



Expanding Access to Health Care in North Carolina:

A Report of the NCIOM
Health Access Study
Group

2009-2010 Interim Report

North Carolina
Institute of Medicine

A report requested by the
North Carolina General Assembly



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INTRODUCTION

OVERVIEW OF THE UNINSURED IN NORTH CAROLINA

Nearly one-fifth of the non-elderly population in North Carolina, more than 1.5 million people, lacked health insurance coverage in 2006-2007.^a North Carolina has seen a more rapid increase in the percent of uninsured than most of the rest of the country. Between 1999-2000 and 2006-2007, North Carolina experienced a 29% increase in the percentage of uninsured compared to a 12% increase nationally. Most of the reason for the large increase in the uninsured is the larger than average drop in employer sponsored insurance (ESI). During this same time period, North Carolina saw a 12.5% decrease in ESI, almost twice the national average of 6.8%. The decline in ESI is due to both a decrease in the proportion of businesses—especially small employers—that offer coverage, and the decline in the number of employees who can afford coverage for themselves or their families when offered.

Unfortunately, working full time no longer guarantees health insurance coverage. The vast majority of uninsured (77%) live in a family where one or more persons work full-time. Most of the uninsured have low incomes, with family incomes less than 200% of the federal poverty guidelines (FPG) (\$42,400/year for a family of four), or their only connection to the workforce is through a small employer with 25 or fewer employees. Approximately four-fifths (79%) of individuals without coverage fall into one or more of three groups:

- Children in families with incomes below 200% FPG (14% of all non-elderly uninsured or 209,000 people),
- Adults with incomes below 200% FPG (46% of all non-elderly uninsured or 705,000 people), or
- Persons in a family with at least one full-time employee of a small employer (36% of all non-elderly uninsured or 555,000 people).

The chief reason that people lack coverage is cost. In 2006 the average annual total premium cost for individual coverage through an employer in North Carolina was \$4,027.¹ Family coverage cost, on average, was \$10,950. The high premium cost is also the primary reason why some employers fail to offer coverage.² Between 2000 and 2006, the cost to employers increased by more than 50% for individual coverage and by nearly 66% for family coverage in North Carolina.^{1,3} Research has demonstrated that increases in health insurance premiums have been the primary reason for the national decline in employer-sponsored insurance.⁴

Lack of insurance coverage translates into access barriers. In a statewide survey of adults, nearly half of the uninsured in North Carolina reported forgoing necessary care due to cost, compared to 10% of individuals with insurance coverage.⁵ More importantly, the lack of coverage adversely affects health. The uninsured are less likely to get preventive screenings and ongoing care for chronic conditions. Consequently, the uninsured have a greater likelihood than people with coverage of being diagnosed with severe health conditions (such as late stage cancer), being hospitalized for preventable health problems, or dying prematurely. In fact, adults who lack

^a Unless otherwise noted, all data on the uninsured are based on NCIOM analysis of the Current Population Survey's Annual Social and Economic Supplement, published by the U.S. Census Bureau.

insurance coverage are 25% more likely to die prematurely than adults with insurance coverage.⁶ The lack of health insurance also affects the productivity of workers and students. Workers in poor health are more likely to miss work and students in poor health have more difficulty learning in school.⁷

The rising number of uninsured also creates an economic strain on healthcare institutions caring for both insured and uninsured patients. In 2005, the cost of unpaid out-of-pocket costs for care for the uninsured in North Carolina was \$1.3 billion, and by 2010 it is estimated that the cost will reach nearly \$2 billion.⁸ Nearly 60% of the costs of services received by the uninsured are borne by paying patients through increases in the prices they (or their insurance company) pay for services.⁹ The cost of care for the uninsured is eventually borne in part by all North Carolinians through taxes and higher insurance premiums. As a result of compensating for the cost of health care for the uninsured, premiums for private employer sponsored individual coverage in North Carolina cost an additional \$438 (2005) and family premiums cost an additional \$1,130.⁸ This additional premium cost was more pronounced in North Carolina than the nation, which had an average additional premium cost of \$341 for individuals and \$922 for families.⁸

The lack of health insurance coverage is not the only access barrier that North Carolinians face in obtaining needed health services. Practitioner supply is also a problem, one which is likely to worsen over time. Trends indicate a decreasing supply of practitioners compared to the population and need for services. This is compounded by an aging population and an aging health care practitioner workforce. People use more health care services as they age. Further, more practitioners are likely to retire as the workforce ages. As a result, it is probable that North Carolina will experience a practitioner shortage in the next decade, especially in primary care.¹⁰ Rural and currently underserved areas are predicted to have the greatest shortages.¹⁰ If there are insufficient numbers of health care practitioners available, access to health care services is limited, even for those who have health insurance coverage.

HEALTH ACCESS STUDY GROUP

The North Carolina General Assembly directed the North Carolina Institute of Medicine (NCIOM) to continue the work of the 2008-2009 Health Access Study Group "to study issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians." Additionally, the Study Group was asked "to monitor federal health-related legislation to determine how the legislation would impact cost, quality, and access to health care" in North Carolina. (SL-2009-451, §10.78). The study group began meeting in October of 2009 and will continue to meet throughout 2010. The Study Group will report its findings and recommendations to the Joint Legislative Health Care Oversight Committee in January 2011. Sen. Doug Berger, Dr. Allen Dobson, and Rep. Hugh Holliman serve as co-chairs of the study group. The study group has 48 additional members.

The Study Group met four times between October 2009 and March 2010. The agendas and materials for these meetings are included.

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**HEALTH ACCESS STUDY GROUP
MEETING DATES**

October 28, 2009 (materials attached)
January 20, 2010 (materials attached)
February 17, 2010 (materials attached)
March 15, 2010 (materials attached)
April 21, 2010
May 7, 2010

Meetings will resume after the North Carolina General
Assembly finishes meeting for 2010

**North Carolina Institute of Medicine
Health Access Study Group**

Co-Chairs:

L. Allen Dobson Jr., MD, FAAFP
Vice President
Clinical Practice Development
Carolinas HealthCare System

Hugh Holliman
Representative
North Carolina General Assembly

Doug Berger, JD
Senator
North Carolina General Assembly

Study Group Members:

Thomas J. Bacon, DrPH
Executive Associate Dean
University of North Carolina at Chapel Hill
Director
NC Area Health Education Centers Program

J. Steven Cline, DDS, MPH
Deputy State Health Director
N.C. Division of Public Health
NC Department of Health and Human
Services

Graham A Barden III, MD, FAAP
Co-Chair
North Carolina Pediatric Society Pediatric
Council
Coastal Children's Clinic

Bonnie Cramer
Board Chair
American Association of Retired Persons

Jeffrey L. Barnhart
Representative
North Carolina General Assembly

Beverly Miller Earle
Representative
North Carolina General Assembly

Louis Belo
Chief Deputy Commissioner
North Carolina Department of Insurance

Abby Carter Emanuelson, MPA
Director of Public Policy
National Multiple Sclerosis Society
North Carolina Chapters

Colleen Bridger, PhD, MPH
Gaston County Health Director

Kimberly Endicott
Owner
Endicott's Repair

Deborah Brown
Income Maintenance Program Manager
Cumberland County Department of Social
Services

Bob England, MD
Representative
North Carolina General Assembly

David Bruton, MD
Retired Pediatrician

Anthony E. Foriest
Senator
North Carolina General Assembly

Kellan Chapin
Executive Director
Care Share Health Alliance

Linda Garrou
Senator
North Carolina General Assembly

Verla Clemens Insko
Representative
North Carolina General Assembly

Sharon Jones
Independent Owner
Premiere Designs

Eleanor Kinnaid
Senator
North Carolina General Assembly

Tara Larson, MAEd
Chief Clinical Operations Officer
NC Division of Medical Assistance

Ken Lewis
CEO
FirstCarolinaCare
President of Board
North Carolina Association of Health Plans

Connie Majure-Rhett, CCE
President & CEO
Greater Wilmington Chamber of Commerce

David Moore, CLU
Past President
North Carolina Health Underwriters
Association

Maureen K O'Connor, JD
Chief Administrative Officer & General
Counsel
Blue Cross and Blue Shield of North
Carolina

Michael D Page
Chair
Durham County Board of Commissioners

John Perry III, MD MS
Executive Director
Wake AHEC

Mary L. Piepenbring
Director
Health Care Division
The Duke Endowment

John Price
Director
North Carolina Office of Rural Health and
Community Care

William A. Pully, JD
President
North Carolina Hospital Association

Anne B. Rogers, RN, BSN, MPH
Director of Integrated Health
Management
North Carolina State Health Plan

Robert W. Seligson, MBA
Executive Vice President and CEO
North Carolina Medical Society

Vandana Shah, LLM
Executive Director
NC Health and Wellness Trust Fund

Steven Slott, DDS
Practicing Dentist

Allen Smart
Senior Program Officer
Kate B. Reynolds Charitable Trust

Josh Stein, JD
Senator
North Carolina General Assembly

Richard Stevens
Senator
North Carolina General Assembly

A. B. Swindell IV
Senator
North Carolina General Assembly

Gregg Thompson
North Carolina State Director
National Federation of Independent
Business (NFIB)

Brian Toomey, MSW
Chief Executive Officer
Piedmont Health Services, Inc.

Tom Vitaglione, MPH
Senior Fellow
Action for Children North Carolina

William L. Wainwright
Representative
North Carolina General Assembly
Speaker Pro Tempore

Mike F. Watson
Assistant Secretary of Mental Health
Development
North Carolina Department of Health and
Human Services

Steering Committee Members:

Jean W. Holliday, CPM, HIA
Regulatory Project Manager
Life & Health Division
NC Department of Insurance

Carolyn McClanahan
Chief
Medicaid Eligibility Unit
Division of Medical Assistance

Steve Wegner, JD MD
President of North Carolina Community
Care Networks, Inc.
AccessCare, Inc.

Gregory Wood
President and CEO
Scotland Healthcare System

Susan Yaggy
President & CEO
N.C. Foundation for Advanced Health
Programs, Inc.

Barbara Morales Burke, MHA
Vice President Health Policy
Blue Cross and Blue Shield of North
Carolina

Maggie Sauer MS, MHA
Associate Executive Director
NC Medical Society Foundation

Flo Stein, MPH
Chief
NC Division MH/DD/SAS
Community Policy Management Section

NCIOM Staff:

Pam Silberman, JD, DrPH
President and CEO

Mark Holmes, PhD
Vice President

Kimberly Alexander-Bratcher, MPH
Project Director

Berkeley Yorkery, MPP
Project Director

Thalia Fuller
Administrative Assistant

Adrienne Parker
Director Administrative Operations

SECTION 10.78.(ee1) Of the three hundred thousand dollars (\$300,000) appropriated for the UNC School of Medicine, Department of Psychiatry, for the 2009-2010 fiscal year, the sum of two hundred thousand dollars (\$200,000) shall be used to: (i) expand the Department of Psychiatry's Schizophrenia Treatment and Evaluation Program (STEP) into a community setting, (ii) provide training for the next generation of psychiatrists, social workers, psychologists, and nurses to address the current workforce crisis, (iii) provide statewide training and consultation in evidence-based practices, and (iv) provide ongoing support for the STEP and OASIS clinics.

Of the three hundred thousand dollars (\$300,000) appropriated for the UNC School of Medicine, Department of Psychiatry, for the 2009-2010 fiscal year, the sum of one hundred thousand dollars (\$100,000) shall be used to provide bridge funding for OASIS, a statewide program providing targeted, intense interventions to individuals in the early stages of schizophrenia when chronicity and disability may be most preventable. Funds shall be used to support OASIS as foundation support ends, allowing OASIS to transition to funding through private insurance, Medicaid, State appropriations for Mental Health, Developmental Disabilities, and Substance Abuse Services, and other funding streams.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

SECTION 10.78.(ff) The sum of two hundred fifty thousand dollars (\$250,000) appropriated in this section in the Substance Abuse Prevention and Treatment Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2009-2010 fiscal year for the North Carolina Institute of Medicine (NCIOM) shall be used to study the following:

- (1) The availability of Medicaid and State-funded mental health, developmental disabilities, and substance abuse services to active duty, reserve, and veteran members of the military and National Guard. The study should discuss the current availability of services, the extent of use, and any gaps in services.
- (2) Issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians. The NC Institute of Medicine (NCIOM) may use funds appropriated for the 2007-2009 fiscal biennium to continue the work of its Health Access Study Group to study these issues. The Health Access Study Group may include in its study the matters contained in Sections 31.1, 31.2, and 31.3 of S.L. 2008-181 and also may monitor federal health-related legislation to determine how the legislation would impact costs, quality, and access to health care.
- (3) Short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness.

The Institute shall make an interim report to the Governor's Office, the Joint Legislative Health Care Oversight Committee, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than January 15, 2010, which may include recommendations and proposed legislation, and shall issue its final report with findings, recommendations, and suggested legislation to the 2011 General Assembly upon its convening. In the event members of the General Assembly serve on the NCIOM Health Access Study Group, they shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1. The Health Access Study Group may include in its study the matters contained in Sections 31.1, 31.2, and 31.3 of S.L. 2008-181 and also may monitor federal health-related legislation to determine how the legislation would impact costs, quality, and access to health care.

MATERNAL AND CHILD HEALTH BLOCK GRANT

SECTION 10.78.(gg) If federal funds are received under the Maternal and Child Health Block Grant for abstinence education, pursuant to section 912 of Public Law 104-193 (42 U.S.C. § 710), for the 2009-2010 fiscal year, then those funds shall be transferred to the State Board of Education to be administered by the Department of Public Instruction. The Department of Public Instruction shall use the funds to establish an abstinence until marriage education program and shall delegate to one or more persons the responsibility of implementing the program and G.S. 115C-81(e1)(4) and (4a). The Department of Public

HEALTH ACCESS STUDY GROUP
Wednesday October 28, 2009
9:00-1:00 p.m.
North Carolina Institute of Medicine
630 Davis Drive, Suite 100
Morrisville, NC 27560

9:00-9:15

Welcome and Introductions

The Honorable Hugh Holliman
Representative
NC House of Representatives
Co-Chair

The Honorable Tony E. Rand, JD
Senator
North Carolina Senate
Co-Chair

L. Allen Dobson, MD, FAAP
Vice President
Clinical Practice Development
Carolinas HealthCare System
Co-Chair

9:15-9:45

Update on the Uninsured

Mark Holmes, PhD
Vice President
North Carolina Institute of Medicine

9:45 – 11:00

Update on Access to Study Group Recommendations (2009)

Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine

Invited comments from:

Carolyn McClanahan, Chief, Medical Eligibility Unit, Division of
Medical Assistance (enrollment simplification, CHIPRA outreach,
NC Pediatric Society outreach grant)

Michael Keough, Director, Inclusive Health (federal grant to provide
subsidies for the high risk pool)

Jean Holliday, CPM, HIA, Regulatory Project Manager, Life &
Health Division, NC Department of Insurance

Tom Wroth, MD, Medical Director, Piedmont Health Services
(federal funding for FQHC)
Thomas Bacon, DrPH, Associate Dean and Director, Area Health
Education Centers program (Expansion of UNC medical school,
changes in health professional workforce, HIT regional extenders)
Allen Dobson, MD, Co-Chair (646 waiver, NC Healthcare Quality
Alliance)
Steve Cline, DDS, MPH, Deputy State Health Director (HIT)

11:00 – 11:45

Cost estimates for the Study Group's 2009 recommendations

Robert Butler
Senior Consultant

Ed Fischer, MBA
Principal

Mercer Government Human Resources Consulting

Will provide cost estimates for: Medicaid buy-in for disabled children
up to 300% FPG; expansion for adults with limited benefit package
up to 200% FPG; interconception care; insurance subsidy for small
businesses

11:45-12:30

National Health Reform Update

Pam Silberman, JD, DrPH

12:30 – 1:00

Next Steps

HEALTH ACCESS STUDY GROUP

10-28-09

MEETING NOTES

(revised 2-17-2010)

Chairs: Rep. Hugh Holliman and Allen Dobson, MD, FAAFP

Task Force Members: Louis Belo, Colleen Bridger, Deborah Brown, Abby Carter Emanuelson, Kellan Chapin, Steve Cline, Rep. Beverly Earle, Kimberly Endicott, Rep. Bob England, Rep. Verla Insko, Sharon Jones, Tara Larson, John Perry, Steve Slott, Allen Smart, Tom Vitaglione, Steve Wegner

Steering Committee Members: Jean Holliday, Carolyn McClanahan, Barbara Morales Burke

Interested Persons: Tom Bacon, Anne Braswell, Robert Butler, John Dervin, Ed Fischer, Dan Gitterman, Polly Hathaway, Nancy Henley, Michael Keough, Abby Pirnie, M. Ben Popkin, Bo Slott, Bill Wilson, Tom Wroth

NCIOM Staff/Interns: Pam Silberman, Mark Holmes, Berkeley Yorkery, Kimberly Alexander-Bratcher, Jennifer Hastings, Thalia Shirley-Fuller, Catherine Liao

WELCOME

Representative Holliman welcomed attendees.

Pam Silberman reviewed the agenda.

Update on the Uninsured

Mark Holmes, PhD, Vice President, North Carolina Institute of Medicine

Dr. Holmes' presentation aimed to provide an overview of the Health Access Study Group's (HASG) 2009-2010 scope of work and trends in the uninsured in North Carolina. The HASG was originally convened in 2008 at the request of the North Carolina General Assembly (NCGA). At that time, the NCGA charged the North Carolina Institute of Medicine (NCIOM) with creating a study group to examine ways to expand access to affordable care in North Carolina. The HASG final report was released in March 2009. During the 2009 legislative session, the NCGA requested that the HASG continue meeting. The continuation of prior study issues are related to cost, quality and access to appropriate and affordable health care for all North Carolinians. It is the NCIOM's goal to make an interim report to the General Assembly in the 2010 session and a final report in the 2011 session. The recommendations should focus on previous or current studies by the NCIOM; successful efforts in other states to improve access and affordability of health care; and analysis of relevant federal initiatives.

The primary data source for state-level uninsured data is the Current Population Survey's (CPS) Annual Social and Economic Supplement. It is important to consider that timing is a major limitation in understanding current trends: data released in September 2009 were based on March 2009 survey of health insurance coverage in 2008. This approach yields "best case" 2008 coverage.

The bulk of the non-elderly uninsured in North Carolina (1.1 million, 78%) fit into at least one of three groups:

- Children (258,000, 18%)
 - 69% (179,000) of these under 200% of the federal poverty guidelines (FPG)
- Low-income adults (<200% FPG) (716,000, 50%)
- Family connection to small (<25 employees) employer (426,000, 30%)

Current estimates predate the bulk of recession effects. The data for 2008 really reflect the best case estimates because the survey questions ask, “Did you have any insurance coverage in 2008?” Thus, respondents who lost coverage in late 2008 would appear as “insured” in the survey. The CPS 2008 estimates looked very similar to 2007: 1.4 million uninsured and an improvement in coverage for children. Using 3-year averages, the Census determines NC has the [13th highest uninsured rate](#). CPS showed little up-tick across the board; other surveys (e.g. NHIS) have shown little of the expected increase. Is it too early? Or is it due to a robust safety net?

In North Carolina, Medicaid enrollment has increased over 16% in the last 2.5 years (with the bulk of increase in the last 12 months). The conventional rule of thumb notes that nationally each percentage point of unemployment leads to increases of about one million in the uninsured and one million eligible for Medicaid.

Statistical adjustment may yield useful estimates for *current* conditions. In March 2009, researchers at NCIOM and Sheps Center projected uninsured estimates based on state unemployment, cost, and Medicaid eligibility policy. NC is projected to have the fastest increase in the uninsured rate from 2007 through January 2009.

Take-away points include North Carolina being in the top 25% of highest uninsured rates in the country; most surveys are still too early to gauge the effect of the recession; and historical patterns suggest that current counts are 20% higher than “official estimates” but programs (e.g. Medicaid, COBRA) may have mitigated the problem.

Update on Access to Study Group Recommendations (2009)

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

Dr. Silberman’s presentation aimed to provide background on existing safety net programs and organizations; an update on the 2009 Study Group recommendations; and information on other health initiatives, including state programs addressing cost and quality and health information technology.

Invited comments from:

- Carolyn McClanahan, Chief, Medical Eligibility Unit, Division of Medical Assistance (enrollment simplification, CHIPRA outreach, NC Pediatric Society outreach grant)
- Michael Keough, Director, Inclusive Health (federal grant to provide subsidies for the high risk pool)

- Jean Holliday, CPM, HIA, Regulatory Project Manager, Life & Health Division, NC Department of Insurance
- Tom Wroth, MD, Medical Director, Piedmont Health Services (federal funding for federally-qualified health centers, or FQHCs)
- Thomas Bacon, DrPH, Associate Dean and Director, Area Health Education Centers program (Expansion of UNC medical school, changes in health professional workforce, HIT regional extenders)
- Allen Dobson, MD, Co-Chair (646 waiver, NC Healthcare Quality Alliance)
- Steve Cline, DDS, MPH, Deputy State Health Director (HIT)

Expanding Coverage to Children: Update

The HASG recommended that the Division of Medical Assistance simplify the enrollment and recertification process and work with others to identify and enroll eligible children. The HASG also recommended expanding Medicaid to cover children with incomes up to 250% of the federal poverty guidelines (FPG) (or 300% if funding available), and to expand Medicaid to cover disabled children with family incomes up to 300% FPG. The NCIOM contracted with Mercer for develop cost estimates for the option of expanding coverage to disabled children with incomes up to 300% FPG. (See below).

Several steps were taken to implement some of the HASG’s recommendations. For example, the NC Pediatric Society was awarded \$678,210 from the US Department of Health and Human Services to conduct outreach to enroll eligible, but not enrolled children in Medicaid or NC Health Choice.

Carolyn McClanahan on simplification efforts:

The Division of Medical Assistance (DMA) is looking at the current enrollment process, including the mail-in process. DMA also is looking at express lane eligibility and other programs to qualify children based on other program eligibility requirements. Also, a provision in CHIPRA authorized removing the 5-year ban for immigrant pregnant women and children . The use of Social Security match to verify citizenship documentation takes awhile on county-level (will take 24-48 hours).

Tara Larson on simplification efforts:

DMA also is looking at the length of application so it is not as long and examining other ways to get information so applicant is not solely responsible. Online applications and electronic signatures also will minimize missing information or unreturned applications (in an effort to be less burdensome for the applicant). DMA is trying to take advantage of technology.

Expanding Coverage for Uninsured Adults: Update

The HASG recommended that the Division of Medicaid Assistance (DMA) develop a Medicaid 1115 waiver to offer a low-cost limited benefits package to enroll more low-income adults into Medicaid. In addition, the HASG recommended that the state identify strategies to provide interconceptional care to low-income women who had prior high risk births, and that the state high risk pool offer premium subsidies to assist low-income

people with pre-existing health problems purchase health insurance through the state's high risk pool (Inclusive Health). Mercer is developing cost estimates for a Medicaid limited benefit package and for the interconceptional care proposal.

To begin implementing the recommendation to expand coverage to low-income adults, the North Carolina Department of Health and Human Services submitted a State Health Access Program (SHAP) grant to the US Department of Health and Human Services to pilot a low-cost insurance product through CCNC networks to low-income parents. North Carolina was awarded \$17 million over 5 years to pilot this initiative.

Michael Keough on NC's high-risk pool:

About 10 days away from launch of Inclusive Health Assist, a premium subsidy program. Inclusive Health Assist is funded through a \$1.5 million (operational loss) grant from the Centers for Medicaid and Medicare Services (CMS). It will offer individuals with incomes up to 300% FPG a 42% premium discount (which would reduce the premium to the same rate as person would pay without preexisting conditions). Monday, November 9, 2009, marks the beginning of implementation/accepting applications, with program to begin January 1, 2010. Inclusive Health has accepted 2,252 individuals out of 3,000+ applications received and is growing at 200-250 applicants/month.

Expanding Coverage to Small Businesses: Update

The HASG recommended that the NC Department of Insurance study the impact of changing the small group rating laws on affordability of coverage, by eliminating small groups of one. The HASG also recommended that the North Carolina General Assembly subsidize the cost of health insurance premiums for small businesses. While the General Assembly did not enact a new small group subsidy, the NCGA did enact a small tax credit for small businesses that offered health insurance. In calendar year 2008, 5,505 small businesses took the existing tax credit (NCGS §105-129.16E) for a total tax credit of \$3,411,152.

Jean Holliday on small group rating laws:

The Department of Insurance (DOI) conducted a survey of nine small employer group health insurers (85% of the market). The effect on the average small group premium after removing one-person groups is to reduce the rates by an estimate 2.8%. Reducing both one- and two-person groups yields a 4.3% reduction. If the one-person group is no longer able to obtain small group coverage and is instead directed to Inclusive Health, then there will be an \$11 million increase in Inclusive Health claims in 2010 but no change to Inclusive Health's multiplier to determine premiums (now at 175%). If the two-person group is directed to Inclusive Health, then there will be a \$26.8 million increase in claims and a change of 1.9 to Inclusive Health's multiplier. At this time, the DOI has decided not to pursue removing one- and two-person groups from small group rating.

Health Care Safety Net: Update

The HASG recommended that the General Assembly increase state funding to safety net health care organizations that provide health services to the uninsured. Last year, the NCGA increased state funding to safety net organizations by \$5 million in recurring funds (for a total of \$6,860,000) and provided an additional \$2 million in recurring funds to create community collaborative networks of care for the uninsured (for a total of \$4.8 million).

Tom Wroth on federal FQHC funding:

Federally-Qualified Health Centers (FQHCs) enjoyed support from state initiatives and the federal stimulus bill and received Increased Demand for Services (IDS) funding: \$8.6 million to FQHCs in the state. Three components:

- (1) increase in base grant for all community health centers (CHCs) of \$100,000 (\$2.3 million of recurring funds);
- (2) two-year, one-time funding of \$6.00 for every patient and \$19.00 for every uninsured patient (will result in 27,000 uninsured patients covered); and
- (3) ARRA/stimulus bill provided capital investments funding (e.g. refurbishments, health information technology).

FQHCs have had bipartisan support over the years. In health reform proposals, there is additional funding that will gradually increase over the next ten years: \$1.0 billion up to \$6.4 billion in 2019 in House proposals.

There are opportunities to fund and expand FQHCs because there are state and federal funding opportunities. North Carolina could expand FQHCs in areas with community support, especially in the western and central part of the state.

Expanding Provider Supply: Update

The HASG recommended that the NCGA increase funding to expand the medical schools at UNC-Chapel Hill and at ECU, and to increase funding for AHEC to support additional residency positions in high priority specialty areas (such as primary care, general surgery, and psychiatry). The HASG also recommended that the NCGA continue to support CCNC, continue to tie Medicaid reimbursement to 95% of the Medicare rates, and increase reimbursement for providers serving in health professional areas. The HASG also recommended increasing funding to the Office of Rural Health and Community Care to recruit and support providers in underserved areas, and to explore different forms of financial incentives to encourage providers to serve in underserved areas.

The NCGA did not implement many of the task force's recommendations, and in fact, decreased Medicaid reimbursement to providers. However, there were some funds to expand the health professional workforce and to support providers in underserved areas as part of the American Recovery and Reinvestment Act (ARRA stimulus funds).

Tara Larson: Medicaid maintained 95% of Medicare reimbursement rates for certain E&M codes (i.e. office visit codes) across any type of physician category. All other codes/rates were cut below the 95% level.

Tom Bacon on provider supply:

- The NCGA appropriated a small amount of planning money to UNC-CH and ECU to support medical school expansion, but neither state-supported medical school actually received money to expand. ECU is working on a clinical campus in Wilmington as a site for students, and UNC-CH is developing satellite clinic in conjunction with the Mountain Area Health Education Centers program and Carolinas Healthcare System in Charlotte..
- The NCGA has provided funding to East Carolina University to open new dental school. The first class is scheduled to matriculate in the summer of 2011. First three training sites: Jackson County, Hertford County, and in Elizabeth City. Additional sites to be developed.
- ARRA provided \$300 million in additional funding to expand the National Health Service Corps (which is used to provide loans or scholarships to health professionals who practice in underserved areas). The funding is sufficient to expand the NHSC from 4,000 to 8,000 practitioners/year nationally. In addition, the legislation changed the definition to allow more communities to qualify for NHSC providers. The ARRA funding also provided a small increase in funding for primary care residencies, and a small increase in funding for Area Health Education Centers (AHECs).
- In four of the five health reform bills currently pending in Congress, there would be additional funding to expand training of primary care providers, and to change funding for primary care residency training. Currently, all federal graduate medical education (GME) funding flows through Medicare and teaching hospitals. Under the proposals pending in Congress, \$230 million over five years in GME funds for primary care residencies could be paid directly to “teaching health centers” in the community. Teaching health centers are federally qualified health centers (ie, community health centers) that meet certain requirements to provide residency training in ambulatory settings.

Quality and HIT: Update

While not directly part of the HASG’s prior recommendations, there have been some other changes in the delivery of health services that affect cost, quality and access.

Allen Dobson on 646 waiver and NC Healthcare Quality Alliance:

North Carolina submitted a Medicare 646 waiver to enroll Medicare beneficiaries into the Community Care of North Carolina (CCNC) and share savings, if any, with the federal Centers for Medicare and Medicaid Services (CMS). The Medicare 646 waiver has been under development for four years, but the state expects the waiver to be approved and to begin enrolling dual Medicaid and Medicare recipients on January 1, 2010. The Medicare 646 waiver is template for accountable care organizations (ACOs).

The NC Healthcare Quality Alliance involves North Carolina health care provider organizations, state agencies (AHEC, Medicaid, State Health Plan), and private insurers. The goal is to develop a multi-payer quality improvement initiative that is based on the existing work of Community Care of North Carolina (CCNC). All

the participating payers/insurers have agreed to use a single set of quality metrics to examine quality of care. This quality measurement is being augmented by practice support to help practices improve the systems of care in order to improve quality. The Area Health Education Centers program is taking the lead on this practice improvement initiative by hiring quality improvement coordinators to work with provider practices to help improve quality of care.

Other health initiatives: Updates on quality and health information technology (HIT)

Steve Cline on HIT:

ARRA funding is available to expand the use of electronic medical records (EMRs) and health information technology (HIT). By improving HIT, we should be able to improve patient quality and safety, population health outcomes, and reduce costs. Investments in HIT represent a down-payment toward health care reform. There are four separate HIT funding opportunities under the ARRA health information technology (HI-TECH) funds:

(1) Medicaid funding is available to the state Medicaid agency to design and implement a system to determine if eligible providers are making “meaningful use” of HIT, and to administer incentive payments to these providers (see below). North Carolina’s application is currently under development. The state plans to submit its Medicaid HIT plan in two phases. Phase one is for planning and design. Phase two is for implementation. North Carolina is eligible to receive an estimated \$20-25 million.

(2) Incentive payments to providers based on adoption and meaningful use of electronic medical records (EMRs). As an industry, health care has had slow progress on adopting interoperable EMRs which would allow for the exchange of health care information among providers. Starting in 2011, CMS will reimburse providers (through Medicare or Medicaid payments) for buying and implementing an EMR system. Later, payments will be based on “meaningful use.” If a provider implements an EMR, and meets the “meaningful use” standards, he or she may be eligible for up to \$63,000 in additional Medicaid funds over the four years. The funding is available per provider (not per practice). This is the biggest pot of money available to NC practitioners.

(3) Regional extension center (REC) funding is available through a separate application to the Office of the National HIT Coordinator (ONC). The REC will provide technical assistance to individual practices to purchase and implement appropriate EMRs. AHEC has put together a consortium of individuals to develop the application.

(4) ONC will fund the state Health Information Exchange (HIE) to create a statewide infrastructure to exchange health information between providers and systems of systems. The state stands to gain \$12.9 million. Led by Health and Wellness Trust Fund (HWTF), a nine-member representative body (HIT collaborative) is advising HWTF on what the application should look like.

Cost estimates for the Study Group's 2009 recommendations

Robert Butler, Senior Consultant; Ed Fischer, MBA, Principal; Mercer Government Human Resources Consulting

Mr. Butler and Mr. Fischer provided a review of Mercer's draft findings for the 2009 HASG recommendations. They were asked to provide costs for four of the HASG recommendations: 1) creation of a Medicaid buy-in program for disabled children up to 300% FPG; 2) expanding Medicaid for adults up to 150% FPG through a limited benefit package; 3) expanding Medicaid eligibility to 185% FPG for non-pregnant women who had a poor prior birth outcome; and 4) providing insurance premium subsidies to small businesses for low-wage workers.

Mr. Butler provided detailed information on the underlying assumptions that they used in developing their cost estimates. They were seeking input from the HASG about their underlying assumptions before finalizing the report. The final report will be presented at a later HASG meeting. The Mercer consultants noted that the design of the program and the underlying assumptions will affect the cost estimates. Some of their assumptions have robust data to support them, but other areas are less certain (e.g. take-up rates by consumers). The costs assume full program implementation, although in reality, enrollment would probably be lower than estimated in the initial years of program implementation.

1. Medicaid buy-in program for disabled children up to 300% FPG

Full buy-in (ie, children do not have other private coverage):

- List of assumptions include: premiums would be capped at 5% of family income for children between 200-250% FPG, and 7.5% of family income between 251-300% FPG; Mercer assumed that 7.8% of the population meets the disability criteria; a 50% participation (take-up rate). Mercer also assumed that the benefit package would not include institutionalization (as those children are probably already eligible for full Medicaid benefits).
- Projected enrollment: 3,572 disabled children
- Projected cost to the state: \$16,569,870 (total costs, including federal: \$47,518,984)

Wrap-around (Medicaid coverage could also be offered to disabled children with private coverage to pay for non-covered services):

- List of assumptions include: the cost estimates assume that Medicaid would cover services that are not traditionally offered in commercial plans, with a 20-25% take-up rate. Premiums would be proportional to the benefits received and consistent with the full Medicaid buy-in (ie, the state would not want to set premiums so high as to encourage people to drop their private coverage).
- Projected enrollment: 7,358 disabled children

- Projected cost to the state: \$12,015,969 (total costs, including federal: \$34,459,331).

2. Medicaid eligibility expansion to 150% FPG for adults.

The HASG recommended that DMA submit a Medicaid 1115 waiver to provide a limited benefits package to adults up to 150% FPG. The HASG also recommended premium assistance for adults with access to employer sponsored insurance. Finally, the HASG recommended the creation of a public-private low-cost insurance product based on CCNC which would be available to small businesses that do not currently offer health insurance.

The initial HASG recommended expansion to adults with incomes up to 200% FPG, but given the discussion at the national level about expanded coverage—the NCIOM asked Mercer to limit its analysis to adults up to 150% FPG (as that was consistent with the House proposal).

Limited benefit package to uninsured adults:

- List of assumptions include: the benefit design was based on the limited benefit package developed for the Cecil G. Sheps Center as part of the Covering the Uninsured report in 2006. The limited benefit package would exclude pregnancy related services (as pregnant women with incomes up to 185% FPG are already eligible for Medicaid). The limited benefit package would have a \$10,000 inpatient limit. The limited benefit package was expanded to include comprehensive mental health and substance abuse services (in order to determine whether we could use existing Integrated Payment and Reporting System (IPRS) funding, which is currently 100% state funds, as the state match of Medicaid expansion). Mercer assumed a 60% participation rate with no premium.
- Projected enrollment: 253,401 uninsured adults.
- Projected cost to the state: \$279,514,508 (total costs, including federal, would be \$801,590,215).

Note: Medicaid 1115 waivers must be budget neutral to the federal government. Thus, North Carolina would be required to find program savings to support the program expansion. North Carolina would not need a waiver to expand coverage to parents (ie, individuals with dependent children younger than 19); but would need a waiver to expand coverage to childless, non-disabled, non-elderly adults. The HASG had recommended using CCNC savings from the expansion of CCNC to the aged, blind and disabled (because at the time, the state had not enrolled this group into CCNC or captured the savings). However, most of the aged, blind and disabled are now enrolled in CCNC so the state will not be able to use these “savings” to support program expansion. Mercer folk also noted that it was difficult to determine how much funding could be shifted from the state mental health system into Medicaid. North Carolina may be able to realize savings in its medically needy Medicaid program (people who are currently eligible for

Medicaid because of high medical expenses), but those savings would not be sufficient to pay for the costs of this program expansion.

Premium assistance for low-income adults with access to employer sponsored insurance:

- List of assumptions include: the premium subsidy would cover the entire portion of the employee's premium (including employee/spouse), coverage would not include children (as children at this income level would already be eligible for Medicaid or NC Health Choice), and Mercer assumed a 60% take-up rate.
- Projected enrollment: 446,820 low-income adults with access to employer-sponsored insurance.
- Projected cost to the state: \$249,257,986 (total costs, including federal, would be \$714,820,723).

Premium subsidies for a CCNC Public-Private Insurance Option:

- List of assumptions include: the costs of the insurance product would be 20% less than a comparable commercial product because of the quasi-public nature of the product; the savings would be equally applied to both employee and employer share of the premiums. The rest of the assumptions were similar to the premium assistance program described previously.
- Projected enrollment: 446,820 low-income adults with access to employer-sponsored insurance.
- Projected cost to the state: \$199,406,389 (total costs, including federal, would be \$571,856,578).

Discussion followed that the cost estimates may be too high, because this product should be limited to small businesses that do not currently offer insurance. Therefore, the potential take-up rate would be lower.

3. Medicaid eligibility expansion to 185% FPG for non-pregnant women who have had poor birth outcomes

Many women who have Medicaid for pregnant women (MPW) lose their Medicaid eligibility after a prescribed post partem period after the birth of the child because their incomes are too high for regular Medicaid coverage. (Their children may still be eligible for Medicaid coverage as the income limits are higher for children). The HASG recommended expanding Medicaid coverage to cover women up to 185% FPG for those women who had a poor birth outcome. Mercer was asked to evaluate potential savings from improved pre-conception care after offsetting the costs of the health benefits provided during the interconception period.

- List of assumptions include: Mercer assumed that the pre-conception care would be similar to the current services provided to AFDC women, the

analysis of potential cost offsets targeted at second births. The average costs of a low-birthweight baby (LBW) is between \$18,000-\$20,000; the average cost for a very low birthweight (VLBW) baby is between \$57,000-\$58,000, and the average cost for a child who subsequently dies is \$30,000-\$46,000. However, not everyone who had a poor birth outcome in their first birth will have a subsequent poor birth outcome. Mercer is still working on developing cost estimates for this proposal.

4. A program providing insurance premium subsidies to small businesses for low-wage workers

Mercer was also asked to develop cost estimates of a premium subsidy for small businesses with low-wage workers (\$35,000/year or less). The premium subsidy would pay 30% of the total premium for small businesses (with 15 or fewer employees). No subsidy is available for dependent coverage.

- List of assumptions include: 55% of employees assumed to earn \$35,000/yr or less, 80% of employees in small firms would be eligible for insurance, and 85% would elect coverage if offered. Mercer also assumed that 83% of employers would pay at least 50% of the premium cost, if they offer insurance.

Employers that do not currently provide insurance coverage:

- Projected enrollment: Mercer estimated that between 6,800-7,600 employers would receive subsidies, and that between 9,400-11,600 employees would receive subsidies.
- Projected cost to the state: Between \$17,300,000-\$21,200,000.

Employers that do currently provide insurance coverage:

- Projected enrollment: Mercer estimated that between 28,400-29,900 employers would receive subsidies, and that between 34,200-36,900 employees would receive subsidies.
- Projected cost to the state: Between \$56,100,000-\$62,100,000.

Comment: Mercer will continue to work with NCIOM to finalize cost estimates, although reform at national level may render some issues moot.

National Health Reform Update

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

Dr. Silberman gave a brief overview of the basics of national health reform. The overview is based on information from the Kaiser Family Foundation's summary of health proposals. The overview included a description of individual mandates and subsidies, expansion of public programs, employer mandate, benefit packages, long-term care, insurance pools/exchanges, insurance reform, prevention and wellness, quality,

health workforce, safety net, state roles, cost containment, financing, and major areas of contention.

Next Steps

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

*Next HASG meeting is scheduled for January 2010.

*At the next meeting, the NCIOM will have an update on whatever has happened on federal level. Future HASG meetings will focus on issues North Carolina can address, and what federal reform will mean to North Carolina.



The NC Uninsured

Mark Holmes, PhD
Vice President
North Carolina Institute of Medicine

Health Access Study Group

28 October 2009



NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state



Overview

- Health Access Study Group's 2009-2010 Scope of work
- Recent trends in NC uninsured





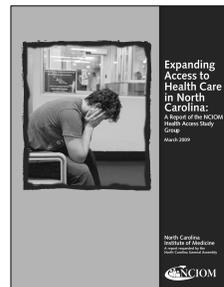
Overview

- Health Access Study Group's 2009-2010 Scope of work
- Recent trends in NC uninsured



Expanding Access to Health Care

- The NCGA charged the NCIOM with creating a study group to examine ways to expand access to affordable care in North Carolina
- Final report released: March 2009





Health Access Study Group: 2009 Legislative Charge

- Continuation of prior study issues related to cost, quality and access to appropriate and affordable health care for all North Carolinians
- Make interim report to the General Assembly in the 2010 session and a final report to the 2011 session
- Recommendations should focus on:
 - Previous or current studies by the NCIOM
 - Successful efforts in other states to improve access and affordability of health care
 - Analysis of relevant federal initiatives



Sec. 10.78(ff) of Session Law 2009-451, Sec. 18.1 of Session Law 2009-574

NCIOM Health Access Study Group (Holmes)

28 Oct 2009

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Upcoming Meetings

- Today
- Jan 20, 2010
- Feb 17, 2010
- Apr 21, 2010
 - *Note earlier Dec 23 date canceled*

.vcs files for importing to your calendar
available on calendar on NCIOM website
(<http://www.nciom.org/calendar.php>)



NCIOM Health Access Study Group (Holmes)

28 Oct 2009

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How many uninsured are there?

- Primary data source for state-level uninsured data is the Current Population Survey's Annual Social and Economic Supplement.
- Timing is a major limitation:
 - September 2009 data release based on March 2009 survey of health insurance coverage in 2008.
 - Furthermore, approach yields "best case" 2008 coverage



Overview

- Health Access Study Group's 2009-2010 Scope of work
- Recent trends in NC uninsured





Who are the uninsured?

- Bulk of the non-elderly NC Uninsured (1.1 million, 78%) fit into at least one of three groups:
 - Children (258K, 18% of UI)
 - 69% (179K) of these under 200% FPG
 - Low –income (<200%FPG) adults (716K, 50% of UI)
 - Family connection to small (<25 employees) employer (426K, 30% of UI)



Current estimates predate bulk of recession effects

- The data for 2008 really reflect the best case estimates because questions ask “did you have any insurance coverage in 2008?”
 - Thus, respondents who lost coverage in late 2008 would appear as “insured” in the survey
 - Statistical magic may yield useful estimates for *current* conditions





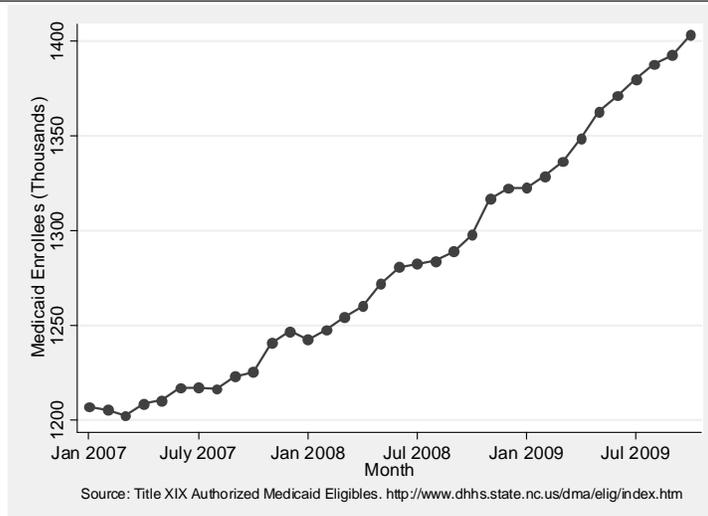
Current estimates

- The CPS 2008 estimates looked very similar to 2007 – 1.4 million uninsured
 - Improvement in coverage for children
- Using 3 year averages, Census determines NC has 13th highest uninsured rate¹
- CPS showed little uptick across the board; other surveys (e.g. NHIS) have shown little of the expected increase
 - Too early? Or robust safety net?

¹ <http://www.census.gov/hhes/www/hlthins/hlthin08/statecomp08.xls>



NC Medicaid enrollment up over 16 percent in last 2.5 years (with bulk of increase in last 12 months)





Projecting to current levels

- Conventional rule of thumb: each percentage point of unemployment leads to increases of about 1 million uninsured and 1 million Medicaid.
- In March 2009, researchers at NCIOM and Sheps Center projected uninsured estimates based on state unemployment, cost, Medicaid eligibility policy
 - Headline: NC projected to have fastest increase in uninsured rate 2007-Jan 2009
- Estimate at the time: 1.75-1.8 million



<http://www.nciom.org/uninsuredstates.html>

NCIOM Health Access Study Group (Holmes)

28 Oct 2009

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Takeaway Points

- NC in top 25% of highest uninsured rates in country
- Most surveys are still too early to gauge the effect of the recession
- Historical patterns suggest current counts 20% higher than “official estimates” – but programs (e.g. Medicaid, COBRA) may have mitigated



NCIOM Health Access Study Group (Holmes)

28 Oct 2009

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Health Access Study Group

Pam Silberman, JD, DrPH
President & CEO
October 28, 2009



Agenda

- Background on existing safety net programs and organizations
- Update on 2009 Study Group recommendations
 - Expanding Coverage for Children
 - Expanding Coverage for Low-Income Adults
 - Expanding Coverage for Small Employers
 - Health Care Safety Net
- Other Health Initiatives
 - North Carolina Programs Addressing Cost and Quality
 - Health Information Technology



● ● ● | Background: Medicaid

- Medicaid is a joint federal-state financed entitlement program to provide health insurance to certain low- and moderate-income people
- To qualify, an individual/family must meet three tests:
 - Categorical eligibility: “type or category” of person, including: pregnant woman, child under age 19 (or 21 at state option), Parents of dependent children (TANF/AFDC related), disabled (meet SSA disability definition), elderly (65 or older)
 - Income limits, depends on program category
 - Resource (assets) limits, depends on program category

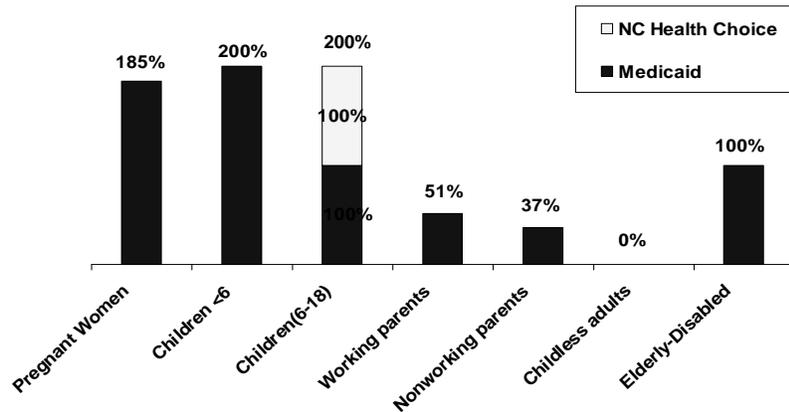


● ● ● | Background: Children’s Health Insurance Program (CHIP)

- CHIP is a joint federal-state financed block grant program to provide health insurance to certain low- and moderate-income people
- Covers children with slightly higher incomes and generally with greater cost-sharing compared to Medicaid
- In North Carolina, called **NC Health Choice** and covers children ages 6-18 with family incomes up to 200% FPG
- New federal legislation authorized states to expand coverage to children with incomes up to 300% FPG



NC Medicaid Income Eligibility Limits (2009)



Kaiser Family Foundation. State Health Facts. Calculations for parents and medically needy based on a family of three.

Health Access Study Group (Silberman)

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Background: Inclusive Health

- NC General Assembly enacted a high-risk pool for people with pre-existing health conditions (2007)
 - Premiums are set at 175% of premiums for healthy individuals
 - This will still be unaffordable for many people with pre-existing conditions
 - People will be eligible if turned down from other insurers due to health problems, or if only offered health insurance with premiums in excess of the high-risk pool premiums
 - High-risk pool began operation Jan. 1, 2009



Health Access Study Group (Silberman)

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Update on 2009 Study Group Recommendations

- Expanding Coverage for Children
- Expanding Coverage for Low-Income Adults
- Expanding Coverage for Small Employers
- Health Care Safety Net
- North Carolina Programs Addressing Cost and Quality



Expanding Coverage to Children

- Approximately 18% (258,000) of all non-elderly uninsured are children in 2007-2008
 - 64% (166,000) are currently eligible, but not enrolled in Medicaid or NC Health Choice
 - **Priority Recommendation (4.1):** The NC Division of Medical Assistance should simplify the enrollment and recertification process and work with others to identify and enroll eligible children





Expanding Coverage to Children

- **Priority Recommendation (4.2):** The NCGA should remove the cap on NC Health Choice and expand coverage to children with incomes up to 250% FPG, and if sufficient funding is available, expand eligibility to 300% FPG
- **Recommendation (4.3):** The NCGA should expand Medicaid to allow children with disabilities with family incomes up to 300% FPG to buy-into the Medicaid program



Expanding Coverage to Children: Update

- CHIPRA: Congress reauthorized CHIP for five years (through FY 2013)
 - Allotments to states were increased
 - States that face a funding shortfall and meet enrollment goals will receive adjusted payments
 - New options available to states to streamline enrollment
 - Bonus payments available to states when they adopt measures to simplify enrollment and reenrollment and enroll already eligible uninsured children





Expanding Coverage to Children: Update

- *Rec. 4.1:* The NCGA directed DMA to implement outreach and enrollment simplifications
 - NC Pediatric Society was awarded \$678,210 from US DHHS for outreach to enroll eligible but non-enrolled children in Medicaid or NC Health Choice (funded through Dec. 2011)
 - Carolyn McClanahan, Chief, Medical Eligibility Unit, Division of Medical Assistance will give an update on simplification efforts
- *Rec. 4.2:* The NCGA appropriated \$17.1 million (SFY 2010) and \$21.9 million (SFY 2011) to expand NC Health Choice enrollment by 7% in 2010 and an additional 3% in 2011
- *Rec. 4.3:* Mercer will report on cost estimates



Expanding Coverage for Uninsured Adults

- Half of all uninsured are non-elderly adults with incomes less than 200% FPG (716,000) in 2007-2008
 - 25% of these are parents
 - Most of the rest are childless, non-disabled, and non-elderly adults who would not meet current Medicaid categorical eligibility requirements





Expanding Coverage for Uninsured Adults

- **Priority Recommendation (5.1):** NCGA, Governor's Office and the NC Congressional delegation should support Medicaid fiscal relief and flexibility in covering adults without categorical restrictions
- **Priority Recommendation (5.2):** The DMA should conduct outreach and simplify enrollment to enroll eligible adults
- **Priority Recommendation (5.3):** The NCGA should direct DMA to seek a Medicaid 1115 waiver to develop a low-cost limited benefits package to enroll low-income adults



Expanding Coverage for Uninsured Adults

- **Priority Recommendation (5.4):** The NCGA should identify strategies to provide interconceptional care to low-income women who have had prior high-risk births
- **Recommendation (5.5):** The NCGA should revise 58-50-180(d) to clarify that Inclusive Health (NC high risk pool) has the authority to offer premium subsidies and should appropriate funding to subsidize premiums for low-income people





Expanding Coverage for Uninsured Adults: Update

- *Rec. 5.1:* Recent and proposed Congressional changes affects Medicaid
 - American Recovery and Reinvestment Act (ARRA) provided enhanced Medicaid funding to states October 2008-December 2010
 - North Carolina expected to receive an additional \$2.4 billion over the nine quarters
 - Health reform legislation being debated at the federal level would all remove the categorical restrictions on Medicaid
 - Would expand coverage to childless, non-disabled, non-elderly adults



Expanding Coverage for Uninsured Adults: Update

- *Rec. 5.2, 5.3:* NC DHHS submitted a SHAP grant to US DHHS to pilot a low-cost insurance product through CCNC networks to low-income parents (CCNC:UP)
 - NC awarded \$17 million over 5 years to pilot this initiative
 - Product will be a low-cost insurance product available to low-income parents with incomes below 125% FPG
 - Will be tested in 2-3 CCNC networks
 - Will test streamlined application procedures





Expanding Coverage for Uninsured Adults: Update

- *Rec. 5.4:* Mercer will report on cost-estimates for interconceptional care
- *Rec. 5.5:* North Carolina awarded grant from federal government to provide subsidies to low-income people to enroll in Inclusive Health
 - Michael Keough, Executive Director, Inclusive Health, will provide an update



Expanding Coverage to Small Employers

- Approximately 30% of all non-elderly uninsured are employed by or in the family of someone employed full-time by a small employer with <25 employees (432,000)
 - *Recommendation (6.1):* The NC Department of Insurance should study the impact of changing the small group rating laws to eliminate groups of one
 - *Recommendation (6.2):* The NCGA should provide tax subsidies or otherwise subsidize the cost of health insurance premiums for small businesses





Expanding Coverage to Small Employers: Update

- Rec. 6.1: NC Department of Insurance conducted a study to examine the impact of changes in small group rating laws
 - Jean Holliday, CPM, HIA, Regulatory Project Manager, Life & Health Division, NC Department of Insurance will provide an update
- Rec. 6.2: No progress on Health Access Study Group's recommendations for small employer subsidy
 - In calendar year 2008, 5,505 small business took the existing credit for Small Business (§ 105-129.16E) for a total tax credit of 3,411,152¹



¹ http://www.dornnc.com/publications/cred_inct_09/business_energy_credits.pdf



Health Care Safety Net Programs

- There are many different safety net organizations with mission of serving the uninsured or other underserved populations (services provided for free or reduced cost basis)
 - FQHCs
 - State Funded Rural Health Centers
 - Local Health Departments
 - Free Clinics
 - Community collaborations
 - Other nonprofits
 - Many private physicians also serve uninsured
 - School-based or school linked health centers
 - Area Health Education Centers programs
 - Hospital emergency departments and outpatient clinics
 - Prescription drug programs





Safety Net Cannot Meet All Needs of Uninsured

- Safety net organizations not available in every community and do not have the capacity to meet all the needs of the uninsured
 - Services for uninsured fragmented in many communities, other communities lack resources to meet needs of uninsured (including primary care, specialty, dental, pharmacy, mental and behavioral health)
 - Uninsured receive some care, but less than half as much care as those with insurance
 - Nationally, only about half of the uninsured knew about safety net organizations, even when within 5 miles of where they live.
 - In NC, information about safety net providers available at: www.nchealthcarehelp.org



Health Care Safety Net: Update

- **Priority Recommendation (7.1):** The NCGA should appropriate \$8 million to expand the availability of safety net services and \$2.2 million to create community collaborative networks of care for the uninsured
- The NCGA appropriated an *additional* \$5 million in recurring funds to expand safety net capacity (total of \$6,860,000) and an additional \$2 million in recurring funds for Health Net (total of \$4.8 million)
 - *Community health grants:* \$1.7 million obligated to support continuation programs, ~\$4.0+ million available to support new programs that expand access to primary care. Grants limited to \$175,000/community or \$125,000 per single organization.



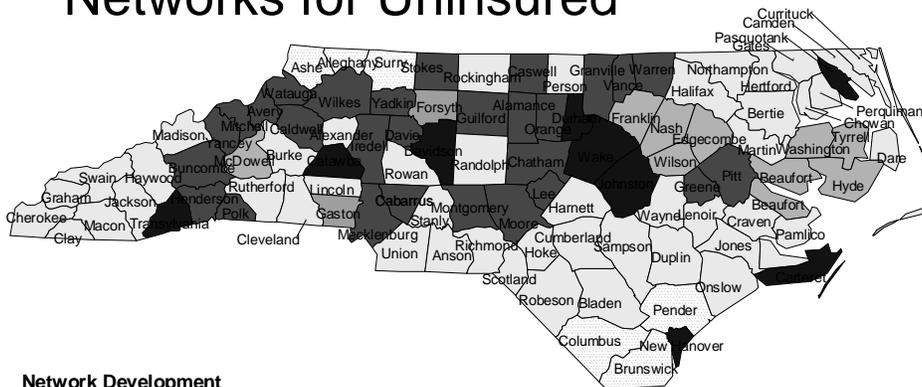


Health Care Safety Net: Update

- **NC HealthNet history:**
 - SFY 2008: ORHCC received \$2.9 million non-recurring funds and supported 16 networks (27 counties)
 - SFY 2009: ORHCC received \$2.8 million recurring, \$950 non-recurring and supported 21 networks (38 counties)
 - SFY 2010: ORHCC received \$4.8 million recurring, plan on supporting 23 networks (46 counties)
- **Care Share Health Alliance providing technical assistance to counties to develop other community networks**
 - Private foundation funding supporting other networks
 - More interest from other counties
- **Tom Wroth, MD, Medical Director, Piedmont Health Services will give update on federal FQHC funding**

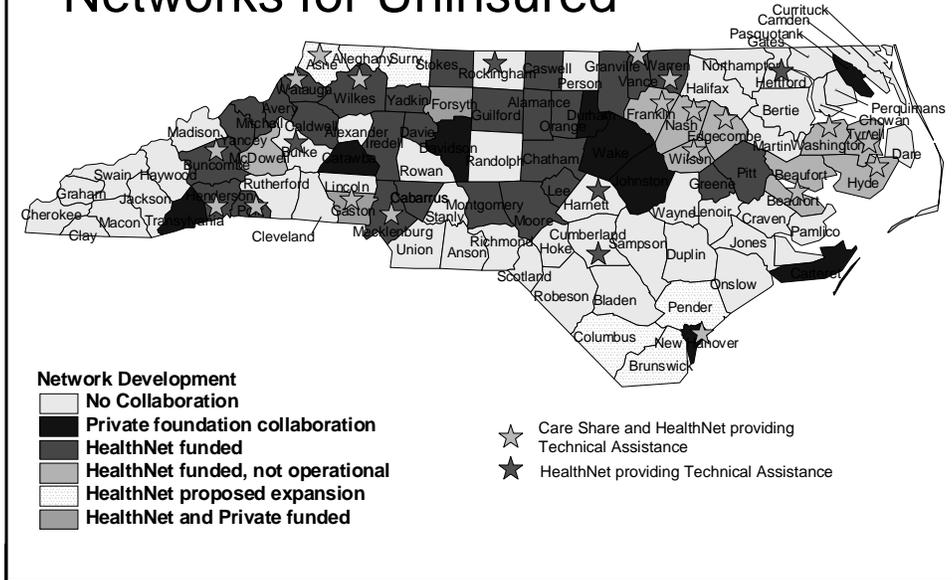


Community Collaborative Networks for Uninsured



- Network Development**
- No Collaboration
 - Private foundation collaboration
 - HealthNet funded
 - HealthNet funded, not operational
 - HealthNet proposed expansion
 - HealthNet and Private funded

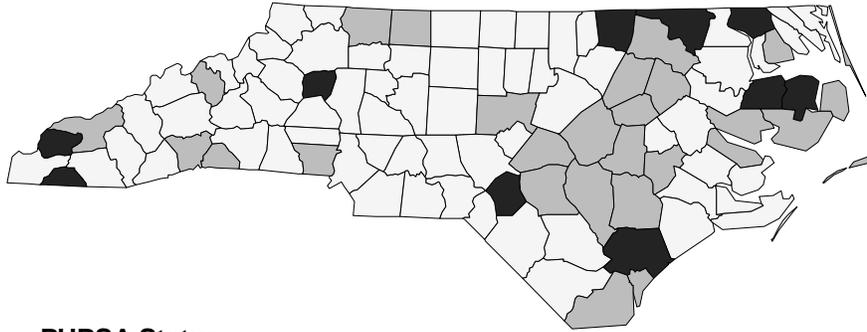
Community Collaborative Networks for Uninsured



Expanding Provider Supply

- North Carolina is likely to experience a shortage of physicians, nurse practitioners and physician assistants over the next 20 years
 - Expanding coverage to more of the uninsured is likely to create demand for additional services
- There is a maldistribution of health care professionals across the state
 - 35 of 100 counties considered persistent health professional shortage areas

Persistent HPSAs



PHPSA Status
Not a PHPSA (65)
Part County PHPSA (25)
Whole County PHPSA (10)

Created by North Carolina Institute of Medicine. "Persistent" HPSAs are those designated in 6 of last 8 designations. Uses HPSA status for 2000-2002, 2004-2006, 2008-2009 (2003 and 2007 deemed unreliable).



Expanding Provider Supply

- Recommendation (8.1): The NCGA should appropriate \$40 million in recurring funds to support the expansion of the medical school at UNC-Chapel Hill and \$1.2 million in recurring funds to AHEC to support additional residency positions in high priority specialty areas (including primary care, general surgery, psychiatry)



Expanding Provider Supply

- **Priority Recommendation (8.2):** The NCGA should continue to support CCNC, and reimburse physicians at 95% of Medicare rates, increase Medicaid reimbursement rates to providers in health professional shortage areas, and appropriate \$1.9 million to the Office of Rural Health and Community Care (ORHCC) to recruit and support providers in underserved areas
- **Recommendation (8.3):** The NCGA should direct ORHCC to explore different forms of financial incentives or other systems to encourage providers to serve in underserved areas



Expanding Provider Supply

- **Recommendation 8.4:** The NCGA should appropriate \$250,000 to ORHCC to support technical assistance through ORHCC and the NC Medical Society Foundation PracEssentials programs





Expanding Provider Supply: Update

- Rec. 8.1. Medical school at UNC-CH implementing pilot programs with existing students to train medical students in Charlotte and MAHEC (to test satellite medical education)
- Rec. 8.2: NCGA cut Medicaid provider reimbursement, but DMA is holding primary care reimbursement at 95% of Medicare



Expanding Provider Supply: Update

- Rec. 8.2-8.4: New federal funds available to double the number of health professionals supported through the National Health Service Corp. (NHSC)
 - ARRA included \$300 million to expand NHSC: from 4,000 to 8,000 practitioners/year
 - Tom Bacon, Director, Area Health Education Centers Program will provide update on new federal funding for medical education





Other Health Initiatives: Updates on Quality and HIT

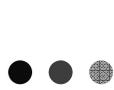
- Medicare 646 waiver: CMS is poised to approve North Carolina's 646 waiver to expand CCNC to dual eligibles (Medicaid and Medicare)
- North Carolina Healthcare Quality Alliance:
 - Allen Dobson, MD, will provide an update on the 646 waiver and the NC Healthcare Quality Alliance



Other Health Initiatives: Updates on Quality and HIT

- Health Information Technology: ARRA included \$36 billion nationally to support health information technology development
 - NC organizations and providers could realize more than \$100 million over the next four years
 - Steve Cline, DDS, MPH, Deputy State Health Director will provide an update





For More Information

- o Websites: www.nciom.org
www.ncmedicaljournal.com

Key contacts:

- Pam Silberman, JD, DrPH, President & CEO
919-401-6599 ext. 23 or pam_silberman@nciom.org
- Mark Holmes, PhD, Vice President
919-401-6599 ext. 24 or mark_holmes@nciom.org
- Berkeley Yorkery, MPP, Project Director
919-401-6599 ext. 30 or
berkeley_yorkery@nciom.org
- Kimberly Alexander-Bratcher, MPH, Project Director
919-401-6599 ext. 26 or
kabratcher@nciom.org





October 28, 2009

North Carolina Institute of Medicine's Health Access Study Group

Projected Cost of Recommendations

Summary of Preliminary Analyses

Overview

The report Expanding Access to Health Care in North Carolina: A Report of the NCIOM Health Access Study Group was released in March 2009. Mercer was contracted by DMA to project costs for the following four recommendations:

1. A Medicaid buy-in program for disabled children up to 300% FPG, Study Group Recommendation 4.3
2. A Medicaid eligibility expansion to 150% FPG for adults, Study Group Recommendation 5.3 (modified)
3. A Medicaid eligibility expansion to 185% FPG for non-pregnant women who have had poor birth outcomes, Study Group Recommendation 5.4
4. A program providing insurance premium subsidies to small businesses for low-wage workers, Study Group Recommendation 6.2

Medicaid Buy-In Program for Disabled Children Up to 300% FPG

Overview

The Study Group recommended that disabled children with household income up to 300% FPG be allowed to purchase Medicaid coverage based upon provisions of the federal Family Opportunity Act. The proposed expansion would allow disabled children between 201-300% FPG to purchase:

- Full Medicaid benefits
- Supplemental Medicaid benefits (i.e. wrap-around services) for families with access to employer-sponsored coverage (ESI)

Primary Assumptions

- Children in households with up to 200% FPG are already eligible for Medicaid or Health Choice
- Severely disabled children with institutional care requirements are assumed to qualify for Medicaid under SSI or Medicaid waiver criteria, therefore institutional (NH, ICF/MR) and HCBS are excluded
- 7.8% rate of population assumed to meet disability criteria (based on Medicaid SSI children <100% FPG)
- Kids' Care implementation between 201-300% FPG would supplant the need for this expansion
- Families must access ESI if available, but families are not required to be without coverage prior to enrollment
- Premiums are capped at 5% of family income for children in households between 201-250% FPG, and at 7.5% of family income between 251-300% FPG

Methodology for Medicaid Buy-In as Sole Coverage

- Based on 7/1/07-6/30/08 NC Medicaid FFS data
- ABD-classified children ages 0-18
- Trended to 7/1/010-6/30/11 (includes rate freezes currently in place)
- Base data adjusted for:
 - Pent-up demand for needed services
 - Household income (lower utilization for higher income levels)
 - Higher FPG (higher income groups typically healthier)
 - Adverse selection
- 50% participation rate (take-up rate)
- Assumed similar enrollment by those dropping private coverage

Projected Enrollment for Medicaid Buy-In as Sole Coverage

Projected Enrollment for Medicaid Buy-In as Sole Coverage for Disabled Children Up to 300% FPG

	Uninsured	Disabled	Private	Projected
FPG	Children	Children	Drop-Out	Enrollment
200-250%	29,000	2,251	1,126	2,252
250-300%	17,000	1,319	660	1,320
Total	46,000	3,570	1,786	3,572

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Projected Costs for Medicaid Buy-In as Sole Coverage

Projected Costs for Medicaid Buy-In as Sole Coverage for Disabled Children Up to 300% FPG

	Projected	Projected				
FPG	Enrollment	Total PMPM Cost	Monthly Premium	Net PMPM	Annual Expenditures	State Share
200-250%	2,252	\$ 1,185	\$ 40	\$ 1,145	\$ 30,932,635	\$ 10,786,210
250-300%	1,320	\$ 1,137	\$ 90	\$ 1,047	\$ 16,586,350	\$ 5,783,660
Total	3,572	\$ 1,167	\$ 58	\$ 1,109	\$ 47,518,984	\$ 16,569,870

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Reduction in Medically Needy Expenditures for Children

- \$6,224,209 in Medically Needy expenditures for children in 2008
- Assume all children in this category are at or below 300% FPG
- Assume Medically Needy children have three times the general disability rate ($3 \times 8\% = 24\%$)
- Approximately \$1.5M of total annual expenditures applicable to children that may qualify for the expansion
- State share of approximately \$500,000

Overview of Medicaid Buy-In for Wrap-Around Services

Although the particular deficiencies of ESI vary considerably based upon a child's medical need and the respective benefit package, generally the need for additional services can be categorized as:

- Coverage limitations based upon benefit limitations
- Coverage limitations based upon unit limits
- Non-covered services
- Cost sharing

Primary Assumptions for Medicaid Wrap-Around Benefits

- Projected costs based upon estimates of necessary non-covered services and out of pocket maximums of typical commercial packages
- Enrollment/disenrollment as households anticipate need
- Recognition of lower payment rates for the Medicaid program compared to commercial rates
- Premiums are proportional to benefits received and consistent with the full Medicaid buy-in
- Average out of pocket maximums for NC are \$2,800/yr (Mercer Survey, 2009)
- Take-up rates of 20-25% depending on FPG

Projected Enrollment

Projected Enrollment for Medicaid Wrap Around Benefits

FPG	Insured Children	Disabled Insured	Projected Enrollment
200-250%	164,886	12,797	2,559
250-300%	247,329	19,195	4,799
Total	412,215	31,992	7,358

Projected Costs

Projected Costs of Medicaid Wrap Around Benefits

	Projected	Annual		Monthly	Net	Annual	State
FPG	Enrollment	Cost	PMPM	Premium	PMPM	Expenditures	Share
200-250%	2,559	\$ 5,000	\$ 417	\$ 14	\$ 403	\$ 12,364,595	\$ 4,311,534
250-300%	4,799	\$ 5,000	\$ 417	\$ 33	\$ 384	\$ 22,094,735	\$ 7,704,434
Total	7,358	\$ 5,000	\$ 417	\$ 26	\$ 390	\$ 34,459,331	\$ 12,015,969

Medicaid Eligibility Expansion to 150% FPG for Adults

Overview

The Study Group recommended using a Medicaid Section 1115 Waiver to expand coverage for adults to 150% FPG. NC Medicaid currently covers adults based on varying criteria, including disability, pregnancy, parental status and income. Childless adults, and those with incomes above current guidelines (particularly males), are not currently eligible. Coverage would be considered through two alternatives:

- Medicaid limited benefit package
- Premium assistance for adults with access to ESI

Comparison of Eligibility Criteria

Currently Covered

- AFDC non-pregnant parents 0-51% FPG
- Pregnant women 52-150% FPG
- AFDC Medically Needy

Proposed Expansion

- Childless and other adults 0-51% FPG
- Non-pregnant women, childless and other adults 52-150% FPG
- All adults up to 150% FPG, eliminating need for Medically Needy within this income range

Primary Assumptions for Medicaid Limited Benefit Package

- Based on the 2006 Mercer report titled Evaluation of HRSA Coverage Options for the Cecil G. Sheps Center for Health Services Research
- Option used included cost sharing and \$10,000 inpatient limit
- Original benefit package was enhanced to include community MH services to estimate coverage equivalent to services provided through IPRS (state funds used to support mental and behavioral health services)
- Pregnancy related services were excluded for women up to 150% FPG, as such women would already qualify under Medicaid Pregnant Women criteria
- Disabled above 100% FGP may be eligible under these guidelines, but beyond the scope of the recommendation
- Does not include nursing home services, ICF/MR services or HCBS

Methodology for Limited Benefit Expansion for Adults to 150% FPG

- Based on 7/1/07-6/30/08 NC Medicaid AFDC (adults ages 19-64) FFS data and the 2006 Mercer study on the uninsured
- Trended to 7/1/10-6/30/11 (includes rate freezes currently in place)
- Base data adjusted for:
 - Differences in cost sharing
 - Limited benefits
 - Pent-up demand for needed services
 - Workforce effect (lower utilization for > 100% FGP)
 - Higher FPG (higher income groups typically healthier)
 - Adverse selection
 - Childless adult risks
- 60% participation rate (take-up rate)

Projected Costs of Medicaid Limited Benefit Package for Adults to 150% FPG

Medicaid Used as Sole Coverage

FPG	Uninsured	Projected Enrollment	PMPM	Total Annual Expenditures	State Share
0-100% FPG	280,895	168,536	\$ 274.96	\$ 556,080,378	\$ 193,905,228
101-133% FPG	98,008	58,803	\$ 241.08	\$ 170,113,190	\$ 59,318,469
133-150% FPG	43,435	26,062	\$ 241.08	\$ 75,396,648	\$ 26,290,811
Total	422,338	253,401	\$ 263.61	\$ 801,590,215	\$ 279,514,508

CCNC Savings

- No more savings projected for AFDC enrollment
- No savings projected for dual eligibles given the limited Medicaid expenditures for cost sharing and additional CCNC fees
- Assumes some Medicaid only ABD eligibles currently exempted/opting out of CCNC program will be enrolled in 2010-2011 (i.e. not all previously enrolled)
- Assumes CMS willingness to recognize CCNC program savings as presented in a waiver
- Assumes approximately 30,000 ABD eligibles to be enrolled in CCNC
- Estimated annual savings of \$71M, or \$25M of state funds

IPRS Funding Shift

Based upon discussions with the NC Division of MH, DD and SAS, the amount of IPRS funded services for individuals that may be eligible for this proposed expansion cannot reasonably be estimated due to the poor quality of the income data. The following should be considered in determining any amounts to be shifted to Medicaid from IPRS:

- The completeness and reliability of IPRS income data
- IPRS services are paid with State-only funds, but Medicaid services for the same individuals would be funded with State and Federal funds. Which basis should be used for determining a transfer of funds?
- IPRS programs have been reduced in the current State budget
- IPRS programs typically incur wait lists each year as the budget is exhausted; therefore, pent-up demand may drive-up utilization, as well as ongoing access to services
- The expansion benefit will provide mental health services to all enrollees, not only individuals previously receiving IPRS-funded services

Medically Needy Offset

- Approximately \$176M of Medically Needy claims in 2008 for services in the limited benefit package
- 37% of all these claims were for hospital inpatient services
- Assumed half of hospital inpatient claims would still be incurred in the Medically Needy program due to the limited benefit package limitation of \$10,000
- Pending additional income analysis, assume 50% to 90% of applicable expenditures may be covered by expansion producing a range of \$72M - \$129M
- State share of above range is \$25M - \$45M

Medicaid Premium Assistance for Adults up to 150% FPG with Access to ESI

Subsidies for individuals with access to ESI could be provided in two ways, based upon the Study Group's recommendations:

- Medicaid premium assistance for employer-sponsored plans
- Medicaid premium assistance for a CCNC public-private insurance product

Primary Assumptions for Medicaid Premium Assistance for ESI

- Subsidy would cover the entire portion of the employee's premium, whether for individual or individual plus spouse
- Coverage applies to the employee and spouse only, as children up to 150% FPG already qualify for Medicaid or Health Choice
- 60% single, 40% married
- 60% participation rate (take-up)
- ESI cost based on the North Carolina data in the 2008 Mercer National Survey of Employer-Sponsored Health Plans
- ESI coverage is limited to ESI benefits and ESI-level of cost sharing

Projection of Cost of Premium Subsidies for ESI

Medicaid Used for ESI Premium Assistance

	Low Income	Projected	Individual	Family	Annual	State
FPG	Employees	Enrollment	Coverage	Coverage	Expenditures	Share
0-100%	378,788	227,273	\$ 95.23	\$ 190.45	\$ 363,589,800	\$ 126,783,763
101-133%	253,546	152,127	\$ 95.23	\$ 190.45	\$ 243,372,608	\$ 84,864,028
134-150%	112,367	67,420	\$ 95.23	\$ 190.45	\$ 107,858,315	\$ 37,610,194
Total	744,700	446,820	\$ 95.23	\$ 190.45	\$ 714,820,723	\$ 249,257,986

Primary Assumptions for Medicaid Premium Assistance for CCNC Public-Private Insurance Product

- Assumed quasi-public nature of the entity will provide a 20% savings compared to current commercial products
- Assumed such savings would be equally applied to both the employee and employer share of premiums (i.e. employee's proportional share would remain comparable to current coverage)
- Subsidy would cover the entire portion of the employee's portion, whether for individual or including spousal coverage. Coverage applies to the employee and spouse only, as children up to 150% FPG already qualify for Medicaid or Health Choice
- 60% single, 40% married
- 60% participation rate (take-up)
- ESI cost based on the North Carolina data in the 2008 Mercer National Survey of Employer-Sponsored Health Plans

Projected Cost of Premium Subsidies for CCNC Public-Private Insurance Option

Medicaid Used for CCNC Product Premium Assistance						
<i>Assumes 20% reduction of commercial premiums</i>						
FPG	Low Income Employees	Projected Enrollment	Individual Coverage	Family Coverage	Annual Expenditures	State Share
0-100%	378,788	227,273	\$ 76.18	\$ 152.36	\$ 290,871,840	\$ 101,427,011
101-133%	253,546	152,127	\$ 76.18	\$ 152.36	\$ 194,698,087	\$ 67,891,223
134-150%	112,367	67,420	\$ 76.18	\$ 152.36	\$ 86,286,652	\$ 30,088,156
Total	744,700	446,820	\$ 76.18	\$ 152.36	\$ 571,856,578	\$ 199,406,389

Medicaid Eligibility Expansion to 185% FPG for Non-Pregnant Women Who Have Had Poor Birth Outcomes

Interconceptual Care

The original parameters of this projection included a benefit package for women up to 185% FPG that had delivered a low birth-weight baby or had a poor health outcome within the prior two years. Mercer is to evaluate potential savings from improved pre-conception care after offsetting costs of the limited benefits.

Initial analysis and modeling have resulted in various questions regarding how this program would be implemented. The details of operational design will be critical to the overall success of the program and realization of any financial savings.

Interconceptual Care - Eligibility

- AFDC eligibles receive full Medicaid benefits
- Medicaid Pregnant Women (MPW to 185% FPG) are supposed to receive pregnancy related services; this includes most Medicaid benefits
- Data shows many women moving from an AFDC category to a MPW category after becoming pregnant.
- Will eligibility be for AFDC women or MPW women only?
- Initial analysis:
 - MPW assumed to be those only for which an AFDC eligibility category was never assigned
 - Evaluating 2005-2007 (3 years of data)
 - An average of appx. 1300 FTEs (annual member months/12) per year projected to be eligible (LBW, VLBW, died/transferred)

Interconceptual Care – Benefits

- Concerns regarding the effectiveness of a limited benefit being sufficient for women with chronic diseases
- Coverage/access alone appear to limit desired outcomes; consideration of improved services/intervention would expand improved outcomes.
- Assumes pre-conception care is similar to current services provided to AFDC women
- Estimated 2009 costs for a non-pregnant woman in AFDC averages about \$200 PMPM

Interconceptual Care – Initial Analysis

- Analysis of cost (pre-natal, delivery, first year of life, etc.) targeted at second births, as women will only be eligible after an initial poor birth outcome
- Depending upon the criteria for a “healthy” birth, average cost over the study period of \$6,500-\$10,500
- Poor birth outcomes show average cost over the study period of:
 - LBW: \$18,000 - \$20,000
 - VLBW: \$57,000 - \$58,000
 - Death or transfer: \$30,000 - \$46,000
- Overall average cost of second births lower than average cost for initial births (poor birth outcome criteria for first birth)
- Certain chronic illnesses consistently result in higher costs (e.g. CHF, hepatitis)

Interconceptual Care – Considerations

- Eligibility shifting between AFDC and MPW
- Eligibility shifting from AFDC (for the mother) to ABD after delivery
- Extensiveness of interventions
- Additional risk adjusting
 - Age issues
 - Chronic conditions

Insurance Premium Subsidies to Small Businesses for Low- Wage Workers

Overview

Subsidies for employers that do not currently offer health insurance

- 15 or fewer employees
- 30% or more of the employees earn \$35,000/yr or less
- 50% or more of the total premium costs must be paid by the employer
- 75% or more of eligible employees, who do not have other creditable coverage, must enroll

Subsidies for employers that do currently provide health insurance

- 15 or fewer employees
- 30% or more of the employees earn \$35,000/yr or less
- 50% or more of the total premium costs must be paid by the employer
- 90% or more of eligible employees, who do not have other creditable coverage, must enroll

Primary Assumptions

- Subsidy is valued at 30% of the expected total premium (employer and employee amounts combined)
- Total premium based on employee coverage only; no subsidy is available for dependent coverage
- Employer can decide how to share the subsidy with employees (Note: To reach the 75% or 90% participation requirements, it is likely the employer will need to share some of the subsidy to qualify.)
- Premiums for the currently uninsured assumed to be the same as those of the currently insured (i.e. demographics of the uninsured are assumed consistent with those of the insured for small groups of 1-15 employees)
- Premiums are based on 2009 levels
- Premiums are reflective of NC small employers with 1-15 employees

Primary Assumptions (continued)

- Total NC employees: 3.4 million (2008 Medical Expenditure Panel Survey (MEPS) Insurance Component)
- 15.1% of total employees in NC are in groups 15 or less
- Depending on size of group, between 54%-62% of NC defined small groups provide coverage, and between 38%-46% do not (based on Employee Research Institute Estimates of the Current Population Survey, 2008 Nationwide)
- 55% (appx.) of employees assumed to earn \$35,000/yr or less (based on 2009 U.S. Census Bureau estimates for NC 18-64 population)
- 80% of employees are eligible for insurance (MEPS)
- 85% (appx.) probability that eligible employees will elect coverage (national average)
- 83% (appx.) probability that if an employer offers insurance, the employer will pay at least 50% of the total premium (Mercer 2008 Survey of Employee Benefits)
- \$4,800 average NC annual total premium (employee only)

Primary Assumptions (continued) (proprietary NC data)

<u>Distribution of Employees by Group Size</u>		<u>Distribution Within Groups With 15 or Fewer Employees</u>	
Group Size	Employee Distribution		
1	0.8%	1	23%
2	1.4%	2	19%
3	1.4%	3	13%
4	1.4%	4	10%
5	1.3%	5	7%
6	1.3%	6	6%
7	1.3%	7	5%
8	1.3%	8	5%
9	1.3%	9	4%
10	0.6%	10	2%
11	0.6%	11	2%
12	0.6%	12	1%
13	0.6%	13	1%
14	0.6%	14	1%
15	0.6%	15	1%
Total	15.1%	Total	100%

Probability Assumptions

- Uninsured Model – The probability of a particular small group providing coverage was determined based upon the group’s characteristics, e.g. health, age, size, etc. Consequently, the lower the expected premium, the higher the probability the group will offer coverage
- Insured Model – Assumed 100% of groups previously providing coverage will continue to provide coverage with the subsidy

Projected Costs for the Currently Uninsured

Subsidy for Currently Uninsured Small Groups

	Percentiles		
	50th	80th	90th
Total Annual Subsidy (total costs)	\$ 17,300,000	\$ 19,700,000	\$ 21,200,000
Number of Employees in Groups Receiving Subsidy	28,600	30,300	32,100
Number of Employers Receiving Subsidy	6,800	7,200	7,600
Number of Employees Receiving Subsidy	9,400	11,100	11,600

Projected Costs for the Currently Insured

Subsidy for Currently Insured Small Groups

	Percentiles		
	50th	80th	90th
Total Annual Subsidy (total costs)	\$ 56,100,000	\$ 60,700,000	\$ 62,100,000
Number of Employees in Groups Receiving Subsidy	119,200	123,500	125,600
Number of Employers Receiving Subsidy	28,400	29,400	29,900
Number of Employees Receiving Subsidy	34,200	35,800	36,900

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Total Projected Costs of Subsidies

Subsidy for All Small Groups

	Percentiles		
	50th	80th	90th
Total Annual Subsidy (total costs)	\$ 73,400,000	\$ 80,400,000	\$ 83,300,000
Number of Employees in Groups Receiving Subsidy	147,800	153,800	157,700
Number of Employers Receiving Subsidy	35,200	36,600	37,500
Number of Employees Receiving Subsidy	43,600	46,900	48,500

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Summaries

Summary – Medicaid Buy-In for Disabled Children

Coverage Description	FGP %	Projected Enrollment	Annual Expenditures	State Share
Medicaid Buy-In Program for Disabled Children: Full Benefits	201-300%	3,572	\$ 47,518,984	\$ 16,569,870
Medicaid Buy-In Program for Disabled Children: Wrap-Around Services	201-300%	7,358	\$ 34,459,331	\$ 12,015,969
Potential Offsets: \$1.5M Medically Needy (\$500,000 State share)				

Summary – Medicaid Expansion for Adults

Coverage Description	FGP %	Projected Enrollment	Annual Expenditures	State Share
Medicaid Eligibility Expansion for Adults: Limited Benefit Pkg	0-150%	253,401	\$ 801,590,215	\$ 279,514,508
Medicaid Eligibility Expansion for Adults: Premium Subsidies for ESI	0-150%	446,820	\$ 714,820,723	\$ 249,257,986
Medicaid Eligibility Expansion for Adults: Premium Subsidies for CCNC Product	0-150%	446,820	\$ 571,856,578	\$ 199,406,389
Potential Offsets: CCNC Savings of \$0-\$71M (\$0-\$25M state), IPRS Funding (?),				
Medically Needy Funding of \$72-\$129M (\$25-\$45M state)				
Note: Above amounts cannot be aggregated as some enrollees may be eligible for multiple programs.				

Summary – Small Employer Premium Subsidies

Coverage Description	Annual Income	Projected Enrollment	Annual Expenditures	State Share
Subsidies for Low-Wage Workers of Small Businesses: Currently Uninsured (90th percentile)	\$35,000	11,600	\$ 21,200,000	NA
Subsidies for Low-Wage Workers of Small Businesses: Currently Insured (90th percentile)	\$35,000	36,900	\$ 62,100,000	NA
Potential Offsets: None				

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Overview of National Health Reform Proposals

Presentation by: Pam Silberman, JD, DrPH
President & CEO
Health Access Study Group
October 28, 2009



Basics of National Health Reform--Overview

- o Under the major national proposals:
 - Individuals would be required to purchase insurance.
 - Larger employers would be required to offer and help pay for insurance.
 - Subsidies would be provided to help make coverage affordable.
 - New insurance “exchanges” would be created where individuals could purchase insurance, with insurance reform.
 - More emphasis on prevention, quality and cost-containment.





Individual Mandate and Subsidies

- *Individual mandate.* Citizens and legal immigrants will be required to have health insurance coverage:
 - Hardship waiver if health insurance is unaffordable.
 - Enforced through tax penalties.
- *Subsidies to Individuals:*
 - Most of the proposals would provide premium subsidies up to 400% FPG on a sliding scale basis (\$43,320/yr. for one person, \$88,200 for a family of four).
 - Bills also provide cost sharing subsidies.



Expansion of Public Programs

- Expands Medicaid to cover all low income people (including childless adults) with incomes below 133%/150% FPG.
- Depending on the proposal, children with incomes too high for Medicaid may have to purchase coverage through the “insurance exchange.”
- States will receive enhanced federal payments for the newly eligible:
 - However, states will have to cover costs of people who are currently eligible but who had not enrolled in the past.



● ● ● | Employer Mandate

- Employers will be required to provide health insurance to employees and pay percentage of premiums or pay into fund
 - Note: Senate Finance does not currently have an employer mandate; instead requires employers with 50+ employees to pay tax if their employees receive a tax credit through the exchange.
 - Exemption from mandate for some small businesses
 - Small businesses would be provided a tax credit to help pay for health insurance for employees (the amount of the tax credit will be based on number of employees and average wages)



● ● ● | Benefit Package

- All of the proposals would establish an essential health care benefits package that includes a comprehensive set of services:
 - Depending on proposal, must either be similar to or not more extensive than the benefits covered through typical employer plan.
 - No annual or lifetime limits, out-of-pocket maximum.
 - Independent commission to help in development of essential benefits package.



● ● ● | Long-Term Care

- Some of the proposals would establish national voluntary insurance program to purchase community living assistance services and supports financed through payroll deduction.



● ● ● | Insurance Pools (Insurance Exchange)

- State or national insurance “exchanges” through which individuals and small employers can purchase coverage:
 - Limited to individuals who do not have access to employer sponsored or governmental supported health insurance, small businesses (defined differently in plans).
- Exchanges will be required to offer 3-4 different levels of plans (with different coverage), with standardized information to help consumers choose between plans.
- Exchange would either offer public, or non-profit coop insurance option to help compete with commercial insurers.



● ● ● | Insurance Reform

- The same rules for guarantee issue, premium rating, prohibition on pre-existing condition exclusions applies in the insured market and exchange.
- Insurers would be required to report medical loss ratio; House would establish medical loss ratio of no less than 85%.
- Senate Finance Committee would allow sale of insurance products across state lines in certain prescribed instances.



● ● ● | Prevention and Wellness

- More funding for evidence-based prevention programs, and incentives for employers to offer worksite wellness programs:
 - Most proposals require coverage for evidence-based preventive services in Medicaid and Medicare with no cost sharing.
 - Most proposals allow employers to offer incentives to employees to participate in wellness activities.



● ● ● | Quality

- Different bills would:
 - Create center to study and disseminate best practices for delivery of health services.
 - Fund comparative effectiveness research to study outcomes, effectiveness and appropriateness of health care services and procedures.
 - Create standardized quality measures that could be used to assess health outcomes, continuity and coordination of care, safety.
 - Require collection of health data based on race, ethnicity, and primary language.



● ● ● | Health Workforce

- Some bills would create a Workforce Commission to study workforce needs and make recommendations.
- Bills provide more funding for graduate medical education training, particularly for primary care providers:
 - Some of the proposals would increase Medicaid and Medicare reimbursement to primary care providers or for providers in health professional shortage areas.
- Bills provide more funding to support training of nurses, public health workforce, dentists, mental and behavioral health.



● ● ● | Safety Net

- Some proposals would expand funding to safety net, including federally qualified health centers (ie, community health centers) and school-based health centers.

● ● ● | States Roles

- States would be required to:
 - Expand Medicaid to cover new eligibles, and facilitate enrollment for eligibles.
 - Create and operate new health insurance exchange.
 - Oversee insurance plans to make sure insurers meet new insurance market regulations.

● ● ● | Cost Containment

- More aggressive efforts to eliminate fraud and abuse.
- Bills would simplify health insurance administration, implement health information technology (HIT), include changes to provider payments to encourage efficiency and quality:
 - Some of the bills would test bundling of post-acute payments.
- Reduce Medicare and Medicaid costs, including:
 - Reducing payments for preventable hospital readmissions, Medicare Advantage plans, Medicare and Medicaid disproportionate share hospital payments (DSH).
 - Increasing Medicaid drug rebate.



● ● ● | Costs of Proposals

- Costs of proposal:
 - Senate Finance: \$829 billion over ten years. With financing proposals, would reduce deficit by \$81 billion over ten years.
 - House: \$1.042 trillion over 10 years.



● ● ● | Financing

- Both House and Senate would finance their proposals through reduced payments to Medicare Advantage plans (which currently receive extra payments than traditional Medicare), cuts to certain safety net hospitals who receive extra payments to care for the uninsured (DSH), and additional drug rebates.
- House would add a surcharge on incomes of wealthy individuals; Senate would add excise tax on high cost insurance plans.

● ● ● | Major Areas of Contention

- *Public plan, non-profit coop, or trigger*—plans differ in how to give consumers choice of plans and increase competition in the health insurance market.
- *Amount of subsidy* – the plans vary in the amount of the sliding scale subsidies for premiums and cost-sharing.
- *Mandates* – the bills differ in whether to mandate that employers offer and pay for insurance coverage, and the affordability threshold that would trigger the individual mandate.
- *Financing the plan*—bills differ in how to pay for the expanded coverage; any provision that taxes groups or cuts payment are controversial.



Useful Resources

- Comparisons of different national health reform proposals:
 - Kaiser Family Foundation: www.kff.org
- House Bill: America's Affordable Health Choices Act. (HR 3200).
 - Available at: <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3200>:
- Senate HELP bill: Affordable Health Choices Act (S 1679).
 - Available at: <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:S1679>:
- Senate Finance bill: America's Healthy Future Act (S 1796).
 - Available at: <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:S1796>:



HEALTH ACCESS STUDY GROUP
Wednesday, January 20, 2010
9:00 am – 1:00 pm
North Carolina Institute of Medicine

Thematic Topic: Delivery System Reform, HIT and Quality

9:00-9:15

Welcome and Introductions

Doug Berger, JD
Senator
North Carolina General Assembly

Hugh Holliman
Representative
North Carolina General Assembly

Allen Dobson, MD
Vice President Clinical Practice Development
Carolinas HealthCare System

9:15-10:00

**Update on National Health Reform
Proposals Relating to Delivery System Reform, HIT and
Quality**

Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine

10:00 – 10:45

Delivery System Reform: Accountable Care Organizations

Aaron McKethan, PhD
Research Director
Brookings Institute

10:45 – 11:45

Delivery System Reform: Patient Centered Medical Home

Medicare 646 Demonstration Waiver
Patient-Centered Medical Home for Medicare Population
Torlen Wade
North Carolina Community Care Network, Inc.

Patient Centered Medical Home for Commercially Insured
Population
Eugene Komives, MD
Vice President
Blue Cross Blue Shield of North Carolina

11:45-12:30

**Update on Health Information Technology in North Carolina
and Meaningful Use**

Steve Cline, DDS, MPH
Deputy State Health Director
Division of Public Health
North Carolina Department of Health and Human Services

North Carolina Efforts to Improve Quality: Meaningful Use

Alan Hirsch, JD
Executive Director
North Carolina Healthcare Quality Alliance

12:30-1:00

Task Force Discussion

HEALTH ACCESS STUDY GROUP
North Carolina Institute of Medicine
Wednesday, January 20, 2010
Meeting Summary

ATTENDEES

Task Force and Steering Committee Members: Senator Doug Berger, Allen Dobson, Representative Hugh Holliman, Tom Bacon, Louis Belo, Deborah Brown, Barbara Morales Burke, Kellan Chapin, Steve Cline, Bonnie Cramer, Abby Carter Emanuelson, Rep. Verla Insko, Sharon Jones, Tara Larson, David Moore, John Perry, Mary Piepenbring, John Price, William Pully, Anne Rogers, Vandana Shah, Allen Smart, Senator Josh Stein, Tom Vitaglione, Steve Wegner, Susan Yaggy, Jean Holliday, Carolyn McClanahan, Maggie Sauer, Flo Stein

Interested Persons: Nancy Henley, Alan Hirsch, Bob Jackson, Eugene Komives, Julia Lerche, Jessica Macrie, Aaron McKethan, Kathryn Millican, Tom Ricketts, Shannon Smith, Torlen Wade, Bill Wilson
NCIOM Staff and Interns: Pam Silberman, Mark Holmes, Kimberly Alexander-Bratcher, Berkeley Yorkery, Thalia Shirley-Fuller, Crystal Bowe

WELCOME AND INTRODUCTIONS

Representative Holliman greeted the participants and began the meeting.

OVERVIEW OF NATIONAL HEALTH REFORM PROPOSALS

Pam Silberman, JD, DrPH, President, North Carolina Institute of Medicine

Dr. Silberman's presentation provided an overview of national health reform proposals (as of January 20, 2010). Her overview compared the Senate's Patient Protection and Affordable Care Act (HR 3590) and the House's Affordable Health Care for America Act (HR 3962). Both bills make changes to public coverage (Medicaid, CHIP, and Medicare), private coverage, financing, and other provisions.

Public Programs: Under both bills' public programs *Medicaid would be expanded to cover all low income people* (including childless adults) who meet certain eligibility requirements (150% of the federal poverty guidelines (FPG) in House bill and 133% FPG in Senate bill). Other Medicaid provisions include demonstration projects to test new models of care and full coverage of preventive benefits if they are recommended by the US Task Force on Clinical Preventive Services. Additionally, both bills provide an enhanced federal match for those newly eligible under the Medicaid expansion. The *Children's Health Insurance Program (CHIP)*, which goes by the name NC Health Choice in North Carolina, *would undergo major changes under both bills*. Under both bills, CHIP would be repealed (in 2014 in House bill and 2019 in Senate bill). Some children would be covered after the repeal under Medicaid and some would enter the health insurance exchange. *Changes to Medicare* included coverage of preventive services with no cost-sharing, reducing the gap in the Part D "donut hole," and various reforms to Medicare payments.

Private Coverage: Under both bills, *individuals will be required to have health insurance coverage* (with a few exceptions based on income). This requirement would be enforced through tax penalties. The bills also provide subsidies to individuals under certain circumstances (circumstances differ in House and Senate bills). The employer "mandate" varies in the two bills. In the House bill, employers are required to provide health insurance to employees and dependents and pay part of the premium (or pay into the subsidy fund). The Senate bill does not have a direct employer mandate but does require certain businesses to pay into the subsidy fund if their employees do not have insurance. Some small businesses are exempt from this mandate and small businesses would be offered tax credits for the first two years to encourage them to offer insurance. The bills also *create a temporary reinsurance program* for employers providing health insurance coverage *for early retirees (55-64)* (which would apply to pre-Medicare

retirees in the State Health Plan). Both bills also recommend *an essential health care benefits package* that would be the required minimum benefits package. The essential health care benefits package includes preventive services as well as mental and behavioral health services and eliminates annual and lifetime limits. Both bills would establish a national voluntary insurance program to purchase community living assistance services and supports. Both bills would *create insurance pools or “exchanges”* to allow individuals and small employers to purchase coverage. These would be limited to individuals without access to employer or government sponsored health insurance. Additionally, both bills would create temporary high risk pools to provide health insurance coverage to people with pre-existing conditions. Under both bills, *insurers would be required to enroll any individual* (regardless of pre-existing conditions), allow children to remain on their parents policies longer, and adopt standards for financial and administrative transactions to promote simplification.

Other Provisions

- *Prevention:* Both bills create task forces on clinical preventive services and community preventive services, establish grant programs to support the delivery of evidence-based and community-based prevention and wellness services, and provide more funding for evidence-based prevention programs and incentives for employer worksite wellness programs.
- *Quality:* Both bills include plans to improve quality.
- *Testing New Models:* Both bills provide ways to test new payment delivery systems (such as accountable care organizations, bundling episode of care payments, and medical home models), encourage states to develop and test alternatives to the current medical liability systems and coordinate care between Medicare and Medicaid for dual eligibles.
- *Safety Net:* Both bills include provisions to expand funding to the safety net, support community-based collaborative networks of care, and create a trauma center program to strengthen trauma centers and emergency care coordination.
- *Workforce:* Both bills establish a Workforce Advisory Committee to develop a national workforce strategy, expand scholarship and loans for primary care, public health, nursing and increasing workforce diversity.

Financing: Both bills finance their proposals through new taxes on people without qualifying coverage, limits on contributions to flexible savings arrangements and increasing the tax on distributions from health savings accounts (HSAs) not used for health expenses, and increased drug rebates and taxes on certain health sectors (durable medical equipment, insurers, etc). The House and Senate bills differ on additional financing methods (the House proposes a tax on high income people and the Senate proposes taxing high cost “cadillac” insurance plans.

Some of the finance reform provisions include more aggressive efforts to eliminate fraud and abuse, simplifying health insurance administration, implementing health information technology (HIT), and reducing Medicare and Medicaid costs.

Cost Estimates of Reform Bills

The Congressional Budget Office estimates the House bill would cover an additional 36 million people, would expand insurance coverage costs by \$894 billion, and, through payment cuts and increases in revenues, would reduce the federal deficit by \$104 billion over 10 years. The Senate bill is estimated to expand coverage to 31 million, would expand insurance coverage costs by \$871 billion, and, through payment cuts and increases in revenues, would reduce the federal deficit by \$132 billion over 10 years.

State Role

States would be required to

- expand Medicaid to cover new eligibles and facilitate enrollment for eligibles, and

- create and operate a new health insurance exchange.

States can

- form Health Care choice compacts to facilitate the purchase of individual insurance across state lines.

Under Senate bill state would be required to

- oversee insurance plans to make sure insurers meet new insurance regulations.

FOSTERING ACCOUNTABILITY IN PROVIDER PAYMENTS: A CRITICAL ASPECT OF HEALTH CARE REFORM

Aaron McKethan, PhD, Research Director, Brookings Institution

Many of the current reform efforts focus on how to cut spending without cutting benefits, but it is difficult to figure out how to improve care while cutting costs. One method is to move away from the current fee-for-service model towards new payment plans that incorporate quality measures. Currently there are a number of different payment demonstration projects that focus on “shared savings.” In these models, providers and patients in a set area are identified and costs are projected based on past use of health care. Providers then implement new practices (technology, admissions reform, etc.) as they wish. Then real costs are compared to projected costs and any savings are shared between the payer and providers. The shared savings model allows providers to share in some portion of the savings from implementing new practices while cutting overall costs.

There are a number of different shared savings models being piloted for Medicare patients including:

- The Physician Group Practice (PGP) Demonstration, which offers 10 large practices, including the Forsyth Medical Group in Winston-Salem, the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service (FFS) beneficiaries. In year 3 of the demo, all 10 PGPs have shown quality improvements and 5 have shared in savings.
- Medicare “646” Waiver Demonstration (North Carolina Community Care Network, Inc. [NCCCN] is one of two demo sites) test the impact of various reforms. NCCCN is testing the impact of a physician-directed care management approach on care quality and efficiency. NCCCN is eligible for a portion of Medicare savings if spending reductions are achieved.
- Accountable Care Organizations (ACOs) are provider collaborations organized around the ability to receive shared-savings by achieving measured quality targets and real reductions in spending growth for the patient population. ACOs are being implemented in a variety of ways around the country from small communities to large teaching hospitals. ACOs rely upon strong relationships between physicians and hospitals.
- Center for Medicare and Medicaid Innovation: both health reform bills include new authority for Medicare and Medicaid to test a range of payment reforms.

There are a number of opportunities for state and regional initiatives to guide payment reform implementation. The stimulus legislation provides funding over several years to promote the use of HIT systems. There is support for broad-based, multi-stakeholder collaborations and priority will likely be given to states, like North Carolina, that can show they are already working on these issues. North Carolina can pursue public and private payment reform opportunities and work to create “learning networks” and technical assistance to support payment reforms.

MEDICARE 646 DEMONSTRATION WAIVER: PATIENT-CENTERED MEDICAL HOME FOR MEDICARE POPULATION

Torlen Wade, North Carolina Community Care Network, Inc.

Mr. Wade presented on North Carolina's "646" Waiver Demonstration Project. The 646 is a five-year demonstration, beginning in 2010, to improve the quality of care and service delivered to Medicare beneficiaries through major system re-design. North Carolina Community Care Networks (NCCCN) is the organization implementing the demonstration project. NCCCN has experience coordinating networks of care that improve quality and service delivery for the Medicaid population. During years one and two, NCCCN will manage approximately 30,000 dually-eligible beneficiaries receiving care in 150 practices in 26 counties. In year three, 150,000 Medicare-only beneficiaries will be added to the demonstration. In years three to five NCCCN will manage the care of 180,000 beneficiaries. To determine cost savings, the US Centers for Medicaid and Medicare will compare the utilization and costs of Medicare beneficiaries in NC 646 counties to that of Medicare beneficiaries in 78 counties in five neighboring states.

The population in this demonstration has high needs (50% have three or more chronic conditions, 75% have hypertension, 25% have heart disease, etc). Priority patients are those with three or more chronic conditions in the past 12 months, those with one or more inpatient admissions within the past six months, those with two or more ED visits within the past six months, and those with no primary care provider visits within the past year. Beneficiaries are assigned to intervention practices based on a retrospective analysis of claims data. Interventions include assisting patients in transition and those with complex conditions, reducing medication problems, strengthening the link between community providers, supporting the physician's ability to manage chronic care patients, and developing nursing home and palliative care initiatives.

The basic strategy will use the NCCCN network infrastructure to develop an effective system of chronic care management for 646 participants. The ultimate goal is to be able to expand this effective system of chronic care to all NC Medicaid and Medicare recipients. This is a major re-design at the central program office level, the network level, and the practice/medical home level in how care management is organized and delivered.

At the central program office level, there are a number of components that are being redesigned including developing an informatics center to provide timely and meaningful data, integrating Medicare data, providing aggregated reports to networks and practices, giving scheduled updates on best practices, centralizing patient education materials, and providing consultation to networks and practices as needed. At the network level, redesign components include building a team of case managers using a holistic approach, developing strong links with various providers, identifying and enrolling additional practices, and designating an informatics expert within each network. At the medical home level, redesign components include designating one or two people to be network liaisons, referring complex patients to network case manager as needed, expediting appointments for patients with acute needs or in transition, building additional capacity to proactively manage chronic illnesses and preventive care, and embedding supports in medical homes as needed.

Success will be determined by CMS expenditure and quality targets. Quality benchmarks will primarily be the benchmarks already used by NCCCN for their disease management initiatives (diabetes, chronic obstructive pulmonary disorder (COPD), and congestive heart failure (CHF)). Each year, NCCCN and CMS will propose a set of quality measures to be used to track changes in quality. Year one performance measures include measures for diabetes care, congestive heart failure, ischemic vascular disease, hypertension, post-myocardial infarction, and transitional care.

Savings will be determined by comparing the actual expenditures for the demonstration group compared to the expenditure targets. The shared savings paid to NCCCN is determined by CMS guidelines and could vary greatly. The use of any shared savings returned to NCCCN has to be approved by CMS. Approved use of savings includes support for on-going operations, per member per month (pmpm)

payments for Medicare patients to support services to the elderly, physician incentives for achieving quality objectives, and services provided to Medicare beneficiaries not covered by Parts A and B.

PATIENT CENTERED MEDICAL HOME FOR COMMERCIALY INSURED POPULATION

Eugene Komives, MD, Vice President, Blue Cross Blue Shield of North Carolina

Dr. Komives presented on the Blue Cross and Blue Shield of North Carolina (BCBSNC) definition of patient centered medical home (PCMH), the role of accreditation by the National Committee for Quality Assurance, and reimbursement strategies to reward medical home providers. Patient centered medical home has become a buzzword in the primary care community. While there are many definitions, BCBSNC needed a reproducible measure to use with their customers and clients. The BCBSNC definition and measure for PCMH has included information from the National Committee for Quality Assurance (NCQA) and measures of administrative efficiency and patient experience with care.

Using the NCQA recognition for PCMH, they created a Bridges to Excellence (BTE) pilot to improve provider quality. The pilot included practices with patients enrolled in BCBSNC and the North Carolina State Health Plan and standard NCQA programs like diabetes, heart and stroke care. The results showed improvements and cost savings.

The current BCBSNC quality program, the Blue Quality Physician Program, expands the BTE pilot. Provider performance will be evaluated for quality of care, administration efficiency, and patient experience. As the program expands, they hope to incorporate cost and efficiency of care as well. The program focuses heavily on quality, but also includes additional electronic prescribing and claims submission, and cultural competency training. In January, three practices had already met the criteria for enhanced reimbursement and many more are in the process. The goal is to have 250 physicians qualified for the program by the end of 2010. Future plans will enhance relationships with the medical home provider by providing reimbursement for behavioral health providers embedded in the medical homes and Community Pharmacist Practitioners, and developing a care management pilot program.

UPDATE ON HEALTH INFORMATION TECHNOLOGY IN NORTH CAROLINA AND MEANINGFUL USE

*Steve Cline, DDS, MPH, Deputy State Health Director, Division of Public Health
North Carolina Department of Health and Human Services*

In the United States, we are trying to completely change the health care system in this country by changing the health information technology (HIT). Currently HIT is hot topic and funding for HIT is relatively new. HIT is still an evolving idea.

In the American Recovery and Reinvestment Act (ARRA) legislation, there was a lot of funding to implement HIT tied to five goals: improving clinical health outcomes; improving population health outcomes; increasing efficiency in the “health care system”; empowering individuals; and improving quality. At the federal level, the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS) are leading the HIT effort.

The ONC is responsible for laying the foundation for a learning health care system that can make health reform a self-sustaining reality. The plan to accomplish this is building a nationwide interoperable health information system with Electronic Health Records (EHR) for all by 2014. The ONC has issued new regulations on “Meaningful Use,” EHR Standards, Implementation Specifications, and Certification Criteria, and the Certification Process. They are also implementing new programs including regional extension centers (NC Lead Agency: NC AHEC), Health Information Exchanges (NC Lead Agency: NC

Health and Wellness Trust Fund – HIT Collaborative), workforce training (NC Lead Agency: Pitt Community College), and Beacon Communities (4 NC communities looking to apply for funds).

CMS is implementing payment programs to incentivize the switch from paper to EHR and other HIT. Under the Proposed CMS rule, medical professional and hospitals must be “meaningful users” of EHR in order to qualify for maximum federal HIT funds. Eligible professionals (EP) and eligible hospitals (EH) shall be considered a meaningful user for an EHR reporting period for a payment period year if they: use a certified EHR in a meaningful way, use an EHR for HIE, and supply specified quality reporting.

CMS will reimburse EP and EH in three stages based on their progress from 2011-2015. Stage I includes the electronic capture of health information in coded format, tracking key clinical conditions, care coordination, and decision support. Stage I Criteria for EP include being a primary care provider (at least initially), using computerized provider order entry (CPOE) on 80% of all orders, monitoring prescriptions for drug-drug interactions and allergies, maintaining a problem list for 80% of patients, e-prescribing for 75% of prescriptions, and 21 more regulations. Similarly there are 23 criteria for eligible hospitals. Stage II expands on Stage I and requires CPOE, transitions in care, electronic transmission of test results, and research. Stage III expands on Stage II and promotes improvements to quality and safety, clinical decision support at a population level, patient access and involvement.

NORTH CAROLINA EFFORTS TO IMPROVE QUALITY: MEANINGFUL USE

Alan Hirsch, JD, Executive Director, North Carolina Healthcare Quality Alliance

People that build health information technology (HIT) systems are in the process of recognizing how important it is to have modern day technology. If we merely do what has always been done on paper on computers, we will not have changed anything. We need to use these changes in HIT to drive changes in actual care and improve quality.

The real message is to be sure that we design better office systems for physicians so their offices are more efficient and can serve patients better (ex. system that flags irregular lab test results rather than just adding them to an electronic health record (EHR)).

EHR and HIT are tools to improve the quality of care. We need to make sure all of this is aligned together with quality initiatives. Although funding streams for these different efforts are separate, they need to dovetail around improving quality.

TASK FORCE DISCUSSION

The meeting closed with discussion of possible topics for future meetings. The next meeting will be held Wednesday February 17, 2010.



Overview of National Health Reform Proposals

Pam Silberman, JD, DrPH
Access to Care Study Group
January 20, 2010



House and Senate Bills in Conference

- House Bill: America's Affordable Health Care for America Act. (HR 3962)
 - Blends and updates three committee versions of HR 3200
- Senate Bill: Patient Protection and Affordable Care Act (HR 3590)
 - Blends and updates two Senate bills: Affordable Health Choices Act (S 1679)(HELP committee), and America's Healthy Future Act (S 1796) (Finance committee)



Information from different sources including two bills, Kaiser Family Foundation, some recent news articles



Basics of National Health Reform--Overview

- Changes in public coverage
 - Medicaid, CHIP and Medicare
- Private coverage
 - Individual mandate and subsidies
 - Employer pay or play
 - Standardized benefit package
 - Health insurance “exchanges”
- Financing and other provisions
 - Prevention, quality, workforce and cost-containment
 - Financing mechanisms



Basics of National Health Reform--Overview

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Expansion of Public Programs

- Expands Medicaid to cover all low income people (including childless adults) with incomes:
 - House: Up to 150% FPG (begins FY 2013)
 - Senate: Up to 133% FPG (begins FY 2014)*

Family Size	133% FPG/yr. (2009)	150% FPG/yr. (2009)
1	\$14,404	\$16,245
2	19,378	21,855
3	24,352	27,465
4	29,327	33,075



* Senate: At state option, state could create Basic Health Plan for people between 133-200% by contracting with private insurers

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Other Medicaid Provisions

- New demonstration projects to test new models of care.
- Full coverage of preventive benefits if recommended by US Task Force on Clinical Preventive Services





Enhanced Federal Match for Medicaid Expansion

- House: Federal government will pay 100% of costs of new eligibles in FY 2013, 2014 and then 91% thereafter.
 - Enhanced rate also applies to costs of increasing primary care provider rates to 100% Medicare
- Senate: Federal government will pay 100% of costs of new eligibles in first three fiscal years (2014-2016)
 - After first three years, federal contribution would vary but NC would receive 34.3 percentage points greater match (2017) in their FMAP rates, 33.3 (2018), 32.3 (2019 and thereafter)
- *However, states will have to cover costs of people who are currently eligible but who had not enrolled in the past.*



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CHIP (NC Health Choice)

- House: CHIP repealed beginning 2014
 - Children <150% FPG covered by Medicaid,
 - Children with incomes above 150% FPG who were enrolled in separate CHIP plan will obtain coverage through the exchange (ie, NC children ages 6-18)
 - Children with incomes above 150% who were in Medicaid will continue to receive Medicaid (ie, NC children ages 0-5) at an enhanced match rate
- Senate bill continues CHIP until 2019.
 - Beginning in 2015, states will receive 23 percentage point increase in CHIP match rate up to 100%. Children ineligible to enroll because of enrollment caps will be eligible for tax subsidies in the exchange.



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Medicare

- Enhances preventive services
 - Covers preventive services with no cost-sharing
- Reduces the gap in the Part D “donut hole”
 - House: \$500 in 2010 (phased out completely by 2019)
 - Senate: \$500 in 2010 (with 50% discount on brand-name drugs covered for most other individuals)
- Reduces payments to Medicare Advantage plans



Medicare Payment Reforms

- Enhances payments to certain physicians
 - House: 5% for primary care providers, additional 5% if practicing in underserved area
 - Senate: 10% for some primary care providers and 10% for general surgeons practicing in underserved areas
- Test payment and delivery system reform
 - Examples: Accountable care organizations, medical homes, bundled payments for post-acute care
- Reduce payments to hospitals
 - For excess preventable readmissions
 - Disproportionate share hospital payments (based on reductions in uninsured)





Basics of National Health Reform--Overview

- Changes in public coverage
 - Medicaid, CHIP and Medicare
- **Private coverage**
 - **Individual mandate and subsidies**
 - **Employer pay or play**
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 - **Health insurance “exchanges”**
- Financing and other provisions
 - Prevention, quality, workforce and cost-containment
 - Financing mechanisms



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Individual Mandate

- Citizens and legal immigrants will be required to have health insurance coverage:
 - Hardship waiver if health insurance is unaffordable.
 - Enforced through tax penalties.
 - House: 2.5% of adjusted gross income above the filing threshold;
 - Senate: greater of \$95/year/person in 2014, rises to \$495 (2015), \$750 (2016) with max. of \$2250/family or 2% household income.
- Exemption/Affordability defined:
 - House: exemption if not required to file taxes
 - Senate: exemption if below 100% FPG or lowest cost plan exceeds 8% of income.



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● ● ● | Subsidies

- *Subsidies to Individuals:*
 - Bills would provide premium subsidies up to 400% FPG on a sliding scale basis (\$43,320/yr. for one person, \$88,200 for a family of four).
 - Bills have differential cost sharing subsidies.
 - Both bills have sliding scale limit on out-of-pocket payments
 - Individuals generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid or Medicare
 - Unless employee premiums exceed 9.8% (S) or 12% (H) of the individual's income.



● ● ● | House Subsidy Example

	Premium credits	Cost-sharing credits	OOP spending limits
133-150% FPG	1.5%-3.0%	97%	\$500 ind/\$1,000 family
150-200% FPG	3-5.5%	93%	\$1,000/\$2,000
200-250% FPG	5.5-8.0%	85%	\$2,000/\$4,000
250-300% FPG	8-10%	78%	\$4,000/\$8,000
300-350% FPG	10-11%	72%	\$4,500/9,000
350-400% FPG	11-12%	70%	\$5,000/\$10,000



Premium credits based on the average cost of the three lowest cost basic health plans. Effective January 1, 2013.

● ● ● | Senate Subsidy Example

	Premium credits	Cost-sharing credits	OOP spending limits
100-150% FPG	2%-4.6%	90%	\$1,983 ind./ \$3,967 family
150-200% FPG	4.6%-6.3%	90%	\$1,983/\$3,967
200-250% FPG	6.3%-8.1%	80%	\$2,975/\$5,950
250-300% FPG	8.1%-9.8%	70%	\$2,975/\$5,950
300-350% FPG	9.8%	70%	\$3,987/\$7,973
350-400% FPG	9.8%	70%	\$3,987/\$7,973



Premium credits tied to second lowest-cost "silver" plan. Effective January 1, 2014.

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● ● ● | Employer Mandate

- Employers will be required to provide health insurance to employees and pay percentage of premiums or pay into fund
 - House: Must cover 72.5% of premium of lowest cost plan for the individual employee; 65% of premium cost of lowest cost plan for family.
 - Senate does not currently have an employer mandate; instead requires employers with 50+ employees to pay lesser of \$750 penalty *per employee* if employer does not offer health benefits and if *any* of the workers obtain subsidized coverage through the health insurance exchange, or \$3000/employee who receives a subsidy.



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● ● ● | Exemptions from Mandate

- Exemption from mandate for some small businesses
 - House: Exempt from mandate if payroll is below \$500,000. Sliding scale “pay” requirement if between \$500,000-\$750,000 (2-6% of wages). Those above \$750,000 in wages pay full 8% if don’t offer insurance.
 - Senate: Exempt if <50 employees.
- Mandatory enrollment
 - House: Employers must enroll employee in lowest cost plan if employee doesn’t select a plan and doesn’t opt out
 - Senate: Employers with more than 200 employees must automatically enroll employees in the plan offered



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● ● ● | Small Employer Tax Credits

- Small businesses <25 employees, avg wages of \$40,000 (H) or \$50,000 (S) will be offered a tax credit for up to 2 years to encourage them to offer insurance.
 - House:
 - 50% of premium costs for employers with 10 or fewer and average wage of \$20,000 or less, phased out as employer size and avg. wages higher
 - Senate:
 - 2011-2013-- Tax credit of up to 35% of employer’s contribution (if employer contributes at least 50%). Full credit if fewer than 10 employees and avg wages of \$25,000 or less. Small credit for tax-exempt organizations.
 - 2014+--tax credit for two years of up to 50% of premium costs if purchase in the exchange.



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Temporary Reinsurance for Coverage of Pre-Retirees

- House and Senate would create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55-64.
 - Program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000.
 - Reinsurance will be used to lower premium cost for enrollees
 - Effective 90 days after enactment.
 - *Applies to pre-Medicare retirees in State Health Plan*



Benefit Package

- Secretary (S) or Health Benefits Advisory Council (H) will recommend an essential health care benefits package that includes a comprehensive set of services:
 - Essential benefit package must cover at least 60% actuarial costs (S) or 70% (H), and be similar to (not more extensive) than benefits covered through typical employer plan.
 - All qualified health plans offered through Exchange, small group or individual market must provide at least essential benefits (except grandfathered plans)
 - Generally, benefits will be the same across different levels of benefits, with different cost sharing limits

● ● ● | **Benefits Package**

- House:
 - Four levels of plans: Basic (coverage of 70% costs), enhanced (85%), premium (95%), premium plus (can offer additional benefits)
 - OOP limits of \$5,000/\$10,000
- Senate Finance:
 - Four levels of plans: Bronze (basic) (65%), silver (70%), gold (80%), platinum (90%) and young invincible plan for people up to age 30 or those who are exempt from purchasing coverage (with catastrophic coverage)
 - OOP: \$5,950/\$11,900



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● ● ● | **Benefits Coverage**

- Preventive services
 - Plans must cover preventive services recommended by Task Force on Clinical Preventive Services with no cost sharing in Medicare, Medicaid and private plans offered through the Health Insurance Exchange
- Annual and lifetime limits
 - Cannot include annual or lifetime limits
- Mental and Behavioral Health
 - Essential benefits package would include mental health and substance abuse treatment services.



22

● ● ● | Long-Term Care

- House and Senate would establish national voluntary insurance program to purchase community living assistance services and supports (CLASS) financed through payroll deduction.
 - Plans provide for a 5-year vesting period and cash benefits of not less than an average of \$50/day to purchase non-medical services and supports
 - Financed through automatic payroll deduction (unless opt-out)
- Senate has provisions to allow states to expand home and community based services to more people through Medicaid.



23

● ● ● | Insurance Pools (Insurance Exchange)

- State or national insurance “exchanges” through which individuals and small employers can purchase coverage:
 - House: National exchange, but states could create own or create regional exchange.
 - Senate: States exchanges, separate for individual and small employer (but can be combined at state option), can form regional exchange.
- Limited to individuals who do not have access to employer sponsored or governmental supported health insurance and small businesses (phased up over time)
- Exchanges will be required to offer standardized information to help consumers choose between plans.



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Public Plan and Cooperatives

- House included a public plan but that appears to be “off the table” in negotiations
- Senate requires Office of Personnel Management to contract with at least two multi-state plans in each exchange.
 - At least one must be non-profit; plans must be licensed in each state.
 - Separate risk pool than Federal Employees
- Both Senate and House promote cooperatives as alternative to existing insurers



Temporary High Risk Pool

- Both bills establish a temporary national high-risk pool to provide health insurance coverage to people with pre-existing conditions
 - Must be uninsured for at least six months
 - House: Premiums not higher than 125% prevailing rate and can vary no more than 2:1 due to age, deductibles limited to \$1,500 ind, maximum cost sharing \$5,000 ind.
 - Senate: Premiums may vary no more than 4:1, cost sharing limited to current HSA limit (\$5,950 ind, \$11,900 family)





Insurance Reform

- Insurers would be required:
 - Enroll any individual, and cannot exclude, charge people more or rescind policies because of preexisting conditions or use of health services
 - Limit age adjustment to 2:1 (H), 3:1 (S)
 - Report medical loss ratio
 - Submit premium rate increases to regulators for review and/or approval
- Children can remain on parents policy until age 27(H), 26(S).
- Secretary with NAIC would adopt standards for financial and administrative transactions to promote simplification.
 - Bills have different requirements about whether federal (H) or state enforcement (S)



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Basics of National Health Reform--Overview

- Changes in public coverage
 - Medicaid, CHIP and Medicare
- Private coverage
 - Individual mandate and subsidies
 - Employer pay or play
 - Standardized benefit package
 - Health insurance “exchanges”
- Financing and other provisions
 - Prevention, quality, workforce and cost-containment
 - Financing mechanisms



28

● ● ● | Prevention

- Both bills create task forces on clinical preventive services and community preventive services
- Establish grant programs to support the delivery of evidence-based and community-based prevention and wellness services
 - Priority given to reduce health disparities (broadly defined as racial, ethnic, socioeconomic, geographic, etc. disparities)



● ● ● | Prevention and Wellness

- More funding for evidence-based prevention programs, and incentives for employers to offer worksite wellness programs:
 - Encourage *small businesses* to offer wellness programs
- Require chain restaurants/vendors to post nutritional content of foods sold



● ● ● | Quality

- Different bills would:
 - Fund comparative effectiveness research to study outcomes, effectiveness and appropriateness of health care services and procedures.
 - Create standardized quality measures and reporting requirements to assess health outcomes, continuity and coordination of care, safety, and health disparities.
 - Reduce payments to hospitals and health care providers for certain adverse health events
- Senate would test value-based purchasing for hospitals and nursing homes



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● ● ● | Testing New Models

- Both the House and Senate would test new payment methodologies/delivery systems
 - Bundling of payments for acute, inpatient and post-acute services; accountable care organizations; patient-centered medical homes; independence at home demonstration project to high-needs Medicare beneficiaries (H)
- Encourage states to develop and test alternatives to current medical liability system
- Coordination of care between Medicare and Medicaid for dual eligibles



32

● ● ● | Safety Net

- Proposals would expand funding to safety net, including federally qualified health centers (ie, community health centers) and school-based health centers.
- Both bills would support community-based collaborative networks of care
 - Networks of safety net and private providers link low-income people to medical homes, help coordinate services, and provide care management
- Both bills create trauma center program to strengthen trauma centers and emergency care coordination



33

● ● ● | Workforce General

- Both bills establish a Workforce Advisory Committee to develop national workforce strategy
 - Expand/reform Graduate Medical Education (GME) with more emphasis given to primary care residencies (H,S) and general surgery (S), and more training in outpatient settings.
- Expansion of scholarship and loans, including primary care, public health, nursing, diversity
- Other training priorities include:
 - Diversity, interdisciplinary team training, oral health professionals, mental health professionals, medical home models, integration of physical, behavioral health, oral health needs.



● ● ● | States Roles

- States would be required to:
 - Expand Medicaid to cover new eligibles, and facilitate enrollment for eligibles.
 - Create and operate new health insurance exchange (House creates a federal exchange, but states can operate if they meet all the requirements).
 - Senate requires state regulators to oversee insurance plans to make sure insurers meet new insurance regulations (ie, consumer protections, rate review, market regulations, premium taxes).
 - States can form Health Care choice compacts to facilitate the purchase of individual insurance across state lines.



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● ● ● | Cost Containment & Financing

- More aggressive efforts to eliminate fraud and abuse.
- Bills would simplify health insurance administration, implement health information technology (HIT), include changes to provider payments to encourage efficiency and quality
- Reduce Medicare and Medicaid costs, including:
 - Reducing payments for preventable hospital readmissions or health care acquired conditions, Medicare Advantage plans, Medicare and Medicaid disproportionate share hospital payments (DSH).
 - Increasing Medicaid drug rebate.



36

● ● ● | Financing

- Both House and Senate would finance their proposals through:
 - New taxes for people without qualifying coverage (unless exempt)
 - Limits on contributions to flexible savings arrangements (\$2,500/year) and increase on tax on distributions from Health Savings Accounts (HSAs) that are not used for health expenses
 - Increased drug rebates, and taxes on certain health sector (DME, insurers, etc.)



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● ● ● | Financing (cont'd)

- Senate:
 - Increase Medicare Part A tax rate (from 1.45% to 2.35%) on earnings >\$200,000/\$250,000
 - Limit deductible of executive and employee compensation to \$500,000 for health insurance providers
 - Tax of 10% for indoor tanning services
- House:
 - 5.4% surtax on high income people (\$500,000/\$1.0 million)
- Senate and House potential compromise:
 - Excise tax on employer-sponsored health plans that exceed \$8,900 ind/\$24,000 family (indexed by CPI plus one percentage point)*



* Higher threshold for people in high risk professions, or plans that have significant numbers of women or older workers. Excludes costs of separate dental and vision coverage (2015). Public employee and union plans would be exempt until 2018.



CBO Estimates of Costs of Proposals

- House bill (HR 3962):
 - Expansion of insurance coverage costs \$894 billion. With other payment cuts and increase in revenues the bill would lead to a reduction in the federal deficit by \$104 billion over 10 years.
 - Would cover an additional 36 million people (leaving 18 million uninsured). Covers 96% of legal, nonelderly people.
- Senate substitute to HR 3590
 - Expansion of insurance coverage costs \$871 billion over 10 yrs (\$132 billion reduction in deficit over 10 years).
 - Would cover an additional 31 million (leaving 23 million nonelderly uninsured). Covers 94% of legal, nonelderly.



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Meetings of Health Access Study Group

- January: Delivery system reform, HIT and quality
- February: Insurance reform and what it means to North Carolina (high risk pool, insurance oversight, health insurance exchange), quality
- March: State Health Plan, Medicaid and CHIP, and prevention
- April: Workforce (funding for new or expanded programs, new training requirements, GME, loan and scholarships)





Useful Resources

- Comparisons of different national health reform proposals:
 - Kaiser Family Foundation:
http://www.kff.org/healthreform/upload/housesenatebill_final.pdf
- House Bill: America's Affordable Health Care for America Act. (HR 3962).
 - Blends and updates three committee versions of HR 3200
 - Available at: <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3962>:
- Senate Bill: Patient Protection and Affordable Care Act
 - Available at: <http://www.democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>



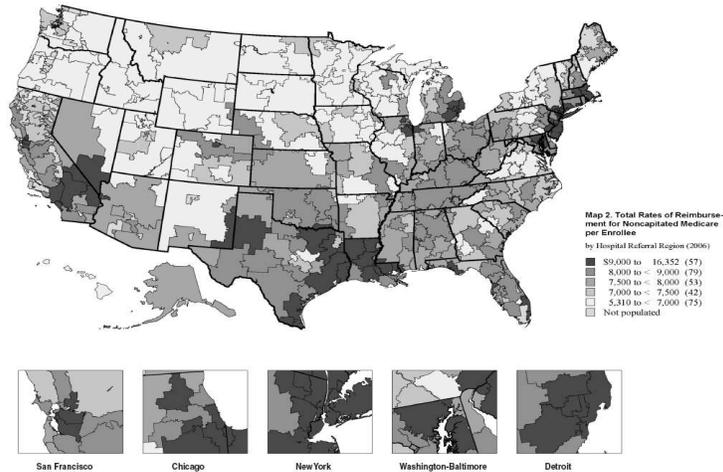
Fostering Accountability in Provider Payments

A Critical Aspect of Health Care Reform

Aaron McKethan, PhD
Engelberg Center for Health Care Reform
The Brookings Institution

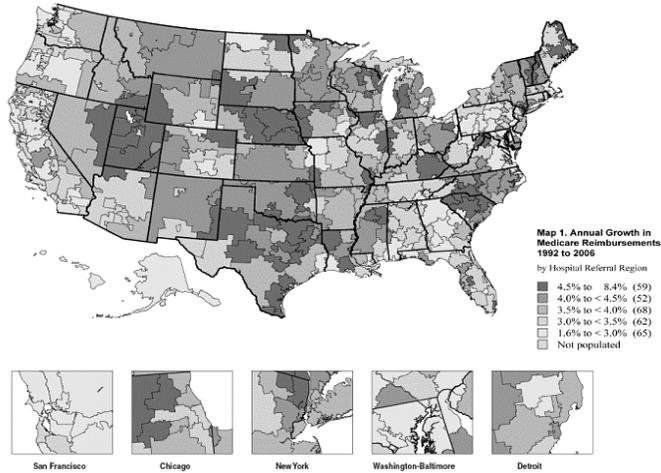
January 20, 2010

Regional Variations in Per Capita Medicare Spending (2006)



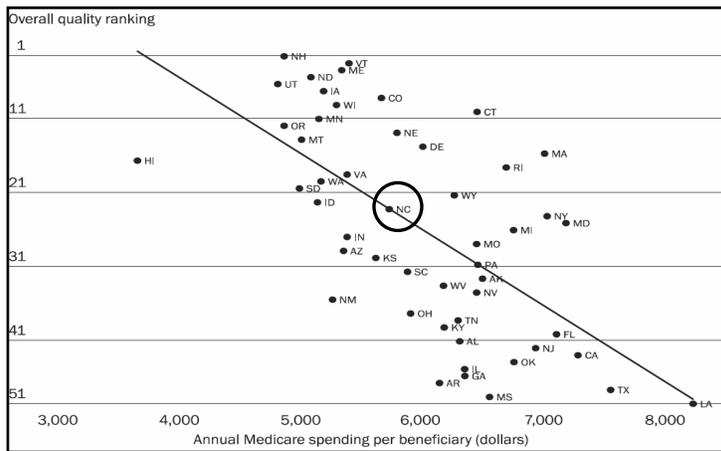
Source: The Dartmouth Atlas Project.

Regional Variations in Growth of Per Capita Medicare Spending, 2006



Source: The Dartmouth Atlas Project.

Higher Health Care Spending Is Not Associated With Better Quality



Source: Baicker K, Chandra A. Health Affairs web exclusive, April 7, 2004.

North Carolina HHRs (1992-2006)

City Name	Total Medicare reimbursements per enrollee (Part A and B) (2006)	Growth rate (1992-2006)
National Average	\$ 8,304	3.5 %
State Average	\$ 7,492	4.3 %
Asheville	\$ 6,359	3.3 %
Charlotte	\$ 7,742	4.7 %
Durham	\$ 7,202	4.1 %
Greensboro	\$ 7,036	4.6 %
Greenville	\$ 7,354	4.4 %
Hickory	\$ 7,764	4.6 %
Raleigh	\$ 8,051	4.5 %
Wilmington	\$ 7,899	3.6 %
Winston-Salem	\$ 7,702	4.4 %

Source: The Dartmouth Atlas Project.

Progression of Payment Reform

Past and Emerging Models of Accountability in Provider Payments

Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
<p>Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.</p>	<p>Payment for coordination. Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).</p>	<p>Pay for performance. Provider fees tied to one or more objective measure of performance (e.g., guideline-based payment, nonpayment for preventable complications).</p>	<p>Episode-based payments. Case payment for particular procedures or conditions based on quality and cost.</p>	<p>Shared savings with quality improvement. Providers share in savings resulting from better care coordination and disease management.</p>	<p>Partial or full capitation with quality improvement. Systems of care assume responsibility for patients across providers and settings over time.</p>

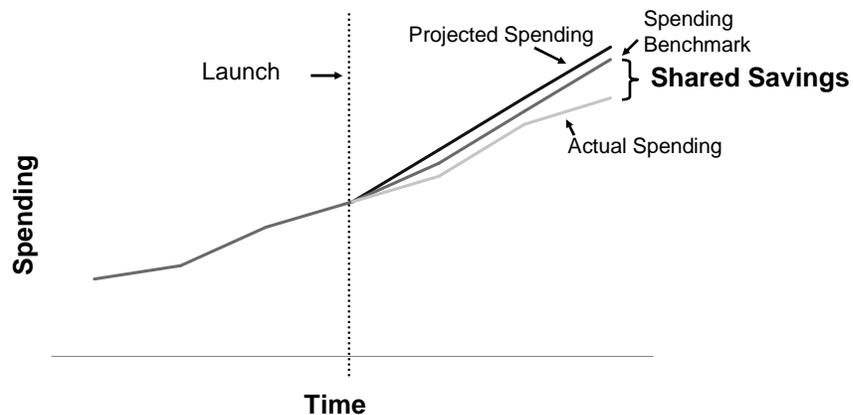
Past and Future Reform Models

Recent and Emerging Federal Payment Reform “Pathways”

- Medicare Physician Group Practice Demonstration
- Medicare Health Quality Demonstrations (“646 Demos”)
- Accountable Care Organizations
- Medicare and Medicaid Innovation Center

How Do “Shared Savings” Models Work?

Shared savings derived from spending below benchmarks



Physician Group Practice (PGP) Demo

- The PGP Demo was legislatively mandated in 2000 as a 5-year shared savings/quality improvement demonstration with Medicare
 - **Billings Clinic**; Billings, MT
 - **Marshfield Clinic**; Marshfield, WI
 - **Dartmouth-Hitchcock Clinic**; Bedford, NH
 - **Middlesex Health System**; Middletown, CT
 - **The Everett Clinic**; Everett, WA
 - **Park Nicollet Health Services**; St. Louis Park, MN
 - **Forsyth Medical Group**; Winston-Salem, NC
 - **St. John's Health System**; Springfield, MO
 - **Geisinger Health System**; Danville, PA
 - **University of Michigan Faculty Group Practice**; Ann Arbor, MI

Physician Group Practice (PGP) Demo Cont.

- **Summary of Results**
 - Year 1
 - All demos improved clinical management of diabetes; 2 demos achieved benchmark performance on all 10 diabetes measures
 - Two demos shared in savings (\$7.3 M in payments)
 - Year 2
 - All 10 demos continued to improve quality scores
 - Four demos shared in savings (\$13.8 M in payments)
 - Year 3
 - All 10 demos continued to improve quality scores
 - Years 1-3: Average of 10% pts on diabetes, 11% pts on CHF, 6% pts on CAD, 10% pts on cancer screening, 1% pt on hypertension
 - Five demos shared in savings (\$25.3M)

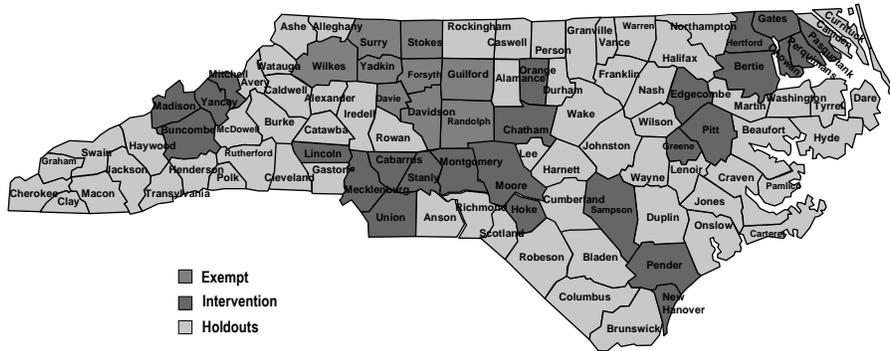
Medicare “646” Demo: Indianapolis

- The Indiana Health Information Exchange (IHIE), through its Quality Health First (QHF) Program, is a community-wide quality measurement and P4P health information exchange made up of a coalition of physician practices, hospitals, employers, private and public payers, and public health officials.
- Multi-payer program includes several components.
 - A comparative performance reporting and tracking system that provides participating physicians with information on the extent to which the care complies with evidence-based practice guidelines
 - A pay-for-performance incentive system that uses information on adherence to treatment guidelines and practice efficiency to distribute savings that are achieved through better care management
- Demonstration waiver authority has added Medicare to the list of participating private and public payers and will allow the IHIE to qualify for a portion of Medicare savings if spending reductions are achieved.

Medicare “646” Demo: North Carolina

- The North Carolina Community Care Networks (NC-CCN) is a non-profit organization made up of regional health care networks of community physicians, hospitals, health departments, and other community organizations.
- Under the MHCQ demonstration, NC-CCN will test the impact that a physician-directed care management approach will have on care quality and efficiency.
 - Enhanced provider fees for medical homes and use of technology to support care coordination and evidence-based practice
 - Regional physician pay-for-performance program supported by a common set of quality measures
- Demonstration waiver authority expands the program population to the dual eligible and general Medicare FFS population and will provide NC-CCN with the opportunity to qualify for a portion of Medicare savings if spending reductions are achieved.

Medicare “646” Demo: North Carolina



Medicare “646” Demo: Shared-Savings Models

Controls	<ul style="list-style-type: none"> Control counties are located in Indiana, Wisconsin, Ohio, and Kentucky 	<ul style="list-style-type: none"> Control counties are located out-of-state
Shared Savings Model	<ul style="list-style-type: none"> Maximum payment to IHIE will be the lesser of three amounts: 80% of net savings; 50% of gross savings; or 5% of the expenditure target Must meet 1.5% savings threshold Shared savings capped at 5% of total expenditures 	<ul style="list-style-type: none"> Maximum payment to NC-CCN will be the lesser of three amounts: 80% of net savings; 50% of gross savings; or 8% of the expenditure target Must meet 2.9% savings threshold (year 1) and (1.5% in year 3) Shared savings capped at the lower of 8% of control group (target) or 50% of gross savings to Medicare
Spending Benchmarks	<ul style="list-style-type: none"> Baseline expenditure targets for physician panels calculated on a per beneficiary per month (PBPM) basis 12 month before demo start Each cohort has its own base 	<ul style="list-style-type: none"> Separate expenditure targets will be calculated for dual-eligible and Medicare-only patient panels. The expenditure target for a performance year will be equal to the beneficiary-month-weighted average
Quality/Efficiency	<ul style="list-style-type: none"> Percent of available savings contingent on performance increases with each year from 50% in year 1 to 80% in year 5 	<ul style="list-style-type: none"> Percent of available savings contingent on performance increases with each year from 50% in year 1 to 80% in year 5

Accountable Care Organizations (ACOs)

ACOs are provider collaborations organized around the ability to receive shared-savings bonuses by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.

1. **Voluntary Provider Participation:** Established governance structure and broad (voluntary) physician and payer participation. Ideally participation by Medicare.
2. **Local Accountability:** Providers, payers, and consumers receive regular, risk-adjusted reports about performance with benchmarks.
3. **Payment Incentives:** Participating payers agree to adopt their own provider payment incentives that, at a minimum, involve QI and may include cost savings and efficiency incentives based on performance across specified populations.
4. **Performance Measurement:** Well-established performance measures relevant to multiple payers/populations. Measures become more sophisticated over time.
5. **Integration with Other Reforms:** ACOs are compatible with and reinforced by other delivery system reforms to ensure coordinated, high-quality care (e.g., consistent with “Triple Aim” goals).

Center for Medicare and Medicaid Innovation

- **Reform legislation includes new authorities for Medicare and Medicaid to test a range of new payment reforms**
 - Historical parallels: Agricultural extension or welfare reform models
- **Key challenges: Authority is necessary but not sufficient**
 - Infrastructure for data support
 - Building an effective organization within CMS
 - Focusing on high-priority payment reforms
 - Transitioning to real accountability for cost/quality
 - Clear guidance to states, regions, pilots through a “model pilot” process

Opportunities For State and Regional Initiatives to Guide Payment Reform Implementation

- **Many upcoming opportunities for Federal support for such reforms**
 - Stimulus legislation (ARRA, 2009) includes funding over several years to promote greater connectivity and interoperability to achieve “meaningful use” of health IT
 - Targeted funds to support delivery system/payment reforms (health information exchange, Regional Extension Centers)
 - Beacon Cooperative Agreement (sustainability a key criterion)
- **Support broad-based, multi-stakeholder collaborations**
 - Including employers, providers, health plans, and consumers
 - Specific, concrete objectives and performance measures
 - Support a transition toward consistent cost and quality measures (in state employee purchasing, Medicaid, and private plans)
 - Governor’s Quality Initiative/NC Health Quality Alliance

Opportunities For State and Regional Initiatives to Guide Payment Reform Implementation (cont.)

- **Pursue public (Medicare and Medicaid) and private payment reform opportunities**
 - Legislative language: “The Secretary may give preference to ACOs who are participating in similar arrangements with other payers”
 - Build on NC’s 646 to develop similar “shared-savings” opportunities with other payers and with non-646 counties
- **Create “learning networks” and technical assistance to support payment reforms**
 - Liaison to national reforms
 - Technical assistance for medical homes, ACOs, other “innovation” pilots focusing on specific, clear opportunities to improve value
 - Consistent methods for measuring performance (cost and quality)

Community Care of North Carolina



HEALTH ACCESS STUDY GROUP

January 20, 2010
Medicare 646 Demonstration

Community Care of North Carolina

“646” DEMONSTRATION PROGRAM

Section 646 of the Medicare Modernization Act (2003) established a five year demonstration to “improve the quality of care and service delivered to Medicare beneficiaries through major system re-design”. Program administered by the Centers for Medicare and Medicaid Services (CMS)



NORTH CAROLINA'S APPLICANT

- North Carolina Community Care Networks, Inc. (NCCCN), an umbrella organization representing the 14 Community Care Networks, was the applicant. NCCCN applied in September 2006.
- Demonstration Agreement was executed in December 2009
- The first demonstration year began January 1, 2010



646 Counties



Updated: October 1, 2009



KEY ELEMENTS OF NCCCN's DEMONSTRATION

- During years one and two, NCCCN will manage approximately 30,000 dually-eligible beneficiaries who receive care from 150 practices in 26 counties.
- At the beginning of year three, an estimated 150,000 Medicare-only beneficiaries who will receive care from those 150 practices will be added to the demonstration.
- During years three to five, NCCCN will manage an estimated 180,000 Medicare and dually-eligible beneficiaries.



COMPARISON GROUP

- A Medicare beneficiary receiving a qualifying service from a primary care practice in a comparison county.
- For comparison purposes, RTI selected 78 counties in 5 states that matched the characteristics of North Carolina's 26 intervention counties:
 - Georgia (18 counties)
 - Kentucky (19 counties)
 - South Carolina (12 counties)
 - Tennessee (19 counties)
 - Virginia (20 counties)



CHARACTERISTICS OF THE 646 POPULATION

- 50% will have 3 or more chronic conditions
- 75% will have hypertension
- 33% will have a mental health condition
- 40% will have diabetes
- 25% will have heart disease
- 20% will have chronic obstructive pulmonary disease
- 40% will have gone to the emergency room at least once during the year
- 25% will have been hospitalized at least once during the year
- Each dual will have an average of 7.8 prescriptions per month



ELIGIBLE BENEFICIARIES

- Be alive at beginning of the demonstration year
- Have at least one month of Part A and Part B enrollment
- Reside in North Carolina during the entire demonstration year
- Have not been enrolled in a Medicare Advantage plan during the demonstration year
- Not have coverage under an employer-sponsored group health plan during the demonstration year.



ASSIGNMENT OF BENEFICIARIES

- Beneficiaries will be assigned to intervention practices based on a retrospective analysis of claims data.
- Did a beneficiary receive a qualifying service from a participating physician during the assignment period.
- The assignment period is 3 months before the start of the demonstration year and ends 3 months before the close of the demonstration year.



PARTICIPATING PHYSICIANS

- Participating Practice/Physician must:
 - Be in an Intervention County
 - Be a primary care provider
 - Be enrolled in Carolina Access
 - Have participation agreement with Community Care



COMMUNITY CARE STRATEGIES

- To use its networks of medical homes and community-based care management infrastructure to develop effective system of chronic care management for 646 participants.
- Build on the Chronic Care Program being implemented in all 14 Community Care Networks to improve the care of Aged, Blind and Disabled Medicaid enrollees.
- Complete a major re-design in how care management is organized and delivered.



COMMUNITY CARE INTERVENTIONS

- Assist patients in transition
- Assist patients with complex conditions
- Reduce medication problems
- Strengthen the link between community providers
- Support the physician's ability to manage chronic care patients
- Develop nursing home and palliative care initiatives



COMMUNITY CARE PRIORITY PATIENTS

- Three or more chronic conditions within the past 12 months
- One or more inpatients admissions within the past 6 months
- Two or more ED visits within the past 6 months
- No PCP visit within the past year



STRATEGIES

- The long-range vision of CCNC is to use its community based networks to develop an effective system of chronic care statewide for Medicaid and Medicare recipients. This approach requires focused re-design efforts at the:
 - Central program office level
 - Network level
 - Practice/Medical Home level



CENTRAL PROGRAM OFFICE REDESIGN COMPONENTS

- Develop informatics center to provide timely and meaningful data
- Integrate Medicare data
- Provide aggregated reports to networks/practices
- Give scheduled updates on best practices
- Centralize patient education materials
- Provide consultation to networks and practices as needed



NETWORK REDESIGN COMPONENTS

- Build team of case managers using holistic (whole-patient) approach
- Develop strong links with practices, community providers (e.g., hospitals, LMEs), and selected specialty practices
- Identify and enroll additional practices
- Designate informatics “champion” within each network to serve as point of contact and informal consultant



MEDICAL HOME REDESIGN COMPONENTS

- Designate 1-2 key people to be network liaisons
- Refer complex patients to network case manager as needed
- Expedite appointments for patients with acute needs or in transition (e.g., at discharge from hospital)
- Build additional capacity to proactively manage chronic illnesses and preventive care
- Embed supports in medical homes as needed



HOW WILL SUCCESS BE DETERMINED?

- CMS will establish expenditure and quality targets that will have to be met or exceeded to achieve success.
- The quality benchmarks will primarily be the benchmarks used by CCNC for their disease management initiatives (diabetes, COPD, and CHF).



SELECTION OF QUALITY MEASURES

- Each year, NCCCN will propose with CMS approval a set of quality measures to be used to track changes in quality.
- These measures will be used in the shared savings calculation:
 - Year 1 = 50% contingent on performance
 - Year 2 = 60% contingent on performance
 - Year 3 = 70% contingent on performance
 - Years 4 and 5 = 80% contingent on performance.



PERFORMANCE MEASURES YEAR ONE

- Diabetes Care
 - 1 hemoglobin A1c measurement in one year
 - Lipid profile done in measurement year (LDL-C)
 - Documented retinal or dilated eye exam by an eye care professional
 - Nephropathy screening or evidence of nephropathy management



PERFORMANCE MEASURES YEAR 1 (continued)

- Heart Health – Congestive Heart Failure (CHF)
 - Patients with left ventricular function assessment in claims history
 - ACE Inhibitor/ARB Therapy (percentage of patients with EF <40%, prescribed an ACE-I or ARB Therapy)
 - Beta Blocker Therapy (% patients with EF <40% prescribed Beta Blocker)
 - Weight Management documented in most recent medical visit
 - BP Measurement (<140/90)



PERFORMANCE MEASURES YEAR 1 (continued)

- Ischemic Vascular Disease (IVD)
 - Lipid Measurement (lipid panel or LDL within past year)
 - BP Measurement
 - Aspirin Use
- Hypertension
 - Blood Pressure Measurement



PERFORMANCE MEASURES YEAR 1 (continued)

- Diabetes & Hypertension
 - Percentage of patients with a diabetes and hypertension diagnosis having an Rx written for an ACE-I or ARB in previous year
- Post-Myocardial Infarction
 - Patients with a written Rx for a lipid lowering medication
 - Patients with a written Rx for beta blockers



PERFORMANCE MEASURES YEAR 1 (continued)

- Transitional Care
 - 30-day readmission rate for all admissions (may need to redefine)
 - Patients hospitalized for CHF having an outpatient visit within 30 days post-discharge (may need to redefine)



SHARED SAVINGS

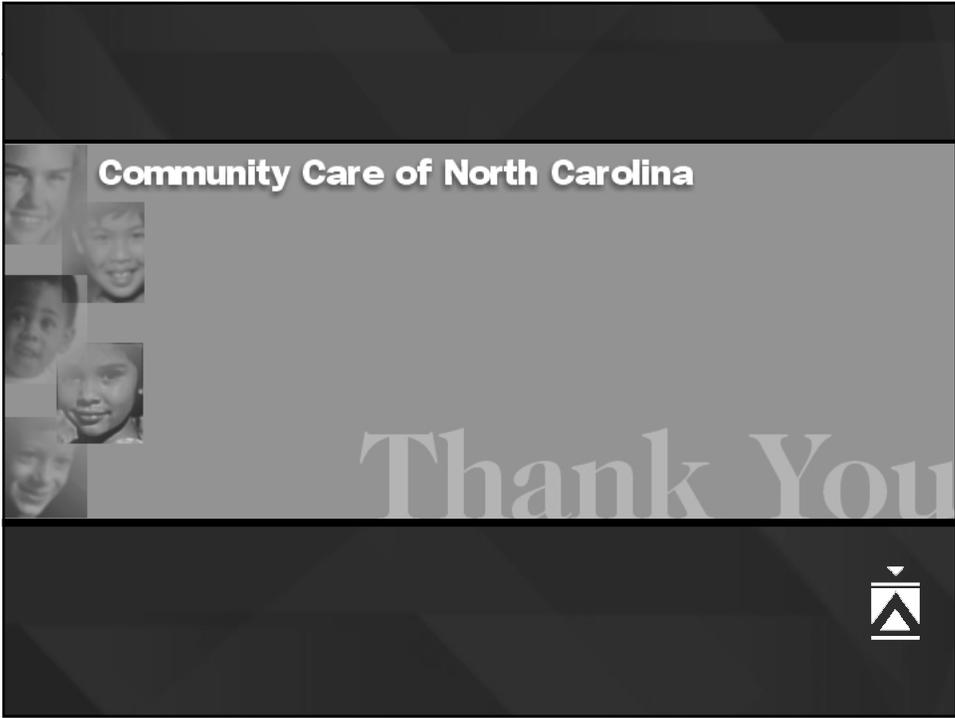
- Savings will be determined by comparing the actual expenditure incurred by the demonstration group to the expenditure target.
- Gross savings will be the difference between the expenditure target and actual expenditure.
- Net savings will be the difference between the savings and the minimum savings threshold. (2.9%-year1)
- Maximum payment to NCCCN will be the lesser of three amounts:
 - 80% of net savings
 - 50% of gross savings
 - 8% of the expenditure target



HOW CAN SAVINGS BE USED?

- Shared savings plan has to be approved by CMS
- Approved uses of savings
 - Support on-going operations
 - Pay ppm for Medicare patients to support services to the elderly
 - Physician incentives for achieving quality objectives
 - Pay for services provided to Medicare beneficiaries not covered by Parts A and B
- At the conclusion of the demonstration, all shared savings funds held in reserve will be disbursed to participating networks.





Terms of Art:
***Health IT and Meaningful
Use***

Steve Cline, DDS, MPH
Deputy State Health Director
NC Department of Health and Human
Services

ARRA – HITECH Goals (5)

- Improved clinical health outcomes
- Improved population health outcomes
- Increased efficiency in the “health care system”
- Empowered individuals
- Quality Improvement – “Learning” health care system

Key Federal Players

- Office of the National Coordinator for Health Information Technology (ONC)
- Centers for Medicare and Medicaid Services (CMS)

Federal Mandates for ONC

- Electronic Health Records (EHR) for all by 2014
- Build a nationwide interoperable health information system
- Lay the foundation for a learning health care system that can make health reform a self-sustaining reality
- Expand ONC to achieve the mandates

ONC Actions: New Regulations

- “Meaningful Use”

(Notice of Proposed Rulemaking on December 30, 2009)

- EHR Standards, Implementation Specifications, and Certification Criteria

(Interim Final Rule released on December 30, 2009)

- Certification Process

(More to come . . .)

ONC Actions: New Programs

- Regional Extension Centers

❖ NC Lead Agency: NC AHEC

- Health Information Exchanges

❖ NC Lead Agency: NC Health and Wellness Trust Fund – HIT Collaborative

- Workforce Training

❖ NC Lead Agency: Pitt Community College

- Beacon Communities

❖ LOIs from 4 NC Communities

CMS Action

- CMS Proposed Rule: Medicare and Medicaid Programs; Electronic Health Record Incentive Program
 - ❖ Defines Eligible Professionals
 - ❖ Defines Eligible Hospitals
 - ❖ Defines Meaningful Use

Other Actions/Programs

- Broadband Access
 - ❖ NC Lead Agency: MCNC
- Comparative Effectiveness Research
 - ❖ NC Lead Agency: multiple applications
- Telehealth Capacity
 - ❖ NC Lead Agency: NC Telehealth Network
- Loan Programs
 - ❖ TBD

“Meaningful Use” is the Key

Eligible professionals (EP) and eligible hospitals shall be considered a meaningful user for an EHR reporting period for a payment period year if they:

1. Use a certified EHR in a meaningful way
2. Use an EHR for HIE
3. Quality reporting as specified

CMS Eligibility

● Eligible Hospital

- ❖ Medicare: Subsection (d) hospitals that are paid under the hospital inpatient prospective payment system, Critical Access Hospitals; in US
- ❖ Medicaid: Acute Care Hospitals, Childrens' Hospitals

● Eligible Professional

- ❖ Medicare: MD, DO, DDS, DDM, Podiatrist, Optometrist, chiropractor
- ❖ Medicaid: MD, DDS, Certified Nurse Midwife, Nurse Practitioner, PAs

Three Stage Implementation

Payment based on progress 2011-2015

- **Stage I** - Electronic capture of health information in coded format, tracking key clinical conditions, care coordination, decision support
- **Stage II** – Expands on Stage I, CPOE, transitions in care, electronic transmission of test results, research
- **Stage III** – Expands on Stage II, promotes improvements to quality and safety, clinical decision support at a population level, patient access and involvement

Medicare Incentive Payments to Eligible Professionals

Calendar Year	First Calendar Year in which the EP Receives an Incentive Payment for Medicare				
	2011	2012	2013	2014	2015>
2011	\$18,000				
2012	\$12,000	\$18,000			
2013	\$8,000	\$12,000			
2014	\$4,000	\$8,000	\$12,000	\$12,000	
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	-----	\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

IT System Applications Needed to Achieve “Meaningful Use”

- Clinical Data Repository
- Clinical Documentation
- Clinical Decision Support
- CPOE
- e-Prescribing
- Financial Information
- Patient Communication

Stage I Criteria for “ME”

- Eligible Professional
 - ❖ 25 criteria
 - ❖ CPOE used on 80% of all orders
 - ❖ Drug-drug interactions and allergies
 - ❖ Problem list for 80% of patients
 - ❖ e-Prescribing for 75% of Rx
 - ❖ . . . 21 more
- Eligible Hospital
 - ❖ 23 criteria
 - ❖ CPOE used on 10% of all hospital orders
 - ❖ Medications list
 - ❖ . . . 21 more

Questions?

*Steve Cline, Deputy State Health Director
NC Division of Public Health
(919)707-5000
steve.cline@dhhs.nc.gov*

HEALTH ACCESS STUDY GROUP
Wednesday, February 17, 2010
9:00 am – 1:00 pm
North Carolina Institute of Medicine

Thematic Topic: Bending the Cost Curve through Comparative Effectiveness Research, Improved Quality and Prevention

9:00-9:15 **Welcome and Introductions**

Doug Berger, JD
Senator
North Carolina General Assembly

Hugh Holliman
Representative
North Carolina General Assembly

Allen Dobson, MD
Vice President Clinical Practice Development
Carolinas HealthCare System

9:15-10:00 **Comparative Effectiveness Research**

Timothy Carey, MD
Director, Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

10:00-10:30 **The Role of Data in Improving Practice**

Annette DuBard, MD
Director of Informatics, Quality and Evaluation
NC Community Care Networks, Inc.

10:30-11:00 **Discussion: Strategies to Improve Quality and Efficiency Practice for Busy Practitioners**

11:00-11:15 **Break**

11:15-11:45 **Hospital Quality and Changing Practice**

Carol Koeble, MD
Director of NC Center for Hospital Quality and Patient Safety
NC Hospital Association

11:45-12:15

**What Can North Carolina Do to Improve Health Status
through Prevention: Update on NCIOM Prevention Task Force**

Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine
Task Force Discussion

12:15-1:00

HEALTH ACCESS STUDY GROUP
North Carolina Institute of Medicine
February 17, 2010
Meeting Summary

ATTENDEES

Task Force and Steering Committee Members: Louis Belo, Sen. Doug Berger, Abby Carter Emanuelson, Bonnie Cramer, Kellan Chapin, Steve Cline, Allen Dobson, Rep. Beverly Earle, Kimberly Endicott, Jean Holliday, Rep. Hugh Holliman, Rep. Insko, David Moore, Barbara Morales Burke, Mary Piepenbring, John Price, William Pully, Maggie Sauer, Robert Seligson, Tom Vitaglione, Steve Wegner, Susan Yaggy
Interested Persons: Tim Carey, John Dervin, Annette Dubard, Ed Fisher, Amber Harris, Casey Herget, Alan Hirsch, Robert Jackson, Carol Koeble, Ann Lefebvre, Jessica Macrie, Kathryn Millican, Erica Nelson, Ben Popkin, Shannon Smith, Edgar Villanueva, Bridgette Wesley, Tom Wroth
NCIOM Staff and Interns: Kimberly Alexander-Bratcher, Thalia Shirley-Fuller, Pam Silberman, Berkeley Yorkery

WELCOME AND INTRODUCTIONS

Senator Doug Berger greeted the participants and began the meeting.

UPDATE

Steve Cline updated the Task Force about federal health information technology (HIT) initiatives. North Carolina was recently awarded two HIT-related grants from the federal government: \$12.9 million to the NC Health and Wellness Trust Fund to develop a health information exchange, and \$13.2 million (over two years) to the NC Area Health Education Centers (AHEC) program to support the regional extension center (REC). Practice management, IT, and quality improvement staff will be hired in each regional AHEC to provide technical assistance to primary care practices around the state to help them prepare for, and select appropriate HIT systems.

Comparative Effectiveness Research

Tim Carey, MD, Director, Cecil G. Sheps Center for Health Services Research

Comparative effectiveness research (CER) is the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. CER compares many things: definable treatments, appropriate outcomes, benefits and harms, care management, payment issues, and care integration. CER is different from standard clinical trials because it does not just compare two treatments, but looks at their relative effectiveness and the strength of existing evidence. (CER) is relevant to health reform and lowering health care costs because it can point to the most effective treatment for various health problems. Although CER itself will not reduce costs, the implementation of the recommendations from CER could potentially reduce costs.

There are many challenges to using CER to lowering health care costs. The main concerns are the time such research takes and the difficulty in disseminating the results. The development of large research networks with access to large amounts of data (such as insurance claims data or electronic health records) will help reduce the amount of time it takes to do CER. Finding quick, efficient ways to disseminate findings in a manner that will change clinical practice is challenging, but CER researchers are working on improving in this area. Websites (such as the US Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) Summary Guides and Consumer Reports Best Buy Drugs Guides) and clinician and consumer guide are some of the best methods for getting CER results data out to providers and consumers.

In addition to improving current practices in CER, moving forward, the field needs to generate new evidence in addition to reviewing existing evidence. To do this will require expanding the workforce by increasing the size and number of training programs in pharmacoepidemiology; developing large research networks as discussed; and larger, more cost-effective randomized control trials of drugs and treatments.

There is a great need for CER research (as highlighted in the Institute of Medicine's report on the top 100 CER Priorities <http://www.iom.edu/Reports/2009/ComparativeEffectivenessResearchPriorities.aspx>).

Currently, there is a lot of CER work going on in North Carolina. There are clinical trials being conducted at all the academic health centers as well as in the private sector. North Carolina has two (of 16 nationally) evidence-based practice centers funded by AHRQ: Duke, and a collaborative involving RTI and UNC-CH. These centers conduct CER using existing data. The Lineberger Cancer Center at The University of North Carolina at Chapel Hill is working on dissemination of CER. Historically funding for CER has been limited and fragmented, however, there is growing interest in CER at the federal level and substantial funds are being invested (including \$1.1 billion in the stimulus package).

Discussion: Discussion around this topic included how to do a better job disseminating results to consumers and practitioners; how to get providers on board when adopting CER results would mean a loss of revenue; the importance of getting insurers to use CER to inform their payment policies; and the use of informatics to implement CER findings.

The Role of Data in Improving Practice

Annette DuBard, MD, Director of Informatics, Quality and Evaluation, North Carolina Community Care Networks

Access to care is not the whole solution to receiving evidence-based, high-quality care. We know that many people receiving care are not getting all the care they need. Many patients do not receive appropriate follow up or fail to follow through with recommended treatment. Community Care of North Carolina (CCNC) is working on improving the quality of care through the use of data to assess care delivery and follow through.

CCNC has chosen to focus on a core set of quality measures that are clinically important, can be impacted by clinical practice, and are scientifically sound. Additionally, CCNC looked to see if the measures were in concordance with other state and national quality improvement activities. For 2009-2010, CCNC has chosen to focus on asthma, diabetes, hypertension, heart failure, ischemic vascular/cardiovascular disease, and prevention (well child visits and dental care for children and cancer screenings for adults).

CCNC gathers data on these measures using the data system used by all providers in the network. This system allows for analyses at the individual patient level, the practice level, and the network level. In 2009, over 1250 practices (out of 1394) were visited and 22,000 charts were reviewed. Individual chart review flag patients for more attention based on their care history (such as being overdue for a certain test or medication adherence alerts) or better care coordination based on their use of the emergency department. Practice level reports can point to areas in need of improvement or compare practices to other practices in their area or to the network. Using the data this way has helped inspire practices to improve quality by showing them exactly where/how to improve.

Through the use of data, North Carolina has begun improving the quality of care provided by CCNC practices. CCNC has been able to put actionable, patient-level data in the hands of practitioners, but is still working on how to best utilize this data to improve quality in a major way. NC is not meeting its quality performance targets so there is room for improvement. Utilizing data to inform patient care at both the practice and patient level is critical to improving quality and we have just begun this work.

A critical part of this work is educating providers and practice staff on how to use data to drive quality improvement. CCNC's 14 networks are working on providing education and technical support to practices through the network area administrators, quality improvement coordinators, HIT facilitators, and expert users. One example of this is helping practices adopt e-prescribing. To do this, CCNC provides pharmacist consultants to CCNC practices to provide a full continuum of support, from product selection, to clinic workflow integration, to local pharmacy preparedness.

CCNC is also working to disseminate best practices and increase the quality of care through other uses of data. Currently CCNC, DMA, DMHDDSA, Division of State-operated Facilities, and the UNC Sheps Center are working together to link multiple datasets to allow 'complete' picture of health system use by patients with mental illness. This dataset will help facilitate CER, program planning and evaluation, and care coordination across agencies and settings of care. Linked data will include Medicaid claims, state facilities, and outpatient mental health services.

Discussion: Discussion around this topic included the importance of team-based care in CCNC; the need for reimbursement reform to cover more preventive health services; the need to improve patient health literacy; how to establish patient care teams across primary, secondary and tertiary care; CCNC is a national model in health reform.

Health Quality and Changing Practice

Carol Koeble, MD, Director of the North Carolina Center for Hospital Quality and Patient Safety, NC Hospital Association

One of the top priorities for the North Carolina Hospital Association (NCHA) is to improve quality and patient safety in North Carolina. As part of this effort, NCHA created the North Carolina Center for Hospital Quality and Patient Safety (NCQC), with funding from The Duke Endowment. Additionally BCBSNC made a substantial donation to the Center. NCQC's vision is to help lead North Carolina hospitals to become the safest and highest quality hospitals in the United States. NCQC has worked with all hospitals in NC and a variety of other health providers in NC.

NCHA has used the National Qualify Forum's (NQF) National Priorities to guide their quality and patient safety work. The NQF National Priorities include six components:

- 1) Engage patients and families
- 2) Improve the health of the population
- 3) Improve the safety and reliability of the healthcare system
- 4) Ensure patients receive well-coordinated care
- 5) Guarantee appropriate and compassionate care for patients with life-limiting illnesses
- 6) Eliminate overuse while ensuring the delivery of appropriate care

In addition, NCHA also chose to add a seventh measure that was not on the NQF priority list: reducing the variability in cost of care.

The staff of NCHA work on all of these priority areas, however, certain groups within the NCHA take the lead on different priority areas. NCQC takes the lead on implementing two of these priority areas: improving the safety and reliability of the healthcare system, and ensuring that patients receive well-coordinated care. NCQC believes the foundation for change involves four key elements: promoting a fair and just culture, optimizing teamwork and communication, reliable design of the processes, and gaining knowledge through organizational learning. If hospitals engage around all four elements then they will be able to change their culture and practices to achieve better patient outcomes.

The NCQC established a set of measurable goals to ensure that North Carolina hospitals are making progress towards the 2 priority areas. For example, one of the goals to improve the safety and reliability of North Carolina's healthcare system is to improve the 30-day mortality rates following hospitalizations for adults ages 18 or older, for selected conditions. The measurable aims to meet this goal include reducing the 30-day mortality rate to not more than: 15.3% for acute myocardial infarction (heart attack)(a reduction of 4% over current state rates); 10.2% for heart failure (a reduction of 6%), and 10.3% for pneumonia (a reduction of 15%). The other three goals under this priority area include: 1) reducing preventable healthcare associated infections and serious adverse events, 2) increasing the use of evidenced based care processes, and 3) reducing the 30 day readmission rates.

The NCQC also tracks specific process measures to determine how North Carolina hospitals compare to national means. Improving these process measures should help improve care and reduce mortality rates. For example, to improve the health outcomes for people experiencing a heart attack, hospitals are tracked to determine if patients received an ACE inhibitor or ARB for left ventricular systolic dysfunction (national mean: 95%); aspirin at arrival (98%), aspirin at discharge (98%), beta blocker at discharge (98%), percutaneous coronary intervention (PCI) within 90 minutes of arrival (87%), smoking cessation advice/counseling (99%), and fibrinolytic drugs within 30 minutes of arrival (58%). NCQC has similar process measures for heart failure, pneumonia, and surgical care. The NCQC tracks and reports NC hospitals' performances on each of these separate disease conditions. The NCQC also tracks and reports an optimal care score. The optimal care score is a condition-level summary score that uses the "all or none" methodology to determine if a patient received all of the recommended treatment for which they were eligible. NCQC is also working on developing hospital dashboards that will show how well hospitals are doing on some of the aims and indicators and will compare each hospital to others in the state, as well as state and national averages.

Data shows that NC hospitals have made improvements on many measures, but that North Carolina still has plenty of room to improve. One area that shows a lot of room for improvement is teamwork between hospital units during handoffs and transitions.

Discussion: Discussion around this topic included how to disseminate information from CER to influence hospital practices; developing informatic systems to prompt providers; the need for payment systems that provide incentives for evidence-based practices; liability concerns and how they impact care delivery; creative financing and reimbursement; the need to develop better transition care from the hospital to community; speed of translation from research to practice to community.

Discussion and Recommendations

Ideas for many potential recommendations arose during the day including:

- Develop systems for prompting providers at the right time.
- Payment systems that incentivize best care or outcomes.
- Engaging patients in their own care- recognizing health literacy issues.

- Support practice improvement efforts through AHEC and regional extenders.
- Implementing electronic health records that can support best practices and feed information back to state for quality improvement activities.
- Importance of giving information back to practitioners in improving quality.

Comparing treatments in the new health care environment

What works and who benefits?

Tim Carey MD MPH

Spring 2010



Support

- NIAMS- National Institute of Arthritis and Musculoskeletal Disease
- NIH CTSA award to UNC
- NCMHD-National Center for Minority Health and Health Disparities
- AHRQ-Agency for Healthcare Research and Quality
- Health Resources and Services Administration
- GSK Foundation
- RWJ Foundation
- DERP- Drug Effectiveness Review Project
- Dissemination grant supported by the Neurontin Special Committee

Nothing new

- **Clinicians have always compared one treatment with another**
- **Most conditions have therapeutic options**
 - Meds vs stent vs bypass surgery for coronary artery disease
 - Surgery vs radiation for prostate cancer
 - Decompression vs fusion vs exercise for spine disease
 - Lovastatin vs simvastatin for hyperlipidemia
 - Fluoxetine vs. paroxetine for depression
- **Increase in efficacious treatments, and especially expensive efficacious rx**
 - Rise in healthcare costs has led to renewed emphasis on comparative effectiveness and cost-effectiveness
 - Direct to consumer advertising
 - Information overload for providers
- **Increased emphasis on comparing treatments**
 - Medications with each other
 - Procedures with each other
 - Procedures compared with medications or physical treatments (exercise, PT, etc)

One problem

(among many)

- Osteoporotic fractures are common, disabling in the elderly
 - Conventional treatment physical therapy, pain control, bone-strengthening medications
- Vertebroplasty was developed in late '90's
 - Biologic rationale
- Case series demonstrated marked improvement after procedure
- > 1,000 procedures in 2007 in NC alone
- 2 RCT's in 2009 demonstrated minimal, if any advantage over sham injection, medical regimen
 - # of patients across both trials=220

Comparative Effectiveness Research

CER is the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers and policy makers to make informed decisions that will improve health care at both the individual and population levels.

Institute of Medicine, 2009

What is being compared?

- Similar, definable treatments?
- Appropriate outcomes
- Are harms being searched for?
- Is the comparison treatment the current state of the art treatment?
- Encompasses comparing systems of care as well as drug A vs drug B
 - Care management
 - Payment issues
 - Care integration (mental health examples)
- Patient preferences taken into account?

Table 1.
Comparison of Traditional Phase III Randomized Clinical Trials (RCTs) and Phase IV Comparative Effectiveness Studies

Characteristic	Traditional Phase III RCT	Comparative Effectiveness Study
Research question	Can the drug work?	Does the drug work in normal practice, and how does it compare to therapeutic alternatives?
Comparison group	Placebo or inferior treatment	True therapeutic alternatives (e.g., head-to-head) based on current choices available to health care professionals
Population	Narrowly selected, usually healthier than patients who will eventually use the drug	Patients who actually use the drug once marketed
Setting	Controlled	Normal or actual practice
Compliance	Strictly enforced	As in normal practice
Outcomes	Often short-term, surrogate, or intermediate endpoints	True outcomes that are relevant to decision-making at the clinical level, policy level, or both
Validity	High internal validity but low external validity, not widely generalizable	Lower internal validity than RCT but higher external validity

Source: Schumock & Pickard, *Am J Health-Syst Pharm* 2009

Coke vs Pepsi

- Risk of losing perspective- how well does treatment work at all for the condition?
- Is it an interesting question to compare two similar medications (or procedures)?
 - Two statins
 - Patent vs generic (Kesselheim JAMA Dec 3, 2008)
 - Harm profiles
 - Drug vs procedure; invasive vs non-invasive
- Potential audiences for comparative effectiveness
 - Payers and regulators
 - Practice community, hospital P+T committees
 - Patients
- Research investment
 - Secondary analysis vs primary data collection
 - Large, simple trials (ALLHAT, CATIE)

Strength of Evidence

- When is sufficient evidence present to say ‘case closed.’
- Relationship between strength of evidence assessment and ‘guideline’
 - Guidelines take into account additional information including cost, convenience, acceptability, cultural and policy issues
- Strength systems take into account: number of studies, size of studies, quality of research, reproducibility (coherence), etc
- GRADE system seems to be center of emerging consensus
 - Transparent, plain English
 - Global qualitative assessment
 - What is the likelihood that an additional study would lead to a different conclusion?

Comparative effectiveness reviews: Subset of Systematic Review

- Within a class of treatments (often meds), is there a difference in efficacy, effectiveness or adverse events among agents?
- Optimally requires head-to-head trials between agents at equivalent doses
 - CATIE (antipsychotics), ALLHAT (antihypertensives), STAR-D (antidepressants)
- Comparing placebo-controlled trials of different agents possible, but should be viewed with caution
- Reviews underway at UNC, multiple sponsors:
 - Non-drug treatments for refractory depression
 - Antiepileptic drugs for bipolar disorder
 - Disease modifying drug for arthritis
 - Controller drugs for asthma
 - Placing mental health providers in primary care offices

Methods

- Prior systematic review methods often highly variable
- Cochrane methods manual provides consistency, but questions often very narrow
- In the past, little funding for methods work
 - Europeans (British, Dutch) often leaders
 - Role of NICE
- EPC methods manual substantial advance, now in 2nd revision
 - New chapters on dx test methods, use of prior systematic reviews
- Risk of consistent methods leading to lack of innovation
- Peer reviewed, chapters published in J Clin Epid, Annals of Internal Medicine

COMPARATIVE EFFECTIVENESS OF SECOND-GENERATION ANTIDEPRESSANTS IN THE PHARMACOLOGIC TREATMENT OF ADULT DEPRESSION

**Final Report
December 2006**

**Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services**

**Prepared by:
RTI International-University of North Carolina
Research Triangle Park, North Carolina**

Key Question 1

Do antidepressants differ in efficacy and effectiveness for the treatment of major depressive disorder, dysthymia, and subsyndromal depression?

Included Medications

SSRIs

Citalopram
Escitalopram
Fluoxetine
Fluvoxamine
Paroxetine
Sertraline

Other

Bupropion
Duloxetine
Mirtazapine
Nefazodone
Venlafaxine
Trazodone

Results: Excluded Studies

62 studies excluded because of poor internal validity

- **High loss to followup**
- **Single blinding**
- **No intention-to-treat analysis**
- **No systematic literature search for systematic reviews**

Major Depressive Disorder: Body of Evidence

- **72 head-to-head trials (including 3 effectiveness trials) on 16,780 patients**
- **18 studies assessed quality of life**
- **We conducted 4 meta-analyses and 62 adjusted indirect comparisons**
 - **Outcome of interest: response to treatment**

Major Depressive Disorder: Evidence of Comparative Efficacy

- Overall, no substantial differences in efficacy
- Statistically significant results from meta-analyses: modest and likely not clinically important
- No differences in quality of life

Strength of evidence: moderate

Major Depressive Disorder: Evidence of Comparative Efficacy

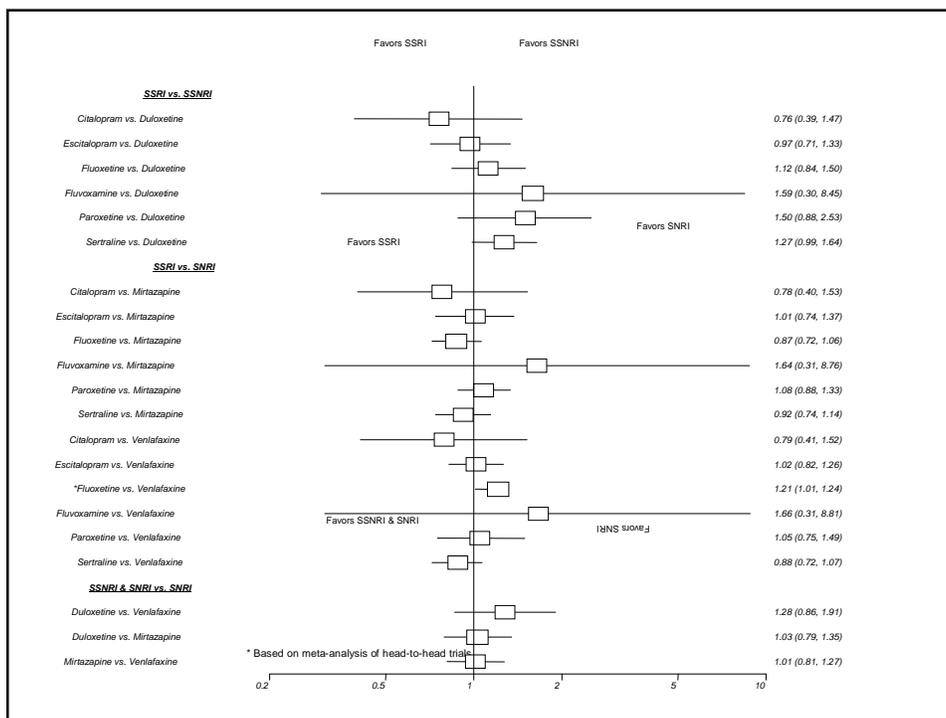
- Although efficacy is similar, second-generation antidepressants are not identical
 - Mirtazapine has a significantly faster onset of action than SSRIs
 - Bupropion has less effect on sexual functioning than SSRIs

Strength of evidence: moderate

Major Depressive Disorder: Evidence of Comparative Effectiveness

- **3 effectiveness trials: studies conducted under “real world” conditions**
 - No differences in effectiveness among examined drugs
 - No differences in quality of life

Strength of evidence: moderate



How certain can we be that the treatments are “the same”?

- Overlapping confidence intervals is not the same as therapeutic equivalence
- Indirect comparisons of limited power to detect differences
- Non-inferiority trials lead to plethora of small, underpowered studies.
- Trials generally are not sufficiently large to determine benefit or harm in population sub-groups
 - Bypass surgery vs stent in the elderly

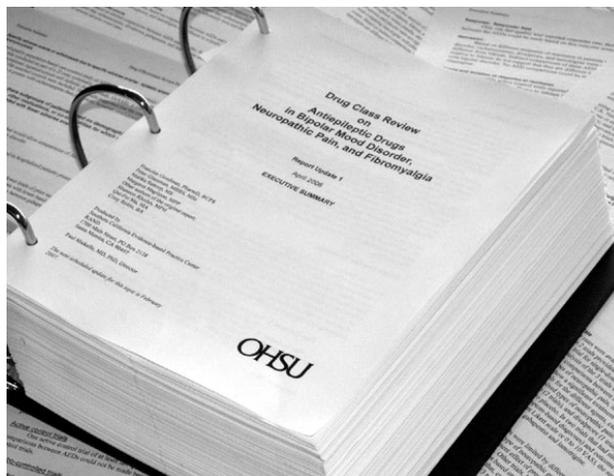
What about harms?

- Limited data from RCT's
 - Better data collection than in observational studies, but patient population young, fewer co-morbidities
- Inconsistent definitions of harms from study to study
- Secondary data and cohort studies may complement RCT information
 - Need for better data- EMR's, pt reports?
- Assessment of benefits and harms may require qualitative, patient-centered judgments
 - Function vs longevity; short vs long-term effects; etc.

Ongoing Issues for Clinicians and Patients in depression treatment

- Multiple treatment options may be necessary for many patients:
 - 40% of patients do not achieve clinical response with initial treatment
 - 10% - 15% discontinue treatment because of adverse events
 - Antidepressants differ significantly in dosing regimens
 - Need for rx of med-refractory patients
 - Add medication? Switch medication?
 - When to use non-drug therapy such as ECT?

The Weight of the Evidence



Dissemination challenges

- Reports are long, technical and full of jargon
- Now many reviews and analyses are of variable quality, how to judge the good ones?
 - Potential for bias in CER research
- Critical to link with EHR vendors
- Links with health information technology initiatives promising but still early
- Providers and 'prompt fatigue'

Deriving Key Concepts from a Systematic Review

- Read it, read it again, include source materials
- Multi-disciplinary "Science Panel"
 - EPC faculty, psychiatry, PharmD, primary author of evidence report
- 8 versions of 10 key concepts
 - Iterative process
 - Start general, become successively more specific, then back off to more general ('granularity')
 - Lots of discussion on language

AHRQ Effective Health Care Program - Summary Guides - Microsoft Internet Explorer

U.S. Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality

Advancing Excellence in Health Care

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Summary Guides

Summary Guides are short, comprehensive summaries of research reviews. They are produced by the John M. Eisenberg Clinical Decisions and Communications Science Center. Other report types are available under each tab located above. To get notified when a new Summary Guide is available, join our e-mail list.

Audience

- For clinicians
- For consumers
- For policymakers

Health Condition

- Cancer
- Diabetes
- Digestive system conditions
- Heart and blood vessel conditions
- Mental health
- Muscle, bone, and joint conditions

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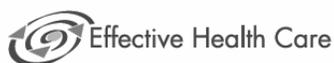
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published 5 Aug 2009
- **Gestational Diabetes: Caring for Women During and After Pregnancy**
Clinician Summary Guide
published 5 Aug 2009

Translation: Clinicians



Choosing Antidepressants for Adults



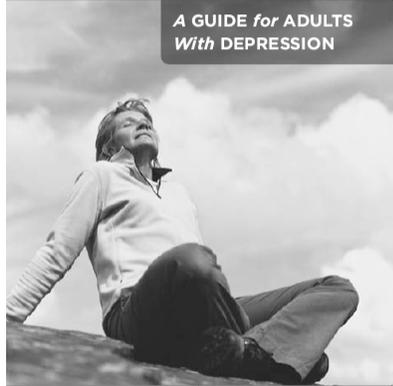
Clinician's Guide

This guide summarizes clinical research comparing the effectiveness and safety of commonly used antidepressants for adults with major depression. The medications included in this guide are the selective serotonin reuptake inhibitors (SSRIs) and other agents approved for depression in the United States over the past 20 years. The reviewed drugs are listed on the back page.

This guide does not cover depression in children or adolescents, postpartum depression, or depression in people with coexisting psychiatric disorders. It also does not include tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), St. John's Wort, psychotherapy, light therapy, or exercise. It does not cover any combination of therapies.

ANTIDEPRESSANT MEDICINES

A GUIDE for ADULTS
With DEPRESSION



Translation: Consumers



AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

August 2007

How can I use the information in this guide?

When talking with your doctor or nurse about antidepressants, think about:

What side effects are most important to you?

- Are you most worried about sexual issues like loss of sexual desire or loss of ability to reach orgasm?

You might ask your doctor or nurse about bupropion (Wellbutrin®).

- Are you concerned about weight gain?

You might ask your doctor or nurse about taking bupropion (Wellbutrin®). You might want to avoid paroxetine (Paxil®) and mirtazapine (Remeron®).

- Are you most worried about nausea and vomiting?

Nausea and vomiting are the most common side effects that cause people to stop taking their antidepressant medicine during the first 30 days.

If your medicine causes nausea or vomiting, or any other side effect, let your doctor or nurse know. There may be a solution.

How often will you need to take the medicine?

Some antidepressants are taken once a day. Others need to be taken more often. Page 8 has a list of antidepressants and how often they need to be taken.

Is cost important?

Use the chart on page 8 to compare the prices of different drugs. If prescriptions are part of your health insurance plan, check with your plan about the cost to you.



Consumer Reports Health.org
BEST BUY DRUGS



Antidepressants

Comparing Effectiveness, Safety, and Price

ConsumerReportsHealth.org/BestBuyDrugs



Table 5. Antidepressant Cost Comparison

Generic Name and Strength	Brand Name ¹	Frequency of Use ²	Average Monthly Cost ³
Bupropion 75 mg tablet	Wellbutrin	Three a day	\$302
Best Buy Bupropion 75 mg tablet	Generic	Three a day	\$58
Bupropion 100 mg tablet	Wellbutrin	Two to four a day	\$294 - \$588
Best Buy Bupropion 100 mg tablet	Generic	Two to four a day	\$43 - \$86
Bupropion 100 mg sustained-release tablet	Wellbutrin SR	Two a day	\$246
Bupropion 100 mg sustained-release tablet	Budeprion SR	Two a day	\$100
Bupropion 100 mg sustained-release tablet	Generic	Two a day	\$100
Bupropion 150 mg extended-release tablet	Wellbutrin XL	One a day	\$222
Bupropion 150 mg extended-release tablet	Budeprion XL	One a day	\$173
Bupropion 150 mg extended-release tablet	Generic	One a day	\$83

Source: ConsumerReportsHealth.org

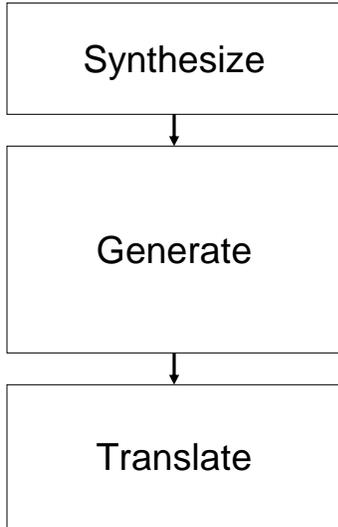
Applicability

Does one size fit all?

- Occasionally a CER analysis applies to nearly everyone with a condition
- Most CER analyses have only limited ability to assess differential effectiveness of treatments in sub-populations
 - Age, gender, ethnicity, income, co-existing conditions
- Large research networks, hopefully incorporating large amounts of insurance claims data and/or EHR data are promising....
- Need to take patient preferences into account when applying CER

New evidence

- Pharmacoepidemiology
 - Need for additional researchers
- Evaluation of drugs, devices and procedures by AHRQ
 - Stent evaluations at Duke
 - Cancer treatment work at UNC
- Electronic health records- bleeding edge
- “Clinically enhanced” administrative data
- “Administratively enhanced” clinical data
- Large effectiveness RCT’s
 - How to conduct these studies more efficiently
 - “Coverage with evidence development” – might have advanced evaluation of vertebroplasty by years



Evidence-based Practice Centers (15)

- Synthesize existing scientific literature to promote evidence-based practice

DEcIDE Network (13)

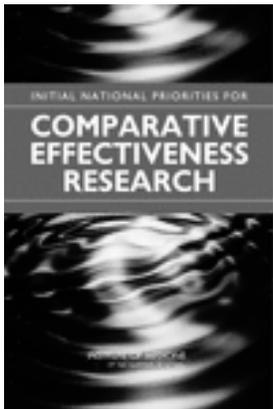
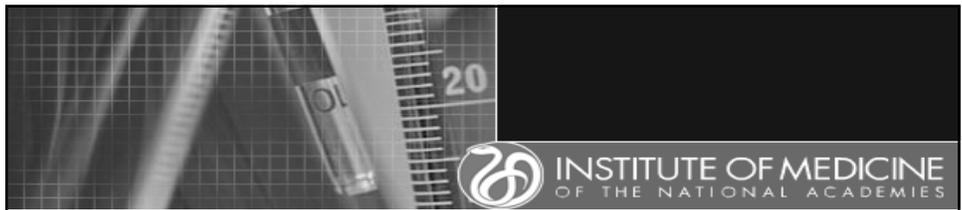
- Generate new knowledge on safety, outcomes, comparative clinical effectiveness, and appropriateness

CERTs (14)

- Demonstration projects on drugs, biologics, and medical devices

Eisenberg Center (1)

- Translate scientific knowledge for consumers, clinicians, policymakers



IOM Report:
Commissioned by
Congress in the American
Recovery and
Reinvestment Act (ARRA)
of 2009

June 30, 2009

Examples of “Highest Priority”

- Compare the effectiveness of dissemination and translation techniques to facilitate the use of CER by patients, clinicians, payers, and others.
- Compare the effectiveness of comprehensive care coordination programs, such as the medical home, and usual care in managing children and adults with severe chronic disease, especially in populations with known health disparities.



IOM June 30, 2009

Examples of “High Priority”

- Compare the effectiveness of strategies for enhancing patients' adherence to medication regimens.
- Compare the effectiveness of diverse models of transition support services for adults with complex health care needs (e.g., the elderly, homeless, mentally challenged) after hospital discharge.



IOM June 30, 2009

Why not more large effectiveness trials?

- CATIE, ALLHAT, Women's Health Initiative, Endarterectomy trials all substantially changed practice
 - But did they change practice enough?
 - Modeling for 'value of information' prior to study
- Expense
- Difficulty determining the appropriate comparison treatment
- Risk (SPORT trials for back pain)
- Problems with non-inferiority trials
- Marketing issues

Funding sources

- FDA
 - Regulatory role, not research
 - ?regulatory capture
- NIH
 - Historically not involved with CER, interest significantly higher now
 - ALLHAT, CATIE, STAR*D, SPORT. More to come?
 - CTSA and 'Type II' (bench to bedside) translational research
- AHRQ
 - Effective Health Care Program
 - EPC's and DEcIDE
 - Discussion of increase in funding by several hundred million dollars
 - Rapid response secondary data analyses
 - EMR analyses
 - Selected head-to-head trials
- Drug Effectiveness Review Program: state Medicaid agencies
- Industry
 - Limited incentive
 - "Do you feel lucky"- some potential to game comparisons

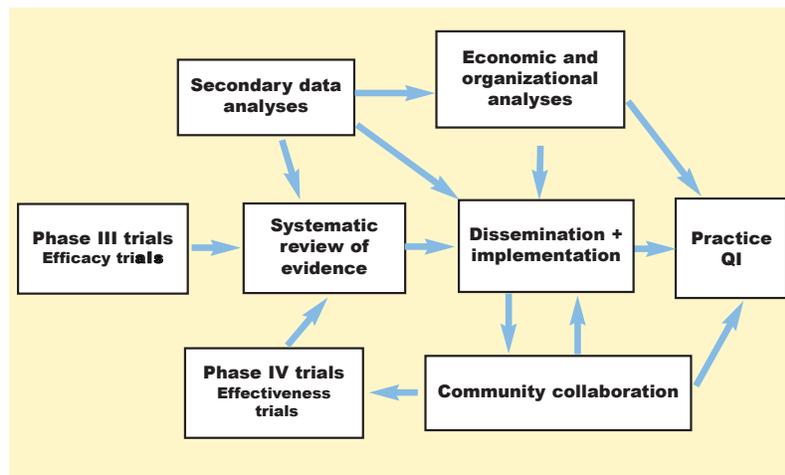
Activity in North Carolina

- Clinical Trials
 - All academic health centers, private sector (Quintiles, etc)
- Drug Effectiveness Review Project (Medicaid consortium)- UNC
- Evidence-based Practice Centers (AHRQ)
 - RTI-UNC
 - Duke
- Secondary data analyses: Developing Evidence to Inform Decisions about Effectiveness (AHRQ DEcIDE network)
 - RTI
 - Duke
 - UNC
- Dissemination activities
 - Lineberger Cancer Center dissemination core, CTSA network
- Centers for Evidence and Research on Therapeutics (AHRQ and FDA CERT)
 - Duke

Public good, public guardian

- Widespread recognition that current system is dysfunctional
- FDA role likely to change
 - Avandia, Vioxx, stents, etc
- Concern regarding FDA funding stream
- CMS taking increasing role
- State Medicaid programs form consortia

Schematic for Type II Translational Research



Current federal proposals

- Substantial budgetary allocations of \$150-350M
 - Secondary data analyses
 - Systematic reviews and meta-analyses
 - Head to head real world effectiveness trials
 - Funded through fees on insurance companies
 - Dissemination
- FDA
 - Established, decades of experience, diminished credibility
- AHRQ (House bill)
 - Established, good methods, infrastructure in place, hx of political vulnerability
 - Currently expending ~200M/year in ARRA funds
 - 2011 budget additional \$200M
- Institute of Medicine (IOM)
 - Universal respect, not a research entity, often slow
 - “Public-private Partnership” (Baucus Senate bill)
 - Potentially nimble, risk of regulatory capture

Stimulus package

- \$1.1 billion over 2-3 yr for comparative effectiveness research (in past ~\$50 million/year)
- Administration by AHRQ and NIH, mixture of RCT's, secondary data analyses, reviews.
 - How 'shovel ready' is CER work?
 - Career development awards
 - Infrastructure

Challenges for NC

- Substantial current activity
- Need to train additional researchers
 - Proposals from UNC, Duke pending at present
 - Train clinicians and administrators in use of research
- Dissemination of findings into practice
- Relationship to health IT initiatives
 - Need for transparent relationship with vendors
 - Information must be combined with ease of implementation
 - Several infrastructure proposals pending to utilize EHR data for research, form consortia- long term goals

Resources

- Agency for Healthcare Research and Quality www.ahrq.gov
- Consumer's Union
<http://www.consumerreports.org/health/best-buy-drugs/index.htm>
- Cochrane collaboration
 - <http://www.cochrane.org/>
- Drug Effectiveness Review Project DERP
 - <http://www.ohsu.edu/drugeffectiveness/>

Comparative effectiveness research

- (Sort of) new wine
 - Interest is predominantly driven by technology availability, payer interest, rising chronic disease burden
- New bottle
 - Definitely, federal and payer interest likely to be great in the next few years
 - Dissemination and implementation
 - Critical will be to maintain equipoise
 - Some research will find that more expensive treatments may be a dominant strategy

right **Patient.**
right **Time.**
right **Setting.**
right **Intervention.**
right **Care Team.**

The Role of Data in Improving Practice

Presentation to the NCIOM Health Access Study Group
February 17, 2010

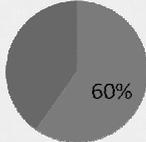
Annette DuBard, MD, MPH
North Carolina Community Care Networks, Inc.

Information Support for Patient-Centered Care

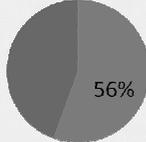


2008 National Healthcare Quality Report
Receipt of Recommended Care by the US Population

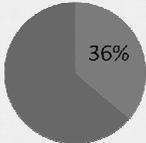
Diabetes Retinal Exam



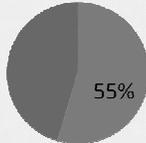
Colorectal Cancer Screening



Blood Pressure Control

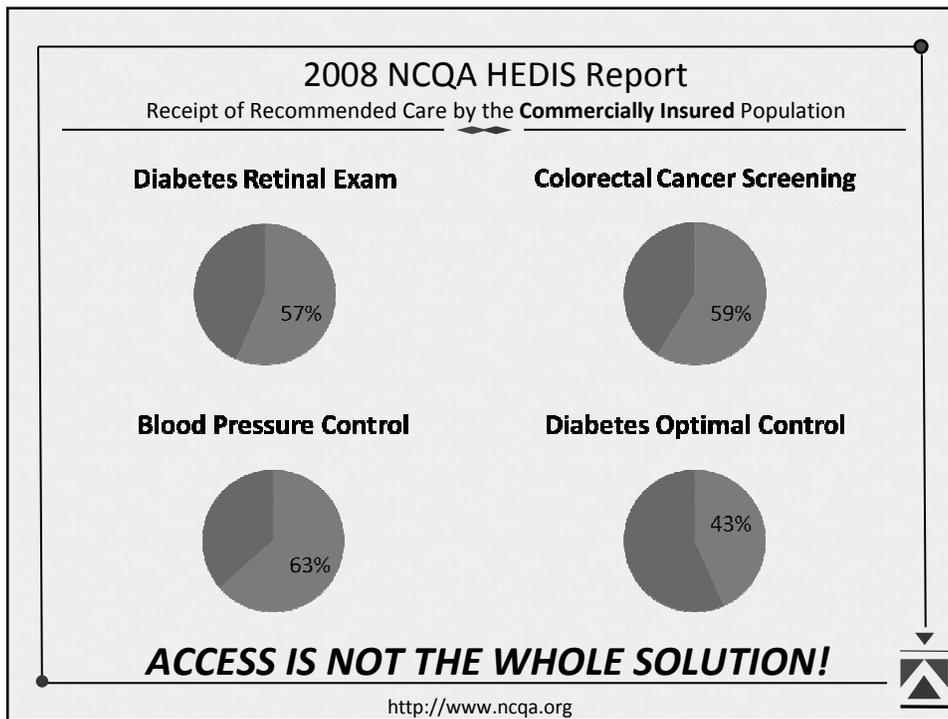


Diabetes Optimal Control



<http://www.ahrq.gov/qual/grdr08.htm>





Other Evidence of a Broken System

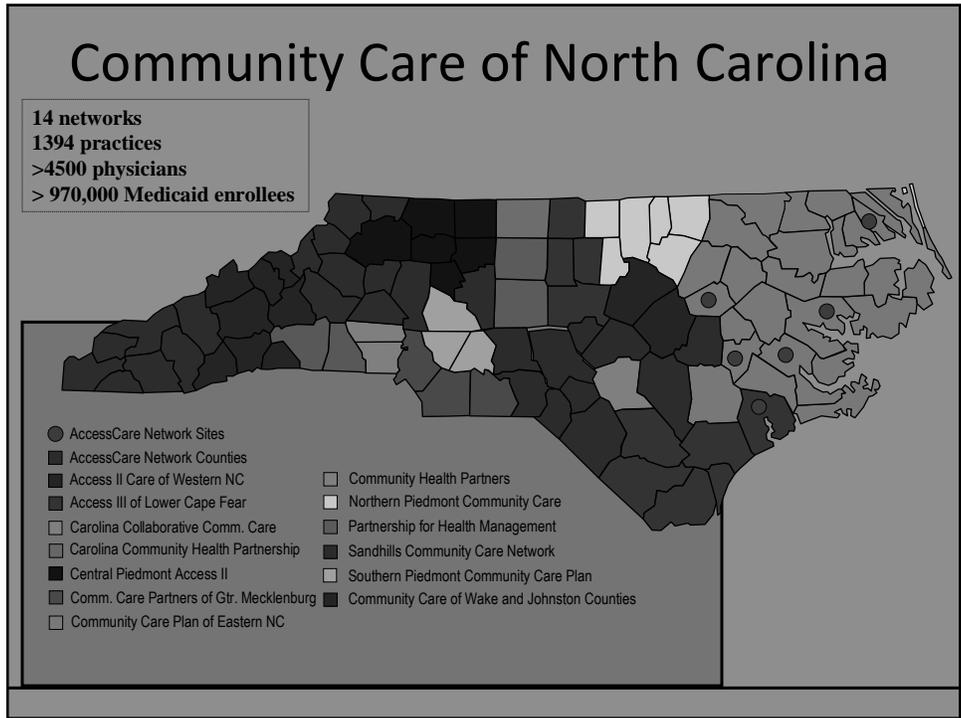
(i.e., access only gets you so far...)

- 20% of hospitalized Medicare patients are readmitted within 30 days of discharge
 - 50% have no follow up with PCP or any physician before being readmitted
 - 20-40% of readmissions occur at different hospitals

- In one study, 41% of inpatients were discharged with test results pending
 - 25% needed further workup on an outpatient basis
 - Greater than 1/3 of those workups were not completed

- 12% of Americans don't fill their prescriptions
 - 12% don't take their medicine after they buy it
 - 10% of all hospital admissions, and 23% of nursing home admissions, are due to patients not taking their medications correctly

Jencks et al. NEJM 2009;360:1418-28
 Moore et al. Archives IM 2007; 167: 1305-11
 American Heart Association "Statistics you Need to Know" www.americanheart.org



Community Care of North Carolina Quality Measurement and Feedback

- **Choosing Quality Measures**
 - Clinical importance, Impactability
 - Scientific soundness
 - Implementation feasibility
 - Concordance with other state and national QI initiatives
 - Endorsement by Participating CCNC Physicians

- **2009-2010 Clinical Quality Measures**
 - Asthma, Diabetes, Hypertension, Heart Failure, Ischemic Vascular/Cardiovascular Disease
 - Peds prevention (well child visits, dental), Adult prevention (cancer screening)

Quality Measurement and Feedback

Chart Reviews

- 1250 practices visited in 2009
- >22,000 charts reviewed
- Next-day reporting of practice results
- Year-end reports include internal and external benchmarks

Audit System - Audit Review

Patient:  Medical ID: _____ ASM
 Birth Date: _____ ✓ DM
 Practice: UNC Infectious Disease Clinic (7902646) HTN
 Review Date: 12/16/2008 9:49 AM CHF
 Review By: Tamra Panzera IVD ✓

Confirmed Disease: ASM 11, DM 12, HTN 4, CHF 3, IVD 8
 Number of Related Sections: ASM 1, DM 1, HTN 1, CHF 1, IVD 1

Note: All dates must be in mm/dd/yyyy format

1. Comments: _____

2. Chart found? Yes No

3. Does chart confirm diagnosis of the following diseases?
 DM: Yes No
 IVD: Yes No

4. Date of office visit (most recent): 1/1/2008 mm/dd/yyyy

10. Smoking status documented? 1/1/2007 - 1/1/2008
 Yes No
 If yes, current smoker? Yes No
 If current smoker, smoking cessation recommended? 1/1/2007 - 1/1/2008
 Yes No
 Most recent smoking cessation date recommended: _____

COMMUNITY CARE OF NORTH CAROLINA
 Quality Measurement and Feedback Initiative
 Practice Report 2/9/2009

Community Care of North Carolina

Network Name: Community Care Plan of Eastern Carolina
 County: Nash
 Practice Name: Bosch With Clinic/Samuel M. Westoga, MD
 Practice Number: 6995558

Round 1 Sample: Patients enrolled with CCNC at least 10 months during CY 2008, identified with chronic condition during CY 2007
 Date of Chart Review: 2/9/2009
 Look-back period of one year from most recent office visit date. 14 Charts Reviewed

	Eligible Patients	Sample Patients
DIABETES	14	10
ASTHMA	5	3
ISCHEMIC VASCULAR DISEASE	10	8
HYPERTENSION	16	11
HEART FAILURE	6	5

DIABETES

A1C Control* < 7.9*	A1C Control* > 9.9*	BP Control* < 130/80*	BP Control* > 140/90*	LDL Cholesterol Control* < 100*	LDL Cholesterol Control* > 130*	Foot exam*
11.1 %	20.0 %	22.2 %	55.0 %	44.4 %	40.0 %	11.1 %

*For patients with no measurement in past year; A1C assumed to be > 9.9 and LDL assumed to be > 130.
 †Limited to Patients ages 18 and older (n=9). See patient-level report for additional details.

ASTHMA

Continued care visit with assessment of symptoms	Assessment of triggers	Action plan
100.0 %	33.3 %	0.0 %

* See patient-level report for information about controller medications prescribed

PREVENTION AND MANAGEMENT OF CARDIOVASCULAR DISEASES

BP Control < 140/90*	Aspirin use*	Lipid testing*	LDL control < 100*	Smoking status and cessation advice?
54.5 %	92.9 %	100.0 %	59.8 %	100.0 %

*Among Patients with HTN
 *Among Patients with IVD or DM over age 40 and older (n=13)
 *Among Patients with IVD or DM over age 18 and older (n=13)
 † Among patients with DM over age 18, IVD, HF or HTN (n=14)

HEART FAILURE

LVCF documented in PCP chart	ACE/ARB use*	Beta Blocker use*
100.0 %	100.0 %	100.0 %

*Among Patients with documented HF < 46% (n=1)

*N/A indicates that no patients were eligible for this measure.

Data used in preparation of this information is from protected data sources. Use of this information is intended only for quality improvement activities.

IC Report Site Home

Quality Measurement and Feedback: Patient-Level Results with Care Alerts

X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
Current smoker?	Cessation recommended?	Date of recommendation of smoking cessation	AIC documented?	AIC date	AIC value	BP documented?	BP date	SBP value	DBP value	Height date
Y			Y	6/5/2008	8.6	Y	8/5/2008	109	70	8/5/2008
			Y	11/18/2008	8.4	Y	6/18/2008	98	70	4/10/2009
N			Y	2/27/2009	7	Y	2/27/2009	100	66	2/27/2009
N			Y	3/14/2008	7.8	Y	1/5/2009	123	74	1/5/2009
Y	Y	10/14/2008	Y	8/28/2008	7.9	Y	2/25/2009	130	84	2/25/2009
N			Y	1/8/2008	8.7	Y	12/17/2008	128	84	12/17/2008
N			N		7.4	Y	3/8/2009		78	3/8/2009
Y	Y	1/21/2009	Y	10/2/2008	6.1	Y	1/21/2009	130	70	1/21/2009
Y	Y	6/17/2008	Y	11/25/2008	8.2	Y	12/10/2008	120	82	12/10/2008
N			Y	10/6/2008	8.2	Y	11/25/2008		84	11/25/2008

IC Report Site Home

Quality Measurement and Feedback: Quarterly Claims-Derived Quality Measures

Community Care of North Carolina
QMAF Claims Measure 2008Q4
Non-Dual Patients

Network	ASTHMA			DIABETES			HEART FAILURE			CANCER SCREENING				
	IF Asthma Tx 1000 MIM	ED Asthma Tx 1000 MIM	AIC Testing	Eye Exam Timing	Cholesterol Screening	Hypertension Screening	IF CHF Rx 1000 MIM	IF CHF 50 Day Rehospitalization Percent	LVEF Percent	Chol Chaser	Cervical Cancer	Recent Cancer Ages 42-51	Recent Cancer Ages 52-69	Recent Cancer Ages 62-69
Access II Care of Western NC	0.9	4.7	87%	50%	66%	79%	19.3	7%	92%	33%	59%	47%	50%	49%
Access III of Lower Cape Fear	1.5	8.5	87%	54%	79%	85%	21.8	13%	91%	42%	60%	46%	54%	50%
AccessCare	0.9	7.5	88%	52%	72%	81%	40.2	44%	96%	38%	59%	44%	50%	47%
Carolina Collaborative Community Care	2.1	20.1	88%	56%	81%	85%	34.1	19%	95%	45%	65%	38%	48%	43%
Carolina Community Health Partnership	0.2	5.8	92%	57%	77%	81%	39.2	25%	93%	34%	53%	34%	34%	34%
Community Care of White and Johnston Counties	2.7	14.4	84%	48%	66%	82%	33.1	28%	99%	35%	60%	38%	49%	43%
Community Care Partners of Greater Mecklenburg	2.0	12.6	85%	47%	76%	87%	37.0	15%	97%	36%	62%	39%	44%	41%
Community Care Plus of Eastern Carolina	1.1	13.3	87%	55%	73%	82%	35.8	25%	96%	40%	59%	46%	56%	51%
Community Health Partners	1.4	9.6	89%	48%	79%	86%	28.8	29%	100%	38%	57%	43%	48%	46%
Northern Piedmont Community Care	1.1	13.4	82%	52%	73%	84%	42.2	20%	94%	36%	62%	43%	51%	47%
Northeast Community Care	1.6	12.6	80%	52%	68%	84%	56.1	36%	96%	37%	62%	43%	52%	48%
Partnership for Health Management	1.9	9.6	83%	48%	65%	82%	31.3	13%	95%	37%	62%	54%	60%	56%
Sawahl Community Care Network	1.6	11.0	84%	58%	70%	83%	38.4	23%	91%	41%	59%	45%	50%	47%
Southern Piedmont Community Care Plus	1.9	9.8	89%	51%	82%	86%	33.3	19%	96%	38%	59%	47%	52%	50%
CCNC	1.4	10.6	86%	52%	73%	83%	36.1	27%	95%	38%	60%	44%	51%	47%

Community Care of North Carolina Report Date: 8/27/2009



Quality Measurement and Feedback: Drill Down Capabilities

Access III of Lower Cape Fear QMAF Claims Measure 2008Q4 Asthma

Network	Network County	Asthma Patient Count	Member Months	IF Asthma Visits	ED Asthma Visits	Results	
						IF Asthma Per 1000 MM	ED Asthma Per 1000 MM
Access III of Lower Cape Fear	BLADEN	96	1110	1	12	0.9	10.7
Access III of Lower Cape Fear	BRUNSWICK	128	1494	0	9	0.0	6.0
Access III of Lower Cape Fear	COLUMBUS	262	2876	10	10	3.5	6.3
Access III of Lower Cape Fear	NEW HANOVER	400	4599	6	51	1.3	11.1
Access III of Lower Cape Fear	ONSLow	46	545	0	3	0.0	5.5
Access III of Lower Cape Fear	PENDER	54	616	0	2	0.0	3.2
Access III of Lower Cape Fear	Network Results	988	11238	17	95	1.5	8.5
CCNC	CCNC Results	17725	205689	296	2175	1.4	10.6

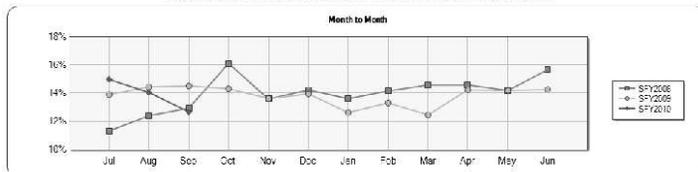
Definitions

Patients: Identified as having asthma during CY2008 (1/1/2008 to 12/31/2008)
 Non-Dual status: Medicaid only patients during CY2008 (1/1/2008 to 12/31/2008)
 Enrollment Eligibility: 10+ months enrollment with Carolina Access during CY2008
 Anchor Date: CCNC enrolled December 2008
 Excluded: Recipients with third party major medical insurance
 Member Months: Carolina Access II (CCNC) during CY2008
 Asthma IP Visits: Hospital admissions with asthma primary diagnosis while enrolled with CCNC during CY2008. Claims paid date prior to 4/1/2009
 Asthma ED Visits: Emergency Dept. visits with asthma primary diagnosis while enrolled with CCNC during CY2008. Claims paid date prior to 4/1/2009

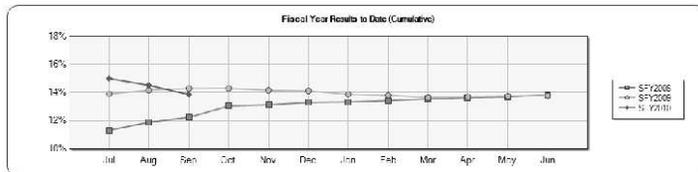


DHHS Scorecard Reports: Monitoring Progress toward Cost and Utilization Objectives

DHHS Performance Measures for CCNC Preventable Readmissions as Percent of Total Admissions, Enrolled Nonduals



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	12.4%	12.9%	16.1%	13.6%	14.2%	13.6%	14.2%	14.6%	14.6%	14.2%	15.7%
SFY2009	13.9%	14.4%	14.5%	14.3%	13.6%	13.9%	12.6%	13.3%	12.5%	14.2%	14.2%	14.3%
SFY2010	15.0%	14.1%	12.7%	-	-	-	-	-	-	-	-	-



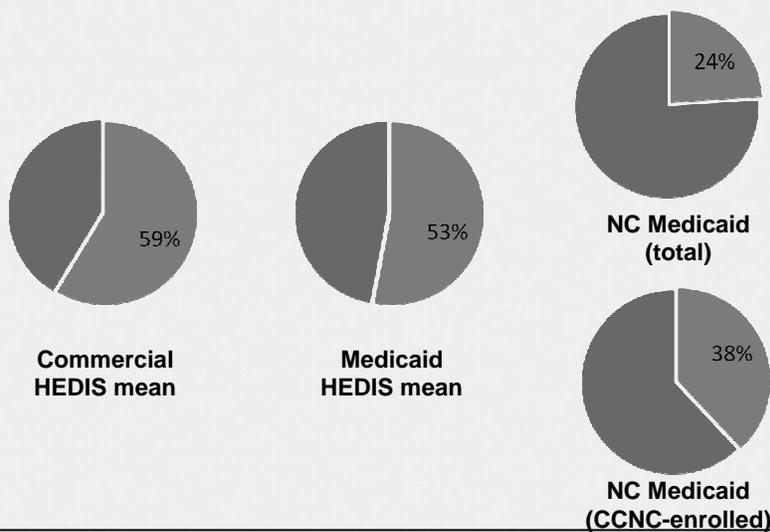
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	11.3%	11.9%	12.2%	13.0%	13.1%	13.3%	13.3%	13.4%	13.5%	13.6%	13.7%	13.8%
SFY2009	13.9%	14.2%	14.3%	14.3%	14.2%	14.1%	13.9%	13.8%	13.6%	13.7%	13.7%	13.8%
SFY2010	15.0%	14.5%	13.9%	-	-	-	-	-	-	-	-	-

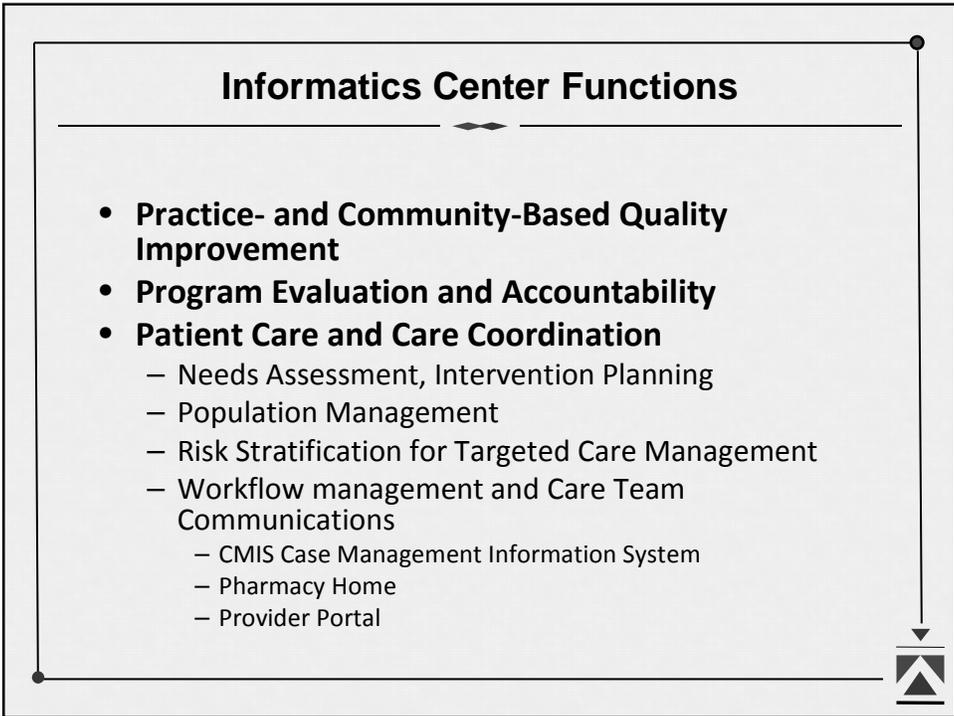
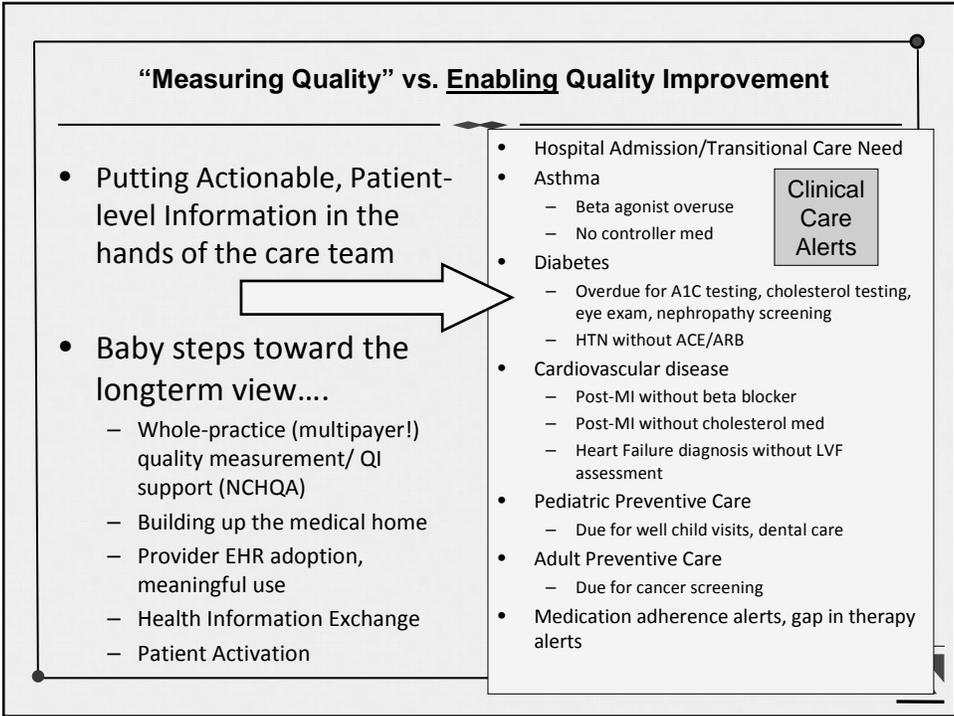


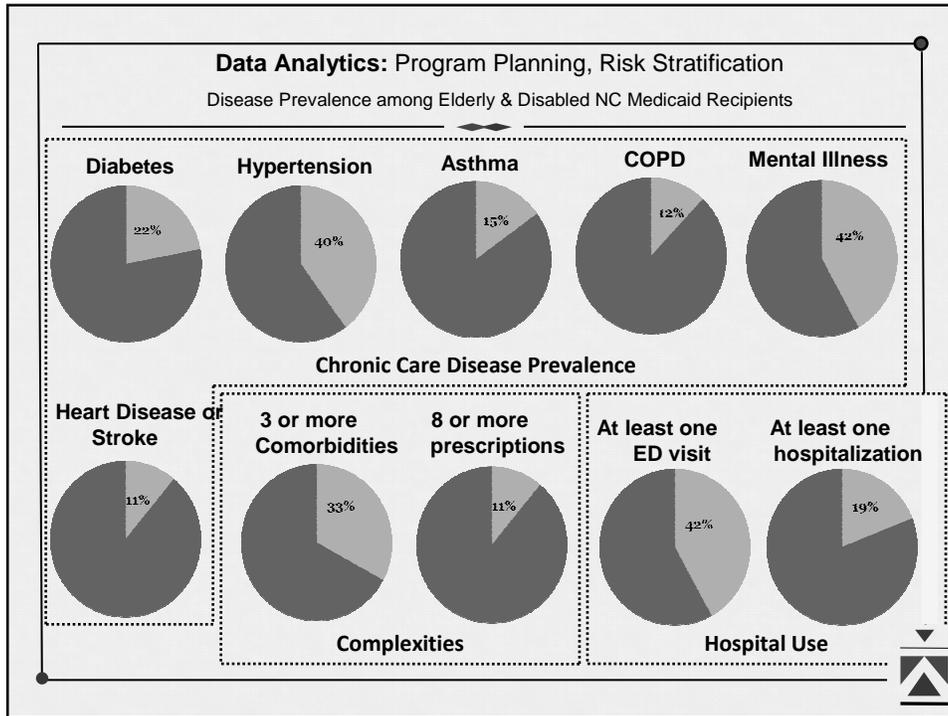
A quality measure only tells you so much...

- HEDIS measure “beta blocker use after acute MI” was discontinued after ‘widespread success’ (Average health plan performance improved from 62% in 1996 → 97% in 2005)
 - Yet only 70% of patients discharged after acute MI ever actually FILL a beta blocker prescription
- In our own CCNC experience: 95% of Heart Failure patients have had an echocardiogram (that’s good!)
 - Yet the result of that echocardiogram is available in the PCP medical record only 82% of the time

What can be done about colorectal cancer screening?







Report Manager - Windows Internet Explorer

https://reports.azdnc.org/Reports/Pages/Report.aspx?ItemPath=%2FAccess%2FCare%2FHTIC%2FStandard%2FChronic%2FCare%2FReport%2FSummary%2FStatistics%2F

Report Manager

New Subscription

Year/Quarter: 2009Q3 Run Report by: County View Report

2009Q3

Report Details

Demographics

Utilization and Cost

Diagnosis

Case Management Planning

Network Number	Network	PCP County	# of ASD Patients	# Diabetes Patients	Diabetes Patients Percent Of County	# COPD Patients	COPD Patients Percent Of County	# HTN Patients	HTN Patients Percent Of County	# CHF Patients	CHF Patients Percent Of County	# Post MI Patients	Post MI Patients Percent Of County	# Ischemic Vascular Disease Patients
8791037	ACCESS CARE OF WESTERN NORTH CAROLINA		7,253	1,382	19.2%	1,104	15.2%	2,851	39.3%	145	2.0%	81	1.1%	76
		Burke	2,564	700	27.3%	521	20.3%	1,308	51.0%	74	2.9%	41	1.6%	38
		Henderson	934	166	17.8%	124	13.3%	318	34.0%	13	1.4%	8	0.9%	7
		Madison	591	125	21.2%	99	16.8%	209	35.4%	12	2.0%	12	2.0%	6
		McDowell	688	151	21.9%	118	17.2%	285	41.4%	10	1.5%	4	0.6%	7
		Mitchell	445	114	25.6%	121	27.2%	239	53.7%	21	4.7%	8	1.8%	7
		Polk	118	22	18.6%	23	19.5%	34	28.8%	3	2.5%	1	0.8%	1
		Transylvania	307	47	15.3%	34	11.1%	100	32.6%	6	2.0%	5	1.6%	4
		Yancey	315	87	27.6%	64	20.3%	132	41.9%	9	2.9%	2	0.6%	3
		CCMC Totals	143,046	30,856	21.6%	17,776	12.4%	57,662	40.3%	3,575	2.5%	1,377	1.0%	16,320

Accountable Care Network -> County -> Practice -> Patient

Report Manager - Windows Internet Explorer

North Carolina Community Care Networks Informatics Center Report Site (Beta)

Home -> Access II Case -> IHC Standard Reports -> Chronic Care Reports -> Patient List (S1)

View: **Demographics** | History | Subscriptions

New Subscription

Year/Quarter: 2009Q3 | PCP County: Suncombe

PCP: 5902540 - ABC Pediatrics of Asst | CCNC Screening: Yes, No

Dual Eligibility Status: DUAL, NON-DUAL | CCNC Priority: Yes, No

Age: >21, 0-21 | LME Priority: Yes, No

Client County: AVERY, BUNCOMBE, BURKE, CAL | Case Manager: Baldridge, Sherry, Bartholomew

Case Status: Deferred, Heavy, Inactive, Light

S1 - Patient List 2009Q3

6701007 - ACCESS II CARE OF WESTERN NORTH CAROLINA

Report Details

- Show Demographics
- Show CA PCP Detail
- Show Utilization
- Show Costs
- Show Diagnoses
- Show Mental Health Detail
- Show Screening Status & Case Management Detail

Count of patients returned 3,836

MRN	Name	DOB	CA PCP	Outpatient Biller (ID, PO, LIC #)	Outpatient Walks (MD, DO, PA, RN)	PT #/Ref	Emergency Department Visits	Inpatient Mental Health Admissions	Inpatient Non-Mental Health Admissions	Professionals	Monthly Average Prescriptions	Monthly Mental Health Visits
-----	------	-----	--------	-----------------------------------	-----------------------------------	----------	-----------------------------	------------------------------------	--	---------------	-------------------------------	------------------------------

PATIENT SNAPSHOT 2009Q1

PATIENT FIRST NAME: HARRY | LAST NAME: POTTER | DOB: 19APR1976

COUNTY OF RESIDENCE: STANLY | MID: 000000014N

PCP: STANLEY MEDICAL SERVICES DBA | DUAL

PCP COUNTY: STANLY

CM FIRST/LAST NAME: Mary Anne Mabry | Admit Date: _____

CM STATUS AS OF JULY 20, 2009: Heavy | DX: _____

BILLING MH THERAPY PROVIDER: _____ | Room No: _____

BILLING ENHANCED MH SVC PROVIDER: _____ | Phone No: _____

CAP PROGRAM: _____ | D/C Date: _____

PROGRAM ELIGIBILITY: MAD

DATA BELOW REFERENCES CHRONIC CARE REPORTS DATED: AUGUST 2009

CLAIMS WITH DATES OF SERVICE APRIL 1, 2008 TO MARCH 31, 2009

CCNC SCREENING: YES | CCNC PRIORITY: YES | LME PRIORITY: _____ | PRIORITY SCORE: 8 | DATE LAST TASK COMPLETED: 7/17/2009

Utilization:

OP BILLERS: 2 | IP MH ADMISSIONS: _____ | ED VISITS: _____ | MONTHLY AVG PRESCRIPTIONS: 4.0

OP VISITS: 3 | IP NONMH ADMITS: 6 | ED VISITS (MH/SA PRIMARY DIAG): _____ | MONTHLY AVG MH PRESCRIPTIONS: 1.5

MH THERAPY VISITS: _____ | READMISSIONS: 2 | ED VISITS (MH/SA 2ND-3TH DIAG): _____

PCP VISITS: _____

Costs for 12 months:

ENROLLMENT MONTHS: 12 | MEDICAID INPATIENT COST: \$12,438

TOTAL MEDICAID COST: \$30,474 | MEDICAID ED COST: \$519

MEDICAID MH DD SA COST: \$9 | MEDICAID DME COST: \$132

MEDICAID NON MH DD SA COST: \$30,465 | MEDICAID PCS COST: _____

TOTAL MEDICAID DRUG COST: \$1,996 | MEDICAID HH COST: _____

MH MEDICAID DRUG COST: \$9 | MEDICAID CSS COST: _____

KNOWIN MEDICARE COST: \$8,630 | MEDICAID LTC AND SNF COST: _____

Conditions: (CH = Chronic disease of the ...)

DIABETES: YES | COPD: _____ | HTN: YES | HEART FAILURE: _____

HEART ATTACK: _____ | ISCHEMIC VASCULAR: YES | ASTHMA: _____ | CH KIDNEY: _____

CH LIVER: _____ | CH GI: YES | STROKE: _____ | CH NEUROLOGICAL: _____

PRESSURE ULCER: _____ | MAGNUSCULOSKELETAL COND: _____ | CANCER: YES | _____

MH INDICATOR: _____ | DD INDICATOR: _____ | DEPRESSION: _____ | DEPRESSION PSYCHOTIC: _____

SCHIZOPHRENIA: _____ | BIPOLAR: _____ | OTHER PSYCHOSES: _____ | POSTTRAUMATIC STRESS DISORDER: _____



IC Report Site
Home

Chronic Care Reports: (e.g.) 30-Day Readmission Report

54-ABD PATIENTS WITH A 30 DAY READMISSION ENROLLED IN NETWORKS AS OF MARCH 1, 2009
CLAIMS WITH DATES OF SERVICE APRIL 1, 2008 TO MARCH 31, 2009

DATE OF BIRTH	CA PCP COUNTY	CA PCP NAME	ADMIT DATE	DISCHARGE DATE	BILLING PROVIDER	PRIMARY DIAGNOSIS
WAKE	WAKE	RALEIGH ASSOCIATED MEDICAL	10/19/2008	12/22/2008	WAKEMED	ACUTE RESPIRATORY FAILURE
WAKE	WAKE	RALEIGH ASSOCIATED MEDICAL	1/19/2009	1/22/2009	REX HOSPITAL	POST TRAUM PULM INFLUPIC
WAKE	WAKE	RALEIGH ASSOCIATED MEDICAL	2/2/2009	2/3/2009	REX HOSPITAL	UNSPECIFIED VIRAL INFECTIONS
WAKE	WAKE	RALEIGH ASSOCIATED MEDICAL	2/6/2009	2/8/2009	REX HOSPITAL	GASTROINTEST HEMORR NOS
WAKE	WAKE	HORIZON HEALTH CENTER	4/4/2008	4/8/2008	REX HOSPITAL	ADVERSE EFFECT ATICOAGULANTS
WAKE	WAKE	HORIZON HEALTH CENTER	4/29/2008	4/30/2008	WAKEMED	CHEST PAIN NEC
WAKE	WAKE	HORIZON HEALTH CENTER	11/1/2008	11/3/2008	WAKEMED	AMI ANT WALL INT EPI EAR
WAKE	WAKE	HORIZON HEALTH CENTER	2/26/2009	3/5/2009	REX HOSPITAL	ATRIAL FIBRILLATION
WAKE	WAKE	HORIZON HEALTH CENTER	3/16/2009	3/17/2009	REX HOSPITAL	ATRIAL FIBRILLATION
WAKE	WAKE	HORIZON HEALTH CENTER	3/26/2009	3/28/2009	REX HOSPITAL	UNSPECIFIED SYSTOLIC HEART FAILURE
JOHNSTON	JOHNSTON	BENSON AREA MEDICAL CENTER	7/5/2008	7/8/2008	JOHNSTON MEMORIAL	CHEST PAIN NEC
JOHNSTON	JOHNSTON	BENSON AREA MEDICAL CENTER	10/7/2008	10/17/2008	JOHNSTON MEMORIAL	CHRONIC OBSTRUCTIVE ASTHMA - WITH (ACUTE) EXACERBATION
JOHNSTON	JOHNSTON	BENSON AREA MEDICAL CENTER	2/19/2009	2/12/2009	JOHNSTON MEMORIAL	CHEST PAIN NEC
JOHNSTON	JOHNSTON	BENSON AREA MEDICAL CENTER	2/12/2009	3/4/2009	WAKEMED	ATRIOVENT BLOCK COMPLETE
JOHNSTON	JOHNSTON	BENSON AREA MEDICAL CENTER	3/23/2009	3/28/2009	WAKEMED	OTHER CHRONIC POSTOPERATIVE PAIN
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	6/3/2008	6/6/2008	WAKEMED	ASTHMA W STATUS ASTHMAT
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	11/16/2008	11/19/2008	WAKEMED	CHRONIC OBSTRUCTIVE ASTHMA - WITH (ACUTE) EXACERBATION
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	3/1/2009	3/4/2009	WAKEMED	ACUTE RESPIRATORY FAILURE
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	3/16/2009	3/18/2009	WAKEMED	ASTHMA W STATUS ASTHMAT
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	6/17/2008	6/23/2008	REX HOSPITAL	ACUTE ON CHRONIC SYSTOLIC HEART FAILURE
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	8/5/2008	8/5/2008	WAKEMED	ACUTE SYSTOLIC HEART FAILURE
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	12/27/2008	12/28/2008	DUKE RALEIGH HOSPT	DIABETES MELLITUS W/O COMPLICATION, TYPE II UNCONTROLLED
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	1/5/2009	1/19/2009	NASH GENERAL HOSPT	RECUR DEPR PSYCH-SEVERE
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	2/11/2009	2/13/2009	WAKEMED	CONGESTIVE HEART FAILURE
WAKE	WAKE	ROCK QUARRY ROAD FAMILY ME	3/15/2009	3/17/2009	REX HOSPITAL	ACUTE SYSTOLIC HEART FAILURE



Case Management Information System

Welcome to Case Manager System :: Login - Windows Internet Explorer

https://hccmk5.srs.us/login.aspx?se=

File Edit View Favorites Tools Help

Welcome to Case Manager System :: Login

Case Management Information System
version 4.0.3
Community Care of North Carolina

LOGIN

Login name:

Password:

CMIS Passport: F3 C3 B1 B3

If you dont have CMIS Passport, leave the CMIS Passport fields blank.
Passport fields are case sensitive. If * is displayed in CMIS Passport fields, it means your passport is saved.

Remember my Passport on this computer

[Forgot your password?](#)

Community Care of North Carolina
Access II and III Networks

Case Management Information System, CMS, is a secure web application intended for the users of organizations participating in Access II - III programs. It integrates the components of the CCHC standardized Plan with accepted case management processes. It allows case managers to build and work with patient-specific, comprehensive care plans. The funding for the application is provided by the North Carolina Foundation for Advanced Health Programs, Inc.

If you are not a user please refrain from attempting to log in to the application.

Information about the Access II - III Programs can be obtained from 919.715.0154 or chris.youngblood@ncmail.net. For technical support, call 919.487.2255 or support@ora.us

Please disable any pop up blockers in your browser. This application is designed to work best with a minimum screen resolution of 1024 X 768 and Internet Explorer version 8.x or higher.

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Case Management Information System
version 4.0.5
Community Care of North Carolina

Care Management Tools: Comprehensive Health Assessments, Screening and Intervention Tools (PHQ9, CAGE, HF Module)



Case Management Information System
version 4.0.5
Community Care of North Carolina

WELCOME
Youngster: Josephine - Apr 21 1942 (Age: 67 yrs 1 month) - None -
Deferred (04/07/2005)

Live Support: Call 919-467-2255 or Email support@5rs.us
Return to Demographics / User Workspace / Patient Workspace / Search

Comprehensive Health Assessment Form

New Comprehensive Health Assessment Add Comprehensive Health Assessment [Patient Home](#)

End of life:

Height: ft in Weight: lb or kg

Provider Name: Practice: Practice Phone:

Referral Source:

<input type="checkbox"/> CAP C	<input type="checkbox"/> OSS	<input type="checkbox"/> Patient/CG
<input type="checkbox"/> CAP Choice	<input type="checkbox"/> OMA	<input type="checkbox"/> PCP
<input type="checkbox"/> CAP DA	<input type="checkbox"/> ED	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> CAP MR/DD	<input type="checkbox"/> Hospice/Palliative Care Program	<input type="checkbox"/> Pharmacist (CCNC)
<input type="checkbox"/> CCNC Data Report	<input type="checkbox"/> Hospital/In Patient	<input type="checkbox"/> Primary CM
<input type="checkbox"/> CCQA		<input type="checkbox"/> LME/Mental Health Provider
<input type="checkbox"/> Community Service Provider / Agency		<input type="checkbox"/> School
<input type="checkbox"/> Specialist(s): <input type="text"/>		

Patient prognosis is poor /short life expectancy

Patient's General Perception of Health: (Poor, Fair, Good, Very Good, Excellent)
 Chief Complaint/Reason for Referral:

309 Characters left 400 Characters left



Case Management Information System
version 4.0.5
Community Care of North Carolina

Claims History— Hospitalizations, ED Visits, Office Visits

ICN: 252003233382781		
Billing Service Provider: MEMORIAL MISSION HOSPITAL INC		
Diagnosis: AC SUPP OTITIS MEDIA NOS		
Date of Service	Procedure Details	Amount Paid
7/28/2003	RC113: ROOM AND BOARD-PRIVATE PEDIATRIC	\$3,080.75
		Amount Total : \$3080.75
ICN: 252003203370083		
Billing Service Provider: MEMORIAL MISSION HOSPITAL INC		
Diagnosis: VIRAL ENTERITIS NOS		
Date of Service	Procedure Details	Amount Paid
4/23/2003	RC113: ROOM AND BOARD-PRIVATE PEDIATRIC	\$1,474.66
		Amount Total : \$1474.66
ICN: 252003253374809		
Billing Service Provider: MEMORIAL MISSION HOSPITAL INC		
Diagnosis: PNEUMONIA, ORGANISM NOS		
Date of Service	Procedure Details	Amount Paid
4/18/2003	RC113: ROOM AND BOARD-PRIVATE PEDIATRIC	\$1,999.12
		Amount Total : \$1999.12
ICN: 252003093328541		
Billing Service Provider: MEMORIAL MISSION HOSPITAL INC		
Diagnosis: UNSPECIFIED ASTHMA, WITH ACUTE EXACERBATION		
Date of Service	Procedure Details	Amount Paid
3/26/2003	RC113: ROOM AND BOARD-PRIVATE PEDIATRIC	\$1,804.90



Case Management Information System
version 4.0.5
Community Care of North Carolina

Care Plan:

Goals, Measures, Tasks, Communications

Case Manager Information System - Windows Internet Explorer

https://nccmis.srs.us/mainframe.aspx

Demographics | **Care Plan** | Goals | Measures | Tasks | Medications

[Add Conditions](#) | [Add Tasks](#) | [Filter Conditions](#) | [Printable Version](#)

ADHD/ADD

State: Ruled In Condition Status: Open Status Date: 8/14/2008
 Start Date: 8/14/2008 Assigned To: ██████████

Conditions Notes:
 /** Pt with ADHD and autism. Failure to thrive. km - ██████████ 08/14/2008.

Care Coordination Needs

State: Ruled In Condition Status: Open Status Date: 9/2/2008
 Start Date: 9/2/2008 Assigned To: ██████████

Conditions Notes:
 /** Pt needs assistance in getting Medicaid to cover Pediasure and for sample bottles until covered. km - ██████████ - 09/03/2008.

Interventions:
 Service Coordination

Health Insurance / Access issues

State: Ruled In Condition Status: Open Status Date: 8/18/2008
 Start Date: 8/18/2008 Assigned To: ██████████

Conditions Notes:
 /** Needs coverage for nutritional supplement due to failure to thrive. km - ██████████ 08/18/2008.

Active Goal(s) and Notes:
Reduce identified risk factors -- 8/18/2008
 /** Get coverage by Medicaid for Pediasure by 2 weeks. km - ██████████ - 08/18/2008.

Interventions:
 Consultation, Service Coordination

Mental Health Concerns

State: Ruled In Condition Status: Open Status Date: 8/14/2008
 Start Date: 8/14/2008 Assigned To: ██████████



Pharmacy Home

Prescription Fill History, Care Alerts

Patient Profile - Microsoft Internet Explorer

Address: http://practices.pharmacyhomeconnect.com/pages/patientprofile.aspx

Medication Regimen - 16 prescriptions From: 8/8/2007 To: 8/8/2008 Show History Show Regimen Add Rx Collapse

Fill Date	Item Description	Qty	Days	Cost	PAA	Unit Cost	DCI	EDC	Prescriber	Pharmacy	Notes	Status	
2/21/2008	EFEVOR XR 75 MG CAPSULE SA	34	24	\$136.32				0.00	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC		Claims	
2/21/2008	CITALOPRAM HBR 10 MG TABLET	3	3	\$2.83				0.00	0.28	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC	Claims	
2/21/2008	POTASSIUM CL 10 MEQ TABLET	32	32	\$6.90				0.95			CARRBORO FAMILY PHARMACY INC	Claims	
2/14/2008	LEPITOR 20 MG TABLET	30	30	\$123.69				0.84			CARRBORO FAMILY PHARMACY INC	Claims	
2/14/2008	LAMIVUDINE 150 UNITS/ML VIAL	10	28	\$97.14				1.04	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC		Claims	
2/14/2008	DIODAN 80 MG TABLET	30	30	\$64.74				0.94			CARRBORO FAMILY PHARMACY INC	Claims	
2/9/2008	METOCLOPRAMIDE 10 MG TABLET	90	30	\$8.45				0.53			CARRBORO FAMILY PHARMACY INC	Claims	
2/1/2008	RISPERIDAL 1 MG TABLET	30	30	\$107.55				0.00	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC		Claims	
1/22/2008	OMEPRAZOLE 20 MG CAPSULE OR	60	30	\$40.68				0.81	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC		Claims	
1/22/2008	WARFARIN SODIUM 5 MG TABLET	31	31	\$7.38				0.98			CARRBORO FAMILY PHARMACY INC	Claims	
1/14/2008	RISPERDAL 0.5 MG TABLET	30	30	\$129.44			DCI	0.95	Prescriber Unknown	CARRBORO FAMILY PHARMACY INC		Claims	
1/10/2008	CLONAZEPAM 0.5 MG TABLET	100	25	\$5.45				0.36	Prescriber Unknown	CARRBORO FAMILY PHARMACY INC		Claims	
1/10/2008	WARFARIN SODIUM 1 MG TABLET	30	30	\$6.80				0.00	Prescriber Unknown	CARRBORO FAMILY PHARMACY INC		Claims	
11/8/2007	GLYCOLAX POWDER	510	25	\$22.75				0.11	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC		Claims	
11/8/2007	CITALOPRAM HBR 20 MG TABLET	30	30	\$4.91			DCI	0.00	0.26	UNC HOSPITALS	CARRBORO FAMILY PHARMACY INC		Claims
9/3/2007	FUROSEMIDE 20 MG TABLET	31	31	\$5.49			263*	0.00	0.41		CARRBORO FAMILY PHARMACY INC		Claims



Medication Review



The Pharmacy Home Medication Regimen Report

Rx claims through: 2/21/2008
Report Print Date: 04/04/2008

Patient Information
Name: Jane D Doe, DOB: 2/20/1944, Gender: Female, MedicalID: 123456789, Medicaid Eligible: Yes, Allergies: Unknown, Medicare Eligible: No

Practice Information
PCP: UNC FAMILY PRACTICE CENTER, PCP Phone: [blank], PCP Fax: [blank], Network: AccessCare

Pharmacist/Case Manager Information
Most Recent Pharmacy: CARRBORO FAMILY PHARMACY INC, Pharm Phone: (919) 933-7629, Case Manager Status: [blank], Network RPH: Troy K Trygstad, Network RPH Phone: 919-260-5241, Network RPH Fax: [blank]

Patient Criteria Information
Rx: Yes, # Practices: Yes, Ave. PDC: [blank], Ave. Rx \$/Mo: \$646.01

Drug Description	Prescriber*	Last Filled	Days Supply	Qty	Paid Amt	AI	Gap/DC	PAL/PA
GLYCOLAX POWDER	UNC HOSPITALS	11/13/07	29	510	\$22.75			
CITALOPRAM HBR 20 MG TABLET	UNC HOSPITALS	11/13/07	30	30	\$4.91	0.26	DC?	
FUROSEMIDE 20 MG TABLET		05/03/07	31	31	\$3.49	0.41	263*	
POTASSIUM CL 10 MEG TABLET E		02/21/08	32	32	\$6.90			
EFEXOR XR 75 MG CAPSULE BA	UNC HOSPITALS	02/21/08	34	34	\$136.32			
CITALOPRAM HBR 10 MG TABLET	UNC HOSPITALS	02/21/08	3	3	\$2.93	0.28		
LANTUS 100 UNITS/ML VIAL	UNC HOSPITALS	02/14/08	25	10	\$87.14			
DOVAN 80 MG TABLET		02/14/08	30	30	\$64.74			
LIPITOR 20 MG TABLET		02/14/08	30	30	\$123.69			
METOCLOPRAMIDE 10 MG TABLET		02/09/08	30	30	\$8.45			
RISPERDAL 1 MG TABLET	UNC HOSPITALS	02/01/08	30	30	\$137.55			
OMEPRAZOLE 20 MG CAPSULE DR	UNC HOSPITALS	01/22/08	30	60	\$40.68			
WARFARIN SODIUM 1 MG TABLET		01/22/08	31	31	\$7.36			
RISPERDAL 0.5 MG TABLET	Prescriber Unknown	01/14/08	30	30	\$129.44		DC?	
CLONAZEPAM 0.5 MG TABLET	Prescriber Unknown	01/10/08	25	100	\$5.65			
WARFARIN SODIUM 1 MG TABLET	Prescriber Unknown	01/10/08	30	30	\$6.90			

* The prescriber(s) listed above may occasionally be mistated due to pharmacy population errors when interpreting a prescriber's signature. In many cases the prescriber is unknown. AI = Adherence Index, GAP = Gap in Therapy, DC = New Drug Filled in Same Class



Printable Patient Med List

- | | |
|---|---|
| 1 Drug: POTASSIUM CL 10 MEG TABLET
Common use: Potassium
Prescriber:
Directions: | 11 Drug: RISPERDAL 0.5 MG TABLET
Common use: Mood
Prescriber/Prescriber Unknown:
Directions: |
| 2 Drug: CITALOPRAM HBR 10 MG TABLET
Common use: Mood
Prescriber: UNC HOSPITALS
Directions: | 12 Drug: WARFARIN SODIUM 1 MG TABLET
Common use: Blood Thinner
Prescriber/Prescriber Unknown:
Directions: |
| 3 Drug: EFEXOR XR 75 MG CAPSULE BA
Common use: Mood
Prescriber: UNC HOSPITALS
Directions: | 13 Drug: CLONAZEPAM 0.5 MG TABLET
Common use: Sedative
Prescriber/Prescriber Unknown:
Directions: |
| 4 Drug: LIPITOR 20 MG TABLET
Common use: Cholesterol
Prescriber:
Directions: | 14 Drug: GLYCOLAX POWDER
Common use: Constipation
Prescriber: UNC HOSPITALS
Directions: |
| 5 Drug: LANTUS 100 UNITS/ML VIAL
Common use: High Blood Sugar
Prescriber: UNC HOSPITALS
Directions: | 15 Drug: CITALOPRAM HBR 20 MG TABLET
Common use: Mood
Prescriber: UNC HOSPITALS
Directions: |
| 6 Drug: DOVAN 80 MG TABLET
Common use: Heart
Prescriber:
Directions: | 16 Drug: FUROSEMIDE 20 MG TABLET
Common use: Water Fly
Prescriber:
Directions: |
| 7 Drug: METOCLOPRAMIDE 10 MG TABLET
Common use: Nausea
Prescriber:
Directions: | 17 Drug:
Common use:
Prescriber:
Directions: |
| 8 Drug: RISPERDAL 1 MG TABLET
Common use: Mood
Prescriber: UNC HOSPITALS
Directions: | 18 Drug:
Common use:
Prescriber:
Directions: |
| 9 Drug: OMEPRAZOLE 20 MG CAPSULE DR
Common use: Stomach
Prescriber: UNC HOSPITALS
Directions: | 19 Drug:
Common use:
Prescriber:
Directions: |
| 10 Drug: WARFARIN SODIUM 1 MG TABLET
Common use: Blood Thinner
Prescriber:
Directions: | 20 Drug:
Common use:
Prescriber:
Directions: |

Pharmacy Home Program Medication Card

John Doe



Community Care of North Carolina
AccessCare

Please carry this card with you at all times
04/04/2008

Drug Allergies
Unknown

My Conditions

Doctor's Name
Dr. Good Medicine - Cary Family Medicine

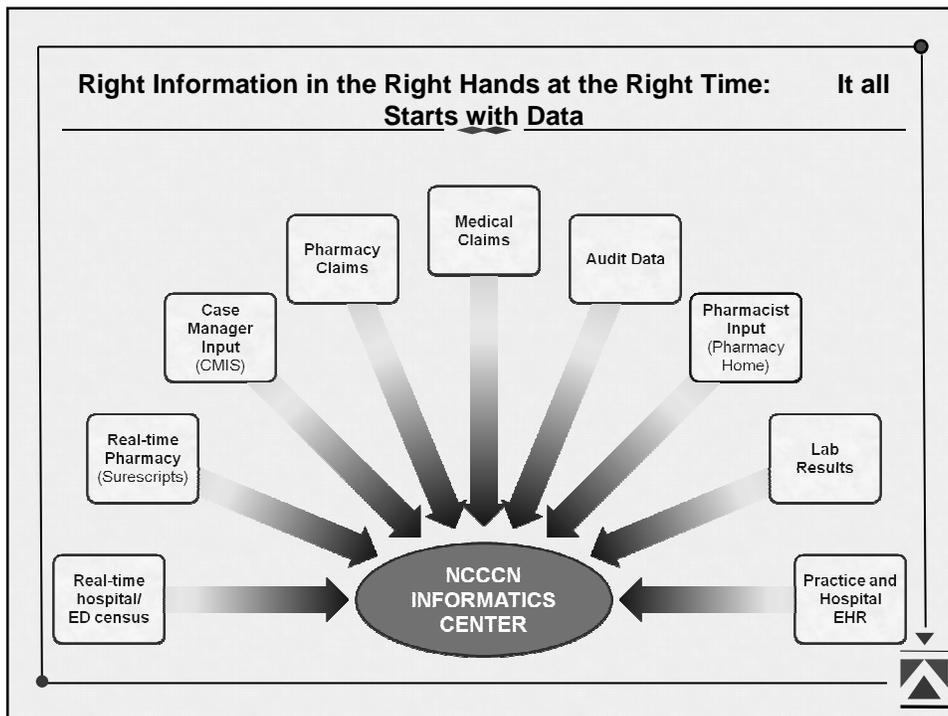
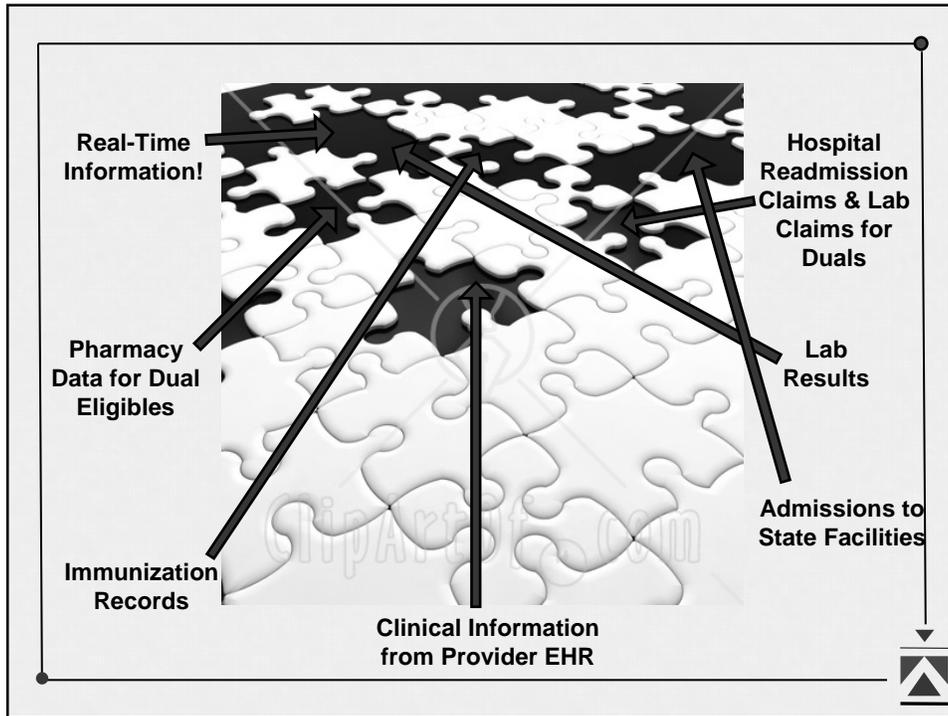
Pharmacy
CARRBORO FAMILY PHARMACY INC (919) 933-7629

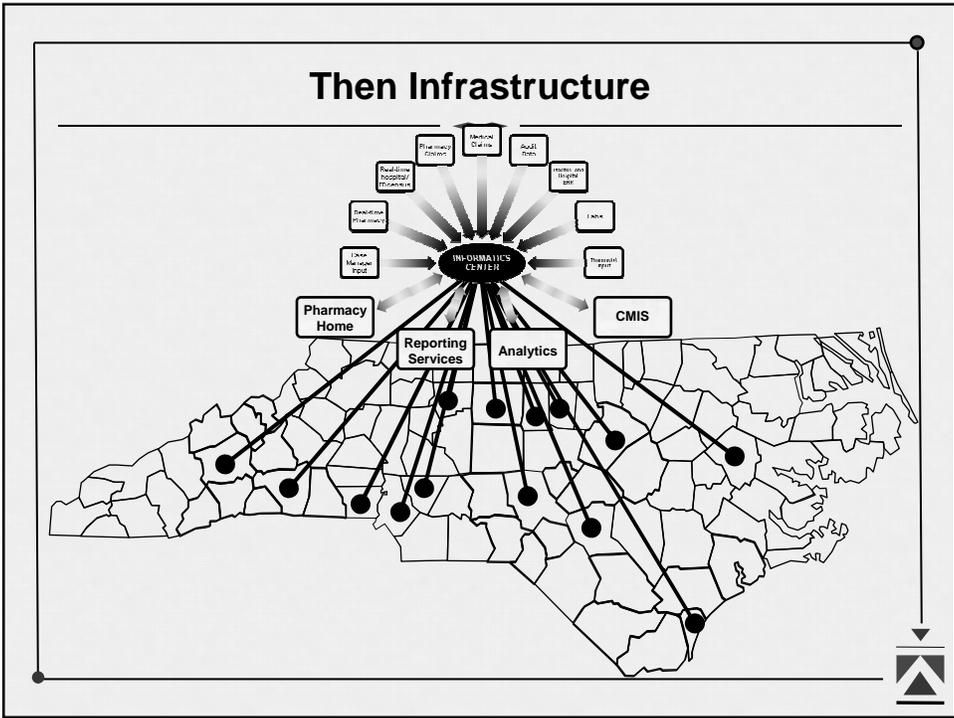
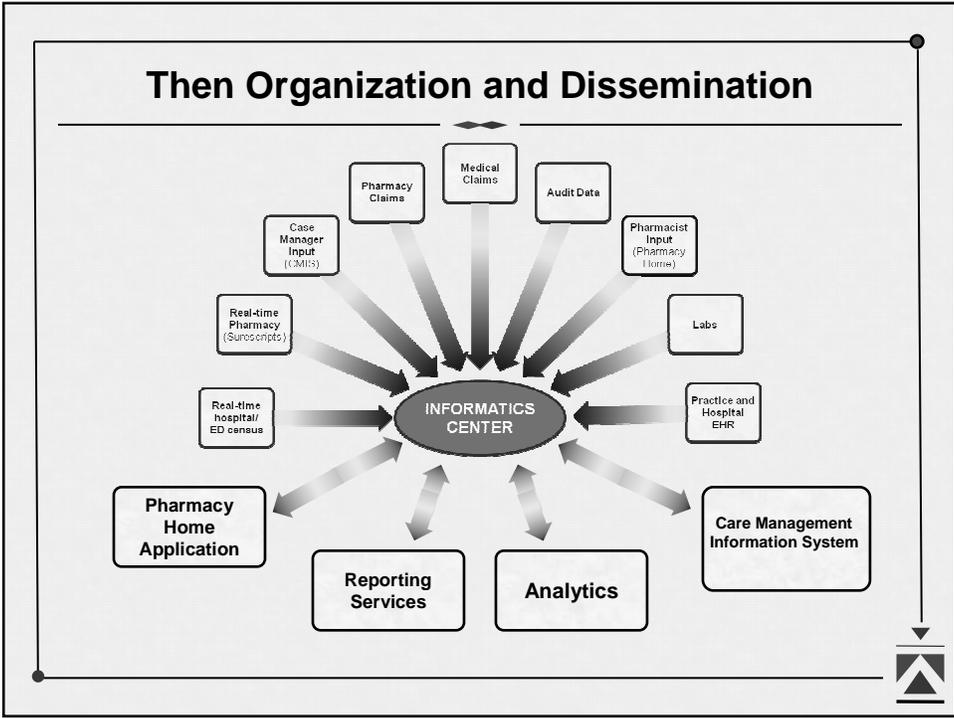
Pharmacy Home Contact and Phone Number
Troy Trygstad PharmD (919)-260-5142

Case Manager Contact and Phone Number
Nanci Newton RN (919)-380-9963

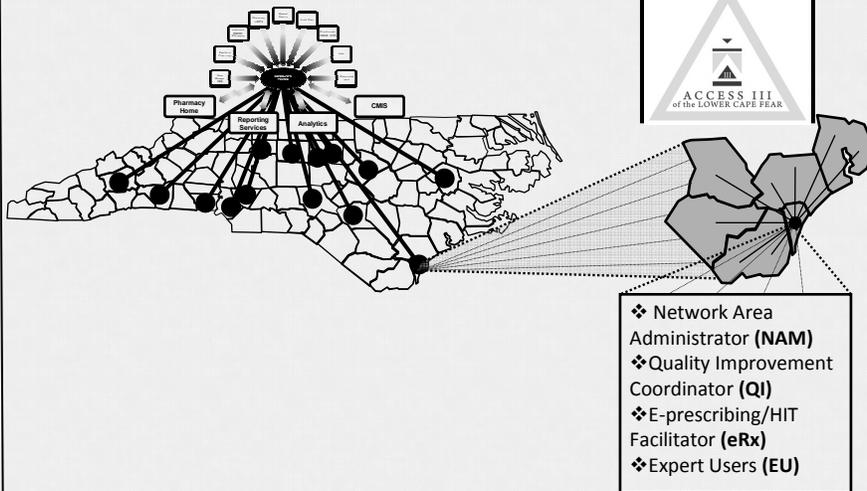
Emergency Contact and Phone Number



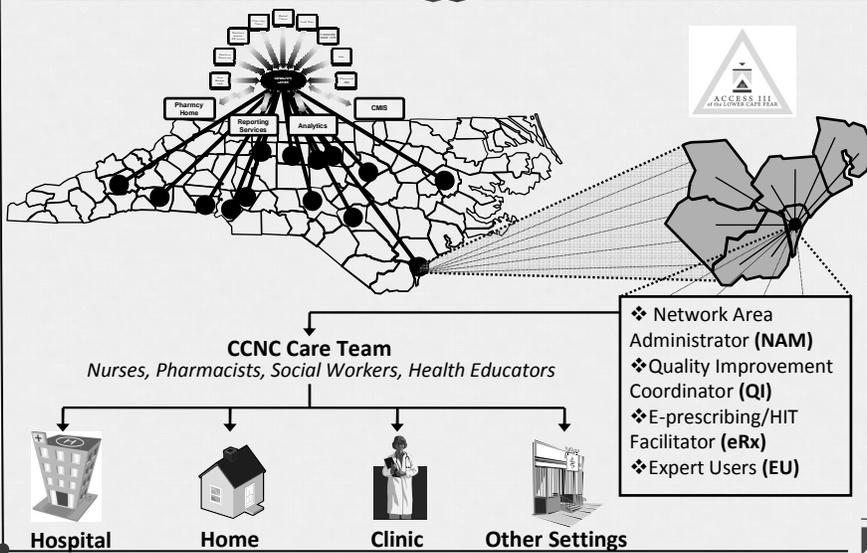


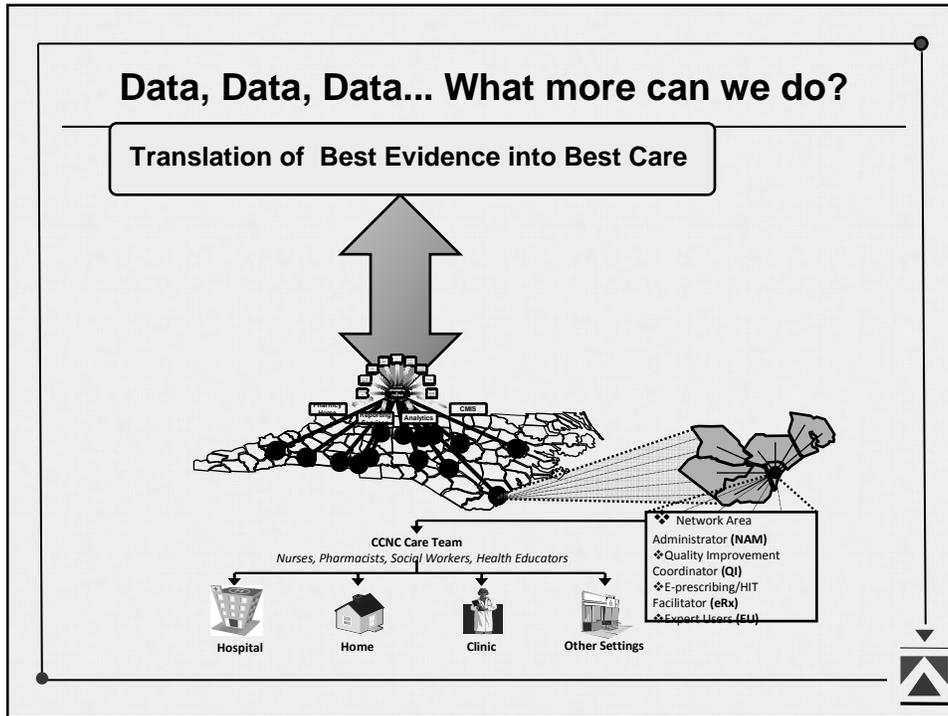


Then Technical, Analytical and Educational Support



Then Caregivers





ARRA: new opportunities for state-academic partnerships?

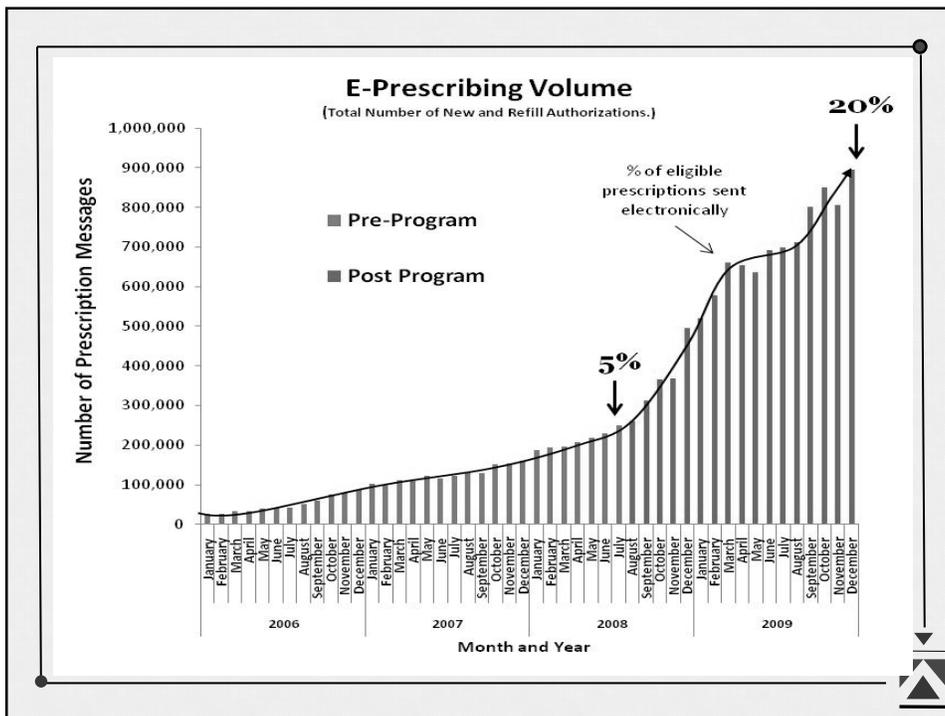
Example:
 AHRQ Grant Submission “Expansion of Research Capability to Study Comparative Effectiveness in Complex Patients”

- Collaboration between NCCCN, DMA, DMHDDSA, Division of State-operated Facilities, and the UNC Sheps Center
- Linkage of multiple datasets to allow ‘complete’ picture of health system use by patients with mental illness
 - Medicaid claims, state facilities, outpatient mental health services
 - Infrastructure to facilitate access for research purposes
- Opportunity for a multiple purpose dataset: CE research; policy research; program planning and evaluation; patient care; care coordination across agencies and across settings of care

New opportunities for dissemination of best practices, public-private partnerships?

Example: CCNC E-prescribing Initiative

- Working within CCNC infrastructure to provide practices with assistance in adoption of e-prescribing
 - Embedded clinical pharmacist consultants, with train-the-trainer approach
 - Vendor neutral!
 - Full continuum of support, from product selection, to clinic workflow integration, to local pharmacy preparedness
- Partnerships with BCBS NC (awareness campaign and seed money for new e-prescribers in 2008); and Surescripts national e-prescription network (provision of geographic data)



right **Patient.**
right **Time.**
right **Setting.**
right **Intervention.**
right **Care Team.**

THANK YOU





The North Carolina Center for Hospital
Quality and Patient Safety

Carol Koeble MD,MS,CPE

NC Center for Hospital Quality and Patient Safety

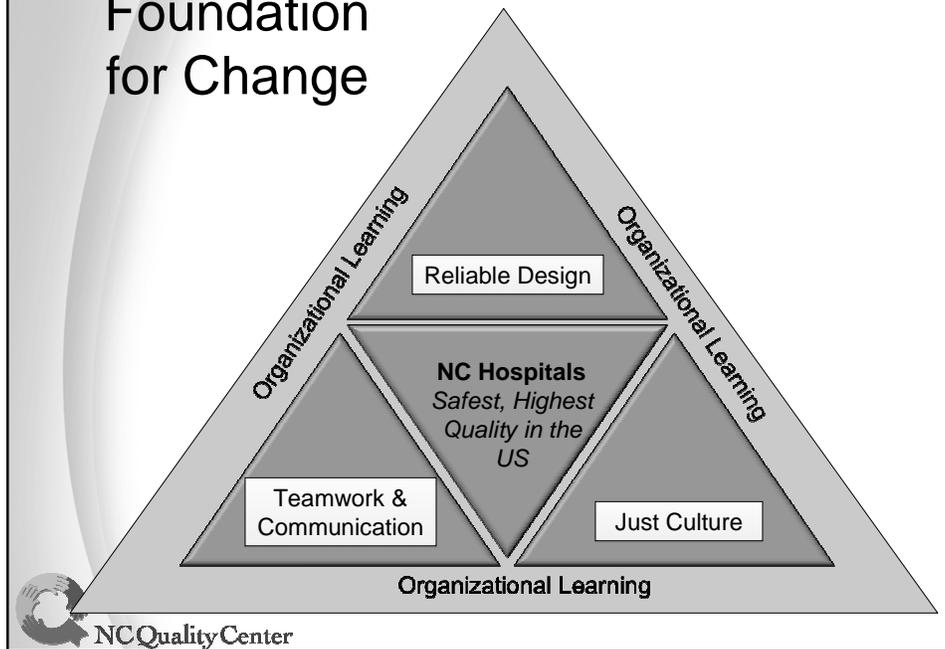
Vision
The Center will lead North Carolina hospitals to become the safest and highest quality hospitals in the United States

Mission
The Center exists to foster a culture of quality and safety within North Carolina hospitals



NCQualityCenter

Foundation for Change



NQF National Priorities

- Engage patients and families
- Improve the health of the population
- Improve the safety and reliability of the healthcare system
- Ensure patients receive well-coordinated care
- Guarantee appropriate and compassionate care for patients with life-limiting illnesses
- Eliminate overuse while ensuring the delivery of appropriate care

NC Quality Center 2010 Strategic Plan

Priority Areas	
<p>Priority 1 Improve the safety and reliability of North Carolina's healthcare</p>	<p>Priority 2 Ensure patients receive well-coordinated care within and across all healthcare settings</p>
Goals	Aims
<p>Goal 1: All NC healthcare organizations and their staff will strive to ensure a culture of safety while driving to eliminate preventable healthcare associated infections (HAIs) and serious adverse events</p>	<p>AIM 1: Reduce HAIs by 25% Reduce CLABSI rate to < 1 /1000 days Reduce CAUTI rate to < 3 /1000 days Reduce the SSI rate for: ◆ Hip prosthesis to <0.68% ◆ Abdominal Hysterectomy to <0.94% ◆ Knee Prosthesis to <0.32%</p>
<p>Goal 2: All NC hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions to best in class</p>	<p>AIM 2: Reduce condition specific 30-day mortality rates by Dec 2014 as follows: AMI to < 15.3 (↓4%) HF to < 10.2 (↓ 6%) PN to < 10.3 (↓15%)</p>
<p>Goal 3: All NC hospitals will improve the reliability of evidenced based care processes</p>	<p>AIM 3: Increase reliable processes of care (OC measures) to 80% for all NCHA hospitals by Dec 2012</p>
<p>Goal 4: All NC healthcare organizations and their staff will work collectively with patients to reduce 30-day readmission rates</p>	<p>AIM 4: Reduce condition specific 30-day readmission rates by Dec 2014 as follows: AMI to 19.1 (↓2%) HF to 23.2 (↓ 5%) PN to 17 (↓9%)</p>



NC Quality Center

2010 Initiatives

- NC SCIP Collaborative
(Surgical Care Improvement Project)
- NC Safer ICUs: Eliminating CLABSI Collaborative
(Central Line Associated Blood Stream Infection)
- NC CAUTI Collaborative
(Catheter Associated Urinary Tract Infection)
- NC Just Culture Collaborative



NC Quality Center

2010 Initiatives

- Patient Safety Training program
- NC Lean Healthcare
- TeamSTEPPS
- The Science of Reliability
- Just Culture
- Transitions in care



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2010 Initiatives

- AHRQ surveys on patient safety culture
- NC Quality Center Patient Safety Organization (*NCQC PSO*)
- NC SHIM
(*System for Hospital Infection Measurement*)
- NC Hospital Quality Performance Report
(*www.NCHospitalQuality.org*)



NCQualityCenter

Average: Not Good Enough

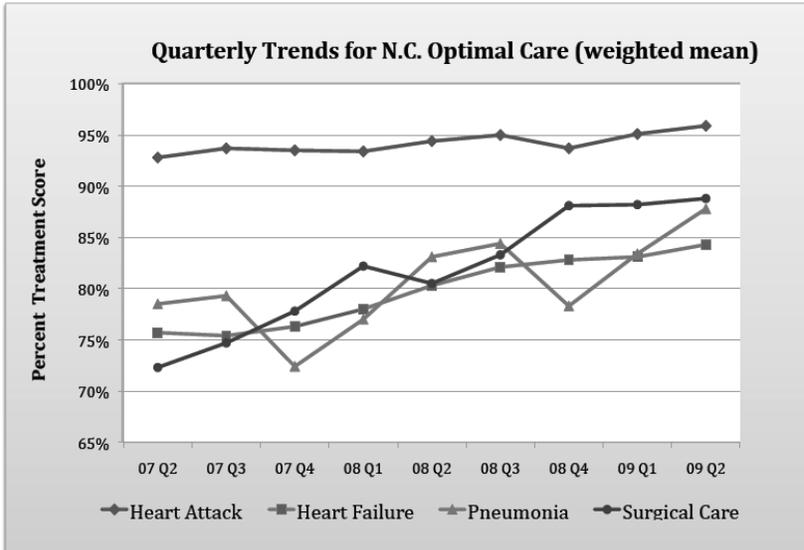
Condition	Measure	Measure Name	North Carolina Hospitals				National
			90th %ile 1/03 - 6/09*	75th %ile 1/08 - 6/09*	Avg. Score 1/09 - 6/09*	W-Mean Score 4/09 - 6/09**	Mean 4/09 - 6/09***
Heart Attack	HA1	ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction	100%	100%	93%	96%	95%
Heart Attack	HA2	Aspirin at Arrival	100%	100%	96%	99%	98%
Heart Attack	HA3	Aspirin at Discharge	100%	100%	95%	99%	98%
Heart Attack	HA5	Beta Blocker at Discharge	100%	100%	95%	98%	98%
Heart Attack	HA6	PCI Within 90 Minutes Of Arrival	100%	99%	88%	94%	87%
Heart Attack	HA7	Smoking Cessation Advice/Counseling	100%	100%	100%	100%	99%
Heart Attack	HA8	Framingham Risk 30 Minutes Of Arrival	50%	25%	19%	29%	58%
Heart Attack		Optimal Care ("All-or-none" Bundle)*	100%	98%	93%	95%	94%
Heart Failure	HF1	ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction	100%	100%	93%	94%	94%
Heart Failure	HF2	Evaluation of Left Ventricular Function	100%	100%	95%	98%	97%
Heart Failure	HF3	Discharge Instructions	99%	95%	82%	85%	86%
Heart Failure	HF4	Smoking Cessation Counseling	100%	100%	96%	99%	98%
Heart Failure		Optimal Care ("All-or-none" Bundle)	98%	92%	81%	84%	85%
Pneumonia	P1	Pneumococcal Vaccination Given/Screened	100%	98%	93%	94%	91%
Pneumonia	P2	First Antibiotic Dose within 6 Hours	100%	99%	95%	95%	95%
Pneumonia	P4	Smoking Cessation Counseling	100%	100%	95%	95%	97%
Pneumonia	P5	Antibiotic Selection Consistent with Guidelines	100%	99%	90%	91%	91%
Pneumonia	P6	Initial Blood Culture Before First Antibiotic Dose (ED only)	100%	99%	94%	95%	95%
Pneumonia	P7	Influenza Vaccination Given/Screened	100%	100%	93%	94%	93%
Pneumonia		Optimal Care ("All-or-none" Bundle)	96%	91%	84%	88%	89%
Surgical Care	CARD2	Pre-Admit and Perioperative Beta Blocker	100%	99%	90%	92%	91%
Surgical Care (1)	INF1	Preventative Antibiotic(s) One Hour Before Incision	100%	100%	97%	97%	96%
Surgical Care (2)	INF2	Appropriate Preventative Antibiotic(s) for Their Surgery	100%	100%	97%	98%	98%
Surgical Care (3)	INF3	Antibiotic(s) are Stopped Within 24 hours After Surgery	99%	99%	93%	95%	93%
Surgical Care (4)	VTE1	VTE ("Blood Clot") Prophylaxis Ordered	100%	99%	91%	94%	93%
Surgical Care (5)	VTE2	VTE ("Blood Clot") Prophylaxis Received	99%	99%	88%	92%	91%
Surgical Care (6)	INF4	Controlled Post-op Glucose - Cardiac Surgery	100%	99%	94%	93%	92%
Surgical Care (7)	INF6	Appropriate Hair Removal ("No Razors")	100%	100%	99%	99%	99%
SCIP-8		Optimal Care ("All-or-none" Bundle)	97%	93%	86%	90%	86%

Legend: Red = below national mean, yellow = at national mean, green = above national mean.
 * 90th, 75th percentile and average (unweighted) score derived from 108 NC hospitals on NCHospitalQuality.org with 10 or more patients per measure.
 ** The N.C. weighted mean (by volume) is 2nd QTR 2009 data for all NC hospitals that submit data to the CMS warehouse (includes CAHs).
 *** The national weighted mean is 2nd QTR 2009 data for all Medicare IPPS hospitals that submit data to the CMS warehouse (excludes CAHs).
 The national mean is a benchmark set for all NC hospitals to meet or exceed.



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February 2010
www.NCHospitalQuality.org

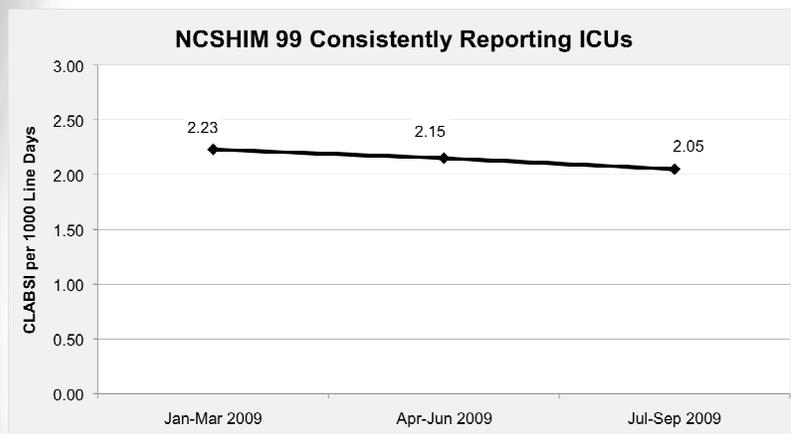


Pneumonia: The optimal care score does not include influenza vaccination during Q2 and Q3 (non flu season).
 Surgical Care: O.C. score includes eight SCIP measures (INF1, INF2, INF3, INF4, INF6, Card2, VTE1 and VTE2).

Data on NC acute-care hospitals received from the Carolinas Center for Medical Excellence
 Optimal Care measures derived from the CMS/HQA Hospital Inpatient Process Measures

1/6/10

CLASBI Trend Rate



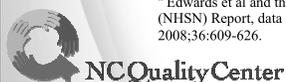
The "ALL SHIM" Report

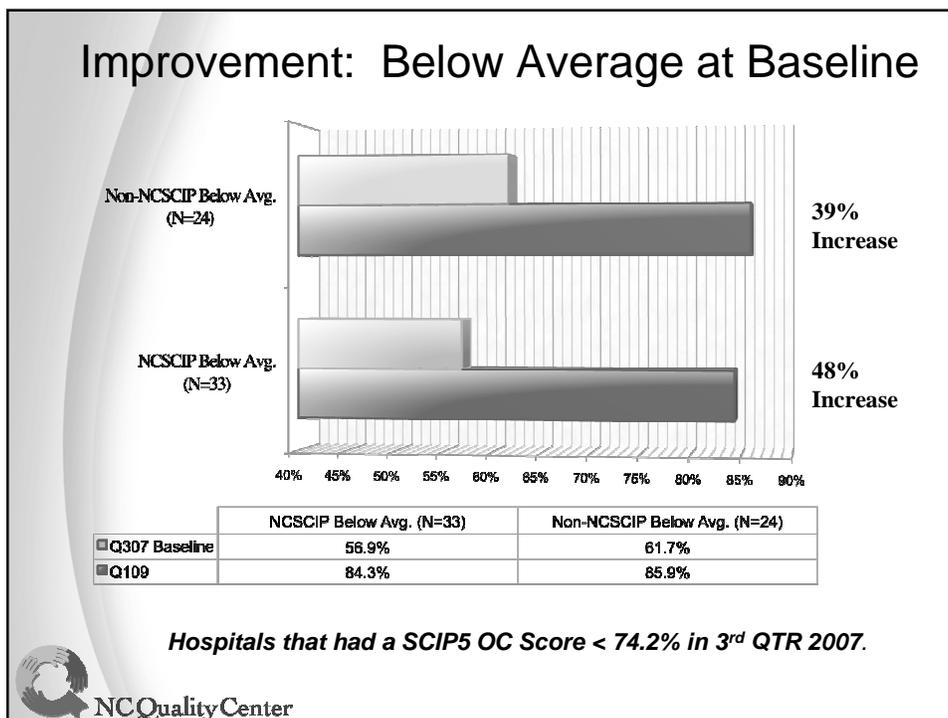
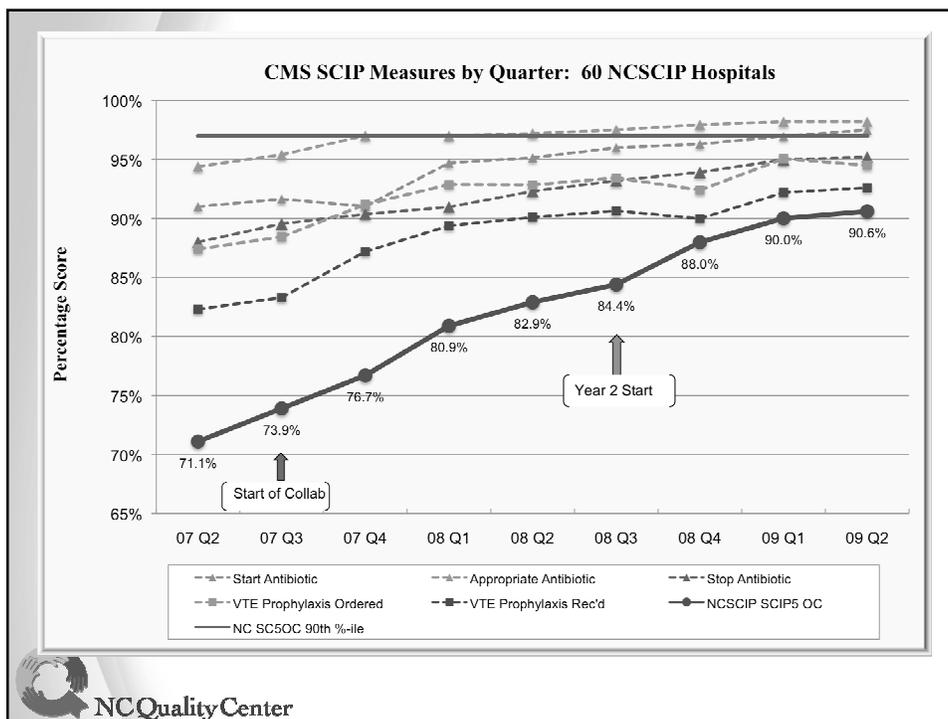
9-Month Central line-associated Bloodstream Infection (CLABSI) Rateⁱ
By Type of Location

Location / ICU	NCSHIM Oct 2008 – June 2009				CDC NHSN 2006-2007 ⁱⁱ
	No. of locations	CL BSIs	Central line-days	Pooled Mean	Pooled Mean
Burn	2	12	3,462	3.47	5.6
Coronary	9	23	12,739	1.81	2.1
Surgical cardiothoracic	9	21	17,454	1.20	1.4
Medical	8	63	16,516	3.81	2.4
Medical/surgical, major teach	1			--	2.0
Medical/surgical, non-teaching	53	64	46,764	1.37	1.5
Pediatric medical/surgical	6	12	5,168	2.32	2.9
Neurosurgical	7	22	10,271	2.14	2.5
Surgical	4	24	7,708	3.11	2.3
Trauma	3	14	4,074	3.44	4.0
Med/Surg Inpatient Ward	11	6	2832	2.13	1.3
ALL LOCATIONS	113	266	129,027	2.06	2.06

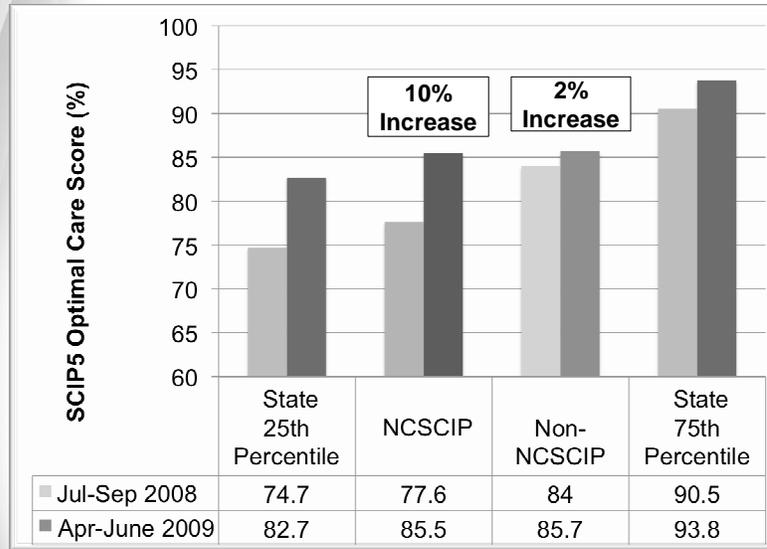
ⁱ Central line-associated blood stream infection (CLABSI) as defined by Centers for Disease Control (CDC). [(Number of CLABSI/number of central line-days)×1000].

ⁱⁱ Edwards et al and the National Healthcare Safety Network Facilities. National Healthcare Safety Network (NHSN) Report, data summary for 2006 through 2007, issued November 2008. *Am J Infect Control* 2008;36:609-626.



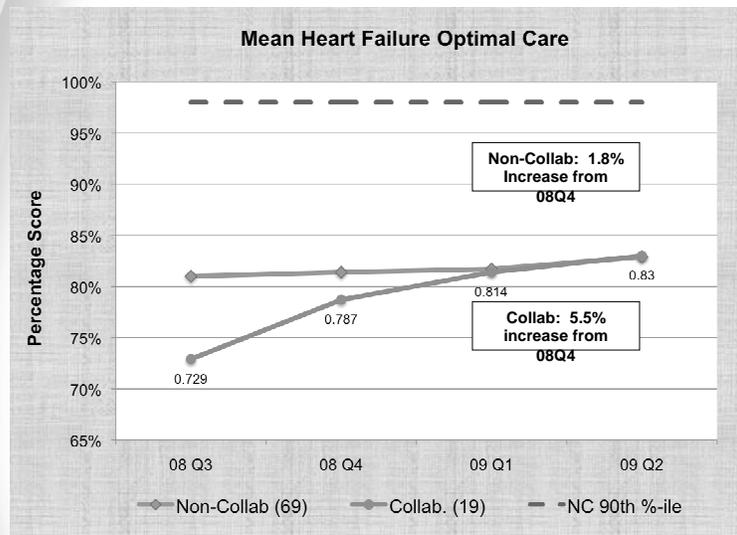


NC SCIP Improvement Year 2



NC Quality Center

Heart Failure Collaborative Trends



*NCCC Collaborative officially started in February 2009



NC Quality Center

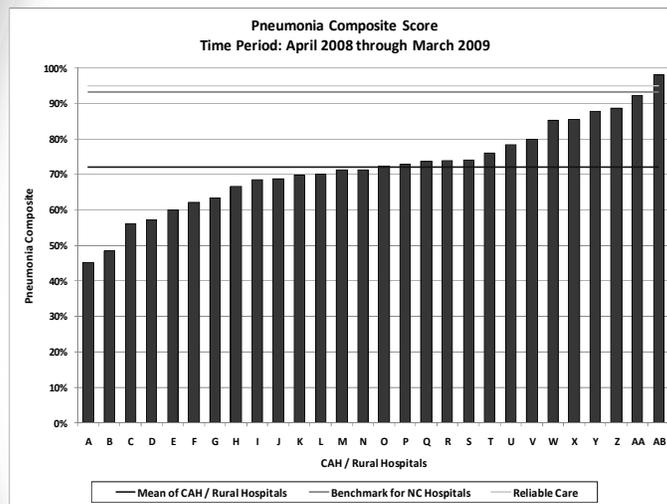
NC Patient Safety Culture

Dimension	32 NC Hospitals	US Benchmark	US 90 th Percentile
1. Teamwork within units	79.4%	79	87
2. Manager actions	76.4%	75	83
3. Org. learning - CQI	74.7%	71	80
4. Management support	72.4%	70	84
5. Feedback about error	64.8%	63	74
6. Overall perceptions	64.0%	64	77
7. Freq of events reported	63.6%	60	71
8. Communication openness	61.2%	62	70
9. Staffing	55.8%	55	69
10. Teamwork across units	53.7%	57	72
11. Nonpunitive response	41.4%	44	55
12. Handoffs & transitions	40.2%	44	61



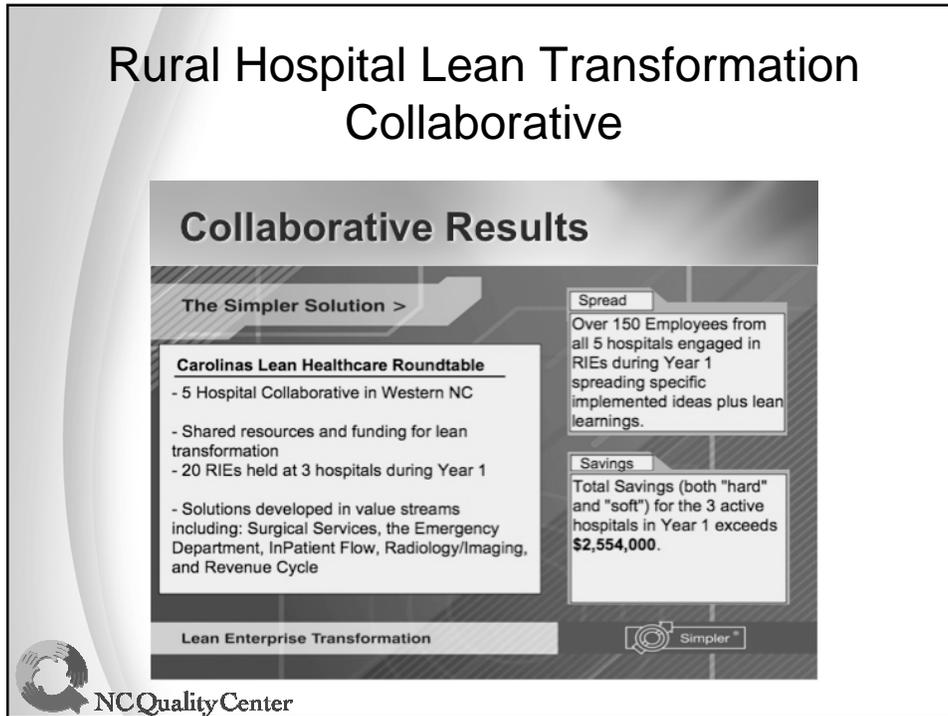
NC Quality Center

Rural Health Quality Improvement Collaborative



NC Quality Center

Rural Hospital Lean Transformation Collaborative



Driving Improvement in NC Hospitals

- Increase infection measures in NC SHIM
 - SSI rates
 - CAUTI rate
- NCQC PSO – 28 NQF serious reportable events
- Transitions in care initiative
 - H2H, BOOST, STARR
- Hospital scorecard

HEALTH ACCESS STUDY GROUP
Monday, March 15, 2010
9:00 am – 1:00 pm
North Carolina Institute of Medicine

- 9:00-9:15** **Welcome and Introductions**
- Senator Doug Berger, JD**
 North Carolina General Assembly
- Representative Hugh Holliman**
 North Carolina General Assembly
- Allen Dobson, MD**
 Vice President Clinical Practice Development
 Carolinas HealthCare System
- 9:15-9:45** **Reforming Health Insurance at the State Level**
- Louis Belo**
 Chief Deputy Commissioner
 NC Department of Insurance
- 9:45-10:15** **Medicaid and NC Health Choice Simplification and Outreach Efforts, Medicaid Budget Forecast**
- Craigan Gray, MD, MBA, JD**
 Director
 Division of Medical Assistance
 North Carolina Department of Health and Human Services
- 10:15-10:45** **Prevention for the Health of North Carolina: Prevention Action Plan**
- Pam Silberman, JD, DrPH**
 President & CEO
 North Carolina Institute of Medicine
- 10:45-11:00** **Break**
- 11:00 -11:45** **Presentation of the Mercer Report**
- Ed Fischer, MBA**
 Principal
 Mercer Health and Benefits
- 11:45-1:00** **Task Force Discussion**

**HEALTH ACCESS STUDY GROUP
North Carolina Institute of Medicine
March 15, 2010
Meeting Summary**

ATTENDEES

Task Force and Steering Committee Members: Louis Belo, Sen. Doug Berger, Deborah Brown, David Bruton, Barbara Morales Burke, Kellan Chapin, Abby Carter Emanuelson, Kimberly Endicot, Allen Dobson, Rep. Hugh Holliman, Rep. Verla Insko, Sen. Eleanor Kinnard, Tara Larson, David Moore, John Price, William Pully, Bob Seligson, Anne Rogers, Maggie Sauer, Steve Slott, Brian Toomey

Interested Persons: John Dervin, Ed Fisher, Julia Lerche, and others

NCIOM Staff and Interns: Kimberly Alexander-Bratcher, Crystal Bowe, Mark Holmes, Thalia Shirley-Fuller, Pam Silberman, Berkeley Yorkery

WELCOME AND INTRODUCTIONS

Senator Berger greeted the participants and began the meeting.

Reforming Health Insurance at the State Level

Louis Belo, Chief Deputy Commissioner, North Carolina Department of Insurance

The B Committee of the National Association of Insurance Commissioners (NAIC) Initiatives focuses on health insurance and managed care. They are slated to begin working on a number of issues affecting health insurance including creating model health insurance exchange laws; a uniform application for health insurance; standard explanations of benefits; and other standardized forms to make things easier for consumers. They will continue this work to help states as they work to implement federal health care reform.

In addition to discussing the work of the NAIC, Mr. Belo presented options for reforming health insurance at the state level. He mentioned that if federal reform was successful, then none of the things that he presented on would be necessary. He presented information on the following options for states:

- Expanding dependant coverage up to age 26.
- Creating health insurance exchanges.
- Creating mandate-lite plans to increase numbers of insured (irrelevant given federal reform).
- Administrative simplification.
- Providing reduced rates for individuals participating in health promotion and disease prevention programs.

One area which Mr. Belo was concerned about that federal reform may not fully address how to reduce the rising costs of health insurance. North Carolina should look at ways to keep health care costs from increasing as steadily as they have been.

Discussion: Discussion around reforming health insurance at the state level included:

- The possibility of regulating health insurance like we do auto insurance.

- The impact of extended dependent coverage to 26 on the state health insurance plan.
- Mandated benefits.
- Creation of a health insurance exchange.
- Selling health insurance coverage across state lines.

Medicaid and NC Health Choice Simplification and Outreach Efforts, Medicaid Budget Forecast

Tara Larson, MAEd, Chief Clinical Operations Officer

Steve Owen, Chief Business Operations Officer

Division of Medical Assistance, North Carolina Department of Health and Human Services

As we look to the future of North Carolina's Medicaid and NC Health Choice programs, we are looking at how to contain costs and sustain current growth. In the past, conversation focused on expanding benefits, but now North Carolina has a lucrative benefits package.

As of July 1, 2010 the administration of NC Health Choice will be moved from the State Health Plan/Blue Cross Blue Shield to the Medicaid program.

Medicaid and NC Health Choice both include a care continuum, including short term medical services, long term and residential services, and behavioral health services. DMA is establishing quality measures within each of these areas in the care continuum.

One way to improve our return on investment is to pay for better value. We are trying to do this by encouraging the use of evidence-based practices; using technology; and paying differently for services for different populations (i.e., if a service works well in some populations but not as well for others).

We are also working on making eligibility simpler which should help cut down administrative paperwork and time-consuming verification problems. DMA is working on exploring strategies to avoid duplicate verification of the same information across different programs. While this may lead to reduced administrative costs, it may lead to increased service costs as more people enroll and retain coverage (rather than dropping in and out of the eligibility). DMA has a number of initiatives going to make enrollment easier and to reach eligibles. For example, outreach workers help enroll eligibles in Medicaid and NC Health Choice and at the same time look to see if they are eligible for other kinds of special assistance programs. DMA also has a CHIPRA grant to work with schools to do special interventions to identify eligible children.

Community Care North Carolina (CCNC) and other managed care efforts are a way to increase access and improve quality. The role of CCNC staff (e.g. clinical directors) has grown over past couple years to include working on improving quality.

DMA is improving its oversight of the budget by regularly monitoring a number of financial measures on an actual time basis. Provider payment rates, eligibility, and utilization of services are what drive Medicaid costs. Because of the downturn in the economy, there are more people enrolling in Medicaid. However, the state is experiencing significant budget shortfalls due to the recession. Congress tried to help the states address this financial crisis by enhancing the proportion of Medicaid costs that the federal government pays (called the FMAP rate or federal medical assistance percentage). The enhanced FMAP rate is expected to expire on December 31, 2010. The North Carolina Medicaid program will be in significantly more trouble without an extension of the enhanced match rates.

Discussion: Discussion around Medicaid and NC Health Choice included:

- Utilization was budgeted to grow by about 0.5%, however, we have seen an approximate 4% growth rate in utilization, in part because of the new eligibles. There has been a 10% increase in eligibles due to the downturn in the economy.
- ARRA funding: North Carolina is listed as one of the top states for diverting Medicaid ARRA funds for other purposes. Would there be as large of a budget hole in Medicaid had money not been diverted? No. If those funds have stayed in Medicaid there would not have been the budget hole. However, the ARRA funds were used to support education, a top priority area.
- As DMA moves forward with simplification, more automation is needed. DMA is working on implementing the necessary changes.
- Do health care providers participate in Medicaid? There are 77,000 providers who take Medicaid in North Carolina (about 75% of primary care physicians). We have higher physician participation rates than in many states, because we have historically paid physicians more than in most other states. We have also seen an increase in dental participation rates when we increased reimbursement rates. Other factors affect provider participation aside from reimbursement, including administrative burdens and no-show rates.

Prevention Action Plan

Pam Silberman, JD, DrPH

President & CEO

North Carolina Institute of Medicine

The burden of chronic diseases and other preventable conditions in our state is high. North Carolina is 36th in overall health and 38th in premature death. Further, North Carolina ranks poorly on many other health indicators, including health outcomes, health behaviors, access to care, and socioeconomic measures. The most practical approach to address such conditions—from both a health and an economic perspective—is to prevent them from occurring in the first place. Relying on prevention as a basic strategy can save lives, reduce disability, improve quality of life, and, in some cases, decrease health care costs. The North Carolina Institute of Medicine (NCIOM), in collaboration with the North Carolina Division of Public Health, convened a Task Force to develop *Prevention for the Health of North Carolina: Prevention Action Plan* for the state. The Task Force was convened at the

request of North Carolina's leading health foundations. The *Prevention Action Plan* includes evidence-based strategies that, if followed, will improve population health in the state.

The Task Force identified 10 preventable risk factors that contribute to the leading causes of death and disability in the state and developed recommendations to improve health and well-being in relation to these areas:

- | | |
|---|---|
| 1. Tobacco use | 6. Exposure to chemicals and environmental pollutants |
| 2. Diet and physical inactivity, leading to overweight or obesity | 7. Intentional and unintentional injuries |
| 3. Risky sexual behaviors | 8. Bacterial and infectious agents |
| 4. Alcohol and drug use or abuse | 9. Racial and ethnic disparities |
| 5. Emotional and psychological factors | 10. Socioeconomic factors |

Dr. Silberman presented the priority recommendations of the North Carolina Institute of Medicine's Task Force on Prevention:

- Increase the North Carolina tobacco tax to the national average.
- Implement quality physical education and healthful living in school.
- Implement the *Eat Smart, Move More North Carolina Obesity Plan* and increase social marketing to promote healthy nutrition and physical activity.
- Schools should adopt an opt-out consent process so that children will be enrolled in the comprehensive sexuality education unless parents specifically opt-out.
- Develop and implement a comprehensive substance abuse prevention plan that includes: an increased tax on beer and wine and implementation of evidence-based prevention programs that both prevent substance use and abuse, and improve emotional well-being.
- Create an interagency leadership commission to promote healthy communities, minimize environmental risks, and promote green initiatives.
- North Carolina should create a high-level task force to reduce unintentional injuries and violence.
- The Division of Public Health should aggressively seek to increase the immunization rates for all vaccines recommended by the Centers for Disease Control and Prevention.
- Increase economic security by increasing the state's Earned Income Tax Credit, and enrollment in the Supplemental Nutrition Assistance Program (formerly known as Food Stamps).
- Increase the high school graduation rate.
- Expand health insurance coverage to more North Carolinians, so that they can access needed health services and enhance insurance coverage to cover all US Preventive Services Task Force's recommended preventive screening, counseling and treatment services.
- North Carolina needs to enhance existing data systems and coordinate across data systems to ensure we have the needed data.

Dr. Silberman also mentioned recommendations around reducing racial and ethnic disparities including:

- Public health should partner with trusted community leaders to improve the health-seeking behaviors of underserved communities.
- Strategies should be used to increase linguistic and cultural competency of health care professionals.

More information on the *Prevention for the Health of North Carolina: Prevention Action Plan* is available online at http://www.nciom.org/projects/prevention/prevention_report.shtml.

Mercer Report

Ed Fischer, MBA, Principal, Mercer Health and Benefits

The report *Expanding Access to Health Care in North Carolina: A Report of the NCIOM Health Access Study Group* was released in March 2009. Mercer was contracted by DMA to project costs for the following four recommendations:

1. A Medicaid buy-in program for disabled children up to 300% FPG.
2. A Medicaid eligibility expansion to 150% FPG for adults.
3. A Medicaid eligibility expansion to 185% FPG for non-pregnant women who have had poor birth outcomes.
4. A program providing insurance premium subsidies to small businesses for low-wage workers

Mr. Fisher reported back on the project costs for each of these recommendations.

Medicaid buy-in program for disabled children up to 300% FPG

Mercer estimated the costs of a Medicaid buy-in program as the sole insurance (~3,500 children for a total cost of \$47,283,200 with \$16,487,700 as the state's share) and the costs for wraparound services coverage (7,300 children for a total cost of \$34,448,100 with \$12,012,100 as the state's share).

Medicaid eligibility expansion to 150% FPG for adults.

NC Medicaid currently covers adults based on varying criteria, including disability, pregnancy, parental status and income. Childless adults and those with incomes above current guidelines are not currently eligible. Coverage would be expanded through two alternatives: Medicaid limited benefit package and a premium assistance for parents with access to employer sponsored insurance (ESI). (Under a premium assistance program, the Medicaid program would pay the premium to enable otherwise eligible people to enroll in ESI. To be eligible for coverage, a person would need access to ESI and be eligible for Medicaid coverage).

- Medicaid limited benefit package *parents* only (47,691 enrolled for a total cost of \$167,949,600 with \$58,564,100 as the state's share)
- Medicaid limited benefit package *non-parents* only (149,334 enrolled for a total cost of \$550,398,700 with \$191,924,000 as the state's share)

- Premium assistance for parents with family income up to 150% of the federal poverty guidelines with access to ESI (74,126 enrolled for a total cost of \$158,750,700 with \$55,356,300 as the state's share)

A Medicaid eligibility expansion to 185% FPG for non-pregnant women who have had poor birth outcomes.

The option includes Medicaid coverage for women up to 185% FPG that had delivered a low birth-weight baby or had a poor health outcome within the prior two years. The goal is to improve the health of the woman (to promote healthier subsequent births) and to delay timing of a repeat pregnancy. Evaluation included potential savings from improved preconception care after offsetting costs of the limited benefits. Assuming a 40% reduction in deliveries, the program would enroll 23,505 women for a total cost of \$13,712,100, however, this program would save \$14,652,000 thereby reducing overall program costs by \$939,900.

A program providing insurance premium subsidies to small businesses for low-wage workers

Mercer evaluated two options for doing this: subsidies for employers with 15 or fewer employees with low income workers or premium assistance for low income workers employed by firms with 24 or fewer employees. A number of different scenarios were presented with different costs associated with them.

Federal reform would expand health insurance coverage options and affordability for all of these groups.

Discussion: Discussion around these options included:

- Why would we want to provide subsidies to businesses that already offer coverage? By offering subsidies to all employers that are a similar size and average wages, you do not penalize those who have provided coverage in the past. Also, it is hard to verify if an employer offers coverage. However, if the state wanted to reduce costs, it could require a "bare" period (i.e., the employer could not have offered health insurance for 6-12 months prior to applying for the subsidy).
- The state should consider the coverage for pregnant women. The initial Mercer cost estimates suggest an overall cost savings to the state.
- There are significant savings to providers, particularly hospitals, to implementing some of these proposals.

Discussion of Potential Recommendations

1. The North Carolina Congressional delegation should support federal legislation to extend the enhanced Medicaid FMAP rate for six months.
2. The North Carolina Division of Medical Assistance (DMA) and the North Carolina Division of Public Health should work with other states that are working with the federal Centers for Medicare and Medicaid Services to explore the development of a Medicaid interconceptional care waiver. DMA should report on the progress of this work to the Health Care Legislative Oversight Commission.

3. The North Carolina General Assembly should enact legislation that would require insurers to allow parents to continue coverage for dependent children up to age 26 under the parents' health insurance policies. For purposes of this provision, "dependent" child means an unmarried child who is living in North Carolina, regardless of student status. However, we need to explore the potential costs to the State Health Plan.
4. We may want to make a recommendation to expand coverage to small businesses. Currently, the state has a small tax credit to help offset part of the costs of health insurance for small businesses. However, this tax credit will expire. We need to extend it or replace it with something else.

Reforming Health Insurance at the State Level

Louis Belo, Chief Deputy Commissioner

Focus

- National Association of Insurance Commissioners (NAIC) Initiatives
- State Reforms
- Federal Private Insurance Reform Initiatives

NAIC Initiatives

- Some of the charges for the Health Insurance and Managed Care (B) Committee for 2010 include:
 - Respond to inquiries from Congress, the White House and federal agencies, analyze policy implications and effect on states of propose legislation; communicate position through letters and testimony when requested.
 - Coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation.

3

NAIC Initiatives

- 2010 Charges (cont.)
 - Monitor, report and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - Review issues surrounding the uninsured/underinsured and strategies for achieving universal coverage, determine what contributions state insurance regulators, from their unique perspective, can make to the debate, and develop appropriate vehicles to convey any positions or principles the Committee develops to a multiplicity of audiences.

4

NAIC Initiatives

- 2010 Charges (cont.)
 - Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery; recommend appropriate revisions to regulatory jurisdiction, authority and structures.
 - Review issues surrounding evidence-based medicine and determine whether rigorous and consistent reporting should be required. If so, develop a model law on the topic or recommend another appropriate vehicle to achieve goals.

5

NAIC Initiatives

- 2010 Charges (cont.)
 - Review issues surrounding internal appeals and external review with respect to regulatory modernization and determine whether national standards are appropriate. If so, recommend an appropriate vehicle to achieve goals.
 - Examine issues and, as necessary, state laws and/or regulations regarding appropriate underwriting questions on applications for health insurance coverage particularly with respect to ensuring that underwriting practices and HIV testing procedures are nondiscriminatory; and, if appropriate, develop a model law or model bulletin to reflect state law and/or regulations on the subject.

6

State Reforms

Extend Eligibility to Young Adults

- One way to possibly decrease the number of uninsured is by extending eligibility under parents' insurance coverage for dependent children who are young adults.
 - Young adults ages 19 to 29 are one of the largest segments of the U.S. population without health insurance.
 - Loss of coverage often occurs at age 19 or upon graduation from high school or college. Age 19 is treated by both public and private insurance plans as a turning point in coverage eligibility. Some young adults able to have some protection under their parents' insurance policies while they are full-time students.

7

State Reforms

Extend Eligibility to Young Adults

- Upon graduation however, these young adults usually lose their family coverage and are faced with finding their own insurance. However, the current high unemployment makes finding employer-based health insurance that much more difficult for young adults.
- The federal health care reform provides in both the Senate and House Bills that children up to age 26 (age 27 in Senate) are eligible for dependent coverage under their parents' insurance plans. The provision would apply to both individual and group health insurance policies.
- According to data on the National Conference of State Legislatures Web site, 26 states have passed laws that extend dependent benefits beyond the age of 19 to young adults regardless of enrollment in school. Six other states limit extended eligibility to full-time students only. New ages for dependency range from 21 in Idaho to 31 in New Jersey. Also, Florida, New York and Pennsylvania use age 30.

8

NC's Laws and Experience with Young Adult Eligibility

- In North Carolina, insurance laws provide that dependent children are covered until age 19, unless mentally or physically disabled and dependent upon the parent.
- These eligibility laws are broad enough, however, to permit the voluntary extension of eligibility to young adults, whether full-time students or not.
- Many insurers provide extension of eligibility beyond age 19, but most require the child to be a full-time student. The extension and the limiting age used are generally at the option of the policyholder.

9

NC's Laws and Experience with Young Adult Eligibility

- BCBSNC voluntarily allows young adults to stay on their parents' policy.
 - May stay on the policy until the age of 26
 - May stay on the policy without regard to student status
 - Applies to both individual and group policies
 - According to BCBSNC's Web site the impact to policies that have dependents is about 1/4 of a percent (.25%) of the family's premium

<http://www.nchealthreform.com/2009/10/progress-on-the-fundamental-eight-extended-coverage-for-young-adults/>

10

NC's Laws and Experience with Young Adult Eligibility

- The State Health Plan covers a dependent child up to the child's 19th birthday. Coverage may be extended until the end of the month following his or her 26th birthday, if unmarried and a full-time student at an accredited school.

11

Dependent Coverage Laws Considerations

- Privately insured families have the option of keeping older children on their plans.
- Improves continuity of coverage and stabilizes coverage for adult children.
- Offers coverage to this population that may not find affordable comprehensive coverage in the individual market.
- Allows a state to expand coverage options without spending state dollars.

12

Dependent Coverage Laws Considerations

- While coverage may be guaranteed, the extension of coverage does not guarantee that the coverage is affordable.
- Could increase the cost of health care
 - Employers may pass on the costs by requiring a higher contribution for family coverage from employees.
 - Adverse selection, where only those with severe health needs choose the coverage, could lead to higher costs for insurer's to provide dependent coverage which could lead to increased premiums for all beneficiaries.

13

Dependent Coverage Laws Considerations

- State initiatives will generally only apply to plans covered under state regulation and therefore do not apply to self-insured employers.
- Most of the states who adopted such laws still have qualification requirements.
- The voluntary system can lead to issues with young adult children losing eligibility as parents' coverage is moved from one insurer to another.

14

Things to Consider When Extending Eligibility for Young Adults

- Key elements to consider when considering legislation:
 - Age limits
 - Student status
 - Family status
 - Place of residence
 - Other restrictions (financial dependency, uninsured and not eligible for other coverage, previously covered under the aged out plan)
 - Limitations on premiums

15

Other State Reforms

- Maine, Oklahoma, Oregon, Utah, Washington and West Virginia have adopted or have laid groundwork for adoption of insurance exchanges for the individual and small group markets. Exchanges are one way to possibly improve the functioning of the markets.
- Several states have adopted “mandate-lite” plans or moratoria on mandates in insurance plans at a bid to keep health insurance coverage more affordable.

16

Other State Reforms

- Several states have adopted administrative simplification directed at insurers to reduce administrative costs. Some of those initiatives include adoption of standard processes, standardized forms, uniform credentialing and uniform claims forms.
- Vermont has adopted provisions which encourage wellness by promoting healthy behavior including laws which specifically permit rewards for insureds who participate in programs of health promotion and disease prevention.

17

Federal Reform Proposals Related to Private Insurance

- While federal reforms are by no means a given, some private insurance reform initiatives included in President Obama's proposal, the Senate and/or House bills include:
 - Prohibitions on rescissions of coverage except in cases of fraud
 - Mandate stronger appeals processes
 - Medical loss ratio and premium rate reviews
 - Ban on lifetime and annual limits

18

Federal Reform Proposals Related to Private Insurance

- Federal Reform Initiatives (cont.)
 - Impose the same insurance market regulations relating to guarantee issue, premium rating and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market.
 - Creation of insurance exchanges where individuals and small business could shop, compare and purchase health insurance coverage.
 - Defines an essential benefit package that qualified health benefit plans would have to offer to individuals and small employers.

IOM: Health Access Study Group

Medicaid and NC Health Choice Simplification and Outreach Efforts, Medicaid Budget Forecast

Division of Medical Assistance

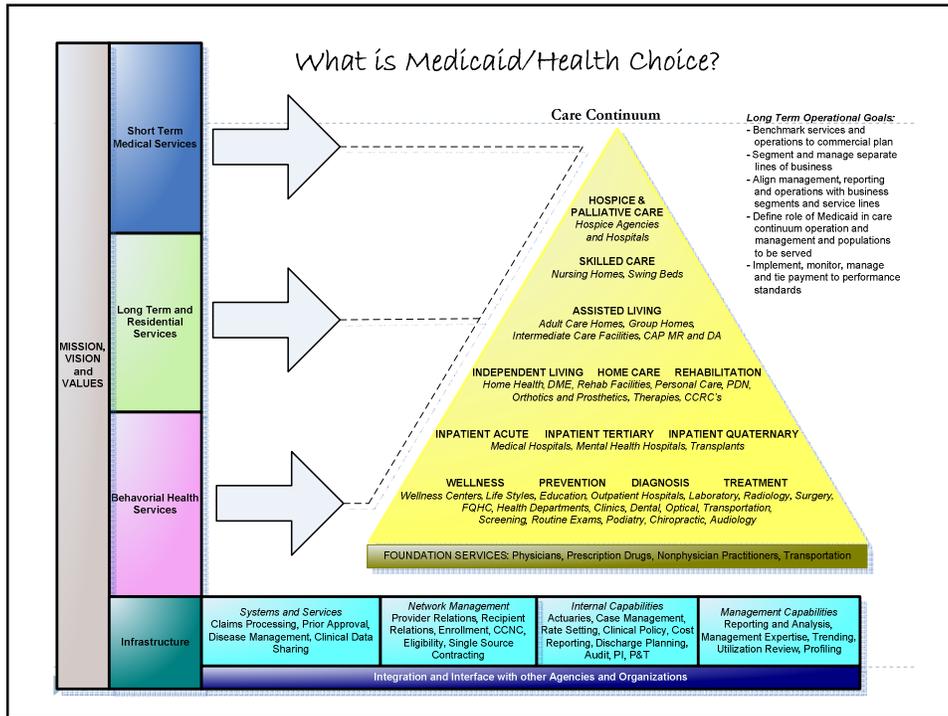
March 15, 2010

▶ 1

Topics for Discussion

- ▶ The current core of Medicaid
- ▶ Current plans for outreach and simplification of eligibility
- ▶ Financial
 - ▶ Impact of loss of the enhanced FMAP
- ▶ Any Current or planned changes to Medicaid to reduce cost, improve access and quality

▶ 2



Better Value

- ▶ Value in Health Care
- ▶ Bringing learning to practice
- ▶ Full application of information technology
- ▶ Determining the value proposition for a particular intervention
- ▶ The right care, To the right patient, At the right time, For the right price
- ▶ Evidence based practice, driven by outcomes
- ▶ Supporting decisions and operations
- ▶ Begins with understanding an its safety, effectiveness, and cost in different populations and circumstances, relative to alternatives and its potential as a source of high-value innovation.

As a result payment methodologies will evolve, clinical coverage may alter and change will be inevitable.

Project Excel and Setting Government Straight

Eligibility

Converging Purposes

- ▶ DHHS - Strategies to avoid duplicate verification of same criteria across different programs
- ▶ CHIPRA – encouraged states to use Express Lane Eligibility for Medicaid & NCHC children
- ▶ Builds upon the recommendations of **Expanding Access to Health Care in NC: A Report of the NCIOM Health Access Study Group, March 2009.**
 - ▶ ...expand its outreach efforts and simplify enrollment and recertification procedures to make is easier for enrollment of eligible low-income children in Medicaid and NCHC.
 - ▶ Different conversation than years past
 - ▶ Weighing cost to budget
 - ▶ administrative cost in counties

▶ 5

Workgroup Tasks

- ▶ DHHS Workgroup
 - ▶ Co-chaired by DMA/DSS
 - ▶ Division of Medical Assistance, Division of Social Service, Division of Child Development, Division of Aging and Adult Services, Department of Public Health - WIC
- ▶ Determine how to eliminate duplicate eligibility verifications/documentation for different programs
- ▶ If possible, identify a “benchmark” program
- ▶ Compare income/resource requirements for all programs
- ▶ Research federal/state regulations and options
- ▶ Review forms/applications
 - other states/programs
- ▶ Look at application & reenrollment process strategies from other states
- ▶ Identify and target current Medicaid/NCHC eligibility policy for simplification

▶ 6

Activities To Date

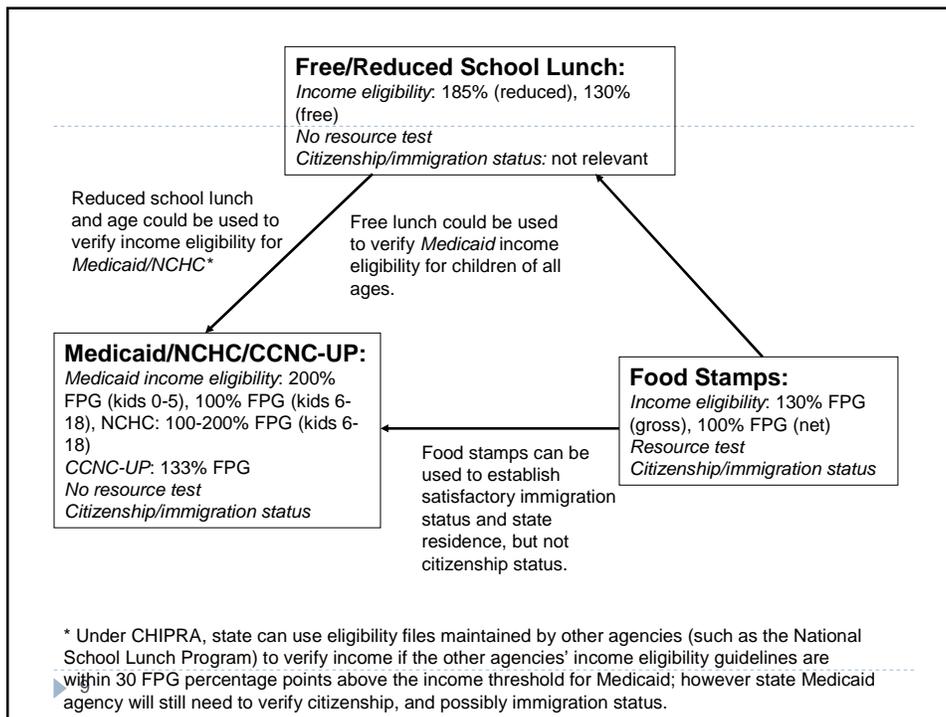
- ▶ Verification of Income by using other databases such as Social Security, Employment Security Commission for unemployment income
 - ▶ Discussions with other states – lag is data entry
- ▶ Review of increase of income limit for Medically Needy – possible but increase in budget ranging from \$31m to \$46.5m at a minimum
- ▶ Presumptive eligibility for children
- ▶ Citizenship documentation – match with SSA – COMPLETED
- ▶ Transitional Reporting Options to give 12 months initially - \$10m increase in costs
- ▶ Certification periods – 6 months to 12 months
- ▶ Age/Blind/Disabled Budgeting Simplification – Implemented for MQB effective 2/2010. All other categories pending due to budget increase

▶ 7

Activities to Date

- ▶ **Exploring**
 - ▶ Increase or reduction of resource limits for certain categories
 - ▶ Flexibility in base periods
- ▶ **Expansion of outsourced eligibility workers.**
 - ▶ Currently in hospitals and some FQHCs, health centers
- ▶ **CHIRPA grant**

▶ 8



DMA's Managed Care CA / CCNC

- ▶ Through the local DSS close to 1 million Medicaid patients have an assigned primary care provider.
- ▶ Primary care practice enroll with DMA to be the CA provider. PCP making a commitment to provide 24/7 coverage and to serve as the “gate keeper” for other medical services.
- ▶ Primary care practice's join together with local DSS, Health Department, LMEs and Hospitals to form CCNC Networks. It is through the Networks that the PCP makes the commitment to locally manage the care of their assigned population.

CCNC Networks

- ▶ Provide the following services by taking a population health approach: quality improvement, disease management, care management, utilization management and cost containment activities for Medicaid.
- ▶ CCNC Clinical Directors adopted a set of quality measures, based on
 - ▶ Disease impact on enrolled population
 - ▶ Opportunity for improvement
 - ▶ Evidence base
 - ▶ Alignment with national quality measures
 - ▶ Inclusion of a broader array high priority conditions among elderly and disabled enrollees: diabetes, heart failure, hypertension, cardiovascular disease
- ▶ The Network's clinical team work as part of the PCP team. At the recipient level for purposes of care management (access to medical staff, E.H.R....), at the practice level for purposes of system changes (QI, Audits, e-prescribing) and at the community level as DMA's managed care. All of which is in powered with data (clinical, administrative claims...)

▶ 11

The Budget

- ▶ Policy
- ▶ Reductions
- ▶ Led by value...Driven by outcomes that result in better care and quality
- ▶ Driven by legislative mandates and identified metrics/benchmarks that position Medicaid to be sustainable

*- Major reductions were mandated in:
Provider Rates, elimination of
Community Support, MH Child
Residential, Personal Care Services,
Case Management, freeze of CAP
slots, Dental coverage, Imaging Prior
Authorization, Drugs and targeted
initiatives by CCNC. Increases in
recoupments via reduction of fraud
and abuse and increase in collection
of third party liability and asset
recovery*

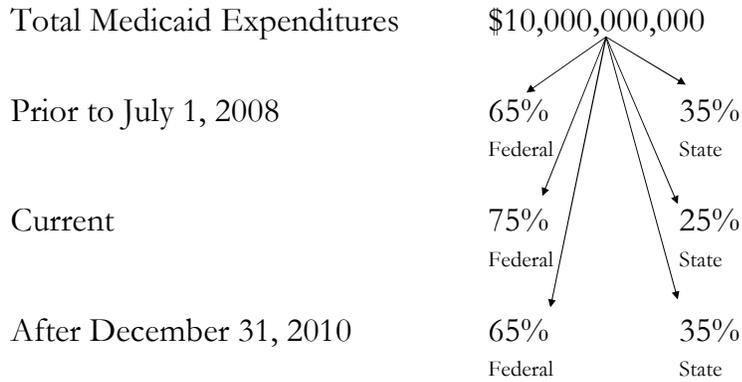
**Total Medical Service cuts
\$497,844,167 FY 09-10 and
\$701,503,496 FY10-11 in State
Dollars**

**Total 2010 reduction in economy
\$1,437,000,000**

***Budget reductions of this magnitude are unheard of.
Implementation timelines have created additional
challenges***

▶ 12

MEDICAID AND ARRA



▶ 13

MEDICAID AND ARRA

▶ 2011 Projected State Expenditures	July – December \$1,250,000,000
	January – June \$1,750,000,000
▶ 2011 Impact of ARRA Ending	\$500,000,000
▶ Annual Impact of ARRA	\$1,000,000,000

▶ 14

MEDICAID FINANCIAL DASHBOARD - JANUARY 2010

Forecast	\$	10,265,350,493	\$	126,220,221	\$	(4,224,742)	\$	392,672,369	\$	443,333,185	\$	582.41	\$	559.70
Average Claim Processing Time		99% processed within 21 days			% of Claims processed electronically				96%					

	Expenditures			Volume Variance		Mix Variance			Consumption			Other			Actual PMPM			Exp PMPM		
	Actual PMPM	Planned PMPM	% Var	2010 Budget	2009 PMPM	Actual Util/1,000	Planned Util/1,000	% Var	2009 Util/1,000	Actual Mthly Cost/Recip	Planned Mthly Cost/Recip	% Var	2009 Cost/Recip	Actual Mthly Cost/Recip	Planned Mthly Cost/Recip	% Var	2009 Cost/Recip			
Foundation	\$ 72.12	\$ 65.04	11%	\$ 62.20	\$ 72.59	857.6	787.6	9%	785.6	\$ 84.10	\$ 81.32	3%	\$ 84.17	\$ 84.10	\$ 81.32	3%	\$ 84.17			
Physicians	\$ 21.26	\$ 18.22	17%	\$ 17.40	\$ 20.63	82.5	72.9	13%	72.7	\$ 257.74	\$ 220.73	17%	\$ 258.78	\$ 257.74	\$ 220.73	17%	\$ 258.78			
Dental	\$ 49.58	\$ 46.91	6%	\$ 43.29	\$ 54.64	71.1	86.2	-17%	71.8	\$ 526.12	\$ 536.05	-2%	\$ 512.01	\$ 526.12	\$ 536.05	-2%	\$ 512.01			
Brand Drugs	\$ 12.15	\$ 12.87	-6%	\$ 13.85	\$ 10.43	152.7	148.5	3%	153.5	\$ 56.79	\$ 61.07	-7%	\$ 52.51	\$ 56.79	\$ 61.07	-7%	\$ 52.51			
Generic Drugs	\$ -	\$ -		\$ -	\$ -															
Practitioners - Other	\$ -	\$ -		\$ -	\$ -															
Short Term Medical	\$ 62.41	\$ 64.58	-3%	\$ 55.99	\$ 69.38	23.5	17.8	32%	17.8	\$ 2,655.28	\$ 3,231.99	-18%	\$ 3,497.58	\$ 2,655.28	\$ 3,231.99	-18%	\$ 3,497.58			
Inpatient	\$ 17.51	\$ 13.84	27%	\$ 12.58	\$ 16.37	58.0	50.6	15%	50.5	\$ 301.70	\$ 224.01	35%	\$ 298.35	\$ 301.70	\$ 224.01	35%	\$ 298.35			
Emergency	\$ 20.21	\$ 22.84	-12%	\$ 21.67	\$ 23.35	72.0	65.3	10%	66.0	\$ 280.65	\$ 355.60	-21%	\$ 273.40	\$ 280.65	\$ 355.60	-21%	\$ 273.40			
Outpatient	\$ 3.79	\$ 4.26	-11%	\$ 4.26	\$ 3.74	1.1	1.0	5%	1.0	\$ 3,544.13	\$ 3,949.95	-10%	\$ 3,615.90	\$ 3,544.13	\$ 3,949.95	-10%	\$ 3,615.90			
Hospice	\$ 16.51	\$ 16.18	2%	\$ 14.86	\$ 17.44	50.6	51.8	-2%	51.7	\$ 326.43	\$ 263.16	24%	\$ 317.00	\$ 326.43	\$ 263.16	24%	\$ 317.00			
Home Health/DME	\$ 8.08	\$ 9.02	-10%	\$ 6.75	\$ 7.41															
Imaging	\$ 9.12	\$ 5.80	57%	\$ 5.33	\$ 6.10															
All Other	\$ -	\$ -		\$ -	\$ -															
Behavioral Health	\$ 5.53	\$ 3.81	45%	\$ 3.65	\$ 4.35	0.5	0.4	24%	0.4	\$ 10,170.35	\$ 8,563.45	19%	\$ 9,060.23	\$ 10,170.35	\$ 8,563.45	19%	\$ 9,060.23			
Inpatient	\$ 29.15	\$ 29.31	-1%	\$ 28.13	\$ 29.94	6.7	6.9	-3%	6.7	\$ 4,351.48	\$ 3,854.88	13%	\$ 4,085.86	\$ 4,351.48	\$ 3,854.88	13%	\$ 4,085.86			
CAP/MR	\$ 7.86	\$ 8.89	-12%	\$ 8.13	\$ 8.38	14.5	14.4	0%	14.1	\$ 542.64	\$ 541.02	0%	\$ 544.43	\$ 542.64	\$ 541.02	0%	\$ 544.43			
Clinics	\$ 5.61	\$ 7.57	-26%	\$ 5.66	\$ 10.59	1.1	1.2	5%	1.4	\$ 4,919.59	\$ 5,085.28	-18%	\$ 6,792.14	\$ 4,919.59	\$ 5,085.28	-18%	\$ 6,792.14			
Group Homes	\$ 26.93	\$ 30.90	-13%	\$ 30.14	\$ 29.59	2.8	2.7	5%	2.7	\$ 9,476.95	\$ 10,619.94	-11%	\$ 11,219.71	\$ 9,476.95	\$ 10,619.94	-11%	\$ 11,219.71			
ICF/MR	\$ 54.05	\$ 44.34	22%	\$ 39.94	\$ 55.44	51.7	51.8	0%	51.9	\$ 835.77	\$ 759.66	10%	\$ 1,051.62	\$ 54.05	\$ 44.34	22%	\$ 39.94			
Practitioners - CS	\$ -	\$ -		\$ -	\$ -															
All Other	\$ -	\$ -		\$ -	\$ -															
Long Term/Residential	\$ 68.69	\$ 70.92	-3%	\$ 68.50	\$ 75.89	19.1	19.2	-1%	18.8	\$ 3,601.85	\$ 3,543.07	2%	\$ 3,646.19	\$ 68.69	\$ 70.92	-3%	\$ 68.50			
Nursing Homes	\$ 15.73	\$ 18.30	-14%	\$ 16.45	\$ 17.46	7.9	8.1	-3%	8.0	\$ 1,980.89	\$ 1,905.33	4%	\$ 2,002.57	\$ 15.73	\$ 18.30	-14%	\$ 16.45			
CAP/DA	\$ 30.32	\$ 24.90	22%	\$ 21.85	\$ 33.05	44.4	45.2	-2%	44.3	\$ 682.32	\$ 411.20	66%	\$ 687.39	\$ 30.32	\$ 24.90	22%	\$ 21.85			
RCS	\$ 2.72	\$ 3.17	-14%	\$ 2.47	\$ 11.89															
All Other	\$ -	\$ -		\$ -	\$ -															
Enrollment	Actual			Planned		Variance			2009			2008								
	1,423,495			1,413,313		10,182			1,368,852			1,228,990								

▶ 15

Status of Reductions

Budget Reduction Activities are posted on the DMA website

- ▶ **Effective September 1st**
 - ▶ Annual Cards
 - ▶ Mandated Electronic Filing of Claims
 - ▶ Mandated Electronic Funds Transfer
- ▶ **Rate reductions were implemented October 1st.**
- ▶ **Personal Care Services**
 - ▶ Current recipients are being reviewed under “existing” policy and criteria by external review process
 - ▶ Phase II includes independent assessment for all new admissions, physician attestation and application of clarified criteria – target date February 1st but pushed back due to litigation. Now on track for April 1st.
- ▶ **Community Support**
 - ▶ Reduction requires State Plan Amendment. On target for elimination of service effective June 30th.
 - ▶ Interim steps were implemented October 1st and next phase will be January 1st.
 - ▶ Case Management and Peer Support will be added as stand alone services. Tied to the creation of CABHA (Critical Access Behavioral Health Agency). July 1st is target date.

▶ 16

Status of Reductions

- ▶ **MH/SA Group Homes and Therapeutic Camps**
 - ▶ Established process and began transitioning children and adolescents. Has gone relatively smoothly
- ▶ **Freeze CAP Slots**
 - ▶ Delayed implementation
- ▶ **Increase Co-pays**
 - ▶ Not implemented yet due to CMS regulations
- ▶ **Prior Authorization on Imaging**
 - ▶ Phase I Implemented October 1st and Phase II (ultrasound) effective January 1st

▶ 17

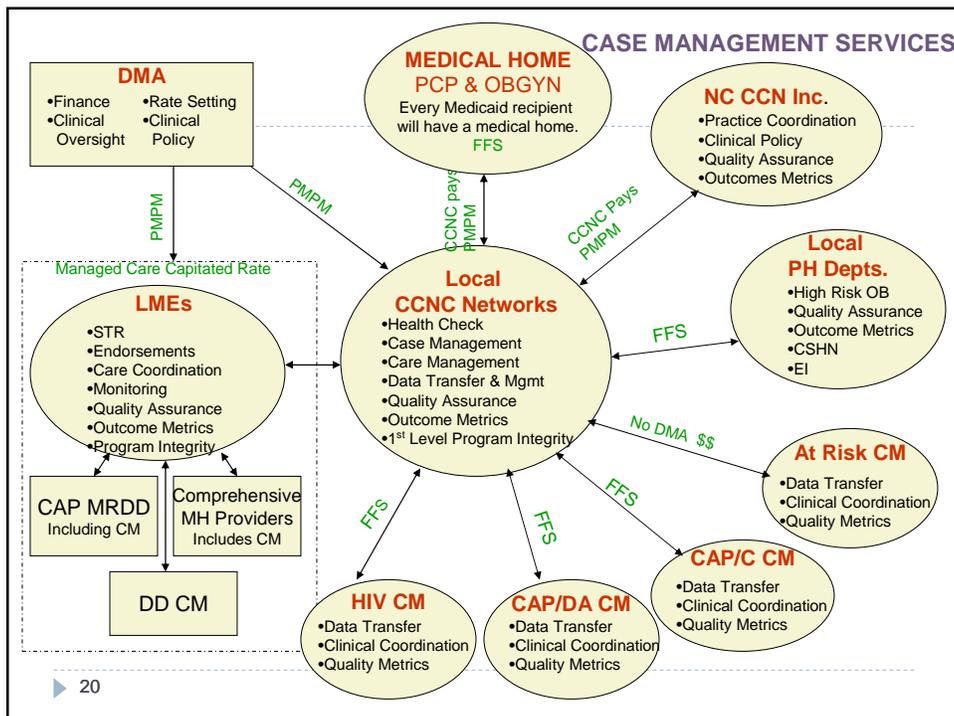
Status of Reductions

- ▶ **Drugs**
 - ▶ SPA required
 - ▶ Multi steps to achieve savings
 - ▶ More use of generics
 - ▶ Additional drugs or conditions for use of name brand placed on PA
 - ▶ Join multi-state pooled purchasing group to get supplemental rebates
 - ▶ Part of the CCNC targeted initiatives
 - ▶ Preferred drug list- effective March 15th
- ▶ **CCNC**
 - ▶ Expanded Initiatives include
 - ▶ Generic / MD easy / E-prescribing
 - ▶ Reduction of hospital readmits
 - ▶ Reconciliation of drugs/pharmacy
 - ▶ Reduction of Emergency Room use
 - ▶ Coordinated discharge planning
 - ▶ Coordination of care and treatment of MH/SA with LMEs and providers

▶ 18

Case Management

- ▶ Multi-division and stakeholder involvement
- ▶ Short and long term tasks identified
- ▶ State Plan Amendment required and a previous pending SPA involving CM is presenting some additional challenges
- ▶ HIV Case Management
 - ▶ Revised clinical coverage and provider qualifications
 - ▶ SPA approval pending
- ▶ Unit limitations went into effect March 1st. Other administrative changes such as changes in PA requirements are effective 4/1
- ▶ Funding methodology to change from FFS to case rate effective upon CMS approval



CCNC's Role

- ▶ Identify high risk factors with TCM agencies and ensure clinical coordination
- ▶ Develop patient risk profiles for entities such as LMEs who are charged with care management activities for an assigned population
- ▶ Expand key medical information to be provided for all Medicaid patients at point of care for CCNC providers to prevent service duplication and optimize coordination of care
- ▶ Expand role of privacy officers and deploy network staff facilitate appropriate data transfer and clinical coordination with private case management agencies on a patient by patient basis
- ▶ Care Management functions to Health Check enrollees
- ▶ Per Member/Per Month will be increased for CCNC to provide for infrastructure enhancements

▶ 21

The Challenges

- ▶ Increase in recipient enrollment
- ▶ Increase in utilization of services
 - ▶ Example - higher use of ERs
 - ▶ Use of higher costs services
 - ▶ More units requested or billed for existing services
 - ▶ Appear to be existing recipients and not new enrollees
- ▶ Increase in billing as a result of flu
- ▶ Working with CMS to gain SPA approvals has resulted in additional work due to CMS "opening up" other coverage areas
- ▶ Implementing the policy change
 - ▶ IT systems
 - ▶ Contract modifications
 - ▶ Coordinating among stakeholders, divisions, training of or notification to providers
 - ▶ Volume of work
- ▶ Carefully watching Access as reductions are implemented.
 - ▶ Clinical areas that access was already challenged such as dental and ob-gyn
 - ▶ Geographic locations.
- ▶ As a result of the above factors, Medicaid expenditures are ahead of projections and above budget

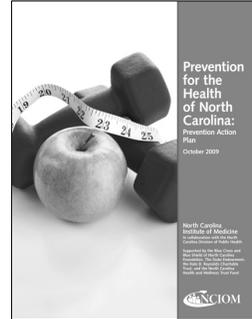
▶ 22

The Now and the Future

- ▶ DMA the publication and analysis of benchmarks and dashboard
 - ▶ 4 Areas: Clinical, Financial, Program Integrity and Provider/Recipient Services
- ▶ Changes in funding or service coverage require measureable outcomes and evaluation criteria prior to implementation
- ▶ CCNC: initiatives that impact DSS. Expanded care management role, increased enrollment, 646, Health Net
 - ▶ Expansion of “medical home” with the formation of a pregnancy home.
- ▶ Health Choice Operations and Management begins transitioning effective July 1, 2010
- ▶ Health Care Reform –
 - ▶ Level of federal poverty
 - ▶ Benefit option
- ▶ Managing competing priorities and agendas



Prevention for the Health of North Carolina: Prevention Action Plan



Pam Silberman, JD, DrPH
North Carolina Institute of Medicine
President & CEO
March 15, 2010



NCIOM Prevention Task Force

- Initiated at the request of the Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, the North Carolina Health and Wellness Trust Fund, and the Kate B. Reynolds Charitable Trust
- A collaboration with the NC Division of Public Health (DPH)





NCIOM Prevention Task Force

- Chaired by:
 - Leah Devlin, DDS, MPH, State Health Director
 - Jeffrey Engel, MD, State Health Director
 - William Roper, MD, MPH, CEO, University of North Carolina Health Care System, and Dean, UNC School of Medicine
 - Robert Seligson, MA, MBA, Executive Vice President, NC Medical Society
- Included 45 additional members



Why Focus on Prevention?

- North Carolina was ranked 36th in overall health status, and 38th in premature deaths in 2008 (with “1” being the state with the best health status).
- North Carolina ranks poorly on many risk factors contributing to population health, including:
 - Adults who are current smokers (37th).
 - Overweight and obese adults (41st).
 - Incidence of STDs (37th).
 - Air pollution (35th).
 - 4-year graduation rate (39th).





Why Focus on Prevention?

- The most practical approach to address these health problems is to prevent them from occurring in the first place.
- Investing more heavily in prevention can save lives, reduce disability, and improve quality of life.



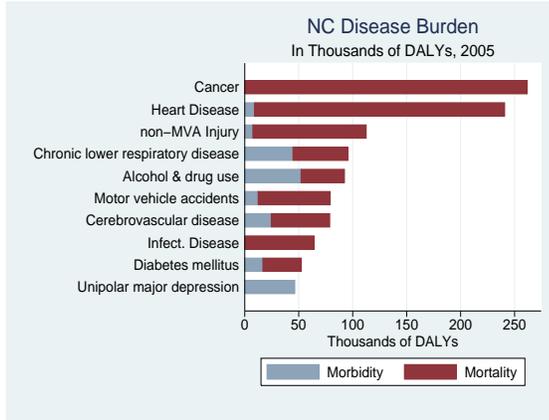
Developing the Prevention Action Plan

In developing the Prevention Action Plan, the Task Force identified:

- 1) The diseases and health conditions that had the greatest impact on death and disability.
- 2) The underlying preventable risk factors which contribute to the leading causes of death and disability.
- 3) Evidence-based strategies that can prevent or reduce the risk factors.
- 4) Multi-level interventions based on a socioecological model of health behavior.



#1) Identify the Leading Causes of Death and Disability



NCIOM staff identified the leading causes of premature death (Years of Life Lost) and years of life lost to a disability.

Together, these are considered DALYs: Disability Adjusted Life Years.



Preventable Risk Factors

Leading Preventable Risk Factors Leading to Major Causes of Death and Disability

Leading causes of death and disability	Tobacco use	Diet, physical inactivity, overweight/obesity	Risky sexual behavior	Alcohol and drug use	Emotional and psychological factors	Exposure to chemicals and environmental pollutants	Unintentional and intentional injuries	Bacteria and infectious agents	Racial and ethnic disparities	Socioeconomic factors
Cancer	✓	✓		✓	✓	✓			✓	✓
Heart disease	✓	✓		✓	✓				✓	✓
Non-motor vehicle injury	✓	✓		✓	✓		✓		✓	✓
Chronic lower respiratory disease	✓	✓				✓			✓	✓
Alcohol and drug use				✓	✓				✓	✓
Motor vehicle injuries (MVI)				✓			✓		✓	✓
Cerebrovascular disease	✓	✓		✓					✓	✓
Infectious diseases			✓	✓		✓	✓		✓	✓
Diabetes		✓		✓					✓	✓
Unipolar major depression				✓	✓				✓	✓





#2) Identify Underlying Preventable Risk Factors

- Tobacco use
- Diet, physical inactivity, overweight/obesity
- Risky sexual behavior
- Alcohol and drug use
- Emotional and psychological factors
- Exposure to chemical and environmental pollutants
- Unintentional and intentional injuries
- Bacterial and infectious agents
- Racial and ethnic disparities
- Socioeconomic factors



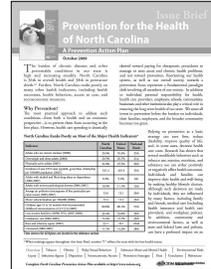
#3) Identify Evidence-Based Strategies

- Evidence-based strategies have been subject to rigorous evaluation and shown to produce positive outcomes.
- The Task Force examined the work of other national organizations that reviewed the evidence of program effectiveness and determined the strength of the evidence.
 - Examples: US Preventive Services Task Force, US Task Force on Community Preventive Services



#4) Develop Recommendations Using Socioecological Model

- The Task Force recognized that health outcomes are often influenced by personal behaviors and choices.
- However, people do not act in a vacuum. Their actions are influenced by:
 - Interpersonal relationships, clinical care, community and environment, and public policies.
 - Issue brief includes multi-faceted interventions for different preventable risk factors.



Reduce Tobacco Use

- Tobacco is the leading cause of preventable death in North Carolina.
 - Tobacco contributes to 30% of all cancer deaths and 90% of lung cancer deaths.
- *Priority recommendation:* Increase the North Carolina tobacco tax to the national average:
 - Will result in a 14% decline in youth smoking, with 73,700 fewer future youth smokers and 45,500 fewer adult smokers.
 - Will raise approximately \$300 million in revenues.





Promote Healthy Eating and Physical Activity

- North Carolina is the 10th most overweight/obese state in the nation.
 - Excess weight increases the risk of type 2 diabetes, high blood pressure, heart disease and stroke.
 - Good nutrition and engaging in regular physical activity are cornerstones of a healthy lifestyle.



Promote Healthy Eating and Physical Activity: *Priority Recommendation*

- *Priority Recommendation:* Implement quality physical education and healthful living in school:
 - 150 minutes/week of physical education in elementary schools, 225 minutes of Healthy Living in middle schools, and 2 units of Healthy Living in high school.
- *Priority Recommendation:* Implement the *Eat Smart, Move More North Carolina Obesity Plan* and increase social marketing to promote healthy nutrition and physical activity.





Reduce Risky Sexual Behaviors

- Risky sexual behavior can lead to sexually transmitted diseases (STDs), HIV/AIDS, and unintended pregnancies.
 - North Carolina had the 14th highest rate of STDs (chlamydia, gonorrhea, and syphilis) in 2007.
 - North Carolina had the 4th highest rate of HIV in 2006.*
 - 45% of all births in the state are unintended.



NCIOM * Only 22 states participated in surveillance of HIV incidence.



Reduce Risky Sexual Behavior: *Priority Recommendation*

- North Carolina General Assembly (NCGA) recently changed the laws to require schools to teach comprehensive sexuality education.
 - School districts must create a consent process for parents.
- *Priority Recommendation:* Schools should adopt an opt-out consent process so that children will be enrolled in the comprehensive sexuality education unless parents specifically opt-out.



NCIOM



Prevent Substance Abuse and Improve Mental Health

- Substance abuse and dependence and mental health disorders are both problems themselves, and contribute to other health problems.
 - Approximately 8% of North Carolinians (age 12 or older) report alcohol or drug dependence or abuse.
 - 17% of 18-25 year-olds and 10% of people older than age 26 report serious psychological distress.



Prevent Substance Abuse and Improve Mental Health: *Priority Recommendation*

- *Priority Recommendation:* Develop and implement a comprehensive substance abuse prevention plan that includes:
 - An increased tax on beer and wine. Note: The North Carolina General Assembly increased taxes on beer and wine this year.
 - Implementation of evidence-based prevention programs that both prevent substance use and abuse, and improve emotional well-being.





Decrease Environmental Risks

- The environment in which we live affects our health.
 - North Carolina has the 15th highest rate of air pollution (2005-2007).
 - Air and water pollution are both linked to certain chronic health problems and cancer.
- The built environment—including neighborhood design, land use patterns, and transportation—also affects health.



Decrease Environmental Risks

- The American Recovery and Restoration Act (ARRA) provided with states with new funding to reduce environmental risks, promote sustainability, and support “green” initiatives.
- *Recommendation:* Create an interagency leadership commission to promote healthy communities, minimize environmental risks, and promote green initiatives.





Reduce Unintentional and Intentional Injuries

- Injury and violence are significant problems leading to deaths and disabilities for thousands of North Carolinians each year.
 - Motor vehicle accidents and other unintentional injuries was the fourth leading cause of death in North Carolina.
- Historically, North Carolina has not given the same priority to injury prevention as to other public health activities.



Reduce Unintentional and Intentional Injuries: *Priority Recommendation*

- *Priority Recommendation:* North Carolina should create a high-level task force to reduce unintentional injuries and violence.
 - The Task Force should examine data, make evidence-based policy and program recommendations, monitor implementation, and examine outcomes to prevent and reduce injury and violence.



● ● ● | **Reduce Vaccine Preventable Diseases and Food-Borne Illnesses**

- Infectious diseases, including pneumonia and influenza, were the 10th leading cause of death in North Carolinians in 2007.
 - Vaccines are available to prevent many of these diseases.
- Food-borne illnesses are the most common infectious diseases.
 - Food safety is regulated by a variety of different federal and state agencies that do not all provide the same level of oversight or protection.



● ● ● | **Reduce Vaccine Preventable Diseases & Food-Borne Illnesses: *Priority Recommendation***

- *Priority Recommendation:* The Division of Public Health should aggressively seek to increase the immunization rates for all vaccines recommended by the Centers for Disease Control and Prevention.
 - DPH should particularly monitor the immunization rates for vaccinations that are not currently part of the state's Universal Childhood Vaccine Distribution Program.





Eliminate Racial and Ethnic Disparities

- Racial and ethnic minorities have poorer health status and experience worse health outcomes than non-minorities—even after adjusting for other socioeconomic factors.
 - This translates into lower life expectancies.
- Racial and ethnic minorities are also more likely to engage in, or be exposed to, some of the preventable risk factors that contribute to poor health.



Eliminate Racial and Ethnic Disparities

- Understanding disparities and their sources is important to target prevention activities.

Recommendations:

- Public health should partner with trusted community leaders to improve the health-seeking behaviors of underserved communities.
- Strategies should be used to increase linguistic and cultural competency of health care professionals.





Reduce Socioeconomic Health Disparities

- A person's income, wealth, educational achievement, and where they work and live can have profound health impacts.
 - People with higher incomes, more years of education, and who live in healthy and safe environments have longer life expectancies and better overall health outcomes.
 - Low-income adults and those with lower educational achievement are more likely to have certain chronic illnesses and engage in risk behaviors.



Reduce Socioeconomic Health Disparities: *Priority Recommendations*

- North Carolina had the 11th highest percentage of low-income people (below 200% FPG) in 2008.
 - *Priority Recommendation:* Increase economic security by increasing the state's Earned Income Tax Credit, and enrollment in the Supplemental Nutrition Assistance Program.
- North Carolina has the 12th worst 4-year high school graduation rate in the country.
 - *Priority Recommendation:* Increase the high school graduation rate.



● ● ● | **Prevention Strategies in Schools, Worksite, and Clinical Settings**

- School-aged children spend approximately one-third of their waking time per week in school.
- *Priority Recommendation:* Promote and enhance the Coordinated School Health Program (CSHP) in schools.
 - CSHP includes health education, physical education, health services, nutrition services, mental and behavioral health services, healthy school environment, and health promotion for staff.



● ● ● | **Prevention Strategies in Schools, Worksite, and Clinical Settings**

- Adults spend approximately one-half of their waking hours in the workplace during the work week.
- *Recommendation:* North Carolina should create a worksite wellness collaborative to encourage employers to offer comprehensive worksite wellness programs.



● ● ● | Prevention Strategies in Schools, Worksite, and Clinical Settings

- Health care professionals can influence health choices of children and adults.
- *Priority recommendation:* Expand health insurance coverage to more North Carolinians, so that they can access needed health services and enhance insurance coverage to cover all US Preventive Services Task Force's recommended preventive screening, counseling and treatment.



● ● ● | Data

- Reliable data are needed to help identify North Carolina's most pressing health problems, the health risks contributing to those problems, and to ensure that our efforts to improve population health are producing meaningful results.
- *Recommendation:* North Carolina needs to enhance existing data systems and coordinate across data systems to ensure we have the needed data.





Next Steps

- Governor's Task Force for Healthy Carolinians, Division of Public Health, and Healthy Carolinians working with the NCIOM to develop the Healthy North Carolina 2020 objectives and targets.
- Part of a larger campaign to make North Carolina the healthiest state in the nation.



Implementing Evidence-based Strategies Will Improve Population Health

- North Carolina has seen a steep decline in youth smoking by implementing multifaceted evidence-based interventions:
 - Examples: TRU social marketing campaign aimed at youth, 100% tobacco free schools and hospitals, NC Quitline, increased tobacco taxes.
 - The dramatic decline in youth smoking rates is due to a concerted effort of multiple partners at the state and local level, although more work is still needed.





Multifaceted Interventions: Healthy Eating/Physical Activity Example

Individual/ Family	Eat healthy and exercise more; provide nutritious meals and snack choices
Clinical	Offer obesity screening and counseling
Schools	Implement child nutrition standards, high quality physical education and evidence-based healthful living classes
Worksites	Institute worksite wellness program; promote healthy foods and physical activity; coverage for obesity screening/counseling
Insurers	Pay for obesity screening, counseling, treatment
Community	Fund and implement Eat Smart, Move More; promote menu labeling; build active living communities
Public Policies	Fund schools to provide nutritious meals and require physical education; fund Eat Smart, Move More community-wide obesity prevention plan



Implementing Evidence-based Strategies Will Improve Population Health

- *Prevention for the Health of North Carolina: Prevention Action Plan* includes evidence-based strategies, that, if followed, will lead to improved population health in North Carolina:
 - Less chronic disease and better health outcomes
 - Fewer school absences and better educational achievement
 - Increased worker productivity
 - Reduced health care cost escalation





Special Thanks to Our Collaborating Partners and Funders



The Duke Endowment



For More Information

- *Prevention for the Health of North Carolina: Prevention Action Plan*
 - http://www.nciom.org/projects/prevention/prevention_report.shtml
- Websites:
 - www.nciom.org
 - www.ncmedicaljournal.com
 - www.nchealthcarehelp.org



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Supplement to
*Expanding Access to
Health Care in North
Carolina:
A Report of the NCIOM
Health Access Study Group
March 2009*

March 15, 2010

Projected Cost of Recommendations March 2010 Final Report

Ed Fischer, MBA

Services provided by Mercer Health & Benefits LLC.

Overview

The report Expanding Access to Health Care in North Carolina: A Report of the NCIOM Health Access Study Group was released in March 2009. Mercer was contracted by DMA to project costs for the following four recommendations:

1. A Medicaid buy-in program for disabled children up to 300% FPG, Study Group Recommendation 4.3
2. A Medicaid eligibility expansion to 150% FPG for adults, Study Group Recommendation 5.3 (modified)
3. A Medicaid eligibility expansion to 185% FPG for non-pregnant women who have had poor birth outcomes, Study Group Recommendation 5.4
4. A program providing insurance premium subsidies to small businesses for low-wage workers, Study Group Recommendation 6.2

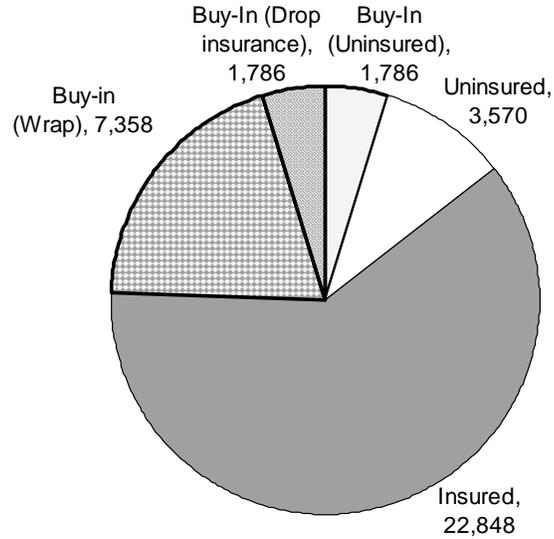
Medicaid Buy-In Program for Disabled Children Up to 300% FPG

Overview – Coverage for Disabled Children 200 – 300% FPG

The Study Group recommended that disabled children with household income up to 300% FPG be allowed to purchase Medicaid coverage based upon provisions of the federal Family Opportunity Act. The proposed expansion would allow disabled children between 201-300% FPG to purchase:

- Full Medicaid benefits
- Supplemental Medicaid benefits (i.e. wrap-around services) for families with access to employer-sponsored coverage (ESI)

North Carolina Disabled Children, 200 – 300% FPG



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Projected Costs – Coverage for Disabled Children 200 – 300% FPG

Projected Costs for Medicaid Buy-In as Sole Coverage for Disabled Children Up to 300% FPG

FPG	Projected Enrollment	Projected Total PMPM Cost	Monthly Premium	Net PMPM	Annual Expenditures Net of Premiums	State Share
200 – 250%	2,252	\$1,179	\$40	\$1,139	\$30,784,000	\$10,734,400
251 – 300%	1,320	\$1,132	\$90	\$1,042	\$16,499,200	\$5,753,300
Total	3,572	\$1,162	\$58	\$1,103	\$47,283,200	\$16,487,700

Projected Costs of Medicaid Wrap-Around Benefits

Take-up and premium is determined on a pro rata basis of the full Medicaid buy-in

FPG	Projected Enrollment	Annual Cost	PMPM	Monthly Premium	Net PMPM	Annual Expenditures	State Share
200 – 250%	2,559	\$5,000	\$417	\$14	\$403	\$12,362,600	\$4,310,800
251 – 300%	4,799	\$5,000	\$417	\$33	\$384	\$22,085,500	\$7,701,200
Total	7,358	\$5,000	\$417	\$27	\$390	\$34,448,100	\$12,012,100

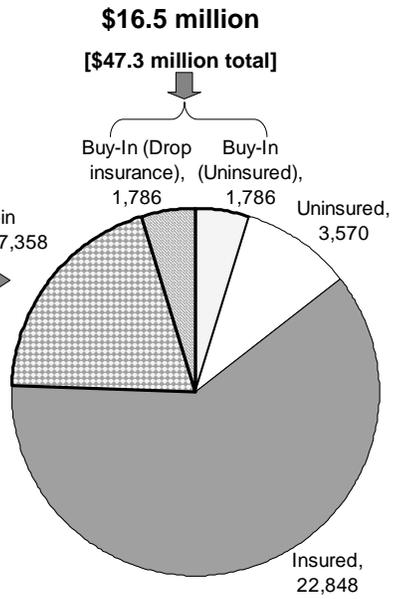
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Projected Costs – Coverage for Disabled Children 200 – 300% FPG

Coverage costs
\$28.5 million
[\$81.7 million total]

\$12 million →
[\$34.4 million total]



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Medicaid Eligibility Expansion to 150% FPG for Adults

Overview

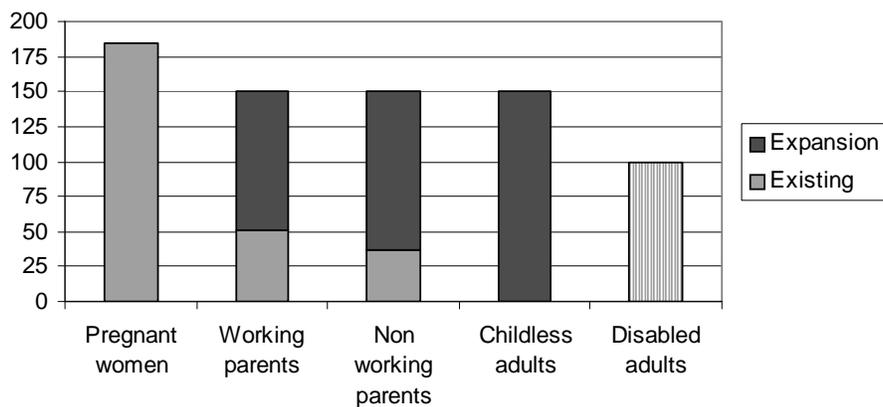
The Study Group recommended expanding coverage for adults to 150% FPG. NC Medicaid currently covers adults based on varying criteria, including disability, pregnancy, parental status and income. Childless adults, and those with incomes above current guidelines (particularly males), are not currently eligible. Coverage would be considered through two alternatives:

- Medicaid limited benefit package
- Premium assistance for parents with access to ESI

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Limited Benefit Expansion for Adults to 150% FPG

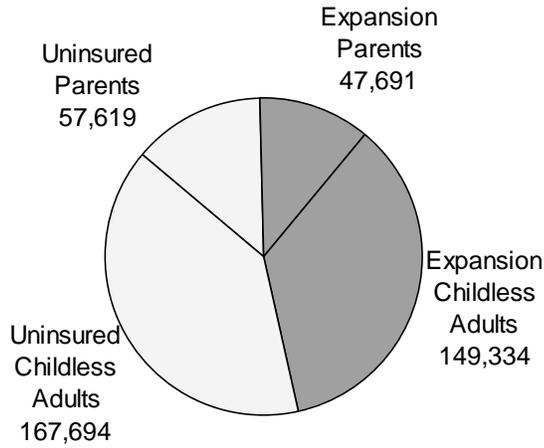


Note: Disabled adults may be eligible under these guidelines, but were not incorporated into the pricing study.

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**Limited Benefit Expansion for Adults to 150% FPG
Impact on Existing Adult Uninsured Population**



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Limited Benefit Expansion for Adults to 150% FPG

Medicaid Limited Benefit Expansion to 150% FPL – Parents Only

FPG	Uninsured Parents	Projected Enrollment	Projected PMPM Net of Premiums	Projected Annual Total Expenditures	Projected Annual State Expenditures
0 – 100%	55,674	27,838	\$311	\$103,792,600	\$36,192,500
101 – 133%	34,393	13,757	\$269	\$44,457,700	\$15,502,400
134 – 150%	15,243	6,096	\$269	\$19,699,300	\$6,869,200
Total	105,310	47,691	\$293	\$167,949,600	\$58,564,100

Medicaid Limited Benefit Expansion to 150% FPL – Non-Parents Only

FPG	Uninsured Non-Parents	Projected Enrollment	Projected PMPM Net of Premiums	Projected Annual Total Expenditures	Projected Annual State Expenditures
0 – 100%	225,221	112,612	\$315	\$425,822,000	\$148,484,100
101 – 133%	63,615	25,446	\$283	\$86,323,300	\$30,100,900
134 – 150%	28,193	11,276	\$283	\$38,253,400	\$13,339,000
Total	317,028	149,334	\$307	\$550,398,700	\$191,924,000

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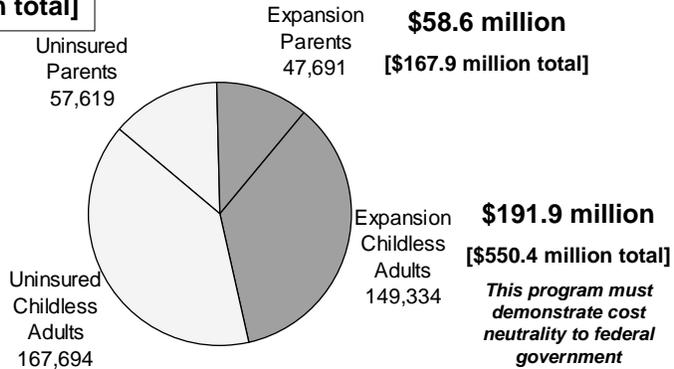
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**Limited Benefit Expansion for Adults to 150% FPG
Impact on Existing Adult Uninsured Population**

Coverage costs

\$250.5 million

[\$718.3 million total]

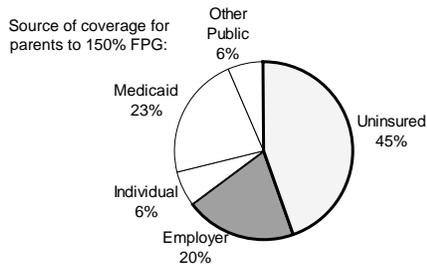


This program must demonstrate cost neutrality to federal government

**Premium Assistance for Parents to 150% FPG with access to ESI
(employer-sponsored insurance), regardless of whether currently insured**

Medicaid Used for ESI Premium Assistance

FPG	Parent Workers with Access to ESI	Projected Worker Enrollment	Worker Coverage PMPM Cost*	Worker+Spousal Coverage PMPM Cost*	Annual Expenditures	State Share
0 – 100% FPG	59,761	29,880	\$123	\$245	\$65,919,200	\$22,986,000
101 – 133% FPG	76,646	30,658	\$114	\$236	\$64,324,200	\$22,429,800
134 – 150% FPG	33,968	13,587	\$114	\$236	\$28,507,300	\$9,940,500
Total	170,375	74,126	\$117	\$240	\$158,750,700	\$55,356,300



This population is comprised of working parents with access to employer-sponsored insurance, both those parents that currently have coverage through their employer and those that are uninsured

Medicaid Eligibility Expansion to 185% FPG for Non- Pregnant Women Who Have Had Poor Birth Outcomes

Interconceptual Care

Includes a benefit package for women up to 185% FPG that had delivered a low birth-weight baby or had a poor health outcome within the prior two years. Evaluation of potential savings from improved pre-conception care after offsetting costs of the limited benefits

Medicaid Eligibility Expansion to 185% FPG for Non-Pregnant Women Who Have Had Poor Birth Outcomes

Subsequent Birth Costs and Initial Year of Life

January 1, 2005 – December 31, 2007

VLBW	MLBW	Critical	Other	No Conditions	Average
\$61,541	\$24,441	\$48,319	\$10,495	\$8,231	\$12,035

Projected Change in Delivery Patterns During 27 Months Following Initial Adverse Birth Outcome

Delivery Outcome	SOBRA					AFDC					Total
	VLBW	MLBW	Critical	Other	No Conditions	VLBW	MLBW	Critical	Other	No Conditions	
Projected Deliveries Without Interventions	10	9	18	686	216	78	84	84	2,854	932	4,971
Projected Deliveries After Interventions	4	6	9	277	268	34	52	40	1,156	1,136	2,983

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Medicaid Eligibility Expansion to 185% FPG for Non-Pregnant Women Who Have Had Poor Birth Outcomes

	Average Enrollment	Reduced Delivery Rate	Additional Program Costs	(Reduction in Program Costs)	Net Cost (Savings)
MPW	7,826	40%	\$13,429,900	(\$2,621,300)	\$10,808,600
		50%	\$13,429,900	(\$3,170,200)	\$10,259,700
AFDC	15,679	40%	\$282,200	(\$12,030,700)	(\$11,748,500)
		50%	\$282,200	(\$14,508,100)	(\$14,225,900)
Combined	23,505	40%	\$13,712,100	(\$14,652,000)	(\$939,900)
		50%	\$13,712,100	(\$17,678,300)	(\$3,966,200)

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Insurance Premium Subsidies to Increase Coverage for Low-wage Workers Employed by Small Businesses

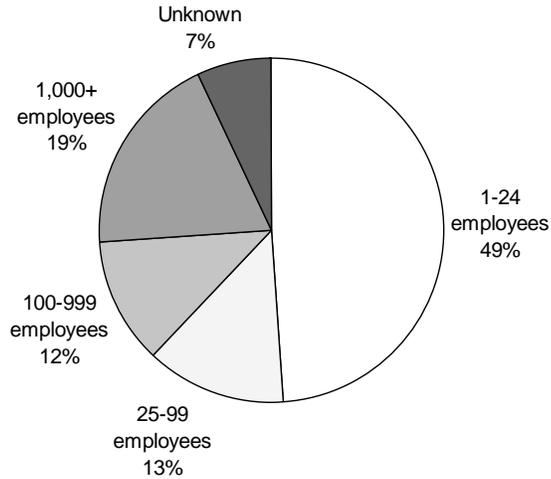
Overview

Two small employer coverage options evaluated:

1. Subsidies for employers with 15 or fewer employees with low income workers
 - 30% or more of the employees earn \$35,000/yr or less
 - 50% or more of the total premium costs must be paid by the employer
 - If employers do not currently offer health insurance, 50% or more of the total premium costs must be paid by the employer
 - If employers do currently provide health insurance, 90% or more of eligible employees, who do not have other creditable coverage, must enroll
2. Premium assistance for low income workers employed by firms with 24 or fewer employees
 - Adults up to 150% FPG
 - Based on development of a CCNC public-private health insurance product
 - Only projected enrollment for small employers that will begin offering coverage, i.e., not those already offering coverage

Insurance premium subsidies to increase coverage for low-wage workers employed by small businesses

Uninsured, full-time workers in North Carolina, by size of employer



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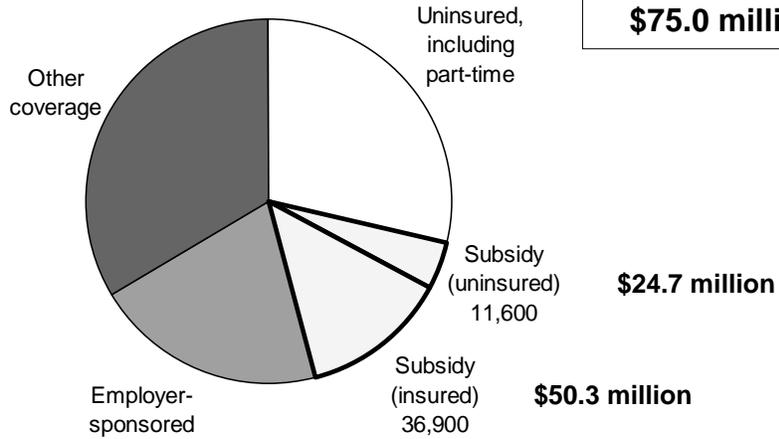
Subsidies for employers with 15 or fewer employees with low income workers

Coverage Description	Annual Income	Projected Enrollment	Annual Expenditures
Subsidies for Low-Wage Workers of Small Businesses: Currently Uninsured (90th percentile)	\$35,000	13,500	\$ 24,700,000
Subsidies for Low-Wage Workers of Small Businesses: Currently Insured (90th percentile)	\$35,000	29,900	\$ 50,300,000
Potential Offsets: None			

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Subsidies for employers with 15 or fewer employees with low income workers



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Projected Cost of Premium Subsidies for CCNC Public-Private Insurance Option

Medicaid Used for CCNC Product Premium Assistance

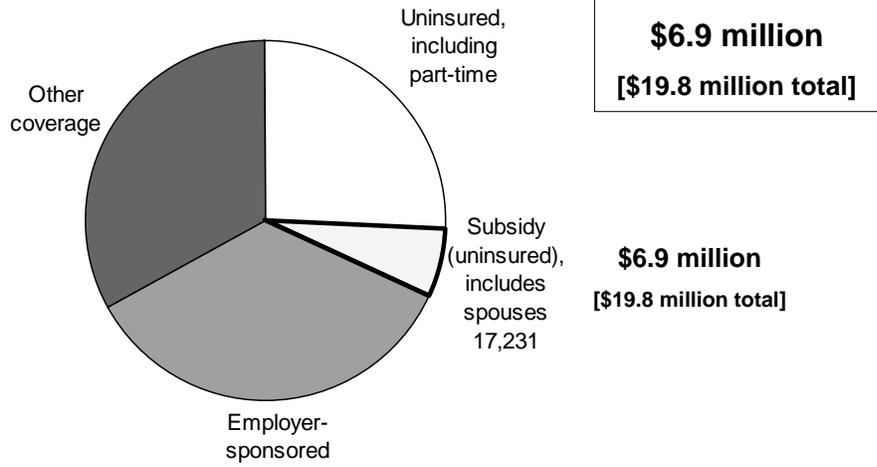
Assumes 20% reduction of commercial premiums

FPG	Low Income Workers in Groups of 24 or Less	Projected Enrollment	Individual Coverage PMPM Cost*	Individual+Spousal Coverage PMPM Cost*	Annual Expenditures	State Share
0 – 100% FPG	150,758	6,702	\$98	\$196	\$11,040,500	\$3,489,800
101 – 133% FPG	87,365	3,884	\$91	\$189	\$6,062,400	\$2,114,000
134 – 150% FPG	38,718	1,721	\$91	\$189	\$2,686,700	\$936,900
Total	276,841	12,308	\$95	\$193	\$19,789,600	\$6,900,700

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Projected Cost of Premium Subsidies for CCNC Public-Private Insurance Option



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