

Health and Human Services Committee

August 5, 2010

Chairman Weisz and members of the Health and Human Services Committee, for the record I am Rod St. Aubyn representing Blue Cross Blue Shield of North Dakota. I have been asked to update your committee on the **availability and affordability of health care services in ND, the role of telemedicine in our state, and efforts to improve health care services in ND.**

BCBSND plays a role, though a minor role, in the **availability of health care services in the rural parts of ND.** Our company recognizes the importance of having services for our members. However in reality, BCBSND is a minor player regarding reimbursement in the rural areas of our state. It is not unusual to see BCBSND at only 20% of some of the rural facilities' reimbursements. Government programs (Medicare and Medicaid) are the major payers within ND, especially in the rural parts of our state. The State has made a significant effort in increasing Medicaid rates. As an overall average, BCBSND reimbursements are about 160% of what Medicare reimburses for the same services. This cost shifting to cover provider shortfalls from government programs has contributed to escalating insurance premiums. With the passage of the Frontier Amendment within the new healthcare reform act (PPACA) the hospitals in the larger communities will definitely see increases. Unfortunately, the rural hospitals classified as Critical Access Hospitals will not see the benefits of this amendment.

For several years now, BCBSND recognized the reduced volume of patients for these rural facilities and increased our outpatient service reimbursement to 125% of our standard fee schedules. Since that time, we recognized a "Mid-Tier" group of facilities within our state that really don't fit the true rural facilities, but also differed from the major city hospitals. Our Board approved reimbursement rates of 115% of our standard fee schedules for these "mid-tier" facilities. However, even with our increases, rural facilities continue to struggle. These facilities suffer with an inadequate volume of patients. As these regions become more and more rural, the challenges of maintaining rural health care become even more critical.

One of the concerns we have is the **affordability of health insurance.** Over 90 cents of every premium dollar go directly to health services (hospitals, medical providers, and pharmaceuticals). With medical inflation, new medical technologies, and an aging population, medical costs continue to escalate, which results in higher health insurance premiums. We are concerned about the increase in health insurance premiums as the result of the new health care reform legislation. As we have previously testified during your joint hearings with the Industry Business and Labor Committee, once the legislation is fully implemented, premiums in the group market could increase by over 15% and over 75% – 100% in the individual market.

Some of these increases may be offset by new premium subsidies in 2014, but there is no question that premiums will continue to increase. Our staff has been working overtime trying to make changes to comply with some of the near-term changes that go into effect on plan years after September 23, 2010. We are committed to implementing these new changes in as seamless manner as possible.

In the area of telemedicine, telemedicine services have been reimbursable by BCBSND since 1998. Even though reimbursement has been available since that time, actual claims volumes have been somewhat minimal. About 1,100 claims are received each year, though that number appears to be increasing in 2010. Most prevalent services billed as telemedicine are psychotherapy diagnostic interview, individual psychotherapy, and pharmacologic management. Almost 60% of all telemedicine claims were from the psych area. Most of the services are on the professional side versus the institutional side. In terms of the provider area, the Grand Forks area is the most prevalent area with the Fargo area being second, and the Jamestown area being third. With the shortage of mental health professionals in the rural areas, telemedicine is and will continue to play an important role in health care, but is only one component in the area of health care.

I wanted to spend a few minutes discussing a program that we offer that will **improve health care in ND**. It is entitled MediQHome. Simply put, it's collaboration between a patient and a primary care physician, aimed at keeping a patient healthy and holding down health care costs. Through MediQHome, Blue Cross Blue Shield of North Dakota provides an online records system to make that collaboration work effectively. Blue Cross Blue Shield of North Dakota's MediQHome Quality Program is designed to promote and sustain a Patient Centered Medical Home approach to the delivery of primary care to all citizens of North Dakota.

This approach requires a personal physician to take a leadership role in managing a team of individuals in order to provide comprehensive primary care to patients by utilizing MDinsight, an interactive information and decision support tool integral to the Project.

With MediQHome, it's all about teamwork and partnerships. Working together, a patient and their physician build treatment plans, schedule follow-up appointments.

MediQHome allows providers to focus on their patients' health outcomes through the use of an interactive decision support tool that helps the provider identify care opportunities. It organizes all available patient clinical data to create clinical summaries and quality reports specific to each patient.

What is different about this interactive decision support tool is the information about care opportunities is stored in one place easily accessible to the provider at the point of care. This

means the provider will have more time to spend treating patients and less time searching for their information.

For example, if a diabetic patient has not had a dilated eye exam in more than a year, this tool identifies this, allowing the provider and the patient to determine together the best options for the patient. Having this information allows the provider to identify current and past missed care opportunities in individual patients or groups of patients with specific chronic conditions.

Providers participating in MediQHome will have access to MDinsight, a free, web-based decision support tool providing the following rewards:

- Actionable patient data at the point of care
- Improved decision support
- Accurate tracking of patient adherence
- Better patient outcomes
- Eliminates manual chart reviews
- Greater patient satisfaction
- Provides financial rewards for efforts that are traditionally not reimbursed

With its focus on results, MediQHome benefits everyone in different ways, though patients get the most benefit in the way of good health, which helps the entire health care system. Using a combination of electronic records, care tracking and patient-care oversight, MediQHome provides the following benefits.

Patients will receive more personalized care specifically for their condition, allowing them to stay healthier and enjoy life. By keeping track of how a treatment is working, they will be able to know how their illness is being treated and how well that treatment works. It will also get patients into a routine that can substitute preventive care for emergency care.

Providers benefit by being able to track a patient's care history, treatment plans can be developed quickly and stored in a centralized area. The primary-care physician determines who can see those records to provide a more efficient health care delivery system through time savings. With the reporting system, providers can see trends in a patient's health that could signal other health care concerns, allowing the provider to take early action to maintain patient health.

Business owners also receive a benefit from the program. Twenty percent of health care consumers account for 80 percent of health care cost. Business owners who provide health benefits to employees know that rising health care premiums reduce profitability, while ill employees can suffer from lost productivity. With MediQhome, employees with chronic illnesses receive the treatment they need at the proper time, reducing sick leave and helping contain health coverage expenditures.

If you want to learn more about the MediQHome program I would like to invite you to visit the following website: <https://www.bcbsnd.com/mediqhome/>

I have included some of the key elements of the program on the following sheets to my testimony. The Medical Home concept is an important component in trying to contain medical costs and improving patients' health. In the new health care reform legislation, Congress recognized the value to the medical home concept by offering a state option to provide health homes for Medicaid enrollees with chronic conditions (SEC. 2703).

One other area we have participated in the past few years is providing Rural Health Grants. The objective of the program is "to encourage and reward three essential concepts, **alignment, innovations, and collaboration** whose measurable outcomes improve the triad of **quality, access and cost** of health services to the population residing in **rural North Dakota**." Since 2000, BCBSND has awarded \$2,645,000 across rural ND for these projects. Since 2005, these grants have been geared toward the development and promotion of health information technology. UND Center for Rural Health helps us with the distribution of information and the grant award process. Between \$400,000 and \$450,000 will be available this year for the grants. The Letters of Intent are currently being reviewed for this year's program. I have included a one page summary of the Rural Health Grant Program for your information at the end of my testimony.

Our CEO, Paul von Ebers, has been having ongoing discussions with the medical providers in our state trying to develop ways to "bend the healthcare cost curve". We all have to work together to make this a success.

Chairman Weisz and committee members, I hope I have been able to cover the areas you requested. I would be willing to answer any questions you may have.

MediQHome

Patient-Centered Principle

MediQHome is based on the Joint Principles of the Patient Centered Medical Home (PCMH), which describe the following characteristics:

Personal Physician

Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-Directed Medical Practice

The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation

Quality and safety are hallmarks of the medical home. The personal physician is responsible for providing for a patient's health care needs or taking responsibility for arranging care with other qualified professionals.

Care is coordinated across all elements of the health care system and the patient's community, facilitated by registries, information technology, health information exchange and other available resources.

- Practices advocate for their patients to attain optimal outcomes
- Evidence-based decision-support tools guide decision making
- Physicians accept accountability for continuous quality improvement
- Patients participate in decision-making with providers seeking feedback
- Information technology is used to support patient care, performance measurement, patient education and communication
- Patients and families participate in quality improvement at the practice level

Improved care access is available through open scheduling and multiple communication options.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Program Advantages

- Actionable patient data at the point of care
- Improved decision support

- Accurate tracking of patient adherence
- Better patient outcomes
- Reduced variability of care
- Greater patient satisfaction
- Eliminates manual chart reviews
- Quick and simple to get started
- Minimal changes to workflow
- Patient summaries and/or alerts can be printed and placed in chart for all patients to be seen that day
- Supports the physicians' success in achieving quality measures that lead to financial reward
- Internet access is all you need to use MDinsight
- Easy data collection from any electronic source
- Flexibility to use evidence-based guidelines or customize protocols
- Custom reports available

Program Goals

BCBSND, using the patient-centered principles, has established the following goals for the MediQHome program.

Improvement in the quality of care

- Increased adherence to evidence-based care standards
- Removal of barriers to clinical information sharing
- Reduction in medication errors
- Increase in cost-effective medication prescribing practices

More patient participation in the medical decision-making process

- Use of a collaborative decision-making process
- Patients have better access to clinical information

Increased patient adherence to treatment plans

- Better medication adherence and persistency rates
- Better adherence to process measures
- Improvement in patient clinical measures

Increased quality of life for the patient

- Less need for emergency care related to poor disease control
- Fewer hospital admissions for complications
- Decreased complication rates for chronic diseases

Increased physician satisfaction with medical practice

- Improved reimbursement
- Increased satisfaction with practice

More cost-efficient management of chronic diseases

- Decreased cost associated with managing chronic diseases

Quality Advisory Committees

BCBSND will establish MediQHome Quality Advisory Committees to provide a forum for collaboration and communication about improving the quality of health care in North Dakota. The committee will have broad representation, including patients and providers.

Charter

- MediQHome Quality Advisory Committees
- Adult and Pediatric

Purpose of the Committees

To act in an advisory capacity to determine quality measurements, metrics and performance standards for the MediQHome Quality Program. The MediQHome Quality Program will allow physicians to engage in a meaningful and clinically relevant chronic disease management program based on the principles of the patient centered medical home concept.

Committee Structure

The committees will be comprised of BCBSND executive staff and physician representatives from various specialty societies that have endorsed the patient centered medical home concept on a national basis and the state provider community. The specialty societies include the American Board of Family Medicine, American Board of Pediatrics, American Board of Internal Medicine and the North Dakota Medical Association.

In addition, each committee will include a consumer member to provide representation and understanding of our consumers' needs and expectations related to quality and an administrative representative on process improvement from participating entities.

The committees will be chaired by Jon R. Rice, M.D., Chief Medical Officer for BCBSND or his designee. Appropriate staff from BCBSND will be available for ongoing support.

Committee Participation Term

Committee participation will be limited to a three terms of two years.

Rural Health Grant Program

Blue Cross Blue Shield of North Dakota

August 20, 2009

Objective: To encourage and reward three essential concepts, **alignment, innovation and collaboration** whose measurable outcomes improve the triad of **quality, access and cost** of health services to the population residing in **rural North Dakota**.

Funding:

- Concept paper originated in December 2000
- BCBSND entered into agreement with UND-Center for Rural Health to help develop and administer the program.
 - \$325,000 allowed for grant projects (Yrs 1-4)
 - \$350,000 - \$ 445,000 – Yrs 5-7
 - \$25,000 payable to UND-CRH to administer program.
- Total amount allowed for program since inception: **\$2,645,000**

Process:

- BCBSND discusses focus with CRH
- CRH notifies providers
- Letters of Intent submitted to CRH
- Blinded LOIs sent to BCBSND
- LOIs reviewed by BCBSND to determine if they meet grant criteria
- CRH notifies approved applicants to submit full application
- Applications reviewed by external grant review committee comprised of:
 - CRH (3)
 - ND Dept. of Health (2)
 - NDHA (1)
 - UND School of Medicine (1)
 - BCBSND Board Member (1)
- BCBSND and grantees notified of award determinations.
- Funds released intermittently through the year
- CRH monitors each program's progress



**BlueCross BlueShield
of North Dakota**



Center for
Rural Health

University of North Dakota
School of Medicine and Health Sciences

Update:

- 59 Grants awarded since inception
- Narrowed focus in Year 4 (2005) to give higher priority to those programs geared towards the development and promotion of HIT.

Health Information Technology

Key Criteria

- Collaboration
- Sharing of communication
- Reduce duplication of services

Year 5 (2006) - \$350,000

- 6 Awards
- \$42,000 - \$65,000
- Electronic Medical Record – Bowman
- Computed Radiography System – Garrison
- Home Tele-health Units – Hettinger
- Picture Archive Communication System – Langdon
- Computed Radiography System – Park River
- EMR – Computerized Physician Order Entry – Rolla and Bottineau

Year 6 (2007) – \$445,000

- 9 Awards
- \$45,000 - \$85,000
- Integrated HIT System – Hillsboro
- Shared EMR System – Hazen
- Computed Radiography System – Linton
- Computed Radiography System – Turtle Lake
- Computed Radiography System – Wishek
- Digital Radiology Imaging System – Beulah
- Picture Archiving System – Kenmare
- Computed Radiography System - Elgin
- Shared Centralized Data Center – Northwood and Six other Northeast Rural Hospitals

Year 7 (2009) – \$375,000

- 11 Awards
- Telepharmacy Project – Kenmare
- Medical Imaging Network – NE ND Hospitals
- Computed Radiography System
 - a. Bowman
 - b. Tioga
 - c. McVile
 - d. Northwood
 - e. Rolla
 - f. Rugby
 - g. Stanley
 - h. Watford City
 - i. Bottineau