

**NEW MODELS OF CARE WORKGROUP**  
**August 5, 2010**  
**North Carolina Institute of Medicine, Morrisville**  
**1:00-4:00pm**

**Meeting Summary**

*Workgroup/Steering Committee:* Karen Adams-Gilchrist, Deborah Ainsworth, Don Bradley, Chris Collins, Tracy Colvard, Allen Dobson, Allen Feezor, Nena Lekwauwa, Beth Lovette, Renee Rizzutti, Valinda Rutledge, Tom Savidge, Alan Smart, Brenda Sparks, Robert Spencer, Gina Upchurch, Tork Wade, Jack Walker, Michael Watson, Jennifer Wehe, Neil Williams, Susan Yaggy

*Interested Persons and Staff:* Kimberly Alexander-Bratcher, Melanie Bush, Connie Christopher, John Dervin, Lee Dixon, Thalia Fuller, Lin Hollowell, Tara Larson, Catherine Liao, Sandi Massey, Cindy Morgan, Lindy Prigden, Sharon Schiro, Lauren Short, Pam Silberman, Chris Skowronek, Patty Upham, Andrew Weniger, Berkeley Yorkery

**Welcome and Introductions**

*Allen Dobson, MD, Co-Chair*

*Vice President, Clinical Practice Development*

*Carolinas HealthCare System*

Dr. Dobson welcomed everyone to the first meeting of the New Models of Care Workgroup.

**Overview of Health Reform, Structure of the Workgroups, and the Charge of this Workgroup**

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

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups project. Click here to view the presentation: [Health Reform overview](#).

**Overview of Workgroup’s Specific Provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010**

*Catherine Liao, MSPH, Project Director, North Carolina Institute of Medicine*

Catherine gave a more detailed presentation of the health reform provisions related to new models of delivery of care and financing. Click here to view the presentation: [Workgroup overview](#).

Discussion/Questions:

- Where is the patient in the discussion of the different health reform provisions? At the very least we need to think of ourselves as health consumers in addition to health providers.
- The delivery system portion of this legislation is wide open, which leaves a lot of room for opportunity and building a new system.
- Are these multi-year grants? How do we guarantee that if we try something new it will continue to be funded? It is important to have long-term support for new efforts in order to encourage providers to make changes.

**New Models of Care: Existing Implementation Efforts at the NC Division of Medical Assistance**

*Tara R. Larson, Chief Clinical Operations Officer, Division of Medical Assistance  
North Carolina Department of Health and Human Services*

Note: The presentation covered both Medicaid and NC Health Choice (NCHC), as the Division of Medical Assistance (DMA) also administers the NCHC program.

We, at DMA, are trying to balance innovation, workforce, and other issues, as it moves forward to implement the ACA. On the Medicaid side, we are taking a long-term view of different ACA options, rather than be constrained by the current budget problems. Then, if the budget situation changes, we will be ready and have a vision for what we should do. We are planning both within the current budget reality and planning for what we would do if there were not budget constraints.

The centerpiece of the NC Medicaid program is Community Care of North Carolina (CCNC). In implementing the ACA, we plan to build off the CCNC medical home, person-centered care, and other programs and linkages that we already have in place. For example, we operate the [Program of All-Inclusive Care for the Elderly](#) (PACE) in two communities, which aims to provide home and community-based services to elderly and frail elderly patients using a capitated model. We are also focusing on pay-for-performance and improving outcomes. DMA is also looking more into person-centered planning, and we recognize the need to strengthen its information systems. We are also exploring new initiatives to achieve budget savings while also improving care for patients. The Division is focusing on integrated case management and care activities and moving away from “siloes” care.

Some laws will need to be changed, at either the federal (regulation) level or by state statutes in order for DMA to implement some of the provisions of the ACA.

Discussion:

- Health insurance benefits do three things: define coverage, define access, and provide leverage. Although we’re talking about models of care, the *benefit* really drives which models of care are sustainable.
- Until patients being taking responsibility for their own health, then we cannot begin to change health care costs.

- It is important that we consider programs other than just Medicaid when thinking about how to change the cost curve. We need to consider incentives and applications from other payers.
- The education and outreach piece is also critical to this effort in designing new models of care and/or building on existing models.
- We should think about what the navigator's role is in a new model of care delivery. As we create these systems, we need to remember that the average person needs to be able to navigate it

### **New Models of Care: Existing Implementation Efforts in Community Care of North Carolina, Inc. and an Update on 646 Waivers**

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

[Community Care of North Carolina \(CCNC\)](#) created not-for-profit community networks that were originally focused on helping providers implement system innovation statewide. CCNC is the core delivery system for Medicaid. We are now working on building additional capabilities to make CCNC more accountable, and to begin to take responsibility for budgets and finance (in addition to clinical outcomes).

Other updates from CCNC include:

1. The aged, blind, disabled population is a different population than we have worked with in the past. There is a new enhanced plan to help this population. It is critical that we have the resources to manage the care and case management of these high needs patients.
2. We are working to improve our pharmacy services. We have folks in all networks to increase generic prescribing and to manage the needs of patients on multiple medications.
3. We are embedding psychiatrists in each network. Much of this work involves coordinating care between providers and the local management entity (LME).
4. We are reexamining services around pregnancy and working to create maternity homes.

Regarding the 646 Waiver, we began this process in 2005. Under traditional care for dual eligibles (Medicare and Medicaid), if Medicaid does a good job managing the care of dual eligibles, the savings accrue to the Medicare program (through reduced hospitalizations). Under the 646 waiver, the state worked with the Centers for Medicare and Medicaid Services (CMS) and set up a system so that if CCNC does a good job saving money for CMS, the state will share in the savings. Currently the state is in a demonstration project of a shared-savings model for dually-eligible patients in 28 counties. It started in January 2010.

One of the other new initiatives in North Carolina is the new Beacon grant awarded to Southern Piedmont CCNC Network. According to the US Department of Health and Human Services, the Beacon Community Cooperative Agreement Program provides

funding to communities to build and strengthen their health information technology (HIT) infrastructure and exchange capabilities.

We also are working to develop a multi-payer advanced medical home model in rural areas of the state. The Division of Medical Assistance, Blue Cross and Blue Shield of NC, the State Health Plan for Teachers and State Employees, and Medicare would be involved.

Question:

- Are OB-GYNs a part of CCNC? Yes, but we are working to develop pregnancy homes with wrap-around high risk services. Because a medical home must meet a number of care requirements, such as administering immunizations and treating asthma, only a few OB-GYN providers are able to become a medical home. But we hope to create a new model of care via a pregnancy home.

### **New Models of Care: Existing Implementation Efforts in Behavioral Health**

*Chris Collins, Deputy Director, Office of Rural Health and Community Care  
Assistant Director, Division of Medical Assistance – Managed Care  
NC Department of Health and Human Services*

We have been conducting a two-year demonstration project examining integrated care (i.e., integrating primary care with behavioral health services). Primary care practitioners have become the main providers for many behavioral health disease states; however, they have not been trained in depth to treat these conditions. We found that primary care providers needed mental health providers embedded in their practices to meet the mental health needs of their patient population. Sixty primary care programs took part in the demonstration project in which a behavioral health provider was embedded in the primary care practice. These behavioral health professionals are not a replacement for in-depth behavioral health services for people with more significant problems, but these embedded practitioners can provide enough care to meet the needs of the majority of primary care patients.

It took a lot of time and effort to fully implement this initiative. DMA had to change billing codes and coverage policies. For example, we now allow primary care providers to do behavioral health screenings and have new codes for tobacco, substance abuse, and behavioral health so that any doctor can bill for providing these services. We needed to expand the billing codes to allow behavioral health specialists to bill for meetings with patients around behavior change.

We've also provided additional psychiatric support to CCNC practices. We found that by embedding one psychiatrist in a CCNC primary care network, we were able to provide support for a large group of doctors and patients. It took some time for both primary care providers and behavioral health providers to adjust to this model.

Sustainability was also challenging because these billing changes were only applicable under the Medicaid program, and practices are not entirely financed through Medicaid reimbursement. Practices had to be very savvy about who they brought on their team to ensure they could sustain funding.

Under the state's prior mental health reform, it was difficult to keep nurses on staff in behavioral health settings. However, under a reverse co-location model, we began to embed nurses with behavioral health providers in order to treat physical health problems in patients with severe mental illness. Currently, we are looking at sustainability of this model based on providers receiving higher payments for managing and treating both the mental health and physical health problems of this population.

Our goal was to implement the right service at the right time at the right cost. We are now looking to share lessons learned and other information about this demonstration project with LMEs, hospitals, and others interested in this type of model.

From a policy perspective, we need to consider other models of payment. For instance, involving nutritionists in diabetes care is important from a quality of care perspective. But how do we ensure they are part of a team? The challenge now is using fee-for-service as the only way of incenting their participation on a team delivering coordinated care. We are looking at ways to achieve this efficiency through a different payment model.

Discussion:

- Blue Cross and Blue Shield of North Carolina (BCBSNC) has set up a system for nutritionists to be reimbursed while also credentialing its providers and being very clear about what it expects. As BCBSNC expands services for which providers may be reimbursed, it is critical to look at what the outcomes are and if it is achieving them.

### **Workgroup Discussion: Other New Models of Care Being Tested in North Carolina**

There is a lot in the ACA about changing how we pay for care. Fee-for-service (FFS) clearly provides the incentive to provide more care, while bundled care payments (i.e., capitated payments) may have an incentive to limit care.

In order to make the delivery and financing of care more efficient, it is important to have measures in place to promote quality, efficiency, and greater access. But what measures do we need to build into any system to ensure that we are getting it right? We need to examine these new models that combine sets of services that are some combination of FFS and capitated services. Our ability to collect data is so much better; we need to be better about our transparency in reporting these measures.

We need to put patients in the center of the new system. We need to change things so that the provision of care is not a payment center but is a cost center. We also need to be asking who the financial stakeholders are: Medicaid, Medicare, insurers, others?

If all players in the health care system are going to work to create a solution to bend the cost curve, everyone should share in the savings, not just the hospitals.

We need to keep in mind simplicity. Whatever we create to deliver and finance care in a more efficient way needs to be simple and elegant.

Two readings may be useful to the group as we continue our discussion about new models of care:

Clayton Christiansen: *The Innovators' Prescription*

Dan Ariel: *Predictably Irrational*

How do we incentivize quality without creating disincentives to care for our most needy patients?

Tort reform may be important to this effort.

In closing, there are several issues that we should not forget, including alternative portals to care; telemedicine; health coaches; group visits; support groups; affinity groups; and domestic tourism and disaggregation of care. It is critical that we consider the consumerism side of this issue; if the system does not meet the needs of the patient, then the system will not work.

There were no public comments.