Comments on the Preliminary Report of the Health Care Cabinet on Cost Containment Strategies

Submitted by

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I appreciate having the opportunity to submit these comments on the preliminary report of the Health Care Cabinet on cost containment strategies. I am a family physician practicing at the Community Health Center in New London, where I also reside. I am also a member of the board of directors of the Connecticut Health Advancement and Research Trust (CHART), a parent organization of the Universal Health Care Foundation of Connecticut. I also serve on the steering committee for the National Physicians Alliance (CT). I am a professor emeritus of family medicine at the Warren Alpert Medical School of Brown University.

I applaud the cabinet for grappling in a serious way with the vexing problem of ever-rising health care costs. There is no mystery about what's driving costs—high prices, too much wasteful and unnecessary care, and poor performance in preventing disease and promoting health. The recommendations in the preliminary report are on the right track and I endorse them in general, but believe they don't go far enough and require some modifications.

Use Altruistic Rather Than Financial Incentives for CCOs

Let me start with the areas where some modifications could strengthen the recommendations. The concerns about conflict of interest with Consumer Care Organizations (CCOs) that might lead to under-treatment would be greatly diminished if any savings would be restricted to practice enhancement and not personal financial rewards to providers. The savings could be used to fund traditionally non-reimbursable expenses that would help patients and caregivers such as respite care, homemaker services, nutritional supports, etc. The savings could also be used to add staff to the CCO such as community health workers. Using altruistic incentives rather than the promise of personal financial gain minimizes the risk that providers would withhold needed treatments for patients in order to put money into their own pockets. Yet it would provide sufficient incentive for providers to be more prudent stewards of clinical resources.

Exclude Poorly Performing CCOs from Value-based Payments

I would also not pursue downside risk with CCOs as contemplated in the recommendations. Instead, I would substitute a penalty for repeated annual financial losses by a CCO that would end value-based payments to the CCO and place the CCO into a discounted fee-for-service arrangement until the CCO could

demonstrate that changes had been undertaken that would predict more efficient operation.

Community Health Workers Contribute to Better Health and Savings

I can't think of anything that would be more helpful to my practice, which serves the most vulnerable in our society, than the availability of community health workers. Many of my patients whose health is precarious and who are high utilizers of emergency room and hospital services find it difficulty to adhere to their care plans and to negotiate our complex health care system. These patients carry not only the burden of their diseases, but often are additionally hobbled by mental illness, homelessness, poverty, low literacy, language barriers, lack of transportation, social isolation, and chaotic lives. Having a neighbor check up on them, make sure they have and take their medications, keep their appointments, understand how to prep themselves for procedures, eat properly, and maintain adequate hygiene can be invaluable in keeping these patients healthier and out of the hospital. The recommendation for community health teams by the cabinet is commendable, but unnecessarily expensive. Community health workers are what we most need and represent the least expensive part of the team. I recommend that a cadre of community health workers be available in every community to work with CCOs and other providers. The rest of the community health team that the cabinet's recommendations envision are already in place in the CCOs, community health centers, hospitals, and other safety-net provider organizations absent only the community health worker. True, there would be other small independent practices that would not have all the other members of the community health teams in place, but often these practices do not serve the most vulnerable populations. Paring down the concept of community health teams to its most essential component—the community health worker—would make it eminently more affordable and practical.

Set Targets for Growth and Use Them to Set Rates

I strongly support the idea of setting statewide health growth targets and then using that target for global budgeting of hospitals and rate-setting for commercial insurance and CCOs. Coupled with this is the need for more robust planning to guide the certificate-of-need process and reduce excess capacity, especially in high-cost, high-technology fields, that leads to excessive, wasteful, and all-too-often harmful overutilization.

Bring Down High Drug Prices Now

High drug prices need to be addressed immediately and not deferred. My patients are suffering grievously with high drug costs, often going without critically needed medications to control their diabetes or hypertension, with catastrophic consequences. Pharmacists should be allowed to substitute therapeutically equivalent drugs for high-priced ones where generics are not available. The state must be allowed to negotiate the best prices on drugs for as many beneficiaries as

possible including municipalities and nonprofit organizations as well as state employees and Medicaid recipients.

Continue the Work of the Health Care Cabinet

The Health Care Cabinet is playing a vital role in the effort to control health care costs. It must continue to play that role as envisioned in the recommendations in conjunction with an Office of Health Strategy. I wish you every success in that worthy endeavor.

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