

Health Reform: New Models of Care Workgroup
Wednesday, May 18, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Allen Dobson (co-chair), Craigan Gray (co-chair), Don Bradley, Peter Chauncey, Steve Cline, Analiese Dolph, Lloyd Michener, Renee Rizzutti, Valinda Rutledge, Gina Upchurch, Torlen Wade, Susan Yaggy

Steering Committee Members: Allen Feezor

NCIOM Staff: Thalia Fuller, Emily McClure, Arijit Paul, Pam Silberman, Rachel Williams

Other Interested Persons: Judy Brunger, Melanie Bush, Darryl Frazier, Markita Keaton, Sarah Lesesne, Gary Massey, Catherine Moore, Debbie Pittard, Lendy Pridgen, Chris Skowronek, Jeff Spade, Elizabeth Walker Kasper, Andrew Weniger, Rebecca Whitaker

Welcome and Introductions

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

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

Dr. Gray welcomed everyone to the meeting.

Health Information Exchange (HIE)

Steve Cline, DDS, MPH
Assistant Secretary for Health Information Technology
NC Department of Health and Human Services

Dr. Cline gave a brief overview of the status of HIE in North Carolina. The federal government has charged states to implement health information technology (HIT) systems. These systems must put clinical information into an electronic format so that it can be shared among providers,

incentivize providers to use electronic health records (EHR), and define standards for EHR vendors. The federal government has also established meaningful use standards that providers must meet in order to obtain incentive payments. To be successful, we need to ensure that providers know how to use the system. North Carolina has created a Regional Extension Center system, through AHEC, to help providers adopt and use electronic health records.

North Carolina will have the core HIE services, including security, patient matching, consent management, and transaction logging, by the end of 2011. Value-added services, including clinical care document translation, quality reporting, and medical histories, will be added in the near future.

Dr. Cline's presentation can be found here: [HIE in North Carolina](#).

Selected questions and comments:

- Q: How are the Medicaid and Medicare incentive payments for using EHRs decided for hospitals? A: It is a very complicated formula. Physicians have to be eligible under Medicaid or Medicare. If an individual physician is eligible for both, the physician has to choose either to receive incentives from Medicaid or Medicare. However, hospitals can apply for both Medicaid and Medicare incentive payments.
- Q: Are there any required interoperability components between state systems? A: States can organize HIE systems in many different ways, as long as information can be shared. State systems must have the capacity to share information from all certified EHR vendors. Since each state will be required to create a HIE system that can share information across all certified EHR vendors, we believe that the different state HIE's should be interoperable.
- Q: How are the value-added services going to be funded and maintained? A: There is \$12-13 million dollars available to build a HIE system in North Carolina. The best estimate of what the HIE board believes it will take to build the system is \$24 million over a three year period. The HIE board has created initial guidelines, to try to obtain funding from different health care sectors. For example, the board is aiming to obtain 35% of the funding from payers/insurers, 35% from hospitals, 20% from Medicaid, and 10% from other providers. The HIE is also exploring the possibility of prepayment. If some of the larger users are willing to prepay, they will get a lower rate thereafter to use the system.
- The HIE does not have a permanency of data; it is a pipeline in which data is shared. Thus, it will not be a repository where data resides, which the state could use to analyze the quality and effectiveness of new models of care, or for use in risk adjustment across insurers.
- Q: Will the HIE provide a consumer portal to provide personal access to health records? A: As currently envisioned, the HIE will not offer personal health records. Many

providers are opening patient portals so patients can get individual lab results, etc. A number of vendors are vying to be the main player in that market, but there is not a big role for the state-level HIE in that.

- Q: How is the HIE going to get consumers involved? Will consumers be concerned about potential breach of privacy with electronic health records. A: Health records are more secure with an electronic system than with a paper system. The electronic system has controlled access and access is traceable to see who has seen the record and where the records have been shared. The HIE is going to facilitate the sharing of information that is already being shared in hard copy. The HIE is entirely HIPAA compliant.

Medical Reimbursement Center

Pam Silberman, JD, DrPH

President and CEO

North Carolina Institute of Medicine

Dr. Silberman discussed the ACA provisions for medical reimbursement data centers. These centers will publicize medical cost data. States that are interested in developing a medical reimbursement data center can apply for federal grants. A handout on medical reimbursement centers can be found here: [Medical Reimbursement Center](#).

Selected questions and comments:

- If the state is looking towards per-member-per-month (PMPM) payments, and if new models can reduce PMPM payments, the data collected by the center can support those models.
- The data from these centers could help the state develop a risk adjustment mechanism. DOI will need to risk adjust payments to insurers inside and outside the HBE.
 - The Secretary will define risk adjustment methodologies, but the state may or may not use what the Secretary defines. Some of the more sophisticated risk adjustment mechanisms use diagnosis, prescription drug, and/or utilization data. If the state wants to include more risk adjustment data elements than age and sex, it will need a system to capture these data.

Update on ACOs

Pam Silberman, JD, DrPH

Dr. Silberman briefly went over accountable care organizations (ACOs) and proposed rules for ACOs from the federal government (42 CFR §425). An ACO is a group of providers responsible for the quality, cost and overall care of Medicare beneficiaries assigned to the ACO. The goals of an ACO are to provide better care, better overall health, and reduce costs. The proposed ACO rules include eligibility and accountability requirements, patient centeredness requirements, rules

on assignment of Medicare beneficiaries to ACOs, payment to providers and savings, quality performance measures and reporting systems, sanctions, review processes, a minimum three-year agreement for a provider to participate in an ACO, data sharing, public reporting, and other provisions.

A new category of ACO, Pioneer ACO, was released by the Centers for Medicare and Medicaid Services (CMS) on May 17, 2011. Pioneer ACOs will test new models that may later be adapted by the shared savings program. Unlike the shared savings program, Pioneer ACOs have a higher level of savings and risk, 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).

Dr. Silberman's presentation can be found here: [Update on ACOs](#).

Selected questions and comments:

- Q: Is the new proposal for Pioneer ACOs going to change what's in place for the shared savings program? A: The Pioneer ACO is multipayer but is still Medicare based. Hospitals can be in both while primary care providers can only be in one or the other. Specialists can be in multiple ACOs.
- Q: Can federally qualified health centers (FQHCs) be in more than one ACO? A: It is not very clear yet.
- There are no appeal rights if a provider doesn't agree with savings or quality ratings. Providers might not participate if they have no recourse to contest beneficiary assignment, quality ratings or savings.
- If the goal of ACOs is to reduce spending, then there needs to be an on-ramp for implementing them, not only in quality metrics but in payment. There needs to be a more coherent plan such as different levels of ACOs.
 - The ACOs are supposed to be operational by 2012 and the Pioneer ACOs are supposed to be operational by the end of 2011. This does not leave much time for an organization to jump in since the government doesn't have regulations out for either ACO model yet.

Update on Medicaid Healthy Lifestyle Initiatives

Melanie Bush, MPP

Assistant Director of Administration

Division of Medical Assistance

NC Department of Health and Human Services

Ms. Bush gave the workgroup an update on the Medicaid Incentives for the Prevention of Chronic Disease Grant. The Division of Medical Assistance (DMA), the Division of Aging and Adult Services, and the 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 (ABD) 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.

A handout with a summary of updates can be found here: [Healthy Lifestyle Initiatives Updates](#).

Selected questions and comments:

- Q: If North Carolina receives the grant, when will implementation start? A: The program will be implemented in January 2012. Three years of the grant has to be implementation and the next two years will be rigorous evaluation.

Update on Medicaid Health Homes

Debbie Pittard, PMP

Senior Project Manager

Office of Project Management

Division of Medical Assistance

NC Department of Health and Human Services

Ms. Pittard gave an update on the status of the North Carolina Medicaid Health Home Initiative. DMA received a \$500,000 planning grant. The state can submit a health home State Plan Amendment (SPA) which 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 steering committee is working on a draft SPA and is awaiting comments. Planning grant money will be used to fund resources, system changes, training and implementation.

A handout with a summary of updates can be found here: [Medicaid Health Homes Updates](#).

Discussion

The workgroup discussed what infrastructure would be needed to implement new models of care in North Carolina. The workgroup focused on coordination in applying for grants, policy needs, creating a data warehouse, and standardizing risk adjustment across payers.

The workgroup felt it was important to keep track of what grants are coming out and to have more coordination between entities applying for grants. More coordination between entities

could help reduce non-constructive competition for the grants, and could potentially help ensure that grant funds are targeted to areas that need it rather than areas that have more capacity and are more competitive. Coordination would also help reduce replication of efforts. Some concern was raised regarding less competition for grants because it could potentially limit which grants entities could apply for. North Carolina Network of Grantmakers (NCNG) has a website to help increase coordination and the workgroup felt more information about the website needs to be disseminated around the state. The NCNG website can be accessed at: www.ncgrantmakers.org. (After accessing the website, click on the link for health, under nonprofits. This will bring you to a sign in page where you can register, and then get access to the health exchange which includes both federal funding opportunities and foundation grant announcements.)

The workgroup discussed policy changes that are needed to assist in the implementation of new models of care. Policy changes included a requirement to participate in the HIE in order to ensure the HIE would have sufficient data. Scope of practice and changes to benefit designs were also discussed. Some members mentioned looking at old health maintenance organization (HMO) policies to address the new ACO models since they are similar.

To address the issue of data collection, the workgroup discussed the feasibility of a data warehouse. Building a single new data warehouse to store EHR data would be too costly. The workgroup discussed alternatives, including using the HIE as a warehouse. However, the HIE is not currently planning on storing data. Duke University uses a system based off of HIPAA agreements. Health data from all of Duke's providers under their HIPAA agreement is collected and used for research and evaluation. The workgroup discussed whether or not HIPAA agreements could be used across the state to collect statewide health data.

Risk adjustment is calculated in many different ways. The workgroup discussed setting a risk adjustment standard in order to compare data across payers. Being able to compare across payers would be useful in evaluating new models of care. There was debate over whether to use actual cost data or normalized cost data to compare service utilization and quality.

Public Comment Period

No further public comments were given.