

TOWN HALL MEETING ON MEDICARE PART D AND PAY FOR
PERFORMANCE
SARASOTA HYATT
SARASOTA, FLORIDA
January 13, 2007

A well informed and interested group of about 100 health providers, community activists, and patients participated in lively discussions of the Medicare Part D prescription drug program and Pay for Performance (P4P) and its impact on health disparities during a Town Hall Meeting co-sponsored by the Cobb/NMA Health Institute, the Gulf Coast Medical Society, and the Florida State Medical Society on Saturday, January 13, 2007 at the Hyatt Hotel in Sarasota, Florida.

The goals of the town hall meeting were to:

1. Document the experiences of healthcare providers, policymakers, and patients with Medicare Part D;
2. Create a list of recommendations on how Part D might be reformed
3. Assess how Part D is working for patients of color in the state of Florida
4. Raise awareness about P4P among the various stakeholders; and
5. Educate the audience about how they can become involved in the P4P debate at the local, state, and national levels.

Greetings and introductions were presented by Dr. John Abu, Acting President of the Gulf Coast Medical Society; Dr. William L. Donley, President of the Florida State Medical Association; Dr. Albert W. Morris, President of the National Medical Association; and Dr. Cato T. Laurencin, Chair of the Steering and Oversight Committee for the Cobb Institute.

“I am very pleased to announce that Dr. Morgan has been selected as Executive Director of the W. Montague Cobb/NMA Health Institute,” Dr. Laurencin stated in his remarks. He added that this appointment was formally approved at an executive session of the Cobb Institute’s Steering and Oversight Committee meeting, which was held at the Sarasota Hyatt on Friday, January 12, 2007.

Dr. Morgan outlined the mission and vision of the Cobb Institute.

Mission

The W. Montague Cobb/NMA Health Institute will focus on identifying and developing solutions that will reduce racial and ethnic health disparities and improve the health of all Americans.

Vision

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| <ul style="list-style-type: none">• To become the pre-eminent resource for data, information, and research pertaining to racial and ethnic health and health disparities• To leverage the scientific skills and clinical acumen of NMA Physicians to produce ground-breaking solutions |
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Mr. James McCloud, Director of Genesis Health Services, Inc., in Sarasota (FL) began the dialogue by describing critical health issues in the Sarasota community. As a lay person, he and other committed members of the community created Genesis Health Services to serve the unmet health care needs of the uninsured and underinsured residents of the community. Through the services of retired, semi-retired, and some active health professionals and through donated services and equipment, Genesis Health Services is working to fill a major gap in health coverage in the region. He listed the lack of dental services as a major challenge facing Genesis.

Episcopal Bishop Council Nedd, Executive Director of Alliance for Health and Educational Development, began the Medicare Part D panel discussion describing the church-based community outreach program he is leading to educate Medicare beneficiaries about Medicare Part D and how to enroll in the program.

Dr. Sheila Davis, Associate Director of the Cobb Institute, presented results of a Part D enrollment analysis that the Cobb conducted in Baton Rouge, Louisiana in the winter of 2006.

Barriers to Enrollment in Medicare Part D

Marginal literacy. Many of the beneficiaries read at an elementary school level. Yet, the CMS materials were written at the seventh grade level. This makes comprehension a challenge for the Medicare beneficiary.

Computer illiteracy. Many of the beneficiaries lacked the computer skills to navigate the Medicare website.

Limited access to computers. Some of the beneficiaries were Katrina evacuees. They currently reside in the Renaissance Village trailer park where computers are scarce.

Co-morbidities. Many of the beneficiaries had multiple chronic medical issues. They take several medications. This makes selection of a plan more challenging.

Propagation of misinformation. The beneficiaries were not given accurate information about the various prescription drug plans from some of the CMS representatives.

Enrollment venues concentrated in urban and suburban areas.

Cultural insensitivity. While Region 6 of CMS made an effort to include African American workers at their enrollment events in Baton Rouge, more culturally sensitive outreach and counseling in the rural communities needed to be done.

Limited understanding about Medicare Part D among healthcare providers. The African American physicians in the Baton Rouge area had not been educated about Medicare Part D. The physician must either hire staff to do the education or educate the patient himself/herself. Educating patients about Medicare Part D takes time. Either way, this affects the bottom line.

Dwindling reimbursement for Medicare patients. Physicians in the Baton Rouge area are accepting fewer Medicare patients because the money isn't there.

Complexity of Medicare Part D. Many seniors felt that there were too many plans from which to choose.

Poorly designed CMS website. Allied health professionals reported difficulties in navigating the CMS website.

Mr. James McCloud, a pharmacist in the Sarasota community, discussed challenges with enrollment in Sarasota – most of which are outlined above. Dr. Walter Faggett, Director of the District of Columbia Medical Assistance Administration, shared success stories in helping the DC dual eligible population navigate the Medicare Part D landscape. Also, he presented a website designed to assist seniors with selecting a prescription drug plan. (Please call Ms. Faith Muhlenburg at 202/962-0295 for details.)

The P4P portion of the Town Hall Meeting was led by former NMA President Rodney G. Hood, M.D. and NMA President Elect Nelson L. Adams, M.D.

Dr. Hood, President of Multicultural IPA and CEO of Careview Medical Group in San Diego, California presented a comprehensive overview of the California Integrated Health Association (IHA), a P4P initiative in California. He began by listing his “so-called--Disclosure Statements”:

- “P4P was proposed and implemented more for cost containment rather than quality improvement.
- As currently being proposed P4P initiatives will exacerbate the financial reimbursement inequities in the health care system.
- P4P health care quality indicators do not always correlate with quality and give a false sense of quality improvement.
- In its current form P4P is a bad idea that can potentially worsen health disparities.
- No matter what we may believe about its inequities, P4P is here and we as ethnic healthcare providers must deal with it.”

He went on to quote Dr. Mark McClellan, former CMS Administrator, who said in 2004, “In the next 5 to 10 years pay for performance based compensation could account for 20% to 30% of what Medicare pays providers.”

He presented statistics from the National Healthcare Disparities Report 2004 (AHRQ) on “Quality of Care and Access to Care Comparisons by Selected Racial Groups” and “Health Care Quality Indicator Disparities” from the August 2006 issue of the American Journal of Preventive Medicine to demonstrate his point on the national level. He also presented statistics from IHA in California and the Multicultural IPA in San Diego County, California.

Dr. Hood cautioned the Sarasota audience as he cautioned the AMA House of Delegates at the AMA Forum on P4P in December, 2004, “Pay for Performance programs that have been initiated do not adequately take into account the documented baseline quality performance variances found within and between different racial and ethnic groups.”...

“Not considering specific health disparities risk variables (SES, geographic location, race and level of disease burdens creates the real potential to economically penalize and cause unintended disincentives for individual physicians, medical groups and health institutions that have traditionally provided health services for these high risk populations. Providers treating high risk populations are penalized even if they obtain significant quality improvement. These inequities will further worsen quality of care in high risk populations and widen healthcare disparities.”

Moving from Dr. Hood’s experiences in California, a state which has implemented P4P, to Florida, a state which has not initiated a P4P program to-date, Nelson L. Adams, M.D., President and Chairman of Access Health Solutions (AHS) in Miami, Florida, presented an overview of the AHS Minority Physician Network (MPN), the third largest Medicaid Managed Care entity in Florida. The MPN model was developed to support Florida’s Medicaid program and to enhance cultural competence and preserve the traditional Medicaid physicians relationships with minorities, public health departments, federally qualified health centers (FQHCs), etc.

MPN was implemented as a pilot program in 2001 and was well received. Dr. Adams reported that it reduced medical and prescription drug costs, was politically popular due to minority physician support, and improved patient care for Medicaid enrollees. It was converted to an ongoing contract in 2003 and renewed in 2005. MPN now manages over 94,000 Medicaid members in 26 counties in Florida.

Dr. Adams concluded his remarks by outlining critical pathways to eliminating racial/ethnic disparities and describing responsible governance of P4P.

Critical Pathways to Eliminating Racial/Ethnic Disparities

- A well informed, culturally competent provider delivery system;
- Claims-based information combined with educational materials and best practice; guidelines to support primary care case managers in their critical role as the patient’s usual source of care;
- Strong collaboration among network physicians and disease specific education of Medicaid beneficiaries (to help improve clinical outcomes);
- Intensive clinical analysis; and
- In depth community outreach and effective communication among all parties

Governance of P4P (from the NMA Presidential Task Force)

- Quality of care measures must be clearly delineated from cost containment measures.
- All measures must be culturally relevant to the population served, with due consideration to and stratified measures associated with social economic status, self reported race, ethnicity, co-morbidities, chronic conditions, high risk, and disease burdened populations.
- Quality measures, cost containment measures, and reimbursement formulas must be appropriate for the population served.

- Capacity-building support must be provided to small and disadvantaged healthcare providers to ensure infrastructure allows quality data gathering and reporting.
- Ample input from a diverse population of specialty and culturally representative physicians and patients should be used in the development, implementation, and evaluation of the effectiveness and impact of P4P measures, policies, procedures, regulations and programs.
- Effectual physician and patient education on P4P measures, policies, procedures, regulations and programs must be provided.

During the question and answer period which followed, the critical roles of local, state, and national public officials and policy makers as partners in this process were emphasized as was the need for the African American physician to “be at the table”. The important role of home health agencies as health care providers in the health care delivery system was brought to the attention of the audience as an additional issue to be addressed.