State

State House Lawmakers Pass Medicaid Reform

In a 105-to-6 vote, North Carolina House lawmakers overwhelmingly passed their chamber's Medicaid reform proposal, the 2015 Medicaid Modernization. Here are some key provisions of the plan:

- **Shift to provider-led care** – Provider-Led Entities (PLEs) will be reimbursed a full-risk, capitated – or per enrollee – fee to manage and coordinate the care for at least 90 percent of the Medicaid recipients in all 100 counties in North Carolina. PLEs will be responsible for all administrative functions, including claims processing, appeals, care, and case management. This move will significantly reduce the state’s operational costs. Each PLE must enroll at least 30,000 Medicaid recipients and meet financial requirements set forth by the Department of Insurance.

- **Increased patient access to primary care** – Each patient will select, or be assigned to, a PLE and a primary physician who will manage their overall healthcare and promote wellness and preventive care. This move aims to decrease emergency room visits and improve each patient’s long-term care outcomes.

- **Advisory Committee** – A committee of experts in healthcare will be established to advise the North Carolina Department of Health and Human Services (DHHS) on the development of the federal 1115 waiver application and performance goals.

- **Gradual transformation of program** – Transformation will occur over a period of up to five years, which includes DHHS preparation and successfully obtaining a federal waiver from the Centers for Medicare & Medicaid Services (CMS) that allows North Carolina to implement this bill. The passing of this bill sets the stage for a battle in the coming weeks with the Senate over who should lead and manage reform.
Leaders in both chambers want to transition the state from a fee-for-service to a full-risk capitated health plan. However, Senate lawmakers envision a Medicaid model in which Managed Care Organizations (MCOs) and Provider-Led Entities (PLEs) would compete for patients. There would be three statewide organizations and six regional organizations to tend to the state’s Medicaid needs.

The Senate also wants a separate cabinet-level agency, the Health Benefits Authority, to oversee the Medicaid program with some, but not much input from DHHS. In addition, the Senate expects to start enrolling patients by April 2017.

These differences are large enough to keep budget negotiators at the table for an estimated two to three months. We’ll keep an eye out and report any shifts.

**Budget Negotiations**

The House approved a continuing resolution late Monday that will provide funding for the 2016 State Budget at the current year’s spending levels until Aug. 14. The measure was approved to allow the two legislative chambers time to reach an agreement on a final version of the state’s two-year spending plan. The Senate has agreed to approve the needed legislation prior to the end of the 2015 fiscal year.

**House Health Committee Pushes for Telemedicine in North Carolina**

The House Health Committee listened to a presentation and short demonstration project on telemedicine by Dr. Alan Stiles of UNC Health Systems and Dr. Lou Martin who is the husband of Rep. Susan Martin (R-Pitt, Wilson).

Telemedicine is broadly defined as the “remote diagnosis and treatment of patients by means of telecommunications technology.” This can include the use of video conference, robotics and telephone technology.

Telemedicine is gaining popularity in North Carolina and other states, as it has been used as a way to treat burn victims, patients with severe disabilities, stroke patients, and patients in hospital emergency rooms.

It gives physicians a way to see more patients in less time. The doctors reported that for patients, telemedicine improves access to care and reduces costs by allowing them to receive care in their communities, without having to miss work or school.

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**Federal**

**Supreme Court Re-Affirms Obamacare – What’s Next?**

Now that the Supreme Court ruling in *King vs. Burwell* allows federal tax credits to continue in states where people purchase health insurance through federal exchanges,
mixed reactions are coming from key stakeholders.

- Hospitals and insurers applauded the ruling, focusing on a continuation of patients’ access to care as a positive provision of the Affordable Care Act.

- The five leading health insurers – UnitedHealth, Aetna, Anthem, Cigna and Humana – that are involved in talks of mergers can focus on the next steps that will alleviate financial uncertainty.

- On Capitol Hill, lawmakers are responding and offering new avenues to protect or repeal the Affordable Care Act.

**Key Senator Introduces Rural Hospital Rescue Bill**
U.S. Senator Charles Grassley (R-Iowa) introduced the Rural Emergency Acute Care Hospital (REACH) Act (S. 1648) last week to address the growing problem of rural hospital closures. The legislation establishes a new Medicare payment designation, the Rural Emergency Hospital, to sustain emergency services in rural communities. Rural Emergency Hospitals would provide emergency room and outpatient services, but not inpatient acute care. They would be reimbursed 110 percent of reasonable costs. The new designation is available to critical access hospitals and hospitals located in rural areas with fewer than 50 beds.

**Senate Committee OKs Extension of Rural Hospital Demo**
A five-year extension of the rural community hospital demonstration program was included in the Senate Finance Committee’s executive session last week. The Rural Community Hospital Demonstration Extension Act of 2015 (S. 607), introduced by Sens. Grassley (R-Iowa), Bennet (D-Colo.), Murkowski (R-Alaska), and Moran (R-Kan.), would extend the demonstration program from five to 10 years. The program enables rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement. There are currently 23 hospitals participating in the demonstration. This expansion would allow them to continue providing high-quality care in rural communities.

**Senate Committee Passes 12 Health Care Bills**
Last week, the Senate Finance Committee approved 12 healthcare bills that will be considered by the Senate later this summer. The bills address a wide range of policies, including preventing and reducing improper Medicaid and Medicare expenditures, electronic health records, rural healthcare, and psychiatric care.

**Study: Medicaid Benefits are Comparable to Private Health Insurance**
Medicaid beneficiaries and people with private health coverage fare about the same when it comes to having a regular doctor and receiving high-quality care, according to a new report from the Commonwealth Fund. The analysis, based on the Fund’s latest health
insurance survey, finds that 95 percent of Medicaid beneficiaries who were covered all of 2014 had a regular doctor, and 55 percent said they received quality care. That’s about the same share, if not slightly higher, than people with private coverage.

**CMS Says More Than 70 Million Enrolled in Medicaid and CHIP**

About 12.3 million people enrolled in Medicaid or the Children’s Health Insurance Program (CHIP) between Oct. 1, 2013 and April 30, 2015, according to a report released last week by the Centers for Medicare & Medicaid Services. That translates to an enrollment increase in the programs of 21.3 percent since the start of the first open enrollment period for the Health Insurance Marketplace. More than 70.1 million people were enrolled in Medicaid or CHIP in those states as of April 30, with Medicaid expansion states showing a 28 percent increase and non-expansion states showing a 9 percent increase.

**Report Indicates NIH Alternative Medicine Initiative Is Evolving**

Recently, *The Atlantic* examined how alternative medicine has evolved with many doctors adopting some principles of complementary medicine into their practice. The article suggests that Congress’ establishment of an Office of Alternative Medicine within the National Institute of Health, or NIH, in the 1990s signaled traditional medicine’s acceptance of these alternative therapies.

**Government Increases Scrutiny of Revolutionary New Lab Tests**

As labs and research start-ups grow, the federal government is scrutinizing their relationships with doctors, as well as their payment and billing practices. Medicare and private insurers are having increasing difficulties with paying for these tests, as they multiply faster than they can be tracked.

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