physicians serving disproportionate numbers of underserved populations (e.g., DSH for doctors)

13. Basic physician care should have three components: 1. Base Management Fee paid to the PCP or qualified specialist as a monthly fee for each patient for whom they provide overall healthcare, health promotion, and preventive services. 2. Condition-Specific Management Fee for certain diagnosed conditions paid at a level consistent with the intensity and complexity of care coordination that patient requires. 3. Fee-for-Service Payments (even if at the individual physician level this is translated into a straight salary), with quality, patient satisfaction, and appropriateness metrics and incentives to promote that services be in the best interest of the patient and overall good care.

14. Allow demonstration projects in which a medical specialty or subspecialty would be exempted from SGR imposed reductions in conversion factors if that specialty maintains an outcomes focused database that captures more than 50% of services provided by the specialty and demonstrates control of growth of the volume of services provided. Provide increases in conversion factors for that specialty if improvements in risk adjusted outcomes can be demonstrated with data from the specialty database or registry.

15. A standard capitation payment for integrated systems could be piloted in those systems that are large enough to be at risk for the overall management of a patient population.

Patient Centered Medical Home

The US health care system currently has poorer health outcomes at a much higher cost than do other industrialized nations.

1. Commercial payors must participate along with Medicare/Medicaid and provide an adequate incentive to help primary care maintain financial viability and growth.

2. Payments should be made for the extra services provided by PCMH such as care coordination (using health status adjusted fee or FFS), time spent meeting with and coordinating the expanded health team, non-visit based encounters, health coaching, mental/social services, access to community services, EHR, and participation in registries.

3. Primary care providers need extra capital to be able to hire staff, create a team and to purchase HIT.

4. In order for this to succeed, educational services must be funded for patients; including weight loss, nutrition, smoking cessation, and patient shared decision-making services/programs/materials.

5. In order for this to succeed, a real time HIT system must be in place in order to help facilitate communication between providers and the rest of the coordinated team. A web based EHR with a patient portal should be available for a reasonable cost. Support for HIT should be provided as well.

6. Part of the PCMH is that the patient actively participates in decision making and provides feedback to ensure expectations are met. Having point of care decision making capacities that include evidence based guidelines, alerts, and reminders as part of HIT will help facilitate this as well as will having access to registries and their results. Linking these to quality improvement reporting should be included.

7. The PCMH of the Community Care of North Carolina is a working example of a PCMH and shows excellent quality and cost outcomes through disease management, evidence based clinical practice and an emphasis on a physician-led team approach. Care coordination services experienced by the patient as extensions of the medical practice should be the goal rather than separate generally telephonic disease management programs.

8. The PCMH should reward primary care physicians for seeing patients for acute care episodes. Incentives should be offered for improved access to care, including after hours care.

9. Incentives for improving chronic disease management via E-mail and electronic communication with the patients should be provided.

10. Care coordination for referrals, medication management, preventive testing should be supported by the PCMH.

WORK FORCE ISSUES

1. There is a predicted 90,000 physician shortage in the U.S., including a current critical shortage of primary care doctors, a significant shortage of general surgeons, and a predicted 40% shortfall of cardiothoracic surgeons by 2020-2025.

2. These shortages are more severe in certain underserved geographic areas necessitating incentives for practice in underserved areas.

3. Funding must be appropriated to medical schools for expansion of existing medical school capacity by 30%. Capitation payments to enable schools of medicine to train more students should be instituted along the lines of the federal capitation support provided in the 1970's This must be coupled with appropriate increases in residency training positions to fully train physicians needed for a sufficient and properly distributed physician workforce.

4. Physician reimbursement must be increased in primary care and specialties that have or will have predicted workforce shortfalls. (A more appropriately composed physician workforce would lead to more cost-effective use of the large amount of healthcare directed by physicians, leading to savings that would offset the costs for these incentives.)

5. The Federal Government should provide complete loan repayment programs for medical school graduates entering primary care and specialty residencies that have current or predicted workforce shortages as a very cost-effective and immediate incentive for supporting growth in these underserved fields.

6. Grants to fund preceptorships for medical students in Family Medicine and primary care General Internal Medicine need to be created to facilitate attracting more physicians into primary care.

7. Increase payments for primary care training to support added costs of training in non-hospital settings, as well as to offer incentives to medical students who choose a primary care career.

ROLE OF PROFESSIONAL SOCIETIES

1. The mission of professional societies should be to improve the quality and value of medical care through:
    a. physician and patient education and research promotion
    b. development and application of standards and guidelines
    c. maintenance of clinical databases and registries that provide the ability to collect information on patient outcomes and feedback of outcomes data to members of the society
    d. Advocacy for health policy that improves patient care and the public's health.

2. This mission can be accomplished through the following strategies:
    a. Educate and communicate medical advances to health care professionals.
    b. Disseminate tools that facilitate best practice.
    c. Promote professionalism and self-regulation – the interests of patients is primary.
    d. Develop clinical standards.
    e. Promote the development of an adequate work force and establish training standards.
    f. Actively promote development of patient-centered health care policies.
    g. Develop credentialing standards.
    h. Develop guidelines and appropriate use criteria to improve quality patient care.
    i. Develop clinical registries that improve our understanding of medical care to further promote the development of best practices and serve to provide feedback on performance to individual practitioners and practices.
    j. Work with other agencies to develop performance measures that are meaningful in the care management of patients.
    k. Promote maintenance of certification with strategies that facilitate continuing education and evaluate the application of knowledge at the point of care.
    l. Collaborate with other health care organizations to promote quality health care delivery.
    m. Advocate for conditions, care and other measures that improve public health.

SUPPORTING ACADEMIC MEDICINE MISSIONS IN HEALTH CARE REFORM

1. Academic Health Centers (AHCs) provide the training for physicians and health professionals in the US.

2. AHCs are the primary home of basic and clinical and translational research and the training of scientists. The continued success of the research enterprise that is supported by AHCs is integral to the nation's and world's health.

3. These academic missions of research and education often require significant institutional cross subsidies that have historically been derived from the margins on clinical earnings. Given the decline in the Medicare physician fee schedule and managed care reimbursement, these margins have disappeared, threatening AHCs' abilities to address workforce shortages via increased class size. This educational expansion is further exacerbated by recent state budget shortfalls across the country.

4. In order to train enough physicians to meet workforce shortages, federal funding on a per capita medical student basis should be provided to American medical schools to allow them to expand training capacity (similar to the medical school capitation payments in the 1970's).

5. Increasing the number of medical school graduates must be coupled with federal policy to appropriately increase and fund additional residency positions.

6. There should be recognition of potential need to redirect Graduate Medical Education support to ambulatory settings where residency training increasingly occurs.

7. There should be recognition of the need to reimburse faculty physicians for residency training costs (current reimbursement to hospitals via Indirect Medical Education payments often does not get passed on to the physicians doing the teaching and mentoring).

8. Funding for GME training should be recognized as the responsibility of all payors, not just Medicare and Medicaid.

9. While universal coverage may eliminate charity care and call into question the continued tax exemptions to some hospitals, university teaching hospitals should retain not-for-profit status based on preservation of teaching and research missions which require extra time and resources.

10. Cost effective, high quality health care is dependent on the continued development of new treatments, procedures, and technologies. AHCs are central to the advancement of clinical care via basic science discoveries, new technologies, and clinical and translational research.

11. AHCs provide a major portion of tertiary health care and the majority of quaternary care in this country. These special institutions represent some of the

greatest experience, expertise and outcomes for our most complex health problems.

12. AHCs not only provide clinical care, research, and education, they are also major economic engines in their communities and states generating thousands of high paying jobs.

13. AHCs train the majority of the health care professionals necessary to meet the health care needs of our society. These institutions' ability to meet expanding workforce shortages is dependent on their economic and programmatic health.

14. Improving the health of Americans relies on the success of the current health care reform initiatives, but it is also fundamentally rooted in the continued success of AHCs' basic and clinical and translational research and health education programs. This will require a sustained commitment and strong funding of NIH and VA research and training programs along with other federal and state initiatives to foster training of an adequate and diverse health care and research workforce.

ACCOUNTABLE CARE ORGANIZATIONS (ACO'S)

1. Is capitated care under a new name.

2. Creates a moral hazard where the fiduciary relationship between patient and physician is jeopardized by financial incentive to reduce the amount of care delivered
   a. Americans already are receiving only 50-60% of evidence based recommended care.
   b. ACO's may drop this percentage lower if financial incentives are present to do so without clear, established quality requirements.

3. Cost Pressure to reduce medical care has been shown to reduce both inappropriate and appropriate care (RAND Health Insurance Experiment) and thus approach does not guarantee that savings accrued would be delivering more preventative care and less unnecessary care. (e.g., extra imaging) as opposed to saving money by delivering less of needed care.

4. Is likely to drive the majority of physicians into hospital based employment models putting hospitals in the position of practicing medicine.

5. Existing ACO like institutions (Kaiser Healthcare, for example)
   a. Are criticized for failing to provide high quality, indicated care in a timely fashion.
   b. Are criticized for failing to provide innovative care, even if cost effective.
   c. Limit options for their patients – leads to high levels of patient dissatisfaction.
   d. May drive up costs by financial incentive to create expensive (redundant) programs within their community.
   e. May drive down quality by diluting the experience (volume) of specialists providing high risk procedures who are in centers outside the ACO.
   f. Are challenged by the rural environment where "critical mass" is hard to achieve.
   g. Work better for health maintenance and chronic disease management than for providing high intensity acute care or caring for uncommon but highly morbid conditions.

6. This concept may be more applicable to limited capitation for medical homes for primary care and chronic (outpatient) disease management.

7. There are alternative methods to reward efficient use of scarce resources such as targeting areas of high expense practice (e.g., imaging, expensive pharmaceutical use, spine surgery, etc.). A way that reinforces engagement of

physicians would be to create professional guidelines and mechanisms for assessing effectiveness for use of new and expensive technologies that could be used to

a. provide feedback to clinicians for use as benchmarks and comparison with their peers in the community, adjusted for patient mix.
b. create financial penalties for misuse of expensive technology and treatment.

HEALTH INFORMATION TECHNOLOGY

1. Required Components:
    a. National real-time accessible data base
    b. Point of use workstations
    c. CCHIT certified EMR software
    d. All systems must be compatible and talk to each other

2. Data base
    a. Centralized (on national basis) server with download and upload capability.
    b. Updatable and upgradeable hardware and software.
    c. Accessed from workstations via EHR software in real time format.
    d. By containing our recommendations in the national database, should help lower the cost of EHR's because they will not have to duplicate programs.
    e. Entire medical record of every patient regardless of the patient's insurance carrier.
        i. Patient medical record files organized and accessed utilizing nationally recognized Patient Insurance Number.
    f. Entire medical record billing history of every patient.
    g. Entire recognized CPT and ICD-9 codes upgraded for free annually.
        i. Needs easy universal search engine for codes, synonyms, definitions, etc.
        ii. Currently physicians pay big dollars to either learn how to code or to pay someone to code for them. This is wasted money.
    h. Medical Necessity comparison between CPT and ICD-9 codes.
    i. Updatable pharmaceutical drug formularies, Eprescribing and medicine reconciliation
    j. Drug interaction programs with all prescribed, over the counter and herbal treatments loaded and updated for free frequently.
    k. Must have architecture to accommodate specialty and disease specific databases and have the ability to form registries which are accessible to the physician and to professional societies to monitor quality, appropriateness of care, efficiency, comparative effectiveness and for clinical research.
        i. Automatic data reporting to registries and for quality reporting is mandatory.
    l. Quality measures should report from accurate electronic data and not be confused with cost data. These measures should be developed by professional societies based on guidelines developed by the societies.
        i. These should not be developed by insurance plans, and should be easily tracked through the database and point of care support must be included.
    m. Data must be easily queried.
    n. Preventive reminders as selected by the clinician as well as tools that facilitate reaching goals in management of the patient.
    o. Pop ups as selected by the clinician to access guidelines, quality measures, algorithms, etc., at the point of care. This is computer decision support at the point of care.
    p.
        i. Retrievable list of all patients with preventative medicine due each month

  ii. This should also include OB reminders and disease specific recommendations, i.e., HgA1C, urine microalbumin, etc.

q. "Trigger" on and off capability for patients to allow PCP to access real time data.
  i. Once "triggered" on, PCP would have authority to allow access to any entity needed for the care and treatment of the patient.
  ii. Once "triggered" off, PCP would only have access from the on to the off point.
  iii. This allows for HIPAA compliance so once a patient is no longer in your care, you can only look up to the time they transferred.
  iv. You would still have access to data for registries.
r. Patient medical records can be downloaded to point of service memory device for archiving purposes.
s. Automatic data extraction to patient personal health record. Data extracted from the medical record can not be altered but can be corrected by clinicians with appropriate attribution. Data entered by the patient needs to be clearly identified.
t. Ability for patients to access their demographics and medical history, i.e. problem list, medications, results of tests. They should be able to update demographics. This is recommended as part of a Patient Centered Medical Home.
u. Interoperability with secure data exchange that is HIPAA compliant
v. Consent free zone when patient seeks care from a physician that permits access to data that is necessary for that physician, consultants and care team members to access data.

3. Workstations
  a. Used for access to the database from the point of service.
  b. Access database via secured internet with EHR software.

4. EMR Software
  a. Web based software.
  b. Used as a bridge between Data base and Workstations.
  c. Scheduling programs should keep track of appointments cancelled, rescheduled or no showed to. This list should be easily retrievable by weekly list of changes in appointments, or by specific patient.
    i. Scheduling programs should also allow for individual practice preferences.
  d. Ability to sign ABN's/permission to treat/ billing and procedure consents on a work pad thus not creating paperwork that must be scanned in.
  e. Ability for patients to pay on line based on EOB information.
  f. Ability to do HEDIS tracking.
  g. Must be interoperable. (President Lincoln mandated that railroad tracks all have the same dimensions which pushed forward the progress of the railways in this country.)
  h. Must be inexpensive and IT support must be financially supported by the federal government and private insurance.
    i. Physicians should not bear this cost alone.
    ii. Private insurances will benefit from more efficient care and better outcomes, thus lowering their costs.

AN ALTERNATIVE MEDICAL LIABILITY SYSTEM

1. Create a Federally mandated alternative medical liability system available to physicians who participate in registries and other quality measurement systems such as PQRI.

2. The system should use standards and guidelines developed by Professional Societies as the standard of care.

3. All cases for participating eligible physicians go to Arbitration Panel, composed of:
    a. Judge
    b. Lawyer
    c. 2 physicians
    d. Lay Person

4. First decision of Panel is:
    a. Negligence
    b. Frivolous
    c. Uncertain

5. Arbitration panel determines need for and hires experts.

6. Encourages settlement or proceeds to arbitrations in cases where negligence exists.

7. When payment is rewarded there should be structured payments that are offset by other coverage such as insurance.

8. Determine percent responsibility of each defendant, each defendant only responsible for their own contribution to negligent behavior.

9. System results in faster resolution of claims for injured patients.

10. Trial option available for defendant or plaintiff if they dispute the arbitration results but party that demands trial is responsible for all cost should that party lose in court.

11. An alternative system would be to have a Medical Tribunal system, similar to the Arbitration Panel. The panel has to determine that negligence occurred or that there is credible evidence to require additional testimony from experts to determine the validity of the complaint. Findings by the Panel that do not support the plaintiff’s claims result in the requirement for a $10,000 bond to be posted by plaintiff’s lawyers before proceeding to trial and forfeitable if trial verdict is in favor of defendants (Massachusetts system).

ATTACHMENTS

Medicare Fee Schedule Changes, 1995 to 2008 Chart

Total Cost to U.S. Physician Practices Interacting with Health Plans Chart

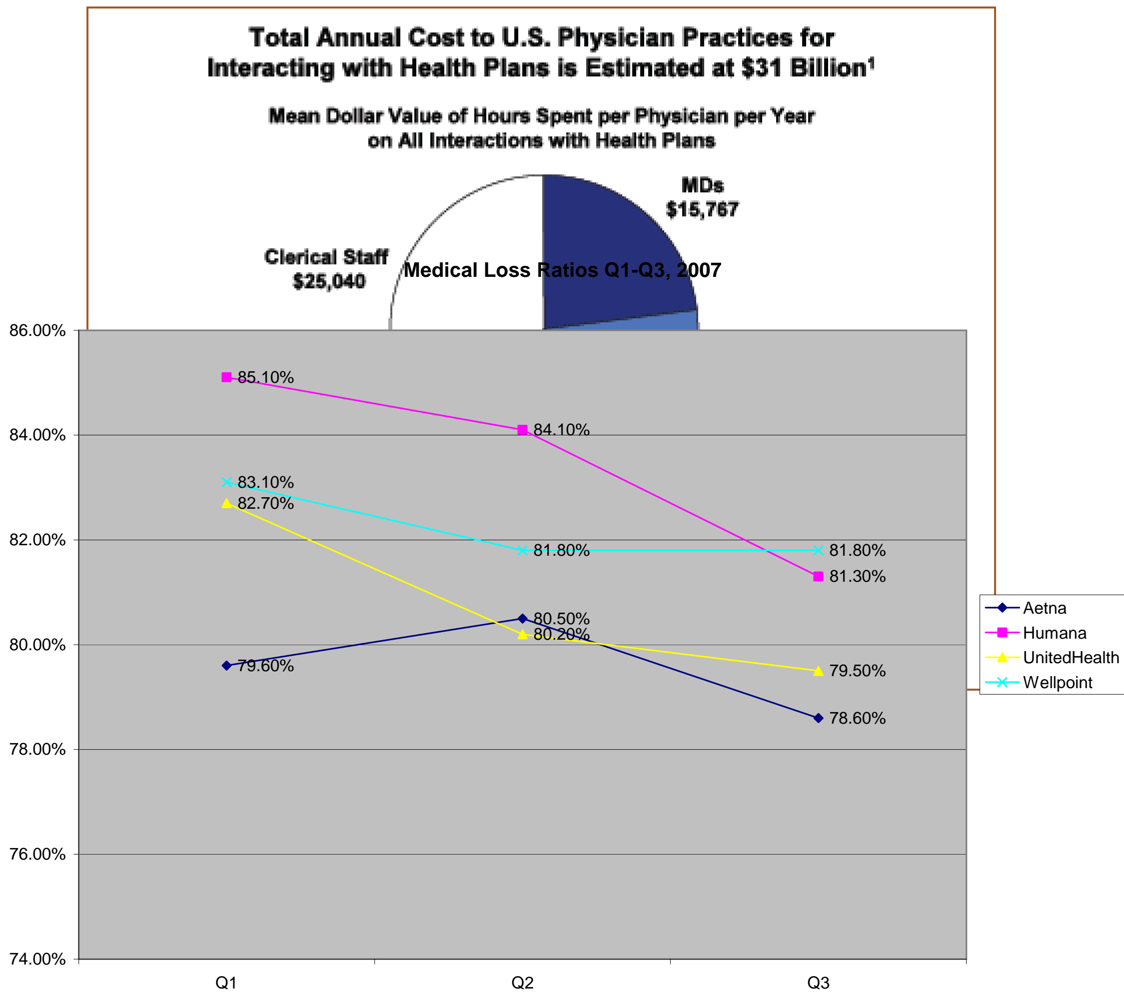
Medical Loss Ratios Q1-Q3, 2007 Chart

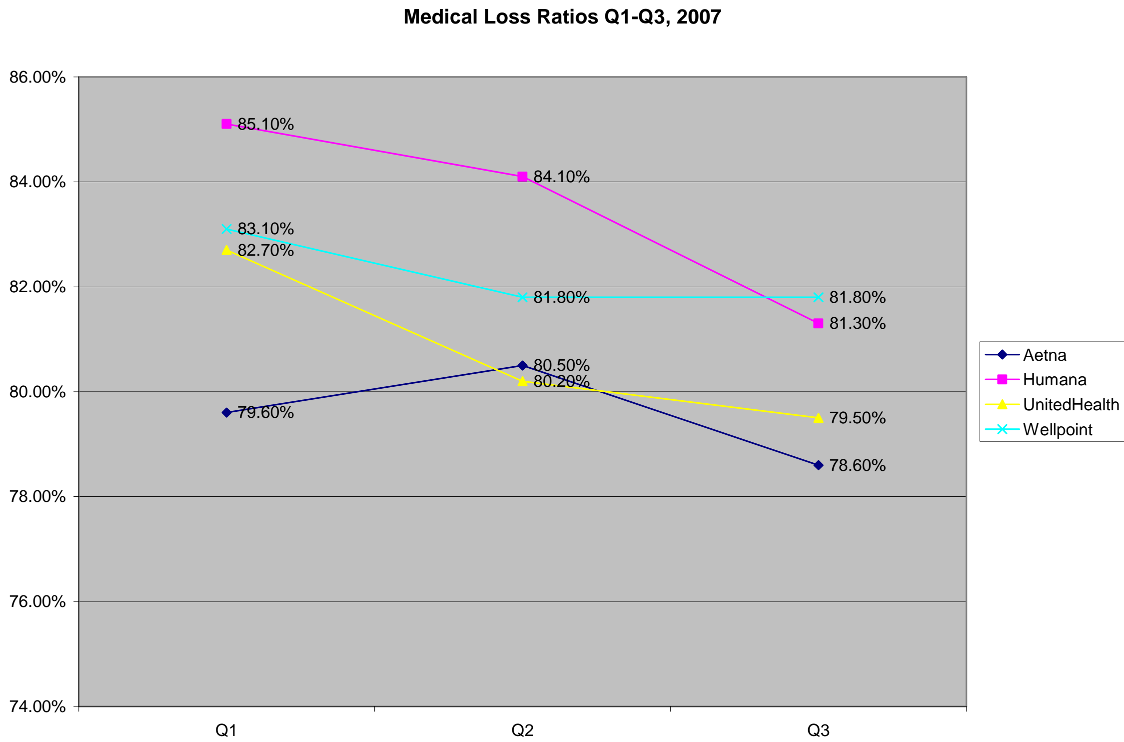
Medicare Fee Schedule Changes, 1995 to 2008

Year	CF Change	CF	CPI*	CF in Constant 1995 Dollars
1995		$ 36.8369	0.0%	$ 36.8369
1996	1.0%	$ 37.2053	2.9%	$ 36.1263
1997	-0.6%	$ 36.9958	2.3%	$ 35.0967
1998	-0.8%	$ 36.6873	1.3%	$ 34.2837
1999	-5.3%	$ 34.7315	2.2%	$ 31.8048
2000	5.4%	$ 36.6137	3.5%	$ 32.3550
2001	4.5%	$ 38.2581	2.7%	$ 32.8953
2002	-5.4%	$ 36.1992	1.4%	$ 30.6892
2003	1.6%	$ 36.7856	2.3%	$ 30.4691
2004	1.5%	$ 37.3373	2.4%	$ 30.1838
2005	1.5%	$ 37.8975	2.7%	$ 30.8095
2006	0.0%	$ 37.8975	2.9%	$ 28.9450
2007	0.0%	$ 37.8975	3.0%	$ 28.0767
2008	0.5%	$ 38.0870	3.0%	$ 27.3706

Collective Effect of CPI, 1995-2008: - 28.1%
Variance of 2008 CF at 1995 Constant Dollars: -25.7%

*CPI: Consumer Price Index from 2008 Medicare Trustees Report


Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans is Estimated at $31 Billion[1]
Mean Dollar Value of Hours Spent per Physician per Year on All Interactions with Health Plans
MDs $15,767
Clerical Staff $25,040
Medical Loss Ratios Q1-Q3, 2007
86.00%
84.00%
82.00%
80.00%
78.00%
76.00%
74.00%
85.10%
84.10%
83.10%
82.70%
81.80%
81.80%
81.30%
80.50%
80.20%
79.60%
79.50%
78.60%
Q1
Q2
Q3
Aetna
Humana
UnitedHealth
Wellpoint



Using the figures in the chart, let's look at UnitedHealth Group to see what its medical cost ratio (MCR) saving might add up to be. Aggregated over three quarters, its MCR added up to a combined decline of 3.2 percent. Based on SEC filings, UnitedHealth Group reported premiums totaling $16,984,000,000 for those same three quarters. If we simply calculate what savings 3.2 percent of those premiums represents, we get a total of $543,488,000. That is, a 3.2-percent decline in MCR over nine months translates to more than a half-billion dollars in savings to UnitedHealth Group's bottom line.