



MEMORANDUM

TO: NCIOM Health Reform Overall Advisory Group

FROM: Pam Silberman

DATE: November 17, 2010

RE: Update on Workgroup Activities

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

HEALTH BENEFITS EXCHANGE (HBE) AND INSURANCE OVERSIGHT

At the October meeting, the workgroup members reached consensus that the advantages of a state-operated HBE outweighed that of a federally operated HBE. At the November meeting, the workgroup members discussed the pros and cons of having a state-operated exchange, versus a quasi-state, public-private non-profit.

- *State agency:* The NC General Assembly could not establish a separate, independent state agency to operate the HBE. Section 11 of Article III of the NC Constitution limits the number of principal (independent) administrative departments to no more than 25. We have already reached that limit; thus if North Carolina wants to create a state agency HBE it would need to be housed in another executive agency. The primary advantage of establishing a state-agency HBE is the level of accountability. Further, the public may have more trust in the credibility and impartiality of a state agency HBE.
- *Quasi-state, public-private non-profit.* The NC General Assembly does not have the legal authority to create a totally private non-profit entity. Thus, if the state is interested in establishing a non-profit to operate the HBE, the entity would be a quasi-public agency. The state's high risk pool, Inclusive Health, is an example of a quasi-public agency. Inclusive Health is a non-profit, but board members are appointed by the NC General Assembly, NC Department of Insurance and Governor's office. The authorizing legislation requires the board to meet many of the requirements of state agencies (NCGS §58-50-175). For example, Inclusive Health is audited by the state auditor, board members must meet the statutory ethics rules, and the Executive Director must make an annual report to the legislature. The main advantages of the quasi-state, non-profit are that the agency has more flexibility and can react more quickly to market changes. The authorizing legislation can still include provisions to ensure accountability and oversight.

The workgroup members generally agreed that there were more advantages to establishing a quasi-state, public-private non-profit entity than a state agency. The new agency should be responsible for meeting open meeting rules, public record laws (with exceptions for proprietary information), ethics laws/training, and conflict of interest and financial disclosure rules. The non-profit should have statutory liability protection, be audited by the state auditor, have rulemaking authority, and be required to file a plan of operation with the Department of

Insurance. However, the non-profit should be exempt from the bidding, contracting and purchasing requirements and the state personnel act (similar to Inclusive Health).

The workgroup also began discussions of the composition of the Inclusive Health board. The workgroup discussed two possible board structures: one which is comprised largely of stakeholder groups (ie, insurers, agents, business/purchasers, consumers, providers), or one that was comprised of people with certain functional skills (ie, HIT, actuarial, marketing, eligibility/enrollment, quality, population health, health economics). The workgroup also discussed the role of board advisory groups comprised of different stakeholders or the use of non-board members with specific expertise on some of the board's workgroups. The workgroup members could not reach consensus on the board composition in the November meeting and will continue this discussion at the December meeting.

MEDICAID AND ELDER JUSTICE

The November workgroup meeting continued its earlier examination of two new state options to expand home and community-based services (HCBS): the Community First Choice option and the Rebalancing Option.

- *Community First Choice Option*: States can provide home and community-based attendant services and supports to people eligible for Medicaid whose income does not exceed 150% FPL or higher, if they would otherwise need *institutional care*. States that implement this option are eligible for a six percentage point increase in their federal Medicaid match rate (called the Federal Medical Assistance Percentage (FMAP)) for covered HCBS. If the state chooses this option, these HCBS would be an entitlement to eligible individuals (ie, the state could not limit the number of people it would cover, as it can with existing 1915(c) Medicaid waiver programs).
- *State Rebalancing Initiative*. States can use this option to provide HCBS to individuals who would *not* otherwise need institutional level of support. Under the rebalancing initiative, states can provide a specific HCB service package for different target populations (eg, people with mental illness, people with developmental disabilities, the elderly, or other people with disabilities who need help with activities of daily living). North Carolina would be eligible for up to a two percentage point increase in the federal matching rate for these HCBS. Again, if North Carolina chose this option, the services would become an entitlement to eligible populations.

The workgroup discussed these new options as well as the potential cost impact to the state. Both options provide an enhanced federal match rate; but both potentially increase expenditures to the state. Because of the state's current fiscal crisis, the workgroup tried to identify options that would provide expanded HCBS to people with disabilities and the frail elderly without significant increases in Medicaid costs.

Some of the suggestions included:

- Expanding respite and adult day care services for the frail elderly or others with disabilities currently cared for at home. This expansion could increase the amount of time a person is cared for by family rather than seeking more costly residential services. One question which we will need to research is whether we can limit the service package

to new eligibles—in other words, if we expand eligibility to cover more people, can we limit the service package to respite and adult day care only and not provide full Medicaid coverage to this group.

- In terms of serving people with intellectual and other developmental disabilities (I/DD), the workgroup discussed the idea of expanding HCBS to people who are in licensed group homes (122C facilities) who are currently receiving 100% state funds for residential supports. If we started with this population, DMA could substitute some of the 100% state funds with matched Medicaid funds. At the same time, the state could seek a moratorium of new 122C facilities so that the number of people served would be limited. The workgroup discussed this idea as a first step to expand HCBS to people with I/DD. This workgroup recognized that this model would only serve a small subgroup of individuals with I/DD who need help with HCBS. However, it may be a good starting point and might be cost neutral to the state.
- The workgroup also discussed the possibility of targeting older adults or people with disabilities who have been identified through the Adult Protective Services system (either as abused or neglected, or at risk of abuse and neglect).
- The workgroup was also interested in exploring other areas where the state is already using 100% state dollars to provide similar services to a similar population.
- The workgroup discussed the need to develop an independent assessment process, using standardized, validated instruments so that the state can more appropriately target services to individuals based on their level of need and other supports. One of the requirements of the ACA rebalancing provisions is that the state implement an independent assessment process.

In order to understand the potential cost implications of any of these options, the state must get further clarification from the Centers for Medicare and Medicaid services as to how the federal government will calculate the enhanced payments. Thus, the workgroup came up with a set of questions for DMA to pursue with CMS to get a better understanding of these state options.

NEW MODELS OF CARE

The new models of care workgroup met in October and reviewed existing geographic service patterns (ie, where patients go to seek services). The workgroup also heard presentations on four primary care innovations that have the potential of improving quality and/or reducing health care costs: low overhead/high technology primary care offices; integrated behavioral health in patient centered medical homes; group medical visits; and home visits to frail elderly in congregate living (senior centers). The group also reviewed some of the existing North Carolina initiatives that might match some of the models identified as part of the ACA.

The workgroup discussed several questions, including:

- Do we need a statewide infrastructure to support demonstration programs, irrespective of specific type of demonstration program?
- What criteria should we use to measure a program's success, and what data do we need to collect? The group discussed the need to reduce health care expenditures, improve outcomes, and improve access to care.
- Are there specific models that we should pursue as a state (ie, involving Medicaid, state health plan, private insurers)?

The workgroup discussed the need to get better information about the problems in our existing system to know what type of delivery system redesigns the state should pursue. The new models of care workgroup will hold its next meeting directly after the Overall Advisory Committee. At that meeting, the workgroup will begin to discuss cost drivers in the commercial insurance market and in Medicaid. The workgroup is trying to understand:

- 1) What proportion of overall health care spending is expended for different types of services (ie, hospital, doctors, pharmaceuticals, home health)? Which of these services are major contributors to the escalation in health care costs?
- 2) What health conditions account for most of the underlying health spending, and which health conditions account for changes in health spending?
- 3) Are there any specific episodes of care that are major health care cost drivers?

PREVENTION

The Co-chairs and Project Director for this workgroup met to discuss plans for the next two meetings. In November, the workgroup will look at whether the NC Division of Medical Assistance (DMA) is already covering all the recommended clinical preventive services with an A or B grade from the US Preventive Services Task Force (USPSTF) and whether DMA is covering all the immunizations recommended by the Advisory Committee for Immunization Practices (ACIP). If not, the workgroup will try to obtain information on the costs of expanding the service package to include this coverage. The workgroup is also getting information about whether these services are offered to all appropriate Medicaid recipients with no cost sharing. The ACA included a provision to increase the state FMAP rate by one percentage point for preventive services and immunizations if the state offered all the recommended preventive services and immunizations with no cost sharing. The workgroup is trying to examine the cost implications of this option (ie, whether the additional one percentage point in the FMAP rate would cover the costs (if any) of covering all the recommended preventive services and immunizations with no cost sharing). The workgroup is also planning to discuss whether Medicaid should provide support to Quitline with the goal of reducing the number of smokers in the Medicaid population.

At the December meeting, the workgroup will address several other prevention programs that are addressed in the ACA including: (1) reasonable break times and appropriate facilities for working mothers, (2) screening of pregnant women for smoking, and (3) small business worksite wellness. The Steering Committee will also develop a preliminary proposal to present to the workgroup on the initial steps the state can take to plan for a Community Transformation grant and to increase and coordinate involvement of community organizations and communities of greatest need.

QUALITY

In lieu of a full workgroup meeting this month, the Steering Committee met to review 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.

The subcommittee will continue to meet to complete a gap analysis. The gap analysis work will involve identifying (1) work that's being done in NC that fulfills the specific requirements of each provision, (2) what gaps remain, and (3) how to address these gaps within the Workgroup structure. We will present this analysis at the December workgroup meeting, work to address the gaps (focusing first on provisions with implementation dates through 2011), and discuss the need, if any, for state legislation.

SAFETY NET

The Safety Net workgroup last met in October. At that meeting, the workgroup continued its discussion of safety net resources available across the state and communities in greatest need or that have barriers to accessing care. The group heard presentations about Critical Access Behavioral Health Agencies (CABHA), Federally Qualified Health Centers, and Free Clinics. With help from a group of students, state agencies, and other safety net organizations, the workgroup has compiled information on many safety net resources and perceived barriers to medical homes in the Medicaid population.

The steering committee met in November to plan the December meeting and future direction of the workgroup. In December, the workgroup will further discuss the data compiled about communities in greatest need and the NCIOM county uninsured estimates to help facilitate some discussion around future planning for grant and other funding opportunities. The group will also discuss the submitted New Access Point grants for FQHCs, the school-based health center capital grants, and the announcement of FQHC continuation funding. The group will also hear presentations about migrant health programs in the state and health information technology options for safety net organizations.

WORKFORCE

The Health Professional Workforce workgroup has not met in full since September. In October the steering committee had a planning meeting and the full group meets again on Friday, November 19th from 9am-noon.

The steering committee met in October to discuss how the NCIOM workgroup and the North Carolina State Health Workforce Planning Grant task force can work together and complement each other (so as to avoid duplicating efforts). They decided that the NCIOM workforce workgroup would focus its energy on the short-term (1-4 years) options to increase the health professional workforce, improve retention and recruitment to health professional shortage areas, and other topics that may have short-term policy options that the state should consider. The federal workforce grant task force will focus on long-term planning for increasing the health professional workforce.

The Workforce workgroup November meeting will look at the coordination of the NCIOM workgroup and the State Workforce Planning Grant task force and then focus on issues related to mental health providers. The December meeting will focus on issues related to primary care and dental providers. At the January meeting, we will have a discussion about the academic,

licensure, and state/federal health policies affecting the deployment of primary health care professionals staffing primary care medical homes. This discussion will help inform the work of the State Health Workforce Planning Grant task force.

FRAUD, ABUSE AND OVERUTILIZATION

The Fraud and Abuse Workgroup has not met since the last Overall Workgroup Steering Committee meeting. However, the subcommittee continues to work on the gap analysis and are gathering background material (e.g., legislation from other states on criminal background checks) to review at our November meeting. Legislation and education of providers will be discussed at each of the next two meetings as part of the discussion of provisions for which gaps are identified.