

Introduction to the Cape Care Model Plan and Summary of Cape Care Community Health Trust

Introduction to the Cape Care Model Plan

Cape Cod has, for many years, been characterized by its high percentage of individuals without health care insurance. Statistics compiled by the Barnstable County Human Services Department estimate this at about 18%, twice the comparable statewide average.

The Institute of Medicine of the National Academy of Sciences reports that lack of health care coverage results in care delayed or denied, and is associated with preventable illness, disability and premature death. Based on their statistics, about eighteen people die unnecessarily every year on this beautiful peninsula, simply for lack of access to care.

With the advent of Commonwealth Care, many more individuals do now have an insurance card. They are, however, finding access to primary care very limited, and access to outpatient specialty care nearly impossible on-Cape.

Improving the availability of such care- and the health- of this large number of individuals has always been a primary driving force in the genesis and development of the Cape Care Model Plan. Better outcomes are known to reflect access to affordable and appropriate care. The Cape Care Plan would provide access to a primary care "home" for every resident, and to specialist services as appropriate.

The current funding of health care expenses, with very high costs and large out-of-pocket obligations, is regressive, and imposes a disproportionate financial burden especially upon families of limited means. This spending represents a diminution in available resources that might well go to housing, thereby making all shelter less "affordable." And in these times, when the threat of foreclosure looms suddenly larger for so many families, the devastating impact of unexpected illness may well spell bankruptcy (studies show that the majority of personal bankruptcies are attributable to medical costs.)

Cape Care, deriving revenues from current state and federal funding, and from community tax support, would remove most unpredictable health care costs. Health crises would not snowball into homeless crises.

The Cape's predominantly small-scale employers (we have twice the state rate of single- proprietor-run businesses, and 95% of Cape employers have less than 20 employees) face a very expensive employee benefit in health care insurance. In fact, most cannot or do not provide coverage. Available evidence suggests that fewer and fewer employers will be.

Even the municipalities have seen annual premium increases of 10-15%, forcing difficult cuts in town operations and services as they must to balance budgets.

Under the Cape Care Plan, every resident would be covered. No employer would be responsible for the costs of providing for their employees' health care coverage and no individual would depend on his or her employment for insurance.

A concern that impacts all of us living on Cape Cod is the adverse economic climate for health care providers and institutions. With its high cost of living, yet "rural area" reimbursement profiles and economic difficulties that limit income, many physicians have found practice here to be unsustainable, and have left the area. The mid-Cape, in particular, suffers a significant deficit of primary care physicians. Appointments are delayed, and new patients have difficulty finding a health care provider.

Cape Care, by reducing the administrative burdens and considerable expenses of the current multiple-payer morass, by improving the practice environment through care coordination, communication and education, and by setting appropriate reimbursement schedules which reflect the critical role of cognitive primary care services, will certainly improve the attractiveness of the Cape as a practice site.

The single dominant institutional health care provider on Cape Cod has faced unprecedented financial challenges, in no small part owing to the contractual arrangements that insurance plans have devised which pit physicians against hospitals. The financial impact has threatened the availability of some services for all residents. With the dramatic reduction in insurer role that would occur in a Cape Care

system, this devastating mal-alignment of interests would be eliminated. In fact, the self-insurance model would create strong incentives toward efficient, cost-saving systems of care. Savings, rather than going to insurers, would be retained, to limit funding requirements, or to improve covered services and reimbursement.

Cost control will be central to the plan. Beginning of course, with the substantial administrative savings of the 'single-payer' structure; a great reduction in the number of different coverage and appeals policies, claims processes, formularies and profit centers that characterize our current structure. We anticipate volume purchase of pharmaceuticals, supplies and some services to bring additional savings.

Beyond these purely fiscal benefits are the real savings anticipated in quality of life, with a public health approach and a strong emphasis on preventive and chronic disease care. Many health conditions can be carefully managed, at a reasonable cost, to avoid much higher-priced hospital care and high-tech interventions.

And a last, but certainly not least concern, one not specific to Cape Cod, nor only to those of low income or uncovered, is the quality of our care. Abundant evidence shows that we, as a nation, are not getting anywhere near our money's worth in the services we receive. Certainly, some of the explanation for our strikingly poor health statistics, compared with most developed countries, lies with the large number of people without access to regular medical care. This is underutilization, and results in the clinical waste of poorly treated chronic disease, and less-than-satisfactory infant health statistics. As noted, these Cape Care Community Health Trust disparities would be greatly reduced under our plan for uniform universal coverage.

There is over-utilization, as well. Excessive use of expensive tests for those covered by insurance, over-prescribing of the newest and most costly pharmaceuticals. In developing the Plan, we have put considerable thought and effort into developing feedback and education systems that will help guide providers toward evidence-based, appropriate utilization of new technology.

Beyond these, however, is an inescapable fact of our current health care environment. We do not have anything that we can honestly call a "system" to deliver our health care. Rather uniquely in the world, in fact, is the absence of real centralized health information collection, planning, budgeting, coordination and oversight. Every other developed nation has established some system to perform these crucial functions. This, in large part, explains both the extraordinary differentials in spending, and their better health outcomes

In the US, there are excellent models of such systems. The Veterans Administration Health System, Kaiser Permanente and others have developed visionary models of care delivery.

We propose, with the Cape Care Model Plan, a community-owned health system, modeled on elements of those others. We see care built around a shared Electronic Medical Record, care teams, independent clinical educators, and appropriate settings of care delivery. Where the quality of the care delivered is a commitment shared across the spectrum, and where the performance of the system is openly reported and discussed with the community.

The Cape Care Model Plan would be much more than just an efficient financing system. It would use the existing and expanded network of private and institutional health care providers to provide an integrated continuum of health care to all residents, accessibly and affordably. To cite again the Institute of Medicine, "The estimated value across the population in healthy years of life gained by providing health insurance coverage is almost certainly greater than the additional costs.

Cape Care Community Health Trust - Section summaries

Section 1: Preamble

Equal access to quality health care for all residents is the foundation for a healthy community. Currently, rising costs are a hardship for all, and care is becoming less accessible across Barnstable County. The Cape Care Community Health Trust will promote cost control and affordability; provide universal equitable access to coordinated, comprehensive health care benefits; and employ evidence-based systems to enhance to quality of services.

Section 2: Definitions

Key terms used in this chapter are defined.

Section 3. Establishment of the Cape Care Community Health Trust

The Trust, a public instrumentality of Barnstable County, is established, and has limits defined for its trustees, officers and employees.

Section 4: Powers

Broad authorizations for the varied activities necessary to carry out the purposes of the Trust, including making contracts and agreements, ownership of property, hiring of officers, employees and consultants, establishing advisory boards, managing and investing funds.

Section 5: Purposes

The Trust will guarantee access for every Barnstable County resident to appropriate health care services, will achieve measurable improvements in outcomes, will save money through a single administrative structure and improve satisfaction among both care providers and consumers.

The Trust shall be the payer for all covered services to residents; and public education as indicated and health-risk reduction efforts.

Section 6: Board of Trustees; Composition; Powers and Duties

Six trustees will be elected, one from each state legislative district on the Cape, and seven to eleven trustees will be appointed ex-officio, representing designated organizations.

Terms and responsibilities are delineated; oversight of administration of Cape Care Community Health Trust, including the Executive Director; oversight of annual budget process; establishment of all necessary policies; prudent management of Trust funds; review and reporting on system performance.

Section 7: Executive Director; Purpose and Duties.

Authority and responsibilities of the executive and administrative head of the Trust; reports to the Trustees.

Section 8: Medical Director and Quality Assurance Division; Powers and Duties

The chief medical officer will have overall responsibility for assuring the appropriateness and adequacy of services delivered under the Trust, and will direct the division. The medical director will establish standards of care, recommend benefit coverage, and review services provided under the Trust.

Section 9: Professional Advisory Board

Comprised of participating health care providers and others, and chaired by the medical director, responsible for the oversight of health care policy and delivery, and provider relations.

Section 10: Administrative Division; Director; Purpose and Duties

The division will be responsible for the collection, investment and disbursement of funds; and budget development.

Section 11: Planning Division; Director; Purpose and Duties

The division will be responsible for coordinating health care resources to ensure all eligible participants reasonable access to covered services, and for the short- and long-21 term planning for the resources required to meet community needs.

Section 12: Information Technology Division; Purpose & Duties

The division will be responsible for development of electronic medical record and prescribing systems; integrating all relevant data sources for planning and public health purposes; and preparing an annual report on outcomes measures to the County and community.

Section 13: Regional Offices

Three regional offices will provide health promotion and wellness activities and other needed member service.

Section 14: Eligible Participants

Defines all Barnstable County residents as eligible to be enrolled and covered; defines out-of-network care coverage provisions.

Section 15: Eligible Health Care Providers and Facilities

Defines eligible licensed providers; establishes conditions for participation, including non-discrimination and no unauthorized balance-billing or out-of-pocket charges.

Section 16: Prospective Payments to Eligible Health Care Providers and Facilities for Operating Expenses

Establishes a range of payment mechanisms, from fee-for-service, to capitated, to overall operating budget basis, for providers of covered services.

Section 17: Retrospective Payments to Eligible Health Care Providers and Facilities for Operating Expenses

Provides for retrospective adjustment of payments made as indicated by unexpected variance in service utilization or expenditures.

Section 18: Funding for Capital Investments by Eligible Health Care Providers and Facilities

The Trust shall not directly fund capital investments by providers. Payments for health care services may be directed to capital needs.

Section 19: Covered Benefits

Sets the goals for provision of all high quality, appropriate and medically necessary health care services; reductions in health risks and increased use of preventive services; the integration of physical, mental and behavioral health; and the assurance of a primary care “medical home” for every covered individual.

Defines the comprehensive lifetime benefits that would be available to every individual -17 as age-appropriate or necessary. Requires development of standards for utilization through an open evidence-based process, and an appeal process for non-covered benefits.

Section 20: Funding Sources

Identifies the proposed financing mechanisms, beginning with the savings expected in a coordinated system approach to care delivery. Premised on retention of current federal, commonwealth and other governmental subdivision expenditures for health care services to residents. Cape Care anticipates Medicare Advantage, MassHealth, Commonwealth Connector certification as a managed care organization for covered residents.

Details the residual funding sources sought; a county property tax, requiring Commissioner authorization; and an Employer Health Care Contribution, with the expectation that this will meet state employer obligations under Ch. 58; and all collateral sources.

Section 21: Insurance reforms

Requires of insurers written disclosure to prospective private insurance purchasers of the comparative availability, scope of benefits coverage, provider networks including ancillary services, and costs of enrollment in the Cape Care Community Health Trust.

Section 22: Health Trust regulatory authority

The Trust shall adopt and promulgate regulations to implement the Trust; emergency regulations in transition period.

Section 23: Implementation of the Health Care Trust

Sets transition timelines; from first meeting of Trustees within ninety days of enactment; to provider enrollments and policy development by two years; and full implementation of the benefit plan within three years of enactment.