SustiNet Health Partnership

Healthcare Quality & Provider Advisory Committee

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SustiNet Healthcare Quality and Provider Advisory Committee Regular Meeting
January 21, 2010
Meeting Minutes

Committee Attendees: *C. Todd Staub, Co-chair; Margaret Flinter, Co-chair; Clarice Begemann; Mark Belsky; Francois de Brantes; Teresa Dotson; Lynne Garner; Kathy Grimaud; William Handelman; Alison Hong; Rodney Hornbake; Mike Hudson; Steve Karp; Willard Kasoff; William Kohlhepp; Claudia Gruss; Mark Thompson; Rick Liva; Sarah Long; Robert McLean; Matt Pagano; Sara Parker McKernan; Jean Rexford; Linda Ross; Jody Rowell; Nelson Shub; Arthur Tedesco; Joseph Treadwell; Jeff Walter*

Office of the Healthcare Advocate: *Vicki Veltri; Africka Hinds-Ayala*

Absent: *Tina Brown-Stevenson; Jane Deane Clark; Kevin Galvin; Paul Grady; Bryte Johnson; Pieter Joost van Wattum; Tom McLarney; Marcia Petrillo; Robert Scalettar; Christine Shea Bianchi; Richard Torres*

Margaret Flinter and Todd Staub, the co-chairs of this Committee, welcomed all members. Minutes from the December meeting were approved with minor corrections.

Todd reported on his attendance at a recent SustiNet Board of Directors meeting.

Margaret said that today's meeting would focus on payment methodology reform in support of the goals of quality, safety access and effectiveness or accountability. She asked how Committee members felt about recommending changes to the Medicaid payment schedule that tie to the Medicare fee schedule. An unidentified speaker said that the low rate of Medicaid participation in CT is driven by the fee structure. In states like North Carolina where 80 – 90% of doctors participate in Medicaid, the fees are equivalent to Medicare rates. Bill Handelman said that several years ago Medicaid fees were raised in order to encourage the participation of providers of pediatric and obstetrical care, but at the same time reimbursement was drastically reduced for adult patients. At one time, for patients who had both Medicaid and Medicare, CT paid the 20% co-pay for Medicare patients. Then CT

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found that federal law allowed a loophole for them to limit payment to what Medicaid alone would pay. If the 80% that Medicare paid was above 100% of the Medicaid fee schedule, there would be no co-pay. That's been in place for 15 years; as a result of that, physicians who took care of patients with both Medicaid and Medicare, who are mostly disabled or in nursing homes, dropped out of Medicare in droves. Bill said that these are two major issues, the 20% co-pay and the disparity in the Medicaid fee schedule.

An unidentified speaker said that historically each state has had to make three choices, with the first being what to pay providers, second, who is eligible to participate, and third, what the program will pay for. Some states pay providers more generously, but they've made compromises regarding eligibility and services covered. CT has been stingier with provider reimbursement but granted eligibility to more recipients and covered more services. Making changes to the delivery platform and the delivery system must occur simultaneously with any payment reform. Changing Medicaid reimbursement to match Medicare rates is necessary but not sufficient. There are other changes that need to come about. The same speaker said that his practice invested in an electronic medical records system as a step to becoming a medical home, and that this considerably increased monthly costs in administration and maintenance. This system facilitates managing people with chronic conditions over time, intervening early and ensuring that these people aren't seeking care at emergency departments; however Medicare reimbursement by itself doesn't make this a sustainable option. Until there is basic and fundamental reform, other physicians won't follow suit.

Claudia Gruss said that the Medicare deductible increases each year. This year it is $155. For doctors who take care of patients with both Medicaid and Medicare, it's not only the 20% co-pay that they don't see, but it's also the $155 up front that they don't see. For doctors who care for patients in nursing homes, they are actually working for free, seeing patients for approximately 3 to 4 months of the year without reimbursement.

Mark Belsky said that he has been a family doctor in practice for about 25 years participating in Medicaid. It is very difficult to find specialists to refer to who participate in Medicaid. Payment reform will need to include adequate reimbursement for specialists. Margaret said that the SustiNet plan calls for moving all public insurances to commercially approximated rates over time. The role of this Committee is to determine the most urgent area to get started on. Nelson Shub said that there is a need to deliver more healthcare to more people for less money. He sees the biggest problem as being how to obtain more money. He said that standardized healthcare and payments need to be enforced, for reimbursement as well as for quality.

Francois de Brantes made a presentation to the committee addressing reimbursement. He said that incentives impact everything in healthcare, so initially there must be a focus on incentives. It's a complicated task, because it deals with multiple interactions of professionals in a very large and complex setting. The main things to look at are fees for service, capitation and episodes of care. There is no single formula for payment that is going to work. It is very likely that in any organization there are various forms of compensation.

The focus of payment reform should be minimizing negative incentives. The big question is how to provide coverage for more people without large tax increases. Francois said that the rate of inflation of medical costs is higher than the GDP inflation. Having a goal of zero inflation for medical costs for six or seven years forces everyone to think about the redistribution of existing resources. Once the goal is stated, the fundamental principles for organizing this payment effort must be determined. Francois said fairness should be a priority, for payors and providers. The second principle he mentioned is transparency. The third principle is patient-centered, ensuring that all providers share the same goal of providing excellent care. All these principles need to be part of the RFP to commercial carriers who will ultimately provide coverage under the SustiNet plan. Francois said that this is the way to legislate change without going through the legislature, and that this is a huge opportunity to implement payment reform.

Rodney Hornbake said that it is necessary to create the right incentives. He said that research done around the country shows that the health systems that produce the highest quality at the lowest costs are those that have the strongest systems of primary care. He said CT has the highest costs and the lowest quality, with weak primary care and strong specialty care. In order to attain zero percent inflation, the long-standing practice of undermining primary care and incentivizing specialty care needs to be reversed. People often visit specialists seeking care that should be provided by primary care physicians, who could provide education, nutrition counseling and other care management that is needed.

Vicki Veltri said that there is much talk about trends and increasing medical costs, but one thing not addressed is increasing administrative costs for insurance. She said that this Committee will need to tackle this issue, and include it in RFPs. Kathy Grimaud said that consumer expectations need to be considered. She said that there is a huge dependence on costly drugs, greatly driving up the cost of healthcare. At some point, patients shifted responsibility for their health to their providers. This is no longer affordable; there needs to be a shift back to the patients, who will need to make behavioral changes, but the current system doesn't help with this. Teresa Dotson said that the current system doesn't incentivize prevention efforts by patients or physicians. Robert McLean said that there are two concepts that haven't been mentioned here, overutilization and accountability. He said that paying primary care doctors more would prevent the overutilization of emergency departments, leading to tremendous savings. Primary care that focuses on the promoting prevention will bring savings. There is a new concept of accountable care organizations; physicians won't change behaviors unless there are incentives to do so. Robert said that he has seen estimates that 35% of care is unnecessary; this is a lot of money to find and redistribute. Steve Karp spoke of incentives for patients. He has heard of insurance companies that conducted a pilot program that reimbursed patients' premiums when behavioral changes were made.

Jean Rexford said that regarding the overprescribing of medications, there are conflicts of interest that exist within the pharmaceutical industry. The education that is provided regarding medications is provided by the pharmaceutical companies but it would make sense

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for it to be provided by academic individuals. She said that she doesn't feel that the various professions want patients to step up and manage their own care. Nelson said that there cannot be change without addressing standards of care, or whatever changes are made will attract lawsuits. Claudia said that an important piece of this is that the patient buys into the process, so this effort will need to involve patient education. Additionally, care must be taken not to penalize primary care physicians for their patients' behavior.

Francois said that regarding medical homes, he feels that there should be incentives created for primary care. The intended consequence is to create more incentives for primary care physicians to manage their patients, but the unintended consequence is that a silo of primary care relative to the rest of the delivery system is maintained. This issue can be addressed and fixed very easily with a slightly different model of patient centered medical homes. Additionally, administrative costs can be addressed in an RFP. Francois said that in order for universal coverage to occur with zero inflation, there are those who will get less than what they get today, and this is inevitable.

Clarice Begemann commented on health education in the schools, saying that currently there is only a recommendation that schools offer one semester of health education every two years between seventh and twelfth grade. In CT, schools with more resources offer health education, and poorer schools don't have health education. This adds to the disparity of poor people having worse health. Clarice said that she thought that this Committee could make a recommendation that health education become a requirement in all schools.

Jody Rowell said that she feels that patients are frequently prescribed medication because it's the easiest way to deal with certain problems, because there is a lack of access to services and providers. Willard Kasoff said that there have been attempts made to bring specialists into medical homes, but that it's been difficult to get specialists to buy into that model. Francois said that this poses a challenge, that there is a need to get away from fee for services, and that this process will be complicated. There is a need for plans that clearly delineate goals around total cost of care to force changes in compensation from the plans down to the providers. Patients won't have unfettered access to any service, and they will be locked into some amount of network based services in a tighter scope.

Bill commented that there are many problems that arise from creating radical reform. One problem is that many of things being advocated here don't achieve cost savings. Prevention is a noble goal but it takes many years to achieve effective cost savings using prevention as the primary motivation to reduce costs. Another problem is that in CT there is no infrastructure for these care models, and there are very few hospital owned practices. These systems work best in integrated models that all have a common goal to make the systems work. Hospitals in CT are starting to buy physician practices, but these aren't generally primary care practices but rather are subspecialists' practices. This presents another problem, namely that physicians are reimbursed at higher rates when they are in hospital based practices.

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Lynn Garner commented that there seems to be a mild consensus that patients need to be driven towards primary care and away from specialty care. She suggested that primary care physicians and specialists should be paid the same fees for the same services. Sarah Long said that she had heard a speaker who discussed healthcare in San Francisco, where the city provides coverage to all residents. They had a system wherein primary care providers could send referrals and information to specialists, and within two weeks they received consult reports back from the specialists, who did this without seeing the patients. The specialist would either make recommendations for the patients or request a patient visit. This model seemed to work well. Vicki said that payment reform would require outcome measures. She said that this Committee may need to adjust its approach for various specialties. Specialties have differing administrative costs, so there is a need to consider different incentives in order for these providers to participate.

Todd said that cost containment is a principle goal for the Committee. There must be interlocking incentives for providers and patients, and outcomes that are meaningful and measurable for both. The payment plan that SustiNet would follow has to have a balanced approach between treatment and prevention. Clinical partnerships must be built into the medical home concept in order to manage health conditions.

Meeting was adjourned.

Next meeting 2/18/10 at 8:00 am at Connecticut Hospital Association in Wallingford.

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