Health Reform: Overall Advisory Committee
Friday, April 15, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:
Workgroup Members: Lanier Cansler (co-chair), Wayne Goodwin (co-chair), Chris Collins, Allen Feezor, Ernie Grant, Bobbi Hapgood, Tara Larson, Benjamin Money, William Roper, Bob Seligson

Steering Committee Members: Louis Belo, Julia Lerche

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Sharon Schiro, Pam Silberman, Rachel Williams, Berkeley Yorkery

Other Interested Persons: Sonya Brown, Rebecca Carina, Laurie Ellis, Renee Godwin Batts, Tina Gordon, Markita Keaton, Karla Kiriako, Andy Landis, Carla Obiol, Jacob Parrish, Benjamin Popkin, Lendy Pridgen, Robert Seehausen, Chris Skowronek, Elizabeth Walker Kasper, Bill Wilson

Welcome and Introductions
Lanier Cansler, CPA
Secretary
NC Department of Health and Human Services

Wayne Goodwin, JD
Insurance Commissioner
NC Department of Insurance

Mr. Cansler and Mr. Goodwin welcomed everyone to the meeting.

Update on Workgroups
A summary of the workgroups' activities can be found here: Update on Workgroup Activities Memo. A copy of the presentation can be found here: Workgroup Updates Presentation.

Medicaid and Elder Justice
New Models of Care
Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman updated the committee on the Medicaid and Elder Justice workgroup and the New Models of Care workgroup. The Medicaid workgroup focused on Medicaid expansion and associated costs, new innovations in Medicaid, and eligibility simplification during its April meeting. In 2014, Medicaid eligibility will expand to those at 138% federal poverty level (FPL)

and below. The Division of Medical Assistance (DMA) estimates that more than 500,000 people will gain Medicaid eligibility as a result of this expansion. DMA estimates the costs to the state to be $830 million in total between 2014 and 2019. The federal government will contribute more than $15 billion to offset the Medicaid costs between 2014 and 2019.

North Carolina is considering two new innovations in Medicaid that are funded through the ACA. The first option, Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) (Section 4108), authorizes grants to provide incentives for Medicaid beneficiaries participating in prevention programs. The DMA has narrowed down possible incentives to two options: providing incentives to the aged, blind and disabled (ABD) population to participate in Community Care of North Carolina's (CCNC) Chronic Care Program or providing smoking cessation interventions for enrollees with two or three simultaneous chronic conditions. The second option, State Option to Provide Health Homes for Enrollees with Chronic Conditions (Section 2703), allows states to submit a state plan amendment (SPA) to provide services for enrollees with chronic conditions to enhance coordination of care. Federal support will be offered to states in the form of an enhanced federal medical assistance percentage (FMAP) rate for a total of eight quarters. North Carolina is planning on submitting two SPAs. The first SPA would be to enhance existing CCNC care management (including efforts to integrate behavioral health and primary care). The second SPA would include tiered network incentive payments (based on outcomes such as reduced readmissions and reduced use of the emergency department); consolidating the Community Alternatives Program (CAP) for children and for disabled adults into CCNC; including HIV case management as part of CCNC; and expanding the local management entity (LME) behavioral health waivers to better coordinate behavioral health services for the Medicaid population.

To simplify Medicaid enrollment, the North Carolina Department of Health and Human Services (NCDHHS) has been working to align its income policies among different programs including Medicaid, food and nutrition services, and NC Health Choice. Once North Carolina Families Accessing Services through Technology (NCFAST) is available, it will further streamline the process of determining eligibility by creating one submission to determine eligibility for multiple state programs. The DMA is also reviewing its applications and policy manuals.

The New Models of Care workgroup last met in February. Three subcommittees (Episodes of Care, Transitions, and Medicaid Healthy Lifestyle Incentives) presented their progress to the group. The New Models of Care workgroup also discussed what infrastructure is needed to support new evaluation metrics. Barriers to implementing new models of care mentioned by workgroup members included scope of practice laws for providers, lack in care coordination between providers, and a lack of standards and specific outcomes to ensure accountability. The state's new Health Information Exchange (HIE) should also be included in discussions related to what kinds of data are needed for proper evaluation of care.

Selected questions and comments:

- Medicaid and Elder Justice
    - Q: Are there any provisions that allow DMA to pay the insurance premium for a Medicaid eligible person to stay in the exchange? A: If they have access to

employer-sponsored coverage then there is, but not on an individual basis. An individual would have better benefits in Medicaid than in the exchange.

- New Models of Care
    - Q: Is there a general agreement on health care cost drivers? A: Drivers include, but are not limited to, the growing prevalence of chronic illness and new technology. One reason there is so much in the ACA about chronic disease management is because it is a large driver of increased costs.
    - Comment: We should also think of ways to improve efficiencies in the current system such as care coordination.

<u>Health Benefit Exchange and Insurance Oversight</u>
Julia Lerche, FSA, MAAA, MSPH
Health Actuary
NC Department of Insurance

Benjamin Popkin, JD, MPH
Health Care Attorney
General Counsel's Office
NC Department of Insurance

Ms. Lerche and Mr. Popkin reviewed the Milliman, Inc. report on the development of the health benefit exchange (HBE) and the current status of House Bill 115: North Carolina Health Benefit Exchange. The North Carolina Department of Insurance (DOI) hired Milliman, Inc., to conduct a study to help plan a HBE in North Carolina. The report provides objective information so that the workgroup can make informed recommendations on state options.

The state will have to make key decisions regarding certain HBE provision options. The report highlights these decisions and offers pros and cons of different state options. Decisions the state will need to make include: influencing the level of exchange participation; requiring carrier participation in the exchange; merging individual and small group markets; allowing small group employers with 51-100 employees to join the HBE in 2014; controlling adverse selection; standardizing benefit packages; continuing coverage of mandated benefits; having multiple regional exchanges; establishing a basic health plan; establishing the HBE as active purchaser or open market; providing value-added services; and determining HBE administrative expenses so the exchange will be self-sustaining.

House Bill 115 establishes the state's HBE. The proposed committee substitute of HB115 has some similarities to the original draft created by the NCIOM's HBE and Insurance Oversight workgroup. Some differences between the two are listed below:

- Section 1
    - There is no mention of meaningful choice as in the NCIOM draft.
- Section 2
    - §58-50-310 in HB115 places overall supervision of the HBE in control of the Commissioner rather than in the hands of the exchange board.
    - §58-50-310(b)(1) of HB115 outlines the composition of the exchange board. The board has 11 members: two medical provider representatives, two insurer

representatives, two business representatives, two general public representatives, one IT systems representative, one rural health representative, and one insurance agent representative. All legislative appointees (provider, insurer, business, and general public representatives) serve terms of three years and governor appointees (IT systems, rural health, and agent representatives) serve terms of two years.
    - §58-50-310(b) of HB115 describes the duties of the board members. All duties are similar to the NCIOM's draft except for Subsections 6 and 7, which address conflict of interest and recusal.
    - The NCIOM's Plan of Operation items included parameters on plans whereas HB115 §58-50-310 does not.
    - §58-50-340(18) of HB115 has patient navigators licensed by DOI rather than "trained and certified" as in the NCIOM draft.

A copy of the HBE and Insurance Oversight presentation can be found here: HBE Updates.
A copy of House Bill 115 can be found here: HB115.
A copy of the committee's substitute can be found here: HB115 Committee Substitute.

Selected questions and comments:

- Milliman Report
    - Adverse selection in the exchange is a big concern. The Milliman report states that the state can take steps to mitigate adverse selection but it cannot be eliminated. For example, Milliman suggests two options for mitigating adverse selection, including requiring all insurers who offer insurance outside the HBE to also participate in the HBE, and requiring insurers to offer all levels of plans inside the HBE. However, that could cause other problems. The Board should continuously monitor enrollment for possible adverse selection into the HBE.
        - The legislature, Commissioner or Board should have the authority to take necessary steps to address adverse selection, if it occurs.
    - Q: Where will people with preexisting conditions tend to go? A: They will tend to go into the exchange. That is why the health will probably be worse inside the exchange at first than outside the exchange.
        - Inclusive Health has had a positive experience with high risk individuals so far. They will mix with healthy people in the exchange.
        - Any unspent money from high risk pools should be used to cushion the exchange's adverse selection; however, those funds will probably be used in other ways to balance the budget.
- HB 115
    - The bill is trying to change dynamics in the marketplace. It emphasizes variation in products and competition instead of "meaningful choice" as the original NCIOM draft had.
    - If the exchange is subject to state rules on appeals it would be a very expensive process and the exchange would have to bear the cost. But since the exchange is a quasi-state entity it could create its own appeals process that is more cost effective.
    - There is concern about how patient navigators will handle the Medicaid population given the provisions on navigator licensing in this bill (§58-50-340(18)). If licensing

is required then navigators may want payment and they wouldn't get that by enrolling someone in Medicaid.
    - Navigators cannot be paid by insurers or work under insurers, but this bill says navigators have to be licensed. It seems like those two provisions are in conflict. Agents cannot be a navigator and be paid by the insurance company.
- Q: Regarding Section 4, if the ACA mandate is overturned then this bill would be repealed? A: No. If the entire ACA is repealed or federal exchange legislation is repealed then this act would be repealed.

Prevention
Fraud and Abuse
Sharon Schiro, PhD
Vice President
North Carolina Institute of Medicine

Dr. Schiro discussed the progress of the Prevention workgroup and the Fraud and Abuse workgroup. The Prevention workgroup has not met since the last update; however, a subcommittee focused on infrastructure has been working on identifying mechanisms to assist communities with limited public health infrastructure to respond effectively to prevention funding opportunities. The subcommittee wants to assist these communities in developing infrastructure in order to address Healthy NC 2020 objectives. Recommendations from this subcommittee as well as recommendations from the rest of the workgroup will be discussed at the April meeting.

The Fraud and Abuse workgroup discussed draft legislation and recipient fraud during the March meeting. The main topics of discussion for the draft legislation included the process for determining whether individual providers are high-risk, overpayment determination, registration of billing agents, prepayment review, and investigations and audits. The workgroup also began discussing recipient fraud, and will continue its discussions at the April meeting.

Health Professional Workforce
Berkeley Yorkery, MPP
Project Director
North Carolina Institute of Medicine

Ms. Yorkery updated the committee on the last three meetings of the Health Professional Workforce workgroup. In December, the workgroup discussed Medicaid reimbursement, recruitment and retention of health professionals in health professional shortage areas (HPSAs), and innovative practices for training, recruiting and retaining health professionals.

In January, the workgroup focused on challenges and barriers to achieving an effective skill mix in patient centered medical homes (PCMH). The barriers identified by the workgroup fell into six categories: financial, educational, skill mix, new models of care, implementing integrated care, and planning for changing workforce demographics.

In March, the workgroup focused on the nursing workforce, including barriers in the most effective use of APRNs (advance practice nurses). Some of the barriers included joint regulation of APRNs between the Board of Nursing and the NC Medical Board and insurance reimbursement policies. Future meetings will focus on the dental workforce and allied health professionals.

Quality
Safety Net
Kimberly Alexander-Bratcher, MPH
Project Director
North Carolina Institute of Medicine

Ms. Alexander-Bratcher updated the committee on the Quality and Safety Net workgroups. The Quality workgroup met for the final time in March. The proposed recommendations from the workgroup will be finalized via electronic communication. Subcommittees of the workgroup focused on legislation and transitions of care. The Legislative subcommittee determined there was no needed legislation to address the gaps identified in the gap analysis. The Transitions of Care subcommittee compiled a report with recommendations that will be included in the final NCIOM report on health reform. Recommendations from the subcommittee and the workgroup focus on topics such as education on quality measures in the ACA, reducing administrative burden, improvements in transitions of care, tracking of grant opportunities, and improved data collecting infrastructure (i.e., health information technology (HIT)).

The Safety Net workgroup has been focusing on how to improve access to care through the use of safety net organizations. In January, the workgroup discussed HIT including federal grants for HIT improvement, current infrastructure in North Carolina, and the relationship between HIT and the ACA. The workgroup also discussed the NC Controlled Substance Reporting System (NCCSRS) and how providers can use it to improve patient care and identify fraud and abuse.

In March, the Safety Net workgroup discussed dental care access. The new dental school at East Carolina University will use a decentralized educational model and graduate its first class in 2015. A representative from the Medicaid dental program informed the workgroup on what Medicaid was doing to implement ACA provisions related to dental care and the program's goals related to basic care, prevention and outreach. Provisions in the ACA related to dental care access (i.e., primary care provisions, workforce provisions, and Medicaid coverage expansion) were also discussed.

Update on ACOs
Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman briefly went over accountable care organizations (ACOs) and proposed rules for ACOs from the federal government (42 CFR §425). An ACO is a group of providers responsible for the quality, cost and overall care of Medicare beneficiaries assigned to the ACO. The goals of an ACO are to provide better care, better overall health, and reduce costs.

The proposed ACO rules include eligibility and accountability requirements, patient-centeredness requirements, rules on assignment of Medicare beneficiaries to ACOs, payment to providers and savings, quality performance measures and reporting systems, sanctions, review processes, a minimum three-year agreement for a provider to participate in an ACO, data sharing, public reporting, and other provisions. A copy of Dr. Silberman's presentation can be found here: ACO Updates.

Selected questions and comments:

- Q: Was there some provision to ensure FQHCs shared in the enhanced savings reimbursement? A: It goes back to broader entity. A FQHC can negotiate since it is voluntary to join.
- Q: How do you see providers, CABHAs and LMEs being treated in the proposed regulations? Would it be comparable to FQHCs? A: Yes. They wouldn't be primary care provider but they can participate.
- Q: Audits and CMS oversight to discourage adverse selection seems like it would be a huge problem. Is there any proactive incentive structure to encourage that? A: There is a claims-based way to look at it easily. Risk scores will be based on diagnosis code and CPTs.
- Q: There is incentive to have larger ACOs. How will that affect rural communities? A: It is an issue that has raised concern. CMS is currently seeking comments on this issue.
- Q: When an individual is notified that they have been assigned to an ACO they can opt out. What are they opting out of? A: They do not have to agree to share individual data with the ACO.

Update on Grants

During the meeting, updates were given on exchange funding opportunities, the Rate Review Grant, and DOI's Consumer Assistance Program. The federal Establishment Grant allows states to apply for funding as needed to develop an exchange. The US Department of Health and Human Services (DHHS) must determine if a state has made progress in creating an exchange before a state can be awarded these grants. States must work toward certification by 2013, start of operations by 2014, and self-sustainability by 2015. There are 11 Establishment Core Areas, including legislative/regulatory action, financial management, and exchange IT systems. Each Core Area has own milestones to help states reach these goals. Establishment Grants are categorized as Level 1 and Level 2. Level 1 grants provide one year of funding to states that have received exchange planning grants and have made some progress in exchange planning. Level 2 grants provide funding through 2014 and are available to states that are further in the planning process.

A $1 million Cycle I Rate Review Grant was awarded to DOI in August 2010. The funding was used to hire rate review staff and to commission a study on how the rate review process can be improved as a result of the ACA. Currently, DOI is applying for a Cycle II grant which will be used to establish an effective rate review program and develop infrastructure. Cycle II grants include a maximum $3 million base grant as well as opportunities for additional grants for

workload and performance. The grant would provide funding through September 2014. The application for the grant is due in August 2011.

A new ombuds program, DOI's new Health Insurance Smart NC program, is going live in April. The program is funded for one year by an $850,000 federal grant. The new office of Ombudsman Services Group (OSG), which will operate separately from the Department, will house the current Senior Health Insurance Information Program (SHIIP) and new NC Consumer Assistance Program (NCCAP). NCCAP will assist consumers with filing complaints, grievances, and appeals. The program will also educate consumers on general health insurance information and enrollment. Data collection on marketplace information via software will help NCDHHS strengthen rules and regulations in North Carolina. Another component of this program is the Consumer Advisory Committee. This committee will consist of representatives from consumer groups, agents, non-profits, advocacy groups, and others. Feedback from the committee will help ensure a strong consumer assistance program. Funding beyond the first year will be continued through a Level 1 Establishment Grant (see above).

Public Comment Period

- DOI should set standards for benefits and health risk managers/consultants.
- The federal budget compromise stripped out $600 million from the health center program. The 30 applications for the grants from North Carolina will likely end up only funding one or two organizations if any new applications are even funded.