GET Committee

From: Stephen Kemble <stephenbkemble@gmail.com>
Sent: Tuesday, August 25, 2020 5:52 AM
To: Charley Ice
Cc: Tamara Paltin; GET Committee; legislativepriorities@gmail.com; philip.verhof@gmail.com; Dennis Miller
Subject: Re: Medicare for all proposal to HSAC on Tuesday agenda public testimony at 9 am via BlueJeans online
Attachments: Response to Draft MedQUEST Hawaii Quality Strategy 2020.docx

Hi Charlie,

I am unable to submit testimony under my name, since I was up late last night responding to a MedQUEST request for responses to their draft Quality Improvement Plan for the Hawaii Medicaid program, and I have a Zoom call at 6 AM with a Rep. from New York wanting information on their Medicaid challenges. However, I could join the videoconference at 9 this AM, if that would be helpful.

Here is what I sent to MedQUEST.

Steve

On Mon, Aug 24, 2020 at 10:41 PM <icec002@hawaii.rr.com> wrote:

> Mahalo, Tamara. I hope this arrives at a suitable place, on time.
>
> me ke aloha pumehana,
> Charley Ice
>
> [Please send testimony before 9 am tomorrow to get.committee@mauicounty.us
> Or via videoconference at https://bluejeans.com/551273481 by 9am or by phone 1(408)915-6290 meeting code 551 273 481
> Tamara]

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Comments on Draft MedQUEST Hawai`i Quality Strategy 2020
August 24, 2020

The Quality Strategy envisioned in the draft document distributed on August 19, 2020 is unlikely to achieve any of its goals and will likely worsen our problems with inadequate access to care and increasing cost. The QUEST program is organized around competing managed care organizations (MCOs). It was initiated in 1994 for the GA and AFDC categories of Medicaid, expanded to the Aged, Blind, Disabled population in 2009, and further modified to comply with the ACA in 2014. The effect of all these reforms has been to drive physicians out of Medicaid, reduce access to care, reduce efficiency due to increased administrative burdens and obstacles to care, and managed care has driven cost up, not down. This draft Quality Strategy promises to double down on the same misguided assumptions and policies that have led to these unfortunate results.

I have been treating Medicaid patients in Hawaii since 1985, both in private practice of psychiatry and working as a psychiatrist embedded in primary care in Queen Emma Clinic since 1989. In the 1990's, the clinic director complained that Queen Emma Clinic did not have enough patients to provide a quality training experience for the JABSOM internal medicine residents, because most of the Medicaid patients were receiving care from private practice physicians. In the 1990's, all Hawaii psychiatrists accepted Medicaid patients. After conversion of the ABD population to managed care in 2009, acceptance of new Medicaid patients among independent primary care physicians and psychiatrists dropped off markedly. Most independent doctors did sign up for the managed care plans on behalf of their existing patients, but stopped accepting new patients covered by any of the managed care plans.

Consider the following headlines of articles published in the Star-Advertiser following conversion of the ABD population to managed care:

July 5, 2011: *Doctors shun Medicaid*
July 18, 2011: *Locating a doctor who takes public insurance proves difficult in isles*
July 1, 2013: *Mental health cuts just cost more later*
July 4, 2013: *Mental illness was 2011's top preventable hospitalization cause*
Sept. 27, 2017: *U.S. Sen. Johnson questions Hawaii's Medicaid spending*
Dec. 25, 2019: *Doctors continue to leave Hawaii, contributing to ongoing shortages*

And consider this Crown Care survey from October 2016

Finding a Primary Care Doctor on Oahu

MedQUEST was required to obtain External Quality Reviews after QUEST expansion to include the ABD population in 2009, and the reports for 2010, 2011, 2012, and 2013 all showed very poor scores on provider satisfaction and access to care (with the exception of the Kaiser QUEST program), but these results were ignored by MedQUEST. According to Kaiser State Health Facts, prior to managed care, Hawaii's per capita Medicaid costs were rising at exactly the national average. Following conversion to managed care, from 2001 to 2014 our per capita Medicaid costs rose around 3% faster than the national average, so it does not appear managed care actually saved any money for the state.

To this day, Medicaid participation among Hawaii's independent primary care physicians and psychiatrists remains very poor, and most care for Medicaid recipients is now provided by Community Health Centers (with federal subsidies) and Queen Emma Clinic (with Queen's foundation subsidies). Although DHS has paid lip service to soliciting input from doctors and Medicaid recipients, for all practical purposes only the interests of the MCOs have been allowed to influence policy. Since Medicaid has been contracted to the MCOs, DHS looks to them for accountability, and they tell DHS what they want DHS to hear, and the voices of those working on the front lines have been ignored. Was it really DHS and MedQUEST's intention to transform Hawaii Medicaid into a managed care system with minimal physician participation? Who knows more about patient needs and managing care, primary care physicians or health insurance companies?

Some of the Project HOPE initiatives are promising, but their efficacy is hampered by fragmentation of the program into multiple plans. Given the "churn" among Medicaid recipients, both in and out of eligibility for Medicaid and between plans, if a patient starts to respond to an initiative under one plan, progress gets disrupted when their coverage changes. The goals of investment in primary care and behavioral health are not helped by driving primary care physicians and psychiatrists out of Medicaid, and in many cases out of practice completely.

On Page 8, Strategy 3 is Payment Reforms and Alignment. This is introduced by the usual self-promoting health insurance industry talking point about needing to move from fee-for-service, that purportedly incentivizes "volume" of services, to "value-based payment" that presumably rewards "value." None of this is based on any actual policy research. Hawaii's Medicaid program was considerably more cost-effective when it was a fee-for-service program, and we never had evidence of excessive volume of services then, especially in primary care. In 2009, when doctors were all paid with fee-for-service, Hawaii had the lowest per-capita Medicare expenditures in the country, and among the lowest commercial health insurance premiums in the country, despite our rich mandated benefits under the Prepaid Health Care Act and our high cost of living.

The essential feature of "value-based payment" is shifting insurance risk onto doctors and hospitals in the form of capitation, partial capitation, bundled payments, and pay-for-performance incentives. Unfortunately, almost all of insurance risk is attributable to patient characteristics, not physician effort or motivation, and risk adjustment formulas are grossly inadequate to correct for this. "Value-based" payment strategies reward doctors for restricting care and taking on large panels of compliant, middle class patients who don't require too much of the doctor's time, and punish doctors who take on more difficult, complex, and socially disadvantaged patients who are likely to cost more and bring down quality metrics. National studies confirm that "value-based"

payment exacerbates disparities in care (Rubin R. How Value-Based Medicare Payments Exacerbate Health Care Disparities. *JAMA* 2018;319(10):968–970).

HMSA has led the country in implementing "value-based payment" for their commercially insured population, starting with pay-for-performance incentives around 2013 and putting primary doctors on full capitation since 2017. Three independent surveys of Hawaii doctors in the past year found the majority were unhappy and doing worse under capitation, complaining of higher administrative burdens and staffing requirements and inadequate capitation rates to cover those added costs. The most recent physician survey by Aimed Alliance, done just prior to the COVID-19 pandemic and published in March 2020, found over 80% blamed HMSA's "value-based" payment transformation as a major contributor to Hawaii's worsening physician shortage. Meanwhile, HMSA premiums have more than doubled since 2009.

"Value-based payment" is a terrible strategy for the Medicaid population.

Finally, I would like to cite the Connecticut experience with terminating their Medicaid managed care contracts in 2014 and reforming their Medicaid program as an enhanced Primary Care Case Management system, with improved fee-for-service payment for primary care specialties and enhanced community support services for difficult patients, but no managed care plans. The result was sharply lower administrative costs, substantial improvement in physician participation, a 25% drop in ER usage, about 6% lower hospital usage, and a 14% drop in per-capita Medicaid spending 4 years after conversion from managed care to primary care case management.

I urge Hawaii's Medicaid program to follow the lead of Connecticut and terminate the Medicaid managed care contracts, converting to enhanced Primary Care Case Management. An approximately 14% drop in Hawaii's Medicaid costs would be very much appreciated now given the severe budget shortfall due to the COVID-19 pandemic. If it would please the Governor to do so, the Hawaii Health Authority, which is still in statute as a health policy planning board under HRS 322H, could be re-activated and assist with designing the program.

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