State-Wide Primary Care Access Authority

Co-Chairs
Margaret Flinter
Tom Swan

Meeting Summary

Thursday, April 3, 2008

3:00 PM in Room 1C of the LOB

The following members were present: Tom Swan, Margaret Flinter, JoAnn Eaccarino, and Sandra Carbonari, Angelo Carrabba

Also present were Fernando Betancourt, David Krause representing Comptroller Nancy Wyman, Barbara Ormond, Randy Bovbjerg, James Rawlings, and Leo Canty

The following members were absent: Commissioner Robert Galvin, Commissioner Michael P. Starkowski, Daren Anderson, Evelyn Barnum, Robert McLean, Lynn Price,

Also absent were: Teresa Younger, and Franklin Sykes.

Margaret Flinter introduced Barbara Ormond and Randall Bovbjerg of the Urban Institute, who will be helping to support and facilitate the work of the HealthFirst Ct. and the Statewide Primary Care Access Authorities. Tom Swan reported on the status of the funds authorized by the legislature for the work of the Authorities. The funds have been transferred from DPH to the Office of Legislative Management, but are still the required signatures before they can be released. The RFP for the primary care inventory cannot be released until these funds are made available.

Tom Swan reviewed the upcoming meetings dates and times of the Quality, Access and Safety Workgroup and the Cost, Cost Containment and Finance Workgroup, and their areas of focus. Dr. Carrabba reported that the Ct. State Medical Society is finalizing a survey/inventory of physicians in Connecticut and will be happy to share similar to the study conducted by Lynex. Dr. Carrabba expressed his willingness to share those results with the Authority so that duplication of efforts can be avoided.

Margaret Flinter asked the Authority to consider the process for reaching agreements by the Authority. She acknowledged that there are many formal models, but they can be cumbersome. Following a brief discussion, the Authority agreed to adopt a strategy of trying to come to consensus, with a commitment to register any substantive disagreements in any final documents that are generated by the Authority. Fernando Betancourt asked when the Authorities would present their findings to the Legislature and the Governor. Margaret Flinter responded that the formal charge requires the Authority to present a report to the Legislature in December 2008, but the work of the Authority actually continues for four years.

Fernando Betancourt requested close collaboration with legislative leadership before the presentation is given.

Barbara Ormond gave a presentation on the Institute of Medicine (IOM) five principles of healthcare coverage: Healthcare coverage should be 1.) Universal 2.) Continuous 3.) Affordable to individuals and families 4.) Health insurance should be affordable and sustainable for society, and 5.) Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

1.) Universal coverage funds care for all, freeing providers from uncompensated care. What is covered affects what care is sought and what care is provided. This frees providers from making decisions over whether someone is covered or not. Universal coverage can assist with, but does not guarantee universal access or quality of care.

2.) Continuous Coverage supports but does not guarantee continuity of care. Explicit attention to efficiency and high value care will help to maintain affordability and sustainability.

3.) Affordability is influenced by income and health status in conjunction with the structure of coverage and benefits. Designing a perfect system is of little value to average residents if it is not affordable.

4.) Affordability for society requires consideration of how much the state will have to pay, how the state will fund the plan, how the funding will be maintained in the face of yearly state budgets, and const containment and efficiency will be critical for success.

5.) Affordability and sustainability for society will depend on cost containment and efficiency, provider and patient incentives, and continuity, coordination, prevention, and health promotion.

The enhancement of health and well being applies to existing coverage as well as expansions. Financing should provide incentives for caregivers to provide efficient, high value care and residents to take responsibility for their health and use care wisely. Policies that affect caregivers should be attractive enough to induce both reasonable availability of care and willingness to undertake value enhancing activities. Providers and residents need systematic support including information, oversight and feedback. Establishing and maintaining the correct price signals will contribute to achieving high-value care.

Margaret Flinter told the Authority that it is rare to find a system of primary care that works and has been embraced by the people of that state. The healthcare system in North Carolina has achieved an almost 100% participation in Medicaid which means you will have access to providers across the state. They are dealing successfully with issues of information and technology exchange, care management, and using data to guide practice. She then introduced Dr. Steven Wegner, President and Medical Director, Access Care of North Carolina.

Dr. Wegner reported that there are 14 networks in North Carolina. There is also a Physicians Advisory Group in North Carolina which has access to many experts in policy and Medicaid. The North Carolina Community Care Network is a private not-for-profit organization that serves as an umbrella group for the 14 networks in North Carolina. That is an entity that is expanding from reliance on Medicaid and

SCHIP to Medicare. North Carolina is working on a demonstration project that could cover one third of the state with Medicare. Finally, the infrastructure has moved beyond Medicaid to private insurance.

Dr. Wegner expressed his opinions on achieving healthcare reform in Ct. There are several items that must be considered before moving forward on a policy recommendation in Connecticut. The first item for consideration must be fair pay. Providers must be paid to get them to participate. It is very hard to build a system that will care for the uninsured. In North Carolina there are 3,500 primary care physicians caring for 876,629 Medicaid and SCHIP patients. That represents about 85% participation of all primary care doctors in the State of North Carolina. There is a long tradition in North Carolina of seeing Medicaid and the uninsured if you practice medicine. This trend has spread into cities because of community pressure to do so.

The second policy item to improve access requires physician, leaders and community partners. A third policy to improve access includes smart and dedicated policy makers. Fourth, an infrastructure is necessary to improve access. He noted that a great deal of time must be spent organizing and coordinating care for some patients.

Each of the 14 networks in North Carolina has a part time Medical Director and a clinical coordinators, and hires and deploys a number of care managers, based on the numbers of patients enrolled throughout that network. The network takes responsibility for quality and data reporting initiatives. The infrastructure is funded by the care coordination fee paid on a pmpm basis by Medicaid.
The primary goals of the healthcare system includes improving the care of the Medicaid population while controlling costs, developing Community Networks capable of managing recipient care, developing the system needed to improve chronic illness and a fully developed Medical Home model.

Data is taken from care providers across the state and compared to similar care providers as a way of measuring results and encouraging competition among providers.

Current initiatives include chronic care, care coordination, disease management, pharmacy management, dental screening and fluoride varnish and case management of high cost – high risk.

Chronic care is extremely important and an area where money can be saved. Extra support should be given for patient self-management.

Key innovations include provider networks organized by local providers which are physician led. There is also evidence based guidelines adopted by consensus rather than dictated by the State. Medical Homes are given the resources for care coordination and get timely feedback on results. Finally, in North Carolina there has been inclusion of other safety net providers and human service agencies.

Dr. Wegner observed that there is a lot of waste in healthcare and there are many ways to improve efficiency of care. Two public perceptions of the healthcare system are the existence of inefficient care and that healthcare technology will improve. It is not clear that health care technology will lead to increased savings but it must be pursued. Preventative care must be done to have savings in the long run even if it doesn't save in a particular fiscal year. The Legislature of North Carolina hired Mercer, an actuarial firm, to look at the savings in the health system. Mercer offered a strong endorsement of the

healthcare system and in SFY 2005 and 2006, estimated that North Carolina saved $231m in healthcare expenditures.

He informed the Authority members that despite success in the medical services, North Carolina has struggled with mental health reform. Co-location has shown some success. In the co-location system, primary care providers use evidence based screening tools to identify patients and refer to the behavioral health provider. Behavior health providers then function in a brief model and refer more traditional and complex cases to specialty mental health. Practices and behavioral health providers provide evidence based care.

North Carolina has partnered with ICARE who has provided partnership with medical societies for reviewing, posting and training on evidence based tools. ICARE provides policy and planning teams with special emphasis on coding and payment as well as developing links to community resources.

The issue of the uninsured continues to create difficulties in North Carolina's healthcare system.

Dr. Carrabba asked if E-Prescribing was used in the pharmacy program and if that was used as a cost-containment method. Dr. Wegner explained that North Carolina does not use E-Prescribing currently but are moving towards implementation.

Angelo Carrabba asked if all the practices were Federally Qualified Health Centers or if private practices were included. He asked how private practices could afford health care coordinators and councilors and other labor-intensive positions. Steven Wegner reviewed the regional network structure and the pmpm fee paid to support the care coordination and medical home related infrastructure and expenses.

Dr. Sandra Carbonari asked about health screenings and referrals and how they are managed? Steven Wegner explained that the intention of the Primary Care Access Authority's focus is primary care. One service that is paid for in North Carolina that may be unusual in other states is that of calls made from primary care doctors to specialists for a telephone consultation. North Carolina has worked on educational systems that have prevented unnecessary referrals. Sandra Carbonari asked how obesity is dealt with by the North Carolina healthcare system. Steven Wegner agreed that obesity is a bad problem. There are three certified obesity centers and community assistance program that involves the family, education, and YMCA programs. Systems and infrastructure are necessary to address the problem.

JoAnn Eaccarino asked about the role of school based health centers in the healthcare system in North Carolina. Steven Wegner responded that the practices serve as the link with the school-based nurse. Medicaid has helped with funding and every year there has been an increase in the number of school nurses. JoAnn Eaccarino added that there has been some success in Connecticut in dealing with obesity in the School Based Health Centers by brining in families and working with food services.

Margaret Flinter asked if there was a pivotal moment during the North Carolina health reform movement when someone said "if we want our private practice community to take care of our most vulnerable patients, we have to pay them," and was that followed by a proposal for payment. She also noted that Connecticut is not broken up regionally the way that North Carolina is, but in North Carolina

it seems that the 14 networks have cooperated very well, and been able to coordinate with each other efficiently. Finally she asked if the care managers were employed by the practice or by Access Care.

Steven Wegner answered that he was not aware of any defining moment. The decision by North Carolina to tie Medicaid payments to 95% of the Medicare rate was made many years ago. He noted that it took years to establish a plan that the State could use to take care of the uninsured and underinsured.

Angelo Carrabba noted that in Connecticut it is difficult to get adequate coverage for the existing population. Connecticut recently increased the Medicaid reimbursement for doctors for the first time in 18 years. Blue Cross Blue Shield is 225% above what we received with the increase. He asked how North Carolina was able to get the health care system running and if there was a way Connecticut could replicate some of that progress.

Steven Wegner responded that the involvement of physicians in government helped. They understood what changed was necessary and they were able to help push the necessary legislation forward. Angelo Carrabba told the Authority there are problems with finding the funding for healthcare programs and the willingness of the legislature does not match the desire to create healthcare change.

Tom Swan asked what infrastructure could be constructed in Connecticut to help incentivize provider participation.

Steven Wegner said information needed to be the primary goal. An institute or a think tank that could regularly monitor issues and report to the Legislature, Governor and general public would also be useful and fairly inexpensive. The fact that leadership in the Connecticut General Assembly want to do something about the healthcare problems facing the State is an opportunity that should be taken advantage of.

Randy Bovbjerg asked if the relationship of the Medicaid payment to the Medicare fee schedule was in statute. Dr.Wegner responded that it was.

Sandra Carbonari commented that her pediatric practice is a medical home where there is an embedded care coordinator that really makes it possible. Funds come through Title 5 and the Department of Public Health. Care Coordination Services are performed by a registered nurse, and the physicians are able to devote their time to seeing their patients. The funding however, is difficult to maintain.

Steven Wegner added that all healthcare players were at the table in North Carolina including physicians, hospital associations, universities, health departments, social services, and industry. He stressed that the input of private doctors is essential for the success of any potential healthcare reform. Steven Wegner expressed his hope that private doctors will express willingness to get together to work on this issue.

Margaret Flinter announced the next meeting of the State Primary Care Access Authority meeting, will be on Wednesday, May 14th at 9:00 AM. Dr. Mitch Katz of the Healthy San Francisco Project will be speaking at the meeting, which is a joint meeting of the SPCAA and the HealthFirst Ct. Authority. The meeting adjourned at 5 pm.