

**MEMORANDUM**

**TO: NCIOM Health Reform Overall Advisory Group**

**FROM: Pam Silberman**

**DATE: April 15, 2011**

**RE: Update on Workgroup Activities**

The memo provides a brief update on the work of the different workgroups since the November written update.

**MEDICAID AND ELDER JUSTICE**

The Medicaid and Elder Justice Workgroup met in April. The group heard updates on the expected new enrollment and costs of the Medicaid expansion. According to the NC Division of Medical Assistance (DMA), the total of number of new enrollees will grow from 525,102 in FY 2014 to 559,252 in FY 2019. In addition to the new Medicaid enrollees, children currently enrolled in NC Health Choice with family incomes between 100-138% FPG will move from NC Health Choice to Medicaid. This will add another 57,714 children in FY 2014, growing to 77,235 children in FY 2019. (Table 1)

DMA also estimated the total new costs to the state, as well as the total new federal funds the state will receive. During the first three years, the federal government will pay 100% of the costs of the expanded eligibles (eventually phasing down to a 90% federal match rate). However, the federal government will pay its regular match rate (approximately 65% of program costs) for the “woodwork population.” In addition, beginning in 2016, the federal government increases its match rate for the NC Health Choice children—thereby reducing state costs in this program. (Table 2)

The total costs (including federal costs) and costs to the state over the six years (2014-2019) are shown in Table 3.

**Table 1**  
**Projected New Eligibles**

	Expanded Eligibility	Woodwork Population	NCHC to Medicaid	TOTAL	TOTAL NEW To State (Non NCHC Transfer)
FY 2014					
Children		77,479	57,714	135,193	77,479
Childless Adults	261,654			261,654	261,654
Parents	150,624	35,346		185,970	185,970
<b>Total 2014</b>	<b>412,278</b>	<b>112,825</b>	<b>57,714</b>	<b>582,817</b>	<b>525,102</b>
FY 2015					
Children		78,661	61,177	139,838	78,661
Childless Adults	265,073			265,073	265,073
Parents	152,593	35,808		188,400	188,400
<b>Total 2015</b>					
FY 2016					
Children		79,904	64,848	144,751	79,904
Childless Adults	268,472			268,472	268,472
Parents	154,549	36,267		190,816	190,816
<b>Total 2016</b>	<b>423,021</b>	<b>116,170</b>	<b>64,848</b>	<b>604,039</b>	<b>539,191</b>
FY 2017					
Children		81,146	68,738	149,884	81,146
Childless Adults	271,714			271,714	271,714
Parents	156,415	36,705		193,120	193,120
<b>Total 2017</b>	<b>428,129</b>	<b>117,850</b>	<b>68,738</b>	<b>614,718</b>	<b>545,980</b>
FY 2018					
Children		82,372	72,863	155,235	82,372
Childless Adults	274,920			274,920	274,920
Parents	158,261	37,138		195,399	195,399
<b>Total 2018</b>	<b>433,181</b>	<b>119,510</b>	<b>72,863</b>	<b>625,554</b>	<b>552,691</b>
FY 2019					
Children		83,556	77,235	160,790	83,556
Childless Adults	278,063			278,063	278,063
Parents	160,070	37,562		197,633	197,633
<b>Total FY 2019</b>	<b>438,134</b>	<b>121,118</b>	<b>77,235</b>	<b>636,486</b>	<b>559,252</b>

**Table 2**  
**Impact on State Appropriations**

	Expanded Eligibility	Woodwork Population	NCHC to Medicaid	TOTAL
FY 2014				
Children		35,719,522	2,366,139	38,085,661
Childless Adults				
Parents		32,368,323		32,368,323
<b>Total 2014</b>		<b>\$68,087,845</b>	<b>\$2,366,139</b>	<b>\$70,453,984</b>
FY 2015				
Children		71,528,642	6,739,037	78,267,679
Childless Adults				
Parents		76,821,176		76,821,176
<b>Total 2015</b>		<b>\$148,403,818</b>	<b>\$6,739,037</b>	<b>\$155,142,855</b>
FY 2016				
Children		74,384,036	(87,438,905)	(13,054,869)
Childless Adults				
Parents		79,608,713		79,608,713
<b>Total 2016</b>		<b>\$153,992,749</b>	<b>\$ (87,438,905)</b>	<b>\$66,553,843</b>
FY 2017				
Children		77,530,463	(99,784,528)	(22,254,065)
Childless Adults	37,502,039			37,502,039
Parents	25,267,565	82,702,422		107,969,988
<b>Total 2017</b>	<b>\$62,796,604</b>	<b>\$160,232,885</b>	<b>\$ (99,784,528)</b>	<b>\$123,217,961</b>
FY 2018				
Children		80,725,555	(113,823,313)	(33,097,758)
Childless Adults	85,621,378			85,621,378
Parents	57,688,697	85,826,793		143,515,490
<b>Total 2018</b>	<b>\$143,310,075</b>	<b>\$166,552,347</b>	<b>\$ (113,823,313)</b>	<b>\$196,039,109</b>
FY 2019				
Children		83,947,886	(129,768,150)	(45,820,264)
Childless Adults	104,913,629			104,913,629
Parents	79,687,143	88,986,047		159,673,190
<b>Total FY 2019</b>	<b>\$175,600,772</b>	<b>\$172,933,933</b>	<b>\$ (129,768,150)</b>	<b>\$218,766,556</b>

**Table 3**  
**Summary Impact (\$)**

	Total Requirements			State Appropriations			
	Expanded Eligibility	Woodwork Population	TOTAL \$ (federal and state)	Expanded Eligibility	Woodwork Population	NCHC to Medicaid	TOTAL \$ to State
Children		1,231,349,157	1,231,349,157		423,890,104	(421,709,721)	2,180,383
Childless Adults	8,185,463,303		8,185,463,303	228,037,045			228,037,045
Parents	5,515,079,607	1,294,179,987	6,809,259,594	153,643,406	446,313,473		599,956,879
Total 2014-2019	13,700,549,910	2,525,529,144	16,226,072,054	381,680,451	870,203,577	(421,709,721)	830,174,308
SFY 2021 Run Rate*	2,876,365,208	502,546,798	3,398,912,006	2,889,636,521	186,091,304	(176,269,065)	299,458,759

\*Assumes the Children's Health Insurance Program continues, with enhanced match rate, after 2019.

The Medicaid workgroup also discussed new federal options the state was considering. The state can receive an enhanced federal match rate for eight quarters to create health homes for Medicaid recipients with chronic conditions (Sec. 2703). North Carolina already meets many of the requirements of a health home through its Community Care of North Carolina program (CCNC). Under this provision, states can receive an enhanced match rate to create health homes for eligible individuals with chronic conditions. (Chronic conditions include mental health conditions, substance abuse disorder, asthma, diabetes, heart disease, and obesity.) Eligible individuals are individuals who have two or more chronic conditions, one condition with the risk of developing another, or at least one serious and persistent mental health condition. Health homes are expected to coordinate and provide access to high-quality health care services using evidence-based guidelines, coordinate and provide access to mental health and substance abuse services, and coordinate and provide access to long-term services and supports. Home health services include comprehensive care management, care coordination and health promotion, transition care, individual and family support, referral to community and social support services, and use of health information technology. Further, services must be provided in a culturally appropriate manner, and must be person and family centered. North Carolina is considering submitting a state plan amendment (SPA) in two phases to enhance care management for people with chronic illness. The first SPA would be to enhance the 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 LME behavioral health waivers to better coordinate behavioral health services for the Medicaid population.

The second option the state is considering is a Medicaid lifestyle incentive grant (Sec. 4108). The ACA authorized the Secretary to award demonstration grants to 10 states to provide

incentives to Medicaid beneficiaries that make progress towards healthier lifestyles or better management of their chronic diseases. The grants are available on a competitive basis. The state must show positive outcome changes as a result of these incentive grants in one or more of the following goals: ceasing use of tobacco products, controlling or reducing weight, lowering cholesterol levels, and/or diabetes prevention/management. Further, these initiatives will be evaluated to determine whether the incentives have led to lower utilization. North Carolina has submitted a letter of intent to apply, and must file its application in May. It is currently considering two options: 1) working with the aged, blind and disabled populations and encouraging them to more actively engage in self-management; and/or 2) tobacco cessation. DMA is also considering different tiered incentives (including an incentive to engage in the program and a separate incentive to complete the behavior change).

The workgroup heard a presentation on changes that NC DHHS is making to simplify and coordinate eligibility rules across NC DHHS programs (including Medicaid, NC Health Choice, food and nutrition services, special assistance, and child care subsidies). NC DHHS has an internal working group that is trying to align income and resource policies across programs (to the extent allowed by federal law). This will ultimately help in the development of NCFAST. When NC FAST is operational, people will be able to apply for all of these NC DHHS programs through submission of an online application. The NC FAST electronic application and enrollment process will need to be coordinate with the application and enrollment process for the Health Benefit Exchange. The Division of Medical Assistance is also working on streamlining the reenrollment process for children.

The workgroup also discussed, in more detail, the challenges the state will face in enrolling new populations in 2014. The ACA simplifies eligibility to make it easier for people to gain coverage. The ACA removes resource eligibility requirements for most groups, relying on income verification (most of which can be verified electronically through other administrative data sources). However, the ACA also requires states to determine individuals who would have been eligible under the old program rules (“woodwork eligibles”), and those who are newly eligible. The federal government has not yet given guidance on how states will be able to identify woodwork eligibles without actually going through the old, more cumbersome, eligibility determination process for all applicants.

Another major concern is the movement of individuals between different programs. Individuals will be eligible for different benefit coverage depending on whether an individual is eligible for traditional Medicaid, expanded Medicaid, or private coverage through the Health Benefit Exchange (HBE). In general, traditional Medicaid has the most comprehensive coverage. States must provide “benchmark” coverage to the Medicaid expansion populations. This benchmark coverage must be at least as comprehensive as the essential benefits offered in the HBE, and must include some traditional Medicaid services (such as EPSDT, family planning, and non-emergency transportation). However, the benchmark plan need not cover all the other traditional Medicaid services.

Studies have shown that there is likely to be significant movement of individuals from one coverage group to another during the course of the year, which can disrupt relationships with existing providers, and may change covered services. For example, a recent study by Sommers and Rosenbaum examined income changes for adults with incomes <200% FPG. This study showed that:

- 35% of adults would have experienced change in eligibility within six months and 50% would have experienced a change within one year
- 24% would have experienced at least two eligibility changes within a year, and 39% would have experienced at least two changes within two years.
- 43% of adults in the sample had children under age 19 who might have experienced similar changes.

This constant eligibility redetermination will create administrative burdens to families, DMA, and the HBE. The workgroup considered options to ease the administrative burden, such as 12-month continuous eligibility for Medicaid eligibles (which would guarantee eligibility for 12 months, regardless of changes in income). This is already allowed for children and pregnant women, but not for adults. The state will need further federal guidance to determine if this is an option. Regardless of whether the state can provide continuous eligibility in the Medicaid program, the HBE must make it easy for families to report changes in income. Individuals who receive the advanced premium tax credit may be subject to a repayment penalty if, at the end of the year, it is determined that they were not eligible for the amount of subsidy they received. As part of the Medicare and Medicaid Extenders Act of 2010, Congress increased the repayment penalty. Individuals and families may be required to repay advance premium tax credits of:

- \$600 for individuals and families with incomes below 200% FPL.
- \$2,500 for individuals and families with incomes between 350-400% FPL.

## NEW MODELS OF CARE WORKGROUP

The New Models of Care Workgroup met in February. There were three subcommittees that met and reported back to the February workgroup meeting: Episodes of Care, Transitions (a joint subcommittee with members of the Quality workgroup), and Medicaid Healthy Lifestyle Incentive initiatives. These workgroups reported on their status and that they were going to continue to meet and would provide updates at a future meeting.

The workgroup discussed what barriers would need to be addressed or new infrastructure put in place to support new models of care. The workgroup felt it was important to look at state regulations that could promote or hinder new models of care. For example, some members of the workgroup suggested that existing scope of practice laws for pharmacists and non-physician clinicians, including nurse practitioners and physician assistants, may be too limited to support new models. The workgroup agreed that practices should work to build teams of providers, including non-physician clinicians, to provide care instead of having care provided by siloed

health professionals. The workgroup also discussed whether there should be standards and specific outcomes to ensure accountability.

The workgroup wanted more information about the data that may become available through the health information exchange. Specifically, the workgroup was interested in understanding what data would be available to help with improving the health of specific individuals (including but not limited to behavioral health data, and continuity of care documents to facilitate transitions of care), as well as whether the HIE would capture data that could help evaluate quality and costs of new models of care. The workgroup also began discussing new payment models such as pay-for-performance.

## PREVENTION

The Prevention Workgroup has not met as a whole since the last update, but a subcommittee has met to work on identifying mechanisms to assist communities with limited public health infrastructure to respond effectively to prevention funding opportunities that may become available through the Affordable Care Act or other sources. An additional objective is to assist these communities with developing the infrastructure to address the HNC2020 objectives. This subcommittee has developed recommendations that focus on recognition of the importance of community engagement, and the need for development of partnerships between HNC2020, the NC Office of Minority Health and Health Disparities, academic institutions, and organizations already working within these communities to help these organizations develop the required infrastructure. These recommendations, as well as draft recommendations for all prevention-related provisions, will be reviewed by the Prevention workgroup members at the April meeting.

## FRAUD AND ABUSE

The Fraud Workgroup focused on developing legislation during the January and February meetings. Draft legislation was developed based on the workgroup's gap analysis and guiding principles document. The workgroup members agreed that the legislation is needed to cover ACA requirements, but there was disagreement between the State and provider representatives on whether the legislation should go beyond these requirements. The primary areas of disagreement were the program integrity sections, particularly pre-payment review and suspension processes. The goal of pre-payment review is to avoid the need for recoupment by identifying outliers, but it also can result in long claims processing times and cash-flow problems for providers. The group discussed the need for clear definitions of reasons for putting a provider on pre-payment review. Suspensions due to alleged over payment were a concern of the provider associations, since payment suspensions also can lead to cash flow problems for providers. They requested a mechanism for due process prior to final decisions on overpayments, so that providers would not be put out of business by an erroneous audit. These concerns need to be balanced with a limitation on the delay in hearings, so that a final decision can be reached and re-payment completed if the audit is correct.

In March the workgroup continued discussion of the draft legislation, but did not come to consensus. The group agreed that the draft legislation should not be a part of the Health Reform

Interim Report, but that the gap analysis and guiding principles should. The second major topic of discussion at the March meeting was recipient fraud. This discussion identified broad topics which will be discussed in greater detail at the April workgroup meeting. Topics include the magnitude of the recipient fraud problem, types of fraud (e.g., asset hiding, billing for services not rendered, elder abuse), changes in eligibility, the impact of identity theft, problems with identifying fraud, balancing the need to identify fraud with the need to encourage appropriate participation in the Medicaid system, and having the necessary manpower to investigate and prosecute the cases.

### **HEALTH PROFESSIONAL WORKFORCE**

The Health Professional Workforce Workgroup has met three times since the last update with meetings focusing on challenges and barriers to achieving an effective skill mix of health professionals in patient centered medical homes, recruiting and retaining health professionals to health professional shortage areas (HPSAs), and the nurse perspective on policy options to reduce barriers to meeting North Carolina's primary care needs.

In December the workgroup heard from presenters on Medicaid reimbursement policies, recruiting and retaining health professionals to HPSAs, and innovative practices for training, recruiting, and retaining health professionals. The discussion on Medicaid reimbursement policies stressed the importance of not cutting rates as North Carolina works towards the goal of being able to meet the primary care needs of the state with the implementation of health reform. In talking about recruiting and retaining health professionals to HPSAs the group was interested in two ideas: looking at ways to capitalize on increases in federal spending around the National Health Service Corp to potentially reduce state costs associated with recruiting health professionals to HPSAs and using some of the state funding that goes towards recruitment to teach communities how to do a better job recruiting health professionals (West Virginia has such a program). The group enjoyed a presentation about the emergence of retail health clinics (i.e., minute clinics, WalMart clinics). Workgroup members stressed that although this is a new and emerging model, it is one that needs to be watched and integrated into current systems so that care is not further fragmented. The workgroup also talked briefly about the potential of teaching health centers to increase interest in both primary care and working with underserved populations. The group discussed many ideas, but did not make any formal recommendations based on the discussion.

In January the workgroup meeting focused on challenges and barriers to achieving an effective skill mix of health professionals in patient centered medical homes. This meeting was structured to provide important information and feedback from the health professional workforce workgroup to the Sheps led State Workforce Planning Grant (a federal grant). Gathering stakeholder input on the challenges and barriers to achieving an effective skill mix of health professionals in patient centered medical homes is a requirement for the State Workforce Planning Grant. Additionally, the Health Professional Workforce workgroup is a larger group and both groups wanted to ensure that, although they have slightly different focuses (short- vs. long-term), the two groups have opportunities to provide input into each other's work. During

the meeting the workgroup heard from an excellent panel of providers representing rural and urban FQHCs, a rural health non-profit clinic, and a private medical practice. After the panel discussion, Erin Fraher, the project director for the state grant, gathered input from participants and then led a discussion around the barriers and challenges that the panel and the Workgroup identified. These barriers/challenges were broadly grouped into the following categories: financial, educational, skill mix, new models of care, implementing integrated care, and planning for changing workforce demographics. Both groups are using the input gathered during the meeting to shape agenda topics and future discussion.

At the March meeting the workgroup heard from a panel of nurses working in diverse settings, a presentation on the RIBN program to increase the education levels of nurses, and a presentation on policy options at the national and state level. The group was very interested in many of the ideas raised, including:

- The barriers raised by North Carolina using a joint regulatory model between the Board of Nursing and the North Carolina Medical Board—particularly the requirement for physician oversight of nurse practitioners.
- Insurance reimbursement policies which can pose a variety of barriers to nurses providing primary care.

The workgroup was very interested in discussing these ideas further but was unable to have a full discussion due to time limitations. These ideas as well as ideas from the December and January meetings will be discussed more at the workgroup's May meeting.

At the upcoming April meeting the workgroup will be discussing short-term policy options for meeting North Carolina's dental needs. In particular the workgroup will focus on the fact that in 2015 North Carolina will begin graduating twice as many dentists each year (140 vs. 70) as we do today. The workgroup is going to discuss policy options that could be used to influence where and who these new dentists serve. The May meeting will focus on allied health professionals and have time for the workgroup to review the ideas that have come up since December and discuss which ideas they would like to include as recommendations in the final report. This workgroup plans on meeting two more times to focus on diversity and pipeline issues as well as physician supply.

## **QUALITY**

The Quality workgroup formed two subcommittees to focus on the gaps the workgroup identified that could require legislation and the issues associated with transitions of care from the hospital to skilled nursing or outpatient care. The legislative subcommittee concluded that while there are issues of interest to the group that could benefit from legislation like safe harbor, there was no need for legislation based solely on ACA gaps identified by the workgroup. The transitions of care subcommittee formed as a joint subcommittee with representatives from the New Models of Care Workgroup. They met and discussed several gaps and best practices in

transitions of care that were presented to both workgroups. The subcommittee report will be included as an appendix in the final overall report.

The quality workgroup met a final time in March. They discussed the workgroup updates and potential recommendations. Their final recommendations are:

1. The North Carolina Hospital Association should provide education to hospitals on the following issues related to the ACA:
  - Hospital acquired conditions: the importance of using the “present on admission indicator” and the meaning and implications of the quartiles (Sec 2702, 3008),
  - Quality reporting requirements (Sec 3004, 3005, 3014, 10301, 10322, 10305),
  - Value-based purchasing (Sec 3001, 10335), and
  - Importance of having a safety evaluation system to allow health benefits exchange (HBE) provider to contract with hospitals with more than 50 beds (Section 1311), and
  - Medical diagnostic equipment requirements (Sec 4203).
2. The Area Health Education Centers Program (AHEC), Regional Extension Centers, North Carolina Medical Society (NCMS), North Carolina Academy of Family Physicians (NCAFP), North Carolina Chapter of the American College of Physicians (ACP), North Carolina Pediatric Society, Community Care of North Carolina (CCNC), Carolinas Center of Medical Excellence, and North Carolina Healthcare Quality Alliance (NCHQA) should partner to educate physicians on the following issues related to PPACA:
  - Impact of the use of quality, efficiency, and resource use data by the public and Medicare (Section 10331),
  - Opportunities to provide input in to the development of quality measures (Sec 3003, 3013, 10303),
  - Penalties for not reporting quality data, and the advantages of integrating reporting and electronic health records (Section 3002, 10327),
  - Value-based purchasing (Section 3007), and
  - The requirement for providers to have a system to improve healthcare quality to allow HBE providers to contract with them (Section 1311), and
  - Medical diagnostic equipment requirements (Sec 4203).
3. American Hospice and Home Care of North Carolina (AHHC of NC) and the Carolinas Center for Hospice and End of Life Care should provide education to NC hospice providers on quality reporting requirements, pay for performance, and the implications of the PPACA value-based purchasing provisions. (Sec 3006, 10326)
4. The Department of Health Services Regulation, AHHC of NC, and North Carolina Healthcare Facilities Association (NCHFA) should provide education to their respective constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value based purchasing (Sec 3006, 103010).
5. The Division of Medical Assistance should partner with AHEC, CCNC, NC Chapter of ACP, and the NCAFP to assume responsibility for educating primary care physicians,

and with NCMS to assume responsibility for educating specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults. (Sec 2701)

6. The North Carolina Health Information Exchange (HIE) Board should investigate developing mechanisms to reduce the administrative burden of the Medicaid eligible adult quality reporting requirement through centralized reporting through the NC HIE and alignment of NC quality measures with Federal requirements. (Sec 2701)
7. The NC HIE Board should investigate storing federally reported data at the state level and make it available for research, and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.
8. NCHQA should partner with NCHA with provider groups and CCNC to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying and working with the NC HIE Board to facilitate IT requirements, and developing mechanism for evaluating outcomes. Partner organizations should also work to:
  - Improve patient (or responsible family member) discharge education at hospitals, with a focus on the health literacy checklist and teach-back methodology;
  - Improve discussions of goals of care and education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge;
  - Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions ;
  - Personal health records, especially a hospital discharge, in the possession of the patient should be emphasized pending the availability of more robust HIE;
  - Align existing initiatives that address care transitions at state and local level ;
  - In each community, stakeholder alliances including provider groups, CCNC, home health representatives and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies;
  - Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation and emphasis on self-management;
  - Encourage collaboration and contracts between hospitals, local management entities, critical access behavioral health agencies, and other community providers (e.g., pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients;
  - Solutions utilizing transition principles should be applied to all patients regardless of payer; and

- Encourage formal development of Medical Home Models that include the use of non-physician extenders to work with some patients (e.g., stable diabetics), with physicians focusing on higher need patients.
- 9. The NCHFA and CCNC should collaborate with DMA to provide reimbursement for nurse practitioner services in SNFs.
- 10. The NC Network of Grantmakers should continue to track funding opportunities that are made available through the PPACA.

The Workgroup also compiled a resource to help providers and organizations know the implementation dates of quality measures. The document focuses on changes that professional and provider organizations need to make to be in compliance with the federal law. Representatives from the professional and provider organizations were identified and the resource was distributed to them.

The Quality Workgroup will communicate electronically to finalize the recommendations and provision summary.

### **SAFETY NET**

The Safety Net Workgroup has focused on how to improve access through safety net organizations. Each meeting has focused on particular aspects of safety net care. In January, the focus was on information technology. The meeting in March focused on dental health.

In January, the workgroup discussed an overview of federal goals for HIT, HITECH (Health Information Technology for Economic and Clinical Health) grants North Carolina has received, HIT infrastructure in North Carolina, and how HIT fits into the Patient Protection and Affordable Care Act. There was also discussion of the North Carolina Controlled Substance Reporting System (NCCSRS), a database that allows providers to create informed plans of care for patients and alerts other entities to possible fraud or abuse. The North Carolina Community Care Networks (NCCCN) Provider Portal is another IT tool can be used to improve patient care and reduce costs. The portal is available to all CCNC providers who register with the site. Patient prescriptions and medical histories can be accessed through the database. The site's "Meducation" section contains prescription instructions, how-to videos for basic medical procedures, and care instructions and can translate them into many different languages (including pictures for low-literacy patients).

In March, the workgroup discussed dental care and access. The East Carolina University School of Dental Medicine, located in Greenville, North Carolina, will begin training students during the 2011-2012 academic year. The school will use a decentralized educational model and will be more case-based than lecture-based, providing students with hands-on training. Ten community service learning centers, located in rural underserved areas throughout the state, will address North Carolina's shortage of dental care access, give students extensive clinical experience, and be fully sustainable. The community service centers will also have telemedicine available to connect with students and faculty at other centers.

The North Carolina Medicaid Dental Program serves mostly children, including those in NC Health Choice, and has received honors for utilization and innovative initiatives. Currently, safety net providers focus on meeting basic oral health needs for Medicaid/NC Health Choice patients. Preventive services and outreach are also important focuses for safety net dental facilities. Some important changes in dental access required by the ACA include new federally qualified health centers (FQHC) will have dental clinics, expansion of school-based health centers to include dental services, and new standards for dental/medical equipment are all included in the ACA. Workforce initiatives are also included in the ACA including loan repayment, dental demonstration grants, and money for dental training. The ACA's mandatory coverage requirement and expansion of Medicaid will increase the number of people eligible for dental care services under Medicaid/NC Health Choice and could place a strain on funding, causing states to reduce or eliminate optional Medicaid benefits, such as dental services for adults. The reduction in services could lead to more emergency department utilization for dental emergencies and higher costs for safety net providers who receive dental patients without dental coverage. It is not yet known if North Carolina will reduce or eliminate optional Medicaid services.

Finally, there was discussion of private practice perspectives on access to dental care including trends in private practice and issues related to the workforce. Private practice has seen an increase in the number of group practices, number of dental management companies, and utilization of dental auxiliaries. The number of dentists in North Carolina has also increased and will continue to increase as UNC expands its program and ECU begins its program. A controversial topic in dental workforce is the utilization and licensing of mid-level providers such as dental therapists. The Workgroup discussed pros and cons of dental midlevel providers, the education process, and how they may play a role in increasing access to dental care.

The Safety Net Workgroup will meet in April to discuss urgent and emergency care and will discuss pharmacy care in May.

## **HEALTH BENEFITS EXCHANGE**

The Health Benefits Exchange workgroup met twice since the last Overall Advisory Committee, in February and April. In the February meeting, the workgroup discussed federal grant opportunities and implementation of the new Medical Loss Ratio regulations (MLR). The April meeting focused on the analysis of North Carolina's insurance market by Milliman, an actuarial group.

The NC Department of Insurance (NCDOI) received a one-year HBE planning grant to help with the initial work to establish an Exchange. NCDOI used the bulk of this funding to contract with Milliman, an actuarial group, to provide an analysis of the North Carolina market and help with some of the design issues. North Carolina is eligible to apply for additional funding to develop a Health Benefits Exchange. There are two types of grants—Level 1 and Level 2. Level 1 grants provide funding to states that have received HBE planning grants and have made some progress

in exchange planning. The NC Department of Insurance is likely to apply for a Level 1 grant until the HBE is established and can meet the requirements for a Level 2 grant. Level 2 grants provide funding through 2014, and are available to states further in their planning process. States must have an operational HBE and a workplan, and proposed operating budget, to obtain a Level 2 grant. States must work towards certification by 2013, start of operations by 2014, and self-sustainability by 2015. If the state is not making sufficient progress, the federal government will establish an Exchange in the state.

The North Carolina Department of Insurance also received funding to establish a new NC Consumer Assistance Program (NCCAP). NCCAP will operate as a consumer ombuds program, and can assist consumers in answering insurance questions, help in the enrollment process, and assist with complaints, grievances, and appeals. NCDOI also received a premium review grant to fund positions at NCDOI to help enhance the rate review process.

The HBE workgroup also discussed the new Medical Loss Ratio (MLR) regulations. MLR is the percentage of premiums an insurers uses to pay for health care claim and quality initiatives, versus the amount spent for administration or profits. Beginning in January 2011, insurance companies are required to meet certain minimum MLR requirements (no less than 80% for individual and small group plans, and 85% for large group plans). States have the option of requesting a waiver or phase-in of the MLR requirements if the state can show that enforcement of the MLR would destabilize the market and create fewer options for consumers. NCDOI surveyed health plans and found that 14 of the 15 carriers that responded are not currently meeting the MLR ratio and would support a full or transitional MLR waiver. NCDOI was analyzing the data to determine whether it would apply for a waiver.

The HBE workgroup met in April to discuss the preliminary findings from the Milliman study. The preliminary findings suggest that more than 500,000 individuals (non-group), and 67,000 people in small groups (<50 employees) will gain coverage through the HBE in 2014. Milliman estimated that individuals who enroll in the HBE (non-group coverage) will have somewhat worse health status than individuals who enroll through small businesses. Thus, if the state were to merge the individual and small group markets, it may lead to increased rates for some small businesses, but might provide a larger, and more stable, health insurance market. Milliman also examined the option of offering health insurance coverage to employer groups of 51-100 in 2014. (Note: states must provide coverage through the HBE to employer groups of <50 in 2014, and may provide coverage to employer groups of 51-100. In 2016, HBEs must offer coverage to groups of 51-100). The health status of the two populations (<50, 51-100) is very similar, so combining the two groups would have little impact on premium rates. If North Carolina offered coverage to groups of 51-100, it could cover an additional 55,000+ people through the HBE. However, this option would require changes in state law—because existing small group insurance laws only applies to groups of <50. Milliman also anticipated the administrative expenses of the HBE. They estimated that it would cost approximately \$22 million to operate the HBE (although this is significantly less than the costs of the Massachusetts Exchange—so Milliman will provide a range of estimates of administrative costs in their final report). If this



administrative cost is born solely by the individuals in the HBE, it would cost ~\$38 per member per year. If it is spread among the total commercially insured population (both inside and outside the HBE), it would cost ~\$9.30 per year, and if it were spread across both the commercially insured and self-funded population, it would cost ~\$4.30 per member per year. Milliman also provided feedback on other design and policy issues. The final Milliman report is expected shortly.