# HEALTH REFORM ADVISORY COMMITTEE MEETING
**September 22, 2010**
**North Carolina Institute of Medicine, Morrisville**
**9:00am-12:00pm**
**Meeting Notes**

**Attendees:**
*Workgroup Members:* Lanier Cansler (co-chair), Tom Bacon, Rep. Jeff Barnhart, Kennan Briggs, Chris Collins, Bonnie Cramer, Sam Cykert, Jeff Engel, Allen Feezor, Laura Gerald, Ernie Grant, Craigan Gray, Greg Griggs, Bobbi Hapgood, Alan Hirsch, Phyllis Horns, Rep. Verla Insko, Al Koehler, Tara Larson, Karen McNeil Miller, Ben Money, Barbara Morales Burke, John Price, Bill Pully, Adam Searing, Steve Shore, Sen. Richard Stevens

*Steering Committee Members:* Louis Belo, John Dervin, Julia Lerche, Rose Williams

*NCIOM Staff:* Sharon Schiro, Pam Silberman

*Other Interested Persons:* Steve Cline, Jennie Dorsett, Beverly Earle, Laurie Ellis, Tina Gordon, Lisa Harrison, Bowen Heath, Nancy Henley, Jean Holliday, Kristin Milam, Ruth Petersen, Mary Piepenbring, Ben Popkin, Lendy Pridgen, Chris Skowronek, Denise Thomas, Joe Vincoli, Elizabeth Walker, Walker Wilson

## WELCOME AND INTRODUCTIONS
*Lanier Cansler, CPA*
*Secretary*
*North Carolina Department of Health and Human Services*

Secretary Cansler and Louis Belo welcomed the participants and asked them to introduce themselves. Louis Belo sent regrets from the Insurance Commissioner. Commissioner Goodwin was invited to a meeting with other state insurance commissioners that morning to meet with President Obama.

## TRIPLE AIM: CMS LIKELY DIRECTIONS
*William Pully, JD*
*President*
*North Carolina Hospital Association*

Mr. Pully met with Dr. Berwick, head of the Center for Medicare and Medicaid Services (CMS), at the National Hospital Association meeting. Dr. Berwick was recently appointed to serve as the Director of the Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. Dr. Berwick has been a strong proponent of the Triple Aim, which focuses

on: improving population health, improving patient experiences (quality, access and reliability); and reducing health care costs. Dr. Berwick noted that saving money is not the only goal of health reform; health reform also aims to achieve better services and outcomes.

The NC Hospital Association has adopted the Triple Aim goals, and incorporated these into the work of the Center for Hospital Quality and Patient Safety and the other work at the NCHA.

**UPDATES FROM WORKGROUPS**
**CLICK HERE FOR PRESENTATION SLIDES**

**HEALTH BENEFIT EXCHANGE AND INSURANCE OVERSIGHT**
**MEDICAID AND ELDER JUSTICE**
**NEW MODELS OF CARE**
*Pam Silberman, JD, DrPH*
*President*
*North Carolina Institute of Medicine*

Dr. Silberman gave a presentation on the work of three workgroups: Health Benefits Exchange, Medicaid and New Models of Care. Her part of the presentation can be accessed from the link listed above. Information on all the workgroups is available on the NCIOM website at: http://www.nciom.org/task-forces-and-projects/

Selected questions and comments:

- HBE:
  - The Department of Insurance (DOI) has a list of the grants they have applied for to assist with health reform posted on the DOI website for public access. (www.ncdoi.com/healthcarereform/hcr_resources.asp) DOI expects to receive notice of grant awards for the HBE grant by October 15, 2010.
  - Q: Have other states made a decision on whether they are going to operate their own HBEs? A: States have started to analyze how they would like to move forward with implementing the HBE. Most states (48) have applied for a planning grant.
- Medicaid:
  - The state has new options under the ACA to expand home and community based services (HCBS). The Community First Choice option is similar to the state's Community Alternatives Program (CAP) waiver program. It is designed to provide support services to people who would otherwise need institutional level of services (eg, nursing facility, intermediate care facility for people with developmental disabilities). Unlike the waiver program, the Community First Choice option is an entitlement for anyone who qualifies for services. States can

receive a six percentage point increase in their federal medical assistance percentage (FMAP) rate for HCBS offered through the Community First Choice option. Similarly, the state can also receive a FMAP increase of two percentage points under the state rebalancing initiative (which is designed to increase the availability of HCBS for people who would not otherwise need institutional level of care).

The federal government has not yet provided guidance on how it will calculate the increase in the FMAP rates. For example, we do not know if the increase will be provided for all HCBS for all eligible individuals, or just for new services or new eligibles. The Division of Medical Assistance needs further clarification from the federal government before being able to determine the cost implications of implementing the new HCBS options available under the ACA.

  - Q: Can the Division of Medical Assistance track individuals who have lost HCBS due to state budget cuts? A: DMA can track recipients to see if they end up in facility care as the result of service cuts.
- New Models:
  - Q: What is the product of the workgroup? A: Our product is to encourage proactive and collaborative approaches to healthcare.
  - It would be helpful to have a list of possibilities, recommendations and the policy changes needed to implement new models of care.
  - Community Care of North Carolina, in conjunction with the Division of Medical Assistance, State Health Plan, and Blue Cross Blue Shield of North Carolina submitted a demonstration proposal to the federal government to test a multi-payer model to improve quality, access and reduce health care costs, using the CCNC platform. This demonstration would be tested in seven rural counties. The goal is to test the impact of a multi-payer model, where all the large payers work together to improve quality, access and reduce costs for all the patients.

**QUALITY**
**PREVENTION**
**FRAUD AND ABUSE**
*Sharon Schiro, PhD*
*Vice President*
*North Carolina Institute of Medicine*

Dr. Schiro presented an update for three workgroups, including quality, prevention, and fraud and abuse. Her part of the presentation can be accessed from the link listed above.

Selected questions and comments:

- Quality:
    - Q: What is the workgroup's definition of quality? A: Quality is a balance between good outcomes and cost-efficiency but not mutually exclusive.
    - The Quality workgroup should collaborate with the New Models workgroup since they have a direct relationship to each other.
- Prevention:
    - The federal government released several RFPs to implement some of the prevention provisions in the ACA. These funding opportunities have generally been targeted to state agencies. Further, states have had very limited time frames to submit proposals or funding requests. As a result, it has been difficult for the NC Division of Public Health to collaborate with local partners before the grant submission. DPH hopes to work collaboratively with local partners in implementing appropriate grants, and in submitting future grants (as time permits).
    - The federal government is placing greater emphasis in the funding to implement evidence-based strategies. However, to achieve positive outcomes, we need to ensure that programs are implemented and monitored to ensure fidelity with program design.
- Fraud and Abuse:
    - There is a distinction between fraud and abuse in their technical definitions. Fraud is more related to misuse and abuse is more related to overutilization.
    - The product of this workgroup is a series of policy changes and the effect of fraud and abuse on quality of care.

**HEALTH PROFESSIONAL WORKFORCE**

*Berkeley Yorkery, MPP*
*Project Director*
*North Carolina Institute of Medicine*

Ms. Yorkery's presentation on the work of the Health Professional Workforce workgroup can be accessed from the link listed above.

Selected questions and comments:

- Low reimbursement in comparison to other medical specialties is one of the primary reasons why health professionals do not choose to enter into primary care fields. In addition, low Medicare reimbursement has caused access barriers for some Medicare beneficiaries.
- There should be a discussion about people practicing to their highest degree of education in order to best utilize the existing workforce. After 2014 there will be a surge of newly insured and there needs to be enough practitioners to handle the large numbers.

- There are problems in educating the new workforce due to faculty shortages, availability of clinical training sites, the number of medical school applicants and the acceptance rate, and graduates going into specialty care versus primary care.

**SAFETY NET**
*Kimberly Alexander Bratcher*
*Project Director*
*North Carolina Institute of Medicine*

Ms. Alexander Bratcher's presentation on the work of the Safety Net workgroup can be accessed from the link listed above.

Selected questions and comments:

- We are well primed to do this work now because of the work of the legislature to pull safety net providers together over the past five years. In addition, Kate B. Reynolds Charitable Trust provided a grant to the NC Community Health Center Association (NCCHCA) to help communities apply for new federal Community Health Center (CHC) grant opportunities. NCCHCA has been working with communities that do not have existing CHCs to determine their interest and readiness to apply for new funding opportunities.
- North Carolina has done a good job in getting health professional shortage area (HPSA) designations for primary care and dental care. However, the state has not historically done as much to designate behavioral health shortage areas. In the future, the Office of Rural Health is planning on taking a more proactive approach to HPSA designation, which will allow communities to apply for National Health Service Corps (NHSC) loan forgiveness or scholarship funds to recruit behavioral health professionals into underserved areas. We need to do more to publicize the availability of NHSC funding for behavioral health professionals. If local management entities (LMEs) or critical access behavioral health agencies (CABHAs) could recruit more behavioral health practitioners into HPSAs, then the ORH can link the practitioner to the National Health Service Corps (NHSC) loan forgiveness program as an incentive.

## UPDATE ON THE UNINSURED

The NCIOM staff prepared new information on the uninsured. However, there was not time to go over the presentation at the meeting. The handout can be accessed at: Uninsured Update Presentation. Information on the uninsured will be presented at a future meeting.

## CROSS-CUTTING ISSUES

## UPDATE ON CONSUMER EDUCATION BY STATE AGENCIES

*KRISTIN MILAM*
*Public Information Officer*
*NC Department of Insurance*

Selected questions and comments:

- Most outreach will be in 2011 with collaboration with other agencies and the media to provide public information on any insurance law changes at the state or national levels.
- It is a struggle to communicate the extremely technical information in the ACA to the public. Some potential options to disseminate information to the public could include booths at local festivals, OpenNet opportunities, Senior Health Insurance Information Program (SHIIP outreach to community groups, the League of Municipalities, faith-based organizations, radio, TV, mail, and/or the internet.

## CROSS CUTTING ISSUES AND DISCUSSION: BROADER CONSUMER EDUCATION

- Kaiser Family Foundation has revised its health reform website: http://healthreform.kff.org/
- Many NC insurers are already implementing the provision for coverage of children up to age 26, but not all plans are implementing this provision until the next plan year starts. For some benefit changes people will get information through the renewal of their own plan.
- There is not a single communications plan. Maybe there should be a subgroup to determine a communications plan because we want the right message to go out.

## GRANT MANAGEMENT

- There is a need to coordinate the grant process. Better collaboration would be very helpful when there is a very short turnaround time to turn in a grant application. Collaboration is also needed for community transformation grants.
    - A 15 minute call with all collaborating organizations once a week would make a difference.

## PUBLIC COMMENT PERIOD

No further public comments.