State

**Joint Oversight Committee Begins to Look at Method State Uses to Pay for Medicaid**

Steve Owen, an analyst from the Legislative Fiscal Research Division, presented a two-part series about how the state pays Medicaid providers.

This presentation focused on payments to health departments, physicians, skilled nursing facilities, and drug and dispensing fees and payments, as well as payments to hospitals and LME/MCOs.

Committee members discussed the possibility of eliminating the state’s participation in federal drug rebate programs; ending supplemental payments to state-supported hospitals such as UNC and ECU; pharmacy payments; drug costs; and physician provider payments.

No legislative action was taken.

The presentations were part of a larger strategy by the committee and the Fiscal Research Division to shift the shape and tenor of health and human services policy and budgeting decisions from paying for services to investing in better outcomes.

**PED Amends Work Plan to Study County Social Service Departments**

The Joint Legislative Program Evaluation Oversight Committee approved a motion to amend the Program Evaluation Division’s (PED) 2013-2015 work plan to authorize an evaluation of county departments of social services administration of the North Carolina Medicaid Program.

Committee Co-Chairman Rep. Craig Horn, R-Union, prompted the request, as part of legislation (Senate Bill 114) requiring a person who has primary custody of a child
receiving subsidy payments to cooperate with county child support services programs as a condition of receiving child care subsidy payments.

The PED study will examine how counties administer Medicaid eligibility. The Program Evaluation Division will study a random, representative sample of the state’s 100 county social services agencies based on population size and rural vs. urban. “We will let you know if there are efficiency problems,” said PED Director John Turncotte. “If so, we will let you know the scale. If counties are efficient, we will let you know how efficient they are.”

In addition, Turncotte said, the PED team will review variations in procedures and processes, benchmarks, as well as best practices in North Carolina and other states. PED staff will then present findings and make recommendations for administration and legislative action.

A preliminary report will be submitted to the Joint Legislative Program Evaluation Oversight Committee in June and a comprehensive report will be submitted to the Joint Oversight Committee on Health and Human Services and the Fiscal Research Division in January 2016.

**Joint Oversight Committee Considers Partnership with Pew Charitable Trust**

The Joint Appropriations Committee on Health and Human Services considered a proposal to partner with Pew Charitable Trust and the MacArthur Foundation (Pew-MacArthur) to evaluate the efficiency and effectiveness of state health and human services programs.

“Everybody wants to make strategic choices, recognizing that you have limited funds given to you through taxpayer dollars,” said Gary VanLandingham, director of the Pew-MacArthur program. “Budget documents don’t tell you what programs are out there or how well those programs are doing. This provides a private sector analysis of our investment choices and whether they are the best buys.”

Should North Carolina participate, the initial study could focus on programs that serve low-income, pregnant women and children from birth to age five.

No legislative action was taken.

**Senate Program Evaluation Considers Private Health Analytics**

The Senate Program Evaluation Committee met to review a presentation by SAS regarding the potential use of the company’s health analytics framework.

The presentation came as a result of Committee Co-Chairman Sen. Fletcher Hartsell’s (R-Cabarrus) interest in using data and analytics to guide the state’s health and human
services program and budgeting decisions.

“There is value in the data because it can tell us where we’ve been, where we are going, and how we can make changes to or improve where we’re going,” Hartsell said.

No legislative action was taken.

**House Health Committee Approves Bill Allowing LME/MCO’s to Oversee Substance Abuse**

The House Health Committee gave a favorable report to House Bill 119.

Sponsored by Rep. Craig Horn, R-Union, the bill mandates the integration of publicly-funded substance abuse treatment programs into the state’s existing community-based mental health service delivery system managed by LME/MCOs.

In addition, the legislation directs the State Division of Mental Health/Developmental Disabilities/Substance Abuse Services to improve its data collection and tracking of long-term health outcomes of substance abuse treatment programs and services.

The transition would take place over three years, from 2016 to 2019.

The bill came as a result of a recent Legislative Program Evaluation Division report that found that the state’s three Alcohol and Drug Abuse Treatment Centers operate with a high degree of autonomy, resulting in operational and treatment differences. As a result, LME/MCOs had no financial incentive to manage and/or restrict utilization of ADATCs. Nor did they have an incentive to invest in expanded community-based treatment options that would serve as a substitute for ADATC services because the state pays for those services.

“This bill does not reduce dollars spent on treatment,” Horn said. “It allows LME/MCOs to spend dollars where they are most needed. By consolidating this, we will get a better handle on the challenges and efficiencies to better utilize every available dollar and every available bed.” Two representatives from the provider community, a staffer from the state Department of Health and Human Services (DHHS), and a LME/MCO representative spoke to the bill, in response to Rep. Susan Martin’s, R-Wilson, request for public feedback.

Dale Armstrong, director of State-Operated Facilities which oversees the treatment centers, said the agency supported the bill, but had significant concerns regarding implementing the transition plan.

“The 196 beds the ADATCs represent are a significant, vital resource in our continuum of care,” Armstrong said. “Back in the mid-2000s, we significantly reduced the number of
beds in state hospitals, recognizing that the ADATCs could absorb that capacity.”

Armstrong urged lawmakers to consider whether passing the bill and implementing the plan would result in a significant increase in the number of patients who are backlogged or go to hospital emergency departments for care.”

Lisa Wainwright, executive director of East Carolina Behavioral Health, said the LME/MCOs were in favor of the transition. “The General Assembly has entrusted us with handling mental health and developmental disability services,” Wainwright said. “Adding substance abuse services to the continuum of care makes a lot of sense.”

**Federal**

"Doc Fix" Deal Has Provider Cuts, CHIP Extension, New Doc Payment System

Senate Democrats seem to be digging in their heals over the House legislation permanently fixing the Medicare physician payment formula (Sustainable Growth Rate - SGR). Leading Democrats say the House package isn't balanced. They are pushing for a four year extension of CHIP. The House bill has only two years. The current payment fix expires April 1. Senate GOP leaders are preparing a "very short term" extension, anticipating that the deal may not be completed until after the Easter recess in mid-April. [Click here](#) to read more about the status of the deal.

- Cuts to providers in the package were limited. [Click here](#) for the 1-page summary of the House deal.
- The most significant changes are how physicians would be paid by Medicare. [Click here](#) for an excellent summary.
- The GOP developed detailed talking points supporting increasing beneficiary costs. [Click here](#).

CMS Releases Stage 3 Meaningful Use Proposed Rule - All Must Comply by 2018

CMS late Friday released the proposed Stage 3 "Meaningful Use" rule for the Medicare Electronic Health Records Incentive Program. The Stage 3 rule proposes to make Stage 3 optional in 2017. Beginning in 2018, however, all eligible hospitals, critical access hospitals and eligible professionals would be required to report on the same eight objectives of meaningful use that incorporate 21 specific measures, many with higher thresholds than in Stage 2. All providers, even those new to the program, would have to meet Stage 3 beginning in 2018. [Click here](#) for the proposed 300-page rule. [Click here](#) for the HHS press release.

- At the same time, the Office of the National Coordinator released a companion rule
that proposes certification criteria, standards and implementation specifications for EHR technology. [Click here for the 430-page rule. [Click here for more details from HHS.

- Meanwhile, members of Congress are urging HHS to fix current problems with Meaningful Use requirements - and there are many. [Click here for their letter.](#)
- CMS last week did explained how eligible professionals can report on clinical quality measures (CQMs) just once to meet CMS requirements for its physician quality reporting system (PQRS), meaningful use electronic health records (EHR) incentive program, and value-based modifier (VM) program. [Click here for details.](#)

**Senators Say Meaningful Use Not Working; EPIC Testifies**
At a Senate health committee hearing on health IT last week, Chairman Lamar Alexander (R-TN) said the government has been too quick to penalize physicians and hospitals for not meeting the goals of the meaningful use. Sen. Sheldon Whitehouse (D-RI) said it’s time for a reboot of the meaningful use program, and said any reboot should include behavioral health homes and nursing homes. A representative from EPIC testified - [click here for their interesting report.](#) [Click here for the concerns raised](#) by the Family Physician association.

**Record Number of Medical School Seniors Match; Big Gains in Primary Care**
A record 16,932 U.S. medical school seniors were matched to first-year residency positions Friday through the National Resident Matching Program, 533 more than last year. A total of 30,212 first- and second-year positions were offered, including more than 600 new first-year positions, half of which were in primary care specialties. Internal Medicine programs offered 6,770 positions, 246 more than in 2014; 98.9 percent of positions filled; Family Medicine programs offered 3,195 positions, 86 more than in 2014; 95.1 percent of positions filled; Pediatrics programs offered 2,668 positions, 28 more than in 2014; 99.5 percent of positions filled. [Click here for all the details.](#) (My daughter-in-law matched with Vanderbilt in Anesthesiology!)

**2016 GOP Budgets Are Tough on Health Care**
While working to find a passable deal on replacing the SGR, Congressional Republicans released their budget proposals for FY16 and the budget committees in both chambers passed their plans. Full House and Senate votes are expected this week. Then they will work to reconcile their two plans into one. Neither plan gives much detail in terms of where Medicare, Medicaid and other health care reductions would be made, but their targets are substantial. Details won’t be available until later this year as Congress works to pass spending bills through September.

- The House FY16 budget plan would reduce Medicare spending by $148 billion and Medicaid and other health care spending by $913 billion over 10 years; repeal the Affordable Care Act; create a block grant program giving states flexibility to tailor the Medicaid program to their communities; and unify the Medicaid and the State

[Click here for all the details.](#)
Children’s Health Insurance Program into a single program. [Click here to see their plan](#). [Click here for the NYT’s take](#).

- The Senate budget plan would adopt the president’s overall Medicare reductions, directing congressional committees to achieve the nearly $431 billion in savings over 10 years; repeal the ACA and provide “reserve funds” to replace it with legislation that “strengthens the doctor-patient relationship, expands choice and lowers health care costs”; and increase state flexibility in Medicaid benefits and administration. Both chambers are expected to consider the plans next week. [Click here to see their plan](#). [Click here for the good WSJ comparison](#) of the House and Senate plans.

**New Study Details Impact of Changing Payment Models on Physicians**

Physician practices are engaging in new health care payment models intended to improve quality and reduce costs, but need help managing increasing amounts of data and responding to the diversity of programs and quality metrics from different payers, according to a study released last week by the RAND Corporation and American Medical Association. Among other findings, physician practices reported making significant investments in their data management capabilities to track and improve performance in alternative payment models. [Click here for the study](#).

**New Medicare ACO Applications Due Soon**

CMS will review the 2016 application process for the Medicare Shared Savings Program (Medicare ACO) during an April 7 National Provider Call. [Click here](#) for the current application process. For more information or to register, [click here](#).

- CMS last week reviewed its new Next Generation ACO in a national webinar. [Click here](#) to see the 47-slide presentation.

**Study: ACA Ignited Fundamental Health Care Shifts**

The Affordable Care Act has energized five fundamental shifts in health care over the past five years, according to a new report by the PwC Health Research Institute. They are a shift in risk away from traditional insurers and onto providers; a renewed emphasis on primary care; an influx of companies to a new health economy focused on innovation; a shift from wholesale to retail health insurance; and an increased role for states in shaping the health care landscape. [Click here for the report](#).

**HHS: More than 14 Million Insured Under ACA**

A new report from HHS found that 14.1 million uninsured adults got insurance since October 2013, when the first open enrollment period for the exchanges began. Another 2.3 million young adults got covered between 2010 and October 2013 by staying on their parents’ insurance plan until age 26, one of the law’s most popular benefits. [Click here](#) for the specifics from HHS.
5 More Common Tests, Practices Targeted as Unnecessary
Indwelling urinary catheters, end-of-life breast and prostate cancer screenings and C. difficile toxin tests are common — but often unnecessary, says the Society for Post-Acute and Long-Term Care Medicine in a report out last week. It’s part of the ABIM Foundation’s Choosing Wisely campaign to list practices and tests that are common, but which aren’t supported as effective or necessary by scientific evidence. The first five came out in September 2013. Click here for the latest.

- Another study in the NEJM says that early scans for back pain in seniors may be a waste of time and money. Click here.

Most Don't Go To Closest ED To Home: Study
Fewer than half of emergency department visits are to the patient's local emergency room, according to a new data brief from the CDC. After analyzing data on ED visits between 2009 and 2010, the analysis found the average visit involved an ED that was located 6.8 miles from the patient’s home even though the nearest ED was on average only 3.9 miles away. Overall, only 43.8 percent of visits were to the ED closest to the patient’s home. Click here for more from the CDC.

Another Cyber Attack Against Major Insurer
A cyber-attack against information technology systems at health insurer Premera Blue Cross may have given attackers unauthorized access to information on members and others who have done business with the organization since 2002, including names, birth dates, Social Security numbers, claims and clinical information, as well as email addresses and bank account information. Click here for an updated announcement from Premera. Senator Patty Murray (D-WA) criticized Premera last week for its response to the attack. Click here.

Medicare: $3.3 Billion Recovered in Anti-Fraud Efforts Last Year
More than $27.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control Program, Attorney General Eric Holder and HHS Secretary Sylvia Burwell announced last week. The government’s health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in FY14. Click here for details.

Report Looks At Impact Court Decision Could Have on Hospitals
The Supreme Court is likely to rule in June on the constitutionality of the federal government providing subsidies to enrollees in health exchanges run by the federal government. A report out last week looked the devastating impact the decision could have on hospitals in 34 states. Click here.