PRIMARY CARE PROVIDER ADVISORY COMMITTEE

Meeting Minutes, June 21, 2006

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregg Allen, DO; Andrea Arena, MD; Stanley Block, MD; Mark Braun, MD; Robert Crausman, MD, MMS; Charles Eaton, MD; Fadya ElRayess, MD; Sarah Fessler, MD; David Gifford, MD, MPH; Victor Lerish, MD; Sharon Marable, MD, MPH; Renee Rulin, MD, MPH; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Associates/Guests*: Kerrie Jones Clark; Patrick Dawson; Celia Gomes-McGillivray, RN, MPH, CHES; David Leveillee; Corrinne Calise Russo; John Young. *HEALTH*: Becky Bessette; Jeffrey Garber; Stephanie Kissam. *PCPAC Staff*: Carla Lundquist; Mary Anne Miller, RN, MPH, CHES.

Unable to Attend: Gowri Anandarajah, MD; Munawar Azam, MD; Solmaz Behtash, MD; L. Anthony Cirillo, MD; Michael Fine, MD; Paul George, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Luke Hansen, MD; Raymond Maxim, MD; Donya Powers, MD; Mark Schwager, MD.

Dr. Borkan opened the meeting at 7:35 AM. Minutes of the May 17, 2006 meeting were approved as written (motion by Dr. Wagner, second by Dr. Block, all in favor). Dr. Borkan asked members to review the advisory letter from the May PCPAC during the meeting. Signatures of all PCPAC members willing will be added to the final letter.

Dr. Rulin updated the committee on the **Initiatives to Strengthen Primary Care**, last discussed at PCPAC in March 2006. Under the leadership of co-chairs Christopher Koller, Health Insurance Commissioner, and Dr. Gifford, the Primary Care Stakeholder Group, including purchasers, payors, providers, and consumers, began holding stakeholder meetings and workgroup sessions in April. The Primary Care Stakeholder Charter was established in May, and group has been working to develop positions on the one or two primary care attributes that most strongly support the vision of improved health of the population and efficiency of the medical system. The areas of highest workgroup interest were Superb Access, Clinical Information Systems, and Care Coordination. The Primary Care Stakeholder Group (PCSG) will meet on June 26th to identify the two innovations to pursue. The stakeholders will be brought together to consider how monies are currently spent on healthcare, and provide direction on how to more effectively use these monies. Mr. Young noted that currently, funds are aligned to drive people to the costliest sites of care; if the funds can be re-aligned, people can be held accountable for their choices. Healthcare purchasers, in conjunction with payors and providers, may be willing to try new models to assure they are getting what they want and need for the money they are spending. The goal is to look at ways to implement improvements and align all the players so change can be made. Dr. Crausman relayed that ACP has been clear that a reallocation of healthcare funding needs to be from outside Primary Care to Primary Care.

PCPAC members would like to see OB/GYNs, hospital networks, and physician groups represented in the PCSG, as well as involvement of specialists. Dr. Borkan noted that adding a feasibility factor may be helpful in the process of choosing priorities.

Dr. Borkan reported that beginning in July, **Medicaid will require all MDs to get pre-authorization for imaging tests (CT, MRI, and PET scans)** other than those ordered in Emergency Rooms or for inpatients, despite activity from RIMS and other professional organizations over the last year to avoid this.

John Young, Associate Director, Healthcare Quality, Financing & Purchasing, DHS, stated that this new requirement, which will apply only to Medicaid enrollees who are not in RIte Care or dually-eligible for Medicare, is due to the budget reduction targets; DHS now has to look for every possible savings area. This measure is expected to save approximately $600,000 annually, based on the experience of 4-5 other states and profiling of claims data. DHS will collect data on all imaging tests ordered to analyze cost variability by testing site, determine alignment with best practices, and identify outliers who have higher rates of test ordering. To ease transition, the pre-authorization requirement will be rolled out slowly. DHS is willing to bring in MedSolutions, the contractor working on this effort, to talk to physician groups. MedSolutions has been working with Texas Medicaid populations for 4-5 months on pre-authorizations for imaging tests; the overall denial rate is 12-17%.

PCPAC absolutely agreed that over-ordering of expensive imaging tests is a problem, but strongly opposed pre-authorization as a solution and requested that DHS seriously reconsider this requirement. The State should carefully consider the unintended consequences of this measure prior to implementation, including damage to long-term goals of building trust and partnership with the primary care community. Effectively, this is collective punishment, with cost shifting from the state to PCPs and specialists. PCPs will be required to do pre-authorizations for a study they are not ordering and from which they will not benefit. PCPs and specialty physicians have expressed concern that this additional burden will exacerbate the problem of access to care for Medicaid populations, as more physicians opt out of accepting these patients. Pre-authorization calls heavily impact physician/staff time (up to 20 minutes to get a live person on the call line, by some reports). DHS has not modeled the cost to practices for this requirement. Physicians advocating for their patients may explore any loopholes existing in the pre-authorization system, such as a quick referral to the ER to access testing, and the State should be prepared for increased ER usage by Medicaid populations.

Suggestions by PCPAC members to improve the pre-authorization process included: 1) Use a check-off form to fax in for imaging test authorization, and return approvals within 24 hours; 2) Publicize the electronic submission process available via the MedSolutions web site www.medsolutions.com; and 3) Require MedSolutions to process requests submitted from Electronic Health Records. Members also expressed interest in cost savings data, both for other states and projected savings in RI, including the contractor services costs of data gathering and the authorization system.

Several alternatives to pre-authorization of imaging tests as cost controls were offered by the committee:

- Set standard Medicaid fee schedules for imaging tests, reducing the variability of cost, or designate preferred providers. Mr. Young explained that the cost variability is due to hospital financing; hospital radiology and laboratory services often prop up loss areas. There have been a number of proposals in the past few years to review hospital financing, but they have not had sufficient support to proceed. Dr. Gifford noted that having the PC community support in these efforts would strengthen the State's position to revise hospital financing. Ultimately, a flat rate fee schedule for imaging tests would best control costs.
- Provide comparative cost data for the various sites to providers. Dr. Gifford pointed out that transparency legislation linking cost and quality is currently being opposed by hospitals, and anyone seeking to compare cost data should support this legislation.
- Analyze claims data to identify outliers and utilize academic detailing, an established methodology to send in a physician team to educate them in best practices, which has been very successful. Experienced personnel exist in the state, and could be put into service quickly.
- Focus cost-control efforts on ERs; redundant imaging testing is mainly a product of ERs
- Create guidelines for ordering imaging tests and distribute to providers.

Dr. Gifford noted that in terms of a balanced health care system, this effort pits medical specialties against each other, and underlines how the reimbursement mechanism for primary care is out of balance compared to the reimbursement mechanisms for hospital specialty services. He reminded the group of the broader principle that will need to be continually revisited over the next couple of years: The way health care is financed and reimbursed must change. As long as health care is reimbursed on a volume fee-for-service basis, there will be an inherently antagonistic relationship between insurers, physicians, and patients. The present system disconnects the physician from making decisions with financial impact, effectively requiring the physician to advocate for the patient without the context of actual costs. Pre-authorization is an extreme example of this. If health care were to be shifted to outcome-based reimbursement, aligning incentives and payments, physicians would become part of the complete decision-making picture. Pay-for-performance, related to past capitation efforts but with better management systems, immediately involves the physician in considering cost as part of the health care delivery equation. Until this can be implemented, there will be more antagonism in the patient/provider/payor relationship.

Mr. Young agreed that the strategies suggested were reasonable, and should be part of the larger discussion of how to bring balance to the health care system, but he was not in a position to defer implementation of the new pre-authorization requirement. However, DHS will take the following actions:

- Implement a grace period during which no pre-authorization requests will be denied
- Gather data on high users of imaging tests
- Engage RIMS regarding training efforts for outliers
- Consider alternative approaches to this problem
- Investigate reports of long wait times on call lines; MedSolutions is required to answer calls within 30 seconds

Dr. Borkan urged members to complete their annual evaluation forms, noted that in addition to the four primary care specialties (OB/Gyn, IM, FP, Ped), PCPAC now includes representation of Residents, Fellows, and medical students, and thanked all participants for their efforts to make PCPAC an open forum for discussion.

Dr. Gifford noted that several Certificate of Need (CON) applications would be reviewed over the summer months, and he would have the information forwarded to PCPAC members via email for their input. Anyone can participate in the open review process either by sending letters with questions for the applicants, or coming to testify. The CON process is required for large hospital capital investments and for a select set of services, currently six, which HEALTH is seeking to expand. HEALTH is working to add charity care requirements to all CONs.

NEXT PCPAC MEETING WEDNESDAY, SEPTEMBER 20, 2006