PRESENTATION TO THE LOUISIANA SENATE

DECEMBER 17, 2008

The Louisiana State Medical Society appreciates the opportunity to address the Senate on one of the most important issues facing our state – Reform of the Medicaid System.

Reform of our Medicaid system has been debated in this chamber and the halls of the Capitol for years. Some changes have been made over time but the basic structure has remained the same and so have the results. Department of Health and Hospitals Secretary Alan Levine briefed you earlier today on the disturbing data and condition of our current system that clearly indicates we must act now. The Louisiana State Medical Society has long advocated the need to change our health care delivery system beginning as far back as December of 1979 when we unveiled the Consumers Health Investment Plan, the brainchild of Dr F Michael Smith, a pediatrician from Thibodaux. Later, in 1995 we introduced legislation outlining the Access to Better Care (ABC) Plan which was proposed as a Medicaid demonstration project. The legislation was passed but a pilot was never established. More recently in February of 2006 the LSMS announced its Health Access Louisiana Plan as a part of the post Katrina/Rita need to reestablish our health care infrastructure and modernize our health care delivery system. The LSMS has strongly supported health system reform, particularly Medicaid reform, for decades and it remains one of our top priorities for improving the quality of life of the people of our state.

The LSMS is pleased that Governor Jindal has moved health care to the forefront of his agenda with the initiation of the Louisiana Health First project. Secretary Levine was charged with developing a reform plan for the Medicaid system and has been working for several months on its conceptual design. The release on November 14th of a Concept Paper for the first time gave us a composite insight into the DHH goals for reform and plans for four regional demonstration programs. This summary will provide our observations and comments on the Concept Paper which has now been incorporated into a federal waiver request. The following LSMS core principles for health system reform were used in our, evaluation of the proposed design of Louisiana Health First.

1) Provide an array of choices of financing mechanisms to individual beneficiaries.

2) Give the individual the opportunity and the responsibility to choose their own coverage with the periodic right to change if dissatisfied with the performance of their previous choice.

3) Portability of coverage and the dollars that cover the actual care follow the patient.

The LSMS is encouraged by the inclusion of some essential concepts in Louisiana Health First that are important to a successful reform of the Medicaid System. Among them are:

1) Patient choice of health care coverage is an extremely important step in a patient centered focus to providing health care. The role that patient choice can play in changing the culture of the current system is absolutely key to building a new and lasting sense of ownership and responsibility in a reformed Medicaid program.

2) The Patient Centered Medical Home, utilizing the principles adopted by the National Committee on Quality Assurance, will bring a core oriented organizational approach to delivering care to patients.

3) Coordination of all patient services available through the Medicaid program in order to achieve better health outcomes, increased operational efficiencies and raise the cost benefit ratio of the program. This includes expanded patient education and health literacy as well as increased awareness of personal health maintenance. Through improved coordination waste and inefficiency will be decreased and transparency projected throughout all patient encounters.

4) Patient incentives to not only take personal responsibility for one's own health but to become prudent users of the precious resources available to provide their needed care. Establishing a personal account that accumulates savings they generate is a concept that is a Part of the LSMS ABC plan proposed in 1995.

5) Mechanisms that allow for the sharing of savings from the efficiencies of the program with those that provide the care. Rewarding dedication and hard work parallels growth necessary to remain viable and successful as a network.

6) The Access to Affordable Care Model in Region 5. The LSMS enthusiastically welcomes it as a demonstration project. This concept is true innovative thinking. It should be our goal in reforming the system to provide access to coverage for everyone through a pluralistic marketplace driven by patient choice. In other words, provide choices of different health care financing plans and put the patient in the driver's seat.

There are also conceptual elements that present concerns to us as to how they will impact the issues of choice, cost and long term patient relationships. The Managed Care model chosen by DHH to provide care in the demonstration projects generates most of those concerns.

CHOICE AND CAPITATION

The LSMS believes patients should have a broad variety of coverage choices. The major benefit of having your own coverage is portability. As Medicaid recipients move to a new or better job they will have the ability to transition to an employer subsidized program and not lose their coverage.

The individual choice concept was an important part of the recommendations from the Louisiana Health Care Collaborative established by the previous administration to address health system reform in Louisiana. The Collaborative consisted of health care providers, insurers, patient advocacy groups, medical educators and legislators. Unfortunately, the year long work of the Collaborative was not included in reform legislation passed by the legislature. This concept is also the heart of the LSMS' Health Access Louisiana Plan.

DHH has made it clear in the Concept Paper and in public statements that the primary goal of their Medicaid reform design is to replace the current fee for service system with managed care. For over 30 years physicians have been dealing with traditional managed care in Louisiana through all their failures and iterations. We understand what a managed care system is and how it functions. The LSMS can not support a plan design that focuses almost entirely on managed care. Managed care was a failure in the 90's and is not a good fit for Louisiana. The Louisiana Managed Care market has been stagnant for several years with little new growth. Many of the national managed care companies operating in Louisiana were sued for their abusive administrative practices in handling claims with the suits eventually settled in federal court in Miami. The Managed Care oriented approach to structuring choices generates these concerns.

1) Traditional managed care plans (HMO's) have higher administrative costs than other financing mechanisms for the delivery of health care. Higher administrative costs mean less of the health care dollar goes to the actual provision of care to patients. The Medicare Advantage plan in use as an option for Medicare recipients has premium costs 12 -15% higher than the per capita average for recipients under the regular payment mechanism. Each year HMO's participating in the plan negotiate increases in premiums 5-6 times higher than payment offered to individual participating physician that accept Medicare patients. Their justification is higher operating costs.

2) The Louisiana managed care market may not provide enough acceptable bidders to provide patients with a meaningful array of choices. Having only two choices is not truly creating a competitive marketplace, especially if they are the only two choices in most of the demonstration areas. Our concerns are heightened if in order to make up for a lack of La plans, organizations outside the state are encouraged to submit proposals. These plans do not have established networks of Louisiana providers, are not familiar with our health care environment and will result in some of our health care dollars going out of state instead of remaining here to continue to work in our economy.

3) The risks for providers are very significant under the managed care capitation form of payment currently required to begin in the second year of the demonstration projects. Whoever is providing the service has to know exactly how much each service costs. After negotiating a capitation rate, the provider is bound to that rate for a specific period of time, usually twelve months. Because the provider assumes or underwrites the insurance risk, they can face financial disaster

if the advance actuarial and budget calculations are not correct. This is not an attractive arrangement to many small and medium size practices. In addition, capitation establishes "first dollar" coverage for patients leaving them with no incentive to use the delivery system judiciously and leads to isolation of the patient to the cost of their care.

4) Long standing patient/physician relationships will be severed by moving patients to managed care if their physician is not a member of the provider panel. These relationships are extremely important to the continuity of care and the patient's trust and confidence. Patient trust is the avenue through which they feel confident in providing personal information so essential to accurate and appropriate diagnosis. It takes time to build and time to maintain its role in patient centered care.

THE MEDICAL HOME SYSTEM

The Patient Centered Medical Home is an approach pioneered by the Patient Centered Primary Care Collaborative to provide comprehensive primary care to all age groups. It is a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. The Patient Centered Medical Home concept incorporates the medical home principles endorsed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association. The American Medical Association House of Delegates recommends these principles when considering and designing a medical home model. These principles recognize that a medical home is not an institution, but a personal relationship with a physician.

The Patient Centered Medical Home includes coordination of all patient services available through the Medicaid program in order to achieve better health outcomes, increase operational efficiencies and raise the cost benefit ratio of the program. This includes not only the medical services provided to patients but expanded patient education and health literacy as well as increased awareness of the responsibility for their own health maintenance. The use of disease management programs helps insure patient compliance with treatment plans through monitoring and follow up protocols tailored to a patient's condition and the desired outcomes.

Our current health care system relies on the patient to initiate an encounter with a "chief complaint." A medical home reviews a patient's health in a prospective way, advising the patient on best practices for health maintenance, but also actively (not passively) keeping track of a patient when there is an episode of an illness.

Primary care is essential for the effective and efficient functioning of America's health care delivery system. It is well established in articles published in *The Millbank Quarterly*, *Journal of the American Board of Family Practice* and *The American Academy of Pediatrics* that having a regular source of care and continuous care with the

same physician over time has been associated with better health outcomes and lower total costs. The medical home puts the emphasis on the patient-physician relationship and financial savings are a byproduct achieved by the patient's wellness enhancement.

Do not confuse the medical home concept with managed care. The two concepts are completely different. The medical home is a personal relationship between patient and physician. What defines a medical home is the willingness of the physician to review and coordinate all aspects of a patient's health, both in a prospective and a retrospective way.

Managed care is an insurance term that focuses on the financing and payment of health care. Managed care is really managed cost because of its primary focus on managing the various cost centers for delivering care. The medical home is not driven by the bottom line approach to care. Instead, the basic premise of the medical home concept is that care managed and coordinated by a personal physician with the right tools will lead to better outcomes at less cost to the system.

CHARITY HOSPITAL FUNDING

There are two other areas of the Waiver request we were asked to comment on and one is Charity Hospital funding. The LSMS does not have a position on the future of the Charity Hospital system. However, in our 2007 membership survey the overwhelming majority of the over 1000 responses felt the system should be thoroughly reviewed and realigned be to more reflective of the way health care is now delivered and financed. That realignment should maintain a strong medical education program in the state to help meet the present and future health manpower needs. The LSMS does support the LSU Health Sciences Center having their own teaching hospitals and that includes LSU New Orleans.

When looking at the Charity Hospital System there is an aspect of its mission that is of great concern to the LSMS. Since the hurricanes of 2005, care for the poor and uninsured in the greater New Orleans area has suffered greatly. The opening of the LSU interim hospital has provided some relief but not nearly enough capacity. The lion's share of meeting that need has fallen on the other hospitals and physicians that have reopened in the area. But their ability to continue to meet that need is now on a razor thin margin. Disproportionate Share Funds to care for this segment of the New Orleans area population have continued to be provided to the LSU Charity Hospital system at pre Katrina/Rita levels while big Charity remains closed. It is our belief that some of that funding should be used to expand care and help with the financial burden hospitals and physicians face as they stand in the gap and care for the poor and uninsured in Region 1. Bringing a new hospital complex on line will take several years and the current infrastructure can not sustain continuous care until that happens. The Medicaid demonstration project planned for Region 1 might be a vehicle to bring badly needed relief to the health care providers of that area.

FEDERAL MEDICAID DISALLOWANCES

The other area we were requested to comment on is the issue of the federal disallowance of use of certain Medicaid funds. This is an on going matter of negotiation between the state and federal authorities. It is a complicated matter of which we have no real knowledge of the circumstances that affect the settlement process, therefore we have no observations about its resolution. We do however understand its resolution has enormous significance for the Louisiana Health First initiative and its needed waivers. If not resolved favorably the initiative will face a serious setback and the issue of funding for Medicaid reform becomes very problematic. Further complicating the future funding of reform and Medicaid in general is the projection of over a one billion dollar shortfall in projected revenue for the state in the next fiscal year. In spite of these uncertain circumstances planning for Medicaid reform must move forward.

CONCLUSION

The LSMS would like to make it clear that we support reform of Louisiana's Medicaid system and that reform must begin now. With Louisiana Health First we have the opportunity to get it right and forge a new way of addressing the health care needs of Louisiana's Medicaid eligible citizens. It brings together many of the important concepts recognized by health care providers as important to improving the care and efficiency of the Medicaid system.

As described in the waiver request, the essential concepts for change are right but the LSMS is deeply concerned by the DHH decision to base reform around the managed care model. The LSMS believes the financing of care should be separated from the actual care management function of a redesigned system. The care management function should be designed around the patient centered medical home concept and include all of the care decisions as well as the monitoring and evaluation of outcomes. The medical home concept then becomes the true Coordinated Care Network (CCN). Financing of care should be based on a marketplace system of coverage options, including managed care, from which the patient may choose individual coverage. Data from the coverage plans would be provided to DHH for the monitoring and identification of fraud within the overall system. Both the care management function and financing function work in tandem to provide the best health care decisions for the patient and generate cost savings in the program.

What now lies ahead is many months of work that will require the continuous involvement of all the stakeholders in the system. The LSMS will be an active partner in this process to help create a system that gives Medicaid beneficiaries the ability to choose their coverage, gives them portability of that coverage and improves quality through efficient care management.