Testimony of Thomas Moseley, MD to the House Committee on Health re: the Administrative Burden Imposed on Primary Care Practices and Suggestions for Improvement

To the Members of the Committee

Thank you for the opportunity to address you regarding an issue of great concern to people actually providing health care in Vermont as well as those who are at work seeking better solutions to our health care financing crisis. I practice as a pediatrician in Newport, Vermont, so I am speaking to you as a long time practitioner of primary health care in Vermont. I am a fervent believer that preventive care is better than episodic or emergency care for avoidable problems. I work from the premise that a Medical Home in which a patient has an ongoing relationship with a primary care clinician and health team yields better and more efficient care than care randomly provided by emergency rooms, tertiary-care-based organ system specialists and disconnected clinicians with little ongoing connection to the patient.

My practice, Newport Pediatrics and Adolescent Medicine, is a federally recognized Rural Health Clinic and has provided pediatric care to over 11,000 children in the Northeast Kingdom in the 33 years I have practiced primary care in Newport. Our practice serves a population overwhelmingly covered by Medicaid---72% of our patients depend on the State of Vermont for their insurance coverage. At no small cost in effort and dollars, our practice has achieved a designation as a Level III Primary Care Medical Home through the Vermont Blueprint for health since 2011, striving to move forward into a new era of quality based, coordinated care. I get health reform and I get the notion that quality care can be delivered in an economically and financially responsible way.

I am here to talk to you about two closely connected topics:

1) Waste and inefficiency imposed on doctors such as myself by payer's requirements for preapproval for certain types of medical care; and
2) Inefficiences created by the various and competing quality initiatives both the State and the payers launch – usually because federal or state law requires them to do so.

First let me talk about preapproval processes. I understand Dr. Ramsay from the Green Mountain Care Board is working on a couple of pilots with the payers to streamline or scrap prior approval requirements, and I'm grateful for that. Even so I want to speak briefly to the topic to underscore the importance of implementing the pilots and then quickly finding opportunities to expand any success they may demonstrate. PA requirements are imposed in the hope that demanding justification by doctors for medical treatment will diminish utilization services and save money in the end. I suppose such programs must demonstrate savings on unnecessary expenses, or how else would payers justify their continued imposition on clinicians of a great deal of paperwork and expense. And I'm sure there's expense on the payer side too. I want you to know the dollars DVHA spends on these programs are a budgetary cost to the state for the bureaucracy, but the programs also impose costs on practitioners and divert resources from real patient care. Because I deal so heavily with the state insured Medicaid

population, my examples of the questionable value of that assumption is drawn mainly from my experience with DVHA, but also apply to our experience with Cigna, Blue Cross and MVP.

Practically speaking, I am not here to attack the notion that looking into prescribing or ordering patterns can save money. We all know the shift from requiring physicians to use generic drugs when available has not had any measurable negative impact on patient care and has saved enormous amounts of money. Rather I am here to suggest we shine a bright light on the assumption that all insurance pre-approval programs have equal worth in saving money and eliminating unnecessary care. Some of these programs only serve to hinder care that will be given anyway (or cost more if not given) and impose a considerable non-accounted for and non-reimbursed external cost on practices such as mine that spend considerable time working the system to get lifesaving care for my patients. Taking it on faith some of these programs can save money within the system, I'd like to see the costs of running the PA programs consider not only the administrative costs to the payer, but the administrative cost to the practice as well. Only then would we understand whether the program is truly saving money for the health care system as a whole. If we incorporate the costs to practices and find the PA programs still save money, then I'd like to see the payers pay some percentage more than their normal fee schedule for each of those procedures they DO approve after PA, to allow us to participate in the savings to the system.

I present two actual cases of children who urgently required out of state care for life threatening illnesses and whose preapproval costs to my practice were enormous. That process only obstructed care that ultimately had to be given. I am sure the DVHA policy makers who establish prior approval requirements mean well and truly believe their duty is to safeguard our (mine too) tax dollars from being wasted on unnecessary care. I appreciate their goal to provide care in Vermont rather than at an out-of-state referral center, as they have frequently reminded my staff. The basic point is the care my patient required was essential, even life saving, and could not have been given in Vermont. The time spent by my office and DVHA in finally approving the request added nothing to the patient's care and was pure friction in the system. Forgive me if the medical terminology is tedious—I will explain anything not clear if you wish. These are two examples that occurred within the past year. They are, as you know, two of many examples.

Case 1: Child with malignant pinealoma ultimately classified as a Grade Three malignant neuroepithelioma, a very aggressive brain tumor. He presented in our office on 4/4/13 with signs of increased and rapidly progressing pressure in his brain and was emergently admitted to a Vermont-based tertiary care hospital where he underwent brain biopsy and drainage to relieve his elevated intracranial pressure. His care depended on a correct diagnosis of what proved to be a very complex tumor. After the chief of the children's cancer service reviewed his pathology reports and discussed his case with experts at Boston Children's Hospital, the Dana Farber Cancer Center and the Massachusetts General Hospital, he recommended a referral for a second neurosurgical opinion and opinions regarding the best course of treatment with chemotherapy, and radiotherapy. He was clear from the beginning optimum outcomes were predicated on speedy decisions regarding exact diagnosis and might require a second biopsy. Our staff spent approximately 8 hours between time spent by two registered nurses and myself in contact with Boston Children's Hospital, the Vermont hospital, and DVHA, my own time in talking with the hospital and various non physician care coordinators at DVHA to gain approval for a

consultation in Boston. He ultimately was approved for a single visit to Boston where his pathology was reviewed, and his care plan developed. This plan did not require another biopsy after his case was reviewed by pediatric brain cancer specialists (neuro-oncologists, neurosurgeons, neuropathologists and radiation therapists). A course of treatment with positron beam radiation (available only at Massachusetts General Hospital) was recommended as the first stage of a multistage treatment plan with subsequent chemotherapy to be done in Vermont. We then had to request approval for his combined radio and chemotherapy in Boston, involving another 8 hours of our professional staff time. A clerk at DVHA approved a single radiation treatment. My staff eventually convinced someone this was ludicrously inadequate as the initial treatment series involved several treatments a week for 6 weeks. This process was so complicated as to make me wonder how such complex clinical determinations can be made, or defended after having been made, by people with a very low level of medical expertise. How can this process be said to save money when it wastes our time, DVHA staff time, and slows down treatment of a rapidly progressing tumor?

Staff time RN @ $33.75 (salary and fringe benefits)	16	$540
MD @ $100	4	$400
	Total	$940

If the payer had denied our request, it obviously would have saved much more than $1000 at a huge cost to the patient. Perhaps the payer denies enough of this type of request to justify its costs to approve this case. That equation, though, as I mentioned earlier, didn't include the $1000 it cost my office to get this case approved. So this takes me back to the suggestion I made a few minutes ago. Since the payer eventually approved this request, I'd like them to pay my office for our time to justify the payment. If they paid us our administrative time only for the cases they approve, the incentive still exists for practices to self-manage effectively. At the same time, I'm guessing the payer could pay us for our time and include that cost in its equations, just as the payer pays its own staff and includes those costs in its cost/benefit calculation, and the PA program would still save money to the overall system.

Another option (and my proposals are not mutually exclusive) is to question the value of some of PA requirements. I'm at a loss to understand why the payer feels the need to approve care for people with diagnoses such as the one this young man had.

Case 2: This child has Goldenhar Syndrome, Klipplel Feil deformity, rapidly progressing congenital scoliosis. These are complicated genetic defects involving the face, neck and spine. This boy has been followed for many years in our office and has required many head and neck and orthodontic surgeries, most of which have been performed at at a local tertiary hospital. During those years he was seen with interruptions by a series of orthopedic surgeons, the last of whom was not a pediatric specialist and failed to appreciate the potential worsening of his spine curvature during puberty. Accordingly, when he appeared in our office on 10/17/2013 for an unrelated complaint, the gravity and urgency of his situation was readily apparent by comparison with his last visit to us. When I sent his x-rays to the chief of spine surgery at Boston Children's Hospital, he agreed to see him almost immediately. There then ensued a battle to get approval for out of state consultation and eventual admission for surgery; the

situation was complicated by social concerns which made it difficult for his mother to negotiate the medical and Medicaid system without a good bit of help. My staff and I spent literally a full 40 work week trying to get everything in place, documentation for which I am happy to provide. The orthopedist's note included the observation that based on his prior experience, he was afraid the Medicaid approval process would drag on so long as to postpone surgery until permanent damage had occurred, as had happened with three other Vermont Medicaid patients in his recent experience.

Staff time RN @ $33.75/hour	32	$ 1,080
MD @ $100/hour	8	800
	Total	$ 1880

I could cite other examples, but did not document actual time spent on the others. I will say the process was made less efficient by numerous small inefficiencies from DVHA procedures such as finding that the only person who could work on a given case wasn't at work on a given day (more than once), or by learning the hard way that a fax sent with appropriate signatures on the DVHA form from Children's Hospital to us to forward to DVHA wouldn't work. We had to fax back to Children's who then faxed directly to DVHA. I suppose that ensures we were not forging signature of Boston specialists, but what useful purpose can it really serve? This level of attention to procedural detail rather than trying to facilitate the care that was desperately needed can't really yield much in the way of cost savings. Of course, the above examples only dealt with approval for a clinical visit or procedure; we also have to spend comparable amounts of time getting approval for transportation for the patient and family for each and every visit.

Allow me to summarize my proposal for how the system could save the money it needs to save without unduly burdening the physicians in the delivery system who take do responsibility for ensuring referrals out of state are warranted . Let's not assume the present prior approval programs actually save money for the system. Begin from first principles. Require a high level of transparency of the cost and efficiency of the so-called prior approval processes. Make the insurer prove with annual data they reduced their own expenditures **and** paid for at least a portion of the imposed expenditures on clinicians. Require the insurer to identify outlier physicians or practices, either by number or by a high percentage of rejected referrals. Require the insurer to focus energy on finding referrals that are inappropriate and helping those practices redirect their referral patterns. I imagine this would leave low volume referrers such as me (with exactly 5 referrals – all of which were eventually approved -- to Boston in the last 12 months) off the hook for the unproductive administrative burden I mentioned. It might leave payer staff free to realize some real cost savings by working with the real offenders. Above all, require the outcome measure be reduction of **TOTAL** costs, by which I mean the real costs to the system, not just to DVHA or an insurance company.

In addition to prior approvals and what we might still do to improve that process, I want to also bring your attention to something I think doesn't get enough attention. Each payer in our system (Medicare, Medicaid, and the commercial payers) has quality program requirements imposed upon it. My understandng is those requirements start in some cases with the federal government (particularly for

Medicare) but many come from the state as well. These programs, of course, are trying to ensure better care is delivered and better results occur between the doctor and patient. So this is another place where the administrative burden shifts downstream to the practice.

For example, each payer conducts quality audits to collect data they are required to report. Each of the several major payers sends us requests that we pull data from our charts, or sends a staff person from the payer in to collect information from the chart – either process is disruptive. With respect to quality audits and the burden they impose on practices with multiple queries, sometimes inconsistent definitions and, in the case of pediatrics, very few meaningful measures, I propose a single simple quality measure: attainment and maintenance of the National Committee for Quality Assessment (NCQA) primary care medical home status. This award, which serves as the benchmark for the Vermont Blueprint for Health, requires a detailed demonstration of policies, procedures, outcome data and ongoing quality improvement projects. It is by no means an easy measure to achieve.

Practices or clinics might choose to collect other data that would be useful, but acknowledging this core program as a sign of inherent quality would reduce redundant requests for data and yet more data from every insurance company and intermediary who appears on the scene. Despite earning NCQA recognition, each year my practice gets numerous requests for data (or visits collecting data) so each of the payers can fulfill their obligations to report and take action on quality data. In addition, we get a report from each of the payers of our practice's quality results, which we then spend time reviewing, because each of the payers is required to publish quality results on its website. All of this in addition to the NCQA recognition my practice already earned which should stand on its own as a statement of the quality of the care we render.

So let me put in a plug to double the funding coming through the Blueprint program to practices and the community health teams. I've heard there's a bill on the Senate side with that idea. We've decided as a state to put our focus on Blueprint and NCQA recognition for practices. The practices have worked hard to achieve NCQA recognition – and neither earning it or keeping it is an easy thing – so let's put our money in the practice setting, and let that be the focus of our programs. I'm wondering if some of the quality solutions that have been in place a decade or more may have outlived their usefulness, and the resource could be redirected. Increasing Blueprint payments for primary care is a way of shifting the focus from payers as the quality solution to practices.

A second dimension of this issue is the huge resource currently being devoted to making practices demonstrate adherence to quality standards. Just as with prior approvals, the costs of the various quality programs is one we should look at as an entire system – both the costs to the system and benefits to the system. Everyone—insurance companies, Medicaid, Medicare, the federal government through the Affordable Care Act Meaningful Use guidelines, the Vermont Blueprint for Health, and the Accountable Care Organizations (ACO)—has his/her own definition of quality. This requires a primary care practitioner to cooperate with an ever burgeoning list of requirements and data collection requests to support similar but not congruent measures of "quality."

I don't think this quality program entanglement is solved simply by mandating the various payers or state initiatives stop doing something or start doing something else. It's my understanding that over time and unintentionally policy makers have created a web of quality programs and quality requirements that create duplication and inefficiencies and waste our precious health care dollars on a system that doesn't make sense as a whole, doesn't achieve its desired aim, and is a drain on everyone in the system.

The first step in untangling this knot is for policy makers to understand what requirements they've imposed on each player, so they can relieve the requirements in places where it makes sense to do so. I believe there are opportunities to simplify or eliminate requirements, thus reducing costs and resource burden to both the payers and the care delivery system.

Thank you very much for your time.