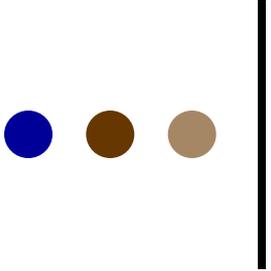




Workgroup Update

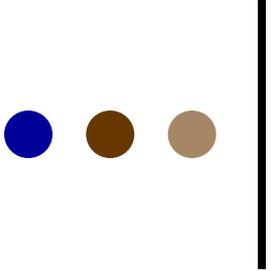
NCIOM Staff

December 14, 2010



Agenda

- **Health Benefits Exchange**
- New models of care
- Quality
- Prevention
- Fraud and Abuse
- Workforce



Health Benefits Exchange

- In the November meeting, the workgroup discussed the legal structure of the Health Benefits Exchange. The two options are:
 - State agency
 - Quasi-public, non-profit; with Board members appointed by the NC General Assembly, Governor's office or DOI*
- Ultimately, the workgroup reached a consensus that the advantages of a quasi-public, non-profit outweighed the advantages of setting up a new state agency

● ● ● | Quasi-public, Non-profit

- The workgroup suggested that the General Assembly create a quasi-public, non-profit, but ensure accountability. For example, the group discussed
 - Maintaining certain state requirements, including: open meeting rules, public records laws (with exemptions for certain proprietary information), ethics laws, liability protection, annual audits from state auditor, authority to use APA rulemaking process, and requirement to file plan of operation with DOI
 - Exemption from: bidding, contracting and purchasing rules; state personnel act

Establishing and Maintaining HBE: Federal Responsibilities

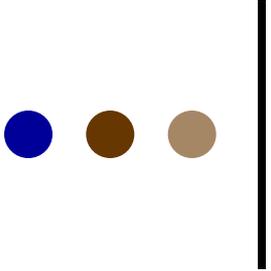
- Federal government responsibilities in establishing HBE include:
 - Defining essential health benefits (Sec. 1302)
 - Setting standards for operation of HBE, including rules for qualified health plans (Sec. 1321(a))
 - Setting benchmarks to determine if state making progress in establishing a HBE (Sec. 1311a(4))

Establishing and Maintaining HBE: NCGA Responsibilities

- NC General Assembly must:
 - Decide whether to establish a state operated HBE or let the federal government run it (Sec. 1321(c))
 - Determine the governance and administrative structure of the HBE (Sec. 1321(c))
 - Decide whether to maintain “mandated benefits” under the HBE (Sec. 1311(d)(3))
 - Provide some type of financing mechanism to ensure the HBE is self-sufficient by 2015 (Sec. 1311(d)(5))
- NCGA may decide, or may delegate:
 - Determination of one or two HBEs, regional or statewide rating pool, merger of individual and small group market (Secs. 1304, 1311(b)(2), 1312(b)(3), 1312(f)(2)(B))

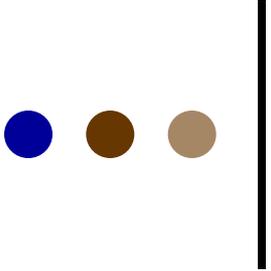
Establishing and Maintaining HBE: Board/Staff Responsibilities

- The Board must:
 - Hire the Executive Director and establish HBE policies
 - Develop a plan to ensure the HBE is self-sustaining by 2015, and ensure the financial integrity of the HBE (Sec. 1313)
- The HBE staff must:
 - Certify and recertify health plans according to federal 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))
 - Establish and maintain an electronic enrollment system (Sec. 1311(d)(4)(F))



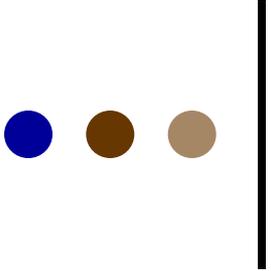
HBE: December Meeting

- At the December 16th meeting, the workgroup will discuss the HBE responsibilities and NAIC model legislation



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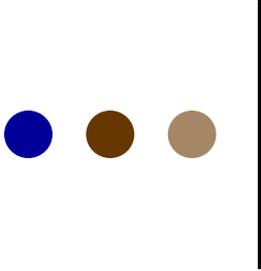


New Models of Care

- At the November meeting, the workgroup discussed North Carolina health system comparison information and began to discuss major cost drivers:
 - Health system performance measures from the Commonwealth Fund
 - Information on cost trends from:
 - Blue Cross and Blue Shield of North Carolina
 - Division of Medical Assistance (more information presented in December meeting)

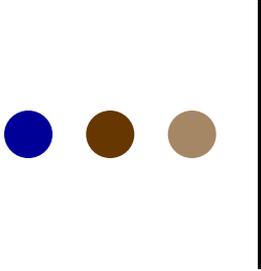
New Models of Care: Health System Performance

- Commonwealth Fund ranks states on health system performance
- Overall, North Carolina ranked 41st (in 2009) (with 1 being highest ranked state)
- States are ranked on 63 different measures, across five domains:
 - Access (ranked 32nd)
 - Prevention & Treatment (ranked 32nd)
 - Avoidable Hospital Use & Costs (ranked 25th)
 - Equity (ranked 43rd)
 - Healthy Lives (ranked 40th)



Important to Improve Health Systems Measures

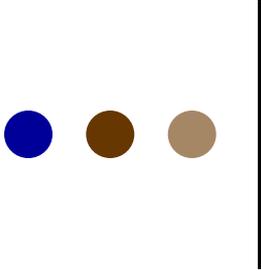
- According to the Commonwealth Fund, if North Carolina's performance improved to the level of the best performing state:
 - 124,733 more adults (age 50 and older) would receive recommended preventive care
 - 23,609 more children (ages 19-35 months) would be up-to-date on all of five key vaccines
 - 23,384 fewer preventable hospitalizations for ambulatory care sensitive conditions for Medicare beneficiaries, contributing to >\$145 million in reduced hospital costs
 - 3,432 fewer premature deaths before age 75 from causes that are potentially treatable or preventable



Drivers of Health Care Costs

- Rising health care costs due to many factors:
 - Increases in the prevalence of treated disease
 - Due, in part, to growing obesity rates
 - Redefinition of certain conditions as “diseases”
 - Increases in utilization and price of services
 - New technology
 - Redundancy, inefficiency, and ineffectiveness
 - Includes administrative costs, disintegrated care, lack of evidence-based care, defensive medicine

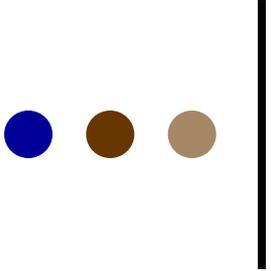
Presentation by: Don Bradley, MD, Senior Vice President of Healthcare & Chief Medical Officer, BCBSNC, Nov. 17. http://www.nciom.org/wp-content/uploads/2010/10/NCIOM_Understanding-and-impacting-medical-expense_11_2010Final-1.pdf



Drivers of Health Care Costs

- Significant geographic variation in costs and utilization across North Carolina:
 - Average per member per month costs (from <\$339 to more than \$390 pmpm)
 - Trends in pmpm costs
 - Emergency room and urgent care visits per 1,000
- NC medical expenses are generally higher than southeast, due to lifestyle choices and cost per unit of care

Presentation by: Don Bradley, MD, Senior Vice President of Healthcare & Chief Medical Officer, BCBSNC, Nov. 17. http://www.nciom.org/wp-content/uploads/2010/10/NCIOM_Understanding-and-impacting-medical-expense_11_2010Final-1.pdf

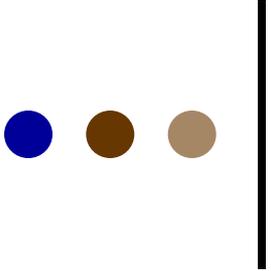


New Models: Next Steps

- Workgroup examining similar data for Medicaid
- Workgroup identifying potential “new models” that can help improve quality and efficiency and reduce health care costs

● ● ● | New Models: December

- *Starting with Medicaid proposals:*
- Expanding concept of primary care medical home
 - Expanding team to use other appropriate health professionals
 - Change payment models, including P4P
- Episode of care payments
 - Need to provide incentives to change how we deliver care, P4P
 - Need to ensure transparency, risk adjustment, attribution rules

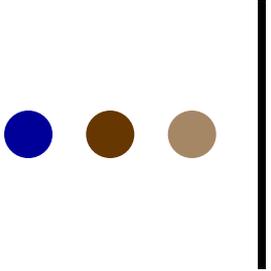


New Models: December

- More effectively engaging patients in their own care
- New reimbursement methodologies. Examples:
 - P4P, bundled payment, value based purchasing
- Transitions of care to reduce hospital readmissions

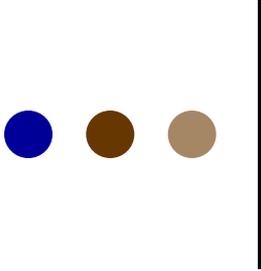
● ● ● | **Work of Subcommittees**

- Each subcommittee will develop proposal:
 - Describing what they want to accomplish with Medicaid (or multipayer)
 - Evidence base to support model
 - Cost data from other demonstrations (implications for NC)
 - Barriers (legal, or other)
 - Metric for success, building off Triple Aim
 - Applicable across both mental health/ substance abuse services and physical health



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Quality Workgroup Gap Analysis

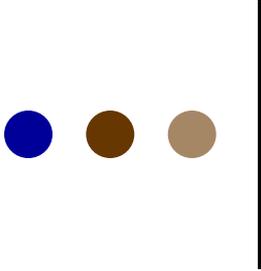
- For each provision:
 - Focused on gaps in education, data
 - Identified initiatives in place
 - Identified a potential “responsible party” for gaps
- Identified potential areas where legislation would be helpful

Example: Payment adjustment for healthcare-acquired conditions

- The Secretary of US Dept. of Health and Human Services (Secretary) shall incorporate payment differentials for health care acquired conditions into the Medicaid regulations (Sec. 2702)
 - Implementation date: Jul 1, 2011
- Education gap: If hospitals show the condition was present at the time of admission, their payments will not be reduced for treatment of this condition
 - However, many hospitals are not aware of this provision and how to reflect this in the health records
- Responsible party: NCHA

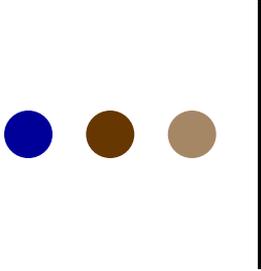
Example: Public availability of quality and efficiency measures

- The Secretary shall define quality and efficiency measures (Sec. 3014, 10305), and develop a framework for public reporting of performance information (Sec. 3015)
 - Implementation date: July 1, 2011
- Hospitals: No gap for hospitals. NCHA and NCMS will share responsibility for reaching in-hospital physicians.
- Gap: Physician awareness:
 - NCMS and AHEC will develop a plan to disseminate information.



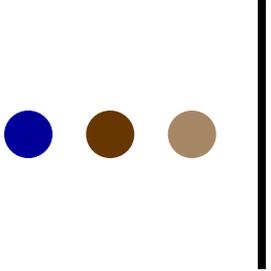
Example: Public reporting of physician quality data

- The Secretary will develop a physician compare website with information on physicians participating in the Medicare program and others who participate in the Physician Quality Reporting Initiative (Sec 10331)
 - Implementation date: Jan. 1, 2012
- Gap: Education of the public on understanding how to interpret information.
 - Responsible party: State of NC.
 - Partners: NCMS, healthcare system advocates (e.g., AARP)
- Gap: Education of physicians on possible impact on income.
 - Responsible party: AHEC with NCHQA and CCME



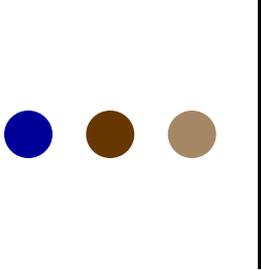
Quality Workgroup: Next Steps

- Three subcommittees appointed to examine:
 - Education of providers
 - Potential legislation
 - Transitions of care



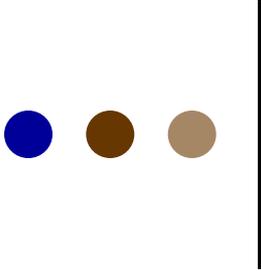
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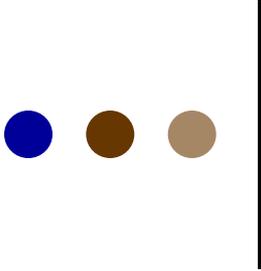
Prevention

- The workgroup compared the preventive services with an A or B recommendation from the US Preventive Services Task Force (USPSTF), and the vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), with those covered by Medicaid
 - *Private insurers* must provide coverage of all the USPSTF recommendations (with A or B grade) and ACIP recommended vaccines *with no cost sharing* (Sec. 2713 of the Public Health Service Act, as amended by Sec. 1001 of the ACA)
 - *Medicare* must provide similar coverage for preventive services recommended by USPSTF with A or B rating (Sec. 4105 of the ACA)



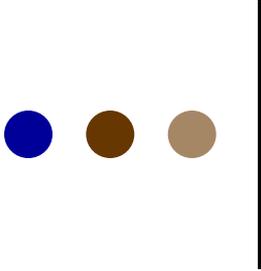
Prevention

- *Medicaid*: The ACA provides states with a one percentage point increase in the federal medical assistance percentage (FMAP) rate for preventive services if the state covers, with no cost sharing (Sec. 4106):
 - All preventive services recommended by the USPSTF with an A or B recommendation, and
 - All recommended immunizations for adults



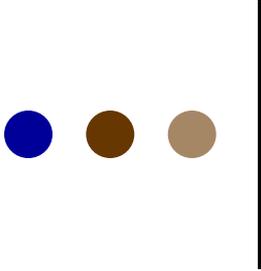
ACIP Recommended Immunizations

- There are two vaccines listed by ACIP that are not covered as recommended.
 - Zostavax is not covered.
 - Human Papilloma Virus vaccine is recommended for ages 9 – 26 years. Medicaid does not cover ages 21-26.
 - The NC Immunization Program provides vaccine for 9 – 18 years. Medicaid pays for ages 19 and 20.



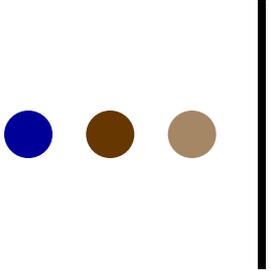
USPSTF Recommended Preventive Services

- Most USPSTF recommendations with A or B rating are covered by Medicaid directly or indirectly (ie, as an expected part of an office visit or annual health exam)
- A few of the USPSTF recommendations are not currently covered by NC Medicaid
 - Genetic counseling for women with high risk: Tests for specific BRCA1 and BRCA2 genes
 - Aspirin to prevent cardiovascular disease
 - Folic acid and iron supplementation for children



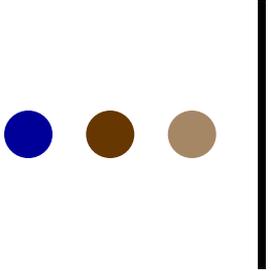
Cost-Sharing

- NC Medicaid does *not* require cost-sharing (co-pays) for the following services
 - Related to pregnancy
 - That are laboratory services
 - That are family planning services
 - Provided to recipients
 - Less than 21 years of age
 - Enrolled in a Community Alternatives Program
 - Residing in Skilled nursing or Intermediate Care facilities
- NC Medicaid *does* require nominal cost sharing for other preventive services or vaccines



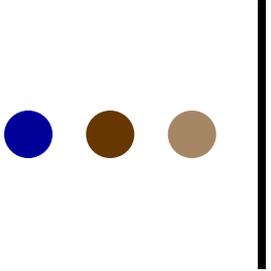
Prevention

- NC Medicaid does cover the majority of the grade A and grade B recommendations directly or indirectly without cost-sharing for the majority of the services.
- DMA is conducting a cost analysis to determine the costs of providing all of the recommended vaccines and preventive services with no cost sharing, versus the additional reimbursement the state would receive (one percentage point increase in the FMAP rate)



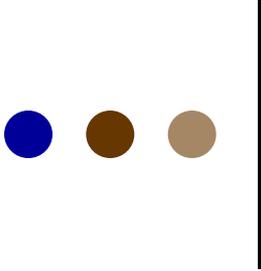
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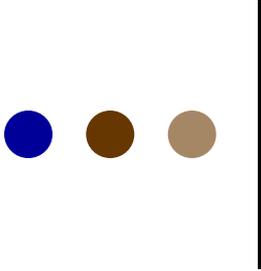
Fraud & Abuse

- Completed gap analysis
 - Evaluated current NC efforts against ACA provisions
- Drafted a list of topics for legislation. Still under discussion
- Next steps:
 - Complete discussion of legislation



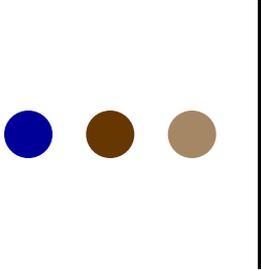
Fraud & Abuse: Gap Analysis Examples

- Educate providers and suppliers that they are required to disclose any past affiliation with a provider who has been subject to payment suspension, excluded from participation, or has had their billing privileges denied or revoked.
(Section 6401, 10603)
 - Current NC efforts: DMA began this process with its vendor in early 2010. It is currently part of DMA provider application process.
 - Gap: None



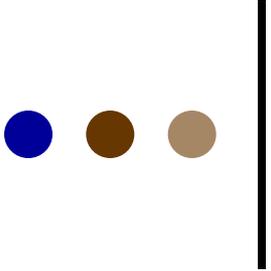
Fraud & Abuse: Gap Analysis Examples

- Groups submitting claims on behalf of providers must register with the state and CMS. (Section 6503)
 - Current NC efforts: New to NC.
 - Gap: Legislation
 - Registration requirement?
 - Definition of billing agents?
 - Impact on small agencies (due to cost)



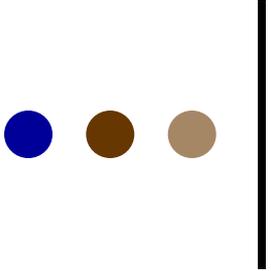
Fraud & Abuse: Gap Analysis Examples

- States must terminate providers from participation in Medicaid who have been terminated from participation in Medicare and CHIP. (Section 6501, Effective 1 Jan 2011).
 - Current NC efforts: Already in effect in DMA to extent it has access to information.
 - Gap: Federal government creating central sanction database. Final implementation dependent on CMS.



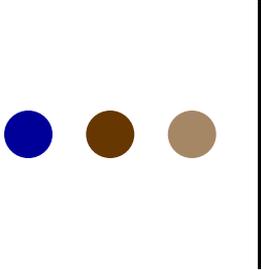
Fraud & Abuse

- New state legislation may be required in order to comply with the ACA provisions
- Staff from the Attorney General's office, DMA, and other workgroup members are helping to identify areas where legislation may be needed
- Workgroup will continue to examine these issues between now and January meeting



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Workforce Workgroup: Behavioral Health

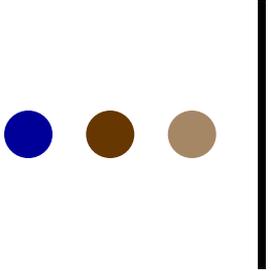
- The workgroup focused on the mental health and substance abuse (behavioral health) workforce
- Existing shortages of mental health professionals:
 - In 80 North Carolina counties, there are fewer than one FTE psychiatrist per 10,000 residents
 - In 85 counties there are fewer than one FTE child psychiatrist per 10,000 children
 - There are many other types of health professionals and paraprofessionals who provide mental health and substance abuse services, however, most experts believe that we still are facing a behavioral health workforce shortage

Short Term Options to Expand Behavioral Health Workforce

- Maintain existing Medicaid reimbursement rates for behavioral health services
- Develop/strengthen recruitment strategies for mental health professionals into underserved areas
- Continue to support and strengthen integrated care strategies
- Increase the number of trained social workers, health techs, substance abuse counselors and other professional and direct support workers to meet the increased demand for behavioral health services

Short Term Options to Expand Behavioral Health Workforce

- As integrated care models expand, increase training programs for nurse practitioners and physician's assistants who have expertise in mental health and substance abuse
- Develop specific training requirements and career pathways for direct care workers and others who provide care for individuals with mental health needs



Other Issues

- Currently, a significant amount of state and federal funding goes to support overuse of psychotropics, rather than supporting the right use of health professionals who can provide treatment and recovery supports
 - Need to analyze Medicaid data to determine if savings could be achieved and reinvested in improving mental health and substance abuse services