PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, November 19, 2008

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; Stanley Block, MD; David Bourassa, MD; Mark Braun, MD; Mathew Burke, MD; Patricia Flanagan; MD; Elizabeth Lange, MD; Meg Lekander, MD; Lauren Meisel, MD; Patrick Sweeney, MD, PhD, MPH; Newell Warde, PhD. *Associates/Guests:* Andrea Arena, MD. HEALTH: Carrie Bridges, MPH; Helen Drew; Carla Lundquist; Arianne Lynch; Pam McCue, RN; Mia Patriarca O'Flaherty; Peter Simon, MD, MPH.

Members& Alternatives Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Francis Basile, Jr., MD; Jeffrey Borkan, MD, PhD; Denise Coppa, PhD, RNP; N.S. Damle, MD; Steven DeToy; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Sarah Fessler, MD; Michael Fine, MD; David Gifford, MD, MPH; Arnold Goldberg, MD; Ellen Gurney, MD; Christopher Jones, MD; Cynthia Holzer, MD; Raymond Maxim, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Kristin Sousa; Richard Wagner, MD.

Open Meeting/Old Business - Dr. Bledsoe called the meeting to order at 7:36 AM, welcomed all attendees, and asked the members to review minutes of the September 17, 2008 meeting. He pointed out the remarks made by Dr. Gifford during that meeting regarding the potential for primary care to provide leadership to the transformative changes the health care system needs, and noted that the November 13, 2008 issue of the New England Journal of Medicine featured seven articles on the Future of Primary Care. The minutes were approved as written (motion by Dr. Block, second by Dr. Braun, all in favor). Dr. Bledsoe emphasized that the seven Priorities for Change in Primary Care identified at the September meeting will be the lens through which PCPAC will view all topics this year.

Department of Health Legislative Priorities for 2009 - Helen Drew, Associate Director of Policy, and Pam McCue, RN, Director of the Board of Nursing, presented a list of potential legislative priorities for the Department of Health (HEALTH), and asked the Committee members present to select those of greatest interest and concern to them for discussion and feedback. The nine potential legislation topics were:

- Self-pay and Charity Care charge limit to 115% of Medicare rate
- E-Prescribing 2012 date for compliance
- Tobacco - Cigar bars clarify obligations or eliminate
- Ban Two-for-One tobacco promotions
- Health assessment to enter 9th grade
- Post Calories/Nutrition on Menu
- Expand Adult Immunization program
- Tax soda, sweetened beverages and alcohol
- HIV/AIDS

<u>Self-pay and Charity Care charge limit to 115% of Medicare rate</u> – This proposal is based on a system in place in Minnesota, and would create a ceiling on charges to self-pay (uninsured) patients of 115% of Medicare rates. It would provide consistency across different sites of the charges for services to self-pay patients, and transparency to consumers who pay out of pocket for health care. There is a movement to make more price information available and this would be a start. Self-pay patients, who have no bargaining power, have historically been subject to much higher charges than insured patients, particularly at hospitals. Section 11.3 of the *Rules and Regulations Pertaining to Hospital Conversions* (R23-17.14-HCA, as amended January 2007) provides Statewide Standards for the Provision of Charity Care. Full Charity Care (100% discount) must be provided for patients under 200% of the Federal Poverty Level (FPL), and Partial Charity Care (sliding scale discount) must be provided for patients from 200% - 300% of FPL. Hospitals may apply assets criterion to determine eligibility. Currently there is no standard discount schedule or limit on charges to patients above 200% FPL. This proposal would cap charges to self-pay patients at any income level at 115% of Medicare rates and would apply to all providers, including primary care practices. Highlights of PCPAC member comments and concerns:

- This proposal would be very difficult, if not impossible, to enforce for private practices. If no encounter report were provided to an insurer, how would the state know what an uninsured patient was charged; this would be a private agreement between the patient and provider. Adding this kind of state mandate on charges for services in private practices would create another barrier to recruiting and retaining primary care physicians in RI. In addition, means testing would increase administrative burdens.
- More data is needed to evaluate the need for this proposal as it relates to primary care, including the rates charged to uninsured patients, and the % of uninsureds cared for by hospital-based physicians and community health centers vs. private physicians.
- Dr. Braun noted that he routinely charges less to uninsured patients, and that he would not consider as "charitable" charging a patient more than the federal government is charged for Medicare services.
- 115% of Medicare rates may be higher than some practices have negotiated in their contracts with insurers. Providers who do not perform their own billing may not know the Medicare rates.
- HEALTH must consider how this will impact charges to affluent uninsured patients, and how to apply it to "boutique" practices.
- Dr. Block emphasized that this has been an enormous problem for uninsured patients at hospitals. Dr. Flanagan added that it is a problem with freestanding endoscopy centers, etc., as well.

Ms. McCue remarked that possibly the proposal should apply only to licensed health care facilities, and agreed they should collect more data. Dr. Bourassa noted that would affect community health centers and hospital outpatient ambulatory care clinics, which are licensed and have existing sliding fee schedules. Dr. Bledsoe pointed out that this proposal could adversely impact progress toward two PCPAC priorities: reforming primary care payment methodology and workforce development, recruitment, and retention.

<u>E-Prescribing 2012 date for compliance</u> - Dr. Bledsoe noted that E-prescribing would aid in promoting the PCPAC priorities of integrated, care-coordinated, interdisciplinary primary care and workforce development, recruitment, and retention. Ms. Drew explained that by 2012 Medicare would have incentives in place for E-prescribing. The proposed legislation would require physicians to have access to hardware for E-prescribing at the places where prescribers are located. It would not mandate usage of E-prescribing, but would mandate that it be available for use. She noted that 98% of pharmacies in RI support E-prescribing, but greater prescriber participation is being sought and it is hoped that a mandate to have the hardware will spark more usage. Dr. Bledsoe noted that a computer and Internet connection are the only

hardware necessary to use SureScripts (practices also need to implement one of a number of approved prescribing software packages). He felt legislating for E-prescribing hardware to be available will not advance actual usage, and suggested instead pursuing incentives for usage. Other PCPAC comments/suggestions on E-prescribing:

- The barriers to adoption of E-prescribing are from outside rather than within practices, particularly the federal prohibition against E-prescribing for controlled substances, and authorization to send three-month prescriptions electronically. HEALTH and OHIC should explore collaborating with the other New England states, health insurers, large Pharmacy Benefit Management companies, and physician organizations to reduce barriers and make E-prescribing more attractive to those not currently using it. Dr. Bourassa noted that Senator Whitehouse is currently working to lift federal prohibitions on E-prescribing controlled substances.

- Dr. Flanagan asserted that the case for E-prescribing is one of a patient safety rather than physician convenience issue. Dr. Bledsoe acknowledged if E-prescribing were deemed "medically necessary", insurers, purchasers, and employers would be required to support it. Medicare cost would cover it and maybe it would be more palatable for primary care physicians if legislated to be a supported feature rather than mandated. Dr. Braun added that the federal government is going to pay 1% more to use E-prescribing and since it is cheap to implement and use, it will cover more than cost.

- Dr. Block remarked that E-prescribing should stand on its own merits and not be mandated; if it is really valuable, it will be adopted. He suggested that HEALTH conduct a survey of practices to determine who is using E-prescribing, why or why not, and the perceived barriers. Problems with usage of E-prescribing that have been discussed include patients not getting prescriptions when expected, and E-prescribing causing computer errors. Once the barriers are known and addressed, usage will increase. Dr. Block stated that it should only be mandated if data shows that fewer errors occur using E-prescribing.

- Dr. Bledsoe mentioned that insurers should support Health Information Exchange, which is the place where patients can agree to share labs and pharmacy records, so that other providers' prescriptions can be seen. Ms. McCue reminded the committee that legislation is an incentive to get connected, have access, and get internet.

- Dr. Braun recommended that the state mandate that insurers' formularies be available to providers.

Health assessment to enter 9th grade – In addition to the existing requirements for students to have health care provider visits in order to enter kindergarten and 7th grade, HEALTH is considering mandating a health assessment for students entering 9th grader. Requiring a 9th grade health assessment will assure that 14-year-olds are up-to-date on immunizations and will have had a recent conversation with a health care provider for guidance. The mandate is proposed for 9th grade in order to capture the population as they approach adulthood but before they can drop out of school at age 16. Dr. Flanagan noted that as much as she is in favor of assuring primary care visits for adolescents, mandates that add another barrier to keeping students in school present a problem. Even now she often sees 7th graders who have been out of class into October/early November because they did not have proof of a health care visit. Dr. Lange agreed and noted that there needs to be some leniency on the part of school nurses so students can remain in class; adolescents should be able to attend school if they can show that a medical appointment is at least scheduled. From a medical point of view, PCPAC members fully supported a requirement for 9th grade physicals. Dr. Bourassa acknowledged that for many adolescent patients, mandated visits are the only way to get them to come in for preventive care. Dr. Sweeney asked if contraceptive counseling should be mandated; Dr. Braun remarked that mandated contraceptive counseling would never be passed.

Vaccines - Ms. Drew requested PCPAC's assistance in defending further attacks on vaccines with thimerosal. Support of the physician community has been key to maintaining use of these important vaccines in past years, but the issue is likely to surface again because the past sponsors are still in the legislature. It is important to note that nearly all pediatric vaccines are thimerosal-free.

Other Business/Announcements - Dr. Bledsoe reminded those present that all committee members represent an organization or constituency. The Department of Health's priorities should be coordinated with primary care community priorities. It is important to know what the priorities are from constituency standpoints, and how each representative effectively communicates information from PCPAC meetings with their organization. Some of the issues of alarm expressed:

- Dr. Bourassa - The Medicaid Global Waiver and how it will impact payment for RIte Care. Dr. Lange responded that RIAAP is working on it, but it is out of their hands at this point. Ms. Drew added that it is important for the community that advocacy surrounding the Global Waiver continues, but Department of Health does not have a role in the discussion of Medicaid Waiver. Advocacy efforts should be directed towards the Governor's office.
- Dr. Sweeney - The issue with BCBSRI, and what patients will have to pay in addition if approved, is of great concern.
- Dr. Bledsoe - Loan repayment/loan forgiveness for primary care is a priority for ACP in RI. Ms. Lundquist noted that a statute for the RI Health Professional Loan Repayment Program exists, but the program is currently unfunded. The next opportunity to apply for federal funds to support State Loan Repayment will be in 2010, and will require state or other matching funds. The RI AHEC Network will be convening key stakeholders next month to begin developing a new loan repayment program for RI.
- Dr. Block – Community Health Centers are apprehensive about the growing uninsured population due to reductions in Medicaid and increases in unemployment. Health Centers cannot serve the totality of uninsured and underinsured persons in the state.

Dr. Warde informed the committee that a RIMS legislative priorities meeting will be held on Tuesday, December 9th, 6:00 PM at Miriam Hospital, open to all RIMS members. It would be of great value to have the perspectives of the primary care academies as well as other medical specialties to discuss priorities. RIMS also will hold a meeting on vaccine safety on December 4th.

Dr. Bledsoe thanked the committee and guests for coming and mentioned that the RI Strategic Partnership Session will be discussed at the December 17th, 2008 meeting, in Conference Room B at the Department of Administration. Starting in January, the Committee will meet in the Health Policy Forum (lower level) at the Department of Health.