

NCIOM HEALTH REFORM WORKGROUP RECOMMENDATIONS

FRAUD AND ABUSE

No recommendations to present

Senate Bill 496, Session Law 2011-399 enacted last summer to respond to ACA requirements.

SAFETY NET WORKGROUP

DRAFT Recommendations

Recommendation 1. Involve Safety Net Organizations in Community Health Assessments

The North Carolina Hospital Association and North Carolina Division of Public Health are working together to encourage community hospitals and local health departments to collaborate in conducting their community health needs assessments.

- a) As part of the hospital and local health department community health assessments, these organizations should:
 - i) Include data from safety net organizations and other community-based organizations that serve low income uninsured individuals within the hospital and public health service area.
 - ii) Examine access to quality care issues along with population health and other community health needs.
- b) In implementing community health needs priorities, hospitals and public health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.
- c) Local communities should use the community health assessment action plan to leverage resources.

Recommendation 2. Reconvene the Safety Net Advisory Council

- a) The Care Share Health Alliance should reconvene the Safety Net Advisory Council to:
 - i) Identify communities with the greatest unmet needs using hospital and public health collaborative community health assessments and other safety net data tools.
 - ii) Increase collaboration among agencies in a region to leverage resources as part of a larger service network.
 - iii) Monitor safety net funding opportunities and disseminate them to appropriate organizations.
 - iv) Make a recommendation and plan for integrating safety net tools including the NC Health Care Help website and the county level resources.
 - v) Serve as a unified voice for the safety net.
- b) North Carolina foundations and other agencies that provide funding to safety net organizations should encourage their recipients to submit or update data to the NC Health

Care Help website on a regular basis.

Recommendation 3. Allow Safety Net Organizations to Function as Patient Navigators

- a) The Health Benefits Exchange (HBE) should train and certify staff at safety net organizations to serve as patient navigators. In accordance with the ACA, these groups would be required to:
 - i) Provide public education to raise awareness of qualified health plans (QHPs).
 - ii) Distribute fair and impartial information.
 - iii) Facilitate enrollment in QHPs.
 - iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or other appropriate state agency for an enrollee with a grievance, complaint or question about their health plan.
 - v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.
 - vi) Meet standards to avoid conflict of interest.
- b) As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.

Recommendation 4. Develop an Emergency Transition of Care Pilot Project

- a) The North Carolina College of Emergency Physicians (NCCEP) and Community Care of North Carolina should work with the North Carolina Hospital Association, North Carolina Department of Health and Human Services, Care Share Health Alliance, the North Carolina Community Health Center Association, North Carolina Dental Society, North Carolina Foundation for Advanced Health Programs, North Carolina Free Clinic Association, Governor’s Institute of Substance Abuse, and others to develop an emergency care pilot project to address common conditions that present to the emergency departments but could be more effectively treated in other health care locations. The pilot project should focus on:
 - i) Dental complaints
 - ii) Chronic conditions
 - iii) Behavioral health issues
- b) NCCEP and partners should seek funding for the emergency care diversion project through the US Assistant Secretary for Preparedness and Response for regionalized systems for emergency care and other federal sources.
- c) If adequate funding is not received from the federal sources, the North Carolina General Assembly should appropriate \$XXX to fund the emergency care diversion pilot project.

Recommendation 5. Expand 340B Discount Drug Program Enrollment among Eligible Organizations

The North Carolina Hospital Association and North Carolina Community Health Center Association should continue their efforts to encourage critical access hospitals, sole community hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.

QUALITY WORKGROUP **Final Recommendations**

Recommendation 1. Educate Hospitals on PPACA Issues

The North Carolina Hospital Association should provide education to hospitals on the following issues related to PPACA:

- a) Importance of using the “present on admission indicator” and the meaning and implications of the quartiles.
- b) Quality reporting requirements.
- c) Value-based purchasing.
- d) Importance of having a safety evaluation system to allow HBE provider to contract with hospitals with more than 50 beds.
- e) Medical diagnostic equipment requirements.

Recommendation 2. Educate Providers on PPACA Issues

AHEC, REC, NCMS, NCAAFP, NC Chapter of ACP, NCPS, CCNC, CCME, and NCHQA should partner to educate physicians on the following issues related to PPACA:

- a) Impact of the use of quality, efficiency, and resource use data by the public and Medicare.
- b) Opportunities to provide input in to the development of quality measures.
- c) Penalties for not reporting quality data, and the advantages of integrating reporting and EHR.
- d) Value-based purchasing.
- e) Requirement for providers to have a system to improve healthcare quality to allow HBE providers to contract with them.
- f) Medical diagnostic equipment requirements.
- g) Care coordination and other important follow up factors to reduce hospital readmissions.

Recommendation 3. Educate Home and Hospice Care Providers on PPACA Issues

The Association for Home and Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care should provide education to North Carolina hospice providers on quality reporting requirements, pay for performance, and the implications of the PPACA value-based purchasing provisions.

Recommendation 4. Educate Facility Personnel on PPACA Issues

The North Carolina Division of Health Service Regulation, Association for Home and Hospice Care of North Carolina, and North Carolina Health Care Facilities Association should provide education to their respective constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value based purchasing.

Recommendation 5. Educate Primary Care and Specialty Providers on PPACA Issues

The Division of Medical Assistance should partner with Area Health Education Centers, Community Care North Carolina, North Carolina Chapter of American College of Physicians, and the North Carolina Academy of Family Physicians to assume responsibility for educating primary care physicians, and with the North Carolina Medical Society to assume responsibility for educating specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults.

Recommendation 6. Explore Centralized Reporting

The North Carolina Health Information Exchange (NC 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.

Recommendation 7. Investigate Options for NC HIE Data Storage

The North Carolina Health Information Exchange 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.

Recommendation 8. Improving Transitions of Care

- a) The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina (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 North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanism for evaluating outcomes. Partner organizations should also work to:
 - i) Improve patient(or responsible family member) discharge education at hospitals, with a focus on the health literacy checklist and teach-back methodology;
 - ii) 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;
 - iii) Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions;
 - iv) Align existing initiatives that address care transitions at state and local level ;

- v) 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;
 - vi) Encourage collaboration and contracts between hospitals, local management entities, CABHAs, and other community providers (e.g., pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients;
 - vii) 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.
- b) 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.
 - c) Individuals should be provided their own personal health records after hospital discharge, pending the availability of a more robust Health Information Exchange.
 - d) Solutions utilizing transition principles should be applied to all patients regardless of payer.

Recommendation 9. Reimburse Nurse Practitioners in Skilled Nursing Facilities

The North Carolina Health Care Facilities Association and Community Care of North Carolina should collaborate with the Division of Medical Assistance to provide reimbursement for nurse practitioner services in skilled nursing facilities.

Recommendation 10. Continue Tracking Funding

The North Carolina Network of Grantmakers should continue to track funding opportunities that are made available through the PPACA.

HEALTH PROFESSIONAL WORKFORCE WORKGROUP

DRAFT Recommendations

Recommendation 1. Create a Center for Health Workforce Research and Policy

- a) The NC Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for future health practitioner workforce needs. As part of their work the Center should:
 - i) Identify, collect, and develop data streams to model future health professional workforce needs. Potential data needs include:
 - A) Population health measures including health status and socio-demographic factors that may influence future health care needs.

- B) Practice level data such as geographic location, types of professionals employed, types health insurance accepted, number of patients, services provided and other capacity information.
- C) Health practitioner workforce data including demographics and education.
- D) Higher education data on number of students in each health education program as well as tracking information to see where and what students end up practicing.
- ii) Use aforementioned data streams to
 - A. Analyze the link between workforce supply, costs, and outcomes.
 - B. Identify practitioner shortages by specialty and geographic location.
 - C. Plan for the state's future workforce needs by identifying priorities for training and education funding.
- iii) Address barriers that affect entry into the health professional workforce or continued practice. As part of this work, the Center should examine state regulations and licensure board requirements to improve the regulatory environment for all licensed health professionals. This examination should allow all health professionals to be able to practice to their full education and competence.
- iv) Report its findings and proposed recommendations on an annual basis to the North Carolina General Assembly, the Governor, the Department of Health and Human Services, and the Department of Commerce.
- b) The Center should have an advisory board that includes representatives from the North Carolina Office of the Secretary, North Carolina Department of Health and Human Services, North Carolina Office of Rural Health and Community Care, North Carolina Areas Health Education Centers program, the North Carolina Community College System, the five North Carolina academic health centers, relevant professional associations and licensing boards, the North Carolina Hospital Association, North Carolina Medical Society Foundation, and nonmedical public members.
- c) The North Carolina General Assembly should provide \$XX in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.

Recommendation 2. Strengthen and Expand the North Carolina Office of Rural Health and Community Care

The North Carolina Office of Rural Health and Community Care (ORHCC) should maintain its independence and flexibility to respond to health professional workforce needs across the state in a timely manner. In order to support and strengthen the ability of the ORHCC to recruit and retain health professionals to underserved and rural areas of the state, the North Carolina General Assembly should use \$XXX of One North Carolina funds to support ORHCC in recruitment and retention of the health care industry and health care practitioners into NC. The funding should be used to:

- a) Provide financial incentives to encourage professionals to remain in practice in health professional shortage areas past their loan repayment obligations.
- b) Recruit veterans with medical training to practice in North Carolina.

- c) Provide enhanced technical assistance to areas to increase the number of communities designated as health professional shortage areas (HPSAs) and to improve the counties' HPSA scores.
- d) Create state-based area and population health professional shortage areas, if this will assist in recruiting practitioners into HPSAs.
- e) Create and maintain a database of private and public loan repayment opportunities for health professionals working in North Carolina.

Recommendation 3. Support and Expand Health Professions Programs to More Closely Reflect the Composition of the Population Served

The North Carolina Area Health Education Centers Programs should collaborate with the Alliance for Health Professions Diversity to create more intensive programs and coordinate efforts to expand existing health professions pipeline programs so that underrepresented minority and rural students who are likely to enter health careers can receive continued opportunities for enrichment programs in middle school, high school, and college. After college, the Alliance for Health Professions Diversity should offer these students continued support in medical and other health professions schools. The North Carolina General Assembly should provide \$XX in recurring funding beginning in SFY 2013 to support these efforts.

NEW MODELS OF CARE
DRAFT Recommendations

Recommendation 1. Create a Centralized Tracking System for New Models of Care

North Carolina and North Carolina foundations should provide funding to the NC Foundation for Advanced Health Programs (NCFAHP) to create and maintain a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state. The role of this organization would be to:

- a) Monitor federal funding opportunities and new regulations identifying new models of care.
- b) Convene stakeholder groups to examine existing data on costs and utilization, geographic areas of the state that are outliers in terms of costs, quality, or population health measures, and help identify appropriate new payment or delivery models of care to test.
- c) Maintain a data base of existing North Carolina demonstrations that test new payment and delivery models of care, whether funded through private or public funds
- d) Collate evaluation data on these demonstrations, and to the extent possible, identify what models work best to address specific problems. The NCFAHP should help identify whether the new payment and delivery models are evidence-based, promising practices, or unsuccessful models.
- e) Disseminate information across the state to other health care providers, health systems, insurers and state policy makers about the success of these initiatives.

- f) Provide technical assistance to communities, health care providers, insurers, or others who are interested in replicating a new model of payment or health care delivery.

Recommendation 2. Evaluate New Payment and Delivery Models

- a) Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. The evaluation should, to the extent possible, be based on existing nationally recognized metric and should include:
 - i) Quality of care metric that includes both process and outcome measures
 - ii) Patient satisfaction data
 - iii) Access to care measures
 - iv) Cost information, including changes in per member per month costs over time
 - v) The potential to improve population health.
- b) Evaluation data should be made public and shared with other health system, group of health care providers, payers, insurers, or communities so that other can learn from these new demonstrations.
- c) North Carolina foundations, payers, insurers, and government agencies that fund pilot or demonstration programs to test new payment or delivery models should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

Recommendation 3. Collect Data to Support New Models of Care

- a) The North Carolina Department of Health and Human Services (NC DHHS) should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to develop a plan to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.
- b) NC DHHS should examine what other states are doing to meet similar data needs including but not limited to all payer data systems or confederated data models, and assess the scope, costs, technical requirements, feasibility, and sustainability for different approaches. As part of this study:
 - i) NC DHHS should examine existing sources of data to determine whether existing systems can provide the necessary data, and if not, the gaps in existing systems.
 - ii) NC DHHS should examine the feasibility, costs, technical requirements, and sustainability of collecting and/or aggregating different types of data to serve different purposes, including but not limited to: *clinical*, operational, population, policy and evaluation.
- c) The plan should ensure that:
 - i) The new data system uses data already collected in the system for other purposes. Such data sources include, but are not limited to: the Health Information Exchange, Community Care of North Carolina Quality Center, Thompson Reuters, and the State Center for Health Statistics.

- ii) All providers and payers are required to contribute necessary data.
- iii) All providers and payers have access to their own data, as well as aggregated data for allowable purposes.
- iv) The new data system meets strict patient confidentiality and privacy protections in accordance with North Carolina laws.
- d) NC DHHS should prepare its plan, including a timeline and potential financing mechanisms and report it to **XXX no later than XXX**.

Recommendation 4. Examine Barriers that Prevent Testing of New Payment and Delivery Models

- a) The **XXX organization** should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers, and other health care organizations from testing or implementing new payment and delivery models that can improve health outcomes, improve population health, and reduce health care cost escalation. Some of the barriers examined should include, but not be limited to:
 - i) Insurance laws which impair the development of value-based insurance design or products which shift some of the financial risk to health care professionals or provider groups;
 - ii) Health professional licensure restrictions which prevent certain health professionals from practicing to the full extent of their education, training, and competency;
 - iii) Anticompetitive contractual arrangements which prevent insurers from implementing insurance designs that incentivize use of high quality, lower cost health care providers or professionals
 - iv) Health professional reimbursement issues which reduce the ability of health care professionals from providing evidence-based clinical services that could lead to improved patient outcomes at lower costs;
 - v) Lack of coordination between public and private payers that create differing and uncoordinated quality and outcome measures for health care professionals;
 - vi) Unnecessary and costly administrative requirements stemming from multiple payers with differing administrative requirements;
 - vii) Resistance to the adoption of new models of care among insurers, health care providers, professionals, and consumers.
- b) **XX should identify barriers and potential solutions. XX should present the potential recommendations to the NC General Assembly, licensure boards, or appropriate groups no later than XXX.**

MEDICAID WORKGROUP **DRAFT Recommendations**

Recommendation 1: Simplify Medicaid Eligibility and Enrollment Processes

The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social

Services offices, and the state, and that help eligible applicants gain and maintain insurance coverage. To accomplish this, DMA should exercise state flexibility to:

- a) Provide Medicaid coverage to pregnant woman up to 185% of the federal poverty level, and count the unborn child in the eligibility determination
- b) Include reasonably anticipated changes into the eligibility determination process, but should develop a strict definition of what meets the threshold of a reasonably anticipated change.
- c) Use annualized income to determine ongoing eligibility.
- d) Use self-attestation to verify date of birth.

(Note: The workgroup is planning one more meeting to discuss other eligibility and enrollment options that states have under the proposed regulations, North Carolina's outreach plan, and the roll that DSS staff may play, if any, as patient navigators. In addition, the workgroup will discuss potential priorities if the state, in the future, has funding to expand home and community based services.)

PREVENTION

DRAFT Recommendations

Recommendation 1: Increase Tobacco Cessation Among Medicaid Recipients

- a) NC-DMA and NC-SCHS should monitor the utilization of tobacco-cessation drugs and the impact on tobacco-related health outcomes;
- b) NC-DMA should provide all FDA approved over-the-counter nicotine replacement therapy (nicotine patch, gum, lozenge) without a physician prescription;
- c) To encourage the provision of counseling and pharmacotherapy to pregnant women for cessation of tobacco use,
 - i. AHEC and the NC Medical Society should partner to provide education to providers on billing options for Medicaid preventive services, particularly for those providers who are not enrolled in the medical home model; and
 - ii. CCNC, through Case Managers, should educate patients on the availability of these preventive services without copayment or application of deductible.
- d) If the state does not take the option to provide all USPS-TF recommended services rated A or B with no cost sharing to Medicaid recipients, then the following additional recommendations would provide tobacco cessation support for Medicaid recipients:
 - i. NC-DMA should reduce out-of-pocket costs for clients for effective cessation therapies.
 - ii. NC-DMA should provide access to all FDA approved tobacco pharmaceuticals without a co-pay for at least two cessation attempts per year. Treatments can include:
 - A) 90 day supply of nicotine patch, gum, lozenge, nicotine inhaler or nasal spray per cessation attempt

- B) And/or up to 6 month supply of Bupropion SR; NRT can be used alone or with Bupropion SR.
- C) Or a six month supply of Varenicline per cessation attempt (which is not used in combination with any other cessation pharmaceutical)

Recommendation 2: Develop Infrastructure to Allow Communities to Respond to Funding Opportunities

The Office of HNC2020 and the NC-OMHHD should:

- a) Encourage partnerships between local health departments and community organizations in responses to funding opportunities.
- b) Provide information to these organizations on available resources for assistance with identifying funding opportunities, grant writing, evaluation design and implementation, development of leadership capacity, and evidence-based interventions.
- c) Cultivate partnerships between communities, community organizations, and academic institutions to provide mutual opportunities for research and service.
- d) Provide training to local providers to improve cultural competence, and work to increase cultural diversity in community partnerships and funding opportunity participants.
- e) Work with communities to develop communication mechanisms facilitating rapid identification of collaborators to permit rapid response to funding opportunities and avoid competition within the same community. Use multiple mechanisms of communicating with community members, recognizing that the availability, ability to utilize, and interest in technology varies widely.

Recommendation 3: Support Nursing Mothers at Work

- a) The NC Department of Labor and the Office of State Personnel (OSP) should partner to educate employers and employees on the requirement for reasonable break time for working mothers, and, as appropriate, the OSP policy.
- b) Small businesses should be encouraged to provide similar support to working mothers. NC-DPH should partner with the SBA to provide information to small businesses on supporting breastfeeding mothers, as well as the requirement to apply for and prove undue hardship for an exemption to this requirement. The ACA applies to all employers that have employees covered by the Fair Labor Standards Act (FLSA). Employers with less than 50 employees must apply for and prove undue hardship if they have difficulty complying with the new provisions.
- c) The NC Department of Labor should partner with the NC Breastfeeding Coalition, who already has trained business outreach workers, to provide guidance on the Business Case for Breastfeeding, a national training model for best-practices.

Recommendation 4: Promote Worksite Wellness Programs

- a) HNC2020 and NC-DPH should provide information to businesses on evidenced-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the ACA for employer worksite wellness programs.
- b) EatSmartMoveMoreNC should provide information on CDC's worksite wellness technical assistance program through its website (<http://www.eatsmartmovemorenc.com/Worksites.html>). The CDC provides tools to employers through its website (<http://www.cdc.gov/Features/WorksiteWellness/>) to promote the use of evidence-based and health promotion approaches

Recommendation 5: Promote and Monitor Utilization of Preventive Care Services

- a) North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to other people with private coverage. Thus, North Carolina should provide coverage of all preventive services and immunizations recommended by USPSTF (with a rating of A or B) and ACIP without cost-sharing.
- b) NC-DOI should monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF, immunizations recommended by ACIP, preventive care and screening for infants, children, and adolescents, and additional preventive services for women that are recommended by HRSA. Tracking of compliance should include tracking of dates of issuance of prevention recommendations, and, thus, the insurance plan year in which the coverage is required.
- c) Electronic medical record (EMR) systems offered in NC should provide clinical decision support tools to identify and promote USPS-TF and ACIP recommended services targeted to the patient needs. NC-HIT should ensure that this requirement is incorporated in to the minimal requirements for companies providing EMRs within NC.
- d) NC-HIT, NC DMA, CCNC, and NCHQA should ensure that quality improvement initiatives at the State level include monitoring of utilization of patient-targeted prevention services.
- e) AHEC, DMA, NC Medical Society Old North State Medical Society, other health care professional associations, NC-DOI, and DSS should partner to educate providers to ensure that health professionals and caseworkers are aware of, and actively advise their patients/clients to obtain appropriate clinical preventive services. They also should partner with NC-DOI to provide education to providers on billing options for Medicare preventive services, particularly for those providers who are not enrolled in the medical home model. Providers also should be encouraged to educate patients on the value of these preventive services, as well as availability without copayment or application of deductible, and to appropriately encourage utilization of preventive services.
- f) AHEC, NCMS, AAFP, AARP, Division of Aging and Adult Services, and CCNC should provide education to primary care physicians on the annual wellness visit benefit for Medicare enrollees.

- g) Senior's Health Insurance Information Program (SHIP), AARP, and Division of Aging should provide education to enrollees on the annual wellness visit benefit.
- h) AARP, DMA, SHIP, and the Division of Aging should engage community leaders to do community outreach for education of the public.

HEALTH BENEFITS EXCHANGE

No Recommendations at this Time

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