New Jersey Chapter GOVERNOR'S NEWSLETTER

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | Doctors for Adults

Summer 2005

Sara L. Wallach, MD, FACP
Governor, New Jersey Chapter

NATIONAL MEETING UPDATE:

The National meetings in San Francisco were near perfection. Highlights of the meeting included an inspiring keynote speech delivered by **Risa J. Lavizzo-Mourey**, MD, MACP in which she challenged physicians to demonstrate leadership in promoting quality in the practice of medicine. There were lectures or workshops on practically every conceivable topic in medicine. The updates in the subspecialties (where significant publications over the past year were presented) are always thought provoking. CDs of the updates and other lectures are available for purchase through the ACP website. Twelve fellows from New Jersey were inducted and our state champions from Overlook Hospital participated in the Associates Competition.

A new initiative to improve diabetes care was unveiled. There will be opportunities for internists to become certified in diabetes care. A position paper was released entitled "Redesigning Medicaid During a Time of Budget Deficits". The main points of this paper are as follows;

1. The Medicaid program should be preserved and expanded to provide coverage for more underinsured patients.
2. Medicaid eligibility should be based on national standards.
3. Long-term care facilities other than nursing homes should be covered.
4. States should have more flexibility in providing Medicaid coverage.
5. Physicians and health care facilities should be adequately reimbursed to enhance provider participation.

This paper will be referred to our Health and Policy committee so that the national concerns can be addressed at a state level.

Prior to the Annual Scientific Session, The Boards of Governor's, and Regent's discussing college policies. Resolutions that were passed included:

1. Examining the Feasibility of Establishing Health Courts to Adjudicate Medical Malpractice Claims.
2. Increasing Vaccine supplies
3. Providing Medicare reimbursement for Family Counseling
4. Ensuring objective medically sound audits of Medicare Charges
5. Promoting member involvement in community education regarding use of external defibrillators.

Resolutions passed with amendment included:

1. Including Private Physicians' Offices and Clinics in Public Health Planning and Communication about Disease and Disease Outbreaks.
2. ACP participation in the"Health Care That Works for ALL Americans" Act.
3. Increase Medicare fees for nursing home visit.
4. Financing Pay for Performance Awards.

5. Assuring that Electronic Health Records are Cost effective.
6. Increasing Physician Compensation for Cognitive Services.
7. Employing Opiate Replacement Therapy Programs in Correctional Healthcare.
8. Encouraging a shift in the Internal Medication Education Paradigm for those Choosing Careers in General Medicine.
9. Providing Information about the "Welcome to Medicare Exam" on the ACP Practice Management Center Website.
10. Developing an ACP Practice Improvement Recognition Certificate.
11. Addressing Internist's Concern's through ACP Involvement in Demonstration Programs and through Communication with Members.
12. Encouraging ACP Interaction with State Medical Societies.
13. Support for Full Accountability of U.S. Detention and Interrogation Practices and for Adherence to Medical Ethics Standards

I am almost never able to predict which resolutions will pass easily and which will inspire a great debate. For further information on these resolutions and those that did not pass, consult the national ACP website.

The Board of Regent's adopted the following resolutions:
1. Increasing Medicare fees for Nursing Homes
2. Encouraging ACP Interaction with State Medical Societies
3. Providing Information about the "Welcome to Medicare Exam" on the ACP Practice Management Website

The rest of the passed resolutions were sent for study to ACP committees.

The sessions of the governor's meetings were primarily devoted to discussions concerning improvement of the dysfunctional payment system. I am including in this newsletter a separate news article on this topic.

LEADERSHIP DAY

Leadership Day in Washington DC was extremely well attended and invigorating. The Chapter's attendees included: **Thomas Comerici**, Camden; **George DiFerdinando** ,East Brunswick; **Francis L. Griffin**, Plainfield; **Mary Herald**, Westfield; **Colleen Taylor**, Long Branch; **John Walker**, New Brunswick; **Sara Wallach**, Fair Haven and **Joseph d' Oronzio**, Summit. Some of the specific issues that were discussed with our Senators, Representatives, and their staff were: halting scheduled cuts in Medicare reimbursement for a least two years, while pay for performance is studied, urging Congress to enact legislation to overcome barriers to the adoption of Health Information Technology (electronic health record systems), and enact legislation to allow restructuring of medical student debt without being locked into set interest rates. As we go to press, I have just read that Medicare cuts have been reversed and replaced with a 2.7% increase this year.

HEALTH AND PUBLIC POLICY COMMITTEE NEWS

The Chapter's Health and policy committee has been meeting regularly and has initiated efforts to facilitate passage of the anti-smoking legislation. **Laura Kahn** M.D. FACP is spearheading this effort. Members of the committee are considering holding a health policy forum in the fall devoted to health care reform and tort reform at the state level. Interested members should contact **Dr .John Walker** via **Stacey Knowles**. I have enclosed in this newsletter a copy of the letter sent to the Board of Medical Examiners concerning the increase in the licensure fee (see page 4).

NJ CHAPTER UPCOMING ELECTIONS:

The Nominations Committee has been working very hard on our upcoming election. **Dr. Francis Griffin** our past Governor is the chair for this committee which includes **Mary Herald**, MD, MACP, **James Brody**, MD, FACP, and **Diana DeCosimo**, MD, FACP. Any questions pertaining to the process should be directed to Dr. Griffin, The New Jersey Chapter is electing a Secretary and Treasurer for the executive council. There are 6 council positions being elected, 3 from the south and 3 from the north. The ballots will be mailed out during the month of July. There will be a special newsletter this summer to announce the results.

The following are the members of the chapter that are running:

Secretary: Eileen Moser, MD, FACP

Treasurer: Richard Kasama, MD, FACP

Council South:
Zia Salam, MD
Laura Khan, MD
David Ross, MD
Lookman Odejobi, MD
Elaine Leventhal, MD
Dennis Cleri, MD

Council North:
William Farrer, MD
William Lowe, MD
Beth Nalitt, MD
Alfred Gaymon, MD
Jeanine Bulan, MD
Jerome Levine, MD

2006 NEW JERSEY CHAPTER SCIENTIFIC MEETING

February 3 & 4, 2006
Sheraton at Woodbridge Place
Rt. 1 South
Iselin, NJ

Special workshop on Heart Auscultation
Breast Cancer and Chemotherapy, IBD, Reading EKGs, Insurance and the Impact it has on Care, Complications of Cosmetic Surgery, Emerging and Re-Emerging Infectious Diseases, Pulmonary Hypertension, Preventative Medicine and much more!

SUPPORTING YOUR CHAPTER THROUGH CHAPTER DUES

Chapter dues are the backbone of local activities and vital to the success of our chapter. While we are provided some financial support from the national office, the chapter dues collected provide the majority of financial support for local activities. Educational meetings, mentoring programs for medical students, local Associates' research competitions, advocacy with state legislators, and participation by chapter leaders in Leadership Day on Capitol Hill are just some of the activities supported by your chapter dues. Many of these activities are orchestrated by unpaid volunteer leaders in our chapter. However, the increase in activities at the local level has created the need for additional staff support to help manage the day to day operation of the chapter. Your chapter dues help support the cost of local staff and provide funding for new and existing chapter initiatives. When you receive your dues notice, please remember to include the chapter dues in your payment. You will be contributing to the success of many grass roots activities happening right here at home.

GENERAL CONTACT INFORMATION FOR THE NJ CHAPTER

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LETTER SENT TO THE BOARD OF MEDICAL EXAMINERS

March 18, 2005
William V. Roeder, Executive Director
New Jersey State Board of Medical Examiners
P.O. Box 183
Trenton, NJ 08625-0183
Re: Proposed Amendment: NJAC 13:35-6.13

Dear Mr. Roeder:

I am writing on behalf of the New Jersey Chapter of the American College of Physicians (ACP), the largest medical subspecialty society in New Jersey, representing over 4,000 member internists. We are responding to the above cited proposed amendment that will raise the annual licensing fees for physicians from $340 to $610, an increase of 80%.

The ACP would first like to acknowledge the Board's legitimate activities in support and protection of the integrity of the medical profession and of the health and safety of the citizens of New Jersey. We accept its role as a public good in maintaining a responsible and effective licensing process and in playing a role in holding licensees accountable in the discipline process. As a professional college devoted, for 90 years to the continuing education of physicians, we especially applaud the efforts of this Board to join other state medical boards to ensure a minimum of CME activity for its licensees. The public of New Jersey - as your constituents and as our patients - deserve the very best, most effective and cost efficient services we can provide for their collective welfare.

The professions and public servants need to cooperate in defining common beneficial objectives and effective strategies to attain them. Our comments are here offered in this collegial spirit of common goals and professional commitments. We are, therefore, opposed to this amendment, as proposed, because we think that it does not meet these criteria of professional and public service responsibility.

***The public good**. A large part of the justification of the 80% increase is based on expected benefits that will accrue to the citizens of New Jersey. We feel it is not reasonable to place the total financial burden of implementing these programs on physicians. These public benefits should be financed by the public purse, as a basic expression of support for expanded services that will add to their health and safety. A similar point needs to be made about restructuring the financial support for the cost of legal representation: this 23% of your budget is also a public good function which might better be the responsibility of the office of the attorney general, rather than that of physicians and other licensees.*

***National standards and benchmarks**. We are insufficiently informed, in this proposal, how this new fee schedule compares with other states and with the services offered by these states for the benefit of the public and the professions. This requirement for full informational back-up is basic for accountability, performance measures, and outcomes. The Board is no less subject to this requirement than the professions it regulates. Therefore, before we can support an increase of such magnitude, we need to know if it is consistent with national standards of cost and efficiency. We are aware, for example, that there seems to be a correlation between fees and the CME requirement of licensing boards. How does New Jersey's old and new scale fit this pattern? Historically, the NJ fees have been just at the mean of all the states: this raise will place it in the top 10%. Clearly, this is extraordinary and therefore seems quite arbitrary. Perhaps there are specific benchmark justifications: we need to consider that information.*

***Specificity and timing**. The proposal does not make clear the specific justification for the additional FTEs. Clearly, a Director of Education is linked with the new CME monitoring and this is supportable. What are the functions of the other 22 FTEs? Perhaps if this information were to be openly shared we might both benefit from being fully informed as a basis for consent and support. We are also concerned that there is no evidence put forward on how the "budgeted positions" will be rolled out. Certainly, this will not happen in July 2005, nor by December 2005, nor perhaps by July 2006 or 2007. This continual surge of revenue expected from this 80% rise in fees will create a surplus the use of which is neither identified nor justified in the proposal. This suggests the possibility of proposing a 3- or 4-year phase-in period for any licensing fee increases.*

***Cost of doing business**. As the representative of the Internal Medicine physician community, the ACP is extremely sensitive to the rise in the costs of doing business that you cite in the justification section of your proposal. Since 1995, moreover, there has been a well-documented decline in physician real income, particularly in primary care specialties, such as general internal medicine. The vast majority of internists in New Jersey run small businesses -- practicing in partnership or small group practices. We, too, have seen the rise of running expenses - not only employee salary increases and fringe benefits, as you cite, but additional expenses to meet regulatory mandates and the costs of liability insurance. None of these increases, we are relieved to report, match the 80% you are proposing. It is an inordinate rise. It is not at all clear how increases in your expenses measurable in single digits can justify a rise in your revenue of 80%.*

These are the major reasons we do not support your proposed amendment. We would like you to address each of our constructive objections with correspondingly responsive and productive alternatives. We feel, on the whole, that we need to see a proposal of a lesser overall increase, more fully justified, phased in over several years, and responsive to both the public and professionals to whom you are accountable. It is not fair to have only the professions bear the burden of your justifiable expenses. The public, a major beneficiary, and the Office of the Attorney General, a major public agency, ought to share this responsibility.

We wish you well in your efforts to resolve this difficult problem and look forward to receiving your response.

Thank you for your attention.
Sincerely,

Sara Wallach, MD, FACP
Governor, New Jersey Chapter
American College of Physicians

UPDATE ON MAINTENANCE OF CERTIFICATION

Over the past year, a collaborative working relationship between the American College of Physicians (ACP) and the American Board of Internal Medicine (ABIM) has resulted in ABIM's granting credit for an attractive new option for ACP's Medical Knowledge Self-Assessment Program 13 (MKSAP 13) to fulfill part of the requirement for maintenance of certification. In addition, starting in January 2006, a modified overall framework for Maintenance of Certification will be instituted by the ABIM, motivated by a desire to increase flexibility, reduce redundancy, emphasize assessment of performance in practice, and simplify the process for physicians recertifying in both Internal Medicine and one or more of its subspecialties. This update of the Maintenance of Certification process will provide a summary of the following specific topics: 1) the new MKSAP option; 2) the modified ABIM framework for January 2006; and 3) reduction of anxiety for candidates taking the closed-book examination. Additional information about the new MKSAP option can be found on the ACP website, and further description of the new ABIM framework can be found on the ABIM website.

The New MKSAP Substitution Option

The MKSAP substitution option was designed to offer recertifying physicians an alternative method to the ABIM Self-Evaluation Process (SEP) modules for fulfilling the maintenance of certification requirement for self-assessment of medical knowledge. By using MKSAP, candidates can simultaneously fulfill this requirement while studying for the closed book examination. In addition, the MKSAP substitution option has been designed to incorporate immediate feedback as well as education (and links to educational resources) into the self-evaluation process.

How does the MKSAP substitution option work?

The MKSAP substitution option is available to MKSAP 13 subscribers (either print or CD-ROM subscribers) as a no-cost benefit. The entire process is completed electronically. Candidates use their MKSAP subscriber privileges to access up to four question modules via the Internet, download them to their computer, answer the MKSAP question sets, and, using their ABIM candidate number, submit their responses via the Internet for ABIM recertification credit. MKSAP 13 subscribers who have registered with ABIM for maintenance of certification can initiate the process by accessing the following: http://www.acponline.org/mksaprecert/

Each question is presented in a way that combines self-assessment with education, and provides immediate feedback to the candidate. After the candidate reads the question, (s)he first selects and enters an answer choice for "grading" by the computer. If the submitted answer is correct, the candidate receives immediate feedback from the computer that the answer is correct, and is presented with the critique and discussion of the question. There is also an opportunity to link immediately to the relevant text from MKSAP 13 in order to obtain further educational material relevant to the question.

If the candidate answers the question incorrectly, (s)he receives that feedback immediately from the computer, and is provided with the link to the relevant MKSAP 13 text. After reading the text, the candidate has a second opportunity to answer the question. Following the second answer, the candidate receives immediate feedback about whether the answer is correct, and is presented with the critique and discussion of the question. Candidates are not required to complete each set of 60 questions at a single sitting, but can do so at whatever schedule is convenient for the candidate.

Following completion of each 60 question module, the candidate receives two scores: a) a score based on the first answer provided for each question; b) a score based on the second answer provided for each question. Because each of the questions has been pre-tested, candidates are provided feedback about how their score compares with the scores of others who have pre-tested the examination. This information is useful to the candidate in allowing him/her to identify areas for further study in preparation for the closed book, secure examination.

Although candidates immediately receive scores based on their completion of the questions, all candidates who complete the MKSAP question sets receive the appropriate amount of maintenance of certification credit (the equivalent of 1 module of credit for each set of 60 questions). Thus, there is no threshold score that one must obtain before receiving credit. The ACP is responsible for processing the information related to completion of the MKSAP questions, and for providing ABIM with the name of each candidate who has completed the MKSAP questions for credit.

The Modified ABIM Framework

Starting January 2006, the previous requirement for completion of five ABIM SEP modules will evolve into a "point system" requirement that incorporates flexible options for self-assessment of knowledge and practice performance. Each candidate will need to complete 100 self-evaluation points as part of the maintenance of certification process. The same points are applicable to all certificates and are valid for 10 years (i.e. extra points are not needed if a candidate is

applying for both internal medicine and a subspecialty within the 10 year period during which the points are valid). The required 100 points are divided in the following way: a minimum of 20 points must relate to self-evaluation of medical knowledge; a minimum of 20 points must relate to self-evaluation of practice performance; and 60 points are elective and can relate to either category of self-evaluation. Each ABIM SEP module counts as 20 points relating to self-assessment of medical knowledge, as does each MKSAP question module.

How Do I Get Credit for Self-Evaluation of Practice?

A variety of options will be available for fulfilling the 20 point minimum requirement for self-evaluation of practice, and the number of points given for each option will depend upon the amount of work involved. There are three basic components to this self-evaluation of practice: 1) measuring practice performance from data that the physician collects or receives from another source; 3) developing and implementing a plan for improvement; and 3) assessing the impact of the improvement plan. The types of options that will be available for assessing practice performance include: 1) ABIM Practice Improvement Modules (PIMs); 2) ABIM survey modules (Peer, Patient, and Practice Inventory); 3) established quality measurement and improvement programs; and 4) self-directed quality measurement and improvement. Credit for performance assessment is given with completion of one of these options; there is no grade given and thus no "passing" score. The ABIM's PIMs will count as 40 points and the survey modules will count as 20 points. The ABIM will assign points to new modules as well as tools and programs developed by others according to pre-established standards and criteria.

What is Happening During the Transition Period Before January 2006?

The new point system framework (and the need to include self-evaluation of practice) will not apply to physicians who complete the current self-evaluation module requirement (including the option for substituting up to 4 modules of MKSAP) before January 2006. If a physician still has one or more SEP modules to complete after January 2006, then the new guidelines will be in effect, and 20 Practice Evaluation points will be needed to complete the Self-Evaluation process.

Reducing Anxiety About the Secure Examination

Although a closed book examination can elicit anxiety, a better understanding of the examination and the types of questions on the examination can help allay that anxiety. As a result, the ABIM is committed to increasing communication about the examination to recertification candidates, and to clarifying what are sometimes misconceptions about the examination.

An important point of clarification is that the maintenance of certification examination is different from the examination used for certification of residents who have recently completed housestaff training. Residents typically are exposed to specialized types of inpatient problems that are primarily handled by subspecialists, and are therefore not part of the "core" practice or experiences that cut across general internal medicine as well as most subspecialties. Therefore, the maintenance of certification examination focuses on topics that are relevant and of clinical importance to all internists. At the same time, the maintenance of certification examination questions are designed to test clinical judgment, not recall of obscure facts. A Board-certified clinician should be able to answer these questions without using additional resources, since the questions are testing judgment rather than factual recall.

The pass rate for the examination is generally approximately 89 percent on the first try, whereas approximately 97 percent of candidates ultimately pass the maintenance of certification examination. The passing score is set as an absolute threshold, and is not based on a curve. Thus, there is no intent to fail a specified percentage of candidates taking the examination.

Perspective About the Recent Collaboration Between ACP and ABIM

Over the past year, ABIM has clearly demonstrated a commitment to a collaborative, cooperative working relationship with ACP. ABIM is also committed to ongoing improvement in the process for maintenance of certification, with specific goals of reducing redundancy and adapting the program for relevance and usefulness in the practice environment. And finally, ABIM and ACP are both committed to continue to work together for the best interests of our physicians, our patients, and the discipline of internal medicine.

—VISIT OUR CHAPTER WEB SITE—

http://www.acponline.org/chapters/nj

GOVERNORS TACKLE FLAWED PAYMENT SYSTEM- By Janet Colwell

No payment for coordinating care. Claims that take three months to process. No incentives to invest in information technology.

These are just a few of the symptoms that the Board of Governors noted about the dysfunctional payment system. That issue topped the Board of Governors meeting agenda earlier this week as Governors, Regents and invited speakers met to discuss the flawed reimbursement system and ways to reform it.

The dysfunctional payment system is a reflection of deeply held cultural values, observed **Glenn M. Hackbarth**, JD, former chief executive officer of Harvard Vanguard Medical Associates and current chair of the Medicare Payment Advisory Committee (MedPAC), one of the speakers who addressed the Governors. Those values include the idea that clinician autonomy is more important than accountability and that all possible interventions must be done, regardless of cost.

There is also a widespread belief in this country that medicine and science can triumph over any illness or disability, he added. That belief drives higher spending on health care-often to the detriment of education, the environment and other important areas. As several of the Governors pointed out, these beliefs also adversely affect the way physicians are paid.

Three perspectives

In a series of workshops in which Mr. Hackbarth and other speakers participated, the Governors looked at the issue from the perspective of physicians, payers and patients.

“The dysfunctional payment system is oppressive, Byzantine and discriminatory,” said **Cecil B. Wilson**, MACP, who led the discussion from the physician's perspective. Dr. Wilson, who has a solo practice in Winter Park, Fla., said he has more than 1,300 insurer addresses in his computer and that three-to-four month payment delays are common whenever a patient switches plans.

Patients often expect their physicians to know the details of all of these plans, he added, while insurers expect doctors to be 100% accurate in their filings or face payment delays. Fear of denied or delayed payments, he added, encourages physicians to adopt tactics such as downcoding to avoid denials.

Dr. Wilson listed other problems of the flawed payment system from physicians' point of view; those include administrative hassles and poor communication between physicians and insurers.

From patients’ vantage point, the flawed payment system doesn't work either, said MedPAC’s **Mr. Hackbarth**. Patients’ concerns include coverage availability, affordability, administrative complexity and a fragmented system that rewards complex, technological solutions over quality of care.

A third speaker, Reed V. Tuckson, MD, senior vice president of consumer health and medical care advancement at UnitedHealth Group, provided the payers' perspective. While payers want to work with physicians, he said, they are facing relentless pressure from big employers, who are “terrified” about how rising health care costs are affecting their bottom line. At the same time, he said, consumer and quality groups continuously point to credible studies on medical errors and the gap between cost and quality.

UnitedHealth has taken steps to improve communication with physicians, said Dr. Tuckson. For example, it has introduced an insurance card that can be swiped in any card-reading terminal, giving physicians instant access to a patient's benefits and eligibility information. Soon, he said, that information will be merged with payment information.

The company is also trying to align its reimbursement policies with Medicare whenever possible, Dr. Tuckson said. “The goal is to achieve consistency so there is less confusion.”

Sellable solutions?

The Governors discussed the idea of the primary care physician's office as the patient's "medical home," with the internist acting as care coordinator and being reimbursed accordingly. Dr. Tuckson said health plans are interested in the idea, but must first see proof that such a system would reduce costs.

Several Governors also suggested changes to the insurance industry, including standardizing benefits across plans and mandating individual coverage. By simplifying communication among insurers, doctors and patients, the Governors said, additional savings would be realized. Selecting an insurance plan should be more like buying a car, allowing consumers to select from a standard menu of options, said Board of Governors Chair Frederick E. Turton, FACP, in his summary of the workshop sessions.

According to Mr. Hackbarth, pay-for-performance programs could hold some answers by rewarding doctors for efficiently using technology and for following evidence-based guidelines.

“Now we are rewarding more care and advanced care instead of quality or right care," Mr. Hackbarth said. "The current payment system discourages doctors from trying to think of innovate ways to meet patient needs.”

The Board of Governors also approved a number of resolutions related to reimbursement that will be considered by the Board of Regents. Those resolutions included:

Funding pay-for-performance rewards with new dollars created from cost savings, separate from inflationary updates in physician fee schedules.

Increasing compensation for cognitive services by exploring changes to the current payment system. Suggested changes included changing the Medicare formula of tying fee increases to the sustainable growth rate and revising the fee-for-service-based payment methodology, which is based on acute episodic care.

Working with the AMA to advocate for an increase in physician fees for visits to Medicare beneficiaries in nursing homes.

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