

Health Reform: New Models of Care Workgroup
Wednesday, November 17, 2010
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Craigan Gray (co-chair), Karen Adams-Gilcrist, Deborah Ainsworth, Don Bradley, Peter Chauncey, Chris Collins, Tracy Colvard, Linda Cronenwett, Analiese Dolph, Nena Lekwauwa, Beth Melcher, Mary Piepenbring, Valinda Rutledge, Brenda Sparks, Gina Upchurch, Jack Walker, Neil Williams, Susan Yaggy

Steering Committee Members: John Dervin

NCIOM Staff: Pam Silberman, Rachel Williams

Other Interested Persons: Kari Barsness, Renee Batts, Judy Brunger, Rebecca Carina, Derek Goldin, Markita Keaton, Tara Larson, Ann Lore, Marisa Morrison, Lendy Pridgen, Chris Skowronek, Chuck Stone, Elizabeth Walker, Rebecca Whitaker, Ashley Wofford

Welcome and Introductions

Craigan Gray, MD, MBA, JD
Director, Division of Medical Assistance
NC Department of Health and Human Services
Co-Chair

Dr. Gray welcomed everyone to the meeting.

Overview of Cost and Quality Comparisons

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

Dr. Silberman reviewed the 2009 Commonwealth Fund State Scorecard on Health System Performance for North Carolina. The State Scorecard ranks states and the District of Columbia based on 38 health indicators in five categories. The five categories are Access, Prevention and Treatment, Avoidable Hospital Use and Costs, Equity, and Healthy Lives. In 2009, North Carolina ranked 41st overall which is down from 30th overall in 2007. The Scorecard also gives the estimated impact of improving state performance based on the best performance achieved by

any state. North Carolina could potentially save millions of dollars and improve the health of hundreds of thousands of people by reaching the best performance rates of other states. The Scorecard can be found here: [North Carolina State Scorecard](#).

More information about the Commonwealth Fund's 2009 State Scorecards can be found here: [Aiming Higher: Results from a State Scorecard on Health System Performance, 2009](#).

Blue Cross Blue Shield of North Carolina: Cost Drivers

Don W. Bradley, MD, MHS-CL

Senior Vice President of Healthcare and Chief Medical Officer

Blue Cross Blue Shield of North Carolina

Dr. Bradley gave an overview of the main medical cost drivers for BCBSNC. Key drivers include increased prevalence of disease, redefinition of disease over time, increased costs to treat diseases, improvements in technology, and redundancy, inefficiency and ineffectiveness. He explained proposed business models for more efficient delivery of care, as described by Christensen,¹ including the solution shop, value-add process business, and facilitated network business. Dr. Bradley's presentation can be found here: [BCBSNC Cost Drivers](#).

Selected questions and comments:

- Q: North Carolina has fewer outpatient visits but higher costs per visit than the South Atlantic region average. Could these differences be due to services being lumped together or additional costs above the per-visit amount? A: It is conceivable that some of that is consolidating services per visit, but more services per visit is essentially more labs per procedure which means different pieces of the procedure are done at the same time.
- Many patients want care immediately which is why they don't wait to get an appointment with their doctor. Instead, they go to the emergency department or urgent care which is more expensive. The population also wants choice. When you have to build redundant systems with a lot of choice it is expensive.
- Q: In your opinion, has EMR improved care? A: In some circumstances yes. Most EMRs don't have registry functions. Many practices would say that implementing EMR is less efficient. However, in the future, having a legible record of what occurred at each doctor visit will be helpful.
- Q: Do you see a relationship between the amount you pay hospitals and the care they give? A: There is not a clear relationship between the amount hospitals are paid and the outcome. We are in the process of moving towards quality-based payments to change that.

¹ Christensen CM, Grossman J & Hwang J (2009). The innovator's prescription: A disruptive solution for health care. New York: McGraw-Hill.

- A vast majority of after-hours care occurs between 5:00pm and 8:00pm in the evening. Parents are more likely to go to the emergency room if they believe they cannot access urgent care. The perception of access is almost as important as actually having access.

Medicaid: Cost Drivers

(On behalf of Steve Owen, Chief Business Operations Officer, Division of Medical Assistance, NC Department of Health and Human Services)

Tara Larsen, MAEd
Chief Clinical Operations Officer
NC Division of Medical Assistance
NC Department of Health and Human Services

Ms. Larsen, on behalf of Steve Owen, gave an overview of the Medicaid budget. The projected overall budget for Medicaid in SFY2011 is \$9.74 billion. Medicaid expenses are broken down into five categories: Foundation Services, Short-term Medical, Long-term and Residential, Behavioral Health, and Financing. Foundation Services, which includes prescriptions and physician services, is the most expensive category at \$3 billion (31%) of the Medicaid budget. Ms. Larsen also noted differences that could account for expenditure variations when comparing Medicaid and private insurance: 1) Medicaid is a payer of last resort—it pays off what private insurance and/or Medicare does not; 2) definitions of case management and health providers are different for Medicaid—Medicaid covers providers who are qualified, not only licensed providers; 3) Medicaid covers Community Alternatives Programs (CAP) and long-term institutional care—few private insurers cover CAP services or long-term institutional services. The presentation can be found here: [Medicaid Expenditure Cost Drivers](#).

Selected questions and comments:

- Q: When a patient is admitted to a state hospital what category is the expense put into?
A: If a patient is under 21 or over 64, the expense is considered inpatient hospital and put into the Short-term Medical category. If the patient is between the ages of 22 and 63, then the expense is all state dollars unless it is a community hospital with a mental health unit.

Workgroup Discussion

The workgroup discussed looking at more detailed expenditure data for commercial payers, the State Health Plan, Medicaid, and Medicare. The workgroup would like to further examine population demographics, the top 20 diseases and services based on percentage of total costs, hospital readmissions/acquired infections/high dollar claims, ambulatory care sensitive admissions, episodes of treatment, and end of life cancer care for each payer.

The workgroup also discussed potential sustaining innovations that could potentially lower health expenditures. Sustaining innovations are incremental improvements to existing products/services.² Examples the workgroup suggested included:

- Bundled payments
- Patient-centered medical homes
- Muti-payer models
- Pay-per-performance models

The workgroup then discussed potential disruptive innovations that could lower health expenditures. Disruptive innovations are less expensive and less complex products/services.² Examples the workgroup suggested that have the potential to lower healthcare costs included:

- Patient education models of care
- Using providers at the full extent of their ability/education
- Payment based on outcomes/performance

Public Comment Period

No further public comments were given.

² Christensen CM, Bohmer R & Kenagy K (Sept.-Oct. 2000). Will disruptive innovations cure healthcare? *Harvard Business Review*. Available at <http://hbr.org/hbr-main/resources/pdfs/comm/philips/disruptive-innovations-cure-health.pdf>.