PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, February 25, 2009

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; David Ashley, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; Mark Braun, MD; Denise Coppa, PhD, RNP; Steven DeToy; Patricia Flanagan, MD; David Gifford, MD, MPH; Elizabeth Lange, MD. *Guests*: Gary Alexander; Aleatha Dickerson; Ann Martino; Yvette Mendez; Deborah Perry; Julie Rawlings. *HEALTH*: Valentina Adamova; Carla Lundquist; Jessica Magnoli; Catherine Morin; Mia Patriarca O'Flaherty, MA; Peter Simon, MD, MPH.

Member/Alternates Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Francis Basile, Jr., MD; David Bourassa, MD; Matthew Burke, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Michael Fine, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Christopher Jones, MD; Cynthia Holzer, MD; Meg Lekander, MD; Raymond Maxim, MD; Lauren Meisel, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD.

Open Meeting/Old Business – PCPAC Chair Dr. Bledsoe called the meeting to order at 7:36 AM, and asked the Committee members present to review the minutes of the January 28, 2009 meeting. There were no comments and the minutes were approved as written (motion by Dr. Borkan, second by Dr. Lange, all in favor). Dr. Bledsoe noted that the final PCPAC advisory letters regarding recommended changes to the Certificate of Need application form and the expansion of the Adult Immunization Program have been delivered to Dr. Gifford and are included in the meeting packet.

RI Global Medicaid Waiver – Dr. Bledsoe welcomed Ann Martino, Director of Policy at the RI Executive Office of Health & Human Services (EOHHS), and noted that many members of the primary care community are both nervous and excited about the upcoming changes to Medicaid in RI. Pending the arrival of Gary Alexander, Director, RI Department of Human Services and Acting Secretary, EOHHS, Ms. Martino provided some context for the Global Waiver negotiations with CMS, noting that that there had been misperceptions regarding the discussions, which were not to develop a complete plan to fundamentally change the system, but were to negotiate a framework for the possibility of change. The negotiations were technical in character and did not address the larger policy issues that are of concern to the health care community. The nature of the system under the waiver is something all interested parties will have a stake in. Ms. Martino asked to address the questions posed on the agenda individually before general discussion.

1. *How will the Global Waiver affect access to comprehensive, integrated health care services?* The Global Waiver gives the state greater flexibility to ensure better access to care. Currently the Medicaid populations are siloed by specific criteria, creating issues for transition from one class of services to another. For example, transition of a beneficiary from child to adult services may be difficult because the criteria for each population are so different. The Global Waiver will allow development of criteria for continuity of services across the life span, and will allow service provision in a wider variety of settings that Medicaid previously could not cover. Medicaid currently has an institutional bias, particularly for long-term care. Some services are covered only if delivered in an institutional setting, not in a residential setting. The Global Waiver will permit Medicaid coverage of services in all delivery settings.

For acute care, there will not be many differences in the nature of services. There are no plans to make any fundamental changes in the nature of RIte Care – the recent generics-only medication policy is not related to the Global Waiver. That policy was recommended by the three Medicaid health plans as a cost-saving measure that would prevent eligibility rollback for adults to income below 133% FPL. Medicaid did not yet have the flexibility to make other changes when the generics-only policy went through.

The Global Waiver will allow the state to establish a system of care that is more integrated and focused on primary care. There are three component goals of the Global Waiver, the second of which is focused on primary care: Re-balancing the Long Term Care (LTC) system, Care Management (all Medicaid beneficiaries to have a medical home), and Smart Purchasing (assuring that all third party payers are paying their fair share).

2. *How can we improve the process to allow transparency, collaboration, and open deliberation by stakeholders – such as the medical community?* The state will solicit stakeholder input for implementation of the Global Waiver. Legislation is pending for a 45-person oversight task force, and in preparation Medicaid is asking anyone interested in serving on such a body to email Ann Martino or Gary Alexander. The oversight task force will serve as an umbrella body, under which other groups such as PCPAC could serve as subgroups dealing with specific components of the waiver. Within the task force, Medicaid needs to increase the number of people who can address issues of the public, and to establish mechanisms for information collection and dissemination with stakeholders and the community.

3. *RIte Care has been a resounding success by many metrics. How will the Global Waiver affect Rite Care?* The state does not foresee any changes to RIte Care. The initial focus will be on LTC to improve the quality and scope of services available in various delivery settings, and reduce over-reliance on high cost service venues such as nursing homes and facilities for children in state custody or persons with developmental disabilities.

4. *How will the Global Waiver affect nursing home residents?* There will be no impact in the short term on those already in nursing homes. New criteria for level of care determination were developed with community input, but current

nursing home residents cannot be subjected to a re-assessment under the new criteria. Medicaid has begun to establish a system to allow patients to move back home and get necessary services in the community. New patients being assessed will have a wider array of service delivery sites from which to choose, including assisted living. Prior to the Global Waiver, the state had three waivers that provided only 300 assisted living slots; Medicaid will no longer be subject to a fixed number of slots, so more patients who would otherwise be in nursing homes could choose assisted living.

5. *How will the Global Waiver affect medication use?* The Global Waiver is not anticipated to have any impact on medication use. As noted, the recent generics-only policy was a result of budget cuts, to prevent eligibility cutbacks. Any further modifications would be the result of federal changes, and Medicaid is not in a position to state that no changes will happen in the future. Mr. Alexander noted that some items are reflective of the current budget climate and what the state can afford, and are not necessarily Global Waiver issues. Ms. Martino remarked that one of the unique features of the Global Waiver is that it would provide a wide range of services, including in-home medication management services to people living in the community, for which Medicaid previously was unable to receive reimbursement.

Discussion - Dr. Lange, while appreciating that the state is now positioned for change, asked about recent developments; within two weeks of the Global Waiver acceptance SCHIP funds were authorized. There is concern that the Global Waiver will preclude access to the SCHIP funds, or that the SCHIP monies will be applied against the Global Waiver causing the state to run out of money sooner. Ms. Martino declared that SCHIP enhanced match is outside the Global Waiver cap. There is not a lot of certainty at the federal level about how components of the stimulus and SCHIP reauthorization will apply, and there are different interpretations about what the state can do, but those opportunities will not be denied on the basis of the Global Waiver.

Dr. Borkan expressed concern related to the transparency of the implementation. It is documented that access to primary care improves health and saves money. How will the waiver affect the supply of primary care physicians (PCPs) in the state, supporting them so they can take care of the community, in terms of numbers and potential restrictions on where patients can be seen? Mr. Alexander replied that all stakeholders realize that PCPs are not reimbursed as well as they should be. The Global Waiver will not limit where a patient can go for primary care or whom they may choose for their primary care provider; limitations that may have been discussed relate to certain non-emergency surgical procedures. Ms. Martino pointed out that RIte Care patients have a choice between three health plans. The biggest problem with RIte Care is Emergency Room (ER) overuse; not enough physician offices are open extended hours. Medicaid may have more flexibility under the waiver to create incentives for practices to stay open evenings and weekends.

Understanding that is not part of the Global Waiver, Dr. Block commented further on the issue of generic-only medications. This policy is influencing how primary care providers practice, especially in the inner city. Providers very much want this policy to work and keep people on RIte Care versus reducing eligibility, and there have been suggestions from PCPAC to make it more workable. Right now the system is difficult for both patients and doctors, and has potential to increase ER usage if not corrected. If a physician cannot be assured that a patient will be able to get a prescribed medication, or if pre-authorization is required but cannot be accessed in evening/weekend hours, the physician may have to send the patient to the ER to get the necessary care. Mr. Alexander replied that Medicaid would have preferred to grandfather in current medications, and/or have had a preferred drug list to leave the decision-making in doctor's hands, but it was not possible. The problem is that each health plan has its own system and that makes it very hard for doctors to prevail, especially after hours. He agreed that PCPAC would be a good resource to address issues with the policy implementation, along with some specialty physicians. Ms. Martino remarked that generics-only program has encountered more stumbling blocks than anticipated given the level of savings.

Dr. Coppa brought up several points about LTC rebalancing; as an overarching policy moving people to less restrictive settings will result in the sickest, most frail, costliest patients remaining in Nursing Homes (NHs). NHs will have less reimbursement dollars with which to hire staff to care for the most needs-intensive patients. Some NHs are experienced in transitions from subacute to acute care, but it takes a finely tuned machine to do so. Dr. Coppa listed four concerns:

1. Lack of infrastructure in RI – the state does not have sufficient home care workers to provide the projected in-home care, and they are not organized. There is little communication between NHs and home care agencies, and this continuity gap would be problematic under the proposed rebalancing.

2. Availability of home settings with supportive family/friend caregivers – in order to move patient to home/community settings, sufficient support must be available to ensure patient health and safety. Friends or family members would have to be able to rearrange their lives to care for the patients, as hiring 24-hour care is hugely expensive. Is there evidence to indicate that a sufficient level of support will be available for the expected number of patients that would remain home/in the community?

3. Assisted Living (AL) costs - AL is not as intensive as NH care, but still is extremely expensive. Unless the state puts limits on AL usage, it is hard to see how cost savings will be achieved over the NH setting that has a system of healthcare providers set up to care for patients more adequately and safely than they would be at home.

4. Care models to reduce ER visits for NH residents – the state needs to embrace innovative care models in order to reduce costly ER visits (including transport to the ER) for NH residents.

Mr. Alexander acknowledged that these issues must be addressed, but emphasize that not taking action now would further imperil the system. RI spending on LTC is 90% NH and 10% AL, compared to the national average of 60% NH/40% AL. RI also is far behind the national rates for home care. Medicaid realizes that the sickest patients would be left in the NHs, and is working on an activity-based rate adjustment. The vast majority of seniors would prefer to remain in their homes, and RI has not done enough to make that option viable. Medicaid is aware that RI needs to develop home care capacity in order to achieve LTC cost savings, or the state will continue to turn to RIte Care as the easiest place to cut the budget. Medicaid is being forced to be cost-conscious, but moreover creating more options for LTC is the right thing to do for RI seniors. If steps to build options for home/community settings are not taken now, the state could reach a 98% NH rate. Medicaid will provide a 10% rate increase to home-care providers; admittedly not much but better than nothing. It is true that there are only a small number of people that could leave a NH and return home, but it is important that patients in skilled nursing facilities who want to go home should be allowed to, and that is dependant upon the ability to get follow-up services in the home. By state law, LTC transition and diversion must happen, with or without the Global Waiver. The Global Waiver gives Medicaid the power and flexibility to accomplish the necessary changes.

Dr. Coppa noted that in terms of oversight of a LTC systems shift, the current structure is fragmented with no mechanism for bringing together interdisciplinary groups for decision-making. Ms. Martino responded that in addition to NHs, other high-cost venues could benefit from interdisciplinary care models. Medicaid is looking at selective contracting; there is great cost variability between AL facilities although Medicaid pays a single rate. Currently a patient must meet the NH level of care to be eligible for AL placement, which is inappropriate. The Global Waiver will allow Medicaid to pay for the appropriate level of services patients need regardless of where the services are delivered. Medicaid is working on alternative models as well, including expansion to elder populations of the 'shared living/adult foster care' models that are often used for persons with developmental disabilities. Current review of the RI NH population, under both the old and new levels of care, shows that most patients require a NH level of care. The questions of interest are how long has the patient been in the NH, and what level of acuity the patient was at upon entering the NH. Patients in NHs over five years show the highest levels of acuity, while rates of transition back to less restrictive settings are best for patients who have been in NHs less than five months. Efforts need to be focused on whether patients resident in NHs from six months to five years could return to less restrictive settings, and what options would be appropriate for them.

Dr. Bledsoe asked what the state is gaining or losing under the Global Waiver. Ms. Martino explained that the major limitation is the spending cap of $12.1 billion of combined state and federal funds over the five-year project period. In exchange for operating under this cap, the state gains considerable flexibility to structure the program to provide appropriate services and levels of care. Before the Global Waiver, NH-eligible patients could not access alternate living arrangements unless they fell into one of nine discrete waiver populations, and the number of slots for these were capped. In addition, the Global Waiver will allow Medicaid to offer specific services (such as podiatric services) targeted to the populations who need them, instead of having to offer the services to all beneficiaries or none.

Dr. Lange pointed out that historically RIte Care funding has been raided to cover other costs; how can we be sure this will not continue? Mr. Alexander conceded that in the current budget climate there are no absolutes or guarantees, but reiterated that Medicaid is doing all it can to be cost-effective across the system and preserve RIte Care eligibility and services. LTC is more expensive and has not yet been as aggressively reformed as acute care has under RIte Care, pitting the various populations against each other in competition for funds. Under the Global Waiver, Medicaid will be able to bring the separate advisory committees for each population together at one table. Ms. Martino emphasized that the Global Waiver makes it much more difficult to change RIte Care eligibility than previously; if changes were to happen they would more likely be in the benefits package.

Dr. Braun asked the presenters to address reimbursement and provision of basic dental services. He stated that it is essentially impossible to get Medicaid patients in to see specialists or dentists; the process is rife with barriers and negative feedback loops. Mr. Alexander acknowledged the particular difficulty of accessing dental care, but noted that currently Medicaid is focused on avoiding program cuts. There may be a possibility of increases in reimbursement rates in the future, or incentives to increase access in areas where there are service gaps.

Mr. Alexander noted there will be very few beneficiaries remaining on fee-for-service Medicaid; most will be within a health plan or primary care case management (PCCM). Medicaid will use selective contracting for PCCM to ensure that the level of payment is appropriate per the scope of services provided. Dr. Braun raised the question of finding or

fostering medical homes for Medicaid enrollees - how is the state handling this? Ms. Martino explained that Medicaid offers three health plans in addition to PCCM and current uptake is about 85%, although fewer beneficiaries choose PCCM. The remaining 15% is non-compliant, the population most likely to access care in the ER and most in need of PCCM. Most Medicaid enrollees are open to having a medical home; eventually it will become mandatory. Mr. Alexander and Ms. Martino expressed interest in further conversations with PCPAC, and urged any persons interested in participating on the Implementation Task Force to submit their name to Mr. Alexander via email. Dr. Bledsoe thanked the guests for their presentation.

Other Business/Announcements –

- Dr. Gus Manocchia, Chief Medical Officer for Blue Cross Blue Shield RI, will present ideas BCBSRI has for primary care at the next PCPAC meeting on Wednesday, March 25, 2009, 7:30 – 8:45 AM, Health Policy Forum (Lower Level), Department of Health, Three Capitol Hill, Providence.
- Also at the March meeting, Neil Steinberg and Owen Heleen from the Rhode Island Foundation will discuss the *Fund for a Healthy Rhode Island*, which will direct resources toward building a model primary care system through a grant program for primary care innovations and a primary care provider loan repayment program. The RI Foundation is seeking community input on the loan repayment program design; PCPAC should develop recommendations to offer.
- Hospital Mergers: Dr. Gifford reported that HEALTH has received the St. Joseph Health Services/Roger Williams Medical Center hospital merger application and is reviewing the package (37K pages) for completeness. Dr. Gifford recapped the review/acceptance timeline and estimated that HEALTH would be seeking PCPAC input on the proposal around May 2009.

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