Wyoming Healthcare Commission
March 21, 2005
Meeting Minutes
Casper, Wyoming

Attendance

T. Chris Muirhead, Chairman, George Bryce, Marlene Ethier, Jack Glode, M.D., Paul Lang, Dixie Roberts, Jack Speight, John Vandel, Commissioners, Ken Vines, Insurance Commissioner, Ginny Mahoney, Chief of Staff, Department of Health, Ex-Officio, Anne Ladd, Director, Emily Genoff, Assistant Director, Jan Kruse, Project Coordinator, staff.

Subcommittee reports

Commissioner Roberts, Medical Errors
Consultant Michelle Mello of Harvard has completed her final report. The subcommittee is continuing to gather information.

Commissioner Lang, Health Policy Board

The Rural Health Study conducted by Navigant Consulting, Inc., last year, has been revised and the subcommittee recommends that the report be released to the public after a $2,500 redaction is completed to summarize recommendations. Motion accepted, vote is unanimous. Health professional recruiting and retention is being analyzed, with a focus on physicians and nurses. By next meeting, the subcommittee will have a draft document to report on the work in that arena, thus far. A third issue the subcommittee is working on is viable, incremental steps toward a health policy board.

Commissioner Bryce, Purchasing Pools

Commissioner Bryce said his subcommittee is working on the consumer side of healthcare coverage issue and how a system can be built that adds responsibility into it at the individual and provider level. The committee has been trying to figure out how we get a coverage system with carriers and providers and everybody playing on the same table that can somehow make the delivery of healthcare services affordable. Commissioner Bryce said, “We’ve spent ad nauseum time talking about Wyo-Care and “tax smart” accounts, and administrative systems with debit and credit cards built in to streamline claims payment. We’ve paid a bunch of money to get a beautiful report from the Department of Employment which says Wyoming employers are willing to continue playing the game and provide employer-based insurance -- if it can somehow stay affordable. The bottom line comes down to, “it’s the cost, stupid.” We really need to address that because that is the outlier fact of virtually every system we look at. We are going to pursue a purchasing pool discussion to see if there is a pool that can be operated efficiently to bring down costs. We can nickel and dime it to death by building in credit cards, electronic claim filing that’s standardized, Department of Family Services

eligibility screening, electronic premium payment and accumulating accounts with the existing set of rules for tax deductibility, but if we don't attack the basic problem of the cost of claims and we don't work with providers to come up with a quality care delivery system, all these other ideas don't make a bit of difference. To that extent we're going to start a conversation with how do we start to build something like this. We want to work with the Wyoming Hospital Association, Wyoming Medical Society and CMS (Centers for Medicare and Medicaid Services) to eliminate gaps that create cost shifting and focus on that big picture with the hope of coming out of it with some delivery system that will help the small group market with a purchasing co-op get designed and help delivery of care even in the large groups."

The committee is working to set up a meeting with WINHealth and Blue Cross Blue Shield in Cheyenne to find out how they would envision this system. Somehow we need to get that dialogue going to figure out how it can be affordable. Meeting with the provider side will be a second step. We want to continue to explore administrative methods of streamlining in hopes the administrative system used in Wyoming can be uniform for physicians to reduce the number of claims handlers they have.

We've been working with Navigant to get a handle on cost shifting. Because of the way the data comes up, it's difficult to quantify cost shifting. The best guess we have been able to get is that Medicare seems to pay system wide about 91 percent, Medicaid pays 98 percent (Critical Access Hospital status helps), while private payors pay 156 percent. The private sector carries 100 percent of excess operating expenses. It's going to take collaboration to figure out the cost side of things. We need to have all the providers sitting at the table as we have these discussions. We need to have the 800-pound gorillas (CMS) there so we can get it all there and figure out an answer. "Personal responsibility" – prevention of sickness by consumers – also is a component of the final product, Commissioner Bryce said. Commissioner Vandel said Until we can reduce the cost to the pool, we can't reduce the premium to the payors,. He said there may be some legislation needed to allow the small groups to join a larger group and not be penalized with an individual group experience rating.

Geoff Smith, M.D., Information Technology Technical Management Committee (IT2)

The group charged with completing an electronic health records study by the 2004 Legislature is planning another face-to-face meeting on April 2 in Casper at the Oil and Gas Commission building. Dr. Smith chairs the subcommittee and said the consultant hired to complete the study, John Snow, Inc. (JSI), has done the bulk of the work required by Enrolled Act 31. He introduced JSI's Michael Rodriguez, in Denver. Mr. Rodriguez said that at the IT2's face-to-face meeting Jan. 22 in Casper, it was the consensus of the group that a regional organization envisioned by the Health and Human Services' National Health Information Technology Coordinator, Dr. David Brailer. The Coordinator's goal is to encourage local oversight of health information exchange that reflects the needs and goals of a population. His belief is that every American should be covered by a Regional Health Information Organization (RHIO) that will support information exchange on their behalf. RHIOs are to provide governance and serve as a

trusted intermediary, facilitate consumer interactions, support the financial, organizational, legal, technical and clinical processes. JSI has been focused on speaking to some of the more developed RHIOs across the country. The Colorado Health Information Exchange has been eager to collaborate with Wyoming and may participate in the April 2 meeting. JSI is in the process of conducting 40 key informant interviews with stakeholders across Wyoming. JSI is also working with Mountain Pacific Quality Health Foundation to look at local electronic health records initiatives up and running in Wyoming, including the one operated by Indian Health Services. JSI is meeting with the Wyoming Community Foundation and Agency for Healthcare Research and Quality on funding potential for the work expected in Wyoming following completion of the feasibility study and a planning process for electronic health records implementation. The process is on track and on budget.

Julie Sapp, Wyoming Governor's Office, Social Policy Team

Ms. Sapp said she was present at the meeting to help frame and facilitate the relationship between the Commission and the Governor's Office. The Governor's Office wants to be more closely aligned with the work that the Healthcare Commission is doing. The Governor's Office wants to be more informed and more educated in order to be able to offer insights, guidance, direction, strategy and ultimately some executive endorsement for the work the Commission is doing. The state has resources to make change. Other states are in the middle of damage control, placing vulnerable residents at risk. Wyoming has a choice due to its financial wellbeing, but with that comes with responsibility. The opportunity stands before Wyoming now, but it's not a lingering opportunity. Data compiled from programs serving 40 percent of the state's population by Dr. Hank Gardner shows that last year, one in five Wyoming people received a poverty-related service. Forty percent of resources and social supports are spent on just under 3 percent of the people. State government spends more on medicines for its population than on food and workforce training combined, Ms. Sapp said.

She added that there needs to be a fundamental shift in the identity and functioning of the Healthcare Commission. The Commission is not a research arm of the Legislative Service Office. The Commission can serve as advisers to the Governor on healthcare policy in Wyoming. The governor works best with incremental, near term, implement-able steps in the right direction that build public confidence along the way. The Commission can help warn the Governor of any potential barriers to implementation. Therefore, the Commission should be firm in its values and sure of which paradigms are going to influence the work being done. One value should be a default to market driven solutions, Ms. Sapp said. The Commission should start conversations with what can the market do and what can it do better and what government can be doing to strengthen the market for better healthcare policy in Wyoming. The Commission needs to have a vivid understanding of who its customers are. "There are a lot of interests in this conversation and they cannot all be satisfied. The residents in the state of Wyoming, the children and families, are the customers the Governor's Office and the Commission are trying to serve. There are a lot of folks, networks, entities, and coalitions with a valid stake in the healthcare debate who have a lot to defend in the status quo. There is a lot of money to be

made from this Commission failing. The Governor's Office has a preference for consumer information and illness and injury prevention. The Commission needs to send a strategic message to the governor, the public and the Legislature. Our customers are not interested in how hard we're working, or the number of studies being done. What they care about is the product," Ms. Sapp said. "For the Healthcare Commission, the product is those fundamental recommendations for policy change and the success of the suggestions for policy change." The Governor and the Legislature need detailed, data-driven recommendations. The Commission needs to be unified in its message. "What becomes the position of the board is your position when you walk out these doors," she said.

She introduced Dr. Gardner, Human Capital Management Services, who is collecting all of Wyoming's health information data, using data provided by the Departments of Family Services, Workforce Services, Employment (including Unemployment Insurance and worker's compensation), Health, Corrections, and Administration and Information. Each agency "buys in" and has access to the accumulated information set, which can be used by individual agencies' analysts and in aggregate form by the Governor's Office.

"Hopefully you've heard a commitment on our behalf to create the relationship we're talking about," Chairman Muirhead said. "We look forward to that relationship and the benefit it can provide the state and its citizens. We realized when we took this thing on none of us were going to make any friends. You do that for the benefit of the whole. That has been the focus of this group. We truly look forward to working with you."

Dr. Gardner talked about his background and why he became interested in government work, and the results he has had in the past with reductions in healthcare expenditures through efforts in the private sector to create better educated and better supported consumers. He described the Wyoming Integrated Database. The notion, he said, was to build the database from where recipients of services funded by government are and to cross silos to find where they are receiving services from other agencies. There have been 180,000 individuals in the state who have used one or more services, or 40 percent of the state's population. In 2004, there were 103,000 (excluding state employees) individuals served. There are 25,000 insured individuals in the state health plan. Some people are in and out of the social services system quickly and others are there to stay. "It's a live database," Dr. Gardner said. "We refresh it quarterly. It's very much growing. We're interested in adding Department of Education information and Department of Health information -- not in the Medicaid claims data – but in programs that support substance abuse treatment and elderly services, for example. It's live, it's growing, it's dynamic. We collaborate closely with the departments we work with; they have analysts of their own," he said. "When I look at whether we're spending too much or too little on health, the question is compared to what. I wonder where our job training investments are relatively to our spending on roads, education, and health."

Dr. Gardner said the database is de-identified. Population health management is the aggregate data's ultimate value. "We think there's a very unique policy management opportunity in Wyoming that quite frankly doesn't exist anywhere else," he said. The

four most prevalent conditions are musculoskeletal conditions (bone and joint injuries, arthritis), mental health services, maternity (half of all pregnancies are covered by Medicaid) and respiratory. Where services are delivered – in physician offices, hospitals, outpatient clinics – has significant bearing on costs. Geographic regional differentiation in costs is also being explored. Children's most frequent diagnosis is mental health, and specifically attention deficit hyperactivity disorder (ADHD).

"We believe quality and price are at the core of how markets work," Dr. Gardner said. "Because price is so obscured, how are you going to judge the quality, if you are a consumer? We need to find ways to change the incentives to people." He reviewed six trends he said he sees emerging from data he has been gathering through the multi-agency cooperative developed in his tenure with the Governor's office. One finding is that in the state health plan and worker's comp and state social services, more resources are being spent on fewer people at the expense of the majority. "We think that's a major opportunity cost that has to be addressed," he said. "More resources are spent on drugs, diagnostic, technical and institutional services as the cost of preventive services. Our insurance model rations prevention. Ninety percent of the services being provided are technical and institutional, 1.5 percent are preventive, and the balance are cognitive/communication/consultation services. If the fee schedule doesn't pay for a physician talking with you, there is going to be less time spent talking and less time committed to preventive services," he said. "That isn't the fault of physicians. Our insurance model rewards 50 times more for passing a gastroscope than for talking to a patient. When preventive and cognitive goes, primary care goes, because that's primarily what people need – to sit and talk and get to know each other because values and beliefs, influence whether a person is going to be compliant with physicians' instructions. More resources expended on the chronically ill and elderly at the expense of children and families.

"We're shortchanging investments in our kids, whether it's in health or education, at the expense of end of life services for chronically disabled and elderly," he said. "We have got to find a way to get more for less on the right hand of this consumption scale. We are under-investing in health with kids and families on the left side. When high risk, high cost people fail in the private sector and move to the public sector for care, it costs more. We've begun to compare the cost of caring for kids in the Medicaid system with those in the state health plan private system, and guess which one costs the most – Medicaid. But guess which ones have less access to preventive and cognitive – Medicaid. Medicaid doesn't operate with market dynamics.

"A new insurance model needs to factor in: health and disease status; health-related paid time off benefits; property and casualty, worker's comp and auto insurance claims; medical services competition; the price, quality and safety issue; insurance cost share and beneficiary income; administrative third parties and cost care disease management; tax subsidies -- HSAs (Health Savings Accounts) are not use it or lose it funds and can accumulate pre-tax dollars; and insurance regulations (if insurance products were viewed as national, you would have much more portability). It's a host of variables," Dr. Gardner said.

Facilitated dialogue – review of Commission retreat goals

The Commission worked with Ms. Sapp and Anne Ladd, Healthcare Commission Executive Director, to revisit the goals that were identified in November and December and consider incremental steps toward meeting desired outcomes within the Commission's remaining 15 months.

Public comment

Sen. Charlie Scott, R-Natrona
"From the perspective of the Legislature: The Legislature works very well with this Governor. Things that you do to satisfy your customer the Governor are likely to go a long way toward satisfying your customer the Legislature. The Legislature has assigned a number of tasks to the Healthcare Commission in statute, and you've completed some of those. The study on Joint Underwriting Associations was very well done, very useful -- not that it led to product -- but it told us where not to go, and sometimes that's as useful as something that says what not to do. The study of the effect of medical malpractice damages caps became academic, in the outcome. We couldn't use it.

"As for ongoing research, I'm really looking forward to the information technology study product. I'm really looking forward to the medical errors commission study findings. I would continue to emphasize that as a different approach to that whole set of problems. We value the healthcare workforce research, the efforts you're doing there -- that's something the Legislature is very much is interested in and is going to inform some of the work we do.

"Regarding the point Dr. Gardner made this morning about incentives -- let me reinforce that by giving you a specific example: when the Labor, Health and Social Services Committee of the Legislature did welfare reform, we were in advance of the federal government. People respond to incentives. If you have a consumer who is knowledgeable of what the costs are, the assumption is that will control the costs. I have a suspicion it may drive costs up, because people are so conditioned by society to associate high cost with quality. When it comes to healthcare, since survival and ability to enjoy life are at stake, people are likely to opt for higher cost products. Better than half the costs incurred in healthcare are for individual incidents that cost more than $25,000 per. With that kind of cost, a third-party payor one way or another is going to pay that cost. The 'hold the cost down' incentive simply doesn't work for the majority of the costs. They won't, they can't and we will get them care one way or another. And there are limitations on potential for personal contributions (co-pays).

"Be wary of large scale government management systems. The government tends to do these kind of things very poorly. There are some fundamental reasons for it. It is very hard to measure how well individual units are contributing to the overall goal. It makes government inherently inefficient and ineffective. It's going to be important to consider as we make proposals what we think we can sell politically, but do not let that constrain

you too much. All these healthcare things are going to step on somebody's toes and offend somebody and impinge of somebody's income. The mood in the public is going to have to change. There has to be a state government role in cost control.

"With regard to universal coverage and when you start to go down that road, those currently are a prescription for financial disaster in any state that have tried them."

Lynne Weidel, Office of Rural Health, Wyoming Department of Health

"Move deliberately and directly forward, and gather as much input as you can," Ms. Weidel said, relating her experience in state government in Oregon and the attempts there several years ago to address healthcare issues similar to those in Wyoming. "Don't oversimplify the problem." A result of Oregon's reforms were populations deferring care, resulting in illnesses "which got worse as time went on."

Chairman Muirhead

"I think the Governor has spoken through Julie that he wants options" from the Commission, he said. "In the past, the Commission functioned in committee structure better than as a whole. Therefore, I'm going to charge Commissioner Lang and Commissioner Bryce with formulating plans to address these issues. I don't want to wait for a month from now when we meet in Gillette to continue this discussion. The committees are going to need to meet before then.

"Meanwhile, the Commission is being asked to help sponsor the multi-agency data organization Dr. Hank Gardner has created with an appropriation of $30,000 to $50,000. Unless I hear major objections, I'm asking Anne to coordinate with Hank to make that transaction to get access to that data, and at that point, he becomes part of the resource team we're trying to build."

Commissioner Muirhead directed the Committees to gel plans for meetings and Julie is expected to participate actively. "We have the Governor's attention," Chairman Muirhead said. Healthcare is "his number one agenda item. Let's generate some options for him. I concur with Hank in this, that options need to be driven around the market side instead of the government side. Charlie Scott also spoke that way."

Meeting adjourned for subcommittee meetings, 4 p.m.