“Those who are too smart to engage in politics are punished by being governed by those who are dumber.”

- Socrates
GA Chapter Goes to Washington

Leadership Day May 21-22, 2014
ACP Advocacy Goal

Leading the way to a health care system that:

1. covers everyone
2. costs less
3. recognizes the value of internists’ services
4. ensures stable and transparent GME financing aligned with workforce priorities
5. puts patients before paperwork
6. uses information technology to improve, rather than detract, from patient care
What happened in January 2014:

- Beginning of Medicaid expansion.
- Insurance coverage on the exchanges started with premium tax credits and cost-sharing subsidies available.
- The bulk of the remaining insurance regulations went into effect, including essential health benefit package, guaranteed issue, premium regulations, etc.
- Most people required to have health insurance.
How Did the Marketplace Do?

- As of 9/3/2014, estimated 9.2 million individuals have selected a plan in the marketplace exchanges.
- 8 million have paid 1st premium.
- 57% of Marketplace individual market enrollees were *uninsured* prior to enrollment.
- Percentage uninsured have dropped in all states, but less so in states that did not expand Medicaid.
Percentage of Adults 18 to 64 Years of Age without Health Insurance, January 2012 through June 2014

10.3 million gained coverage
ACP Enrollment Resources Updated

- Help patients enroll in health coverage:
- Updated State-specific guides to the ACA coverage section
- Updated one-pagers for patients
- Extensive FAQs on what physicians and patients need to know about ACA coverage.

http://www.acponline.org/advocacy/state_health_policy/aca_enrollment/
ACP Advocacy to Improve the ACA

1. Improve network adequacy standards.
2. Require greater transparency in network adequacy criteria and drug formularies.
3. Improve appeals rights for physicians excluded from a network and for medications left off of formularies.
4. Provide patients with access to out-of-network physicians at no higher cost if service is unavailable in-network.
ACA Advocacy to Improve the ACA

5. Provide “real-time” access to accurate network directories at time of health plan selection and enrollment.

6. Monitor formularies for potential discriminatory impact on high cost patients.

7. Inform physicians when patient enters 90-day grace period for non-payment of premiums.
Medicaid Expansion Status

The latest:

CMS has approved PA plan to expand Medicaid; at least 5 more states expected to join them

NOTES: Data are as of June 10, 2014. *AR and IA have approved waivers for Medicaid expansion. MI has an approved waiver for expansion and implemented in Apr. 2014. IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS [here](#). States noted as “Open Debate” are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.
In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.

- **MEDICAID**: Limited to specific low income groups
  - 0% FPL State Medicaid Eligibility Limit for Parents as of Jan. 2014 (Median: 47%)
  - 100% FPL ($11,490 for an individual)
  - 400% FPL ($45,960 for an individual)

- **NO COVERAGE**

- **MARKETPLACE SUBSIDIES**

**NOTE**: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid.
Patients in non-expansion states remain uninsured

- People with incomes below the FPL fall into the “coverage gap” (ineligible for Medicaid, ineligible for the Exchanges)
- Nationwide, 7.6 million people were excluded from Medicaid, including 4.8 million in the coverage gap (79% of whom are in Southeastern U.S.)
Medicaid Expansion & Georgia

- Extending coverage in GA would reduce the numbers of uninsured by up to 42%
  - ~843,000 would be eligible for Medicaid coverage
  - ~684,000 newly eligible under the ACA
- ~409,000 Georgians now fall in the coverage gap – all below 100% FPL ($14,800 single, $31,000 family of 4)
- Expansion crucial for hospitals as DSH payments going away (FY2012 – GA hospitals received $276 million)
- Will cost GA hospitals $12.8 Billion over 10 years
Medicaid Expansion & Georgia

Georgia's rural hospitals teeter as solutions are debated

- Eight rural hospitals in GA have closed or downsized in the past 2 years, and another 15 are teetering on the brink of closure and could be gone in the next 2 years.
- GA has 3rd highest uninsured rate
- GA has 6th highest poverty rate
- “Wood work effect” - Large number enrolling in the Health Exchange were found to be already eligible for the current GA Medicaid, estimated 70,000-100,000
Medicaid
Largest Insurer of Americans

- Overall, 65 million men, women and children ~ 1 in 5 now receive health coverage through Medicaid or CHIP.
- Medicaid payment rates on average, 66% of Medicare rates
- An additional 6 million Americans have enrolled in Medicaid and CHIP since October, 2013 under the ACA
- The Medicaid Pay Parity program included in the ACA to make sure enough participating physicians available to treat the expected increase in enrollment.
- Program expires January 1, 2015
Medicaid Pay Parity with Medicare

- Medicaid pay parity program was designated only for primary care and vaccine services
- Care provided by internists, pediatricians, and family physicians—and IM and PED subspecialties
- Funded by Federal Government
- GA Physicians have received ~ $53 million additional dollars/year x 2 years
Current programs to create incentives for primary care are now at risk of going away:

- Medicaid primary care pay parity *(expires 1/1/15)*
- Medicare primary care 10% bonus on E/M codes *(expires 1/1/16)*
Medicaid Pay Parity

S. 2694 - The Ensuring Access to Primary Care for Women & Children Act

- Senators Patty Murray (D-WA) and Sherrod Brown (D-OH)
- Prevent an across-the-board Medicaid primary care cut on January 1, 2015 by extending the current-law Medicaid Pay Parity program through December 31, 2016
- Add Ob-Gyns if 60% of their billings are for designated primary care and vaccine codes (maternity care not included)
- Include NPs in Primary Care as authorized by state law—at the Medicare NP payment rate (85% of the MD rate)
Medicare Payment for Chronic Care Management (CCM)

- Proposed Rule: Medicare would begin paying for chronic care management (CCM) in 2015

- But there are concerns about the:
  - Amount of payment
  - Practice requirements
Medicare Payment for Chronic Care Management (CCM)

- New proposed G code: chronic care management services
- Patients with two or more chronic conditions
- Pts expected to last at least 12 months or death
- Conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- 20 minutes or more per 30 days
- Estimated payment is $41.92 – is this enough???
- RUC has recommended higher RVU
SGR: Is the end in sight???
SGR widening gap between Medicare Payment Updates & Physician Practice Costs

**MEDICARE PAYMENT UPDATES**
For more than a decade, physicians have been threatened by Medicare payment cuts due to the sustainable growth rate (SGR) formula.

**PRACTICE COST INFLATION**
After adjusting for inflation, average 2015 Medicare payment rates will be 35% less than they were in 2001.

25%
The cost of a decade of temporary patches now exceeds the cost of a permanent fix.

The cumulative cost of patches is now over $169.5 billion, which is more than the cost of a permanent fix.

Passing temporary patches is short-sighted and fiscally irresponsible. We cannot afford to continue to fund patches that do nothing to fix the flaws in the SGR formula itself.
Name: Senator Johnny Isakson
Address: 
Date: 2/20/14

Rx 1: NO MORE
Signature: 
Refill: 0 1 2 3 4 5 PRN

Rx 2: SGR PATCHES!!
Signature: 
Refill: 0 1 2 3 4 5 PRN

Rx 3: Pass S. 2000 NOW
Signature: 
Refill: 0 1 2 3 4 5 PRN

To insure Brand Necessary, prescriber must write BRAND NECESSARY

LMN PHARMACY
ACP helped create a bipartisan and bicameral solution to replace the SGR with a payment system that supports **value rather than volume**.

Congress came closer than ever of repealing the SGR in March, with agreement between both political parties and both houses of Congress on the basic framework.

Partisan disagreement on how to pay for it
SGR Repeal Goes Up in Smoke.... Again!

- Congress instead passed its 17th SGR "patch" in 11 years.
- Current SGR patch halted a 24 percent cut that was set to go into effect on January 1, 2014, which provided a 0.5 percent update in physician pay.
- Delayed ICD-10 until October 1, 2015.
- Expires March 31, 2015.
SGR: HR 4015 & S 2000

- Would permanently and immediately repeal the SGR.
- Includes a payment update of 0.5 percent per year for five years (2014-2018).
- Includes an annual bonus of 5.0% for physicians who employ alternative payment models (APMs) – voluntary from 2018 to 2023.
- Includes a 1.0% update for physicians in APMs and a 0.5 % update for all other physicians in 2024 and beyond.
- Retains the existing fee-for-service payment model
SGR: HR 4015 & S 2000

- Provides $40 million for technical support between 2015 and 2019 to help small practices participate in APMs.
- Provides $15 million per year from 2014 to 2018 to develop quality measures. (Physicians would retain their oversight role in developing such standards.)
- Would consolidate and streamline the existing quality incentive and payment programs while mitigating the aggregated financial risk that is associated with penalties for physicians under the current law.
“Sorry, the doctor can’t see patients. He’s still doing the government paper work on his last patient.”
More and more administrative tasks and paperwork are being imposed on physicians, without any assessment of need, value or impact.

Major contributor to dissatisfaction with practice, disincentive to enter or remain in primary care, and less time with patients.
ACP’s initiative to reduce administrative complexities

**Patients Before Paperwork:**
Reinvigorating the Patient-Physician Relationship By Challenging Unnecessary Practice Burdens

**Goals:**

1. Educate members, policymakers, public on what makes up administrative challenges and why they are not all equal
2. Identify which are the highest priorities and why
3. Implement most effective strategies to mitigate or eliminate top priority challenges and help members address those that can’t be eliminated
Roadmap: Fall 2013 – Fall 2014

Conduct underlying research/policy development

- Look at intent of hassle
- What is the impact on physician, patient, and health system?
- **Surveys & Focus Group – Top hassles identified by the survey:**
  - #1 Electronic Health Records
  - #2 Quality Reporting
  - #3 Helping Patients get reimbursed by insurance companies
- Literature review
- Definitional Paper
- EHR Clinical Documentation Paper
- GOAL: To support and prioritize the work internists
Recent ACP Study

Use of Internist's Free Time by Ambulatory Care Electronic Medical Record Systems

ACP study:
Mean Loss for attending physicians was
- 48 minutes per clinic day,
- 4 hours per five day clinic week

*JAMA Intern Med*. Published online September 08, 2014. doi:10.1001/jamainternmed.2014.4506
EHRs: What are the solutions?

- Poor usability in EHRs due to
  - documentation requirements of payers/government
  - impossible MU timeline placed on EHR vendors
- ACP working with the EHR vendors to improve usability & address the timeline problem with ONC and CMS
- ACP policy/position paper on Clinical Documentation in EHRs.
ICD 10 Help & Resources
OCTOBER 1, 2015 DEADLINE

ACP website includes a variety of tools to help physicians and their practices, including

- an implementation tool for small practices
- a list of commonly used codes that can be printed out
- FAQs
- transition basics
- myths and facts
- target dates and deadlines
- educational materials are also available in book and video form.
Congressional Approval Ratings

"HOW LOW CAN YOU GO?"
CONGRESS GOES ON RECESS

- Money-go-round
- Political grandstanding
- Kick the can marathon
- Obamacare bashing
- 2016 sandbox
Everything is changing. People are taking the comedians seriously and the politicians as a joke. With Congress, every time they make a joke it's a law, and every time they make a law it's a joke.

- Will Rogers
GEORGIA

- Georgia General Assembly – State Legislature
- Georgia Congressional Delegation
- Georgia Health Demographics
- 2014 Legislative Summary
Legislative Internship for Residents
IM Resident Eddie Fatakov & Chairman of House HHS, Sharon Cooper
<table>
<thead>
<tr>
<th></th>
<th>Senate</th>
<th>House</th>
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<tbody>
<tr>
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<td>56</td>
<td>180</td>
</tr>
<tr>
<td>Republicans</td>
<td>38 R</td>
<td>118 R</td>
</tr>
<tr>
<td>Democrats</td>
<td>18 D</td>
<td>62</td>
</tr>
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</table>

House– Dr. Ben Watson, Internist, Savannah – R**
**running unopposed for State Senate

Senate – Dr. Dean Burke, Ob/Gyn, Bainbridge – R
Georgia Congressional Delegation - 2014

Senate 2 R
House 14 9 R 5 D

- What will delegation look like in 2015?
- House Races – 3 current congressmen ran for open Senate seat and all three lost. We will have at least 3 (possibly 4) new Congressmen (all Republican)
- Senate Race - Current polls have Senate seat as a toss up between Michelle Nunn(D) & David Perdue(R)
### Georgia Health Ranking

#### 2013 Overall Health Ranking

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of smoking</td>
<td>20.4%</td>
<td>30 (worse)</td>
</tr>
<tr>
<td>Prevalence of obesity</td>
<td>29.1%</td>
<td>30 (worse)</td>
</tr>
<tr>
<td>High school graduation</td>
<td>69.8%</td>
<td>45 (same)</td>
</tr>
<tr>
<td>Lack of health insurance</td>
<td>19.2%</td>
<td>45 (worse)</td>
</tr>
<tr>
<td>Primary Care MDs/100K</td>
<td>102.5</td>
<td>35 (worse)</td>
</tr>
<tr>
<td>Dentists/100K</td>
<td>47.3</td>
<td>45</td>
</tr>
<tr>
<td>CV Disease deaths/100K</td>
<td>283.9</td>
<td>40 (same)</td>
</tr>
<tr>
<td>Cancer deaths/100K</td>
<td>191.9</td>
<td>28 (same)</td>
</tr>
</tbody>
</table>

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Georgia Health Ranking

Commonwealth Fund Scorecard 2014

- **Overall** 45
- **Access & Affordability** 39
- **Prevention & Treatment** 43
- **Avoidable Hospital Use & Cost** 33
- **Equity*** 46
- **Healthy Lives** 38

* **Equity gap** = difference between US national average for a particular indicator & the rate for state’s most vulnerable group by income & race/ethnicity

Commonwealth Fund Scorecard on State Health System Performance, http://www.commonwealthfund.org
Commonwealth Overall State Health System Performance, 2014
## Georgia Demographics

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>9,992,167</td>
<td></td>
</tr>
<tr>
<td>Pop. in poverty</td>
<td>2,198,277</td>
<td>22% (down 1%)</td>
</tr>
<tr>
<td>Median income</td>
<td>$45,642</td>
<td>(no change)</td>
</tr>
<tr>
<td>Unemployment</td>
<td>8.1%</td>
<td>(down ~1.2%)</td>
</tr>
<tr>
<td>Health Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>1,918,496</td>
<td>19.2% (down 0.5%)</td>
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<tr>
<td>Medicaid</td>
<td>1,398,903</td>
<td>14% (no change)</td>
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<tr>
<td>Medicare</td>
<td>1,099,138</td>
<td>11% (down 2%)</td>
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<tr>
<td>Employer</td>
<td>4,696318</td>
<td>47% (down 1%)</td>
</tr>
<tr>
<td>Individual</td>
<td>499,608</td>
<td>5%</td>
</tr>
</tbody>
</table>

Kaiser Family Foundation (kff.org) & US Census Bureau
Georgia Legislative Summary, 2014
2014 State Budget Affecting Physicians

State Budget for FY 2015 $20.8 billion budget

A $6.8 million (combined) increase in operating grants for the Mercer University School of Medicine and the Morehouse University School of Medicine

**$2 million for the Georgia Board of Regents’ “Health Professions Initiative” to address funding graduate medical education

Nearly $641,000 for eight additional family medicine residency slots at the Gwinnett Medical Center (five) and the Houston Medical Center (three)

Nearly $500,000 to increase the amount of “Georgia Physician Workforce Board” residency grants by $333 per resident
A $300,000 increase for “Area Health Education Centers” in the state for housing for medical students serving in six-week rural, primary care rotations

** $200,000 for 10 additional loan payment rewards for the Georgia Board of Physician Workforce’s “Physicians for Rural Areas” program

Nearly $32,000 for a new medical student capitation contract for five certified Georgia residencies at the Georgia Campus – Philadelphia College of Osteopathic Medicine

A little more than $115,000 for the Georgia Composite Medical Board to implement the pain management licensure program that was created during the legislative session in 2013.
State Legislation

- **S.B. 391** Every medical facility in the state to make a “good faith” effort to become certified by TRICARE though (those facilities would not be required to join the TRICARE network)

- The bill was amended to include the provisions of **H.B. 922** – which would provide a tax deduction for certain medical clerkships as a way to get medical faculty in the state to serve as clinical preceptors

- **Outcome**: Passed.
State Legislation

Scope of Practice Bills

APRNs ordering advanced radiographic imaging (S.B. 94).

- Would have allowed advanced practice registered nurses (APRNs) the authority to order advanced radiographic imaging
- ACP opposed bill given patient safety and cost concerns associated with unnecessary radiographic procedures
- Did not pass
PAs prescribing Schedule II narcotics (S.B. 268)
- Would have allowed physician assistants (PAs) to prescribe Schedule II narcotics
- ACP opposed based on tremendous abuse of these drugs now and the increasing DEA focus on these prescriptions
- Did not pass
Pharmacists to administer _every_ vaccine under a blanket protocol S.B. 85 & H.B. 1081

- Would have allowed pharmacists to provide _all_ vaccines _without_ a doctor’s prescription
- ACP opposed due to patient safety particularly w/ live vaccines, patient privacy, fragmentation of care, undermining of the PCMH, poor communication and coordination of medical information by pharmacies
- Did not pass.
State Legislation

Georgia Prescription Drug Monitoring Program to be shared across state lines.

- Sen. Buddy Carter (pharmacist) was bill sponsor (S.B. 134)
- ACP position “for it before we were against it”
- Amendments to the bill that would have given pharmacists the authority to administer all vaccines to adults under a blanket protocol (i.e., the S.B. 85 provisions)
- Did not pass
Allow patients who take oral chemotherapy medications to receive the same kind of health insurance as those who receive IV chemotherapy drugs (H.B. 943)

- The measure was amended to include the provisions of another bill (H.B. 707) that would:
  - 1) prohibit state agencies, departments or political subdivisions from using state resources to expand the Medicaid program in the state and
  - 2) prohibit the state from running an insurance exchange and/or accepting federal funds for the purpose of creating or running a state insurance exchange and
  - 3) prohibit the Georgia Commissioner of Insurance from investigating or enforcing any alleged violations related to the federal health insurance requirements that are mandated by the Patient Protection and Affordable Care Act.

- ACP opposed the bill because of these amendments and our support of Medicaid expansion, the health exchange, and believing the Insurance Commissioner should protect GA consumers

- **Outcome**: Passed.
State Legislation

Using Cannabidiol for Treatment of Seizures

- (H.B. 885) would have expanded the state’s law permitting the use of cannabidiol extract in strictly controlled research programs for patients who have cancer or glaucoma to patients who suffer from seizures.
- H.B. 885 was amended to require health insurance policies that are sold in the state to cover behavioral therapy for children six and under who are diagnosed with autism.
- Did not pass.
- Gov. Nathan Deal is exploring other options [e.g., an “executive order”] to enable Georgians to have access to the cannabidiol extract.)
State Legislation

- **Patient’s Compensation Act” (S.B. 141) (H.B. 662)**
  - Would replace the state’s medical malpractice system with an “administrative compensation system” that would establish independent medical review panels to evaluate patient injury claims – as well as a board to oversee the system
  - Funded by physicians and other health care providers.
  - ACP Opposed:
    1) it would increase the number of claims and costs
    2) it would repeal the remaining provisions of the tort reform bill S.B. 3 that passed in Georgia in 2005
    3) it could be ruled unconstitutional
  - Did not pass
"Can you prescribe something with side effects that will entitle me to compensation?"
1. Medicaid parity pay extension for primary care
2. Medicaid expansion
3. Scope of practice issues
4. Physician workforce
5. Tort reform
6. Third party payor issues of SHBP, narrow network adequacy, prior authorization issues
7. Electronic prescribing of narcotics
So What’s a Good Doctor To Do?
Physicians’ Responsibility

- Get involved in your government
  www.votesmart.org

- Be an active member of the ACP, and contribute your time, talent, service; Recruit a colleague.
  www.acponline.org

- Check out your ACP’s Advocacy page
  www.acponline.org/advocacy

- Contribute to your ACP’s PAC
  www.acpservices.org
Advocates for Internal Medicine Network (AIM\textsuperscript{n})

- Grassroots advocacy networks (formerly Key Contact Program)
- Participate by contacting Senators and Representatives about issues important to internists
- http://www.acponline.org/advocacy
Physicians’ Responsibility

- Join our state medical society the Medical Association of Georgia
  [www.mag.org](http://www.mag.org)
- Talk to, write, & email your legislators regularly on the issues that concern you
- Support good people who run for office
- One final option...
New First Family in the White House
The trouble with practical jokes is that very often they get elected.

- Will Rogers
New President in Charge

What if...
Should we expand Medicaid in GA?

1. Yes
2. No

86% for Yes, 14% for No.
Who are you voting for Governor?

1. Deal (R) 33%
2. Carter (D) 67%
3. Hunt (I) 0%
Who are you voting for Senator?

1. Nunn (D) 68%
2. Purdue (R) 32%
The overall performance of the speaker:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent

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<tbody>
<tr>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
<td>91%</td>
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</tbody>
</table>

91%
Overall quality of this session:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent

- Poor: 0%
- Fair: 0%
- Average: 0%
- Good: 19%
- Excellent: 81%
How well were the learning objectives met?

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
Did speaker present a balanced view of therapeutic options?

1. Yes
2. No
3. N/A
Were relationships between grantor and speaker announced prior to the presentation?

1. Yes (73%)
2. No (27%)
How useful will this session be in your practice?

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
As a result of this program, do you intend to change your patient care?

1. Yes
2. No

60% Yes
40% No
Thank you!