

HEALTH ACCESS STUDY GROUP

October 21, 2008

9:00-1:00

NC IOM

Meeting Summary

ATTENDEES:

Task Force/Steering Committee: Allen Dobson, Graham Barden III, Deborah Brown, Abby Carter Emanuelson, Kimberly Endicott, Bob England, Allen Feezor, Angela Floyd, John Frank, Verla Insko, Eric Ireland, Sharon Jones, Eleanor Kinnaird, Tara Larson, Ken Lewis, David Moore, Barbara Morales Burke, John Perry, Robert Seligson, A.B. Swindell, Brian Toomey, Tom Vitaglione

Interested Persons: Tom Bacon, David Bruton, Kellan Chapin, Jennie Dorsett, Andrew Dugan, Sharon Elliott-Bynum, Alison Goetsch, Robert Jackson, Adam Linker, Cindy Mann, Kathryn Millican, Tom Ricketts, Carolyn Sexton, Shannon Smith

Staff: Kimberly Alexander-Bratcher, Mark Holmes, Julia Lerche, Jesse Lichstein, Thalia Shirley-Fuller, Pam Silberman, Berkeley Yorkery

WELCOME AND INTRODUCTIONS:

L. Allen Dobson, Jr., MD, FAAFP, President and CEO, Cabarrus Family Medicine, PA

Dr. Dobson welcomed attendees and asked them to introduce themselves.

EXPANDING COVERAGE TO CHILDREN

Cindy Mann, JD, Executive Director, Center for Children and Families, Georgetown University Health Policy Institute

North Carolina's efforts over the past ten years, including adoption of the State Children's Health Insurance Program (SCHIP) and further expansion efforts, have led to millions of children gaining coverage. However, the percentage of children who are uninsured remains in the double-digits and trends indicate that the number is creeping higher. In addition, the recent economic downturn and the drop in employer-sponsored coverage could lead to an even greater increase in the number of uninsured children.

At the national level, Congress has on the agenda discussion of a temporary increase in the Federal Medical Assistance Percentages and the reauthorization of the State Children's Health Insurance Program (SCHIP). The SCHIP reauthorization has a particular urgency as funding of the SCHIP extension ends in March 2009, at which point as many as 42 states will face funding shortfalls.

In light of the uncertain future of SCHIP and the recent economic situation, many states are continuing to move forward with expansion efforts to cover uninsured children. Since 2005, two-thirds of states have adopted significant improvements to their children's coverage

programs, and in 2008 alone, 19 states have authorized or implemented new measures to cover children. Changes include eligibility expansions up to 300% of the Federal Poverty Line (FPL), some coupled with “buy-in” options for families, and improvements to boost enrollment among children already eligible for public programs. To increase enrollment many states are focusing on improving renewals and using technology to simplify enrollment and renewals. Increasing coverage for families is another option for boosting enrollment of children.

In North Carolina, 61% of uninsured children are already eligible for coverage, and with the SCHIP expansion to 250% of FPL, 7 out of 10 children would be eligible. Still, as many as 70% of eligible children are not receiving public coverage. Five key strategies are suggested to boost enrollment: 1) offer multiple ways to apply, such as by telephone, online, or presumptive eligibility, 2) use technology to verify eligibility to cut down on administrative time and costs and to decrease the number of denials due to missing information or paperwork, 3) link families who are receiving other benefits or services, such as school lunch, 4) provide outreach, and 5) have data systems to provide information and to be used for evaluation.

Renewals are a particular risk point for children, as the drop-out rate for children with public coverage has been increasing. This can lead to unnecessary gaps in coverage and administrative costs. Key strategies to stem the drop-out rate are to offer multiple avenues and times to renew, use technology to verify eligibility, and use data for evaluation and accountability.

Discussion:

Discussion focused on the impact of covering children on overall health care costs, the gap between the number of children who are eligible and who are enrolled, and the need for data for evaluation purposes. In addition, North Carolina Medicaid and Health Choice data on reenrollment and recertification were reviewed.

PRIMARY CARE SUPPLY TRENDS

*Thomas Ricketts, III, PhD, MPH, Editor, North Carolina Medical Journal
Deputy Director, Cecil G. Sheps Center for Health Services Research
Professor, Health Policy and Management, Social Medicine, University of North Carolina at Chapel Hill*

At the national level, trends point to a declining supply of physicians compared to the population. This projected decline is greatly due to a large number of physicians reaching retirement age, younger physicians working fewer hours, and continued increase in utilization of services. Compounding the problem is that medical school enrollment has remained relatively flat and residency positions are growing slowly. In addition U.S. medical school graduates are choosing higher paying specialties with controllable life styles while International Medical Graduates (IMGs) are trying to fill the gaps in internal medicine, family medicine, and preventative medicine. The increase in the demand for and utilization of health care services has been stimulated by general population growth, growth in the 65 and older age bracket which has more chronic diseases and uses more services, higher expectations of baby boomers, increasing rates of obesity and diabetes representative of lifestyle changes, past economic growth, and technological advances. It is projected that by 2025 there will be a shortage of full time physicians, even with the expansion for graduate medical education (GME), also called

residency, and the increase in the numbers of Nurse Practitioners (NPs) and Physician Assistants (PAs).

North Carolina has experienced a significant cumulative growth in physicians, NPs, and PAs since 1990, although the number of physicians has only grown by 32%. Even with this growth it is projected that around 2016 the number of physicians and other practitioners will begin to decline. Like the nation, North Carolina has a large cohort of physicians who are reaching retirement age.

North Carolina is also experiencing a problem with the distribution of health care professionals, which can result in difficulty in accessing care. Metropolitan counties have a greater proportion of physicians, primary care physicians, NPs, and PAs per 10,000 population than non-metropolitan counties. There has also been a concentration phenomenon in which practitioners are leaving rural areas and concentrating in other places. It is the rural areas that are now and are projected to continue to have the bulk loss of physicians, general surgeons, psychiatrists, NPs, and PAs.

Discussion:

Discussion focused on financial incentives, tort reform, and other methods for recruitment and retention of physicians in North Carolina. The effect of new types of practice models, such as concierge medicine, on physician supply was also discussed.

RESIDENCY PROGRAMS

Thomas Bacon, DrPH, Associate Dean and Director, Area Health Education Centers Program School of Medicine

There are thirteen primary care residency programs in North Carolina, four of which are academic health centers, five are Area Health Education Centers (AHEC), and three are Family Medicine Rural Track Sites. In 2006, 2,723 residents were in training in North Carolina. Retention of primary care residency graduates varies between around 40% for academic medical centers and around 70% for Rural Family Medicine sites. Graduates that remain in North Carolina tend to settle near where they spent their residency.

The 2007 report of the North Carolina Institute of Medicine (NC IOM) Task Force on Primary Care and Specialty Supply recommended that North Carolina should expand the number of residency positions; appropriate funds for expansion; focus new positions in the high priority areas of primary care, general surgery, and psychiatry; and target new positions to sites designed to maximize retention of graduates in underserved areas. The Task Force also recommended expanding loan repayment, improving marketing strategies, and improving the racial and ethnic diversity of graduates.

The 2008 Graduate Medical Education (GME) Task Force was established to make recommendations building off those of the 2007 NC IOM Task Force on Primary Care and Specialty Supply report. While the GME Task Force is currently determining capacity for expansion of graduate medical education in North Carolina, they plan to recommend expansion

of residency programs in high priority areas. In addition the GME Task Force will likely recommend increased recruitment and increased loan repayment funding and eligibility.

However, funding residency expansion remains a challenge. Medical student debt and lifestyle issues remain dominant factors in a medical graduate's choice of residency. Without increasing reimbursement for primary care and other high priority areas, simply increasing residency positions in these areas may not result in more residents.

Discussion:

Discussion included issues related to Medicare funding of GME, recruitment of minority medical students and residents, access problems resulting from fewer practitioners, and re-entry of inactive physicians, PAs, and NPs.

GENERAL DISCUSSION

Discussion of workforce issues focused on the effect of North Carolina's medical home model on the number of primary care physicians, the economic and supply strains on rural practices, the cost of new residency programs, the capacity to expand programs, and incentives to attract physicians to practice in rural areas.

Discussion concerning covering children focused on reauthorization of SCHIP, improving outreach to help with enrollment and re-enrollment, simplification of the eligibility and retention processes, and the NC Kids Care expansion.

IDEAS FOR RECOMMENDATIONS

Workforce

- Need to explore different strategies to encourage providers to practice in rural areas.
 - Explore higher Medicaid reimbursement or higher per member, per month payments in rural areas
 - Higher reimbursement for primary care
 - Pay for performance for workforce development, potentially focused in underserved areas and specialties
 - Recruitment and loan forgiveness
 - Create more rural and community residencies
- Need to develop practice managers
- Increase medical student and residency slots
 - Focus on underserved specialties and underserved areas

Covering Children (under assumption that SCHIP reauthorized or extended)

- Pilot electronic verification
- Need to advocate with the Centers for Medicare and Medicaid Services to increase SCHIP federal allotment
- Improve outreach to community organizations to help with enrollment and re-enrollment
- Outreach to small businesses so they know about Medicaid and NC Health Choice
- Use schools to work with parents to get children enrolled and re-enrolled
- Primary care physician incentives to help with enrollment and re-enrollment
- Expand coverage for parents of children

- Allow a window of time for re-application
- Evaluate eligibility and retention process to simplify and reduce administrative costs
 - Expand presumptive eligibility and Ex Parte enrollment
- Kids Care
 - Move forward with coverage up to 250% of FPL