State-Wide Primary Care Access Authority

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Meeting Summary

April 29, 2009, 7:30 A.M. in Room 1E

Members Present:

Evelyn Barnum, JoAnn Eaccarino, Margaret Flinter, Dr. Robert McLean, Lynn Price, Tom Swan, Dr. Sandra Carbonari, Teresa Younger & Jody Rowell.

Also Present:

Dr. Todd Staub and David Krause.

Margaret Flinter opened the meeting. She asked for the Authority to review the minutes from the last meeting and address corrections.

Dr. Sandra Carbonari asked for a correction to the minutes of the previous meeting. At the bottom of page 5, where she referenced approximately how many APRN's go into primary care, it should read 70%.

JoAnn Eaccarino asked for a correction on page 5. It states that it is the choice of the parent and the community health center about what organization or entity is going to administer the school-based health center. It should say that it is the choice of the community about what organization or entity shall administer the school-based health center.

Dr. McLean asked for a correction on page 7, in the sentence that begins "hopefully". He asked to replace "they" with "the legislators". Also, in the sentence that begins "The problem", instead of "pay into", I meant to say "rely on".

Dr. Sandra Carbonari asked for a correction on page 8. She stated that she did not mean to say that it was "categorically not working". She asked for it to be replaced with "experiencing difficulties".

Dr. McLean asked for a correction on page 6, in the paragraph attributed to Dr. Daren Anderson. Dr. McLean should be attributed with the statements beginning with the sentence that starts, "There is no data".

JoAnn Eaccarino asked for a correction on page 4. She stated that she did not mean to say that "school-based health centers are really the answer". What she meant to say was "school-based health centers are an important piece of the answer".

The minutes were accepted as amended on a voice vote.

Margaret Flinter stated that the Department of Public Health (DPH) has completed a draft of the online survey renewal questions for physicians. They are still working on the nurse and dentist questions. She asked for the Authority to determine what is missing from the questions and give feedback to DPH.

Lynn Price asked what kind of process DPH has in place for feedback because this is a pilot.

Margaret Flinter answered that she does not know.

Dr. McLean stated that since this is through DPH, Dr. Galvin would presumably have input. He stated that it would be nice if he was here to discuss it.

Margaret Flinter agreed and stated that DPH is doing a phenomenal job in organizing this response. The Authority will invite Dr. Galvin. The Authority can try to agree on priorities at this meeting.

Dr. McLean stated that the New York survey had several questions that were key to addressing the issues the Authority felt were important. It is important to know why DPH does not want to include those questions that the Authority recommended.

Margaret Flinter stated that the Authority has strongly encouraged DPH to look at the New York survey. This is the first draft that has been seen, and DPH has stated they are open to comments. It is important to agree on what the Authority feels are priorities.

Lynn Price stated that the Authority should make a strong recommendation for exactly what is in the New York survey, but as a back-up, compromise and state that the information on primary care should be included at the very least. DPH is well aware that this survey is being used to gather data on primary care. Without the identification of particular specialties, it could be asked "Is your practice primarily primary care" or "estimated percentage", and the rest would be presumed to be specialty. It is best if the data is specific as possible.

Dr. McLean commented on the DPH survey, question 2. There are so many people in Connecticut who are associated with the medical schools, that it will be very difficult to decide what percentage of their practice is primary care. Choosing one category, and not more than one, is a real problem in terms of accurately describing their practice. This question is clearly inadequate.

Margaret Flinter stated that the New York survey reads "What percent of your patient care time is spent in your principle specialty". Is that question adequate?

Dr. Carbonari stated that number 7 in the New York survey asks to indicate hours per week in medicine for which the major activity is, and then lists a breakdown of different categories. This gives more information in the question.

Dr. McLean stated that instead of question 2 on the DPH draft, something similar to question 7 in the New York survey could be used. Question 2 on the DPH draft does not give enough useful information.

Margaret Flinter stated that the Authority would recommend to replace question 2 on the DPH draft with question 7 from the New York survey.

Dr. Carbonari stated that number 5 on the DPH draft could then be eliminated.

Dr. Todd Staub asked why the DPH draft is shortened.

Margaret Flinter stated that it is believed that this is primarily an adaptation of what physicians have filled out for years. The questions that appear to be different are questions about patient care practice status, if new patients can be accepted, what percent of patients have the following source of payment, and retirement plans. DPH heard the concerns about needing to forecast what will happen in the future and addressed them. The Authority has been advocating for exactly these kinds of questions, particularly that there is more information regarding primary care and depth about what is actually being done.

Dr. McLean stated that it is not known if someone at DPH actually read the New York survey, it may not have been read.

Margaret Flinter stated that she does not think that is the case.

JoAnn Eaccarino stated that there is no place to specify what type of primary care a physician is practicing.

Margaret Flinter stated that the Authority feels that the most important question is number 15 which says "mark one principle and one secondary if applicable" and then lists subcategories of specialties. The one thing that is not indicated in this question is hospitalists.

Dr. McLean stated that hospitalists should be included. Regarding workforce issues, knowing specific subspecialties is going to be important. The state medical society does not have this

data either. Having it for a central data repository would be very helpful. In addition, the other item that was on the New York survey that was not included in the DPH draft was the information regarding education and background. Information regarding where physicians did their residency, and where they went to medical school is helpful to get a sense of if they are staying in the state.

Dr Todd Staub stated that the residency and medical school information is in the physician profile on the state website. The information is collected and put in the physician profile. DPH has this on their website.

Jody Rowell stated that she likes the New York survey because it addresses child, adolescent and adult psychiatry. It is known that this is a problem in Connecticut and it would be very helpful to have data.

Lynn Price asked about question 8 on the DPH draft. How could a physician know what percentage of their patients have a certain payment source? Is that data already collected elsewhere?

Dr. Staub stated that most physicians guess on this answer and make an estimate.

Dr. Carbonari stated that most physicians know because when it comes time to do referrals and what formulary can be used, it depends on what kind of insurance or noninsurance patients have. That would be easy to find out from the administrators of physicians offices.

Lynn Price asked why this question is being asked for information regarding licensure.

Margaret Flinter answered that the Authority wanted to know if people are taking Medicaid, Saga, Medicare and if they are close to taking those programs. There may be a better way to get this data. This is an attempt to respond to the issue of if people are accepting and if there is a problem with acceptance by insurance.

Dr. Carbonari stated that the question only asks for Medicare, Medicaid, self-pay and other. So is other commercial?

Margaret Flinter answered yes, other is commercial insurance.

Dr. McLean stated that an interesting question that may come up is that maybe all the people who are taking Medicare are getting burned out and are going to retire. There may be trends with what their patient panel looks like. There may be trends that are seen that would be helpful to notice.

Margaret Flinter stated this question came from the New York survey which included Medicare/Medicaid and what percentage of the practice participates. It might be a better statement for the physician to state that they have zero Saga rather than say they are a provider, because they could be enrolled and have no participants.

Joann Eaccarino commented about question number four. The line that states "please identify the principle, indicate the zip code", does not make sense and takes up too much space. They could just put spaces on the line for the zip code.

Margaret Flinter stated that they want to geo-code this so the zip code is important.

Lynn Price stated that it looks like the original stem of the question is asking for the zip code and then they want to know the zip code of the primary work setting versus where the most time is spent. It might be asking if the physician is in a satellite location.

Teresa Younger stated that the New York survey gives more real data to be able to track some of the trends. In question number 8, what may be interesting to note is whether there is an increase in these areas. There could be a question between 8 and 9 that states "Has there been an increase in these categories of payment?". If they have seen increases in these payment areas they may be considering retiring or changing methods.

Margaret Flinter asked if there is going to be a question regarding languages. The standard is becoming that interpretation services have to be offered and it would be good to have workforce diversity data.

Dr. McLean stated that this would be useful. Most of the insurers, as part of their credentialing, always asks that question to meet requirements and document that they are providing appropriate services. When looking at access to a diverse population, it is a simple question that would provide very useful information.

Margaret Flinter stated that on the draft they ask for gender on the New York survey. They have race/ethnicity according with federal standards in question number 21.

Dr. Carbonari stated that they should ask for the date of birth for retirement purposes.

Teresa Younger stated that it would be helpful to know years of practice. There is no indication that gives any comparative analysis.

Dr. McLean stated that years of practice is a better piece of information, and it would be helpful to have.

Margaret Flinter stated that she would try to put these suggestions into a summary memo from the Authority to DPH. The priorities are to replace number 2 and 5 in the Connecticut survey with number 7 from the New York survey, to add number 15, to add school and residency, replace number 4 from the Connecticut survey with number 10 from the New York survey, add date of birth and years of practice.

Dr. McLean stated that to simplify getting at more detail on how many hours are being spent on various activities, full-time or part-time as their overall designation is irrelevant. There will be a breakdown, so question number one is not needed. It is an arbitrary definition when getting at the details.

Evelyn Barnum stated they are doing delegating credentialing and she would like to see how that database could be useful.

Dr. McLean stated that VA should be listed, because when looking at access issues, only veterans can access VA physicians. Those doctors have limited access.

Margaret Flinter stated that the key charge at this point is to get going with the development of recommendations in our report that we should complete by the end of June. We looked at recommendations for insurance coverage and we need to be specific about that. Workforce development, retention and monitoring will be primarily written by Lynn and JoAnn. Also, geographic and special population access was not assigned. Daren stated that he would chair the writing of improving quality of primary care. Payment and reimbursement mechanisms were added to support access and quality primary care, including the patient centered medical home. Do we want to study any of these models further, and decide what we want to propose for adoption in Connecticut.

Tom Swan stated that he would like to comment on models. The presentation from Steve in North Carolina about PCCM was extremely interesting and effective. I am disappointed in the progress in Connecticut and with DSS not taking it seriously enough. Is there something we can do to help prod DSS or encourage them to do a more effective job?

Dr. Carbonari stated that it has been a struggle. Those who have been directly involved in trying to get this going have not had the support we thought we would have. Education of the patients and practitioners is important. There is no name that is easily identifiable, and patients don't have an insurance card that other patients get. They have been understandably reluctant to make any kinds of changes and the entire marketing effort has been on the practices to explain it. The other barrier is that DSS looks at families, so if parents want to have their children in a PCCM model then they have to join as well. The internal medicine has had more struggles with this model for the adults. The pediatric part of this is relatively seamless compared to the adult part. The amount of financial support is predicated on already getting the patients into the system. So it is a catch-22 kind of problem.

Dr. McLean asked what amount North Carolina paid for the per/member per/month fee.

Tom Swan stated that he thinks it was about $3 or $5.

Dr. Carbonari stated that Connecticut's is $7.50 and North Carolina's is $3. Another big difference with North Carolina is that they started out with a couple of the big insurance companies as partners, not as competitors. They way this plan has been set up is that it is competition, so we are competing for PCCM patients against MCO's.

Dr. Todd Staub stated what he got out of the North Carolina presentation is that when they scaled down the version of the medical home, it didn't work. What they realized is that they needed a construct around that along the lines of Victor Villagra's public utility. Within each of those regions on that map of North Carolina they have a corporation provides care

management and data aggregation and outreach. They created a structure that these little homes could connect to. They created a model in which physicians could buy services from an entity that could pool those resources and create a meaningful organization to get them done. The lesson from North Carolina is that the medical home experiment may fail if we don't provide an infrastructure for it to relate to. I thought that was one of the important things that this body could accomplish. We can recognize the shortcomings of that model and begin to think about what larger structures that we have in the state that will support small practices in their medical homes. In and of themselves they are good building blocks for a larger structure. The transfer from the experience of the American Academy of Family Practice showed that there were a number of practices that went out of business under the strain of trying to make the medical home work. There were a lot of reforms that were attempted to put into these practices. A number of them went out of business and they had mixed success with implementing this.

Tom Swan stated that is not sure where we can include this infrastructure concept in the current report.

Dr. Staub stated that this should fall within the section that Daren is writing.

Margaret Flinter (inaudible, microphone not on)

Dr. McLean stated that looking at what New York is doing is a good example of a neighboring state. They have a lot of different issues than we do, but I do believe that there has been significant movement in their state legislature to increase Medicaid rates. They are doing things, that recognize the primary health crisis and are trying to keep people in the fold. If Medicaid rates are not addressed, providers will just get fed up and more and more will say that they do not take insurance, cash only. Then, when we try to incorporate these new systems, they will say, they don't need it. We can't let them become so frustrated now that they fall off the radar screen.

Tom Swan asked if there are other things that the Authority should look at in this report.

Lynn Price stated electronic communication is essential but expensive. Last time it looked like the electronic medical record money is steering toward providers that are doing Medicaid and Medicare, but it its retroactive. It seems that we can make describe all the infrastructure we want, but if we don't make some recommendation around better use of that money, or understand how that money is being used, then we are just spinning our wheels.

Tom Swan asked if this is in reference to the stimulus money.

Lynn Price stated that she is not sure what money source it is, it could be stimulus money. Whatever the source is, it is vital for disease registries, reimbursements, anything, to have very good, deep databases. Practices are not in the position to go out and spend the kind of money to be able to get that.

Dr. Staub stated of the 19 billion dollars that is in the stimulus package for healthcare, 2 billion is going to the HHS for discretionary projects, and the other 17 billion is going to providers. Medicare is going to be one source, the electronic health records have to be up and running by the end of 2010. The funding is given out over a period of 5 years, and it is frontloaded, $18,000 the first two years, and then a trailing amount thereafter. There will be a penalty for if a practice does not have their electronic health record system running. There will be a reduction in reimbursement for Medicare. For pediatrics, the threshold is that you need 20% of Medicaid in your population, and that is $66,000 of potential reimbursement in that period of time. A lot of pediatricians outside of the community health center will not be able to participate due to the structure of that. It is all retroactive. It will be a challenge to have it all up and running by the end of next year.

Tom Swan asked what Dr. Staub means by the structure. Is it the calling for the 20% Medicaid mix, is that the structural problem? Or is it having it up by 2010?

Dr. Staub stated that it is both. Pediatricians in general practice that have 10 or 15% of their patients in Medicaid do not qualify for this funding.

Tom Swan asked what is the percentage of the Medicaid reimbursement for pediatrics.

Dr. Carbonari stated that it is a variety depending on what kind of practice it is.

Tom Swan asked from a patient perspective, is it something like 40% of children in the state of Connecticut are eligible for Medicaid or S-Chip or something?

Dr. Carbonari stated that it is closer to 25% of children who are eligible. There are large practices that have 90+% of those Medicaid kids. Those are mostly the community health centers and hospital based clinics.

Dr. McLean referred to Dr. Staub's dollar amounts. Those dollars are being sent to providers, and I believe that includes physicians and hospitals. I am not certain if that has been pulled out or is that all non-hospital providers. Do you know?

Dr. Staub replied it is all physician-based reimbursement.

Dr. McLean asked if there is separate reimbursement for hospitals that are doing the same.

Dr. Staub replied that they might be part of the $2 billion. They have to go after that money with proposals and it is still an unclear process of how it happens.

Evelyn Barnum stated that there are opportunities to think about structuring this under the ARRA or under CHIP. If we picked a structure that wasn't totally based on what those opportunities are, but instead something that is about getting people enrolled, covered and insured, involving electronic health records, and wellness and prevention and quality care. It might be helpful in terms of organizing this and bringing resources to it. One of the frustrating thins about what is happening now is that there isn't a plan. CMS has not issued any guidance

about how the states are going to make use of some of the funds that will bring in resources for coverage and insurance. We should just follow whatever that money is. I think it integrates a lot of what we have already covered. Coverage and insurance are part of payment and reimbursement mechanisms. I am trying to think of a simpler system of how you get people into the system and then how you track the outcomes the system produces.

Tom Swan asked for more comments, and if anyone would like to take one of the sections that have not been assigned yet.

Jody Rowell stated that she would like to add her name to the workforce development. That is an important piece for the mental health in Connecticut.

Margaret Flinter (inaudible, microphone not turned on).

Dr. McLean stated so many people have put their eggs in the medical home basket that it is worth following that through. There are a lot of demonstration home projects that are ongoing that are trying to show that. The payment reimbursement is wrapped into the other things as well. The workforce issues are going to look at reimbursement and pay rates and what is keeping people in primary care or keeping them out of it. Some of the workforce issues will look at the loan forgiveness issues.

Margaret Flinter (inaudible, microphone not turned on).

Evelyn Barnum stated that she was gravitating more toward chronic disease management.

Margaret Flinter (inaudible, microphone not turned on).

Dr. Carbonari stated that she has not volunteered to be any part of it but she would gravitate toward the quality of medical home because that is where she has the most access to information.

Margaret Flinter (inaudible, microphone not turned on).

The meeting was adjourned.