

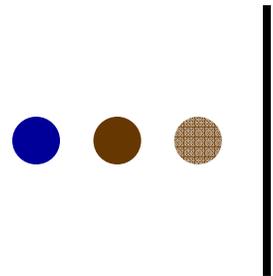


Overall Advisory Group

Review of the Work of the Health Reform
Workgroups

September 22, 2010





Eight Different Workgroups

- Health Benefits Exchange and Insurance Oversight
- Medicaid
- New Models of Care
- Quality
- Prevention
- Fraud and Abuse
- Health Professional Workforce
- Safety Net



Health Benefit Exchange and Insurance Oversight

- Co-Chairs:
 - Louis Belo, Chief Deputy Commissioner, North Carolina Department of Insurance
 - Allen Feezor, North Carolina Department of Health and Human Services
 - 28 other members
- Meetings: August 9, September 15
- Charge:
 - Development of the Health Benefit Exchange
 - Provide guidance on insurance oversight, insurance ombuds program, and the creation of patient navigator program
 - Coordinate enrollment between Medicaid and the Exchange



Health Benefit Exchange and Insurance Oversight

- North Carolina Department of Insurance has submitted grants to the US Department of Health and Human Services for:
 - Rate review and insurance oversight: North Carolina submitted a grant and received \$1 million
 - Development of a health benefit exchange (in collaboration with NC DHHS, NCIOM): States are eligible for up to \$1 million (grant submitted 9-1-2010)
 - Creation of a consumer ombuds program: States are eligible for a minimum of \$130,000 (grant submitted 9-10-2010)



HBE: Workgroup Discussions to Date

- Developing a set of principles to help in establishing a health benefit exchange. For *example*:
 - Ensure a reasonable choice of affordable health plans that offer value to the individual and/or businesses
 - Facilitate the ability of individuals and small employers to be able to shop, compare and purchase health plans based on cost, quality, and provider network
 - Change the structure of competition among carriers from medical underwriting to price, quality and improved health outcomes of members
 - Simplify the eligibility and enrollment process for individuals applying for private insurance or public coverage, and ensure seamless transitioning between public and private plans



HBE: Focus of Future Workgroup Discussion

- Should North Carolina establish a HBE or leave it to the federal government? If North Carolina develops the HBE:
 - Should there be one or two HBEs (ie, should we merge the non-group and small group markets/risk pool; should we create separate administrative bodies)?
 - Should we create regional HBEs? Regional rating districts?
 - Should we initially open the HBE exchange to small employers <50 or <100?
 - What type of organizational structure should operate the HBE? Governmental agency, quasi-governmental, non-profit? What should the governance structure look like?
- Goal: Develop options for the state agencies and legislature to consider for the 2011 session



Medicaid and Elder Services

- Co-Chairs:
 - Craigan Gray, MD, JD, MBA, Director, NC Division of Medical Assistance, NC Department of Health and Human Services
 - Steve Wegner, MD, JD, President of NCCCN, Access Care
 - 32 additional members
- Meetings: August 11, September 9
- Charge:
 - Identify implementation steps for Medicaid expansion
 - Explore Medicaid state options to expand services, including but not limited to: prevention, home and community-based services
 - Coordinate enrollment between Medicaid and the Exchange
 - Examine funding opportunities for Elder Justice Act



Medicaid: Workgroup Discussions to Date

- New home and community-based service (HCBS) options available to the state
 - *Community first choice option*: alternative to institutionalization. Federal government will increase FMAP rate by 6 percentage points.
 - *State rebalancing initiative*: to increase proportion of LTC funding for HCBS. Federal government will increase FMAP for HCBS by 2 percentage points.
 - *Money Follows the Person*: State receives an enhanced rate for up to one year after a person transitions from an institution to community.
 - Many of these optional programs would change existing HCBS waiver programs with limited “slots” to an entitlement program, available to anyone who qualifies



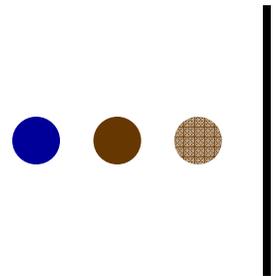
Medicaid: Workgroup Discussions to Date

- Workgroup discussions focused on:
 - *Guiding principle:* The state's overall policy should be to support individuals in having choices that would enable them to live in the least restrictive setting appropriate to their needs
 - Data needed to help advise the state about HCBS:
 - What is the cost of HCBS vs. institutional care (ie, nursing home, developmental centers, or ICFs-MR)?
 - Who does the state already serve through its existing waiver programs?
 - Is there a way to gain efficiencies in existing programs, or to better target services based on their need for HCBS?
 - How much would the state gain in enhanced federal matching through the Community First Choice Option or Rebalancing Initiative?
 - If we expand Medicaid to cover more people with HCBS, can we free up existing state funds to serve as the match?



Medicaid: Next Meeting

- The ACA includes provisions which will simplify eligibility and enrollment:
 - Eligibility is extended to non-elderly adults who are citizens or lawfully present for 5 or more years, based solely on an income test
 - Applications can be taken electronically, income and citizenship verified electronically
 - “No wrong door” with the health benefits exchange
- The next meeting will focus on the new eligibility and enrollment process, and the “no-wrong door” approach envisioned in the ACA



New Models of Care

- Co-Chairs:

- Allen Dobson, MD, Vice President, Clinical Practice Development, Carolinas HealthCare System
- Craigan Gray, MD, MBA, JD, Director, Division of Medical Assistance, NC Department of Health and Human Services
- 26 other members

- Meeting: August 11, September 22 (after Overall Advisory group)

- Charge:

- Explore new methods of financing care, including accountable care organizations, bundled payment, global payment
- Explore new methods of delivering care, including patient centered medical home, coordinated care for chronic illness, medication management



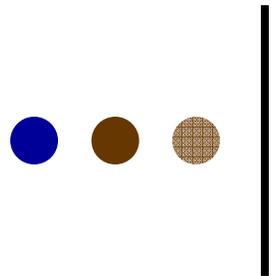
New Models of Care: Potential Principles

- Beginning to develop guiding principles, which will be discussed more fully in later meeting. For example:
 - Consumers should be the center of any new health system.
 - Funding opportunities should not drive the models of care. North Carolina needs to identify the key elements that will improve health care quality and outcomes, increase access, and reduce costs and then identify funding sources to accomplish those goals.
 - North Carolina should build on what already is working to improve health and reduce health care costs in North Carolina, but should not be limited by these initiatives.
 - To the extent possible, the new models of care should involve other payers aside from Medicaid and Medicare. Multi-payer, multi-provider initiatives have greater possibility of improving quality, access to care, health outcomes, while reducing health care costs.



New Models of Care: Potential Principles

- In order to improve the capacity of our health care system to be able to serve all the newly insured, we need to consider new models that will utilize health professionals to the fullest extent of their training.
- We support testing patient-centered, interdisciplinary teams that include primary care, dental and behavioral health professionals, nutritionists, allied health, and lay health advisors. We also support testing models that incorporate health extenders, such as lay health advisors, or the use of group health visits to determine if these models improve access, reduce costs and improve health outcomes.
- North Carolina should explore options to involve the consumers more directly in their own health (supporting self-management). Any new model of care should ensure that consumers are given health information that is culturally and linguistically appropriate and that is understandable to people with lower health literacy.



Quality

- Co-Chairs:

- Alan Hirsch, JD, Executive Director, NC Healthcare Quality Alliance
- Sam Cykert, MD, Associate Director for Medical Education, NC Area Health Education Centers Program
- 26 other members

- Meetings: August 18, September 17

- Charge:

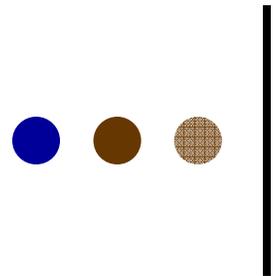
- Understand federal guidelines for patient outcome quality measures and reporting requirements
- Identify strategies to improve quality of care provided to meet the new quality requirements
- Build on existing state quality initiatives





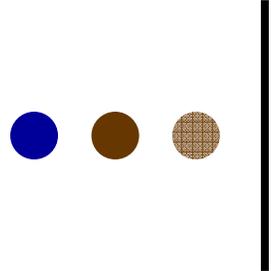
Quality: Discussions to Date

- North Carolina should consider existing programs on quality, but not be bound by them
- Meaningful Use: How are our current programs meeting this requirement and what do we need to focus on?
- North Carolina needs to improve transitions between healthcare entities/providers by considering:
 - ACA requirements
 - Existing programs and efforts
 - Gaps
 - Mechanisms to address the gaps
 - Data requirements



Quality: Next Steps

- Develop a system for tracking of funding opportunities and opportunities for partnerships
- Consider mechanisms for reducing provider burden through consolidation of reporting requirements and quality initiatives
- Provide for education of providers on ACA requirements.
- Develop a map or flowchart of transitions as a method for identifying gaps between existing programs, ACA requirements, and the “ideal” support for transitions in care



Prevention

- Co-Chairs:
 - Jeffrey Engel, MD, State Health Director, Division of Public Health, NC Department of Health and Human Services
 - Laura Gerald, MD, MPH, Executive Director, Health and Wellness Trust Fund
 - 31 other members
- Meetings: August 31, September 21
- Charge:
 - Identify funding opportunities for prevention and wellness programs
 - Identify communities of greatest need
 - Encourage collaboration in funding opportunities

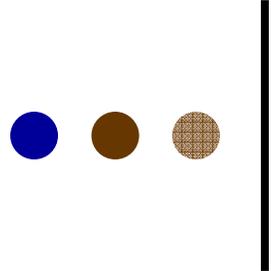
● ● ● | Prevention: ACA Grants

- In progress
 - Tobacco Cessation Through Quitlines
 - BRFSS Supplemental Funding Components I and II
- Submitted
 - Personal Responsibility Education Program
 - Support for Pregnant and Parenting Teens
 - Public Health Infrastructure
 - Epidemiology Laboratory: Capacity for Infectious Disease
- Notice of grant award received
 - Maternal, Infant, and Early Childhood Home Visiting Program



Prevention: Discussions to Date

- Grant submissions to date by DPH, DPI
 - State infrastructure
 - Support directed to local communities
- North Carolina should:
 - Build on existing strengths
 - Focus on evidence-based strategies
 - Involve communities with greatest need
- Local communities and non-profits need to be able to partner with the state on new initiatives



Prevention: Next Steps

- Discussion of how to ensure equity and quality across the state
- Identify communities of greatest need
- Consider how we should build capacity in communities so they can respond to funding opportunities
- Develop a tracking mechanism for funding opportunities to foster connections with partners, and coordinate responses
- Ensure that communities have the infrastructure and technical support required to implement evidence-based strategies



Fraud and Abuse

- Co-chairs:
 - Al Koehler, Chief Investigator, NC Department of Insurance
 - Tara Larson, MAEd, Chief Clinical Operations Officer, NC Division of Medical Assistance, NC Department of Health and Human Services
- 12 other members
- Meetings: August 16, September 20
- Charge:
 - Examine new program integrity provisions under Medicaid, Medicare (as it affects the state), and insurance
 - Identify implementation steps to meet new federal requirements
 - Understand and educate providers on financial integrity and fraud and abuse reporting requirements



Fraud and Abuse: Discussions to Date

- Description of existing monitoring and enforcement programs and identification of gaps
- Need for increased integration between agencies involved in monitoring, enforcement, licensure
- Data sharing and reporting requirements
- Reducing audit burden:
 - Licensure review and Medicaid audits
 - Relationship between fraud/abuse and quality of care



Fraud and Abuse: Discussions to Date

- Recipient fraud and abuse
- Training of providers
 - Required or offered? Incentives offered for completion?
 - Program requirements, sanctions, audit process
 - Target by provider type
- Concerns regarding timeline for implementation of ACA requirements versus time required for administrative code and rule changes



Fraud and Abuse: Next Steps

- Gap analysis: existing programs in NC versus ACA requirements
- Information sharing & data system needs
- Relationship between Medicaid audits and licensure
- Additional education and training for provider associations
 - Informing providers when they are “outliers”
- Billing agent registry
- Centralized screening
- Develop proposed legislation for 2011 session



Health Professional Workforce

- Co-Chairs:

- Tom Bacon, DrPH, Director, North Carolina Area Health Education Centers Program
- Kennon Briggs, Executive Vice President and Chief of Staff, North Carolina Community College System
- Alan Mabe, PhD, Vice President for Academic Planning, UNC General Administration
- John Price, Director, NC Office of Rural Health and Community Care, NC Department of Health and Human Services
- 33 other members

- Meetings: August 19, September 21



Health Professional Workforce

- Charge:
 - Examine funding opportunities for workforce development, including but not limited to: primary care, nursing, allied health, behavioral health, dentistry, public health, direct care workforce
 - Outreach about loan repayment opportunities
 - Identify best models for quality improvement and interdisciplinary training in workforce development programs
 - Fostering collaboration and coordinating implementation



Workforce: ACA Grants

- Workforce grants awarded to the state (with either ARRA or ACA funding):
 - Training in primary care (\$261,311)
 - Oral health (\$610,932)
 - Equipment to enhance training for health professionals (\$1,624,978)
 - Public health training center (\$643,000)
 - Nursing: Advanced nursing education (\$2,522,713); Advanced education nursing traineeship (\$393,478), nurse anesthetist traineeship (\$67,200), Nurse education, practice, quality and retention (\$776,845), nursing workforce diversity (\$498,241), faculty development (\$253,672), nurse faculty loan program (\$1,231,531)



● ● ● | **Workforce: ACA Grants**

- Workforce grants awarded to the state (with either ARRA or ACA funding):
 - Geriatrics: Geriatric education centers (\$623,533), geriatric training for physicians, dentists, and behavioral and mental health professionals (\$350,036), comprehensive geriatric education program (\$490,075)
 - Scholarships for disadvantaged students: \$2,124,184
- Of the potential workforce funding awarded under ARRA or ACA (since March), NC received 3% (\$12,471,729 of \$412,010,817).



Workforce: Discussions to Date

Goals of the Workforce Workgroup

- How to ensure North Carolina has the correct mix of health professionals to meet the health care needs of the state
 - Increasing supply
 - Anticipating the new practice environment
 - Ensuring health training centers are providing the types of education and training needed to meet the demands of a reformed health care system
 - Addressing barriers to entry into health professions and to continuing to practice



Workforce: Discussions to Date

- Discussed the best way to plan for future health professional workforce needs
 - Plan for population needs
 - Look at how health care will be provided- what are the new/emerging models of care
 - How to staff delivery systems to meet the needs of the population
 - Broader definition of “primary care workforce”
 - New career paths and types of health professionals may be needed



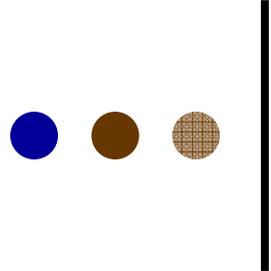
Workforce: Discussions to Date

- Although future delivery model is uncertain, there are salient problems we can know will persist
 - Must address the geographic imbalance of health professionals
 - Certain health professional specialty needs (specifically, dentists, psychiatrists)
 - Having a health professional workforce that matches community needs (diversity, language, location)
- The need to adjust health professional training to prepare today's students for tomorrow's workplace
 - New skills are needed: team-based environment, prevention, telemedicine, HIT, etc.



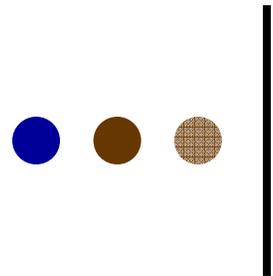
Workforce: Next Steps

- October: we will look at what successful “new” models of care in North Carolina to address:
 - How they configure integrated care
 - The skill mix needed to staff and run patient-centered medical models
 - MDs, NPs, Pas, allied health, HIT staff, admin staff, community health workers- what does it take to make these models work
 - What are the barriers to such care in terms of health professionals
- November: we will look at how health professional education needs to change to meet new workplace models



Safety Net

- Co-Chairs:
 - Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care, Assistant Director, NC Division of Medical Assistance, NC Department of Health and Human Services
 - E. Benjamin Money, Jr., MPH, Executive Director, NC Community Health Center Association
 - 30 other members
- Meetings: August 16, September 15
- Charge:
 - Identify areas of the state with greatest unmet need, and encourage collaboration in funding opportunities
 - Examine new requirements for safety net providers
 - Support development of community collaborative networks of care



Safety Net: ACA Grants

- HRSA released grant opportunities for federally qualified health center new access points (CFDA 93.527)
 - Grant applications due: November 17, 2010
 - NC Community Health Center Association had received funding from Kate B. Reynolds Charitable Trust to work with communities to help them prepare grant applications
 - North Carolina expected to submit up to 45 applications: 31 are in the grant writing process and 14 more are considering writing grant applications
 - Nationally, HRSA expecting approximately 1000 applications, of which approximately 350 will receive funding.
- School based health center grant opportunities were posted, but withdrawn. New grant opportunities expected later in the fall.



Safety Net Workgroup: Discussions to Date

- ACA appropriated \$1.5B over 5 years to expand the National Health Service Corps (NHSC) (Sec. 5207, 10503)
 - Loan repayment or scholarships for providers willing to practice in health professional shortage areas (HPSAs) for certain number of years:
 - Eligible providers include:
 - Primary care providers: physicians, nurse practitioners, physician assistants
 - Behavioral health providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, licensed professional counselors
 - Dental providers: dentists, dental hygienists



Safety Net Workgroup: Discussions to Date

- Health Professional Shortage Designation (HPSA) is a federal designation that identifies communities (or parts of communities) that have health professional shortages
 - Three separate designations: primary care, dental, behavioral health
 - Office of Rural Health and Community Care (ORHCC) helps communities obtain HPSA designation at communities' request
 - ORHCC will try to more proactively help communities obtain HPSA designation so that we can collectively (as a state) recruit more providers into underserved areas
 - Need help educating communities about the availability of federal NHSC funds



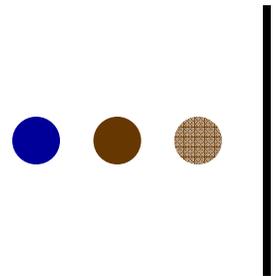
Safety Net Workgroup: Discussions to Date

- Work group spent time trying to identify communities of greatest unmet need for safety net services
 - Looked at communities with highest poverty rates, percent uninsured, numbers uninsured, communities with highest rate of preventable hospitalizations, persistent health professional shortage areas
 - Communities with highest numbers of uninsured are generally urban areas; communities with highest percentages of uninsured are generally rural (Northeast, southeast and far western counties)
 - Looking to refine these data by examining communities where there are Medicaid access barriers (ie, too few providers to serve Medicaid recipients)
 - These data can help us identify communities that need new safety net capacity or new providers



Safety Net Workgroup: Next Steps

- Work collaboratively within health systems to promote quality and control costs
 - Connect points of access (“minute clinics”, etc.) to comprehensive care
- How to meet the needs of people who have never been insured
 - Role of mid-level health professionals
- Risk stratification of newly enrolled
 - Much more time involved in initial appointment
- Data systems
 - Collaboration, data sharing, immunization rates, problem lists, prescriptions

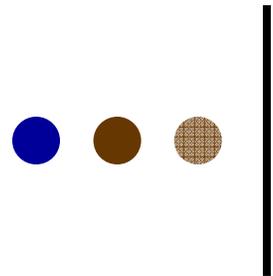


Cross-Cutting Themes

- Grant opportunities
 - Most of the workgroups have agreed that we should not let grant opportunities drive North Carolina activities, but should think proactively about how to best address the needs of the state, and then seek grants that support our priorities
 - How can we prepare so that we are ready to take advantage of grant opportunities that are likely to be issued?
- Grant management
 - What group will keep up with different grant opportunities and circulate these opportunities to appropriate groups?
 - NCIOM does *not* have the staff to do this

● ● ● | Cross-Cutting Themes

- Grant management, cont'd
 - Should we coordinate grants from different organizations across the state, and if so, how?
 - How can we encourage collaboration in grants (ie, between the state and communities most in need; between different academic institutions, etc.)?
 - How do we make sure communities in need have the capacity to respond and/or participate in grant opportunities?
 - How do we ensure high quality grants with limited time and resources?



Cross-Cutting Themes

- Communications

- How do we educate the general public about the new law and opportunities available. Examples:
 - Immediate provisions: High risk pool, small employer tax credit, insurance law changes as of September 23, 2010
 - General ACA provisions
 - New coverage provisions that will go into effect in 2014
- How do we disseminate information about new requirements of the bill to health care professionals, organizations, businesses, and other groups that may be affected by the ACA



For More Information

- All of the workgroup information is available on the NCIOM website:

http://www.nciom.org/projects/health_reform/healthreform.shtml

