



CONNECTICUT CHAPTER
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**Connecticut State Medical Society Comments on
Connecticut Healthcare Innovation Plan**

On behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) we respectfully submit these comments regarding the proposed Connecticut Healthcare Innovation Plan. CSMS and its members have been at the forefront of efforts to increase the quality of care provided by physicians to patients, increasing access to care and reducing the overall cost of health care in Connecticut. For these reasons, CSMS supports reform of the health care delivery model in Connecticut through expansion of the use of Person Centered Medical Homes (PCMH), improved transfers of care including coordination of services between primary care physicians and medical specialists and surgeons, and allowing for data collection and interpretation through increased implementation and operability of Electronic Medical Records (EMR) and related health information technologies. Expectations of a carefully designed program including these facets would, hopefully, lead to improved quality of care with reduced overall costs, improving the value of health care services in Connecticut.

CSMS recognizes the intent of the reform concepts contained in the State Innovation Model (SIM) effort and the proposed outline of a model that allows physicians of all medical specialties and types of practice to engage in improved care coordination in order to reduce costs and improve access to care for Connecticut's patients. CSMS represents a diverse constituency of physicians across all medical specialties, sub-specialties, including surgical specialties, as well as primary care. Practice settings vary from solo or small, non-integrated practices, to those practicing in larger integrated health systems, such as physician hospital organizations, independent practice associations, as well as physicians employed by hospitals or academic institutions or stand alone clinics and federally qualified health centers. As a result, CSMS believes a model of care coordination and cost management must be developed that accounts for all practice types and does not disadvantage one type or approach to medical care in Connecticut.

Regardless of practice type, location or specialty, one message that has been clear from all physicians providing comment on the SIM is the fact that the core of the doctor-patient relationship should not be encumbered or impeded by cost control measures or design. When cost enters the equation, it must be absolutely transparent (both to physician and patient) and must not interfere with the traditional relationship that exists between patients and the physicians

who provide their medical care. Therefore, we wish to focus our comments on general areas we feel are relevant to all physicians as well as the healthcare system. Our areas of focus are those where physicians have raised questions about how the SIM model might impact, both positively and negatively, access to care in Connecticut and the patient physician relationship.

Transparency

CSMS appreciates that the SIM process has involved individual physicians representing a number of types of practices, areas of practices and medical specialties. The general transparency afforded through the SIM process has allowed for various comments and input throughout the initial process. That said, CSMS has concern with the information gathering process as it relates to the proposal. It appears that the synthesized content in the proposal is missing some critical information from those physicians engaged in the process. The failure to take into consideration the information and resources provided by the physician participants could lead to some disenfranchisement of those who have volunteered their time and efforts. Also, we have concerns that the numbers and types of providers in Connecticut are particularly overestimated in the large group setting is both misleading and inaccurate. CSMS is concerned that the SIM continues to use data that underestimates the number of practicing primary care physicians in Connecticut and overestimates those practicing in large group structures. These miscalculations will lead to access issues down the road if these assumptions are not corrected. Additional transparency must be obtained in demonstrating the geography and location of the identified primary care physicians.

CSMS stands ready to help the SIM bridge this apparent information gap and provide relevant information on the number of practices, types of practices and number of privately practicing physicians actively providing medical care to Connecticut residents. In addition, it still remains unclear what constitutes "primary care" and why obstetrician/ gynecologists are not identified as providers of primary care services. In reality, OB/GYNs provide primary care to a large percentage of the female population of Connecticut, both during child bearing years and subsequently. In order to achieve true transparency in the SIM process, there are questions that must be answered with regard to clinical and cost data and how this information would be identified to the general public.

Finally, though CSMS appreciates the SIM's efforts now to reach out to privately practicing physicians through CSMS and state based medical specialty societies, there needs to be more opportunities to solicit comment and input from privately practicing physicians who cannot take countless days out of their busy practice schedule seeing patients to attend the various SIM meetings. CSMS believes that the further gathering of information from private practicing physicians, in both large groups as well as those in small and solo practice, is essential in further

identifying the issues and concerns of physicians as well as identifying those opportunities that may become available to physicians through the SIM grant.

Quality and Cost

More detailed specifics must be included regarding quality and cost metrics to be developed as it relates to the SIM model, especially with regard to the Value Based Models (VBM) and physician rating systems that are only tangentially discussed in the SIM model, but could have profound and potentially problematic impact on care delivery in Connecticut. Rating systems based solely on financial criteria are not generally appropriate and do not promote efforts to increase quality. CSMS believes that quality factors and analysis should and must come first and subsequently economic considerations and cost drivers can be considered. Many of the currently established rating systems do not account for co-morbidities of patients, and are limited by attribution methods or models that fail to identify the actual volume of care provided by the identified physician. Detail must be provided to physicians in advance regarding the metric development process and such metrics must be representative of all types of physician practices. Furthermore, the SIM is devoid of detail as to whether and how national quality measures and metrics developed by national medical specialty societies are to be used or employed in the proposed model. With regards to rating systems, there is some considerable concern that any ranking or rating system would be similar to that of Massachusetts where the tiering methodology appears not to have much connection to the actual practice of medicine or the provision of medical care. The Massachusetts system allows for a tiering of networks that cause physicians to be frustrated and patients to be confused, leading more toward a scorecard than a true quality measurement of medical care. Before any rating or ranking were to occur in Connecticut, CSMS would want assurances that quality of care is the primary focus and cost would be secondary. Further, CSMS would be opposed to any tiering or narrowing of networks based on rankings. CSMS is not opposed to evaluation and measurement of quality and even cost, but the focus needs to be on improving and increasing access to medical care and not decreasing access through a narrowing of networks. Additionally, high quality physicians must not be penalized for admission to potentially higher cost facilities because of geographic factors.¹

Payment Mechanisms and Care Delivery

The SIM proposal suggests a paradigm shift from currently established payment mechanisms, such as fee for service, toward a payment approach that is more reminiscent of accountable care

¹ With mergers and acquisitions of facilities, many physicians have little or no choice where to admit patients if they want their patients to be cared for close to home where there is a family and social support system in place.

organizations that focus on both upstream and downstream risk. Contrast this focus with the established and successful PCMH models that provide up front per member per month payments for care coordination and case management in addition to traditional fee for service payments. PCMH models also allow for some shared savings opportunities as it relates to improving quality and reducing costs. Contrary to the PCMH model, the SIM proposal does not acknowledge that some form of a fee for service will be necessary within the program to allow solo and small practice physicians the opportunity to continue to provide the desired and necessary primary care services. The failure to include a fee for service model or discussion implies that fee for service does not promote quality or value by health care providers. This implication has raised some considerable concern among the physician community in Connecticut, especially by individual physicians who may not be in large integrated or employment based practices or systems. Previously established payment models such as capitation, and so-called “pay for performance” models, that shifted the focus away from a payment-for-service approach, have essentially failed. These models did not incentivize improved quality and value and, as a result, medical care was more restricted. Such models, as pointed out by several advocacy groups, simply serve to limit or deny care if they do not first take into consideration what constitutes quality of medical care and then look at reduction or elimination of costs. Certainly, all physicians, physician groups and/or integrated health systems must be allowed the opportunity to engage in alternative payment arrangements or VBMs when determined to be in the best interest of their patients. However, some form of fee for service must be the foundation of any payment system, particularly for those physicians in solo and small practices. The SIM only focuses on the “eleven” larger primary care entities or groups and fails to really demonstrate a meaningful way for small practice physicians to participate in this model, unless they give up their independence and become part of a much larger organization. The SIM fails to address the 60% of primary care physicians who today still provide care in rural and urban centers throughout Connecticut in small offices that were, are and will continue to be, the fabric of their communities.

In addition to the payment method, questions have been raised as to why the PCMH model that exists today in Connecticut, most often following the National Committee for Quality Assurance (NCQA) standards, is not presented as the standard for care delivery. The SIM speaks to a new model of medical home standardization or certification, but it fails to speak to why the existing models are not utilized, relied upon or even modified. The vast majority of physicians who engage in PCMH models in Connecticut follow existing standards. The SIM model appears to disenfranchise these physicians, many of whom have achieved their levels of recognition as early adopters, and who have been practicing patient centered care for years. CSMS believes the basis of the SIM model should start with the existing national models of patient centered care so that the hundreds of physicians who have achieved a specific status or certification are not required to start over or relearn another model that may not fit into their care delivery system. Finally, by utilizing the existing standards as the core of any care delivery system model, SIM can encourage physicians graduating from nationally recognized medical schools and graduate

medical education programs that promote these standards to come to Connecticut and practice. A model that is unique to Connecticut could limit its adoption by Connecticut physicians who have achieved other levels of care through national standards, as well as those who might wish to come to Connecticut to provide care in the future and have been trained to follow national standards of patient centered care. The SIM could, as presently outlined, reduce the number of primary care physicians engaging in patient centered care because existing physicians that are certified in patient centered care could simply bypass involvement or not seek to achieve the Connecticut specific standard.

The SIM model does not necessarily identify how solo and small practice physicians can transition to larger medical practices. The model is further devoid of details specifying how physicians might be able to achieve connectivity and interoperability of quality and cost information across systems in light of the anti-trust concerns and limitations contained in rulings by the Federal Trade Commission (FTC) and Department of Justice (DOJ). The only way that the SIM model works effectively for solo and small practices is to accurately and efficiently share clinical and cost information real time with their peers across the system (and across practices). The SIM needs to further evaluate how this could be achieved against anti-trust restrictions. One potential solution is through a state action anti-trust exemption that would allow the collaborative sharing of such information as monitored by a state actor, such as the health care advocate's office. The SIM model necessitates a sharing of information that can only be achieved through greater collaboration among and between practices. To achieve both quality improvements and cost savings, physicians must be allowed, in independent practices, to collectively negotiate with insurers and the state to determine cost savings and payment rates.

Health Information Technology

To benefit from the proposed model and new care delivery system, all participants will need to have implemented an EMR or similar health information technology system. Such systems must demonstrate and specifically achieve interoperability within practices and connectivity across the entire health care delivery system. This raises a few issues. First, with many competing EMR systems established in the state, there is no one method for interoperability. Second, solo and small physician practices already face tremendous financial stress as they work to transform the way they practice medicine. Most do not have the financial or professional resources that would be required to meet criteria for use that may be established when more detail is added to the model. Plugging in their systems and using them within their own practice for meaningful use is one thing, but sharing data across systems and practices presents a very different situation. Today the thousands of care sites and primary care physicians do not have the financial or staffing resources necessary to make health information technology extend beyond the care delivery site. This lack of resources will disadvantage these smaller practices from participation and meeting

potential cost sharing benefits in the program. Furthermore, many physicians have already made substantial investments into EMR systems that may not be able to provide the necessary transfer of information without significant assistance that is somewhat nebulous within the context of the proposal. The system must account for this health information technology adoption and adaption and not force physicians to abandon established health information systems that are working to assist and improve quality at the point of care.

Medical Liability

The SIM proposal suggests a major shift in the manner in which many physicians will practice medicine in Connecticut, focusing on quality of care standards, cost and/or efficiency standards, and health information technology. In addition to concerns about increased exposure to medical liability for services provided across an integrated collaboration of health care providers, VBMs will require physicians to establish standards or guidelines or risk violation of the VBM and likely face financial penalties such as the inability to access shared savings. In future years, downside risk could cause practices and groups, or other entities, to lose some of the upfront or service based revenue in addition to elimination of shared savings potential. This presents a significant issue for physicians from a medical liability perspective.

It is well established that the cost of the medical liability system in Connecticut is among the highest in the country. This includes the cost for physicians to purchase medical liability insurance and the costs associated with claims of medical liability cases. However, what is also a significant issue, and potentially more problematic in terms of systemic costs, is the practice of defensive medicine. By practicing defensive medicine, physicians provide additional services or procedures, such as tests, because the potential for legal action, the fear of a lawsuit, causes them to provide additional confirming tests to their initial diagnosis or analysis of the patient's condition. The test is ordered or the procedure provided, not because it will likely find something new or undetected, but it will find what is suspected and already identified. This confirming test provides great relief to the physician in the knowledge that as a result of the additional testing the patient is less likely to sue for any identified medical condition or later procedure.

Although the practice of defensive medicine may reduce physician liability, it increases the cost of the patient's condition and more specifically the overall cost of care quite substantially. It is this fear or threat of legal action that is not identified or addressed in the SIM proposal. If physicians are to adhere to identified and established standards, it then reasons that physicians should receive some specific protection against legal action if the standards are met. There must be liability protections in place for physicians. What the SIM proposal must do is provide physicians with some level of certainty and some necessary protections against threats of legal

action if physicians adhere to specified standards of care. Adherence to identified and specific standards of care means that services may not be provided either because they are not truly necessary or because they have a very low probability of providing additional information regarding a patient's diagnosis. Physicians who do not order certain tests and services as a result of following set standards of care should and must receive protection from liability. Such a suggestion is consistent with a proposals included in what is known as the original "Sustinet plan" but were removed by the General Assembly during the legislative process. If quality standards are established and require physicians and others to adhere to these recognized care guidelines, then the physicians and others providing medical care must have some safeguards. Without these safeguards, medical liability cases could be increased and associated costs, including medical liability rates and defensive medicine costs, are also likely to increase. Finally, there is some concern that if physicians are asked to rein in costs by limiting certain high-cost tests and restricting referrals to certain medical specialists, who may or may not share in financial risk pools, that physician liability could also increase, even when the physician is practicing according to the established standards. The entire issue of medical liability needs further review by the SIM and greater incorporation of medical liability concerns into the SIM model. Finally, CSMS encourages the SIM coordinators to discuss the medical liability issues with the major medical liability carriers covering physicians and other medical providers in Connecticut to ascertain whether or not the SIM model increases or decreases potential liability and related liability expense for those who are providing medical care.

Health Equity

There needs to be more specificity in the proposal associated with how health equity is to be incorporated into the SIM proposal, which today appears relatively devoid of enough specificity to even comment

CSMS has been involved in providing health equity education to our physician members and their clinical and administrative staff for the last 5 years and we strongly believe that health equity needs to be woven into the fabric of both continuing medical education and graduate medical education, but has a place and a role within the health care delivery system change models. Following are suggestions that we believe will help strengthen the SIM proposal:

CSMS believes that mandated signage (multiple languages) at medical care sites encouraging patients to call if they've been denied care is important and that the SIM model should incorporate the verbiage of qualified and trained interpreters and avoid untrained interpreters and never use minors. The SIM should also add sexual orientation and other high risk groups experiencing health disparities in the disease registry to track population health at a more granular level where changes in care delivery and access to care could have a more profound

difference and associated impact.

Workforce development should focus on young or newly practicing physicians (residents and 15 years of experience or less) in multicultural clinical interviewing skills, health literacy, motivational interviewing and other types of skill-based culturally competent care to engage new and encourage new patient groups. What is needed is a way to integrate Culturally & Linguistically Appropriate Service (CLAS Standards) and multicultural clinical skills (even basic communication skills) throughout the medical school/residency curriculum and part of the core competencies.

The Health Equity Workgroup recommended that the SIM proposal should work to ensure the feasibility and sustainability of the CLAS Standards at the same time cost-savings and efficiency standards are designed and implemented. CLAS adoption and implementation are essential if certain populations of patients are to have access to quality medical care. There is a role for health insurers and large employers to play when it comes to reducing health disparities. As SIM stakeholders, health insurers could commit to making investments in concerted efforts to collect self-reported reliable race, ethnic and language (REL) data at the point of enrollment that would allow for stratification of health utilization data to identify health disparities. Health insurers could encourage voluntary reporting by incorporating community-tested messaging on enrollment forms/screens, identifying why data is being collected and what it will be used for. Large employer purchasers of healthcare, with diverse employee populations such as the State of Connecticut, could commit to incorporating strategies for addressing disparities in health insurer purchasing discussions and decisions. Finally, there are really no goals or objectives to focus the SIM proposal on achieving any measurable health care disparity reductions. What are the priorities tied to health equity? What disparities are we trying to address and how are we to align the health care delivery system and payment system to encourage and increase care to minority populations? No longer is simply raising red flags sufficient. More needs to be included about how the SIM model will achieve measurable goals of reducing health care disparities through education, tools and resources available to practicing physicians who today provide the majority of care to very disparate populations throughout Connecticut.

Workforce

The SIM model is devoid of any information as to how to recruit and retain young physicians. CSMS believes that the SIM model should incorporate some loan forgiveness and forbearance to further incentivize young physicians to move to Connecticut (or stay in Connecticut after medical school and residency) that would focus on providing care in health care professional shortage areas and in primary care and specialty areas where access is lacking or suffering in Connecticut. Today many of the medically underserved communities have open slots but fail to attract young physicians because they are generally in low resourced environments without much

connection to the physician community or larger community as a whole. These opportunities need to be expanded to other practice types, small practices, where the young physician would be valued and incorporated into the fabric of both the practice and the medical community. At the same time, these care sites need to be equipped with newer health information technology to allow for information sharing and further learning.

Patient Responsibility

CSMS also believes that there should be some patient responsibility built into the model. It isn't clear if that should just be a cost sharing component to health and medical decisions (such as non-compliance with treatment regimen or failure to follow up on care- no shows), but patients must have some incentives to maintain their health and more specifically improve their health for the system to be as effective as possible. Physicians and other providers of medical care should not be punished by the lack of motivation by a patient with high risk of readmission who refuses to show up for their follow up appointment, fill a necessary prescription or contact the physician before going to the emergency room for medical care.

Health Insurer Participation

It is unclear if health insurers in Connecticut have fully committed to the SIM model and are willing to adopt the quality and efficiency or value standards developed through the SIM process. It would be extremely detrimental to the SIM process if quality metrics are developed for application by the SIM program, but the health insurers each had their own interpretation of these standards or used their own proprietary measurement software to evaluate physician medical care and costs. There must be initial and continual support and commitment from health insurers to readily implement the quality standards that form the foundation of the quality measurement model outlined in the SIM proposal. Without these guarantees, quality standardization would be illusory.

Conclusion

CSMS appreciates this opportunity to comment and recognizes that this is an initial outline of a model of care delivery and payment that is to advance some fundamental aspects of health care system transformation. However, CSMS believes that much more specificity is needed in the details of the foundational model in order to receive the society's support and endorsement of any application going to the Centers for Medicare and Medicaid Services (CMS) in the near future. CSMS looks forward to continuing to work within the framework of the SIM process to provide more information, advice and assistance as the SIM proposal is more fully developed.

We look to work with you to create a design that all physicians, regardless of medical specialty area of practice and type of practice, can participate in and benefit from the new care delivery system and payment methodologies that have been outlined in rudimentary terms within the context of the current proposal. CSMS views the proposal as a working document with significant room for growth and also considerable opportunities for physicians and their patients, but the steps to development must continue to include private practicing physicians who are today still providing the majority of primary and specialty care throughout Connecticut. The process of discovery and structural development must incorporate the thoughts and ideas of those who are today providing the medical care in Connecticut and not be based on state agency assertions or comments, ideas and opportunities for one subset of the physician or provider community. In order for the SIM process to engender true change and to encourage and promote transformation, it must recognize the existing dichotomy in medical care in Connecticut. Instead of leading all physicians down a path of employment or large group assimilation, the SIM should provide opportunities to physicians of all medical specialties and all practice types to not only survive but thrive in a new environment that is focused more specifically on outcomes and the quality of medical care provided. However, this new found quality must not be achieved through a reduction in access to medical care or it will have the reverse effect and lead to fewer individuals receiving high quality medical care at increased costs.

Regards,



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