

New Models of Care Workgroup

Inventory of Existing NC Innovations

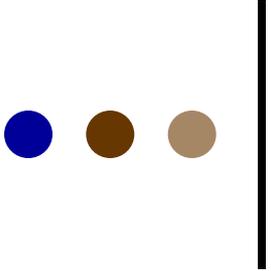
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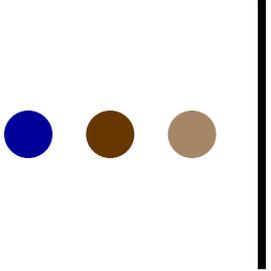
North Carolina Institute of Medicine

October 20, 2010



Agenda

- Overview
- Centers for Medicare and Medicaid Innovation (demonstrations)
- Medicare demonstrations
- Medicaid demonstrations
- Dual demonstrations
- New models not specific to Medicare or Medicaid



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- **Overview**

- Centers for Medicare and Medicaid Innovation (demonstrations)

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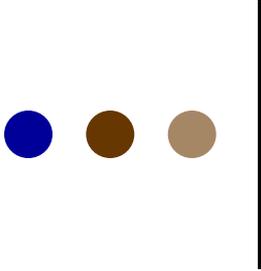
New Models: Overview

- The ACA creates a new CMS Center for Medicare and Medicaid Innovation (Sec. 3021)
 - Identifies new models which may be tested as 1115 waivers; must be budget neutral
 - Secretary has the authority to expand these pilots if expansion expected to reduce spending (without reducing quality) or improve quality (without increasing spending)
 - Richard Gilfillan, former president and CEO of Geisinger Health Plan selected as acting director
 - \$5M appropriated to design, implement and evaluate, \$10B to test over the next 10 years



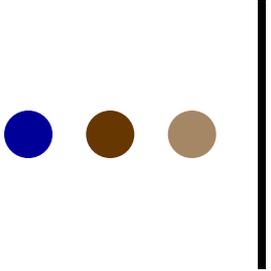
New Models: Overview

- In addition to the models described as part of the Centers for Medicare and Medicaid Innovation, the ACA also directed the Secretary to establish other demonstrations:
 - Medicare: Shared savings program (ACOs) (Sec. 3022, 10307), payment bundling (Sec. 3023), independence at home (Sec. 3024), hospital readmission reduction program (Sec. 3025), community-based care transitions program (Sec. 3026), extension of gainsharing demonstration (Sec. 3027), hospice concurrent care demonstration program (Sec. 3140)



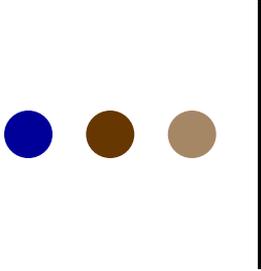
New Models: Overview

- Medicaid: Health homes for Medicaid enrollees with chronic conditions (state option, Sec. 2703), integrated care around a hospitalization (Sec. 2704), global payment system demonstration (2705), pediatric ACO (2706), Medicaid emergency psychiatric demonstration project (Sec. 2707)
- Dual eligibles (Medicaid, Medicare): payment coordination for dual eligibles (Sec. 2601, 2602)
- New models not specific to Medicaid or Medicare: interdisciplinary, interprofessional patient-centered medical home (Sec. 3502, 10321), co-locating primary and specialty care in community-based mental health settings (Sec. 5604), medication management (Secs. 3503, 10328), medical malpractice (Secs. 6801, 10607), shared decision-making (Sec. 3506), nursing home culture change (Sec. 6114)



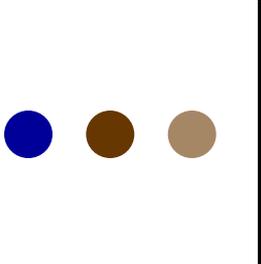
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- Medicare demonstrations
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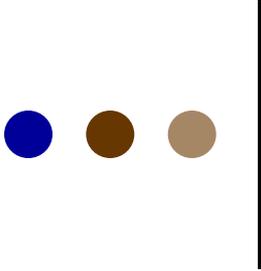
Center for Medicare and Medicaid Innovation

- Potential models include:
 - Broad payment and practice reform in primary care including patient-centered medical homes for high-need individuals, women, and models that transition primary care practices away from FFS to more comprehensive payment or salary based payment (Sec. 3021(b)(2)(B)(i))
 - **CCNC, Medicare/Medicaid 646**
 - Contracting directly with groups of providers to promote innovative care delivery models through risk-based comprehensive payment or salary-based payments (Sec. 3021(b)(2)(B)(ii))



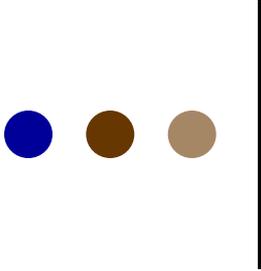
Center for Medicare and Medicaid Innovation

- Using geriatric assessments and care plans to coordinate care to people with multiple chronic conditions and an inability to perform 2 or more ADLs or cognitive impairment (Sec. 3021(b)(2)(B)(iii))
 - **Duke's Just for Us**
- Care coordination between providers of services and suppliers that transition providers from FFS toward salary (Sec. 3021(b)(2)(B)(iv))
- Supporting care coordination for chronically-ill individuals at high risk of hospitalization through health information technology-enabled provider network that includes care coordinators, chronic disease registry, and home telehealth technology (Sec. 3021(b)(2)(B)(v))
 - **Roanoke-Chowan telehealth network grant**
 - **ECU and Duke use of telepsychiatry**
 - **Foundation for Advanced Health Program grants to: Sandhills, 4C**



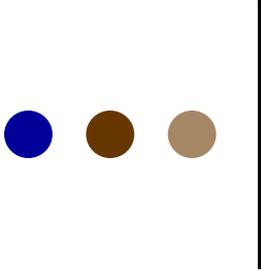
Center for Medicare and Medicaid Innovation

- Varying payment to physicians who order advanced diagnostic imaging according to adherence to appropriateness criteria (Sec. 3021(b)(2)(B)(vi))
- Using medication therapy management services (Sec. 3021(b)(2)(B)(vii))
 - **Health and Wellness Trust Fund check meds**
 - **Senior PharmAssist**
 - **CCNC pharmacy management initiative**
- Assisting individuals in making informed health care choices by paying providers and suppliers for using patient decision-support tools that improve understanding of treatment options (Sec. 3021(b)(2)(B)(ix))



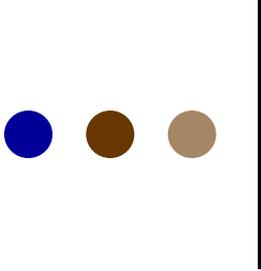
Center for Medicare and Medicaid Innovation

- Allowing states to test and evaluate fully integrating care for dual eligible individuals, including management and oversight of all funds with respect to these individuals (Sec. 3021(b)(2)(B)(x))
 - **Medicare 646 demonstration program (shared savings program, not fully capitated)**
 - **PACE pilots**
- Allowing states to test and evaluate systems of all-payer payment reform for medical care of residents of the State, including dual eligible individuals (Sec. 3021(b)(2)(B)(xi))
 - **North Carolina proposal for a multi-payer initiative in 7 counties**
- Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives in treatment planning and follow-up care (Sec. 3021(b)(2)(B)(xii))



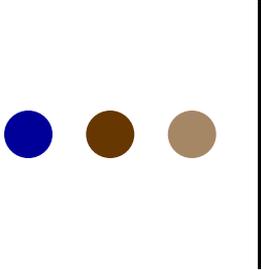
Center for Medicare and Medicaid Innovation

- Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or SNF during inpatient and 30 days immediately following discharge (Sec. 3021(b)(2)(B)(xiii))
- Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams (Sec. 3021(b)(2)(B)(xiv))
- Developing a collaborative of high-quality, low-cost health care institutions responsible for developing and disseminating best practices, implementing, and providing assistance to other health care institutions (Sec. 3021(b)(2)(B)(xv))



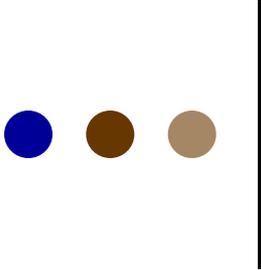
Center for Medicare and Medicaid Innovation

- Facilitate inpatient care of hospitalized individuals at their local hospital through use of electronic monitoring by specialists based at integrated health systems (Sec. 3021(b)(2)(B)(xvi))
- Promote greater efficiencies and timely access to outpatient services through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care, when such service is furnished by a health professional who has the authority to furnish the service under existing state law (Sec. 3021(b)(2)(B)(xvii))



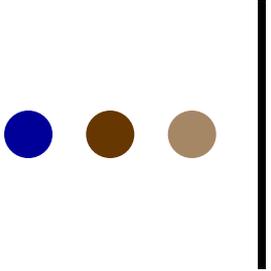
Center for Medicare and Medicaid Innovation

- Healthcare innovation zone: “Groups of providers that include a teaching hospital, physicians and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for clinical training of future health care professionals.”
(Sec. 3021(b)(2)(B)(xviii))
- Using telehealth services in medically underserved areas and facilities of the Indian Health Service to treat behavioral health issues, stroke, and improve the capacity of non-medical providers to provide health services for people with chronic complex conditions (Sec. 3021(b)(2)(B)(xix))
 - **ECU use of telepsychiatry, Roanoke Chowan, NCFAHP funds for two CCNC sites**



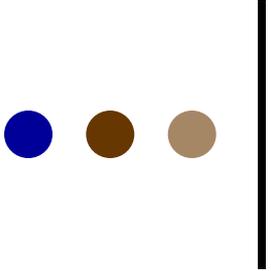
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- Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals with 2 or more chronic conditions and a history of prior-year hospitalization (through Medicare Coordinated Care Demonstration Project under BBA of 1997) (Sec. 3021(b)(2)(B)(xx))



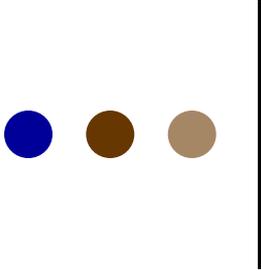
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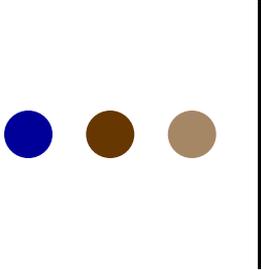
Shared Savings (Medicare)

- Shared savings program with qualifying accountable care organizations that meet quality performance standards (beginning in 2012) (Sec. 3022, 10307)
 - HHS Secretary will establish quality performance standards to assess the quality of care furnished by ACOs.
 - **North Carolina 646 program: Operates in 26 counties across the state**
 - **Forsyth Medical Group: Physician Group Practice Demonstration (started in 2000 as a 5 year shared savings/quality improvement demonstration)**
 - **PACE model: Currently operating in Alamance/Caswell, Wilmington, Fayetteville (soon to open); planning to create PACE programs in Buncombe, Durham, Hickory, Mecklenburg, Wake**



Independence At Home (Medicare)

- Independence at Home Demonstration Program (to begin no later than January 1, 2012) (Sec. 3024)
 - Physician and nurse practitioner home-based primary care teams care for high-risk beneficiaries with two or more chronic illnesses, prior hospitalization, and functional dependencies in their homes.
 - Providers may share in savings if they reduce preventable hospitalizations, prevent hospital readmissions, reduce ER visits, improve health outcomes, improve efficiency of care, reduce health care costs, and achieve beneficiary/family caregiver satisfaction.
 - **Duke operates an independence at home model “Just for Us”**
 - **CCNC has just started to enroll “Doctors making house calls”**



Community-Based Care Transitions (Medicare)

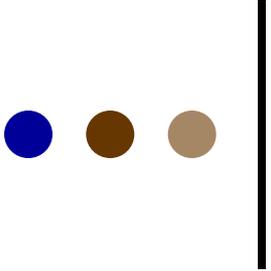
- Community-Based Care Transitions Program (Sec. 3026)
 - \$500 million (FY 2011-2015) to CMS to support collaborative partnerships between hospitals and community-based organizations that provide improved care transition services to high-risk Medicare beneficiaries
 - Focus on high-risk traditional fee-for-service Medicare beneficiaries with chronic illnesses, including cognitive impairment, depression, and history of multiple readmissions
 - **Part of the focus of the 646 waiver**

Other Medicare Demonstration Possibilities: Not Currently Being Tested

- Hospice Concurrent Care Demonstration Program (Sec. 3140)
 - 3-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services at the same time.
 - Up to 15 hospice programs and will be independently evaluated to determine whether the program has improved patient care, quality of life, and cost-effectiveness for participating Medicare beneficiaries.
- Payment Bundling: National pilot program for payment bundling of acute, inpatient and outpatient hospital, physician, and post-acute services under traditional fee-for-service (not later than 2013) (Sec. 3003, 3023, 10308)

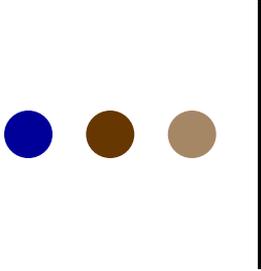
Other Medicare Demonstration Possibilities: Not Currently Being Tested

- Coverage of environmental health hazards (Sec. 10323)
 - Pilot program to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care to individuals affected by environmental exposure to asbestosis or mesothelioma
 - Competitive grant program for hospitals, CHCs, NCI-designated cancer centers, state/local government, and non-profits to screen at-risk individuals for environmental health conditions



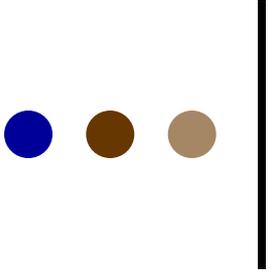
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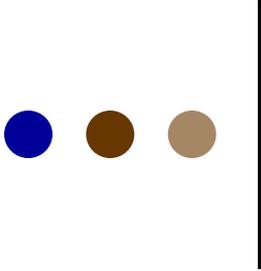
Health Homes for People with Chronic Illness (Medicaid)

- Health homes for people with chronic illness (Effective Jan. 1, 2011; Sec. 2703)
 - A health home is a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.
 - Health home services include comprehensive care management, care coordination and health promotion, patient & family support
 - 90% match for payments to health homes for eight FY quarters; total amount of payments made to states shall not exceed \$25M
 - **Community Care of North Carolina. Operates in all 100 counties.**



Pediatric ACO (Medicaid)

- Pediatric ACO Demonstration Project (Sec. 2706; authorizes such sums)
 - Allows pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments.
 - Effective January 1, 2012 to December 31, 2016.
 - **CCNC could potentially meet requirements for pediatric ACO demonstration (similar to the 646 model for shared savings for the adult population)**

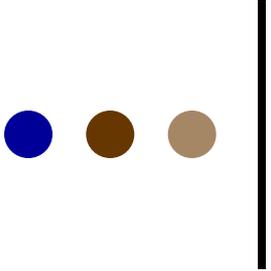


Emergency Psychiatric Demonstration (Medicaid)

- Emergency psychiatric demonstration project for up to 3 years (Effective FY 2011-2015; Sec. 2707)
 - Payment to private Institutions of Mental Diseases (IMD) for Medicaid eligibles ages 21-64 who need emergency medical care to stabilize threats to self or others
 - Appropriates \$75 million for FY 2011-2015 for FMAP for participating states
 - **Nothing similar being tested in NC currently, but state officials are interested in exploring this option**

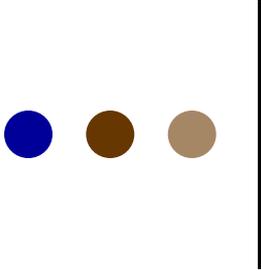
Other Medicaid Demonstration Possibilities: Not Currently Being Tested

- Bundled payment demonstration project for up to 8 states for episode of care that includes a hospitalization (Effective January 1, 2012 to December 31, 2016; Sec. 2704)
- Global Payment System Demonstration Project (Effective FY 2010-2012, Sec. 2705)
 - Up to five participating states will adjust the payments made to an eligible large safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.
 - The Center for Medicare and Medicaid Innovation will test and evaluate the demonstration project to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.



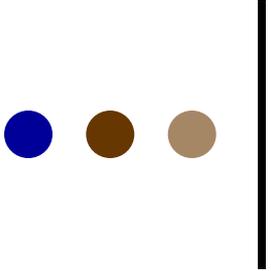
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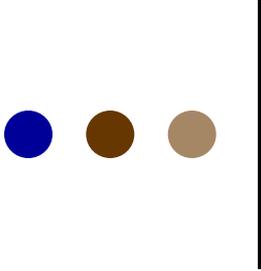
Improve Coordination for Dual Eligibles

- Improved coordination for dual-eligible beneficiaries
 - Clarifies Medicaid 5-year demonstration authority for coordinating care (Sec. 2601)
 - Creation of the Federal Coordinated Health Care Office within CMS to align access, quality, care continuity, and benefits for dual-eligibles. (Sec. 2602)
 - **North Carolina's 646 waiver meets this requirement. The 646 is operating in 26 counties.**
 - **Medicaid is paying the pmpm for all duals enrolled in CCNC. The networks are providing chronic care management, transitional support, medication reconciliation for any enrolled dual regardless of 646.**



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Co-location of Primary and Behavioral Health Providers

- Co-location of primary and specialty care in community-based mental and behavioral health settings.

(HHS Secretary will award grants to establish demonstration projects. Authorizes \$50M in FY 2010 and such sums as necessary in FY 2011-2014; Sec. 5604)

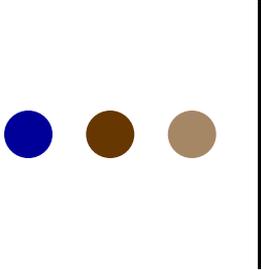
- **ORHCC / CCNC networks funded and supported 60 primary care practices with co location and 5 mental health agencies with reverse co location.**
- **Health and Wellness Trust Fund provided funding to NC Foundation for Advanced Health Programs to create Center of Excellence in Integrated Care to support co-location and reverse co-location.**

Interdisciplinary, Interprofessional Health Teams

- Community-based interdisciplinary, interprofessional health teams to support patient-centered medical home (HHS Secretary will establish grant program. Authorizes sums necessary. Sec. 3502, 10321)
 - **CCNC is a model of an interdisciplinary, interprofessional health team**
 - Networks include clinical directors, quality improvement specialists, care managers, pharmacists, psychiatrists
 - Some practices have broader teams
 - **Multipayer demonstration grant submitted to test model in model including Medicaid, BCBSNC, State Health Plan in 7 counties.**

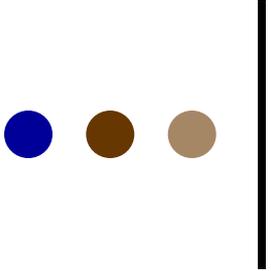
Medication Management

- HHS Secretary shall establish grants or contracts to provide medication management for people with 4 or more medications, high risk medications, and/or chronic diseases to improve quality of care and reduce overall costs. (Authorizes sums necessary, Sec. 3503, 10328)
 - **Health and Wellness Trust Fund has funded CheckMeds, which is available statewide and free for older adults age 65 or older who have Medicare Prescription Drug Plan**
 - **Some communities have medication counselors available to a broader group of individuals (eg, Senior PharmAssist in Durham)**
 - **CCNC has pharmacists available to help with medication management to all CCNC enrollees throughout the state**
 - **Beacon grant in 3 communities has pharmacotherapy as part of its demonstration**



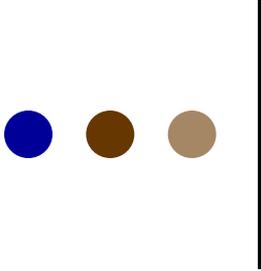
Medical Malpractice

- **Medical Malpractice** (Sec. 6801, 10607; Authorizes \$50M for 5-year fiscal period beginning FY 2011)
 - The HHS Secretary is authorized to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.
 - **NCORHCC and Access II Care (Henderson, Buncombe and McDowell) have been awarded a demonstration to develop a system of near-miss reporting and improvement tracking in primary care.**



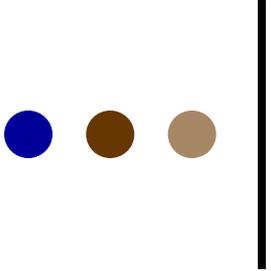
Shared Decision Making

- Program to facilitate shared decision-making (Sec. 3506)
 - Facilitate collaborative processes between patients, caregivers, or authorized representatives and clinicians
 - Provide information on trade-offs among treatment options.
 - **Some work to increase consumer participation through CCNC care managers**
 - **Some targeted work to address health literacy to more actively engage patients through work at UNC, Greensboro**
 - **CCNC starting a palliative care initiative.**
 - **DPH, Division of Aging and CCNC – have Master trainers in the Stanford self management model**



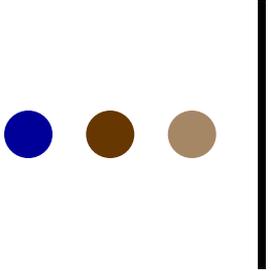
Other New Models Not Being Specifically Tested in NC

- Nursing Homes Demonstrations (Sec. 6114)
 - Two 3-year demonstration projects by March 2011 to develop best practice models for culture change and use of information technology to improve resident care.
 - **DHHS and NCFAHP & partners developed NC NOVA-- new voluntary licensure designation to improve work environment/standards for nursing home, assisted living and group home care.**



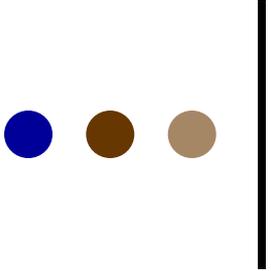
Other New Models

- Note: This presentation does not include other new models of long-term care, including home and community based service options (HCBS)
 - The HCBS state options are being addressed in the Medicaid workgroup



Questions for Group

- How can we help disseminate successful pilots and demonstrations across the state?
 - What types of data do we need to determine if a program is successful?
- Do we need a statewide infrastructure to support demonstration programs, irrespective of specific type of demonstration program?
 - Do we need a claims data repository once we have electronic health records?
 - Do we need state TA capacity to help disseminate successful initiatives?
 - What other infrastructure is needed?



Questions for the Group

- Recognizing that there are some demonstration/pilot opportunities that individual providers/health systems can pursue, are there other *Medicaid* demonstration opportunities that we may want to consider on a more statewide basis?