

State-Wide Primary Care Access Authority

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Meeting Summary

September 23, 2009, 7:30 A.M. in Room 1C

Members Present: Margaret Flinter, Dr. Sandra Carbonari, Jody Rowell, Dr. Robert McLean
Lynn Price, JoAnn Eaccarino, Evelyn Barnum

Members Absent: Comptroller Nancy Wyman, Commissioner Robert Galvin, Commissioner Michael Starkowski, Dr. Daren Anderson, Tom Swan, Teresa Younger, Glen Cassis and Werner Oyanadel

Others Present: Dr. Todd Staub

Margaret Flinter opened the meeting. She noted that Co-chair Tom Swan will not be attending today's meeting due to other business.

Margaret Flinter asked for a review and approval of the July minutes. She asked if there are any corrections that anyone would like to make. The Authority decided not to take any action on the minutes, pending email review by the members.

Margaret Flinter presented a packet of material that contains the draft outline of the proposed report to the legislature. She noted that it includes material that Jody has submitted regarding behavioral health. She also noted that she has contacted the dental representative to the Authority, who stated he has been following the proceedings but has not been able to attend; he will try to attend subsequent meetings. She asked the group to consider a decision to make the report a draft interim report vs. a final report since there is so much at play currently in the health reform arena. There will be recommendations we clearly want to make as people are drafting legislation for the upcoming session.

Margaret reported that the Universal Healthcare Foundation has given a positive response to our request for help in drafting the report. They will support work by Barbara Ormond at the Urban Institute to write the report for us. She will rely on both what we have already submitted in draft form, and will also talk with members of the Authority.

Lynn Price noted the short timing of the session this year and suggested it would be very helpful to have the co-chairs of Public Health at the next meeting. She also recommended that we try and have a final draft as soon as possible of the report. She suggested that we aim for end of October vs. mid-November.

The Authority members discussed making the report an interim vs. final report so that the Authority can continue to monitor and comment on the progress of Sustinet and any other legislation that is forthcoming that affects primary health care. The Authority members agreed that it should be an interim vs. final report.

Lynn Price asked that we expand the bullet “workforce capacity issues” and noted that there are additional barriers for all providers in terms of the insurance empanelment. This might be titled “other business barriers and issues”

Jody Rowell noted that a lot of what she recommends dovetails on all of the primary workforce capacity issues in behavioral health, and whether it shouldn't just drop below and note that, as reflected in the primary care workforce issues, these are also behavioral health barriers and hurdles”. She stated that the one thing she would add is that the whole license renewal for primary care was wonderful, and specifically addresses the capacity issues for those particular licenses. Perhaps a different questionnaire for dentists and behavioral health clinicians is needed. When you look at the workforce, for instance, you really want to know if that clinical social worker is working in an FQHC, are they working in a non-profit or are they working for the state because the clinical social worker should reflect that.

Margaret Flinter commented that those issues are there in the survey. She asked Jody to review the survey and comment at the next meeting on what changes or additions would be needed.

Dr. Robert McLean said that one of his charges is to look at the performance measurement question and how to do that; he is looking at where to put this. It probably goes in two places. Under the “HIT”, he would add “strategies to incorporate performance measurement”, because it is really an HIT issue in terms of tracking. Under “payment reform”, he suggests like two things, “Role of performance measurement” and “Questionable pay for quality/performance”. He would also write there, specifically, endorsement of the patient-centered medical home, should be there.

Dr. Sandra Carbonari questioned exactly where the medical home falls in the draft outline.

Margaret Flinter noted that the outline references PCCM, but not the medical home, specifically, which can be added.

Dr. Sandra Carbonari asked that this be done and noted that PCCM has a payment attached to it but medical home does not...

Dr. Robert McLean commented that there is a premise in the medical home literature that there should be a global, per-head, fee for all that care management, or for the home-management. That is part of the formula, granted there aren't enough people that have it.

Dr. Sandra Carbonari agreed that that is not happening. McLean said it is not happening, but that is part of the description of medical home and it should be happening.

Margaret Flinter commented that the Sustinet plan has a whole advisor group devoted to the establishment of medical homes. She noted that she believes the formal plan says that either the practice gets additional money for it or that money can be combined by groups or practices and providers to pay for the additional services of care coordination and things like that. Dr. Robert McLean stated that part of that fee is to pay for all of those ancillary providers that you need to make it happen. The idea is to make it fiscally feasible.

Margaret Flinter asked the members for other issues, items, recommendations that are missing. What about innovations? She asked specifically about things like telehealth, retail clinics.

Dr. Robert McLean noted that the patient-centered medical home is an innovation. That is a new concept

Lynn Price spoke to the IT issues. It is really important to have a statement about any type of electronic records or database needing to be able to freely communicate with any other such databases. That is a huge issue.

Dr. Todd Staub stated that the regional extension centers that are proposed for funding under the stimulus package is going to try to get 1000 primary care providers up on EHR. They are prioritized by serving the underserved, and there are 2 or 3 other criteria that say "these are the 1000 providers in the first wave that should get going". He raised the question "now what? You have the practices up on electronic health records, and now what are you going to do? So the question really becomes: how do you get, a state like ours, where most of the care is being provided in small offices in disparate setting, how do you get the where-withal to do something with the data? Can you inject some kind of organization into the system that begins to allow small practices to do something meaningful with the data? That is what we learned from North Carolina. Medical home is a tiny boat in the sea. How do you connect them all up in some kind of meaningful way so that you are doing something with the data so you coordinate care in a meaningful way. What they learned in North Carolina is that you had to create some sort of a central utility for case management, for outreach, for data warehousing, for interacting with specialists and hospitals so that primary care can begin to fulfill the potential of the medical home,

Margaret Flinter: The outline, under "HIT" referenced the regional extension centers. These all need to be fleshed out in the final report.

Dr. Todd Staub asked: Well could they have a new life, these regional extension centers, beyond training? Could they become the locus then for bringing organization to these activities? Because you are going to have staff, you are going to have people, you are going to have data. Does that become a place to organize primary care?

Lynn Price commented, to continue that thought, if we are examining some kind of performance measure, and link to payment, than you have to tie this in to how things are reimbursed.

Margaret Flinter asked Todd to talk a little bit about the visit by the primary care development corporation of New York City, which came to Ct. last week to speak to the Primary Care Coalition. She noted that that's the kind of concrete structure where something is actually funded to watch out for, to

support the development of, primary care. Do we need something like a primary care development corporation, which on an ongoing basis can float bonds, provide financial support whether that is to build more FQHC's in an impoverished area, or to support something like the implementation of a new system or to do workforce funding. She asked that people think about bigger goals like that under "Strategies and Recommendations". Margaret also added that under "Innovation" we might want to comment on two other innovations. One is nurse managed health centers, of which there are hundreds around the country but none in Connecticut; they have gotten significant attention in the federal reform bills. The other, she said, is a project that her organization has developed; residency training for primary care nurse practitioners committed to serving in the safety net setting. She stated that she thought the report should comment on the stimulus funds received in Connecticut to help FQHCs meet increased demands for service, to improve capitol facilities, and to support HIT development.

Lynn Price stated that we have not talked about the issue of specialty services very much, because our emphasis is on primary care, but we also need to make a statement about the need for specialty services. She stated that in New Haven it is very difficult to find a vascular surgeon that will take Title 19, for instance, or other kinds of specialty. She said we could not leave them out of the loop if we are going to have good care for patients.

Margaret Flinter responded that we would add to the outline, the need for primary care to have access to specialty services and recommendations to make that happen.

Dr. Robert McLean referred to the "Legislative Recommendations" about converting SAGA and Charter Oak to Medicaid, which are great ideas, but Medicaid still pays poorly. Therefore, you are not going to get a specialist to accept Medicaid. It cannot be emphasized enough that if we are going to switch people over to Medicaid and they are going to have access, Medicaid funding needs to be significantly higher. I would go so far as to say that it's got to be the equivalent of Medicare. People are scared to death of Medicare too, and often times they say Medicare is not high enough, but unless you hit Medicare, you are not going to get doctors in the state to accept Medicaid.

Margaret Flinter noted that this was one of the final recommendations of HealthFirst, Certainly in terms of payment reform; we can put that both in terms of engaging private providers in primary care but also private providers in specialty. Margaret added that she will send out the HealthFirst report (again) to everyone, because it is worth repeating some of those recommendations in our report. Even with Sustinet coming, there is a lot we can do to get started now, and a lot that has to be done now for that to be effective and to make a difference in 2014 and 2015 when it is implemented. One of these areas is payment reform. Raising the Medicaid level is one of those things where you might as well start the debate now, get the figures, debate it in the legislature, find out from OMB what it will really cost—and how much we might save in preventable admissions, admissions to hospitals, delayed diagnosis, etc.

Dr. Robert McLean commented that the legislators passed an increase in Medicaid, but do we have data showing whether it affected the number of Medicaid providers?

Jody Rowell said that she sits on the Medicaid Managed Care Council, and there is data showing that. In addition, it could be highlighted that they did do something with the rates after 20 years of not moving the rates at all and then there was a big excitement, but that is after years and years.

Dr. Robert McLean said we need to point to places like North Carolina where changes have been made in the Medicaid fee structure that have actually increased with measurable results.

Jody Rowell added that there was an increase, and DSS made the decision about where the increases were going. A huge increase went to the hospitals, and then there was a trickle down to dentistry, outpatient clinics for behavioral health. The data is out there.

Margaret Flinter commented that the Sustinet bill calls for Medicaid, SAGA, all of those things to be combined, and for it to be to move towards commercial rates, which are higher than Medicare rates. She added that she thought you would never get that kind of one-step giant increase so everything we can do now to start moving there and planning to recover that 50% match, getting ready for the submissions to the federal government is critical.

JoAnn Eaccarino asked, under that primary care capacity, what are we going to say about the programs to prepare the primary care providers?

Margaret Flinter suggested that after we finish the outline, we go back to the last chunk of the agenda, which was initiatives that can be advanced around strategies and recommendations, including workforce, HIT, medical home, waivers, automatic enrollment, and into Medicaid and safety net expansion. It sounds like maybe we are ready to do that. We have still not really said “here is what we would like in terms of either loan forgiveness, scholarship or some other incentive for people to choose primary care, study for primary care, train for primary care, and stay in primary care, in Connecticut”. We have not advanced a strong enough set of specific recommendations.

JoAnn Eaccarino commented that to do that, we need to have the educators.

The Authority discussed specific strategies. We might want to develop a strong loan repayment program, but then advance legislation that says first people who want loan forgiveness would need to apply to the National Health Service corps. If not accepted by the National Health Service corps, the state of Connecticut would then step up for the primary care areas with equal to National Health Service corps reimbursement. We might want to model it on the federal program, which includes dentistry, medicine, nursing, physician assistants, nurse midwives, and behavioral health providers.

Dr. Robert McLean asked if eligibility would require being in an underserved area?

Margaret Flinter said that generally, these providers work in safety net settings, in underserved areas; but you are not required to work in a safety net setting like an FQHC. Certainly, we might want to recommend that providers accepting help with loans be required to accept a capacity of publicly insured patients.

Jody Rowell said it is very difficult for non-profits like her organization, with 98% percent of patients are on Medicaid. It is very hard for them to get loan forgiveness, and even to do the applications. If the state could help, groups like that that would be helpful. Therefore, a recommendation might be for DPH to assign somebody to this.

The Authority discussed the NHSC, a Connecticut-specific NHSC type program, and how to keep primary care providers in Ct. Dr. Robert McLean cautioned that data does not necessarily support a lot of what we are recommending. If you look at other situation where people graduate without loans, like the uniformed services situation in the military, they go into various subspecialties that are higher paying at the same frequency as everyone else. So while that loan forgiveness issue may be a short term one, it's long term lifestyle and income that are driving much more decision making. At least data would suggest that.

Jody Rowell commented that there are national data and Connecticut data that shows that behavioral health and dentistry is suffering almost to the same degree that primary care is, particularly those in the Medicaid population, the more vulnerable populations because they're getting paid less. It is much easier to go work for the state and get paid twice as much.

Dr. McLean returned to performance measurement and noted that he has reviewed the policy statements put out by the ACP on how to go about doing performance measurement correctly. It doesn't say endorse national health quality or NQH, etc. It says, whatever you do, these are the guidelines you need to pick. He will put that those policies in something that we can put together in a recommendation.

Margaret Flinter asked Evelyn to comment on the FQHCs and data. Given that, the health centers are such a huge part of primary care in the state, and we generate these uniform data sets, which actually are good. They speak to capacity, utilization, health disparities, but also clinical outcomes. Can we look at these for the state? We might want to include that in the final report as a measure and it might serve as an interim marker for reporting that people could consider.

Dr. Sandra Carbonari asked if there were any pediatric markers in that. Evelyn stated immunizations and birth outcomes. She also said mental health and dental are included and some of those measures are specific to children.

Margaret Flinter said that Voices for Children annual report also has important data for children. She asked Dr. McLean if his best recommendation would be that we fully adopt and endorse ACP's measure.

Dr Robert McLean referenced the patient centered medical home, the Vermont pilot, and the broad definition endorsed by a number of medical organizations.

Lynn Price commented that there are disagreements about who can lead a medical home. Dr. McLean agreed that these definitions currently say physicians, but there has been some broadening in pilot projects to include APRNs. Lynn stated that she would like to see us endorse that.

Dr. Todd Staub addressed the medical home issue and referenced the NCQA requirements. This is formidable in terms of E.M.R., hours, access. He stressed how tough it will be for practices to meet the standards.

Dr. Robert McLean said he thinks it has to be centralized and hopefully Sustinet will potentially be a state organizing structure to help do that and bring groups together to share resources and share some of those ancillary providers that you have to have to qualify.

Dr. Todd Staub noted that again, it might be another role for those regional extension centers where it is not just the HR, its medical home, it is using data in a meaningful way, its housing data, developing reports that are meaningful, report cards, etc.

Margaret Flinter said that in terms of our final report, that was a good concrete suggestion, to really push for the regional extension center and have that also serve as a body to help groups come up to the standards. She added that the Joint Commission is also developing a certification program that is going to be kind of a sister program to the NCQA and is more focused on the healthcare home, in response to a lot of pressure from the federally qualified health centers and the big practices. Therefore, there may be more than one group that is certifying. The fundamentals are what we all agree are important, the access, the communication, the coordination across levels of care.

Dr. Robert McLean: Another organization or group that is now politically being discussed are “accountable care” organizations. To make sure we are current and accurate it would probably make sense to make reference to that concept which looks at taking these larger groups where they are collecting and storing data and then making them accountable for endorsing or enforcing standards of practice. Whether these regional extension centers could at least, in our state, somehow incorporate some of the accountable care organization concepts and put those under one roof which would really help push forward a lot of all this.

Dr. Sandra Carbonari : Looking at PCCM, some of the requirements for that are the access and a certain number of hours, so some of those requirements mirror or reflect the medical home standards for whichever organization that is going to be the one that is going to be certifying them. The other point is that there is a medical home initiative and pediatric medical home initiative for children with special health care needs in Connecticut, which is regionalized. We already have sort of an infrastructure and a basis that we might want to look at. There are five regions in the state and each region has a core group. There are specific medical home practices. Each practice has an embedded RN care coordinator. For all the other patients in the region, which is a huge region, it goes from Danbury all the way to the Massachusetts border all the way to the New York border. There is a care coordinator that helps coordinate care for patients that are not in practices that are specific medical homes. It is not perfect, but it is working, so we may want to look at that. Our practice is one of the medical home practices, and we are also PCCM. The patient satisfaction is through the roof.

Margaret Flinter: We may want Barbara Ormond to look at that. Also, we need to push to get those waivers to convert SAGA and Charter Oak to Medicaid and to increase the Medicaid payment to the Medicare payment, is there any disagreement around the table that needs to happen and that should be a push in any recommendations to the legislature? She asked if there was any disagreement on these issues; there does not appear to be.

Dr. Robert McLean: It might be worth seeing if there is a survey of other states and what percentage of Medicare that Medicaid pays, and if there is any correlation or if they can show what percentage of primary care providers are actually in Medicaid. Margaret agreed, and added we should also include automatic enrollment into Medicaid as a strategy to support primary care, lower uninsured, and get people into medical homes.

Margaret Flinter referred back to the outline, and addressed the safety net expansion. She said we really need a status report on the state of expansion of the safety net providers in Connecticut. She asked Evelyn if she would work with Barbara on getting that information together.

The next meeting is scheduled for October 28, 2009.

The meeting adjourned at 9:00 am.