



MEMORANDUM

TO: NCIOM Health Reform Overall Advisory Group

FROM: Pam Silberman

DATE: December 14, 2010

RE: Update on Workgroup Activities

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

HEALTH BENEFITS EXCHANGE (HBE) AND INSURANCE OVERSIGHT

In the November meeting, the workgroup continued the discussion of whether the HBE should be housed in an administrative agency, or whether the HBE should be an independent non-profit. The North Carolina General Assembly does not have the authority to create a totally independent non-profit corporation; thus, if the legislature decides to create a non-profit, it would operate more like a quasi-public organization. The workgroup heard a presentation from John Friesen, Chair of the Inclusive Health board, North Carolina's high risk pool. The board members for NC Inclusive Health are selected by the Insurance Commissioner, Governor and legislature. In addition, while a separate nonprofit organization, Board members are subject to the Government Ethics Act, the organization is audited by the State Auditor, and Inclusive Health submits an annual report to the North Carolina General Assembly. In addition, Inclusive Health complies voluntarily with the public meeting laws, and has a strong conflict of interest policy for board members. The workgroup members generally agreed that the HBE should have a similar structure. In particular, the workgroup members agreed that a separate non-profit agency offers more flexibility and can be more nimble to address issues as they arise. However, the new organization also needs to be accountable to the public. Thus, the work group members suggested:

- The Board be appointed by the state officials (the NC General Assembly, Governor, or Department of Insurance) (No decisions could be reached about Board composition)
- The HBE be required to submit reports annually to the General Assembly
- The HBE be required to comply with public meeting and public records laws (with protections for proprietary information)
- The HBE be audited annually by the State Auditor
- The HBE Board be subject to the state ethics requirements, and the Board would have a strict conflict of interest policy

While the HBE should comply with many of the state accountability provisions, the workgroup members generally believed that the HBE should be exempt from the state procurement and contracting provisions, and from the State Personnel Act.

At the November meeting, the HBE workgroup began to discuss, in more detail, the responsibilities of the federal government, North Carolina General Assembly, HBE Board and staff, and other agencies in establishing and operating the HBE. For example:

Some of the federal government responsibilities include:

- Defining the essential health benefits, periodically update essential health benefits, and develop guidelines to allow for *de minimis* variation in actuarial variations of different "metal" plans (Sec. 1302)
- Issuing regulations setting standards for operations of the HBE, offering qualified health plans, reinsurance and risk adjustment, and other requirements (Sec. 1321(a))
- Setting benchmarks to determine if the state is making progress towards establishing a HBE (Sec. 1311a(4))
- Establishing criteria to certify qualified health plans (Sec. 1311(c))

Some of the NC General Assembly's responsibilities include:

- Deciding whether to establish a state operated HBE or let the federal government run it (Sec. 1321(c))
- Determining the governance and administrative structure of the HBE (Sec. 1321(c))
- Providing a revenue or funding source to ensure the HBE can be self-sufficient by 2015 (Sec. 1311(d)(5))
- Determining whether to maintain "mandated benefits" inside the HBE (Sec. 1311(d)(3))

In addition, the General Assembly could make other decisions, or delegate those decisions to the HBE Board, such as:

- Determining whether to create one or two HBEs, and if one HBE, whether to combine the small group and individual market (Secs. 1311(b)(2), 1312(b)(3))
- Determining the size of the small firms initially allowed to purchase health insurance in the HBE (ie, <50 or <100 employees)(Sec. 1304, 1312(f)(2)(B))

In addition to the responsibilities which the North Carolina General Assembly may delegate to the HBE Board, the Board will have other responsibilities, including but not limited to:

- Hiring the Executive Director
- Establishing exchange policies
- Developing a plan to ensure the HBE is self-sustaining by 2015, and ensure the financial integrity of the HBE (Sec. 1313)

The HBE staff will have other responsibilities, including:

- Certifying and recertifying health plans according to federally prescribed rules (Sec. 1311(d)(4)(A), 1311(e))
- Ensure the operation of a web portal to provide comparison information about health plans (Sec. 1311(d)(4)(C),(G))
- Establishing and maintaining an electronic enrollment system to determine and coordinate eligibility for subsidies, Medicaid and NC Health Choice (Sec. 1311(d)(4)(F))

The workgroup is going to continue to discuss and refine the responsibilities of the different groups at the December meeting. Once the workgroup has a better understanding of the different responsibilities of the HBE board, the members will discuss the Board structure.

The workgroup also heard a presentation from students in the School of Public Health at the University of North Carolina in Chapel Hill about what consumers look for when they choose a health plan, and how much “choice” is too much “choice.” The students gave a summary of the research literature on this topic. They reported that the research suggests that to make it easier for consumers to choose a health plan, North Carolina should decrease the amount of data presented to the consumer at one time, make it easier to create a step-wise decision process, and standardize plan designs.

MEDICAID AND ELDER JUSTICE

The Medicaid workgroup met before the last Overall Advisory group meeting and did not meet in December. The workgroup is waiting for additional guidance from the federal government on the new home and community based service options (in order to understand the financial incentives). The workgroup is also waiting for further federal guidance on the eligibility and enrollment process, and how the federal government expects the states to determine “new eligibles” from those who were previously eligible but not enrolled.

NEW MODELS OF CARE

At the November meeting, the workgroup received materials from the Commonwealth Fund which rates states on a number of different measures of health system performance. Overall, North Carolina ranked 41st (out of 50 states, with “1” being the highest rated states). North Carolina ranked 32nd on access measures, 32nd on prevention and treatment, 25th on avoidable hospital use and costs, 43rd on equity, and 40th on healthy lives. More information on the rankings is available at:

http://www.commonwealthfund.org/~media/Files/Chart%20Maps/2009%20State%20Scorecard/North_Carolina_combined_tables_v2.pdf.

The workgroup also heard a detailed presentation from Don Bradley, MD, MHS-CL, Senior Vice President of Healthcare & Chief Medical Officer, Blue Cross and Blue Shield of North Carolina (BCBSNC) on the cost drivers in BCBSNC. Don Bradley noted that part of the reason for the increase in health care expenditures is due to:

- 1) The increase in the prevalence of treated disease. This is due, in part, to lifestyle choices. For example, our growing obesity rates contribute to an increase in the prevalence of diabetes, as well as an increase in the number of knee replacement surgeries.
- 2) Redefining certain diseases. For example, some conditions which would not have been treated in the past are more likely to be diagnosed and treated.
- 3) Costs of treatment, which is impacted both by the underlying price of the service or procedure and utilization. There is significant geographic variation in the costs of treating certain conditions. For example, the allowed cost per service for a MRI is consistently higher in North Carolina than in the South Atlantic or nationally. Further, there are variations in costs and utilization of services across North Carolina.

- 4) Use of new technology, including imaging, pharmaceuticals, biological therapeutics, genomics, and medical devices.
- 5) Redundancy, inefficiency, and ineffectiveness, including administrative costs, disintegrated care, lack of evidence-based care, defensive medicine.

The workgroup spent most of the November meeting discussing medical cost trends, and heard preliminary information on Medicaid cost trends. The group will learn more about the Medicaid cost drivers in the December meeting, and then will begin to discuss different models of care that have the potential to increase quality and patient outcomes and reduce health care cost escalation.

QUALITY

The Quality Workgroup subcommittee met twice this month to complete an analysis of gaps in resources and technical assistance for providers. We are working with the provider associations to attempt to identify resources that are in place to assist providers in identifying the changes they need to make to meet ACA requirements, tools available to assist providers in measuring their success, and the percentage of the providers that these organizations have been able to reach regarding these requirements.

In the December Workgroup meeting, we reviewed and modified the gap analysis and discussed the need for legislation. Three subcommittees were defined to work on specific gaps. They will report back to the workgroup at the next meeting.

1. Education: The assignment of “primary responsible parties” for some of the education gaps needed a greater depth of discussion than was possible in the workgroup session. The subcommittee will undertake this discussion, as well as discussion of best practices for disseminating information to the various provider groups with goals of penetration and retention of information.
2. Legislation: This committee will focus on the gaps the workgroup identified as requiring legislation. They will develop legislation recommendations with pros and cons for each issue.
3. Hospital Readmissions and Transitions of Care: The Quality workgroup discussed the challenges in reducing hospital readmissions. The failure to coordinate transitions of care from the hospital to outpatient or skilled nursing helps contribute to high rates of hospital readmissions. There are some consistent, evidence based interventions that can improve transitions and decrease readmissions. The subcommittee will identify these interventions and identify possible options that could be implemented based on community needs. Since many of the providers involved in a patient care episode are represented in the workgroup, it was felt that this provided an opportunity for developing methods for improving communication between providers groups, identifying infrastructure needs (intra- and inter-provider), defining minimum information required for successful transfers, and developing templates for this information transfer that would be consistent statewide.

PREVENTION

The Affordable Care Act requires that all private insurers and Medicare provide coverage for all the clinical preventive services recommended by the US Preventive Services Task Force (USPSTF) with an A or B recommendation and the immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) with no cost sharing. (Sec. 2713 of the Public Health Service Act, as amended in Sec. 1001 of the ACA; Sec. 4104 of the ACA) However, the ACA does not appear to have the same requirements for the Medicaid program. Instead the ACA provides a one percentage point increase in the federal medical assistance percentage (FMAP) rate for preventive services and immunizations if the state provides the same recommended coverage with no cost sharing. (Sec. 4106)

At the November meeting the Prevention Workgroup examined the current Medicaid coverage of preventive services and immunizations to determine if the state provides the coverage of the recommended preventive services and immunizations, and to identify existing cost-sharing requirements. A subcommittee was formed to review the cost implications of covering these services without cost sharing, and to calculate the cost offset if North Carolina were to qualify for the increased FMAP rate. The results of this analysis will be reviewed at the next meeting. The workgroup also discussed the need for education of providers on the reimbursement codes to be used to increase penetration of preventive services that currently are covered by Medicaid. Due to the interest from the group in developing a plan for coordinating the involvement of community organizations and communities of greatest need in ACA funding opportunities, and for helping communities develop the required infrastructure for participating in funding opportunities, a subcommittee was formed to work on this issue. The subcommittee will report back at the January meeting.

At the next meeting three provisions will be discussed:

1. Reasonable break times and appropriate facilities for working mothers
2. Screening of pregnant women for smoking
3. Small business worksite wellness

FRAUD, ABUSE AND OVERUTILIZATION

The Fraud and Abuse workgroup has been working on a gap analysis. Specifically, the workgroup has been examining the ACA provisions and comparing these to the existing North Carolina compliance efforts and laws.

In November, the workgroup discussed three areas:

1. Risk categories for compliance programs: Specific issues addressed included which provider types will be required to have compliance programs, whether NC should match or exceed the Federal categories for high risk providers, and how to designate/identify high-risk providers.
2. Criminal background statutes: What information from criminal background checks should preclude someone from being able to be hired?
3. Payment suspensions: How many chances do providers get to implement a plan of correction? What is a “substantial issue” for suspension? What sort of safe-haven do you give to a provider who has accepted clients from a troubled provider? (In other

words, should you give the new provider some time to address the problems that arose from the first provider before sanctioning the new provider for the same issues?)

A subcommittee was formed to develop legislation (recommendations, pros, cons) from this discussion.

In the December meeting we discussed the following issues:

1. Billing agents:
 - a. What is a billing company?
 - b. Impact of registration charges on small vs large billing agencies (The ACA requires billing agencies to register with the state and the Secretary in a manner to be deemed by the Secretary)
 - c. How will multi-state billing companies be impacted by these provisions, and how can the state recoup from a multistate company if there is a problem?
 - d. Goals of registration
 - e. Who is educating billing agencies about ACA provisions/requirements?
 - f. What should be required for registration? Several items were considered: business license, liability insurance, contact information, notice if they are being investigated by another entity, continuing education, compliance plan, and a client list.
2. Should private insurers follow the same fraud, abuse and overutilization provisions that are in the ACA for Medicaid, Medicare and CHIP? The consensus was that consistency in the rules makes it easier for providers and decreases the risk of error.
3. County DSS/Recipient fraud: What education needs to be provided to the public? Who should provide it? Concerns discussed included creating a consistent system across the state for dealing with recipient fraud, and the need for standards for those doing presumptive eligibility work to improve accuracy.

WORKFORCE

Dr. Swartz presented an overview of mental health workforce needs in North Carolina. North Carolina, and the rest of the nation, has a shortage of mental health professionals; especially child psychiatrists. In approximately 80 North Carolina counties there are fewer than one full-time equivalent psychiatrist per 10,000 residents; in 85 North Carolina counties there are fewer than one full-time equivalent child psychiatrists per 10,000 children. The lack of workforce in mental health is due to difficulties in training and retaining staff, lack of career ladders, marginal wages, and inefficient resources. Dr. Swartz also presented potential strategies to increase the supply of mental health professionals recommended by the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.

After Dr. Swartz's presentation, the workgroup discussed strategies that could help meet North Carolina's mental health needs over the next 1-4 years. The workgroup agreed that the following were important to maintain and expand the mental health workforce to meet the state's short-run needs.

Maintaining or Expanding Access to Mental Health Services

- Keeping Medicaid reimbursement rates for mental health visits high is critical to efforts to maintain or expand access to mental health services for low-income populations.
- Need to develop/strengthen recruitment strategies for mental health professionals.
 - Publicizing the National Health Service Corp loan program for mental health professionals.
 - Look into expanding the definition of mental health provider under the state loan program.
- Continue to strengthen and support integrated care strategies such as co-location.
- Need to increase the numbers of social workers, health techs, substance abuse counselors and other professional and direct support workers to meet the increase in demand for mental health services.
- Monitor the ability of nurse practitioners and physician's assistants who graduate with a mental health specialty/focus to obtain jobs. As integrated care increases, demand for individuals with this type of training will increase. Once this occurs, North Carolina health professional schools should increase the NP and PA programs that produce professionals with a mental health specialty. This level of health professional—who can provide both basic medical care and basic mental health care—are more likely to be able to be financially viable integrated care providers.

Workforce Development and Expansion

- Develop specific training requirements and career pathways for direct care workers and others who provide much of the care for individuals with mental health needs. Educational programs, current professionals, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the Division of Medical Assistance (DMA), and relevant licensing bodies should be included in these discussions. Service definitions and billing rates (set by DMA), influence the mental health workforce significantly and more needs to be done to ensure that decisions being made about training requirements, service definitions, and billing rates are coordinated so that who can practice, the type of care they can deliver, and their training requirements are clear and help support career pathways for all levels of health professionals working in mental health.
- Currently a significant amount of state and federal funding goes towards inappropriate care models (e.g. overuse of psychotropics) rather than to training the right mix of professionals. Need to analyze current Medicaid data to see where savings could be achieved and reinvested in improving mental health care.

SAFETY NET

The Safety Net workgroup did not meet in November. In the December meeting it will focus on:

1. An understanding of the new data on the uninsured, including county level data
2. Behavioral health integration models
3. Farmworkers and health access