

Health Reform: New Models of Care Workgroup Meeting
Tuesday, December 14, 2010
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Craigan Gray (co-chair), Deborah Ainsworth, Don Bradley, Peter Chauncey, Chris Collins, Tracy Colvard, Linda Cronenwett, Beth Melcher, Renee Rizzutti, Valinda Rutledge, Brenda Sparks, Gina Upchurch, Torlen Wade, Jack Walker, Neil Williams, Susan Yaggy

Steering Committee Members: John Dervin, Allen Feezor

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Kari Barsness, Lee Dixon, Tara Larson, Jennifer Nelson-Weaver, Steve Owen, Sarah Pfau, Lendy Pridgen, Chris Skowronek, Jeff Spade

Welcome and Introductions

Craigan Gray, MD, MBA, JD

Director

Division of Medical Assistance

North Carolina Department of Health and Human Services

Co-chair

Dr. Gray welcomed the group to the meeting.

Medicaid: Cost Drivers

Steve Owen

Chief Business Operations Officer

Division of Medical Assistance

North Carolina Department of Health and Human Services

Mr. Owen gave an overview of trends in Medicaid expenditures and utilization. Factors that affect costs include rate reductions, policy changes, payment policies, enrollee changes, the economy, and increasing consumption. Mr. Owen also broke down trends in expenditures and utilization by service. Medicaid is currently seeing an increase in outpatient service utilization but a decrease in outpatient expenditures due to decrease in payments. There has been an

increased in the number of hospital days/1,000, but an overall decrease in hospital costs due to rate reductions and patient mix. His presentation can be found here: [Medicaid Cost Drivers](#).

Selected questions and comments:

- Q: The first six months are the most intensive for a new enrollee in Medicaid. After the first six months do you see that level go back down to the level you usually see or does it remain higher than average? A: What we see is that after the first six months enrollees are coming back down to traditional usage levels. However, we are also seeing more utilization overall no matter how long someone has been on Medicaid.
 - I think we will see the same trend when Medicaid enrollment expands in 2014. We need to find out if this utilization is just due to people playing catch up or if these people are chronically behind the people who have had access to care.
- Q: Are you surprised that long-term care utilization does not continually go up? A: No because there is a limited supply of nursing homes and the state cannot meet demand. North Carolina relies more on adult care homes than most other states.
- Q: Should Medicaid have a policy to not reimburse for hospital readmissions like Medicare does? A: Medicaid is currently implementing its “never events” policy which means Medicaid will not pay for events that should have never happened.
- It is important to consider how different the cost drivers for Medicaid are compared to cost drivers for private insurers due to the difference in populations.

Workgroup Discussion

The workgroup discussed some of the new models identified in the ACA and which models could help North Carolina improve quality, outcomes, efficiency, and reduce costs of health care. The workgroup identified ACA models it would like to look into further: primary care medical homes, episodes of care (as a building block to ACOs), engaging patients in their own care, changing the way providers are reimbursed to promote quality and efficiencies, and transitions of care. Subcommittees will research each of these models before the next meeting and present a proposal that describes the model in detail, current evidence that supports the model, the barriers to testing the model, and the measures to evaluate different models (based on the Triple Aim initiative). Discussion slides can be found here: [Discussion of New Models](#).

Selected questions and comments:

- The episode of care model is particularly effective with orthopedic procedures, catheters, and transplants. It also works well in places with efficiencies and standardization of procedures such as in single specialty hospitals or ambulatory care centers.
- An example of provider payment reform is the medical home for pregnant women. DMA increased Medicaid payments to obstetricians working in the medical home. It costs more initially, but it increases access to private physicians, creates relationships with

patients, and increases coordination of care thus improving outcomes (and reducing long-term costs). This model can be applied to other diseases or conditions as well.

- We need to provide incentives to change the way providers deliver care, not just reduce payments to hospitals.
- We need policies that provide incentives to individuals in order to support a self-management model.
- Is there a way the federal government to help providers transition from the current model to a new model? Providers want to move towards new models but do not want to go bankrupt in the process.
- CCNC does a good job of integrating public health into its medical homes. We should look at ways of better using the staff in health departments and social services to improve cost effectiveness.
- The pay for performance (P4P) model would allow us to use dollars that are currently not being used cost-effectively and reallocate them to more cost-effective services.
- The Triple Aim initiative enhances patient experience and quality of care. We can look at this initiative as a framework and a way to measure our success.

Public Comment Period

No further public comments were given.