Better Measures and Better Health: Task Force Rationale, Organization and Timeline

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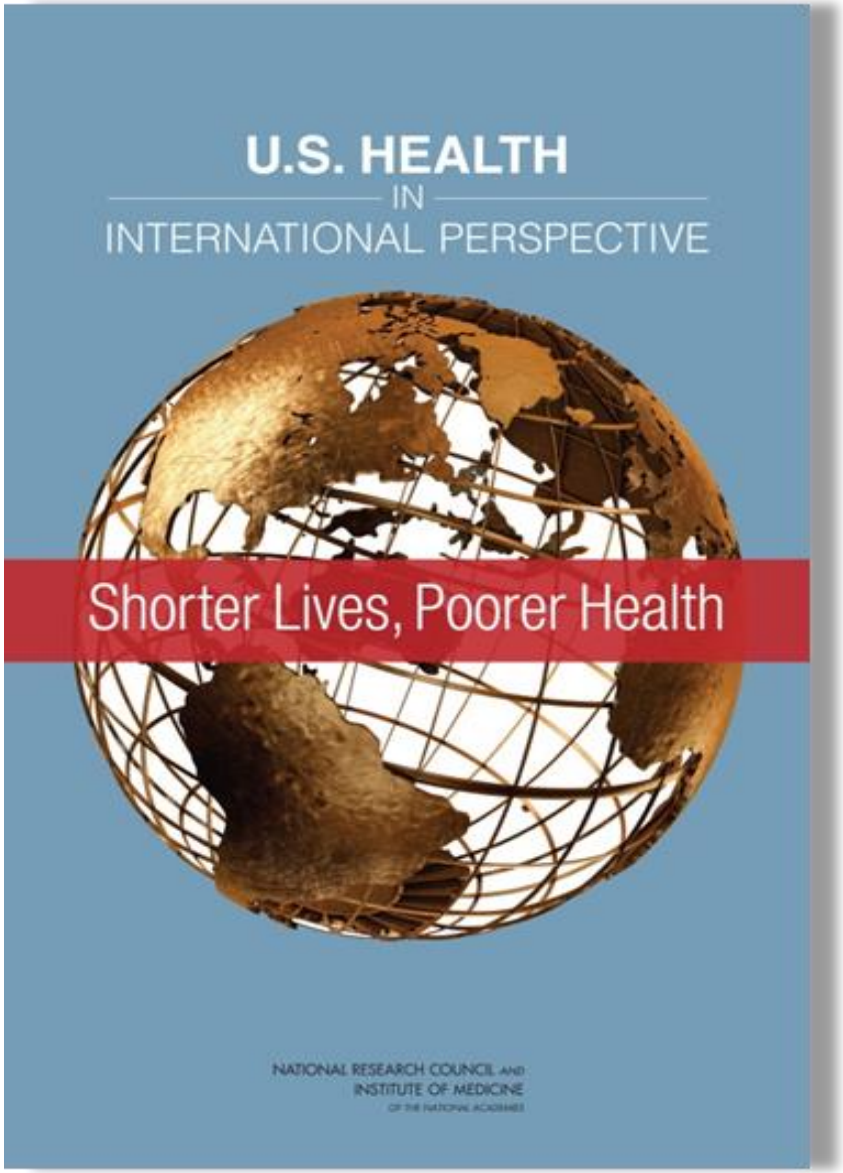
NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

NC Nothing Compares

Objectives

- Environment: North Carolina health outcomes, clinical environment, Medicaid reform process
- Give points of emphasis about Workforce charge/rationale, how Medicaid works
- Describe what we want to be the product of the task force
- Propose how we will get our work done
- Get your input on all of this…



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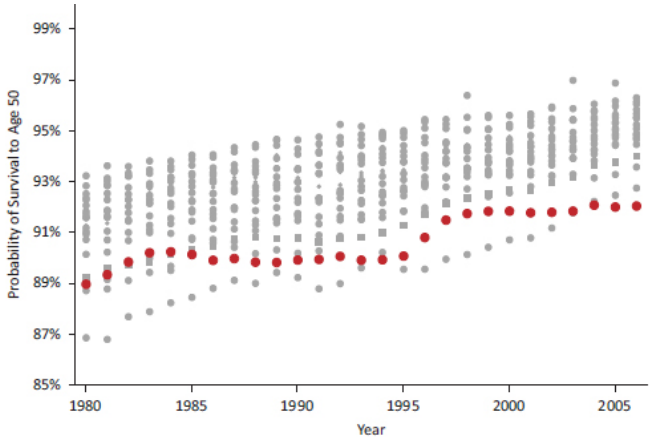

FIGURE 1-7 Probability of survival to age 50 for males in 21 high-income countries, 1980-2006.
NOTES: Red circles show the probability a newborn male in the United States will live to age 50. Grey circles show the probability of survival to age 50 in Australia, Austria, Belgium, Canada, Denmark, Finland, France, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and West Germany.

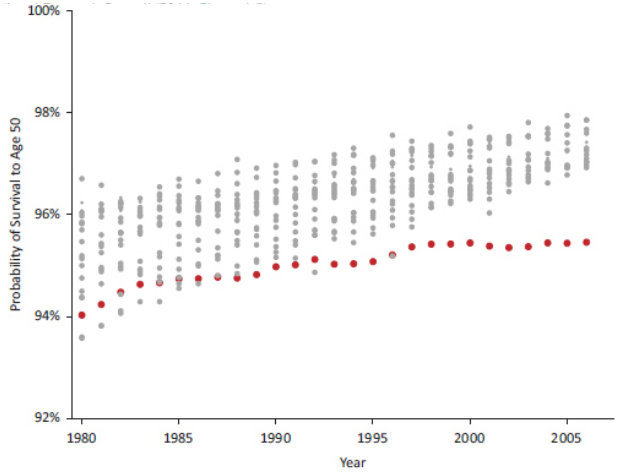

FIGURE 1-8 Probability of survival to age 50 for females in 21 high-income countries, 1980-2006.
NOTES: Red circles show the probability a newborn female in the United States will live to age 50. Grey circles show the probability of survival to age 50 in Australia, Austria, Belgium, Canada, Denmark, Finland, France, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and West Germany.

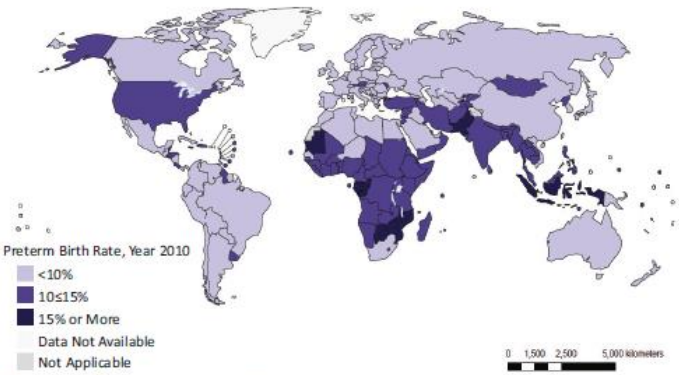

FIGURE 2-3 Global prevalence of preterm births, 2010.
SOURCE: Blencowe et al. (2012, Figure 3).

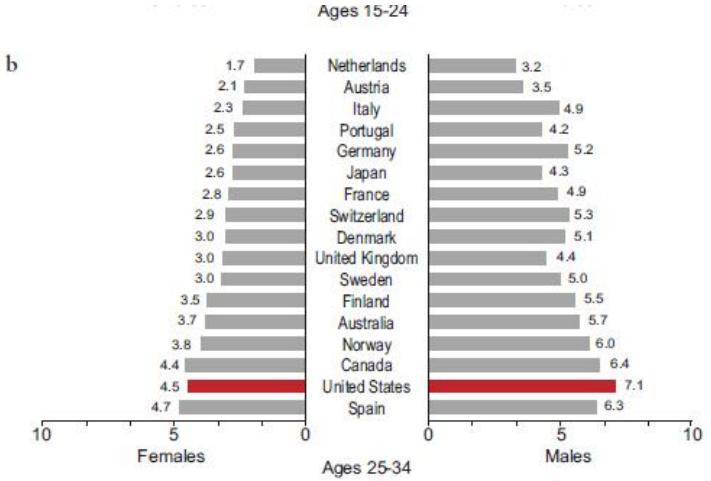

FIGURE 2-10 Self-reported prevalence of diabetes, by age and sex, in 17 peer countries, 2008.
SOURCE: Data from the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (2012), diabetes by country.

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Where does North Carolina rank?

- 1943: 48/48 in unfitness for military duty..
- Today, low 30's/50
  - Above average in immunization rates
  - Worse than average in key risk factors, such as smoking, obesity, and inactivity
  - Below average life expectancy and many disease specific outcomes, especially preterm delivery and infant mortality

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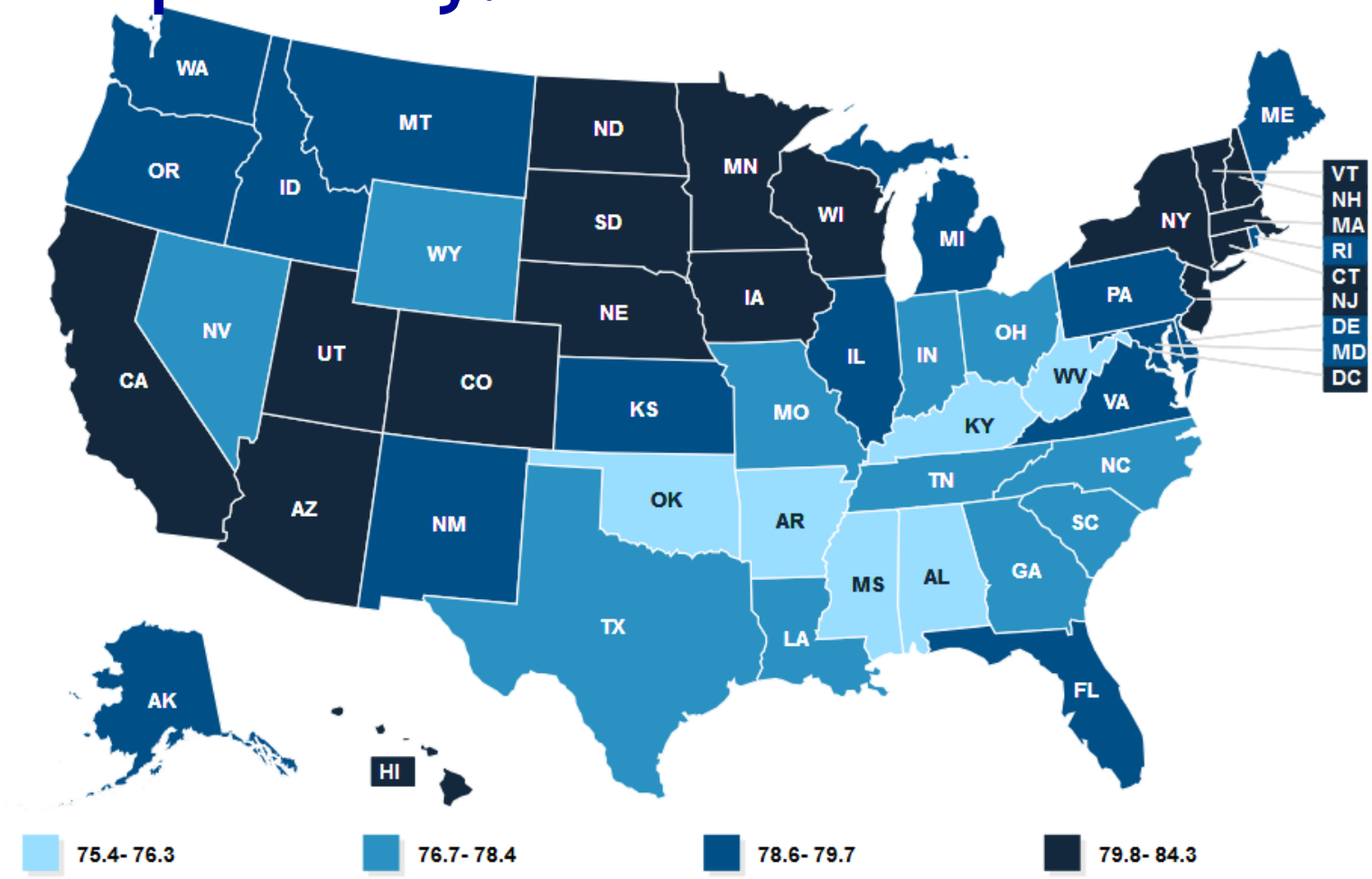
Life Expectancy: NC Ranks 37



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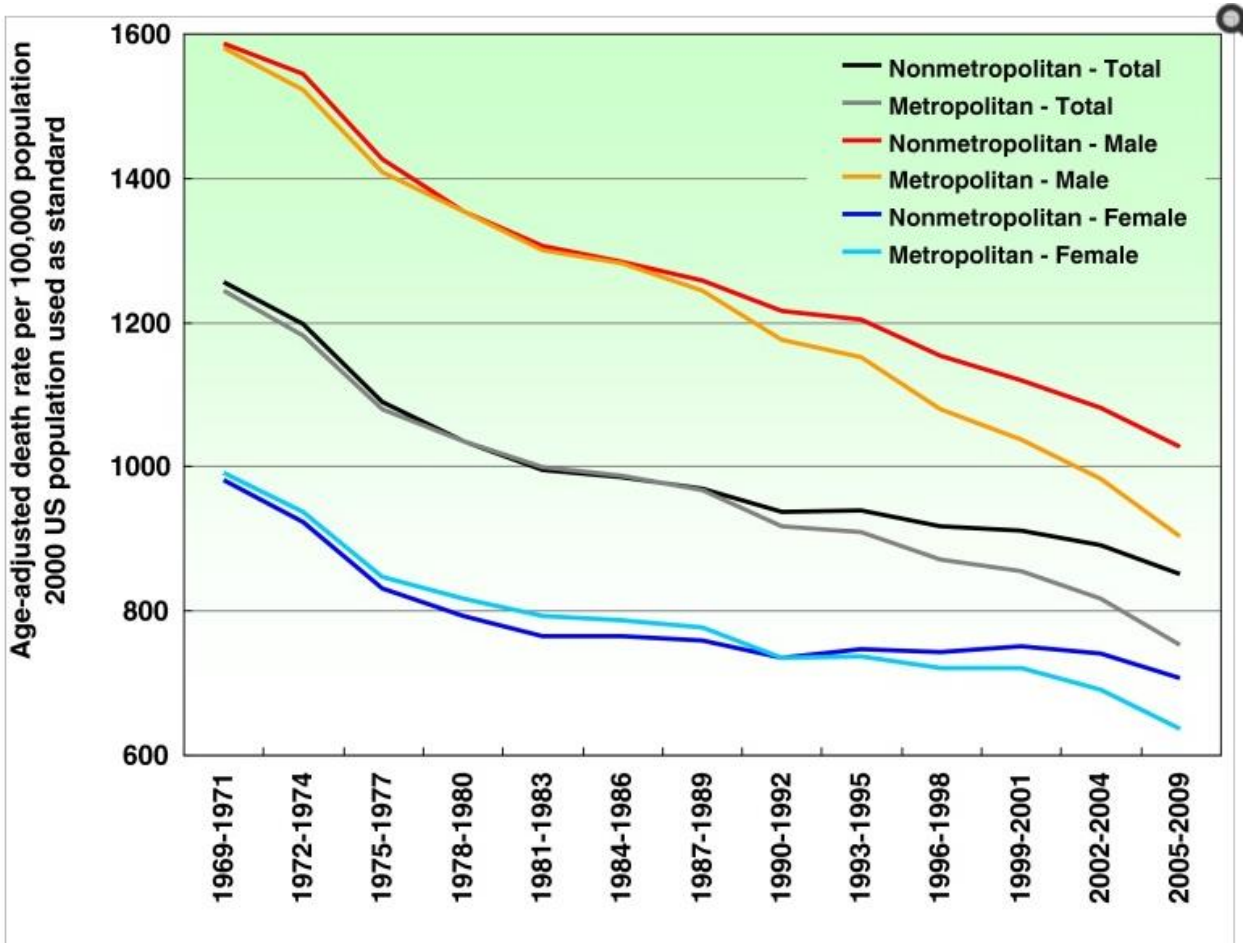
Disparities



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Where does Medicaid fit in?

- 1965: children, pregnant women, disabled, elderly, with gradual development since then
- Federal/State collaboration, where Federal set eligibility, define/finance core benefits, and states adjust/add
- *Comprehensive* services; limits to financial contribution for patients; support of safety net
- North Carolina: 1.8+M, $13.5B: over half of pregnancies and children, long term care
- A leadership role in driving improvement of health of the people

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What does an "entitlement" mean?

Person in Household	2016 100% Federal Poverty Level Minimum to Qualify for ACA Assistance	138% FPL Medicaid Cap (in States that Expanded)	250% FPL CSR Subsidies Cap	400% FPL Premium Tax Credit Cap
1	$11,880	$16,394	$29,700	$47,520
2	$16,020	$22,108	$40,050	$64,080
3	$20,160	$27,821	$50,400	$80,640
4	$24,300	$33,534	$60,750	$97,200
5	$28,440	$39,247	$71,100	$113,760
6	$32,580	$44,960	$81,450	$130,320
7	$36,730	$56,428	$91,825	$146,920
8	$40,890	$61,335	$102,225	$163,560

*Medicaid eligibility is different in states that did not expand Medicaid. Federal Poverty Guidelines are different in Hawaii and Alaska.

NOTE: If your family contained more than 8 people, add $4,160 for each additional person. Note that Hawaii and Alaska use different guidelines. This is unchanged from 2015.

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A Time of Health Care Transformation in North Carolina

- Consolidation of Hospitals, employment of clinicians—but independents remain
- Spread of electronic health records
- Transitions of Leadership
- Insurance Market Changes—Medicare, MACRA

Medicaid Reform Timeline

- Summer 2015: Capitation, Hybrid Model for Insurers; Division of Health Benefits; HIE
- 1115 Waiver selected
- Dually Eligible held out; Mental Health (LME/MCO) integrated after waiver
- 6/1/16: Waiver submitted to CMS
- Little movement until election, then
- NC: new governor, but still republican supermajorities in legislature
- US: Trump administration

Now what?

Block grants/expansion/per capita payments?

A time to set our own destiny…

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What do we have to do together?

Why the North Carolina IOM?

Why You?

- Hospitals, clinicians *and* patients
- QI and Population Health experts
- Different disciplines, payers
- Across the state—regions, health systems
- Medicaid staff
- A wise group…

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What is the Charge?

- Recommend key metrics/specifications to achieve the quadruple aim (better health, better health care experience, better clinician engagement at lower cost) for the populations Medicaid takes care of
- Prioritize measures for North Carolina—and for now
- Focus on Medicaid, but align as much as possible with other insurers
- We advisory to the Secretary of DHHS

How will we prioritize?

- The importance of parsimony
- Potential impact on health of NC
- Benchmarking with other states

We will also need to address…

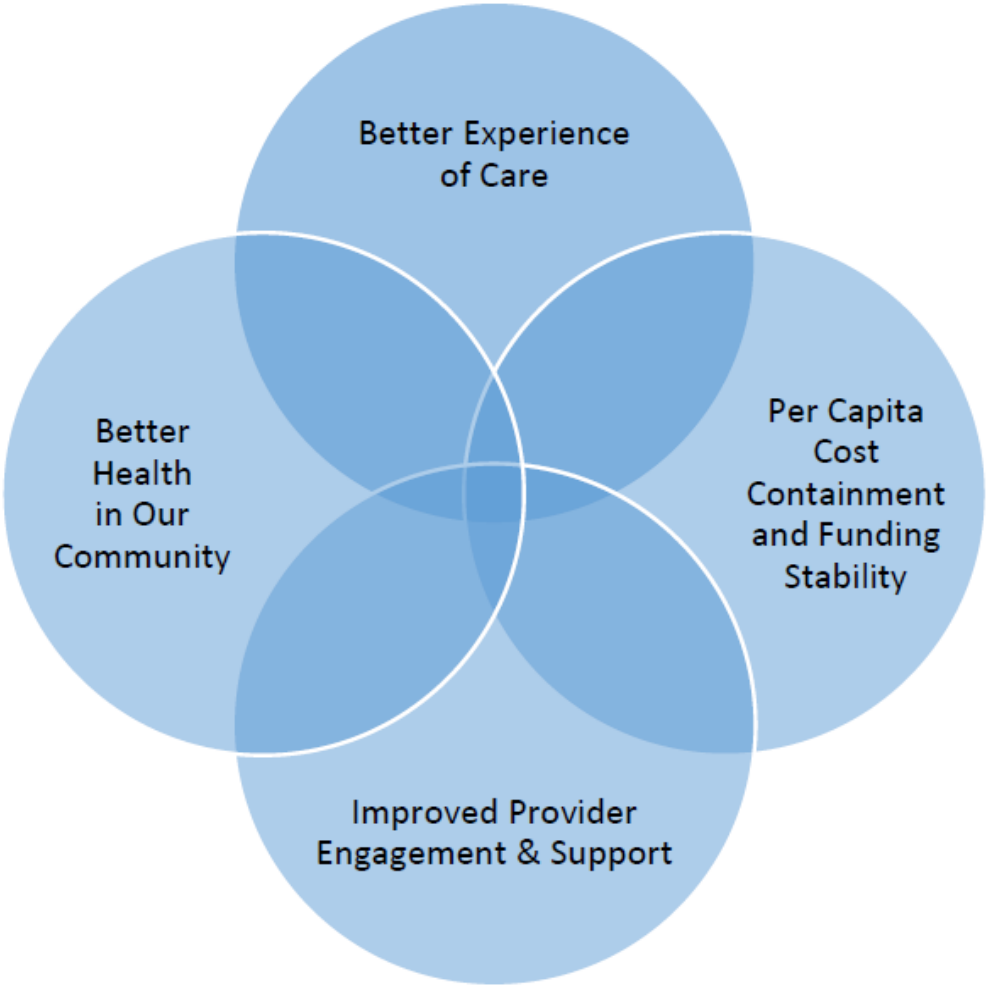
- Measures…and specifications
- Where will the data come from?
- Attribution
- Risk adjustment
- Social Determinants of health

What We Won't Focus On…

- Financing/incentives
- Implementation details
- Evaluation of reform itself

Pesky Questions…

Is the Quadruple Aim just a slogan?



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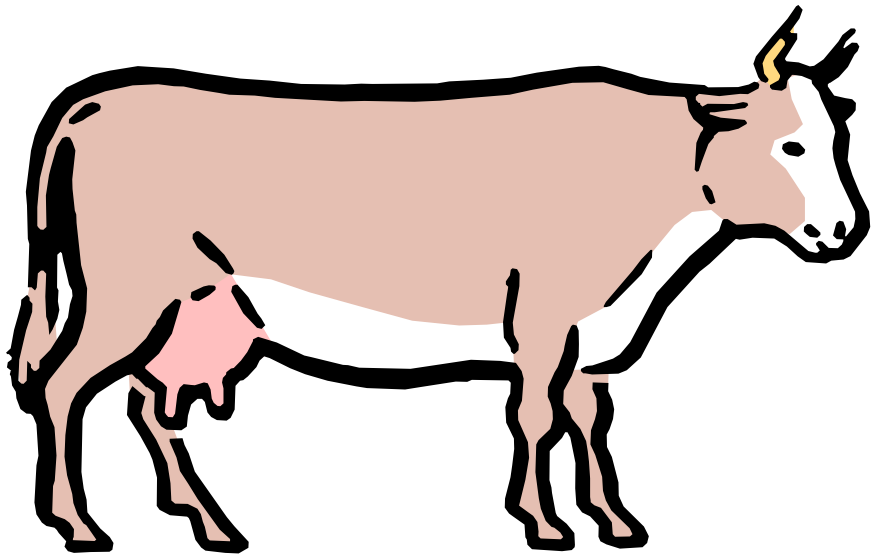
Why are we focusing so much on measures?

"You can't fatten a cow by weighing it."



--Palestinian Proverb

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How will Medicaid use the metrics?

- Start with the end in mind…
- Organize care and Medicaid administration around metrics; support spread and sustainability of best practices

What about other insurers?

- Major focus is Medicaid, but
- Align as much as possible with other insurers
- Key issue is burden to clinicians and hospitals
- Numerous states are developing multipayer collaboration

How transparent will we be?

- We will post materials internally and externally
- Phase of public and stake holder comment
- Publish in peer reviewed journal and on line

How will the task force work?

The Task is Challenging…

- Hundreds of possible measures, difficult task, 50+ members of task force, in six meetings
- Strategy:
  - focus on measures;
  - level set the group as much as possible;
  - Modified Delphi process—iterative, with discussion and focused presentation
  - Standard of “near consensus”
- Start with end in mind;use “parking lots”

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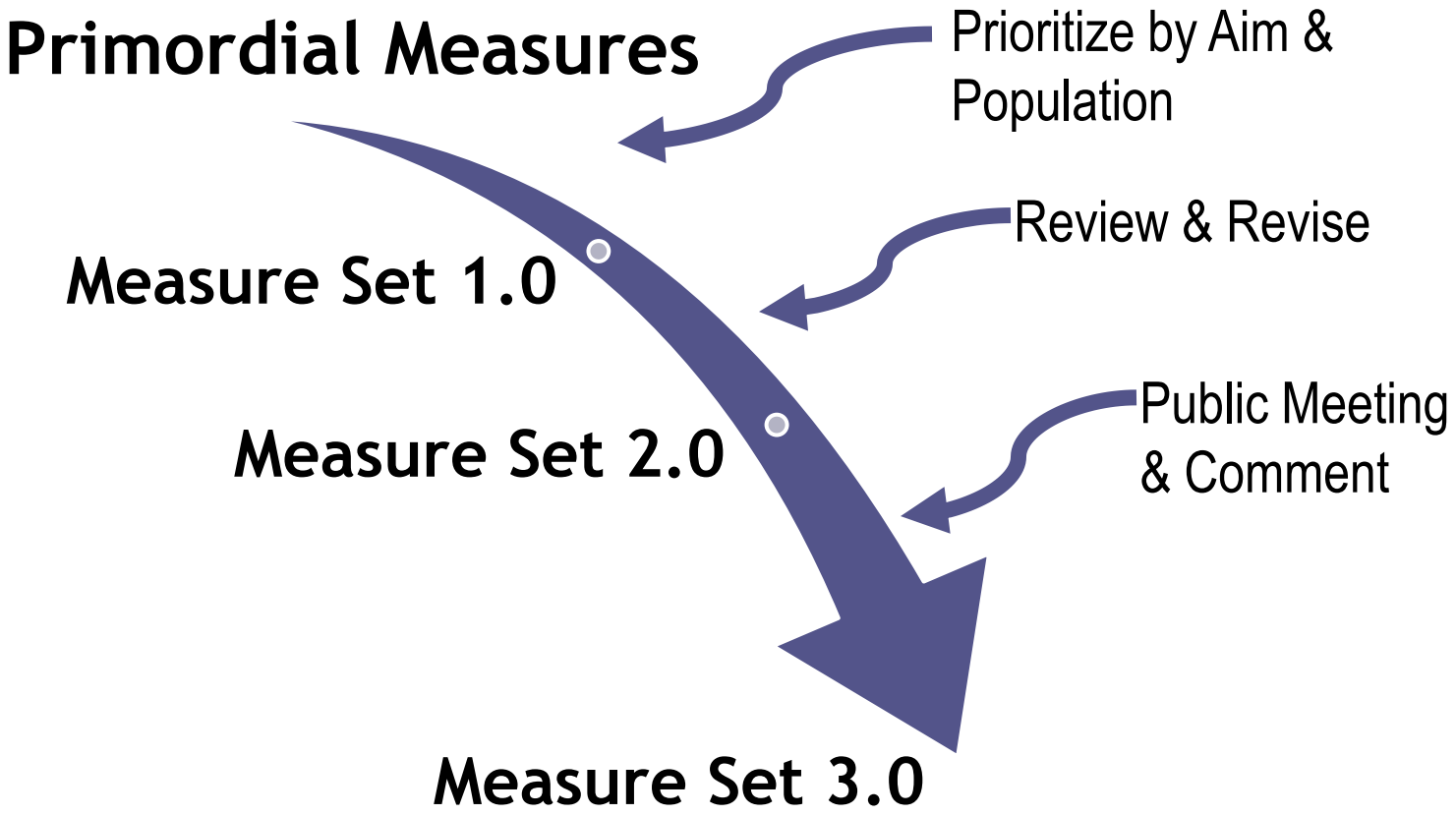
Beginning Measure Sets—vetted, aligned

- DMA starter set
- CMS cores
- PCMH/ACO
- CPC+
- IHI 2.0
- Others…

How we will proceed….



Approximate Schedule

- Session #1: Level-set regarding context, charge, medicaid and process
- Sessions #2-5: Production of draft measure set 1.0, by population and aim
- Session #6: Review, revision, re-voting—2.0
- Later Session #7: Public input, stake-holder commentary
- Creation of version 3.0 for delivery to DHHS by fall 2017

A Day in the Life of the Task Force…

- Pre-work—prereadings (brief) and initial voting
- Presentations and discussion on key issues
- Revoting and prioritization at end of day
- Minutes will follow up shortly
- We will adapt as necessary.
- If questions concerns contact any of the Steering Committee, Michelle Ries or Adam Zolotor

Questions/Comments?