



**OVERALL ADVISORY COMMITTEE  
WORKGROUP UPDATE  
October 31, 2011**

The last meeting of the Overall Advisory Committee was on April 15<sup>th</sup>. Over the last few months most of the workgroups have either completed their work or are in the process of completing their work and finalizing their recommendations. The following is a brief status report for each of the workgroups. Several plan on presenting their final reports and recommendations at the next meeting of the Overall Advisory Committee. **Please note that the next meeting of the Overall Advisory Committee will be held on November 21 from 9:00 am - 12:00 pm at the NCIOM offices in Morrisville.**

**HEALTH BENEFIT EXCHANGE WORKGROUP**

The Health Benefit workgroup met on August 22, September 28, and October 26. In addition, a subcommittee, focused on navigators, met on October 24.

- *August 22:* In the August meeting, the workgroup reviewed the status of state legislation to create a Health Benefit Exchange (HBE). HB 115 would establish a state-based HBE. The bill passed the House but is pending in the Senate. However, the NC General Assembly passed HB 22, which indicated the General Assembly's intent to create a state-based HBE, and directed the NCDOI and NCDHHS to continue the HBE planning process.

As a result of this directive, NCDOI submitted a Level 1 planning grant to the USDHHS. North Carolina was awarded \$12.4 million on August 12, 2011. The Level I planning grant will be used to:

1. Engage stakeholders and perform policy analysis on different policy issues.
2. Expand DHHS' eligibility IT system to include NCHBE functions.
3. Develop requirements to build non-eligibility IT systems.
4. Propose legislation and develop regulations for market reform.
5. Prepare a consumer assistance program.
6. Develop required elements for a Level II (implementation) application.
7. Support the start-up of the NC HBE, assuming the HBE is established during the project period.

Because North Carolina has not yet passed legislation creating a state-based HBE or governance Board, the NCIOM HBE workgroup will develop a series of implementation options for the Board to consider, if and when appointed. This is the primary responsibility of the NCIOM in the Level 1 implementation grant (bullet #1 above). Specifically, the HBE workgroup will provide input into: the

requirements that HBE contract with navigators to educate and help small employers and individuals enroll; coverage of mandated benefits in qualified health plans offered inside the HBE; different options to ensure financial sustainability of the HBE in 2015; evaluation criteria to judge the success of the HBE; HBE certification requirements; and potential value-added SHOP Exchange services.

At the August meeting, NCIOM, DHHS, and DOI staff also presented updates on DHHS plans to develop the HBE/Medicaid eligibility and enrollment system, the final Milliman actuarial report, and the two notices of proposed rulemaking that addressed the establishment and operation of the exchanges, and standards for reinsurance, risk corridors, and risk adjustment. A copy of the meeting summary can be found at: [http://www.nciom.org/wp-content/uploads/2011/07/HBE\\_Summary-8-22-11-final.pdf](http://www.nciom.org/wp-content/uploads/2011/07/HBE_Summary-8-22-11-final.pdf).

- *September 28:* In the September meeting, staff reviewed the new federal proposed regulations covering the health insurance premium tax credit, health insurance exchange eligibility determination process, and Medicaid eligibility determination processes. As part of the Level I planning grant, NCIOM will work with the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill and subcontractors to hold a series of small employer focus groups to obtain input that could be used to design the SHOP elements for small businesses in the HBE, and to design an outreach and education effort. We solicited input from workgroup members about questions for small employers during the focus groups. A copy of the September meeting summary can be found at: [http://www.nciom.org/wp-content/uploads/2011/07/HBE\\_summary-9-28-11-final-2.pdf](http://www.nciom.org/wp-content/uploads/2011/07/HBE_summary-9-28-11-final-2.pdf).
- *October 26:* The October meeting focused on certification requirements for qualified health plans, new accreditation requirements, North Carolina insurance law requirements for HMOs and PPOs, and financing options. A copy of the meeting summary will be posted on the NCIOM website shortly.

The HBE workgroup also created a subcommittee to consider the role of navigators in educating the public and helping them enroll in appropriate coverage. The first meeting of this subcommittee was held on October 24<sup>th</sup> at the NCIOM offices. The subcommittee discussed the existing Senior Health Insurance Information Program (SHIIP), which trains volunteers to provide impartial information and counseling to older adults and people with disabilities trying to enroll in Medicare supplement, Medicare Advantage, or Medicare prescription drug plans. The SHIIP model is similar to that envisioned in the federal navigator law. The subcommittee discussed whether North Carolina could use a similar system to train navigators in North Carolina. The subcommittee will meet one more time this fall, and bring back potential recommendations to the full HBE workgroup to consider. A copy of the navigator meeting summary is available at: [http://www.nciom.org/wp-content/uploads/2011/10/HBE\\_Navigatormeetingsummary.pdf](http://www.nciom.org/wp-content/uploads/2011/10/HBE_Navigatormeetingsummary.pdf).

**All NCIOM-hosted Health Benefit Exchange related meetings through November have been cancelled until further notice. The \$12.4 million Exchange Establishment grant awarded to NCDOI (working in partnership with NCDHHS) in August 2011 was not heard by the Joint Legislative Commission on Governmental Operations (Gov. Ops) as scheduled on October 27. As a result, NCDOI has ceased all major activities related to the Health Benefit Exchange until such time as consultation with Gov. Ops has taken place and use of the awarded grant funds has been authorized. (Note that to-date, all Exchange activities have been funded through a \$1 million Exchange Planning grant awarded in September 2010.)**

#### **NEW MODELS OF CARE WORKGROUP**

The New Models of Care workgroup met May 18, August 4, and September 6. The group discussed the following topics:

- *May 18:* The new models of care workgroup discussed the Accountable Care Organization (ACO) proposed regulations, Medicaid healthy lifestyle grant opportunity, Medicaid health homes, Health Information Exchange, and federal funding available to create a medical reimbursement center. A copy of the meeting summary can be accessed at: [http://www.nciom.org/wp-content/uploads/2010/12/NM\\_Summary-5-18-11-final.pdf](http://www.nciom.org/wp-content/uploads/2010/12/NM_Summary-5-18-11-final.pdf).
- *August 4:* The workgroup discussed the importance of collecting data to evaluate any new demonstrations or new models of care, and to make this information broadly available across the state. The workgroup heard presentations on the work of the data consortium information workgroup (discussed in more detail below), other states' all payer claims data systems, the CCNC Informatics Center, and discussed potential recommendations. A copy of the meeting summary can be accessed at: [http://www.nciom.org/wp-content/uploads/2011/06/NM\\_Summary-8-4-11.pdf](http://www.nciom.org/wp-content/uploads/2011/06/NM_Summary-8-4-11.pdf).
- *September 6:* The workgroup spent the day on September 6<sup>th</sup> discussing potential recommendations to present to the Overall Advisory Group. The workgroup will have one more meeting later in the fall to finalize the recommendations. The proposed recommendations are summarized below:
  1. Creating a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state.
  2. Ensuring that any new payment and delivery demonstrations or pilots include a strong evaluation. Evaluation data should be shared with other provider and payer groups, and the public.
  3. Developing 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.

4. Identifying barriers that prevent testing and implementation of new payment and delivery models, and strategies to reduce those barriers.

#### **MEDICAID WORKGROUP**

The Medicaid workgroup did not meet during the summer, as the group was waiting for further federal guidance from the federal government on the Medicaid eligibility and enrollment rules. The notice of proposed rulemaking was issued August 17, and the group met again to discuss the notice of proposed rulemaking on October 13, and will meet again on December 1 (9am-12pm). The proposed regulations give states some flexibility in how the Medicaid eligibility verification and enrollment process will operate. Eligibility for most Medicaid program categories, CHIP, the Basic Health Plan (if the state chooses to develop this option), and advance payment of the premium tax credit and cost sharing subsidies will be based on a person's modified adjusted gross income (MAGI). Individuals will be able to apply in person through DSS, or can apply online, by phone, mail, or fax. The ACA and proposed regulations requires states to verify eligibility for insurance affordability programs (Medicaid, CHIP, Basic Health Plan, and premium tax credits and cost sharing subsidies) based on data matches with federal and state databases (eg, Social Security Administration, Internal Revenue Service, Employment Security Commission). When fully implemented, NCFAST will be the conduit to determine eligibility using electronic data matches for all DHHS programs (eg, SNAP, TANF, Medicaid, NC Health Choice, child care subsidies), and for the premium tax credits and cost sharing subsidies in the HBE. The Medicaid, NC Health Choice, and HBE portion of NCFAST is scheduled to become operational in the summer of 2013. A copy of the Medicaid meeting summary is available at: [http://www.nciom.org/wp-content/uploads/2011/09/Medicaid-Workgroup-notes\\_20111013\\_JHps.pdf](http://www.nciom.org/wp-content/uploads/2011/09/Medicaid-Workgroup-notes_20111013_JHps.pdf).

The workgroup discussed some of the potential eligibility options given to states as part of the notice of proposed rulemaking, and made the following recommendations:

1. Continue to count both the pregnant woman and the unborn child in the eligibility determination, and continue coverage for women with incomes up to 185% of the federal poverty limit.
2. Include reasonably anticipated changes in the eligibility determination process, but develop a strict standard for what is a "reasonably anticipated" change in circumstances (such as gain or loss of a job, or change in the number of hours worked on a regular basis).
3. Use annualized income for ongoing eligibility determinations (so that people don't constantly move on and off of Medicaid due to fluctuating work hours).
4. Allow self-attestation for date of birth.

The workgroup will continue to work through the optional eligibility provisions in the December meeting, December 1 (9:00am-12:00pm).

#### **HEALTH PROFESSIONAL WORKFORCE WORKGROUP**

The Health Professional Workforce workgroup met on April 26, May 27, August 26, and September 23, and will meet again November 3 (9am-12pm), and December 6 (9am-

12pm) to try to wrap up its work. The meetings focused on the following topics:

- *April 26:* The Health Professional Workforce discussed dental health professional supply and distribution. The workgroup heard about changes to Medicaid adult dental health benefits; the impact of the new dental school at ECU on dentist supply; methods for recruiting and retaining dental health professionals; and potential policy options for meeting the dental needs of our rural communities. A copy of the meeting summary can be accessed at: [http://www.nciom.org/wp-content/uploads/2010/12/WF\\_Summary-4-26-11.pdf](http://www.nciom.org/wp-content/uploads/2010/12/WF_Summary-4-26-11.pdf).
- *May 27:* The workgroup spent the day on May 27<sup>th</sup> discussing potential recommendations to present to the Overall Advisory Group. The discussion focused on the role of the Office of Rural Health and Community Care, Medicaid policies, the need for a NC workforce planning board, need for data about the workforce and population health needs, and the need to examine state regulations and licensure board requirements to improve the regulatory environment for all licensed health professionals. The recommendations discussed at the May meeting are summarized below.
- *August 26:* At the August meeting, the workgroup discussed the allied health workforce. Presenters discussed the supply and distribution of allied health professionals, current state policy work around the allied health workforce, and the allied health training programs in the UNC and NC Community College systems. A copy of the meeting summary can be accessed at: [http://www.nciom.org/wp-content/uploads/2011/08/WF\\_Summary-8-26-11.pdf](http://www.nciom.org/wp-content/uploads/2011/08/WF_Summary-8-26-11.pdf).
- *September 23:* At the September meeting, the workgroup discussed workforce diversity and training pipelines. Presenters shared information about the importance of having a diverse health professional workforce as well as provided updates on diversity programs at Winston-Salem State University, North Carolina Central University, and the University of North Carolina at Chapel Hill. A copy of the meeting summary can be accessed at: [http://www.nciom.org/wp-content/uploads/2011/09/WF\\_Summary-9-23-11.pdf](http://www.nciom.org/wp-content/uploads/2011/09/WF_Summary-9-23-11.pdf).

The workgroup has finalized its content meetings, and is crafting its recommendations. The recommendations will likely cover:

- The role of ORHCC in recruitment and retention efforts, including obtaining additional funding to provide incentives to practitioners who are willing to remain in underserved areas past their loan repayment obligation period.
- The creation of a database of private and public loan repayment opportunities.
- The creation of a North Carolina Health Workforce Commission to proactively model and plan for future health professional workforce needs.
- State regulations and licensure Board requirements to improve the regulatory environment for all licensed health professionals so that all health professionals are able to practice to their full capacity.

Other potential areas may also be addressed, including:

- Faculty shortages;
- Need for more primary care and community-based clinical sites; and
- Need to increase diversity of health professional workforce at all levels and provider types.

### **PREVENTION WORKGROUP**

The Prevention workgroup met on May 31 to discuss the new Community Transformation Grant application, and to solicit feedback from stakeholder groups about the state's application. A copy of the meeting summary can be found at:

[http://www.nciom.org/wp-content/uploads/2011/05/PR\\_Summary-5-31-11-final.pdf](http://www.nciom.org/wp-content/uploads/2011/05/PR_Summary-5-31-11-final.pdf).

The workgroup is now in the process of finalizing its recommendations, focusing on: pregnancy and parenting, tobacco control, worksite wellness and promotion of healthy lifestyles, coverage of preventive health services, personal responsibility and abstinence education, outreach and education, improving access to preventive services through Medicaid, and defining mechanisms to ensure that prevention activities target both communities with the highest rates, as well as those with the highest numbers of people with preventable conditions. The workgroup plans on presenting the recommendations to the full Overall Advisory group in the November meeting.

*Funding update:* On September 28th, the CDC announced the funding for the Community Transformation Grant. The CTG was a competitive grant award to support states or large cities (population of 500,000 or more) with multifaceted interventions to improve population health. North Carolina was one of 35 states and communities that received an implementation grant. The state received \$7.466 million, the 4<sup>th</sup> largest award announced. North Carolina plans to disseminate these funds to between 10-20 communities throughout the state through a competitive request for proposal process. Funding must be used to focus on 11 strategies in three core areas: tobacco free living, active living and healthy eating, and use of high impact evidence-based clinical and other preventive services. All counties, except Mecklenburg and Wake, will be able to compete for funding through the Division of Public Health. (Note: under the federal CTG grant, Mecklenburg and Wake were required, as large counties, to submit their own grant applications. Neither of their grant proposals was selected for funding.)

### Tobacco free living

1. Increase smoke-free regulations in local government buildings and indoor public places.
2. Increase tobacco-free regulations for government grounds, including parks and recreational areas.
3. Increase smoke-free housing policies in affordable multi-unit housing, and other private sector market-based housing.
4. Increase the number of 100% tobacco free policies on community college campuses and state and private university/college campuses.

### Active Living and Healthy Eating

5. Increase the number of convenience stores that increase the availability of fresh produce and decrease the availability of sugar sweetened beverages.
6. Increase the number of communities that support farmers' markets, mobile markets, and farm stands.
7. Increase the number of communities that implement comprehensive plans for land use and transportation.
8. Increase the number of community organizations that promote joint use/community use of facilities.

### High impact, evidence-based clinical and other preventive services

9. Increase the number of health care providers who utilize quality improvement systems for clinical practice management of high blood pressure and high cholesterol.
10. Increase the number of health care organizations that support tobacco use screening and referral to cessation services.
11. Increase the number of community supports for individuals identified with high blood pressure, high cholesterol and tobacco use (eg, chronic disease self-management programs, weight management programs, tobacco cessation programs).

### **SAFETY NET WORKGROUP**

The Safety Net workgroup met on April 25, May 23, June 14, and July 28. The meetings focused on the following topics:

- *April 25:* The Safety Net workgroup discussed emergency care including recommendations from the North Carolina College of Emergency Physicians. They also discussed emergency department diversions involving mobile crisis services and safer opioid prescribing. A summary of the meeting can be accessed here: [http://www.nciom.org/wp-content/uploads/2010/11/SN\\_Summary-4-25-11.pdf](http://www.nciom.org/wp-content/uploads/2010/11/SN_Summary-4-25-11.pdf).
- *May 23:* The workgroup discussed pharmacy care in FQHCs and the 340b discount drug purchasing program, pharmacy care for older adults, and medication assistance programs. A summary of the meeting can be found here: [http://www.nciom.org/wp-content/uploads/2010/11/SN\\_Summary-5-23-11.pdf](http://www.nciom.org/wp-content/uploads/2010/11/SN_Summary-5-23-11.pdf).
- *June 14:* The workgroup reviewed the provisions of the ACA pertaining to safety net organizations to determine the focus for its recommendations.
- *July 28:* The workgroup discussed potential recommendations to respond to ACA opportunities and increase access to care.

The Safety Net workgroup is in the process of finalizing its recommendations and writing the final section of the report. The recommendations will focus on three main topics: 1) leveraging safety net resources; 2) education, information dissemination, and patient navigation; and 3) addressing gaps in the safety net system. The group is also finalizing a tool that maps safety net resources across the state with Community Care of North

Carolina data about access to primary care providers. The Safety Net workgroup will finalize its recommendations in a meeting on November 16.

*Funding update:* North Carolina was recently awarded almost \$1.5 million in ACA funding to create two new FQHCs through Greene County Health Care and in Elizabeth City (Albemarle Regional Hospital Authority). In addition, two other organizations were awarded \$80,000 planning grants to prepare plans to transition to FQHC: Triad Adult and Pediatric Medicine (Greensboro), and Community Health Interventions and Sickle Cell Agency (Fayetteville).

In addition to the grants to create new health centers, the US Department of Health and Human Services also provided grant opportunities to increase the capacity of community health centers to provide patient centered medical homes. The federal government offered two new funding opportunities:

- *BPHC's PCMH Supplemental Funding Opportunity:* At the end of September, BPHC announced supplemental awards to approximately 900 FQHCs nationwide to support the practice changes needed to transition to patient-centered medical homes. Eighteen FQHCs in NC received this \$35,000 grant award. (FQHC-Look Alikes were not eligible for participation). Grantees must “agree to seek recognition, increase their recognition level, or maintain the highest level as a PCMH through a national or State-based recognition or accreditation program.” The following North Carolina Health Centers received this additional funding: Roanoke Chowan Community Health Center (Ahoskie); Medical Resource Center for Randolph County (Asheboro); Western NC Community Health Services (Asheville); Piedmont Health Services (Carrboro); C.W. Williams Community Health Center (Charlotte); Lincoln Community Health Center (Durham); Stedman-Wade Health Services (Fayetteville); Gaston Family Health Services, (Gastonia); Blue Ridge Community Health Services (Hendersonville); First Choice Community Health Centers (Mamers); CommWell Health (Newton Grove); Robeson Health Care Corporation (Pembroke); Wake Health Services (Raleigh); Rural Health Group (Roanoke Rapids); Greene County Health Care (Snow Hill); Metropolitan Community Health Services (Washington); New Hanover Community Health Center (Wilmington); Carolina Family Health Centers, Inc (Wilson).
- *FQHC Advanced Primary Care Practice Demonstration:* This is a three-year demonstration project for FQHCs and FQHC Look Alikes offered to approximately 500 health centers nationally. Funding is provided from the Center for Medicare and Medicaid Innovation, within the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA). The demonstration project is “designed to evaluate the effectiveness of the advanced primary care practice model, also known as the patient-centered medical home, in improving care, promoting health, and reducing the cost of care” by moving sites toward NCQA Level 3 recognition by the end of the three years. CMS received more than 800 applications, and 18 sites representing 10

FQHC organizations were selected for participation in North Carolina, including: First Choice Community Health Center (Spring Lake, Angier, Cameron), Gaston Family Health Services (Bessemer City), Greene County Health Care (Snow Hill, Greenville), Metropolitan Community Health Services (Washington), Opportunities Industrialization (Roanoke Rapids), Piedmont Health Services (Burlington, Prospect Hill), Roanoke Chowan Community Health, (Colerain), Robeson Health Care Corporation (Pembroke, Maxton), Wake Health Services (Raleigh, Apex), Rural Health Group (Norlina, Hollister, Whitakers)

To help participating FQHCs undergo practice transformation and progress toward PCMH recognition, they will receive an \$18 quarterly care management fee per eligible Medicare beneficiary receiving primary care services. These quarterly payments are in addition to Medicare's per visit payments. CMS and HRSA will provide technical assistance, and FQHCs are required to submit NCQA Readiness Assessment scores every six months. The demonstration awards were announced on October 24, and the demonstration will begin on November 1.

#### **QUALITY WORKGROUP**

The Quality workgroup held its final, in-person meeting in March, and is in the process of finalizing recommendations. The nine recommendations focus on provider education, health information exchange, and transitions of care. The group hopes to present its final report and proposed recommendations to the Overall Advisory Group in November.

#### **FRAUD AND ABUSE WORKGROUP**

The Fraud and Abuse workgroup held its final meeting in April and is finalizing its proposed recommendations and report by email.

The workgroup helped draft proposed legislation to address ACA implementation requirements. DMA used this proposed legislation, along with the 19-point concept list from the Dec 2010 meeting, to draft its recommended fraud and abuse legislation. DMA's proposals were introduced into the 2011 Session (Senate Bill 496), and were ultimately enacted as Session Law 2011-399. The legislation included provisions addressing the following topics:

- Medicaid and Health Choice provider screening
- Criminal history record checks for certain providers
- Payment suspension and audits utilizing extrapolation
- Registration of agents, clearinghouses, and alternative payees
- Prepayment claims review
- Threshold recovery amount
- Provider enrollment criteria
- Change of ownership and successor liability
- Cooperation with investigations and audits
- Appeals by Medicaid providers and applicants
- Procedures for changing medical policy

A copy of the legislation is available at:  
<http://www.ncleg.net/Sessions/2011/Bills/Senate/PDF/S496v5.pdf>.

Although this legislation covers the requirements of most of the ACA fraud and abuse provisions, DMA continues to work on rules to address some of the remaining requirements, such as provider compliance programs, fingerprinting as part of provider screening, registration of groups submitting claims on behalf of providers, face-to-face requirement for certification for home health services, surety bond size adjustment for DME and home health agencies, and withholding of payment for DME suppliers with significant fraud risk. In addition, final federal rules for the Recovery Audit Contractor (RAC) program were released in Sep 2011, so the state now will issue a request-for-proposal (RFP) for a RAC. The state plan amendment has been approved, and an interim contractor is in place, which puts the state in compliance with the RAC program requirement. The state needs further clarification from the federal government before addressing two additional provisions regarding submission of Medicaid encounter data.

#### **DATA COALITION**

As noted earlier, one of the outgrowths of different workgroups was the need for data to support different initiatives. For example, cross payer data will be needed to evaluate multipayer initiatives, and the NC Department of Insurance may need claims and diagnosis data to establish a risk adjustment system (to adjust payments to health plans inside and outside of the HBE). Further, an all payer claims database (APCD) could be helpful to hospitals to identify when patients are readmitted (when admitted to a different hospital than where the patient received the initial treatment). The federal government offers states limited funding to help states establish APCDs. NCIOM staff were able to identify 11 states with active APCDs, and six states in the process of implementing APCDs. The data are being used by states to compare utilization patterns, identify cost saving strategies, disease surveillance, and program evaluation.

The NC DHHS has taken the lead in pulling together an ad-hoc group of stakeholders to identify the need for a similar data system in North Carolina. NCIOM staff have worked with others to compile a catalog of existing North Carolina health-related data systems, to determine if existing data systems can address the data needs listed above. This catalog includes information on ownership, access restrictions, availability of specific types of data (e.g., patient identifiers, demographics, diagnoses and procedures, charges or cost), time lag between patient visit and data availability, and intended use.