A Quality Focused, Financially Responsible Approach to Medicaid Reform

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Guiding Principle for Medicaid Reform

A focus on the "triple aim"

- Simultaneously working to…
  - ✓ Improve the health of populations – **quality**
  - ✓ Improve patient engagement – **service**
  - ✓ Reduce per capita costs of health care – **bending the cost curve**

Medicaid Reform in Context

- Medicaid reform is a necessary part of broader health system reforms currently occurring in Medicare and in the private sector
- Must be based on sound policy – no quick fixes appropriate
- Two critical components for meaningful and sustainable reform:
  1. Health care delivery redesign focusing on care coordination, data-driven approaches, and eliminating fragmented services
  2. Payment reform providing incentives for value and quality care instead of service volume

North Carolina Medical Society Position

Key principles in Medicaid reform for the NCMS:

1. Systems for providing medical care must be led by physicians
2. Decisions – clinical and business – must be driven by evidence, consisting of clinical and claims data.
3. Reform must include a risk structure that makes it possible for physicians and other provider entities to participate in the reform process

Therefore, the NCMS advocates reform using Accountable Care Organizations

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ACO Model

Quality and Service

- Physician-led organizations taking responsibility for meeting the health care needs of a population while reducing costs, improving health status, and improving patient experience, engagement, and compliance.

- ACOs improve care coordination and defragment services existing currently in the health care system

- Ensures simultaneous focus on quality and cost, while addressing barriers to care

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ACO Model

Payment Reform

- All taxpayer funds go to care of the patient, not to corporate stockholders
- ACO approach is modeled after Medicare Shared Savings Program
  - "One-sided risk" – rewards for cost savings and quality measures
  - "Two-sided risk" – greater incentive for cost savings and quality coupled with greater cost risk being assumed by ACO
- ACOs should begin with one-sided risk, as in the Medicare Shared Savings Program
- Adequate time is required to manage business risks before assuming two-sided risk or capitation.

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Access to data is essential

- Reform will fail without universal access by ACOs to clinical and claims data
  - Clinical and claims information are essential to population health management and point of care decision making
  - Data must be universally accessible to providers for clinical and business decision making
  - No one single group should control access to this information

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Reform Using Accountable Care Organizations

Managing the risk of capitation

- Sufficient time is required to move from a volume-payment system to a capitated model
  - Providers need time to benchmark quality and financial measures
  - Currently lack access to the necessary data
  - Currently lack access to capital required for infrastructure investments
  - ACOs will require a regulatory environment that ensures they have the tools and resources needed to increase quality and ameliorate the sources of inefficiencies.

Reform Using Accountable Care Organizations

What makes up an Accountable Care Organization?

- ACOs can be comprised of various provider arrangements such as:
  - Providers in group practices
  - Networks of individual practices of ACO providers
  - Partnerships or joint ventures between hospitals and providers
  - Hospitals or health systems employing ACO providers

Reform Using Accountable Care Organizations

ACOs are different than Managed Care Organizations (MCO)

- ACOs simultaneously focus on improving quality and patient service while lowering costs. Evidence-based coordinated medical care for individuals is more efficient and higher quality than adherence to cost-driven corporate protocols.

- ACOs do not limit services categorically; they use clinical knowledge of individual patients with medical evidence to provide only necessary services and improve outcomes for their patient populations.

ACOs in North Carolina

NC ACOs: leading the state in payment reform efforts

Medicare Shared Savings Program ACOs

- Accountable Care Coalition of Caldwell County, LLC (2012)
- Accountable Care Coalition of Eastern NC (2012)
- Cape Fear Valley Health System (2015)
- Carolinas ACO, LLC (2014)
- CaroMont Health (2014)
- CHESS (Catawba Valley Medical Group, Inc., Cornerstone Health Care, P.A., High Point Regional Health System, Regional Physicians LLC, and Wake Forest University Health Sciences) (2015)
- Coastal Carolina Quality Care, Inc. (2012)
- Duke Connected Care (2014)

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NC ACOs: leading the state in payment reform efforts

Medicare Shared Savings Program ACOs (cont)

- Carolina Medical Home Network Accountable Care Organization, LLC (FQHCs) (2015)
- Mission Health Partners (2015)
- Physicians Healthcare Collaborative (Wilmington Health) (2013)
- Pinehurst Accountable Care Network (2015)
- Triad Health Network, LLC (2012)
- WakeMed Key Community Care (2014)
- Coastal Plains Network, LLC (Vidant) (2015)
- Bayview Physician Group (2014)
- Central Virginia Accountable Care Collaborative, LLC (2014)
- Pioneer Health Alliance (2015)

ACOs in North Carolina

NC ACOs: leading the state in payment reform efforts

ACOs with contracts with commercial payers

- Accountable Care Alliance (Wilmington Health and NHRMC) (BCBSNC)*
- Boice Willis Clinic (Cigna)
- Cape Fear Valley Health System (BCBSNC)*
- Carolina Advanced Health (BCBSNC)
- Carolinas Health System (Aetna)
- Cornerstone Health Care, PA (all commercial payers)*
- Key Physicians (Cigna)*
- Novant Health (Cigna)
- WakeMed Key Community Care (BCBSNC)*

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