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Health & Human Services Committee
ND Legislative Council
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Chairman Weisz and Committee Members, I'm Bruce Levi and I represent the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota physicians, residents and medical students. On behalf of NDMA I appreciate the opportunity to provide information regarding your study of unmet health care needs in North Dakota, as well as to comment on the bill draft relating to the administration of influenza immunizations and other immunizations of children by pharmacists.

Unmet Health Care Needs

Federal Health System Reform

NDMA has been active on a number of issues relating to your study. Certainly, as discussed in your June 16 meeting, health system reform as enacted by Congress in the *Patient Protection and Affordable Care Act* (PPACA) will have a major impact on future access to health care as well as the future health care delivery system. NDMA has testified on several occasions before the interim Industry, Business & Labor Committee regarding the impact of PPACA on North Dakota. NDMA plans to continue to advocate for PPACA amendments regarding those provisions that are inconsistent with NDMA policy, and to assist physicians in evaluating opportunities to participate in demonstration programs and other opportunities under the new law. The PPACA includes a range of pilots and demonstrations designed to test changes to the way health care is organized and reimbursed – with the goals of improving health outcomes and controlling costs. This approach takes into account that people not only need insurance coverage; they need access to physicians and other medical professionals who can provide them with high quality and affordable care.

In addition to initiatives designed to strengthen primary care, the PPACA could spur significant delivery system innovation – through linking service delivery reform and payment reform. These models include accountable care organizations (ACOs or shared savings programs), the medical home, and other initiatives.

Participation in all of these demonstrations is voluntary for Medicare providers. We anticipate and are already observing physician practices and our health systems begin evaluating their capacity to participate in these initiatives, and those organizations may need to invest in tools and systems that are required to coordinate care and measure performance.

NDMA is encouraging interested physicians to begin evaluating their ability to participate, since organizing to join in these demonstrations may require long-term planning. Even for those who do not want to participate, it is important to recognize the goal to test and refine these new models as potential federal payment and delivery reforms in the future. Presently, the Association is simply trying to ensure that physicians become familiar with the underlying concepts and overall approaches.

The following are among the many approaches envisioned under the PPACA, which may impact the capacity of the state to address unmet health care needs:

Center for Innovation

The PPACA establishes the Center for Medicare and Medicaid Innovation (CMI) within the federal Centers for Medicare and Medicaid Services (CMS) to test payment and delivery models that improve quality and slow cost growth (Sec. 3021). By January 1, 2011, the HHS secretary is required to establish the CMI to test care models that improve quality and slow the rate of growth in Medicare costs. The secretary must publicly make an evaluation of each model, including an assessment of the quality of care provided. The secretary may limit model testing to certain geographic areas, and model designs do not initially have to ensure budget neutrality. The secretary also has discretion to develop any model that meets certain requirements, although the law suggests a number of specific models that may be tested. The center would have broad authority to select the programs best suited to its objectives, including these:

-Promoting broad payment and practice reforms in primary care, including patient-centered medical home models for high-need individuals and medical homes that address women's unique health care needs;

-Using geriatric assessments and comprehensive care plans to coordinate care for patients with multiple chronic conditions who are unable to perform daily living activities or who have cognitive impairments;

-Supporting care coordination for chronically ill individuals at high-risk of hospitalization through a health information technology-enabled provider network;

-Establishing community-based health teams to support small-practice medical homes by assisting primary care providers in chronic care management, including patient self-management activities;

-Assisting individuals in making informed health care decisions by compensating physicians and other providers for using patient decision-support tools to improve understanding of medical treatment options.

Payment Bundling

"Bundling" payments refers to paying a single fee for an entire episode of treatment (e.g. for hospital readmissions or for care for chronic conditions). The PPACA creates a National Pilot Program on Payment Bundling (Sec. 3023). By January 1, 2013, the HHS secretary is required to establish a Medicare pilot program for integrated care. This will include episodes of care involving a hospitalization to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care.

Accountable Care Organizations (ACOs)

An accountable care organization is a concept that would allow a provider-led organization to take greater accountability for the overall cost as well as the quality of healthcare delivered to

patients. There is no one structure for an ACO; in fact, an ACO is centered more around an outcome rather than a structure or process – reducing or controlling the costs of health care for a population of individuals while maintaining, or improving, the quality of that care.

Multiple forms of ACOs are possible, including large integrated delivery systems, physician-hospital organizations, multi-specialty practice groups with or without hospital ownership, independent practice associations, and virtual independent networks of physician practices. The PPACA created a Medicare Shared Savings Program (Sec. 3022). By January 1, 2012, the HHS secretary is required to establish certain Medicare ACO shared savings programs for various providers. These providers include groups of physicians, networks of individual practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, and any other provider groups that the secretary determines is appropriate. To qualify, an ACO must agree to be accountable for the quality, cost and overall care for the Medicare fee-for-service beneficiaries assigned to it. An ACO must have at least 5,000 assigned Medicare beneficiaries and have in place, among other things, the following: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments will continue to be made to physicians and other ACO participants under the usual Medicare payment structure. Additionally, ACOs would share among their provider participants a portion of any savings achieved in excess of a threshold benchmark. ACOs must agree to participate in the demonstration for at least three years.

Care Coordination Including Patient Centered Medical Homes

This is an approach to making comprehensive primary care available through a physician-led team of individuals who collectively take responsibility for providing ongoing, coordinated, and integrated care to patients. The medical home model puts emphasis on medical management rewarding quality, patient-centered care. The PPACA created a program of Community Health Team Support for Patient-Centered Medical Homes (Sec. 3502). The HHS secretary is required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including

obstetrics and gynecology practices) within their local hospital service areas, and to provide payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Independence at Home Demonstration Program

The PPACA created the Independence at Home Demonstration Program (Sec. 3024). By January 1, 2012, the HHS secretary is required to establish an independent at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target.

Healthcare Workforce Recruitment and Retention

It has been suggested that the health system reforms signed into law will cover an estimated 32 million uninsured patients by 2019. But the question being asked is whether there will be enough physicians to care for them, and whether projected shortages of physicians, especially in primary care, could make it harder for patients to access care. While there are provisions in the federal legislation aimed at addressing projected workforce shortages, NDMA has testified to the interim Industry, Business & Labor Committee that there is a need to do more in North Dakota to address the projected shortages in physicians and other healthcare professionals. For physicians, there is at least a ten-year period of time or "pipeline" from college entry until a physician is ready to practice medicine.

The UND School of Medicine & Health Sciences advisory council has proposed a plan approved by the State Board of Higher Education for further budget consideration that would look to

expand upon our state's proven ability to "home grow" North Dakota physicians. The plan was developed prior to consideration for any additional workforce needs caused by the impacts of federal legislation, using current rates of retention of our students and residents in North Dakota and assuming our state as things stand today will experience a projected shortfall in 2025 of about 210 physicians. Many medical schools across the country are increasing class size, and the UNDSMHS advisory council plan includes a proposal over time for 16 additional medical student slots for each of the medical student classes, 30 additional health science students in each class, and 17 additional residency slots per year. The committee may benefit from a more detailed presentation of this proposal by the UNDSMHS at a future meeting. It is clear from NDMA's perspective that there is a need to focus on physician recruitment and retention strategies to ensure good access to care for North Dakota patients. The need for these strategies existed before the enactment of federal health reform legislation, and is likely now an even greater need after reform.

Health Information Technology

NDMA participates in the Health Information Technology Advisory Committee which was discussed at your June 16 meeting by Sheldon Wolf, Health Information Technology Director. As you heard in your previous meeting, there is considerable activity stemming from the efforts to address health information technology issues in the 2009 Legislative Assembly (SB 2332). The goal of establishing a statewide health information exchange is embraced by the medical community, which is also challenged by the need to meet federal HIT "meaningful use" requirements.