



MEMORANDUM

TO: Overall Advisory Committee
FROM: North Carolina Institute of Medicine
DATE: June 2, 2011
RE: PROGRESS UPDATE FROM THE HEALTH REFORM WORKGROUPS

The following workgroups held meetings since the last Overall Advisory Committee met on April 15: new models of care, prevention, health professional workforce, and safety net. This memo provides a brief overview of the work of these groups. The other groups are beginning to wind down their work, or waiting for further federal guidance before meeting again.

NEW MODELS OF CARE (MAY 18)

The new models of care workgroup met in May. The focus of the meeting was to discuss the new Accountable Care Organization (ACO) notice of proposed rulemaking (NPRM), Medicaid opportunities to support new models of care, as well as the infrastructure that is necessary to support new delivery and payment models intended to improve individual and population health, and to reduce rising health care cost escalation.

The group discussed the ACO NPRM, as well as the new announcement about a new category of ACOs—called the Pioneer ACO. Pioneer ACOs have a higher level of savings and risk, allow for prospective or retrospective beneficiary assignment, and can have a population-based payment arrangement. Unlike the ACO proposed rules, Pioneer ACOs have a higher level of savings and risk sharing, allow for prospective or retrospective beneficiary assignment, and has provisions to make advance payments to the ACO to support the infrastructure needed to manage the patient population. (These advance payments will then be subtracted from any shared savings).

The workgroup heard presentations on North Carolina's application for a Medicaid Healthy Lifestyle competitive grant. The Division of Medical Assistance (DMA), Division of Aging and Adult Services, and Division of Public Health partnered with CCNC to submit a grant requesting \$10 million for a new initiative. The proposed initiative targets the aged, blind and disabled population with co-morbid hypertension and diabetes. Interventions will be conducted through eight of CCNC's fourteen networks and include the Stanford disease management model, the Chronic Care program, telephonic coaching, and QuitlineNC. Awards will be announced in August 2011. DMA also has the opportunity to submit a State Plan Amendment (SPA) to support the expansion of health homes in North Carolina. The SPA would provide enhanced federal match for up to eight quarters to expand and further strengthen the state's CCNC and other care coordination efforts.

The workgroup also heard a presentation about the state's efforts to implement a Health Information Exchange. The group was interested in learning about the HIE to determine if this

could be a vehicle to gather data to support and analyze the effectiveness of new models of care. The group learned that the HIE will not have the capacity to hold data; rather it is a pipeline through which health information will travel from one provider to another. Thus, the HIE—as currently envisioned—will probably not have the capacity to collect or maintain the data needed to evaluate the costs and quality of new models of care.

The state has the opportunity to apply for federal funds to support a medical reimbursement data system (Sec. 1003 of the ACA). These centers would need to be established at academic or other nonprofit institutions and would be used to collect medical reimbursement information from health insurers, analyze and organize the information, and make the information available to insurers, health care providers, health researchers, policy makers and the general public. Presumably, these data could be used to help analyze the costs of new models of care. However, while the state can apply for this funding, the ACA specifies that the new law does not compel health insurance issuers to provide data to the center.

Another section of the ACA may ultimately require the state to collect utilization and/or cost data. The ACA requires states to develop and implement a risk adjustment mechanism to adjust payments to insurers inside and outside the HBE. The Secretary will define risk adjustment methodologies, but the state is not required to use the Secretary's risk adjustment mechanism. Some of the more sophisticated risk adjustment mechanisms use diagnosis, prescription drug, and/or utilization data. The state will need to develop a system to capture specific data elements if it wants to utilize a risk adjustment mechanism that incorporates more than age and sex.

Ultimately, the workgroup focused on the infrastructure and policies needed to support the testing and evaluation of new models of care. Group members discussed scope of practice issues, and the need to change certain insurance laws to support new benefit design. In addition, the workgroup began the discussion of whether the state needs to develop a new data warehouse to capture cost, diagnosis and utilization data—or whether there is another way to obtain the needed data to support and evaluate new models of care.

PREVENTION (MAY 31)

The Prevention workgroup met in May to discuss the new funding opportunity announcement for the Community Transformation Grants (CTG). The workgroup first heard about federal and state funding cuts, including substantial cuts to the federal Prevention Block Grant, which will force layoffs in the Division of Public Health and in local health departments. The workgroup also heard updates on potential legislative changes to the North Carolina Health and Wellness Trust Fund.

The workgroup spent most of the time discussing the new CDC funding opportunity for CTGs. CDC will be awarding up to 75 grants for a total of \$102.6 million in FY 2011. There are two potential types of grants: 1) Capacity grants (\$50,000-\$500,000), or 2) implementation grants (\$100,000-\$10,000,000).

CDC has identified five strategic directions:

- 1) Tobacco free living,
- 2) Active living and healthy eating
- 3) High impact evidence-based clinical and other preventive services (specifically prevention and control of high blood pressure and high cholesterol)
- 4) Social and emotional wellness
- 5) Healthy and safe physical environments

Applicants must address the first three strategic direction areas: tobacco free living; active living and healthy eating, and high impact clinical and other preventive services. Further, they must show that they have the capacity to meet 5% improvement targets in these three priority areas.

Many different types of groups could apply, including state and local governmental agencies, nonprofits, or tribal units. However, the CDC funding requirements will make it difficult for groups to apply on their own. Essentially, counties with greater than 500,000 population (Wake and Mecklenburg) must apply on their own. Other non-tribal applicants must apply to cover the remainder of the state. In other words, if a community group from County X seeks to apply for a CTG grant, it must have the capacity to serve the entire state (minus Wake and Mecklenburg). CDC will *not* award more than one grant to cover the same geographic area.

In order to maximize the potential grant opportunity to the state, the North Carolina Division of Public Health (DPH) plans to submit an implementation grant application to cover the state (except Mecklenburg and Wake Counties). According to information obtained from the CDC—if North Carolina successfully obtains an implementation grant, at least 50% will be distributed to communities (and of that, at least 36.39% of the total award must be spent in rural areas). The Division of Public Health believes it will be competitive in seeking an implementation grant as it has already received CDC funding for prevention infrastructure, and has a well-developed prevention action plan and statewide 2020 objectives. However, to be successful, DPH must also be able to demonstrate partnerships with key stakeholders including other state agencies and community partners.

SAFETY NET (APRIL 25, MAY 23)

The Safety Net Workgroup met in April to discuss emergency care. Recent reports from the CDC state that only 8% of patients in the emergency room have non-urgent medical conditions, but a recent study by Aetna reports that 60% of patients in emergency departments could be treated elsewhere. The workgroup focused specifically on appropriate emergency care and successful emergency diversion programs in North Carolina.

The North Carolina College of Emergency Physicians created an Access to Care Committee (ATCC) to address concerns over ACA requirements and the current budget crisis. The ATCC recommendations focused on preserving Medicaid reimbursement rates to ensure ongoing participation of emergency and primary care physicians for patients who are uninsured or have Medicaid coverage, access and utilization of the Community Care of North Carolina (CCNC)



provider portal to identify patients with chronic pain, alternative networks of care for non-emergency patients, liability reform, and EMTALA reform. The ATCC action plan aims to identify ED patients that can be better treated in an alternative health care setting. Three groups of patients have initially been selected as appropriate groups for intervention: dental complaints, chronic pain, and behavioral health. Patients in these categories without an emergency medical condition would be referred or transferred to a more appropriate health care setting (i.e., a dentist office for dental complaints).

The group also heard about diversion methods from two North Carolina programs. The Division of Mental Health Developmental Disabilities and Substance Abuse Services operates 41 mobile crises teams that serve all 100 counties of the state. The purpose of the mobile crisis teams is to reduce emergency room utilization and inpatient admissions for behavioral health conditions that can be better treated elsewhere. The teams are currently funded by state appropriations and Medicaid. Project Lazarus is a community-based drug overdose (OD) prevention program that provides naloxone rescue to patients within the specified target populations, including patients on opioids for chronic pain. Naloxone is a drug that counters opioid pain killers and therefore prevents an OD from causing harm or death. Within the first two years of the program, Wilkes County has seen a 13% drop in the number of ED treatments related to OD and substance abuse saving over \$16,000 per avoided OD episode. Their Wilkes County Chronic Pain Initiative changed opioid prescribing policies in the local ED by lowering the number of doses prescribed at a time and refusing to refill opioid prescriptions in the ED to help ensure proper follow up with a primary care provider. The initiative also began substance abuse prevention programs in the community and advocated to increase the number of substance abuse treatment facilities in the state. After three years, the program had effectively reduced the number of ED visits related to substance abuse and ODs, saved money, and improved care and access.

In May, the workgroup discussed the 340B drug discount program, successful pharmacy models in North Carolina, and lessons learned from pilot programs to extend insurance to previously uninsured populations.

The 340B program is administered by the Federal Office of Pharmaceutical Affairs and designed to increase access to brand name prescription drugs at a lower cost for low income patients and increase revenue to participating providers. In accordance with the ACA, the Health Resources and Services Administration (HRSA) published a notice of proposed rulemaking (NPRM) in the *Federal Register* on the 340B program. The NPRM added several new categories of eligible program participants, including certain children's hospitals, critical access hospitals, sole community hospitals, and rural referral centers. Orphan drugs are exempted from the discount for new 340B entities.

The North Carolina Office of Rural Health and Community Care developed and operates several programs to assist with patient medication. The Medication Access and Review Program (MARP) uses software to ease the administrative burden in establishing and maintaining a prescription assistance program (PAP). The software checks patient eligibility and potential adverse events, tracks costs of medications, and tracks the steps needed to access medications.

There is potential to integrate the data from MARP into medical data such as EHRs. NCRx is a state PAP which provides financial assistance to Medicare Part D beneficiaries under a specified income level. The program is funded through the Health and Wellness Trust Fund, but current budget proposals defund the program after June 30, 2011. ChecKmeds is a medication therapy management program for all Medicare Part D enrollees. The program offers medication review, prescriber consultation, patient compliance consultation, patient education and patient monitoring. There are no income limits for the ChecKmeds program.

Medication management is a hallmark of Durham's Senior PharmAssist program. Senior PharmAssist uses medication therapy management, financial aid, tailored referral, insurance counseling through the Seniors' Health Insurance Information Program (SHIIP), and medical records to reduce the number of adverse drug events in older adults 60 years or older in Durham. Financial assistance is given to those 60 years or older at or below 200% of the federal poverty level. Any Medicare beneficiary can receive insurance counseling services free of charge.

The workgroup also heard about the challenges of enrolling a newly eligible population in a limited benefit package. These lessons were helpful for the workgroup in preparation to discussion potential recommendations in June.

HEALTH PROFESSIONAL WORKFORCE (APRIL 26, MAY 27)

The Health Professional Workforce Workgroup met in April to discuss short-term policy options for meeting North Carolina's dental needs. In particular the workgroup focused on the fact that in 2015 North Carolina will begin graduating twice as many dentists each year (140 vs. 70) as the state does today. The workgroup discussed policy options that could be used to influence where and who these new dentists serve.

Data were presented that show that despite the increase in dental school graduates, the ratio of dentists to population in the state is expected to decline by 2020. Therefore, the state needs to not only retain graduates, but also attract dentists from other states. Further presentations focused on potential policy options for increasing dental access in preparation for the increase in the number of insured seeking dental care in 2014.

A presentation by the Division of Medical Assistance showed that increasing reimbursement rates could increase provider participation which in turn would increase access—a critical point to meeting the needs of the newly insured in 2014. However, budgetary concerns could lead to limiting adult dental services which would greatly limit access. The workgroup also heard about potential emerging models including using a CCNC-like model of public-private partnership and per-member-per-month fees for care coordination and administrative services. The workgroup heard recommendations about how to increase the dental workforce in underserved areas. One recommendation was to encourage dental schools to recruit more students with a motivation to serve in underserved areas, or who are from disadvantaged backgrounds. The workgroup also discussed increasing support for new dentists early in their careers, either through new policies or support from the communities they serve. The group also discussed options to increase retention in underserved areas, including strategies to express appreciation, offer flexible loan



repayment options, and more evenly distributing the Medicaid caseload. The workgroup also heard about the new ECU dental school and how it may meet some of North Carolina's dental needs.

In May, the workgroup discussed ideas for potential recommendations in the final report. They focused on changes needed to maximize North Carolina's ability to take advantage of federal funding opportunities for workforce development, ensure the most people have access to high quality primary care as eligibility increases in 2014, and patient-centered, team-based care (health home) envisioned in the ACA. The workgroup was charged with identifying short-term solutions (one to five years) to the workforce issues raised by the ACA. The group discussion included recruitment and retention through the National Health Service Corps, the creation of a State Health Workgroup Planning Commission to help the state plan for future workforce needs, billing and reimbursement related to Medicaid access, restructuring the workforce to meet the demands of 2014, workforce size, and increasing health professionals in underserved. This workgroup plans on meeting two more times to focus on diversity and pipeline issues as well as allied health supply.