State

Joint HHS Committee Holds Final Meeting of Interim

The Joint Legislative Oversight Committee on Health and Human Services (HHS) met to conclude its interim work before the “short session” of the General Assembly begins on May 14. Committee members heard updates concerning several ongoing health care service delivery challenges, including: the Medicaid budget shortfall, Medicaid data analysis, proposals to consolidate county public health and social services departments, and information technology systems used to process and pay claims (NC Tracks and NC Fast).

Additionally, the committee unanimously approved its report to the General Assembly. Based on committee and sub-committee hearings held during the interim, the report made numerous policy recommendations and proposed five new pieces of legislation to be considered during the short session.

Medicaid Shortfall:
The state faces a potential Medicaid shortfall of between $120 million and $140 million. New claims as a result of implementing the Affordable Care Act, unrealized savings, hardship payments, and cost settlements were cited as culprits. The state Department of Health and Human Services (DHHS) hired Alvarez & Marsal, a global business services firm, to help the Division of Medical Assistance, which oversees Medicaid, to identify and resolve deficiencies in the agency’s financial reporting systems. Alvarez & Marsal has performed similar work for South Carolina and other states.

Medicaid Data Analysis
DHHS Chief Information Officer Joe Cooper explained a new system called NC Analytics, which is basically a data warehouse used to analyze and forecast state Medicaid expenditures. NC Analytics stores current and historic trend information and uses it for general financial forecasting, fraud and abuse detection, and clinical policy analysis and reporting. Sen. Ralph Hise, R-Mitchell, asked if DHHS could use NC Analytics to prevent Medicaid fraud and abuse. Acting Medicaid Director Sandy Terrell said the system examines provider trends and then takes action. Rep. Nelson Dollar, R-Wake, recommended DHHS share its data with Community Care of North Carolina (CCNC) because the organization can “turn the data into savings, population
management and improved outcomes."

**Medicaid Update:**
Nearly 86,000 Medicaid applications are pending processing, said Terrell. She attributed the “unprecedented backlog” to changing rules and procedures, unpredictability and uncertainty following the full implementation of the Affordable Care Act. North Carolina is one of many states struggling under the changes. In addition, while there has been a 24 percent increase in Medicaid cases, there has been just a 4 percent increase in staff. However, Terrell could not quantify in percentage terms how much of the increased Medicaid application backlog was due to federal health reforms when asked by Sen. Tamara Barringer, R-Wake.

**NC Tracks:**
Since going live in July 2013, NC Tracks paid $8.1 billion to providers, processed 159 million claims, and paid 98 percent of claims within 30 days. DHHS said they would address ongoing problems processing crossover payments and customer service through aggressive training and monitoring. Committee members asked whether NC Tracks achieved the savings that were touted when the program was introduced last year. DHHS officials said the program has saved the agency $3 million in contracts it no longer needs and will continue to demonstrate savings as the program matures. In addition, the department has levied $1 million in penalties when service-level agreements with the vendor were not met.

**Purchase of Private Insurance:**
State lawmakers asked DHHS last year to explore the possibility of the state purchasing health insurance for individuals who might be eligible for cheaper health insurance than the cost to be enrolled in the state’s Medicaid, AIDS Drug Assistance and/or disability programs. A similar pilot program was enacted for AIDS Drug Assistance patients and it was on track to achieve a savings of 20 to 24 percent. However, cuts in federal aid ended the program before savings could be realized, said Marjorie Donaldson of the DHHS’ Division of Budget Analysis. Arkansas, Iowa and Michigan have similar programs that are purchased through the medical home model, but Donaldson didn’t provide specifics on the programs or how they fared.

**Consolidating Local Public Health and DSS Departments:**
In 2012, all counties in North Carolina gained authority to restructure their public health and social services departments. Some counties kept the traditional service delivery system, while others contracted services, adopted a regional approach, consolidated governance and administration, and/or drafted county commissioning boards to also operate as their social services board.

Buncombe County was featured as a success story for its approach, which resulted in a three-year savings of $12.4 million and included the following actions:

- Isolating core services and partnering or contracting with others for service delivery.
- Creating a Human Services Support Team to restructure administrative functions across HHS agencies.
Locating to a new building, which contained an integrated in-take lobby area.
Using GIS to map similar client groups across different programs.
Introducing community service navigators to assist clients for public & nonprofit services.

Committee Report Moves Forward:
The committee unanimously approved its report of recommendations, which will be forwarded to the General Assembly when it convenes for the “short session” next month. It contains 32 recommendations made by various subcommittees and five pieces of proposed legislation. “In no way is this the final product,” said Committee Chairman Sen. Hise, R-Mitchell. “This is just the vehicle to make the legislation eligible for the short session. It will still have to go through both chambers of the General Assembly (before becoming law).” Sen. Hise also said the committee report is a list of priorities that define the general legislative direction in the delivery of health care services. However, the full General Assembly would have to consider expansion requests in the recommendations within the context of the entire state budget picture.

Among the chief recommendations are:

- Increase outpatient, crisis stabilization and treatment options for mental health patients other than hospital emergency departments and state psychiatric hospitals.
- Appropriate funds to increase facility-based crisis services at LME/MCOs.
- Expand three-way contracts and the telepsychiatry programs.
- Proposed legislation of interest include:
  - Bill Draft 2013-MGz-141 – This requires DHHS to develop and report on strategies and recommendations for improving the delivery of mental health, developmental disabilities and substance abuse services.
  - Bill Draft 2013-MEZ-100 – This requires additional public posting and notice of State Plan Amendments and requires the submission of a State Plan Amendment to the federal government prior to its effective date.

NC Meets Food Stamp Deadline
HHS Secretary Wos has said that the state has processed over 350,000 food stamp applications, bringing down the total number of pending applications to 375. The USDA has threatened the loss of $88 million to continue administering the program unless the state met the March 31 deadline to erase the backlog. North Carolina has more than 825,000 cases statewide.

Short Session to Begin May 14
With interim committees wrapped up for 2014, lawmakers have begun to focus their attention on the start of the upcoming legislative session. Scheduled to begin May 14, the legislative “short session” falls on even number years and is typically used to make minor budget adjustments. Only bills that have been previously passed by one chamber or are directly related to the state budget are eligible for consideration. Legislative leaders are still in the process of outlining their proposed session agenda but have indicated that they will seek to find revenue to support a statewide teacher pay raise initiative. It is still unclear whether the General Assembly will
consider comprehensive Medicaid reform or put the issue off until the 2015 session. A comprehensive committee schedule is expected to be released soon.

**Federal**

**Truven Names Top 15 Health Systems**
Last week, Truven Health Analytics released its 2014 list of the nation’s top 15 health systems. Mission Health was the only North Carolina Hospital named to the list. Click [here](#) to review the full list. Truven released its 100 best hospitals list in March - click [here](#) to see that list.

**Senator’s New Report Says Hundreds of Thousands Die in Hospitals from ‘Errors and Preventable Harm’**
Between 210,000 and 440,000 Americans die annually from errors and preventable harm at hospitals, according to research cited in a report released late Friday by U.S. Senator Barbara Boxer (D-CA). The report calls such errors “a quiet and largely unseen tragedy.” The report calls on the federal government to incorporate a standard way of reporting medical errors in the next round of regulations for electronic medical records and on Congress to review whistleblower protections for health care workers. Click [here](#) for the Senator’s report.

**Moody’s Reviews Not-For-Profit Hospital Financial Position Expense**
Expense growth continued to outpace revenue growth in the not-for-profit hospital sector in fiscal year 2013, leading to lower operating and cash flow margins for the second year in a row, according a report released last week by Moody’s Investors Service. Also contributing to the decline is an increase in high-deductible health plans, which leave patients with larger bills and hospitals with more bad debt; and a shift from inpatient admissions to lower reimbursed outpatient visits and observation stays, the report stated. Click [here](#) for details.

**Report Lists Top Conditions Associated With Most Hospital Readmissions**
Hospitals working to reduce 30-day readmissions can gain insights from a new federal report that lists the top conditions associated with approximately 3.3 million readmissions in 2011. The report also analyzes how conditions vary depending on insurance coverage. Readmissions in 2011 contributed $41.3 billion in total hospital costs. The study covered Medicare beneficiaries aged 65 and older, and individuals aged 18 to 64 who were privately insured, covered by Medicaid or uninsured. Click [here](#) for the report.

**Researchers: ACOs May Need Better Incentives**
Harvard researchers found that one-third of those on Medicare assigned to accountable care organizations (ACO) in 2010 and 2011 weren’t assigned to the same ACOs in both years, according to a study published last week in JAMA Internal Medicine. The patients assigned to different ACOs tended to be in high-cost categories, such as those with end-stage renal disease, disabilities and Medicaid coverage. Researchers also found that 66.7 percent of visits with specialists were
provided outside the assigned ACO. The findings suggest that ACOs might need better incentives and more ways to improve care efficiency. Click here for more information.

**Top CMS Officials Outline Agency's Strategies**
In a JAMA article published last week, the top Centers for Medicare and Medicaid Services (CMS) administrators outlined their goals in testing a variety of payment reform initiatives, including ACOs and reform efforts with the states. If you want to get a good idea of where CMS is headed, this is a must read. Click here.

**Report: Rural, Urban Hospitals Face Very Different Challenges**
It's no surprise that the challenges facing rural and urban hospitals are markedly different. A new report from the Centers for Disease Control and Prevention (CDC) demonstrates just how different. For example:

- A higher percentage of inpatients in rural hospitals were aged 65 and over (51%) compared with inpatients in urban hospitals (37%).
- The average number of diagnoses for rural and urban inpatients was similar, as was the average length of stay.
- 64 percent of rural hospital inpatients, compared with 38 percent of urban hospital inpatients, had no procedures performed while in the hospital. Click here for the full report.

**Study: Rural, Urban Hospitals Have Comparable Outcomes**
Rural hospitals are equal to their urban counterparts in care quality, patient safety and outcomes, and their emergency departments are more efficient and less expensive, according to a study released last week by iVantage Health Analytics. Click here for the report.

**Ambulance Services Targeted for Fraud**
HHS has identified ambulance service as one of the biggest areas of overuse and abuse in Medicare -- companies billing millions for trips by patients who can walk, sit, stand or even drive their own cars, according to new reports. “It’s a cash cow,” said Assistant U.S. Attorney Beth Leahy, who has prosecuted six ambulance fraud cases. “It’s basically like a taxi service except an extremely expensive one that the taxpayers are financing.” Click here for the story.

**Medicare Paid Chiropractors about $500 Million in 2012**
Almost half a billion Medicare dollars went to chiropractors in 2012, according to a Forbes review of the $77 billion in provider payments released by CMS earlier this month. In the column, the author argues that Medicare shouldn't cover chiropractic services. Click here.

**Physician House Calls Coming Back for some Services**
Physician house calls are making a comeback, particularly as part of hospitals' palliative care programs, according to a report last week in the NY Times. Patients would rather be at home, and palliative, in-home care teams can often cost less than expensive return visits to a hospital. Palliative care teams can also improve the quality of care. Click here for the report.
UnitedHealth, Aetna Give Views on Insurance Exchanges
The nation's two largest insurers, UnitedHealth and Aetna, are giving their perspectives on how the new insurance exchanges are working for them. So far, it appears generally positive. Click here for Aetna's CEO summary. Click here for UnitedHealth's take.

Big Medicaid MCO Touts Rapid Growth
Centene Corporation – one of the nation's largest Medicaid managed care companies (MCO) – last week touted double-digit revenue growth, and said that about 39,700 people have enrolled in and paid premiums for qualified health plans (QHPs) the company is offering through the exchanges in nine states. However, the insurer still expects to have about 70,000 paid enrollees by the second business quarter. Click here for their financial summary.

CO-OPs Enroll more than 400,000 People
More than 400,000 people have enrolled in the nonprofit health insurance cooperatives called CO-OPs, created by the Affordable Care Act to sell QHPs through state health insurance marketplaces, the National Alliance of State Health CO-OPs announced last week. There are currently CO-OPs in 23 states, and three additional states expect to offer them next year, the alliance said. Click here for their report.

CBO Lowers Estimate of Medicaid Costs to States
The Congressional Budget Office (CBO) has reduced by one-third its estimate of how much more states will spend on Medicaid in the coming decade because of the Affordable Care Act. In early February, the budget office estimated that state spending on Medicaid and a related program for children would be $70 billion higher from 2015 to 2024 because of the law's coverage provisions. In a new report, the budget office puts the cost at $46 billion. Click here for the CBO report.

10 Major Medicaid Trends Outlined
Major changes are underway for Medicaid as states work to reduce their financial exposure and increase quality outcomes. A new report from LifeHealth Pro outlines the 10 most significant trends in Medicaid reform. Click here and here for the two-part series.

Administration Targets Fixed Benefit Plans
The Obama administration is quietly trying to stamp out some of the skimpiest health plans, a decision that industry officials say could trigger yet another wave of cancellation notices, according to at least one major health plan. The administration is targeting a type of coverage called fixed benefit or indemnity insurance, which give patients a fixed sum of money whenever they visit the doctor or require a stay in a hospital. Click here for the story. Click here for the letter to HHS from Assurant Health.

Some Democratic Candidates Cozying Up to Affordable Care Act
Something must be going right for Affordable Care Act if Democratic candidates are becoming more vocally supportive just six months until the election. Candidates for governor and senator
in numerous states are airing commercials that put a positive spin on the health care law. Click here for the NY Times story.

**CMS Publishing Inpatient Psych Quality Scores**
CMS last week announced for the first time that quality measures from inpatient psychiatric facilities will be publicly reported on its Hospital Compare website. Hospital Compare now has data from 1,753 inpatient psychiatric facilities on patient care for the period of Oct. 1, 2012 through March 31, 2013. Click here for further details.

**CMS Takes Position on Medicare Advantage and Sequestration Cuts**
CMS seems to be supporting hospitals in a long-standing dispute over whether Medicare Advantage plans may pass along sequestration pay cuts to providers, according to a CMS letter last week to the American Hospital Association. CMS Administrator Marilyn Tavenner said the agency cannot get involved in contract disputes between plans and providers, but she clarified a key policy position. Click here for the letter.

**National Health Expenditures up 6.7%**
A report by the Altarum Institute's Center for Sustainable Health Spending last week revealed spending on health care reached a seasonally adjusted $3.05 trillion in February, and expenditures increased by 6.7 percent over the previous year. Physician and clinical services accounted for 20 percent of total health spending, while hospital expenses accounted for 32 percent and prescription drugs for 10 percent. Click here for details.

**Health Care Mergers and Acquisitions Hit New High**
Health care mergers and acquisitions (M&A) are hitting a new high, according to business analysts. Most of the M&A activity has occurred in the pharmaceutical industry. Click here for CNN’s summary.

**FDA Issues Warning on Autism Products and Therapies**
The U.S. Food and Drug Administration (FDA) issued a warning last week that several companies are making false or misleading statements about products or therapies that claim to treat or cure autism. The so-called treatments, such as “chelation” therapy, or mineral treatments, carry significant risks, the FDA says. Click here for the FDA announcement.

**Scientists Creating Largest Patient Medical Record Database**
Government-funded scientists have begun collecting and connecting together terabytes of patient medical records in what may be one of the most radical projects in health care ever attempted, according to press reports last week. The data — from major hospital centers across the country — include some of the most intimate details of a life: vital signs; diagnoses and conditions; results of blood tests, X-rays, MRI scans and surgeries; insurance claims; and, in some cases, links to genetic samples. Click here for the story.

**FDA Proposes Regulations on E-Cigarettes**
After years of planning to control electronic cigarette use, the FDA last week proposed its first regulations on such devices, while also including other tobacco products such as some types of cigars, pipe tobaccos and hookahs. The proposed measures would prohibit the sale of e-cigarettes among individuals younger than age 18 as well as require manufacturers to gain FDA approval for their products. The proposal doesn’t contain any marketing restrictions. Click here for more from the FDA.

**Children Given Behavioral Health Drugs**
An estimated 7.5 percent of 6- to 17-year-olds, or about 3.2 million children, were given prescription drugs for treatment of behavioral or emotional problems in 2011, according to a CDC report released last week. Children covered by Medicaid or the Children’s Health Insurance Program were more likely to be prescribed such medications than those with private insurance or no insurance. Officials also found that boys had higher prescription rates than girls. Click here for the details from CDC.