



## **ACCESSIBLE AND AFFORDABLE HEALTH CARE FOR ASIAN AMERICANS: POST-MARKETPLACE CHALLENGES AND RECOMMENDATIONS FROM PHYSICIANS**

### **EXECUTIVE SUMMARY**

The National Council of Asian Pacific Islander Physicians (NCAPIP) conducted in 2015 seven regional meetings in four U.S. states with Asian American physicians and other health care stakeholders to document physicians' perspectives on the implementation of the Affordable Care Act. NCAPIP is a national health policy organization that represents physicians committed to the advancement of the health and well-being of Asian American, Native Hawaiian and Pacific Islander communities. The topics focused on the impact of expansions of health insurance exchanges (HIE) on their patients and practices, the provision of culturally and linguistically appropriate care, use of electronic medical records, participation in medical home and accountable care initiatives, and readiness for value-based payments and other health care reforms.

This report documents the important role of Asian American physicians in solo and small group primary care practices in providing health care to their patients and communities. The physicians who participated in the regional meetings recognized that accessibility and affordability of health care two years post marketplace are still a challenge for their patients, putting an emphasis on the rising costs of prescription medications.

They acknowledged the benefits of using electronic medical records (EMR) but pointed to specific challenges in the provision of culturally and linguistically appropriate services, i.e., consent and release forms only available in English language. The lack of interoperability and structured health information exchange were identified as another significant one.

In discussing clinical practice transformation in support of health care quality improvement, physicians strive to do their best and are generally doing well on quality measures. However, they believe that the patient satisfaction surveys might be culturally biased.

The shortage of psychiatrists and behavioral health providers pose a challenge to primary care physicians as they implement patient-centered medical home model. As team-based care is being in place in some practices, training has to be provided in order for physicians to know how to delegate responsibilities and to better explain team-based care and patient-centered care to their patients.

In some discussions, physicians reflected on the state of their profession and the context of continuing changes and reforms. They expressed feeling of being powerless to negotiate with health plans in their regions. There also was discussion about how the local hospitals in that region had been leading accountable care initiatives, intentionally excluding the local

independent practice association and local physician leadership from the final design of shared savings from accountable care initiatives.

While the seven regional meetings do not allow the results to be generalized for all Asian American primary care physicians, many common themes were articulated about how Asian American primary care physicians might be better recognized, valued, and supported.

The eight recommendations that emerge focus on:

1. Access and Affordability;
2. Culturally and linguistically appropriate outreach and education;
3. Culturally and linguistically appropriate HIE and Medicaid care services;
4. Open source, interoperable EMR solutions;
5. Active role of solo and small group primary care physicians and racial and ethnic minority physicians in the design, implementation, and evaluation of clinical practice transformation and value-based payment initiatives;
6. Committed supporting role of the Transforming Clinical Practice Initiative (TCPI), Regional Extension Centers (REC), Primary Care Extension Centers, Community-Based Collaborative Care Networks, and Community Health Teams to solo and small group primary care physician practices;
7. Ability of independent practice associations (IPAs), racial and ethnic minority physician organizations and other physician-support entities to provide technical assistance to their membership and peers on clinical practice transformation and value-based payment; and
8. Inclusion of health care delivery system reform, health insurance, quality improvement, and culturally and linguistically appropriate services into medical school and other health professional academic curricula.

## BACKGROUND

Between August 2014 and November 2015, NCAPIP conducted seven regional meetings in four states of the U.S. with Asian American physicians and other health care stakeholders to learn about and document their experiences and perspectives about the continuing implementation of the Affordable Care Act (ACA) and national health care delivery system reforms. The meetings were hosted by local independent practice associations, which recruited physicians from their leadership and membership to participate. The majority of the physicians participating were primary care providers, most in solo and small group practices<sup>1</sup>. The majority were primary care physicians, most in solo and small group practices. Other stakeholders represented local physician associations, health plans, hospitals and health systems, local health departments, and medical schools. A total of 50 physicians, three nurse practitioners and 10 community leaders attended the regional meetings and participated in the discussions

The topics included the impact of expansions of health insurance coverage through health insurance exchanges (HIE) and Medicaid on their patients and practices, provision of culturally and linguistically appropriate care, use of electronic medical records (EMR), participation in medical home and accountable care initiatives, and readiness for value-based payments and other health care reforms.

## DISCUSSIONS AND FINDINGS

### ***Being a Physician Today***

Many physicians were strongly committed to their patients and to community service: “It is gratifying when we see our patients getting better,” or “I ask myself why I come to work and it’s because I want to serve the community.” Several noted that their language, culture, and background (as Chinese Americans) were important assets to bring to their practices and patients: “Working here is like coming home for me,” referencing how similar community-based physicians took care of her grandparents, and now she takes care of patients and families in the same community.

However, they noted a sense of fatigue and exhaustion as this quote:” I requested fewer hours schedule in order to re-gain a sense of work/life balance.” A relatively new physician in a community-based practice noted that the other colleagues are making more money in their first year of practice than what his practice’s medical director currently makes. Another said that she liked the team aspect of the practice, and is often thinking about not just keeping herself happy and motivated, but also all the members of the team. Others noted similar concerns for their entire health care teams.

### ***Impact of Affordable Care Act on Health Care Coverage and Affordability***

Consistent with national and local data<sup>2</sup> physicians at the regional meetings reported seeing an increase in individuals with health insurance in their practices. “Many people have benefitted. The neediest and poorest can get health care, rather than deciding between paying for health care, or the rent or mortgage, or for food,” said one physician. However, a

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<sup>1</sup> National Council of Asian Pacific Islander Physicians, Asian American Physicians in Solo and Small Group Primary Care Practices: Essential Health Care Providers for Our Communities (2012), accessed at: [http://s3.amazonaws.com/NCAPIPportalDocfiles/NCAPIP\\_Report\\_Asian\\_Primary\\_Care\\_Practices.pdf](http://s3.amazonaws.com/NCAPIPportalDocfiles/NCAPIP_Report_Asian_Primary_Care_Practices.pdf); Liaw WR, Jetty A, Petterson SM, Peterson LE, Blazemore AW. Solo and small practices: A vital, diverse part of primary care. *Ann Fam Med*. 2016;14(1):8-15

<sup>2</sup> <https://www.whitehouse.gov/blog/2015/02/17/more-11-million-americans-are-signed-health-coverage>

physician who works at a free clinic said that many of the patients are no longer eligible and are struggling to find a primary care doctor through their health plans.

The needs of Compact of Free Association (COFA) migrants, who have been disqualified from Medicaid since 1996 were discussed at the regional meeting in Hawaii. Many COFA migrants coming to Hawaii have not had regular source of health care and present with multiple and serious health conditions, some presenting first to a hospital or emergency department. Legislation establishing Medicaid eligibility for COFA migrants remains pending in Congress (S.1301, H.R.1974, H.R.2249).

Physicians at some regional meetings described the continuity of care challenges for patients who have transitioned to new health insurance offered by the health insurance exchanges. Their concerns were whether their former patients were receiving the necessary follow-up and continuity of care. They observed that there was no process to determine whether an individual patient was now covered by new health insurance and seeing another provider, or has been lost to care. While there have been occasional requests for medical records from a new provider, this is still rare. More often, these physicians only discover that their patients have new providers when there were requests for reconciliations for automated prescription refills. Their former patients still called with questions about their health care, and often do not understand their new health insurance coverage. Others expect to continue to see the same physician and do not understand that their physician may not be in their new health insurance network, and that they have to find a new physician. This is especially common among limited English proficient patients. The concern was that there was not a good hand-off to a new provider, especially when a patient has acute or chronic care needs.

However, the dominant theme that emerged was how the primary barrier to access to care for their patients has shifted from eligibility for health insurance to the affordability that coverage<sup>3</sup>. While more individuals are now insured, most have high deductibles, co-payments and co-insurances in the plans that are available<sup>4</sup>. The physicians reported that many health insurance plans require co-payments of about \$50 for an office visit with a primary care physician, \$75 for an office visit with a specialist, and up to \$50 for medication. Many emphasized how these high deductibles and co-payments have become the new barriers to care: “for middle income patients, the high co-payments are very expensive; they are suffering.” One physician astutely observed that: “Many who are now insured still can’t access services because of high deductibles and co-payments, and some are deferring their care because of this reason.” One physician noted that, in his state, there is no Basic Health Program option that would have lower monthly premiums and co-payments, and potentially reduce churning<sup>5</sup>.

The physicians noted that many patients expect “free” care once they have health insurance and do not want to pay the co-payments. They contrasted this expectation with other patients who were formerly uninsured and willing and able to make the co-payments. Several noted that their patients try to bargain with them about the co-payments. They described how

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<sup>3</sup> Consistent with 2015 Kaiser Family Foundation survey of primary care providers, accessed at: <http://kff.org/slideshow/experiences-and-attitudes-of-primary-care-practitioners-after-the-aca/>

<sup>4</sup> Shartz A, Long SK, Anderson N. Care access & affordability improved following ACA implementation; problems remain. *Health Aff* (2016); 35(1):161-168; Islam I, Trouble ahead for high deductible plans? *Health Affairs Blog*, October 7, 2015, accessed at: <http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans/>

<sup>5</sup> Only Minnesota and New York implemented a Basic Health Program, <https://www.medicaid.gov/basic-health-program/basic-health-program.htm> See also, Kaiser Family Foundation, The ACA’s Basic Health Program Option: Federal Requirements and State Trade-Offs (2014) at: <http://files.kff.org/attachment/the-acas-basic-health-program-option-federal-requirements-and-state-trade-offs-report>

community practices and norms also impact this complicated issue of affordability and that some physicians in the local area intentionally do not ask for co-payments as a way to obtain and retain patients.

Many noted that it was unfair for the health plans to place the burden on physicians to collect the co-payments. More than one noted that patients owed them thousands of dollars in uncollected co-payments and some just wrote off as losses.

With co-payment and affordability issues dominating much of the discussions, the physicians were skeptical about continuing to increase enrollment in health insurance coverage for the remaining uninsured. Many felt that the remaining uninsured would rather pay the penalties instead of health insurance premiums of \$400-\$600/month, plus co-payments. They had patients who come in for one office visit, and then dis-enroll as being unable to continue paying the premiums. Several physicians still see some uninsured patients without charge.

At a policy level, there seemed to be continued disagreement with the concept of the individual mandate, or individual responsibility to purchase health insurance. Several physicians felt that their patients were being forced to pay these high costs: “The law is forcing people, in the middle class and senior citizens, to buy health insurance that they can’t use.”

There also continued to be differing opinions about long-term solutions, with at least one physician supporting a single payer approach, “a nationalized U.S. health system, with one big buyer that has national purchasing power and a guarantee of a basic health plan for everyone,” allowing for “add-ons” for additional services such as optional MRIs. However, other physicians quickly disagreed, observing that any government-run system would have problems and not necessarily be better: “Having just one system would kill competition.”

The shortage of physicians, especially those willing to accept new Medicaid patients or new patients through the marketplaces was identified. Many physicians are not accepting new Medicaid patients, and some of those newly on Medicaid or newly insured through the marketplaces still use the emergency department for their care. Several noted that, even with health insurance, many patients: “Have to beg for an appointment, especially with specialists.” One physician said that a patient who used to be under his care has liver cancer and: “No surgeon would take the case, and no hospital would cover the surgery; I care for this patient for over 30 years, and now I can’t help him.”

### ***Access and Affordability of Prescription Medication***

There was significant discussion about the high prices of prescription medication for their patients, even when they had health insurance coverage<sup>6</sup>. During the past year, public opinion polls have reported that concerns about the high costs of prescription drugs have risen to the top of the American public concerns about health care, ahead of revising or repealing the Affordable Care Act<sup>7</sup>. One physician said: “Co-payments for medication are unacceptable.” Examples were given of patients paying up to \$2,000/month for osteoporosis

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<sup>6</sup> Martin AB, Hartman M, Benson J, Caitlin A, National Health Expenditures Account Team. 2014 National health spending: Faster growth driven by coverage expansion & prescription drug spending. *Health Aff* (2016); 35(1):150-160; Islam I, Rising costs of drugs: Where do we go from here? *Health Affairs Blog*, 08/31/2015: <http://healthaffairs.org/blog/2015/08/31/rising-cost-of-drugs-where-do-we-go-from-here/>

<sup>7</sup> Prescription drug costs remains atop public’s national health care agenda, Kaiser Family Foundation, 10/28/2015: <http://kff.org/health-costs/press-release/prescription-drug-costs-remain-atop-the-publics-national-health-care-agenda-well-ahead-of-affordable-care-act-revisions-and-repeal/>; Prescription drug costs unreasonable: Kaiser Family Foundation, 06/16/2015: <http://kff.org/health-costs/press-release/poll-finds-nearly-three-quarters-of-americans-say-prescription-drug-costs-are-unreasonable-and-most-blame-drug-makers-rather-than-insurers-for-the-problem/>

medication, and generic medication costing as much as \$300/month. As quoted by a physician: “These types of costs wipe out any Medicare Part D coverage.”

Others noted that many medications that their patients need are not included in health plan formularies: “We just can’t give out medication samples.” Another lamented: “There are no caps on what drug companies can charge for medication, and there is no transparency about how medications are priced; how can the middle class accept such costs?”

Patients wanted brand name drugs, as they did not know the names of the generics. Physicians would have to do extra work to get prior authorization for the brand name medications: “There is misinformation in the media and on the internet against generics.” They agreed that more drug discount (patient assistance) programs were needed as many patients had to recourse to mail order or online pharmacies to lower prescription drug costs, which creates issues during medication reconciliation.

### ***Providing Culturally and Linguistically Appropriate Health Care***

Physicians at the regional meetings described the continuing challenges in providing culturally and linguistically appropriate health care services. For example, few pharmacies provide translated medication instructions, and there is a shortage of specialists who are available and willing to provide consultations (e.g. radiologists, dieticians), especially for patients on Medicaid. Primary care physicians who served limited English proficient patients reported spending “up to five times the usual amount of time” with their patients, taking the time to explain their diagnoses and treatments, and coordinating their care with other providers. These providers explained: “When our patients don’t speak English, we have to handle all their follow-ups and referrals; they come in with their lab results or medications because we speak Chinese.”

Several physicians discussed telephonic health care interpreter services made available by various health insurance plans: “Our Chinese-speaking patients don’t use it as they don’t know about it, and or they don’t know how to use it.” New immigrants often do not understand the U.S. health care system and how to use their health insurance. Many still think their health insurance is for catastrophic events and do not come and see their physicians for prevention.

***Ironically, one unanticipated consequence of health insurance coverage expansion is that some physicians with practices in safety-net institutions, or working as community providers are seeing new types of patients.*** The new patients are more diverse from racial backgrounds and more English-speaking. This increased diversity has challenged these physicians to ensure culturally and linguistically appropriate services, i.e., one physician who usually refers patients to a smoking cessation program offered in Cantonese Chinese now needs to find a good program for patients who do not speak Cantonese, or that the orientation session for new patients being offered in Cantonese now needed to also be in different languages. This is a challenge for physicians and other health care providers that specialize in providing culturally and linguistically appropriate services for a specific patient population.

### ***Use of Electronic Medical Records***

At one meeting, it was reported that over half of its state’s physician practices had implemented EMR and that the state was setting a goal of having EMR in 80% of all

practices within the next five years<sup>8</sup>. Almost all physicians at the regional meetings continued to have complaints and challenges in using EMRs<sup>9</sup>: “The more you use, the worse care you provide as you can’t focus on the EMR and the patient at the same time.”

More than one physician agreed that: “We are cutting down on the number of patients and still spend more time at night documenting in the EMR.” Many shared their reality: “I can’t eat dinner until midnight as I have to catch up on charting in the EMR.” Many agreed: “There is extra work to use EMR; if something is not documented, it is not considered done even if you did do it; EMR do not produce better care, only more documentation.” Others noted that sometimes the documentation is required for procedures that they feel unnecessary: “We are now paid based on documentation, i.e., patient height and weight don’t change that much but we have to document each time; it’s many clicks and pages, so much cut and paste.” One individual observed: “As physicians, we used to spend time with our patients. Just because something is documented doesn’t mean that it was done well.” Another one concluded: “Practicing medicine has become filling out paperwork. Each click takes time.”

Despite the complaints and challenges, the physicians acknowledged the benefits of using EMR. They recognized that EMR provide more complete and consistent information about problem lists and medications, especially for transitions of care, and the monthly reports help set and meet quality improvement goals (Pap smears, A1c, depression screening).

However, there are specific challenges in using the EMR to provide culturally and linguistically appropriate services. It was noted that their patients still need everything printed out or even written out (in Chinese) because of both health literacy and computer literacy/access challenges. One physician observed that it would be helpful to have basic anatomy and other diagrams available to be printed out from the EMR, as well as more Chinese language health education materials. All consent and release forms now only available in English still need to be interpreted for Chinese-speaking patients.

The lack of interoperability and structured health information exchange among EMRs continues to be a significant challenge<sup>10</sup>. The physicians described having to toggle between several systems to access and document all the needed information about any one patient. Many of the entries in the EMR are still scanned documents that take a long time to review. It also takes time to obtain some of these records by fax, and then having them scanned into the EMR. One physician noted that in his current EMR, it takes fifteen minutes to locate a pharmacy in his system to send an electronic prescription. Another noted the inefficiency and extra work to review and electronically sign/approve many items such as routine lab results.

Some physicians made specific recommendations for improving EMRs<sup>11</sup>. They suggested more intuitive and efficient navigation such as touch screen features, or having what is needed on one screen rather than having to open new pages or screens. The size of

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<sup>8</sup> Hsiao CJ, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001-2013. NCHS Data Brief. 2014;(143):1-8

<sup>9</sup> Friedman A, Crosson JC, Howard J, Clark EC, Pellerano M, Karsh BT, Crabtree B, Jaén CR, Cohen DJ. A typology of electronic health record workarounds in small-to-medium size primary care practices. *J Am Med Inform Assoc.* 2014;21(e1):e78-e83; Howard J, Clark EC, Friedman A, Crosson JC, Pellerano M, Crabtree BF, Karsh BT, Jaen CR, Bell DS, Cohen DJ. Electronic health record impact on work burden in small, unaffiliated, community-based primary care practices. *J Gen Intern Med.* 2013;28(1):107-113

<sup>10</sup> U.S. Department of Health and Human Services Office of National Coordinator for Health IT, A Shared Nationwide Interoperability Roadmap, accessed at: <https://www.healthit.gov/policy-researchers-implementers/interoperability>

<sup>11</sup> Olayiwola JN, Rubin A, Slomoff T, Woldeyesus T, Willard-Grace R., Strategies for primary care to improve electronic health records. *J Am Board Fam Med.* 2016;29(1):126-134; Shaha JS, El-Othmani MM, Saleh JK, Bozic KJ, Wright J, Tokish JM, Shaha SH, Saleh KJ. Growing gap in electronic medical record satisfaction between clinicians and health information professionals: *J Bone Joint Surg Am.* 2015;97(23):1979-1984

scanned documents makes it difficult to read and some icons that need to be clicked on are too small and difficult to find. It would be useful to be able to see when a new document (for example, lab result) has been added to the medical record. Another hoped for more automatic patient data trend reports rather than having to query the EMR. One physician noted that, even with EMR, there still needs to be much more standardization in medical terminology so that everyone is using agreed-upon terms and to have more search features for easier search for information.

At the policy level, one stakeholder noted that: “EMR is really for billing, for Current Procedural Terminology (CPT) codes; it’s just shifting the cost of billing to physicians.” Even one of the few physicians who felt that EMR were necessary stated: “I hate charting in the EMR, but now it is more organized and efficient, for example, electronic prescribing is working well, but I hate the meaningful use requirements.”

Several made the suggestion that: “Federal government should consolidate all the EMR and have one product for everyone; or we should wait until the EMR are more mature before they are forced on us.” One physician felt like his practice had gone through about ten upgrades already, with more to come. Another noted that there were system-level challenges in having the appropriate permissions to access certain features, and that it seemed there were constant computer bugs being discovered. Some felt that other EMR systems might be better than the one they were using but they did not know how to compare among systems.

Many agreed that: “Federal government should pay for the EMR and the training that ensue. We are not paid for all the time we spent on learning how to use an EMR.” One physician said that he had three months with no income as he learned how to use his EMR, with a loss of up to \$100,000. One physician felt that: “There should be more exemptions from having to use an EMR.” It was noted that there were physicians who were willing to take the Medicare penalty, or dropping Medicare, or have retired because of the EMR requirements.

Other challenges in using EMR in the future were discussed: “Now physicians will be fined if they don’t use ICD-10.” One physician noted that physicians also are responsible for the security of all their data and can be fined or jailed if there are security breaches, referring to the risk of the growing market for “medical scribes” to assist physicians with data entry.

### ***Clinical Practice Transformation***

In discussing clinical practice transformation in support of health care quality improvement, the physicians felt that they strive to do their best, and are generally doing well on quality measures. One stated that it is still challenging to document everything that happens during an office visit, so they might not be getting credit for everything that they do.

However, it was noted that patients have multiple conditions and need much more care and services, especially new ones. With expansions in health insurance, physicians were now seeing patients with more health issues; for example, a patient with diabetes with A1c of 15 because they had not been insured and had not had regular care. Another noted that a goal of a follow-up in-person visit to the primary care provider within one week of a hospital discharge is not realistic or feasible for many sicker patients: “We can’t control our patients’ behavior; if a patient eats a cookie, then their A1c will be high, and we will be penalized; it should be illegal for us to try to control the behavior of others; it’s un-American.”

Many agreed that quality should be defined by outcomes, not process measures: “Good health care quality is not just checking boxes.” They acknowledged their success in providing



care for those with metabolic syndrome or high cholesterol and treating patients with hepatitis B. More than one shared that it was rewarding when their patients' conditions were under control and successfully treated. Some felt that it was "good that prevention is covered," and to see more patients for their annual check-up (as there is no co-payment required under Medicare). However, it is challenging to then conduct follow-up care.

Several stakeholders talked about the need to redefine how quality is measured. They talked about how payers should focus on non-performers, while recognizing and rewarding the high performers. Several of the leaders of independent practice associations described themselves as among the physician high performers in their service areas.

Technical assistance activities available to support physician practice transformation, especially EMR adoption and patient-centered medical home recognition were discussed. The physicians felt that the technical assistance was better received when coming from the IPAs instead of from health plans, even though health plans might be the funder and driver of the initiatives<sup>12</sup>. Unfortunately, it's still challenging to document improvements in quality outcomes from the practice improvement activities.

At one meeting, there was discussion about how patient satisfaction surveys are culturally biased<sup>13</sup>, as one explained that, culturally, you would never ask a Chinese person about which hospital to send a family member or friend because you would never want anyone to go to the hospital. However, the most important question on patient surveys is "would you recommend this hospital to a family member or friend?" One physician asked whether quality measures are evolving to take into account the medically underserved<sup>14</sup>?

### ***Patient-Centered Medical Home***

The primary care physicians felt pressured with the continued implementation of patient-centered medical home. They acknowledged the challenge of being responsible for behavioral health when there is a shortage of psychiatrists and behavioral health providers. At one regional meeting, it was reported that both health insurance plans and the independent practice associations have been supporting medical home implementation, and that nearly half of all primary care physicians in that state had achieved patient-centered medical home recognition.

Some physicians (at safety-net providers and in larger group practices) have implemented team-based care in their practices, with teams including nurses, medical assistants, behavioral health providers, pharmacists, and eligibility workers. There is no common model about how these teams operate and no written protocols for how the medical team operates. Generally, medical assistants are responsible for following up on lab results. However, it was noted that it takes time for physicians to trust the competency of their medical assistants.

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<sup>12</sup> Lake TK, Higgins TC, Ginsburg PA. Fostering Health Information Technology in Small Physician Practices: Lessons from IPAs. National Institute for Health Care Reform Research Brief Number 5 (2011), accessed at: <http://www.nihcr.org/HIT-and-IPAs.pdf>; Abrams M, Schor EL, Schoenbaum S. How physician practices could share personnel and resources to support medical homes. Health Aff. (2010); 29(6): 1194-1199; Highsmith N. Creating Physician-Support Entities in Medicaid. Center for Health Care Strategies Policy Brief (2011): [http://www.chcs.org/usr\\_doc/CMWF\\_Shared\\_Support\\_Practices\\_FINAL.pdf](http://www.chcs.org/usr_doc/CMWF_Shared_Support_Practices_FINAL.pdf); Highsmith N, Berenson J. Driving Value in Medicaid Primary Care: The Role of Shared Support Networks for Physician Practices, Center for Health Care Strategies (2011): [http://www.chcs.org/usr\\_doc/Report.pdf](http://www.chcs.org/usr_doc/Report.pdf)

<sup>13</sup> Saha S, Hickam DH, Explaining low ratings of patient satisfaction among Asian-Americans. *Am J Med Qual.* 2003;18(6):256-264; Ngo-Metzger Q, Legedza AT, Phillips RS. Asian Americans' reports of their health care experiences: Results of a national survey. *J Gen Intern Med.* 2004;19(2):111-119.

<sup>14</sup> NQF, Risk Adjustment for Sociodemographic Factors: [http://www.qualityforum.org/Risk\\_Adjustment\\_SES.aspx](http://www.qualityforum.org/Risk_Adjustment_SES.aspx); Institute of Medicine, Accounting for Social Risk Factors in Medicare Payment: <http://www.nap.edu/catalog/21858/accounting-for-social-risk-factors-in-medicare-payment-identifying-social>

Physicians implementing medical home models are learning how to delegate more responsibilities to nurses and medical assistants on their team, to raise their level of knowledge and skills, and to model for them good patient care. However, since payment is still focused on the physician's time, it is challenging to achieve the ideal level of patient engagement as time spent on patient engagement and patient education by other members of the team is not billable. In addition, many patients still want to only see the physician.

It was noted that, even with team-based care, patients don't feel that they are at the center of the care universe as the model is still very clinician-directed with little time to spend on the patient, negative or insufficient reimbursement for preventive care or self-care.

Many physicians stated that having sufficient time with their patients is the greatest challenge. Others noted that there were ways that their practices could improve, including better explaining team-based care and the goal of patient-centered care to patients, especially new ones. There also are continuing challenges to explain and provide useful information to patients: "It is not just language interpreters, but providers who could translate "medical-ease" into "common-ease".

**Model of Successful IPAs in Asian Populations:**

<p><b>Chinese American IPA, New York, NY</b></p> <p>+ 876 members: 336 PCP, 282 specialists &amp; affiliated physicians)          No membership dues          Contracts: 23 health plans with 450,000 covered lives          IPA does the contract negotiations with health plans (HP), processes claims, claims' chart reviews, care coordinators - coders for high risk (Medicare) patients</p> <p>+IPA Services for Physician Members:          Provides/maintains care monitor software          Patient education; provider directory twice/year          Digitize paper records - update website and applications, mobile access (i.e. educational materials)          E-Discharge summaries from hospitals          Exploring private health information exchange</p> <p>+Patient-Centered Medical Homes:          Every PCP is recognized as PCMH Level 3; gets PCMH bonuses from HP</p> <p>+Social Daycare Center for Older Adults -CAIPA Foundation - Brooklyn          Funding: 5% of annual surplus (\$500,000/year)          Care assessment (medication checks, blood pressure monitoring) - health education - social activities (tai chi, mah jong, dancing, singing) – meals – transportation - Respite for families - Regardless of ability to pay</p>	<p><b>Allied Pacific IPA, Alhambra, CA</b></p> <p>+Building a "Medical Neighborhood"          Clinical offices for providers (primary care and specialists)          Labs and pharmacy - Urgent care center - Same-day surgery center          Administrative offices for IPA and ACO</p> <p>+Senior Center          Provides social activities and health education, including individualized physical therapy, nutrition classes, dance classes, ping pong, computer classes; documents basic vitals (weight, blood pressure)          No meals provided (not yet licensed as adult day health facility)          IPA physicians refer clients</p>
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**Accountable Care Organizations (ACO) and Value-Based Payments**

Two IPAs that hosted the regional meetings are leading Shared Savings Program ACOs. According to these IPAs, one significant problem is the way that quality benchmarks and minimum savings rates are established nationally in order to qualify for shared savings. Since the quality measures performance for at least one of these ACO was already at the top of the national benchmark (60% less hospital admissions, 40% less emergency department utilization), it did not qualify for any shared savings. The ACO felt that it was

being punished for having higher quality outcomes, and its investors (its participating physicians) were losing money. Since the Centers for Medicare and Medicaid Services (CMS) originally took the position that it could not change the benchmark methodology in the Medicare ACO program, this IPA felt like it has been discriminated against. This experience of failing to receive shared savings reflects the mixed results from the program nationally<sup>15</sup>. One leader concluded: “The ACO model is a dead end<sup>16</sup>.” In its June 2015 final rule revising the Medicare ACO program, CMS made changes to the benchmarking methodology<sup>17</sup>, and announced the Next Generation ACO model<sup>18</sup> with additional options for calculating shared savings combined with shared risk.

Physicians and other stakeholders expressed how shared savings models had to be used for the big changes being sought in health care reform. According to them, even using a full capitation model will not work, because it does not increase the capacity to provide more care to patients. One physician noted: “we are only receiving chump change to capitalize the types of organizational changes being required, such as EMRs and patient-centered medical homes.” She said she felt like she was “practicing guerilla medicine to take care of her patients while fighting for revenue streams.” Another physician concluded that: “we need a game-changing amount of resources in order to implement the game-changing transformations being expected and required, not just incremental incentives for incremental changes.”

### **Other Issues and Discussion**

In some final discussions, physicians reflected on the state of their profession and the context of continuing changes and reforms. Many participants wanted to become a doctor to take care of patients; however, the profession is now increasingly becoming more business-oriented. Many physicians commented that health care should not be profit-driven. Others blamed health insurance plans, saying “you shouldn’t mix up health care and health insurance; basic health care should be available for everyone and everyone should contribute/pay; health insurance only should be for catastrophic cases and major illnesses.” They felt that the health insurance plans keep physician payments low, and they are driven by profits. As one said: “the insurance companies run the show.”

At one meeting, the physicians noted that two-thirds of patients on Medicaid are in managed care plans, and they constantly have to fight with health plans for pre-authorizations. When pre-authorizations are denied, they often lose their patients. “When we request for a pre-authorization, we are not prescribing the most expensive medication but the right

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<sup>15</sup> Introcaso D. MSSP Year Two: Medicare ACOs show muted success. *Health Affairs Blog*, September 24, 2015, accessed at: <http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/>

<sup>16</sup> Christensen C, Flier J, Vijayaraghavan V. The coming failure of accountable care. *WSJ* 02/19/2013: <http://online.wsj.com/article/SB10001424127887324880504578296902005944398.html>; Burns LR, Pauly MV. ACOs may have difficulty avoiding the failures of integrated delivery networks of the 1990s. *Health Aff.* (2012);31(11):2407-2416; Berenson RA. Shared savings program for accountable care organizations: A bridge to nowhere? *Amer Jour Managed Care.* (2010);16(10):721-725; Devers KJ, Berenson RA. Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries? *Urban Institute* (2009): <http://www.urban.org/publications/411975.html>

<sup>17</sup> CMS, Medicare Shared Savings Program ACO Final Rule, 80 Fed. Reg. 32692-32845 (June 4, 2015), accessed at: <https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf>; Colla C, Heiser S, Tierney E, Fisher E. Balancing goals in the MSSP: Consider variable savings rates, *Health Affairs Blog*, 06/16/2015: <http://healthaffairs.org/blog/2015/06/16/balancing-goals-in-the-mssp-consider-variable-savings-rates/print/>

<sup>18</sup> <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>; 21 Next Generation ACOs began operations in 2016: <http://www.hhs.gov/about/news/2016/01/11/new-hospitals-and-health-care-providers-join-successful-cutting-edge-federal-initiative.html>

medication,” said one physician. “Sometimes I am on hold for up to 30 minutes to talk to a nurse or decision maker who is not a physician,” said another. Many agreed that: “there should be less pre-authorizations required and more decisions by peer review.” At another regional meeting, a physician leader noted: “In the past, doctors had the upper hand/power, but now decisions are made by policymakers and insurers.” She cited a local health plan that bypasses physicians and deploys care coordinators to develop care plans for high health care utilizers directly with the patients.

Many solo practitioners felt powerless in negotiating with health plans. Large practices get a higher volume of referrals and have other advantages over solo practice physicians: “as solo practitioners, we get beat up with trying to follow all the new laws and regulations.”

At one meeting, it was noted that there is no consideration for the increased costs of practice such as rent and minimum wage increase in certain cities and states.

The recent and rapid consolidation of local hospitals were mentioned at one meeting with the sense that the hospitals would gain too much power in the local health care market to the detriment of physicians. The local hospitals in that region had been leading accountable care initiatives and intentionally excluded the local IPAs and local physician leadership from the final design of shared savings from accountable care initiatives.

The feeling was that there were too many changes in health care today: “Medicare is doing a lot of experiments about how health care providers will be paid.” At least one physician expressed support for tiered provider networks: “There should be more transparency in fee schedules so that patients know what their charges really are; there could be tiers of providers by cost; let them choose how much they want to pay.”

Many noted that: “Health care regulations and policies are so bureaucratic,” and: “One needs a lawyer to read all the fine prints; there is too much paperwork; there always seem to be more laws but no laws are ever repealed; there should be a rule that you have to eliminate a current regulation before you can require a new one.” At least one physician raised the issue of medical malpractice liability: “We need tort reform so there is less defensive medicine.”

They are seeing more physician assistants and nurse practitioners replacing physicians. At one regional meeting, it was a conversation about how some physicians are changing their practice to concierge medicine, becoming “non par” (“non-participating” physicians who decline to contract with health insurance plans). It was felt that most of these physicians were not doing so to make money but to regain control of their relationship with patients.

### ***Medical Education and Training***

To address the future physician shortages, some medical schools have increased the size of their classes. Some are working on organizing their various health professions schools (medicine, nursing, pharmacy, social work) into more inter-professional education. The physicians felt that medical school graduates are more interested in being employees rather than being entrepreneurs and start their own practice, and that the culture of the millennial generation is to expect a salary and benefits, limited work hours, and paying off student loan. They are afraid that physicians of the future will be “blue collar” workers. Several noted these trends also are being perpetuated by admissions criteria and that medical schools could admit more students based on commitment to community service rather than grades and test scores: “Medicine used to be a mission, a calling to help others but fewer and fewer practicing physicians and medical students feel that way today.”

Several medical students participated in the discussions. Health care reform wasn't addressed in their medical school curriculum neither discussion on health insurance coverage. Those who volunteered or done community service prior to medical school had some exposure to EMRs. However, they were taught to chart by handwriting.

## RECOMMENDATIONS

Based on the discussions NCAPIP makes the following recommendations:

1. Monitor and ensure the affordability of health insurance coverage offered from health insurance exchanges, especially high deductibles, co-payments and co-insurance and the access and affordability of prescription medication; support implementation of the Basic Health Program option in additional states;
2. Fund community-based partners and ethnic media to conduct culturally and linguistically appropriate outreach, education, and engagement of consumers in understanding and optimizing the use of their health insurance coverage as they move from "coverage to care"<sup>19</sup>;
3. Require and support the provision of culturally and linguistically appropriate health care services offered through the health insurance exchanges and through Medicaid, specifically by ensuring language access at all points of contact, cultural competency training, and workforce diversity;
4. Fund and make available open source, interoperable EMR solutions; impose more aggressive, time-specific requirements for interoperability and structured health information exchange;
5. Create specific and ongoing opportunities for solo and small group primary care physicians and racial and ethnic minority physicians to participate in the design, implementation, and evaluation of clinical practice transformation and value-based payment initiatives;
6. Provide technical assistance to solo and small group physician practices on clinical practice transformation and value-based payment using the Transforming Clinical Practice Initiative<sup>20</sup>, Regional Extension Centers, Primary Care Extension Centers, Community-Based Collaborative Care Networks, and Community Health Teams;
7. Fund independent practice associations, racial and ethnic minority physician organizations, and other physician-support entities to provide technical assistance to solo and small group primary care physician practices on clinical practice transformation and value-based payment; and
8. Integrate health care delivery system reform, health insurance, quality improvement<sup>21</sup>, and culturally and linguistically appropriate services into medical school and other health professional education and training.

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<sup>19</sup> <https://marketplace.cms.gov/technical-assistance-resources/c2c.html>

<sup>20</sup> <https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/>

<sup>21</sup> Wong BM, Levinson W, Shojania KG. Quality improvement in medical education: Current state and future directions. *Med Educ.* 2012;46(1):107-119

**REGIONAL MEETINGS**  
**AUGUST 2014 - NOVEMBER 2015**

Honolulu, HI: August 4, 2014
San Francisco, CA: October 17, 2014
San Francisco: November 6, 2015
Gaithersburg, MD: October 13, 2015
Alhambra, CA: October 15, 2015
New York, NY: November 4, 2015
Oakland, CA: November 17, 2015

***Honolulu, HI***

- Josh Green, MD, Executive Director, Hawaii Independent Physician Association (Hawaii IPA); Hawaii State Senator
- Martina Kamaka, MD, Department of Native Hawaiian Health, John Burns School of Medicine (JABSOM), University of Hawaii; Member, Board of Directors, NCAPIP
- Nadine Tenn Sale, MD, President, Hawaii Independent Physician Association; Member, Board of Directors, NCAPIP
- Roy Magnusson, MD, Associate Dean, Clinical Affairs, JABSOM - University of Hawaii; Chair, Board of Directors, Hawaii Health Information Exchange (Hawaii HIE)
- Hilton Raethel, Executive Vice President and Chief Health Officer, Hawaii Medical Service Association (HMSA)
- Greigh Hirata, MD, Secretary/Treasurer, Hawaii Independent Physician Association; Medical Director, Fetal Diagnostic Institute of the Pacific
- Ira Zunin, MD, Medical Director, Manakai O Malama
- Neal Palafox, MD, Department of Family Medicine, JABSOM - University of Hawaii
- Gerard Akaka, MD. Vice President, Medical Affairs and CMO, Queen's Medical Center
- Janet Onopa, MD. Medical Director, Queen Emma Clinics
- Victoria Page, Executive Vice President of Health Innovation, National Kidney Foundation of Hawaii
- Troy Tamashiro, Director of Health Innovation, National Kidney Foundation of Hawaii

***San Francisco, CA***

- Sunny Pak, MD, MPH: Primary Care
- Zhi Huang, MD: Primary Care
- Roger Eng, MD: San Francisco Medical Society
- Michael Siu, MD: Family Medicine
- Don Ng, MD: Internal Medicine, University of California San Francisco
- Yee-Bun B. Lui, MD: General Practice – Chinatown Department of Public Health
- Albert Yu, MD: Family Medicine, San Francisco Department of Public Health, NCAPIP Board Member
- Dexter Louie, MD, MBA, JD: Otolaryngology, NCAPIP Board Member
- Alice Hm Chen, MD, MPH: Internal Medicine, San Francisco Health Network, NCAPIP Board Member
- Edward A. Chow, MD: Internal Medicine, NCAPIP Board Member
- L. Eric Leung, MD: NCAPIP Board Member
- Winston Wong, MD: MS, Family Medicine, NCAPIP Board Member
- George W. Ma, MD: Internal Medicine, NCAPIP Board Member
- Kenneth P. Moritsugu, MD, MPH: NCAPIP Board Member
- Suhaila Khan, MD, PhD: NCAPIP Staff

- Betty Ng, NP: Primary Care Provider
- Julie Tse, NP: Primary Care Provider
- Shirley Li, NP: Primary Care Provider
- Julie Wu, 2nd Year Medical Student
- Sneha Tahtipelli, 2nd Year Medical Student
- Irving Lang, 1st Year Medical Student

### ***Alhambra, CA***

- Kenneth Sim, MD
- Thomas S. Lam, MD, MPH
- Jo Espino, RN
- Marie Claire Kitayama, MPH
- Paul Chu, MD
- Mary Kitayama, MPH

### ***Gaithersburg, MD***

- Mark K. Li, MD: Internal Medicine, Solo Practice; sees 20-30 patients/day
- Mo-Ping Chow, MD: Internal Medicine, Solo Practice; in practice over 20 years; Medical Director at free clinic with CAACSC
- Benson W. Yu, MD: Internal Medicine, Solo Practice; Medical School Faculty
- Terry Cui, MD: Internal Medicine; Solo Practice
- Sharon Young, MD: Internal and Geriatric Medicine; Solo Practice
- Jay Hee, MD: Endocrinologist
- Jeff Cheung, MD: Ophthalmology; Solo Practice; Medical School Faculty
- Alan Chung: Pharmacologist; Military and Federal Government Services
- Lucy Li: Office Manager, Dr. Li's practice
- Mrs. Chow: Office Manager, Dr. Chow's practice
- Van Son Truong, MD: General Practice; Solo Practice
- Ming Lee, MD: General Practice, Solo Practice

### ***New York, NY***

- George C. K. Liu, MD, PhD: Internal Medicine, Solo Practice
- Sun-Hoo Foo, MD: Primary Care
- Ching Yin Lam, MD: Primary Care
- Jonathan Chang, MD: Family Medicine
- Ming Der Cheng, PhD
- Mary Wong, MD: Primary Care
- Warren W. Chin, MD: Cardiology
- Don Lee, Chinese American IPA – Chief Financial Officer

### ***Oakland, CA***

- Lawrence Ng, MD
- Vanessa Chan, MD
- Sijie Zheng, MD, PhD