

NEW MODELS OF CARE WORKGROUP
Wednesday, September 22, 2010
North Carolina Institute of Medicine, Morrisville
1:00-4:00
Meeting Minutes

Members present: Allen Dobson (co-chair), Craigan Gray (co-chair), Deborah Ainsworth, Peter Chauncey, Chris Collins, Tracy Colvard, Linda Cronenwett, Nena Lekwauwa, Beth Lovette, Mary Piepenbring, Tom Savidge, Karen Smith, Brenda Sparks, Robert Spencer, Gina Upchurch, Tork Wade, Jack Walker, Jennifer Wehe, Neil Williams, Susan Yaggy, Annaliese Dolph

Steering committee members: Chris Collins, Allen Feezor, Tork Wade, Susan Yaggy

Staff: Berkeley Yorkery, Lauren Short

Other interested people: Kari Barsness, Judy Brunger, Melanie Bush, Connie Christopher, John Dervin, Bowen Heath, Eric Ireland, Ann Lore, Jan Lowery, J. Nelson-Weaver, Chris Skowronek, Elizabeth Walker, Judy Walton, Andrew Weniger, Rebecca Whitaker

WELCOME AND INTRODUCTIONS

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

Dr. Gray opened the meeting and welcomed the workgroup members.

WORKGROUP DISCUSSION: COMMON PRINCIPLES TO PROMOTE FOR NEW MODELS OF CARE FUNDING OPPORTUNITIES

Berkeley Yorkery, MPP, Project Director, North Carolina Institute of Medicine

Ms. Yorkery presented draft versions of guiding principles to be considered by the workgroup in creating a plan for the New Models of Care workplan. She asked the workgroup for their comments, asking specifically if the list accurately reflected the prior discussion, and if not, which principles should be modified. To view the draft principles, click [here](#).

Selected questions and comments:

- Q: Related to the point about reinvesting savings to improve quality, access and health care outcomes, how will we track savings and how they are reinvested?
A: The intent of this principle is to keep any health care savings from implementing new models in the health care system.
- Perhaps this principle should say, “any benefits derived from savings in system should be reinvested back into system.” After reform, the system needs to save consumers money and improve outcomes, so reinvested funds should go to decrease consumer rates, quality improvement initiatives, and provider incentives to keep them engaged. Also, savings may be put toward gaps in funding by the General Assembly (to avoid cost shifting and premium increases).

- In the past, there has been no consensus on what communities should do with the savings accrued in health care. Perhaps community needs should play a larger role in the distribution of reinvestment funds. Perhaps some funds should go into the public health system.
- At some point in the future, these principles will need to be prioritized.

WHAT DO WE EXPECT FROM CMS—CENTERS FOR MEDICARE AND MEDICAID INNOVATIONS
Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care, Assistant Director, Managed Care, Division of Medical Assistance, NC Department of Health and Human Services

Ms. Collins offered the workgroup a summary of her meeting with Tony Rodgers at the Centers for Medicare and Medicaid (CMS) Innovations about participation in the CMS innovation projects. She presented several take-away observations that the workgroup could benefit from. First, she explained the projects will not operate like federal grants, but will resemble contracts between the federal government with the state or region conducting the project. It will behoove any applicants to be well-versed in Medicare facts upon applying for project funding.

CMS Center for Innovation will look for innovation project applications to:

- Be community based.
- Be patient-focused.
- Demonstrate primary care access for 2014 (current uninsured).
- Offer not simply a medical home model, but a system of care.
- Collaborate with partners.

In reviewing projects, CMS will consider:

- Depth of the applicant’s primary care provider panel.
- Payment methodology (multi-payer approach).
- Clinical care and cost variations.
- How well does project meet the triple aim: How will it improve health? How will it improve patients’ experience? How will we be controlling cost?

Selected questions and comments:

- Q: It is clear the CMS Center for Innovation projects will focus on Medicare. How do we try and align current model and future models of delivery at the provider level?
- Comment: Medicare is always the leader driving change. It is easier to have Medicare drive change, as its run solely by the federal government and there is only one model. Conversely, Medicaid is 50 different programs so it would be hard to innovate because of the differences in the systems that already exist.
 - North Carolina’s Medicaid department would consider a partnership with public or private organizations to innovate.
- Q: How does North Carolina gain access Center for Innovation?
 A: CMS, via Cindy Mann, encouraged the state to bring forward ideas, as CMS would be willing to support a wide range of ideas financially.

- Comment: CMS wants innovation projects to build on what's already working on small scales around the country.

OVERVIEW OF ACCOUNTABLE CARE ORGANIZATIONS (ACO)

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

Dr. Dobson discussed core principles and key design features of ACOs. ACOs are currently a “hot topic” in health care reform. Features of Accountable Care Organizations include medical homes and bundled payments as a way to address current fragmentation in the system. Dr. Dobson explained that the core principles of developing the ACO system. First, aims must be clarified, second, data must be gathered on the community health needs and the system, third, organizations must be made accountable for their aims and management, and then finally, aims must be realigned once data and organizational structure can support the new system. Dr. Dobson asserted that local accountability to patients is the goal for ACOs. The providers and network of the ACO is accountable for the quality of care available to patients in their region. Currently, even in the most progressive systems operate on the local level, and they meet a very low threshold for controlling cost and quality. Dr. Dobson explained that ACOs are only theoretical at present, yet there are pieces in operation (i.e. Geisinger Health System in Pennsylvania and Community Care of North Carolina) but no full ACOs have been successfully implemented. Dr. Dobson discussed challenges facing the state in implementing ACOs and opened the floor for further comments and questions. To view Dr. Dobson's full presentation, click [here](#).

Challenges for ACOs:

- Will critical mass of providers join?
- Will payers agree to participate?
- Adequate financing for ACO start-up costs?
- Adequacy of performance measures, patient assignment algorithm, and budgeting methodology?
- Can ACOs change patient behavior and provider culture?
- Potential to increase provider concentration and power?

Selected questions and comments:

- Comment: The health care system nationwide has spent the past decade isolating every part of the system to its “maximum inefficiency”.
- Comment: ACOs are important because they offer primary care as cornerstone of health system.
- Comment: Medicare and Medicaid can participate in these types of arrangements, they should be multi-payer.
- Q: ACOs currently don’t require patients to participate, but how to do put leverage on patients?
A: The state will likely need a combination of incentives and penalties to encourage participation.
- Q: How many ACOs will be necessary for North Carolina?
A: This is currently unknown.
- Q: There is a fear as a part of an ACO, providers will have to be employed by a large organization. Is this true?
A: No. ACOs can be community-established networks voluntarily established to meet primary care needs of its patients, through several overarching goals, such as patient-centered practice and continuity of care.
- Comment: The current delivery model uses individual provider report cards, and accountability to the patient rested with them. Individual provider report cards could continue under ACO model, but the difference is that ACO network would be accountable to individual patient, and provider report cards would make individual physicians accountable to each other.
- Comment: ACOs need to be an inclusive of behavioral health needs (MH/DD/SA) in addition to physical symptoms. The structure should include access to chronic care services.
- Q: How are patients are assigned or enrolled in ACOs?
A: As a delivery system, they are not gatekeepers, do not require changes to benefit structures, do not require patient enrollment.
- Q: How does the system engage patients if no one has experienced ACOs? How does the system encourage patients to enroll in its network when the patient wants his/her choice of provider?
A: This is a problematic issue. Perhaps if the ACO measured patient preferences, then it could direct that patient to the providers that he/she would like the most.
- Q: How does the patient experience change with ACO? Does the patient know the ACO exists?
A: Key components of the ACO are the medical home, bundled payments around specialties, and physician collaboration and communication so that care is integrated. This will mean that a team of providers come to same location to see patient and meet all of their various needs. This also means all team members are accountable for patient care. The system will be “high tech and high touch” with low cost.
- Comment: There are many aspects of the current system in North Carolina that should be preserved or enhanced in the new integrated system.
- Comment: If the transition toward ACOs and system innovations are not pursued, the system will face price controls in health care. It is estimated that a three to four year window exists until the system will face difficulty.

- Q: Why does North Carolina face an advantaged in implementing ACOs?
A: North Carolina has historically had strong collaboration between delivery systems, and is not as deeply competitive between health systems as many other states. It has willing government partners and health providers involved in the reform discussion. Community Care of North Carolina (CCNC) serves as a progressive model of care, and has a 9 or 10 year head start over other states. From the Medicaid perspective, NC has all its data in one place.
- Q: Is CCNC appropriately configured across the state for the ACO model?
A: A few regional CCNC sites are constructed so they could be Medicaid/Medicare eligible ACOs now, but this is not true of all sites.
- Q: How will there be quality control on organizations indiscriminately claiming to be ACOs, since there are no real restrictions?
- A: ACOs are designated under a Medicare statute, so in order to officially be an ACO, the network will have to meet Medicare's requirements. ACOs will need to be clinically integrated, multi-payer, and not-for-profit. There will be no quality control on arbitrary declaration of ACOs.
- Q: Who will run the ACO and who manages the data? Will they require another level of administration?
A: This distinction will be made locally.
- Comment: Perhaps the designation for ACOs should be based on patient needs to create regional spheres. Incorporating patients' needs may require alteration of the delivery systems and incentives.
- Comment: A key difference between ACOs and managed care system is multi-payer system with the ACO.
- Q: What is the hand-off like from patient in a hospital in the Triangle, for instance, who goes back and needs primary care in another county?
A: This is one point we will have to establish.
- Q: How are community ACOs woven together (between ACOs)?
A: Perhaps community health outcomes can be used to weave system together.
- Comment: A well functioning system will not need a large number of case managers in the ACOs

GENERAL WORKGROUP DISCUSSION

Selected questions and comments:

- Q: What are the options for expanding CCNC to multi-payers?
A: The state is looking are working on what that looks like moving forward. How that plays out network by network might be different.
- Q: When will there be parity for Medicare?
A: Parity for Medicare will go into effect by 2014. Parity will be a basic package, it will not have enhanced benefits.
- Q: Medicare will be fed more and more unhealthy people every year. In the state health plan, people are sicker and sicker (by 1% each year) entering Medicare. How do we know that costs will be curbed through reform and innovation if population is getting more unhealthy due to part time jobs, unhealthy behaviors, and poor literacy)?

A: Hopefully prevention services and integrated systems of care will reduce chronic conditions in the population. Case management and medical home allied health workers should be involved in ACOs to help with continuity of care for chronic cases as well.

- Comment: If the state urgently wants to address high costs, it needs to address reform for behaviorally disordered, who incur significant health care costs. This includes transportation, housing, and rehabilitation, which are associated with significant cost.

PUBLIC COMMENT PERIOD- NEXT STEPS

- Workgroup should look at principles and identify priority components.
- Workgroup should consider which data and information it needs to inform the discussion? Including:
 - ER data –perhaps by acuity level, by payer source
 - Standardized community health assessment data (standard across counties)
- Workgroup should look in to finding a speaker to present at the next meeting about the current care referral network now in order to gauge perhaps how ACOs may be organized in the future.