



MEMORANDUM

TO: NCIOM Health Reform Overall Advisory Group

FROM: Pam Silberman

DATE: October 21, 2010

RE: Update on Workgroup Activities

The memo provides a brief update on the work of the different workgroups since the Overall Advisory Committee last met on September 22nd.

HEALTH BENEFITS EXCHANGE (HBE) AND INSURANCE OVERSIGHT

The workgroup focused the last meeting on two questions: 1) Should the state develop its own HBE or leave it to the federal government; and 2) If the state develops a health benefit exchange, what type of administrative organization should operate the HBE. After considerable discussions of the pros and cons of a state vs. federal HBE; the workgroup members reached consensus that the advantages of a state-operated HBE outweighed that of a federally operated HBE. Some of the advantages of a state-operated HBE include:

- State maintains regulatory authority over a large share of the commercial market
- The state has greater ability to mitigate risk selection that can result from different rating and underwriting rules for insurance sold in and outside the HBE. For example, the state can choose to limit initial enrollment to small groups of 50 or fewer employees (which may be important if some of the larger groups with 51-100 employees self-insure, so that only the unhealthy risks choose to purchase insurance inside the HBE)
- Greater ability to coordinate eligibility and enrollment between the HBE, Medicaid and NC Health Choice
- Ability to promote state health reform strategies and priorities through the HBE (including payment reform, support for patient centered medical homes, etc.)
- More control over the number and types of plans offered through the HBE
- If the federal government operates the HBE, carriers may be subject to two sets of rules and reporting requirements for policies sold in the HBE (federal oversight) and those sold outside the HBE (state oversight)
- We do not know what a federal HBE will look like, and have greater control over the initial decisions
- Greater state flexibility, creativity and oversight of costs if the state operates the HBE
- Greater ability to modify the operations if we discover some aspects not working well for North Carolinians
- State policy makers have a voice in the process, and would be potentially more committed to make sure the agency is meeting the needs of North Carolinians

The disadvantages of a state-operated HBE (advantages of a federally operated HBE) include:

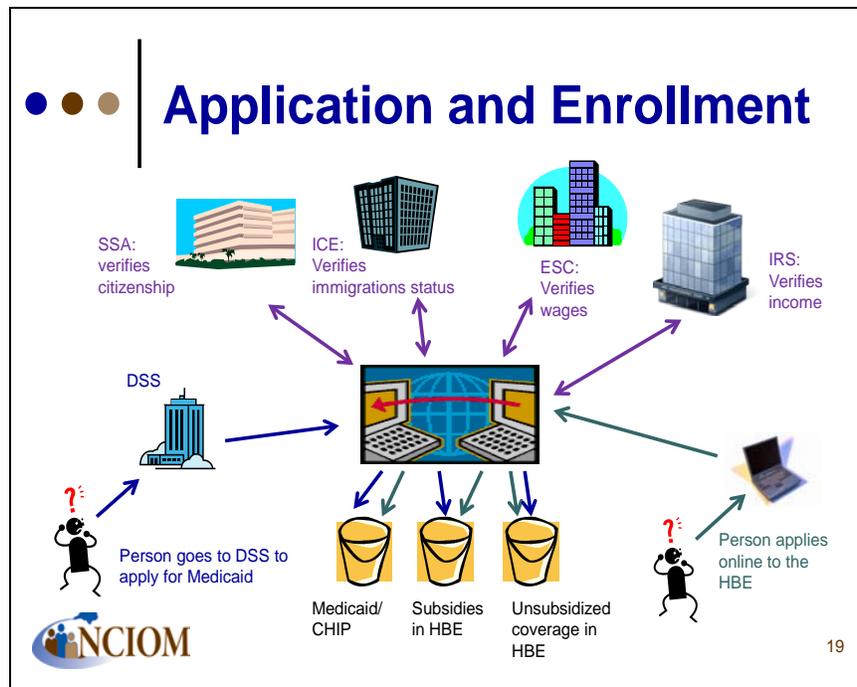
- The state would not be burdened with developing a new program
- The federal government would need to ensure that the HBE was self-sustaining by 2015

- Tension between keeping administrative fees low and satisfying demands for high quality customer service
- While the group thought it may be easier to address risk selection if the state were regulating insurers both inside and outside the HBE; the group recognized that the federal government would also have to address this potential problem if it were operating the HBE
- May be economies of scale if the federal government were operating multiple HBEs, and this could reduce administrative costs (although the group did question whether it would be more or less affordable at the state or federal levels)

The workgroup also began discussions of whether the HBE should operate through an existing state agency, or whether to create a new quasi-state agency or non-profit. The workgroup members will continue to explore this issue at the November meeting.

MEDICAID AND ELDER JUSTICE

The Medicaid workgroup examined the new requirements for eligibility and enrollment that will go into effect in January 2014. The law requires the state to coordinate enrollment between Medicaid, NC Health Choice and the Health Benefit Exchange. Effectively, there should be a “no-wrong door.” Thus, if someone applies for a subsidy through the Health Benefits Exchange, and is determined to be eligible for Medicaid, they must be enrolled automatically into Medicaid. Similarly, if someone applies for Medicaid, but is over-income, but eligible for a subsidy for insurance offered through the HBE—then they should be enrolled automatically into a subsidy program. Also, most people will be able to file their application online, and have income and citizenship (or immigration status) determined through a data match with other federal or state agencies. (See graphic below)



The NC Department of Health and Human Services is already in the process of trying to simplify the Medicaid application and recertification process, and to streamline eligibility requirements

across all of the DHHS means-tested programs (eg, Food Stamps, TANF, child care subsidies, etc.) In addition, NC DHHS was in the process of replacing its different legacy eligibility and enrollment systems, and replacing it with a new information system—NC FAST—that would capture and share information across all the DHHS programs. Because of the new ACA requirements, the timeline for implementing the new Medicaid electronic enrollment system will be expedited, so that it will be operational by January 2014.

NC DHHS does not have the resources (staff, funding) or the time to be able to take on the new responsibilities of developing the HBE enrollment portal; but does want to work collaboratively with whatever group that is ultimately responsible for designing this information system.

The workgroup also began to discuss the role of DSS once this new system is operational in 2014. Instead of processing all the new applications, DSS may play more of a role in outreach, and helping people who are having difficulties having their applications processed electronically (for example, because of a recent change in circumstances that may not yet be reflected in administrative databases that have time lags).

NEW MODELS OF CARE

The workgroup heard presentations on patient care seeking patterns (for example, for hospital discharges, primary care) to see if there were any logical referral and use patterns. While there is some congruence between care seeking patterns in some communities; there is not direct overlap in other communities. Further, care seeking patterns for overall hospital care, may not be the same if one were to look at treatment of specific conditions. These data could have significant impact on the ability of a health system or state to develop Accountable Care Organizations.

The workgroup also heard presentation of four primary care focused initiatives that are being implemented in different parts of the state that are “promising” in terms of increased efficiency, improved quality, and improved patient outcomes: integrative behavioral health in a patient centered medical homes; group health visits; home visits for the frail elderly; and high tech, high touch, low overhead model.

The workgroup then began a discussion of what key elements need to be in place to help reduce health care costs, improve patient quality and access to care. We also discussed the importance of developing appropriate outcome matrices and measures to ensure that we learn what works under what conditions. The workgroup will continue this focus at its November meeting.

PREVENTION

The prevention group has focused to date on mechanisms to foster collaboration between counties, non-profits, and the state as funding opportunities present. We now will switch gears to look at specific provisions that are not tied to funding, e.g., identifying evidence-based prevention strategies that encourage healthy living for low-income or Medicaid populations.

QUALITY

This workgroup has created a spreadsheet which identifies the different ACA requirements addressing quality (including new reporting requirements and initiatives that can affect provider payments). The workgroup is also in the process of identifying existing state quality initiatives. The workgroup will use this information to identify potential gaps. Some of the areas that the workgroup will consider include: 1) provider education (is there a mechanism to ensure that

providers are knowledgeable about the new quality requirements); 2) technical assistance or quality improvement initiatives (are there existing state resources to help the providers meet the ACA quality requirements); 3) do the existing state resources have the capacity to help all the different providers who need help meeting the new quality requirements.

SAFETY NET

The workgroup has spent the last two meetings describing different safety net resources that exist across the state, and identifying communities of greatest unmet needs. For example, at the most recent meeting, the workgroup heard a presentation about the new Critical Access Behavioral Health Agencies (CABHA). The workgroup also examined preliminary data on counties where there were problems linking Medicaid recipients into a CCNC primary care home. The data included information for children and adults separately. The goal is to combine these data, with new county level data on the uninsured (when that becomes available), and other data that helps identify communities with the greatest access barriers. The workgroup is starting by examining access to primary care, but understands that similar data are needed for behavioral health. (The workgroup members noted that with the exception of a few communities--access to dental services was a barrier throughout the state). The workgroup also received updates on new federal safety net grant opportunities, including the recently released opportunity for school-based health centers; and an update on the timing of the FQHC funding opportunities.

WORKFORCE

North Carolina was recently awarded a State Health Workforce Planning Grant. The focus of the State Health Workforce Planning Grant is to develop strategies to expand the supply of primary care providers over the next 10 years. Because of this recent award, the workgroup leaders decided to postpone the full workgroup meeting until November. Instead, the steering committee members are meeting in October to discuss how these two efforts can work together and complement each other (so as to avoid duplicating efforts).

FRAUD, ABUSE AND OVERUTILIZATION

The workgroup developed a gap analysis spreadsheet that compares the ACA requirements to current work in NC. The workgroup members are also identifying those provisions that require new legislation or rules to implement. The next two meetings will focus on three gap areas each. The November meeting will focus on creating risk categories (ie, provider groups that need heightened scrutiny versus those that require a lower level of oversight), the need to change state laws that govern criminal background checks, and review of the state's existing payment suspension policies. The December meeting will focus on recipient fraud; whether private insurers/payers should use the same guidelines on fraud, abuse and overutilization; and registration of billing agents. The workgroup will discuss ways to educate providers about the new provisions in each of the meetings.