Here Comes the Sun (An Optimistic Reprisal on the State of North Carolina's Health and Health Policy)

Adam Zolotor, MD, DrPH

President & CEO, North Carolina Institute of Medicine

June 25, 2019, NC Primary Care Conference

NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

NCGS §90-470

Objectives

- Describe trends driving the cost of care ever higher and the value for those high costs.
- Discuss the policy challenges and opportunities in NC
  - Medicaid
  - Value based purchasing
  - Social determinants

HNC 2030 Indicators and Targets

Health Factor Topic Area	Indicator	NC Current Rank	Current	Target
Health Outcomes	Life expectancy	36th	78 years	TBD
Health Outcomes	Infant mortality	41st	7 per 1,000 live births	TBD
Health Behaviors	Youth tobacco use	---	28.8%	15.0% (or equal to Healthy People target, if lower)
Health Behaviors	Drug overdose deaths	32nd	22.2 per 100,000	18.0 per 100,000
Health Behaviors	Youth consumption of sugar-sweetened beverages (≥ 1 per day)	---	Clarifying current data	50% reduction from current
Health Behaviors	Teen birth rate	28th	26.7 per 1,000	10.0 per 1,000
Health Behaviors	HIV diagnosis	40th	15.2 per 100,000	6.0 per 100,000
Clinical Care	Primary care providers (Physicians, Nurse Practitioners, & Physician Assistants)	---	40 counties not within 1:1,500 threshold	Finalizing with work group after additional analysis
Clinical Care	Uninsured	42nd	13%	8%
Clinical Care	Suicide	16th	13.3 per 100,000	11.0 per 100,000
Clinical Care	Early prenatal care	37th	68.6% live births	80.0% live births

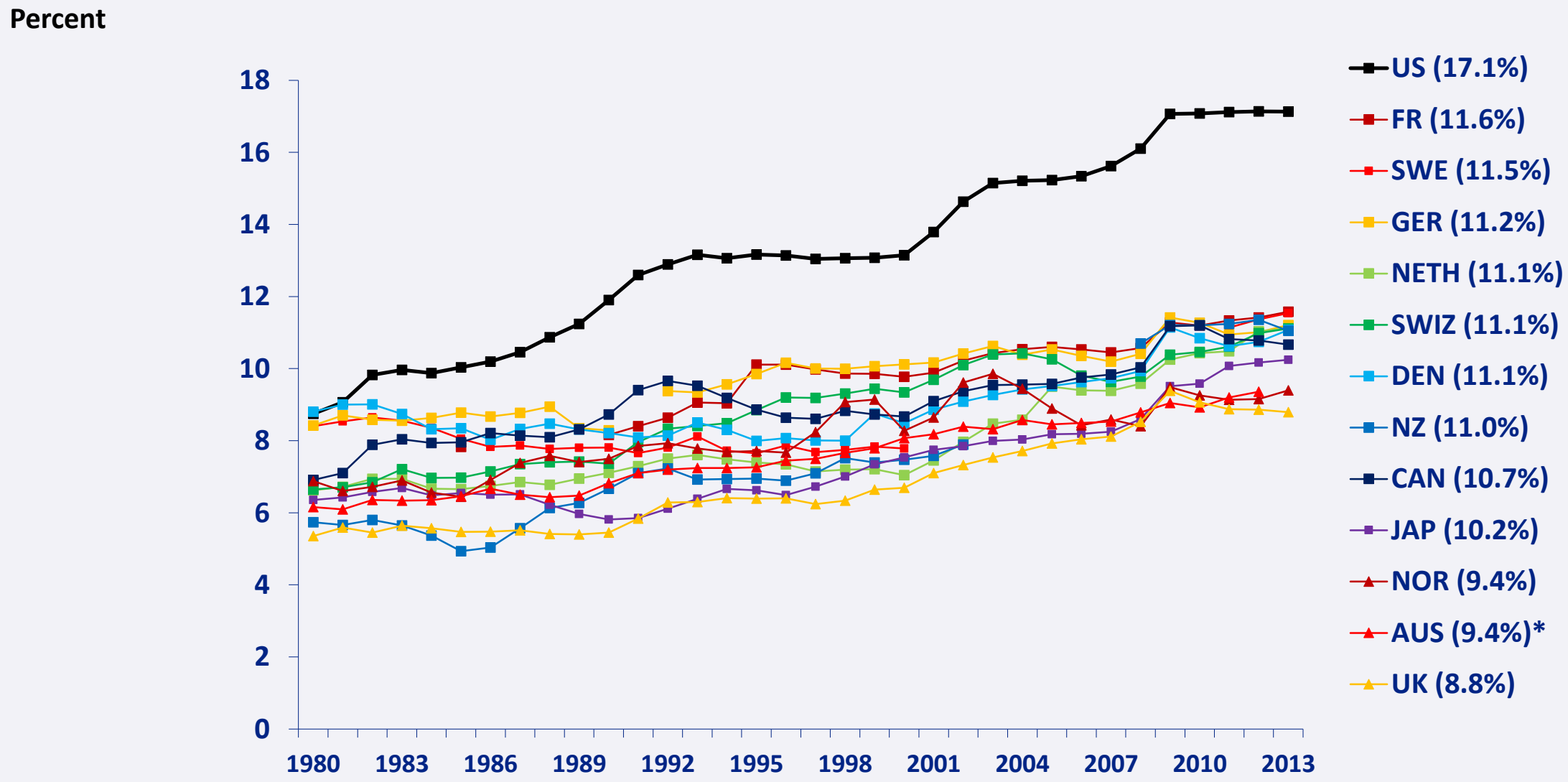
DRAFT

HNC 2030 Indicators and Targets

Health Factor Topic Area	Indicator	NC Current Rank	Current	Target
Social & Economic Factors	3rd grade reading proficiency	---	55.9%	80.0%
Social & Economic Factors	Incarceration rate	21st	341 per 100,000	150 per 100,000
Social & Economic Factors	Families ≤ 200% Federal Poverty Level	40th	30%	20%
Social & Economic Factors	Unemployment	26th	3.9%	3.0%
Social & Economic Factors	Adverse Childhood Experiences (children)	35th	23.5%	18.0%
Social & Economic Factors	Short-term suspension rate	---	1.39 per 10 students	.80 per 10 students
Physical Environment	Severe housing problems	28th	16.1%	14.0%
Physical Environment	Access to exercise opportunities	41st	73%	92%
Physical Environment	Limited access to healthy food	26th (tied with 9 states)	7%	5%

DRAFT

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

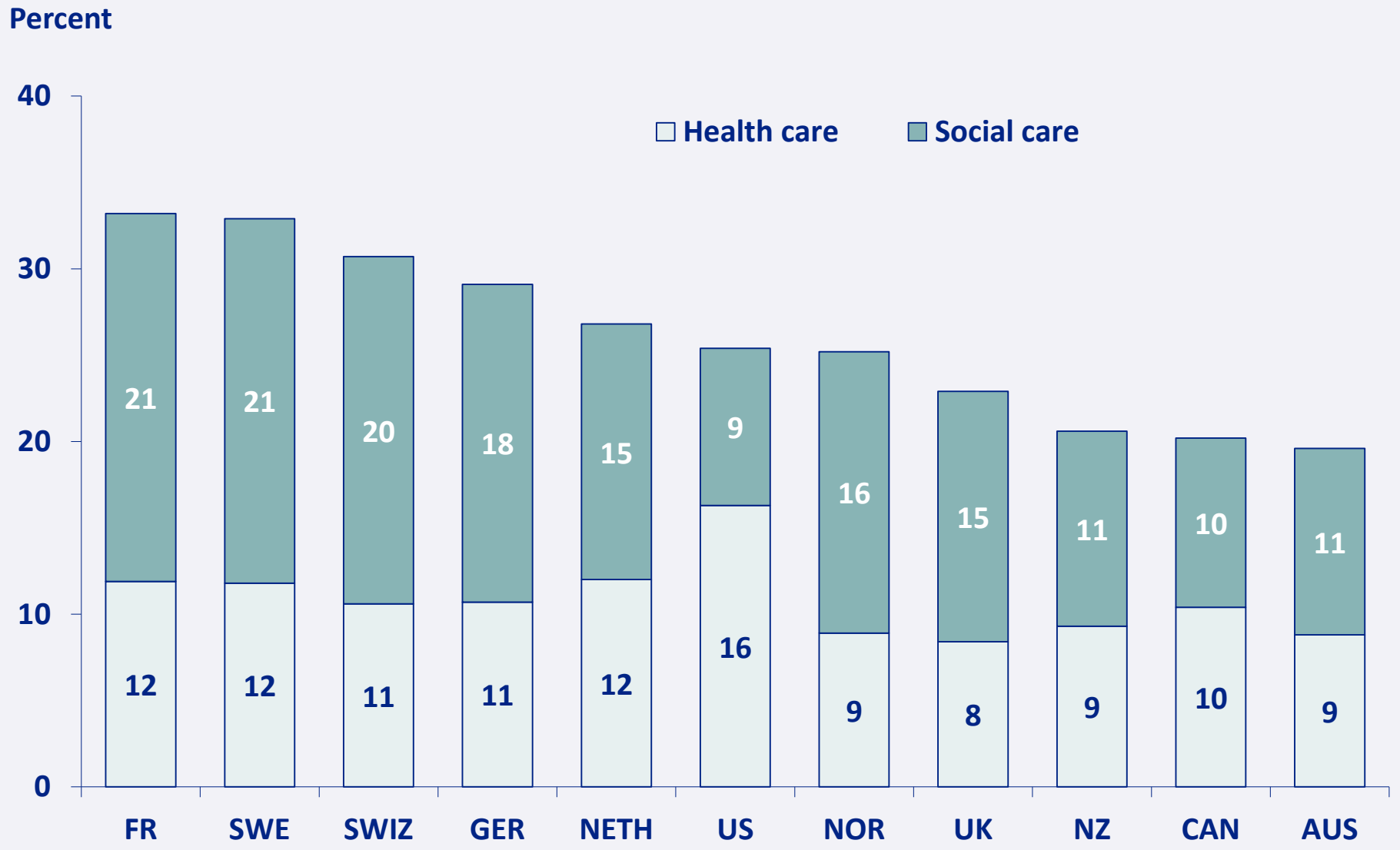
Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	—	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	—	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	—	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

Why? What Are the Drivers?

Exhibit 8. Health and Social Care Spending as a Percentage of GDP

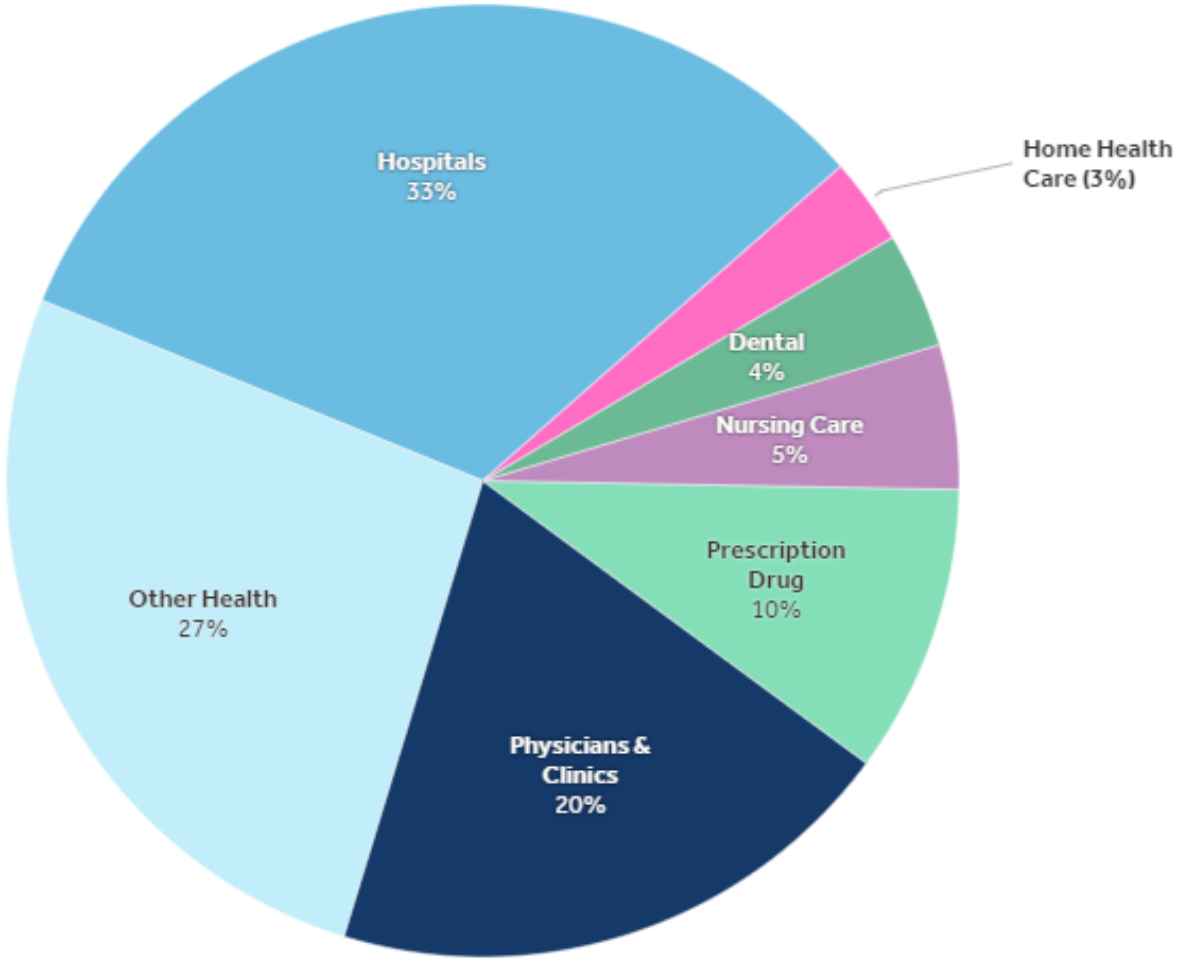


Notes: GDP refers to gross domestic product.

Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Hospital and physician services represent half of total health spending

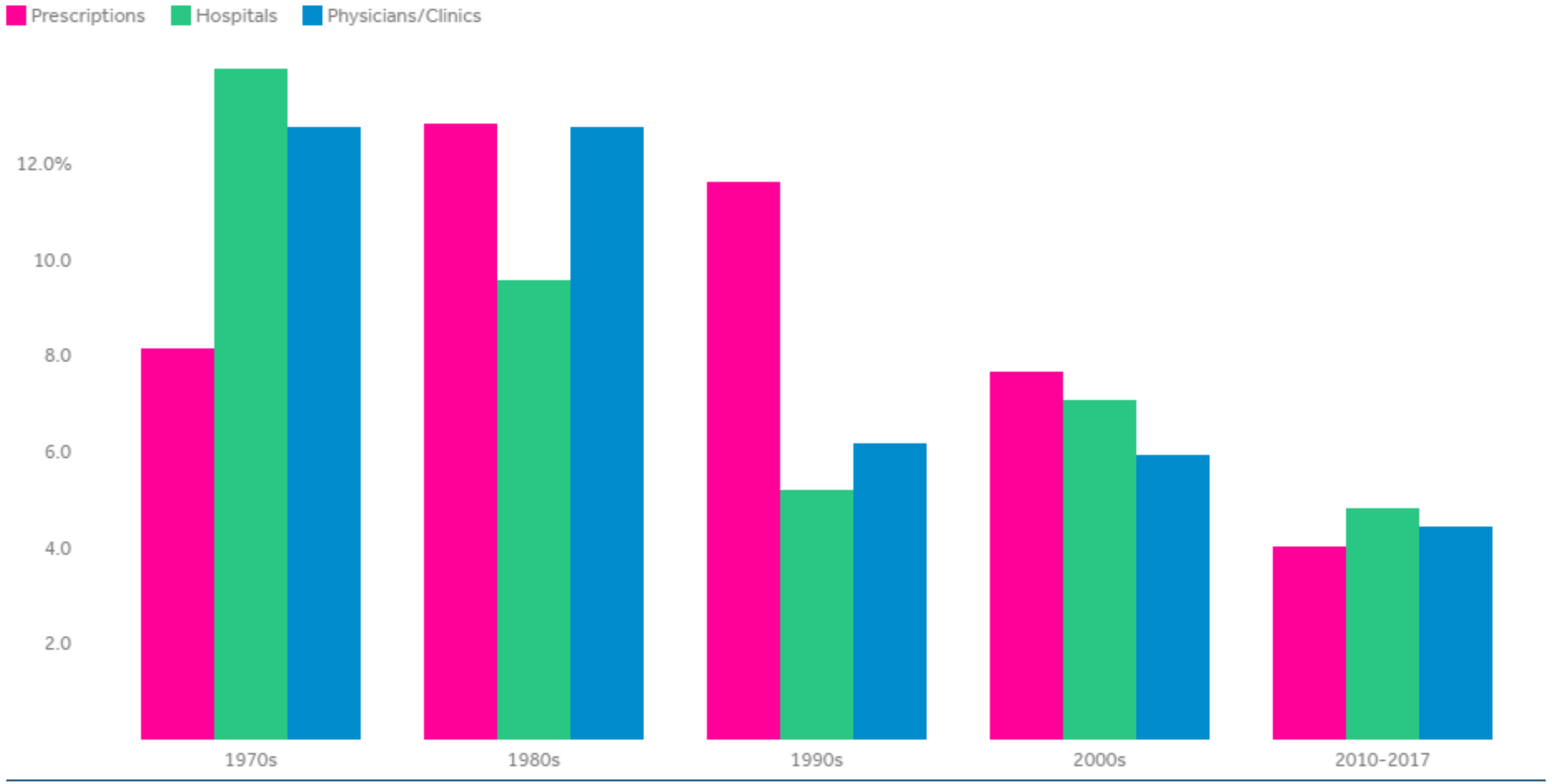
Relative contributions to total national health expenditures, 2017



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-Kaiser
Health System Tracker

Average annual growth rate for select service types, 1970 - 2017



Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-Kaiser
Health System Tracker

Use of Technology? Rx Drugs

- Compared to same counties:
  - More MRI scanners than any other county except Japan.
    - More MRI scans than any other county.
  - More CT scanners than any other county except Japan and Australia
    - More CT scans per capita than any other county.
  - More PET scanners than any other county except Denmark
    - More PET scans per capita than any other county except Denmark
- Highest number of prescription drugs per capita for adults (2.2, tied with NZ).

Exhibit 7. Prices for Hospital and Physician Services, Pharmaceuticals, and Diagnostic Imaging

	Total hospital and physician costs, 2013[a]		Diagnostic imaging prices, 2013[a]		Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)[b]
	Bypass surgery	Appendectomy	MRI	CT scan (abdomen)	
Australia	$42,130	$5,177	$350	$500	49
Canada	—	—	—	$97	50
France	—	—	—	—	61
Germany	—	—	—	—	95
Netherlands	$15,742	$4,995	$461	$279	—
New Zealand	$40,368	$6,645	$1,005	$731	—
Switzerland	$36,509	$9,845	$138	$432	88
United Kingdom	—	—	—	—	46
United States	$75,345	$13,910	$1,145	$896	100

[a] Source: International Federation of Health Plans, 2013 Comparative Price Report.

[b] Numbers show price indices for a basket of in-patent pharmaceuticals in each country; lower numbers indicate lower prices. Source: P. Kanavos, A. Ferrario, S. Vandoros et al., "Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs," *Health Affairs*, April 2013 32(4):753–61.

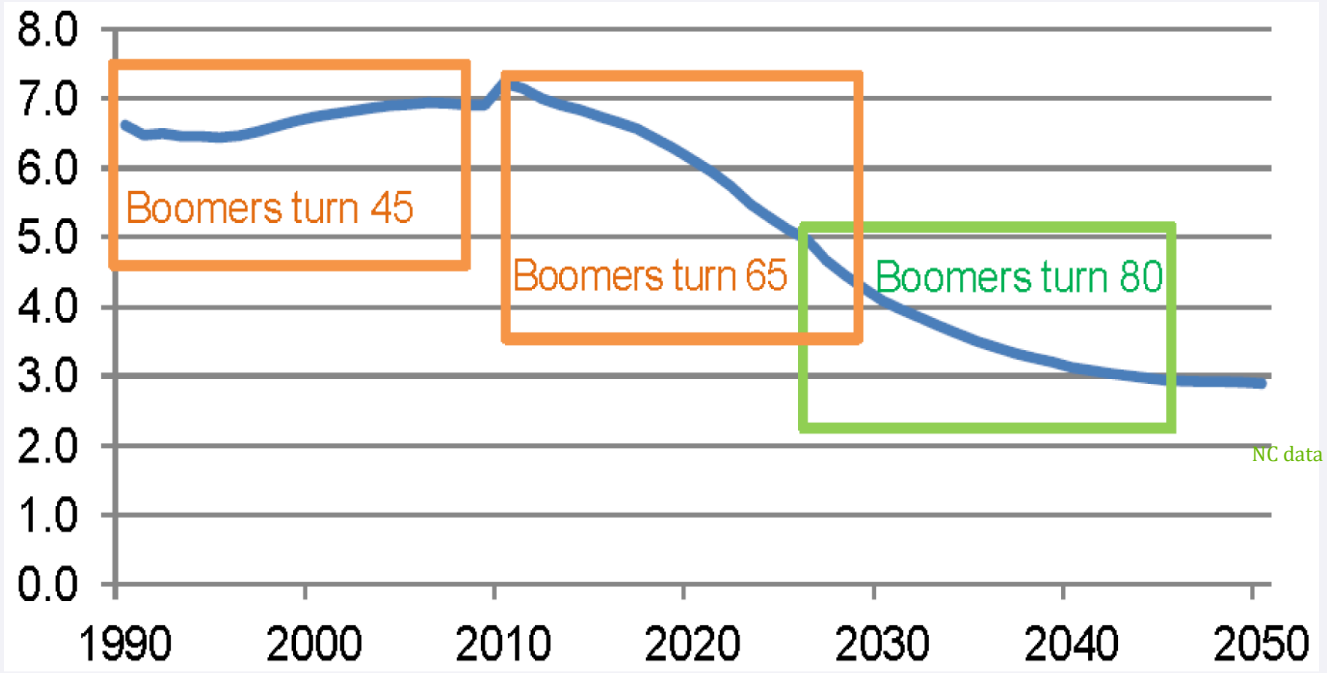
Rank	1	2	3	4	5	6	7	8
Health-adjusted life expectancy*	JAP 74.9	SWIZ 73.1	FRA 72.6	CAN 72.3	NETH 72.2	SWE 72.0	AUS 71.9	UK 71.4
Generalist physicians' compensation (in US$)	US 218,173	GER 154,126	CAN 146,286	UK 134,671	JAP 124,558	FRA 111,769	NETH 109,586	AUS 108,56
Total pharmaceutical spending per capita (in US$)	US 1,443	SWIZ 939	JAP 837	UK 779	FRA 697	DEN 675	GER 667	CAN 613
Spending on governance/ administration (as a % of total national health care expenditures	US 8	GER 5	NETH 4	SWIZ 4	CAN 3	AUS 3	UK 2	SWE 2

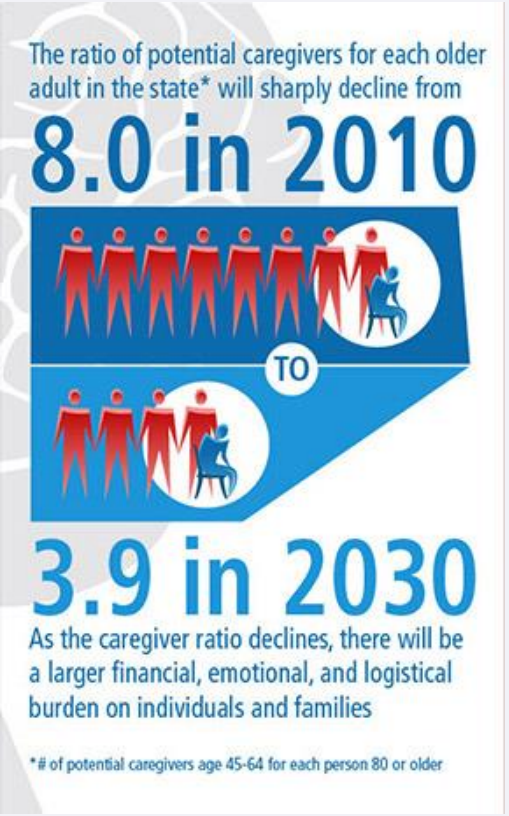
Papanicolas, 2018, Commonwealth Fund

Older Adults

- The number of adults 65 and older will **increase dramatically** over the next 15 years.
- North Carolina ranks **9th nationally**, both in total population and in the number of people 65 and older.
- In 2025, **one in five North Carolinians will be 65 and older**.
- Our 65 and older population will almost double in NC in the next 20 years from 1.5 to 2.5 million

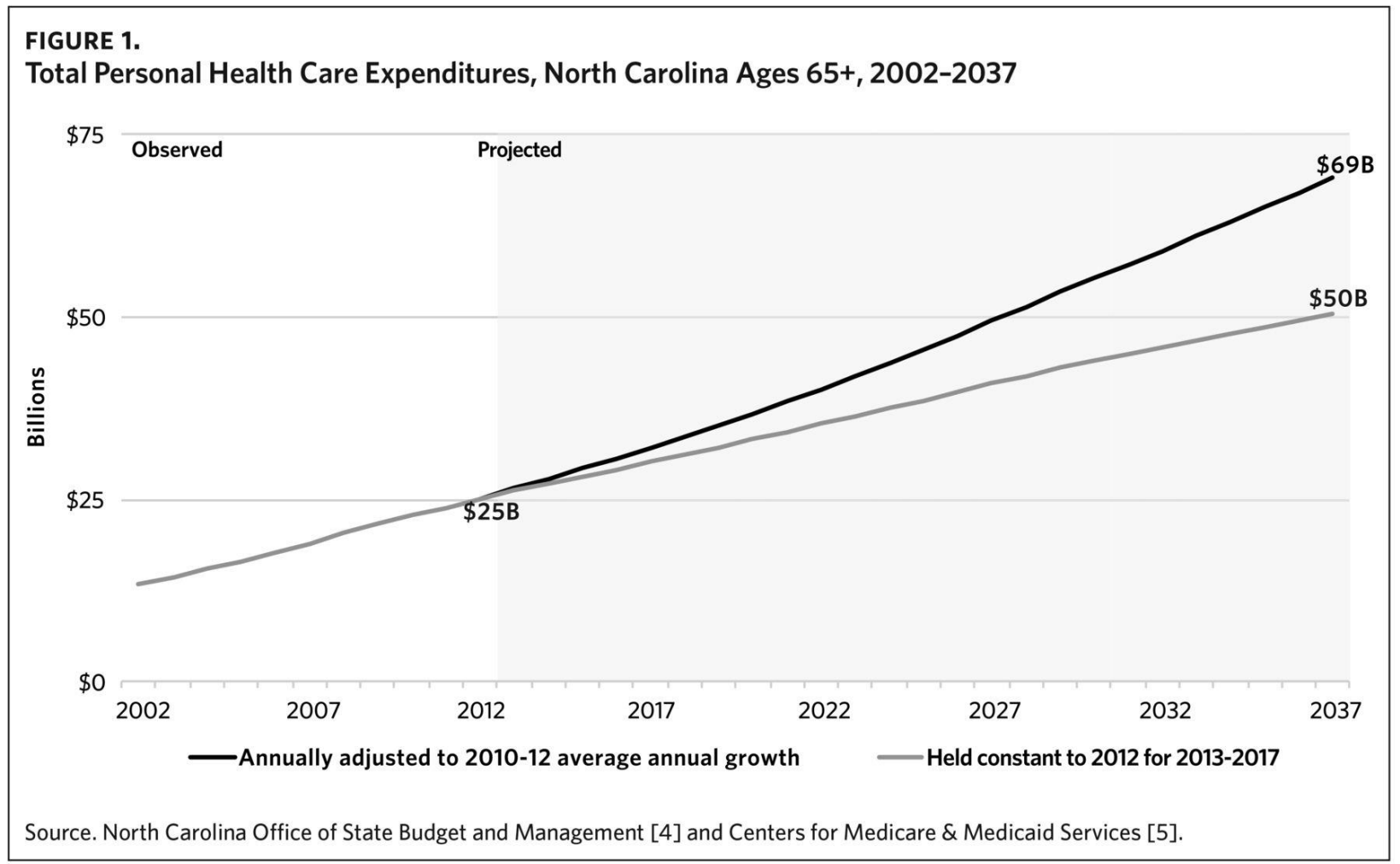
Caregiver Support Ratio





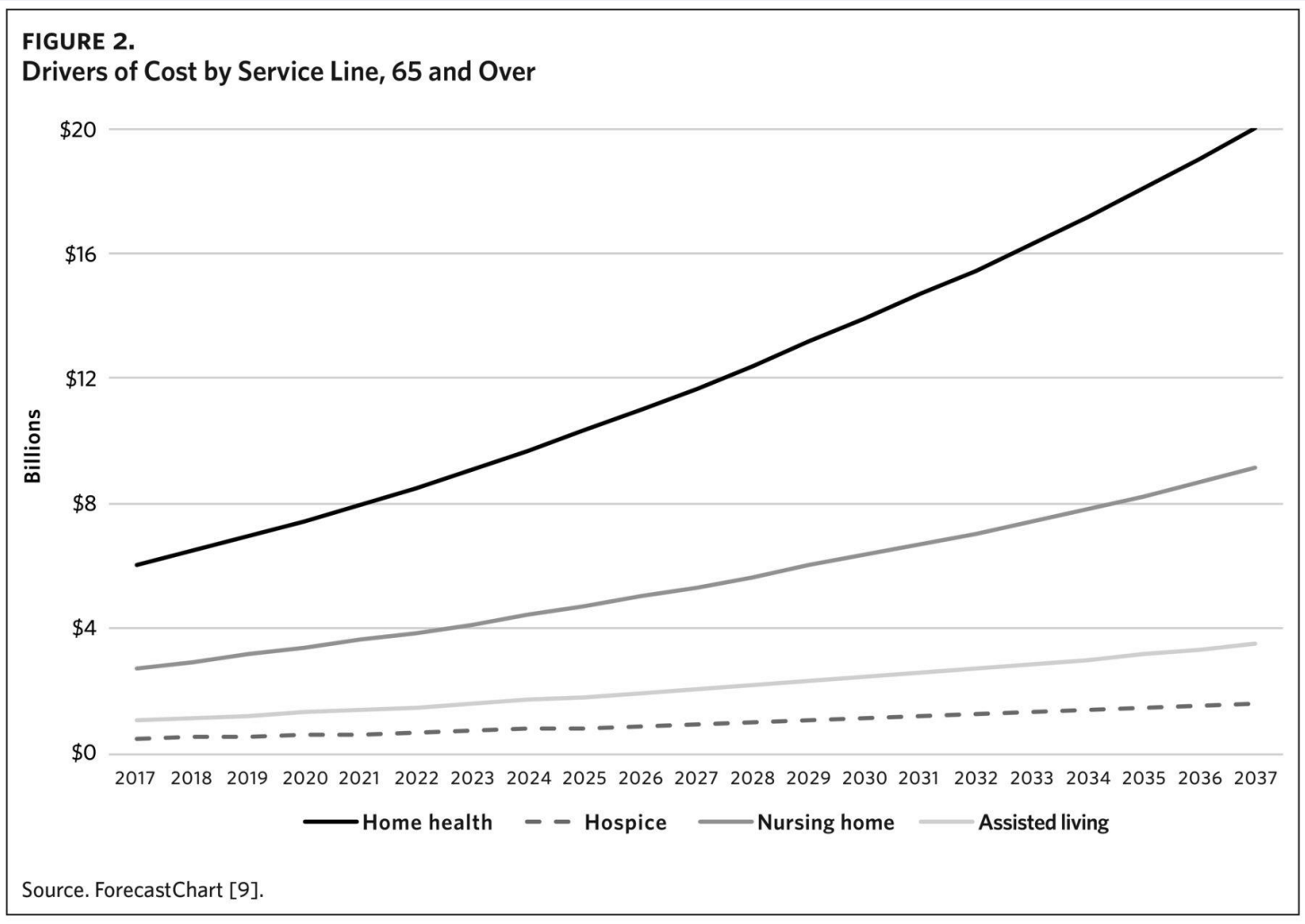
AARP Public Policy Institute US Data

Total Personal Health Care Expenditures, North Carolina Ages 65+, 2002–2037.



Adam J. Zolotor, and Rebecca Tippett North Carolina Medical Journal 2018;79:66-69

Drivers of Cost by Service Line, 65 and Over.



Adam J. Zolotor, and Rebecca Tippett North Carolina Medical Journal 2018;79:66-69

What Can NC Do?

- Medicaid (transformation vs expansion)
- Value-based purchasing (public and private)
- Addressing social determinants (in Medicaid and for the population)
- Many of these drivers are outside of control of the state or the state has limited control. Change the structure of insurance, the salary for physicians, or the price of pharmaceuticals for example, will require a national approach.
- Lots of other issues that we will not talk about. Oral health care, rural health, behavioral health, licensure, certificate of need.

Medicaid

- Transformation versus expansion
  - Transformation is the movement to managed care the is upon us.
  - Expansion means to expand the pool of potential Medicaid beneficiaries to adults that are below 138% of the federal poverty level (non-pregnant, non-elderly, non-disabled, and without dependent children).
- Medicaid Basics
  - Insurance program for those with low income and meeting another categorical eligibility criteria (children, pregnant women, disabled or elderly adults, adults with dependent children). Does not cover undocumented immigrants or adults without dependent children.
  - 2.2 million North Carolinians
  - $14 billion annual cost.
  - Joint Federal/State program. FMAP (Federal match) varies by state. NC 67%.

Medicaid Reform

- In the midst of massive shift in payment for Medicaid services.
- Three goals, 1) improve heath, 2) maximize value and 3) improve access.
- Part of rapid acceleration from volume to value.

Snapshot

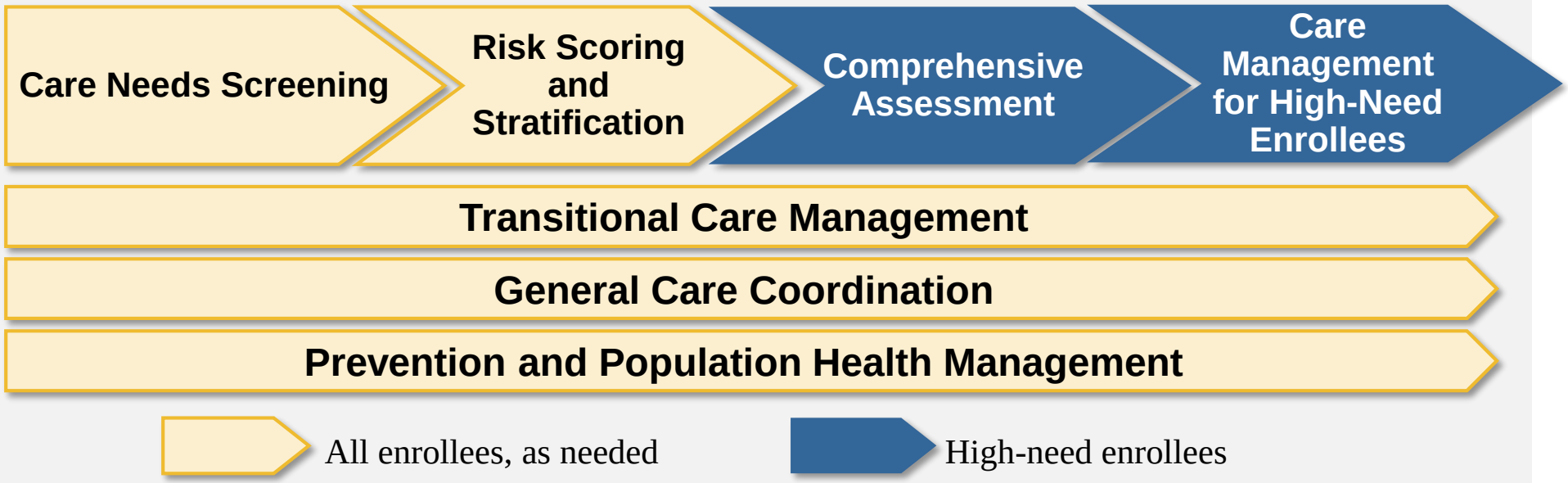
- Transition 1.6 million Medicaid beneficiaries to managed care
- 4 statewide MCOs, 1 regional Provider Led Entity.
- Standard plans roll out in 2 regions in November and 4 regions in February
- Tailored plans in 2 years
- Use of 1115 waiver with CMS to enhance and study design elements

Core Design Features

- Coordinated care management
- Integration of physical, behavioral, and social health
  - Standard plans
  - Tailored plans
- Move towards value based arrangement
- Statewide quality strategy

Primary Care Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate, local care management

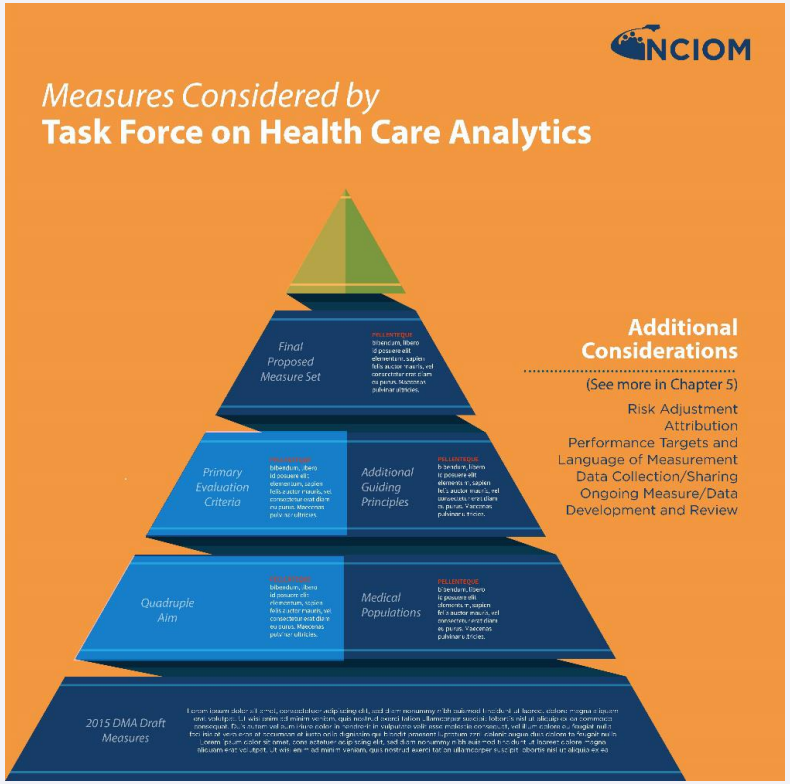


- **PHPs must also implement processes to identify priority populations, including:**
  - Children and adults with special health care needs*
  - Individuals in need of long term services and supports (LTSS)
  - Enrollees with rising risk
  - Individuals with high unmet resource needs
- **AMHs are required to use methods that identify priority populations "to the greatest extent possible"**

**Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

Quality Strategy

- NCIOM Task Force on Health Care Analytics
- Process to identify from over 300 measures the most important for the Medicaid quality strategy.
- Principals included
  - Harmonization
  - Importance
  - Feasibility
  - Usability
- Quadruple Aim orientation



AMH Tiers

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans**: practices will need to interface with multiple PHPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

AMH Payments
(paid by PHP to practice)

- **PMPM Medical Home Fees***
  - Same as Carolina ACCESS
  - Minimum FFS payment floor

Tier 3

- PHP delegates primary responsibility for delivering care management to the practice level
- Practice requirements: meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities
- **Single, consistent care management platform**: Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 PHP contracts

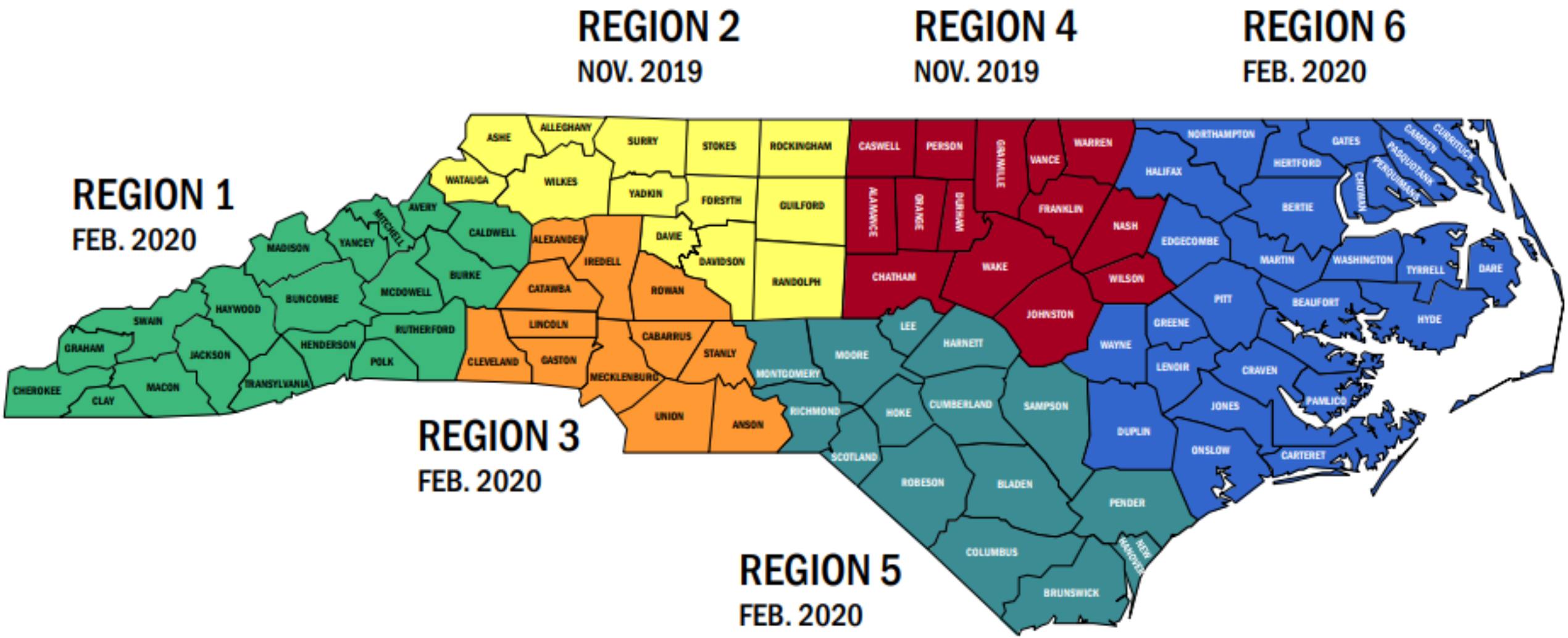
AMH Payments
(paid by PHP to practice)

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum FFS payment floor
- **Additional PMPM Care Management Fees***
  - Negotiated between PHP and practice (i.e., no floor)

Tier 4: To launch at a later date

**Note: Medical Home Fees and Care Management Fees will commence once the practice has contracted with a PHP and no earlier than Nov. 2019*

NC Medicaid Managed Care Regions and Rollout Dates



5 plans

- Blue Cross Blue Shield of NC
- UnitedHealthCare of NC
- Wellcare of NC
- Amerihealth Caritas NC
- Carolina Complete Health (Regional Provider Lead Entity Regions 3 and 5, partnership with NCMS, NCCHCA, Centene)

Challenges

- Provider information and education (**shift to manage care**)
- Beneficiary information and education
- Networks (and changing networks)
- Negotiation and contracting with 4 (or 5) insurers rather than 1
- Navigating 4 (or 5) care management programs
- Patient attribution
- One statewide Medicaid formulary!!!
- Centralized/Uniform credentialing!

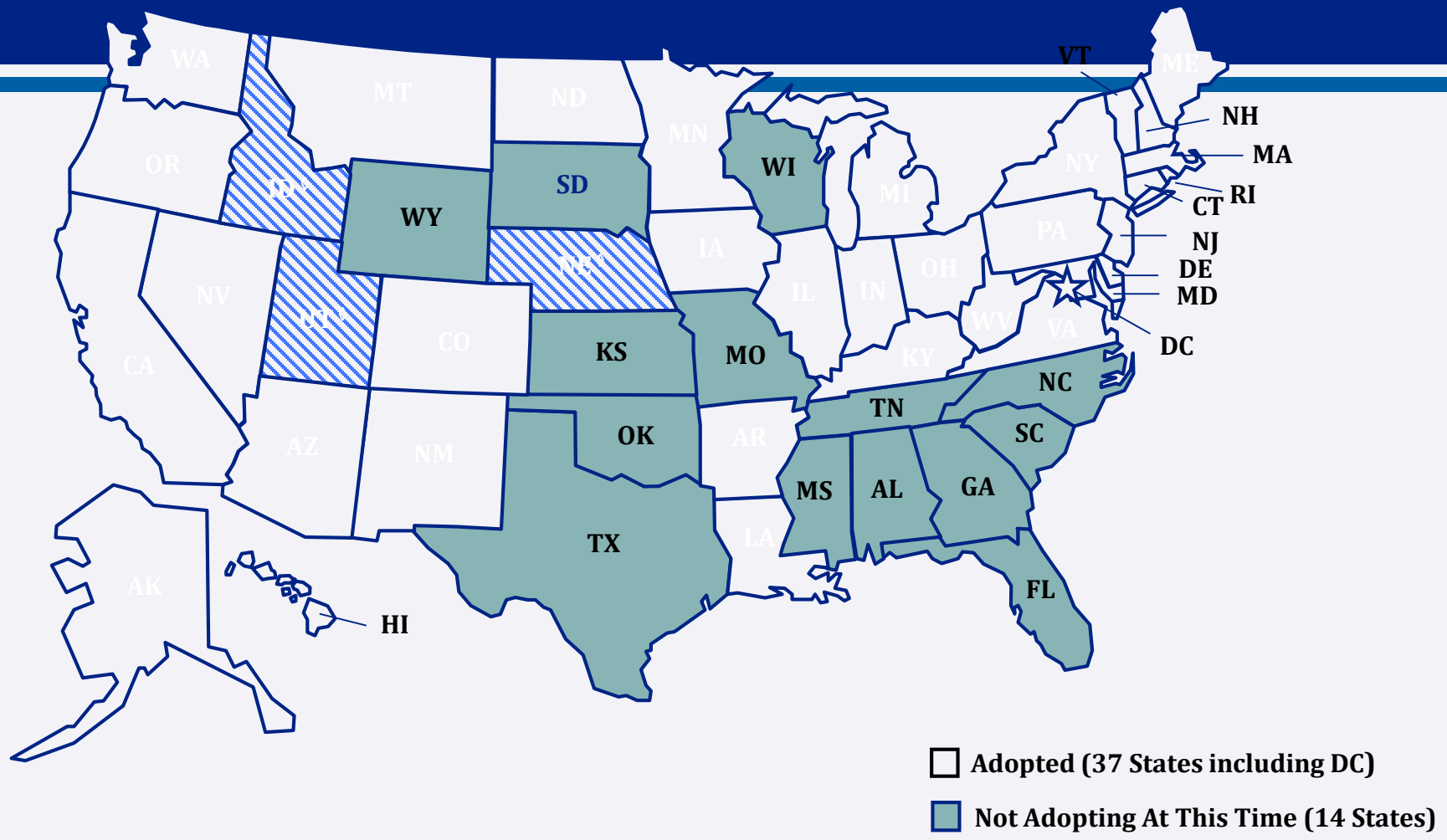
What is Medicaid Expansion?

- Under the ACA and based on supreme court ruling, states have the option to expand Medicaid to adults with incomes less than 138% of the FPL that don't already qualify under other criteria.
- The federal government originally paid 100% of cost, decreasing to 90% in 2021 and thereafter.
- About 500,000 North Carolinians would qualify for Medicaid under expansion. Some already have insurance through the exchange.

Medicaid Expansion

- Unlikely to decrease cost
- Shift in cost
  - From consumers and health systems to (mostly) federal government
- Improved access
- Improved health
- Health insurance as an extreme poverty prevention program
- Jobs program

Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. ◊Expansion is adopted but not yet implemented in ID, NE, and UT. (See link below for additional state-specific notes).
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated May 13, 2019.
https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

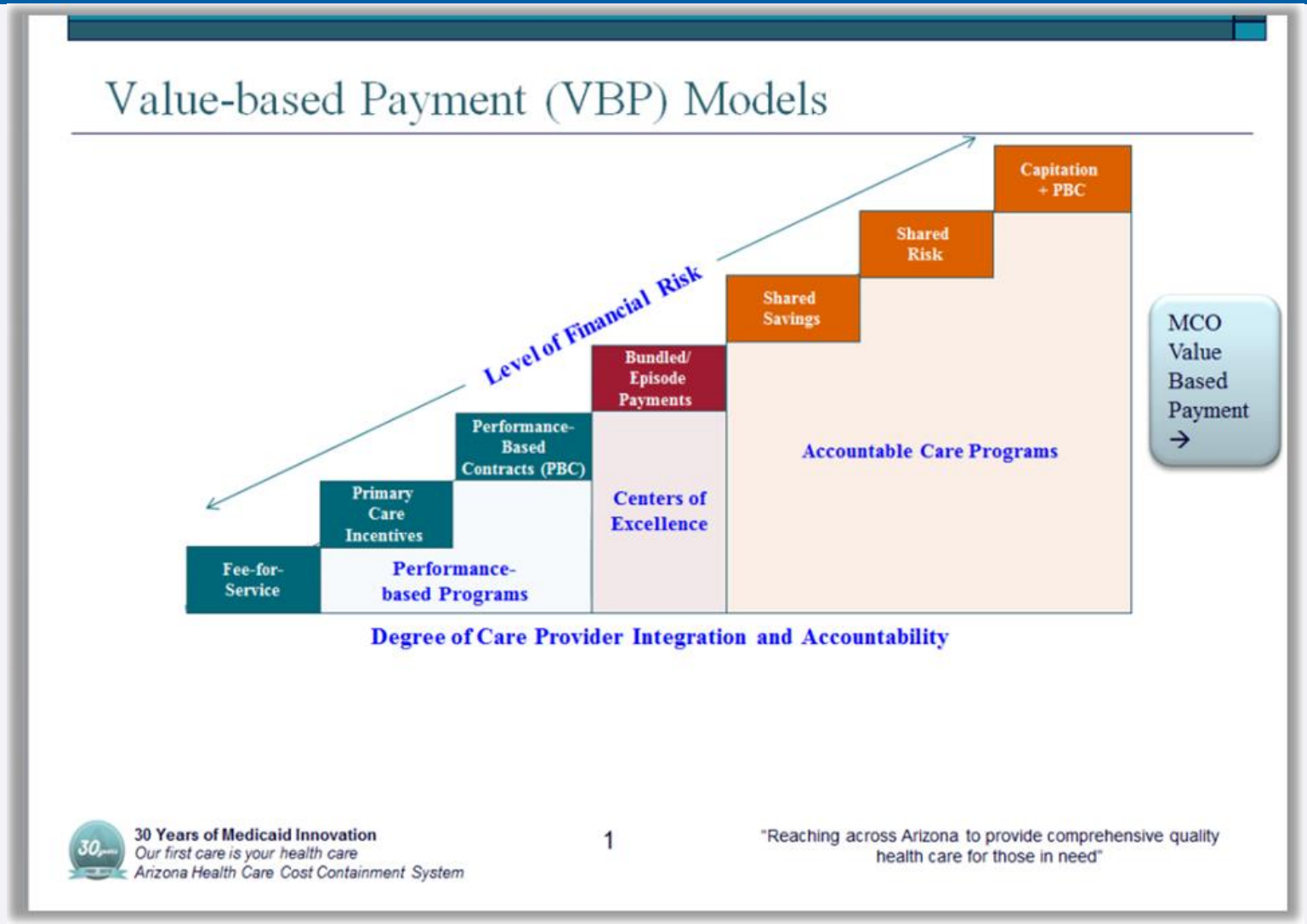
Why Not Expand Medicaid?

- Increase in cost to taxpayers (true, but which tax payers?)
- Concern about stress to system; a system in transition
- Concern about a bloated system
- Concern that the federal government will repeal the ACA or change its obligation of state match (sunset clauses).
- Ideological opposition to reliance on government, a welfare state, disincentives to work, etc.

Current Status

- HB 655 – NC Health Care for Working Families
  - Introduced by Republicans
  - Work requirement
  - Premiums (up to 2% of household income)
  - Heard in the house, sent to committee
- HB 5/SB 3 – Close Health Insurance Coverage Gap
  - Introduced by Democrats
  - Never heard

Value Based Care



Move Towards Value

- 30 Medicare ACOs (includes bundled payments, MSSP, and comprehensive care for joint replacement)
- Medicaid reform
- Blue Premier contracts with 5 health systems
  - Goal of two sided risk contracts for at least 50% of beneficiaries by 2020 and all beneficiaries will be in in alternate payment models within five years.
- Other private insurers (United, Cigna, Aetna)
- Blue cross and Medicaid will rapidly drive the move towards value.

Key Ingredients

- Large portion of patients to transform practice
- Large enough entity to bear some risk
- Adequate data and reporting infrastructure
- Emphasis on quality
- Emphasis on patient experience
- Care management
- Integration or at least adequate access to behavioral health
- Staff skilled in population health and quality improvement

Move to Value

- Is this a euphemism for capitation? How is this different from managed care of the 80's?
  - Quality is a bedrock of payment---not simply decreased cost
- What will this look like for the provider?
  - Transitions are difficult
  - Increased support for care management/disease management/population health
  - Productivity should not be measured by in person visits. New role for virtual visits (synchronous and asynchronous).

Social Determinants of Health

- Medicaid Healthy Opportunities portfolio
- NCIOM Task Force on Accountable Care Communities

Healthy Opportunities

- Standardized Screenings (Medicaid +)
- Care Management (Medicaid, some private, some Medicare)
- Enhanced payment opportunities for PHPs (health related services in MLR and use of in lieu of services) (Medicaid)
- NC Care 360 (All)
- Regional Pilots (Medicaid)
- **Priorities: Food security, transportation, housing stability, interpersonal violence**

Standardized Screening

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically and emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally		

NC Care 360

- Partnership of NC DHHS, FHLI, United Way, Unitus
- Shared public utility, public facing, supported by call center
- Curated resources to address unmet social needs
  - Generate referrals, close referral loop, promote care coordination, and track outcomes
  - Ability to connect to other community and service providers – No Wrong Door
  - Shared client record – Patient Journey
  - Community based services providers can use internally to manage their clients

Regional Pilots

- 2-4 multi-county regional pilots (at least one rural and one urban)
- $650 expanded expenditure authority over 5 years.
- Organized by Lead Pilot Entity who will serve as fiscal agent, contracting authority/purchaser of services. Will need to build partnerships between providers of services (CBO's, Health care) and PHPs.

Overview of Approved Pilot Services

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Pilots will not be required to offer all approved services.

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)
- Short-term post hospitalization housing

Food

- Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

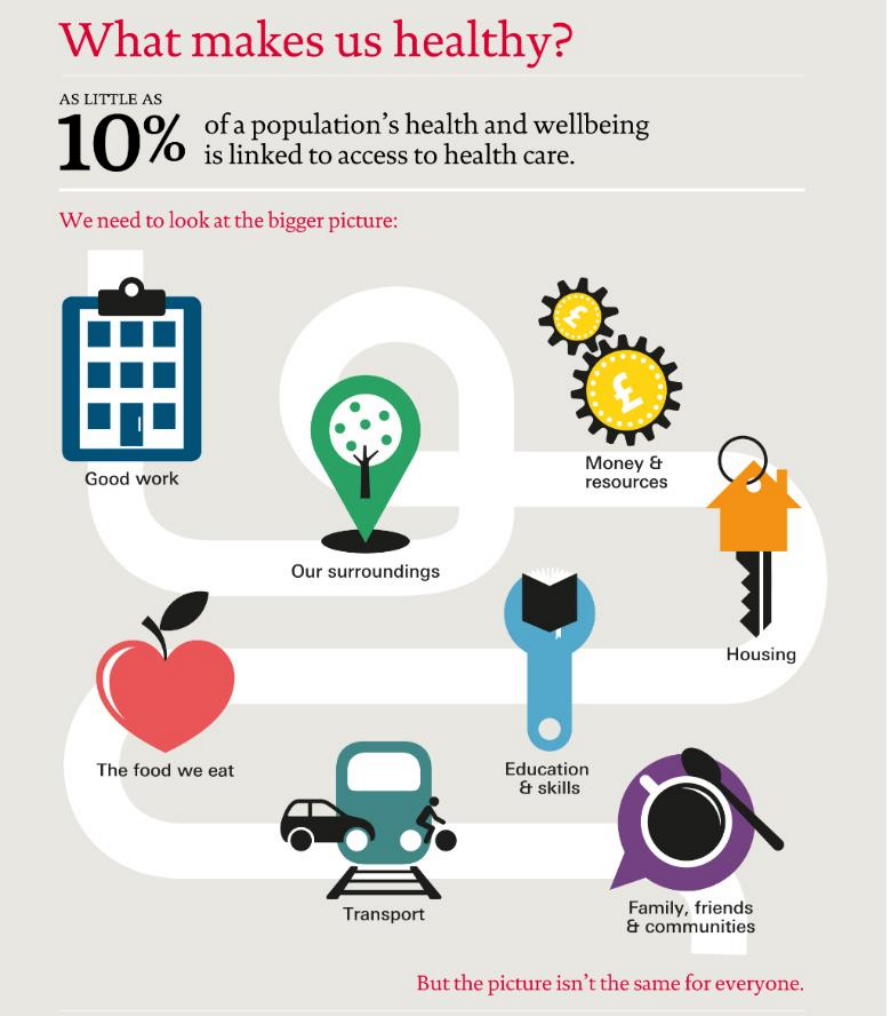
ACC Task Force

- Co-Chairs: Secretary Mandy Cohen, Mr. Reuben Blackwell, Dr. Ron Paulus, Mayor Miles Atkins
- Funded by The Duke Endowment and Kate B. Reynolds Chartable Trust
- 12 meetings through 2018.
- Task force: 53 members, broad constituencies: health, health care, faith, transit, housing, food, faith, wellness

Public Health 3.0

US DHHS Public Health 3.0

Model in which **leaders serve as Chief Health Strategists, partnering across multiple sectors** and leveraging data and resources **to address social, environmental, and economic conditions that affect health and health equity.**



Cross-sector Partnerships to Address Barriers to Health

Accountable Care Community model:

- bring together
  - traditional health care with its focus on preventing and treating illness,
  - community-based partners whose focus is on creating the conditions necessary for good health, and
  - those who purchase and pay for health care

www.nciom.org

www.ncmedicaljournal.com

Questions

- Websites: www.nciom.org
  www.ncmedicaljournal.com

- Key contacts:
  - Adam Zolotor, MD, DrPH, President and CEO, NCIOM
    919-445-6150 or adam_zolotor@nciom.org