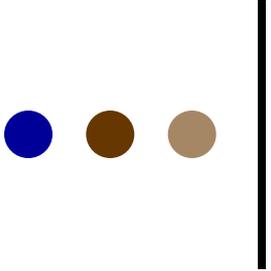


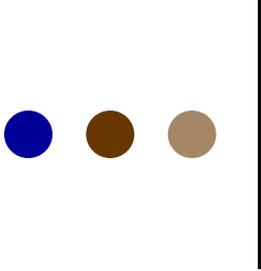
# Workgroup Update

November 17, 2010



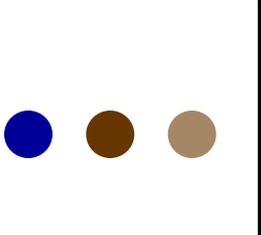
# Agenda

- Written update included in the materials
- Presentation will focus on key decision points or other discussion items
  - Health Benefits Exchange
  - Medicaid
  - New models of care



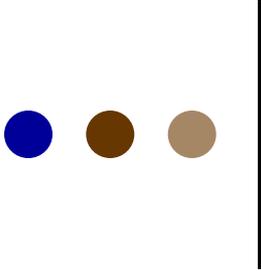
# Health Benefits Exchange (HBE)

- The state must decide if it wants to develop its own HBE or have the federal government establish and operate an HBE for the state
  - The HBE workgroup discussed the pros and cons of both approaches
  - Ultimately, the workgroup reached a consensus that the advantages of a state-operated HBE outweighed the advantages of a federally operated HBE



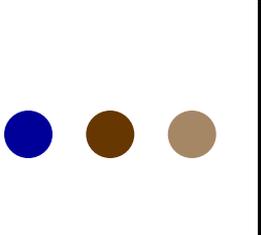
# State vs. Federal HBE

State HBE	Federal HBE
<ul style="list-style-type: none"><li>•State policy makers have voice in the process and can more easily assure the HBE meeting needs of North Carolinians (costs, quality, choice of plans, etc.)</li><li>•State has greater ability to mitigate risk selection that could result from different rating and underwriting rules for insurance sold inside and outside HBE</li><li>•Greater ability to coordinate eligibility and enrollment between the HBE, Medicaid/NCHC</li><li>•More state control over the number and types of plans offered through the HBE</li><li>•If the federal government operates the HBE, carriers might be subject to two sets of rules and reporting requirements</li></ul>	<ul style="list-style-type: none"><li>•State would not have responsibility of establishing a new program</li><li>•Federal government would have to ensure the HBE was self-sustaining by 2015</li><li>•May be economies of scale of federal government operating multiple HBEs and this could reduce administrative costs</li><li>•Federal government would have to address the tension between keeping administrative fees low and satisfying consumer demands for high quality customer service</li></ul>



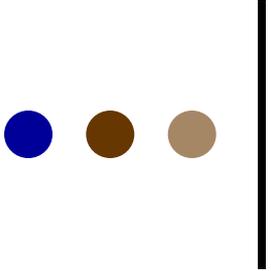
# State Agency vs. Quasi-Public/Non-Profit

- 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\*
- The workgroup heard a presentation on Inclusive Health, the state's high risk pool. This is a quasi-public, non-profit.
- 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



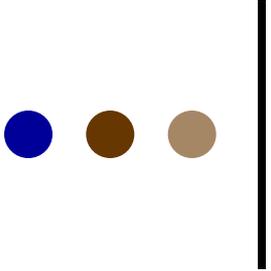
# State vs. Federal HBE

<b>Quasi-public, non-profit</b>	<b>State agency</b>
<ul style="list-style-type: none"><li>• Greater flexibility and ability to respond quickly to market changes</li><li>• Less bureaucracy in decision-making</li><li>• More sheltered from political decision making</li><li>• Accountability can be built into the organizational design</li></ul>	<ul style="list-style-type: none"><li>• Potential for greater accountability</li><li>• May have greater credibility or appearance of impartiality from the public</li></ul>



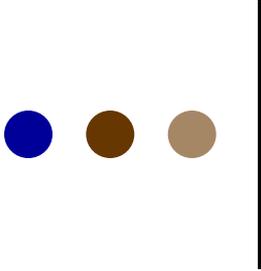
# Quasi-public, Non-profit

- 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



# HBE Board Structure

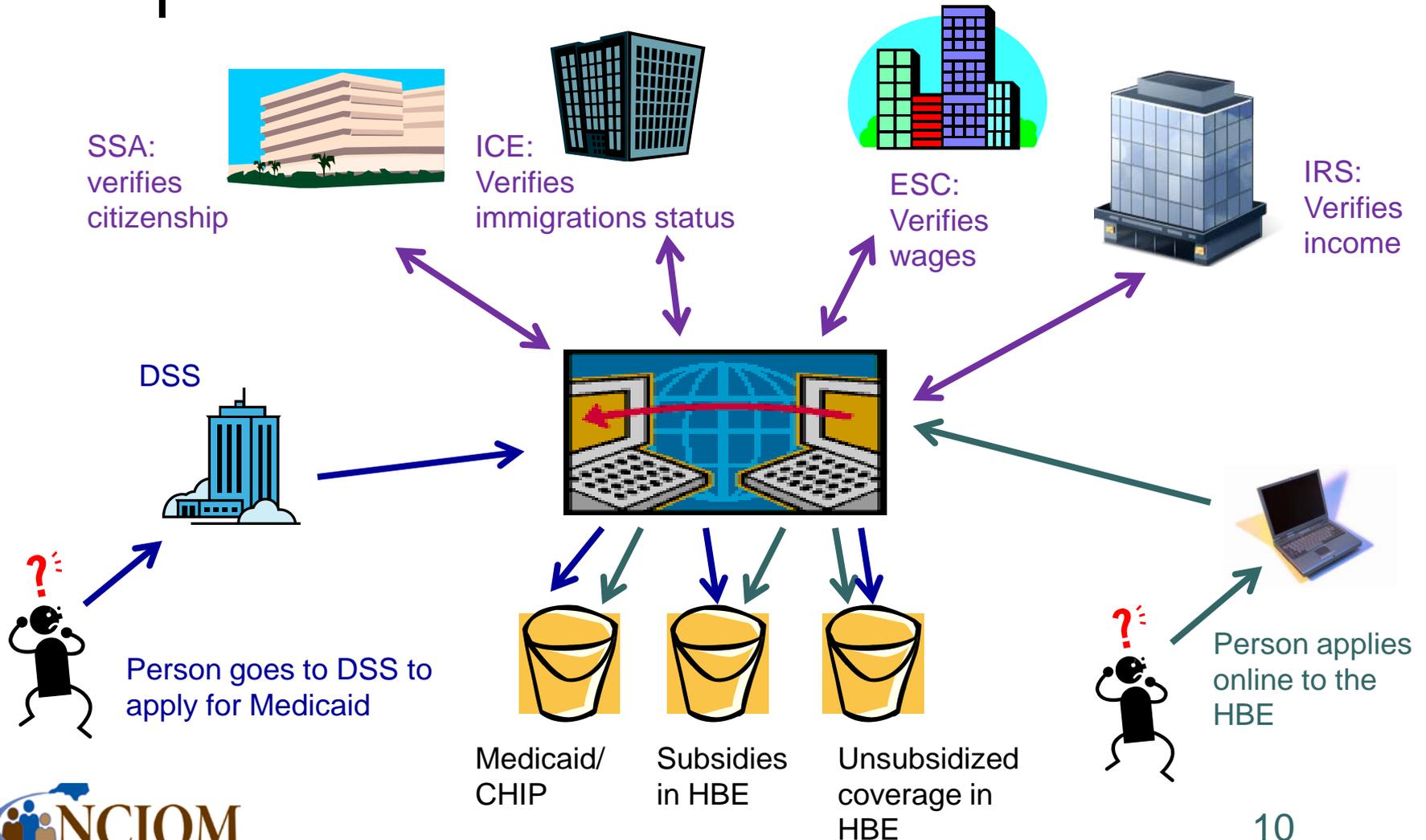
- At the next meeting, the workgroup will discuss the HBE board structure
  - Stakeholder composition
  - Functional abilities composition
- NAIC model legislation

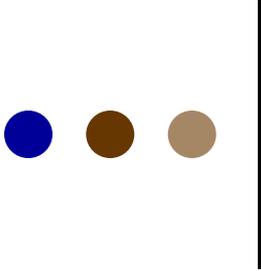


# Medicaid Workgroup

- Medicaid workgroup met two times since the last Overall Advisory Committee
- At the first meeting, the workgroup discussed the new eligibility and enrollment process envisioned under the ACA
  - DHHS and the HBE will need to coordinate the eligibility and enrollment system, but DHHS does not want to build new system
  - DHHS has been in the process of building a new eligibility and enrollment system for all of DHHS programs (NC FAST) to replace existing legacy systems
  - Medicaid/NC Health Choice has been moved up in the implementation timeline so that it will meet 2014 requirements

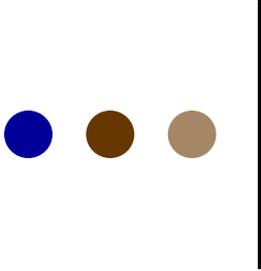
# Application and Enrollment





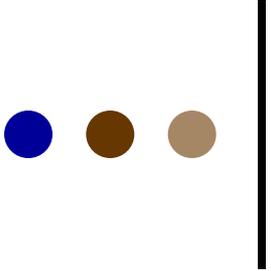
# Medicaid: Home and Community Based Services

- The workgroup also spent time discussing new home and community based service (HCBS) options available to the state (2011)
  - Community First Choice: states can expand HCBS to people who would otherwise need institutional level care. States eligible for a six percentage point increase in FMAP.
  - State rebalancing initiative: states can provide HCBS to people who do not need institutional level of services. North Carolina would be eligible for a two percentage point increase in FMAP.



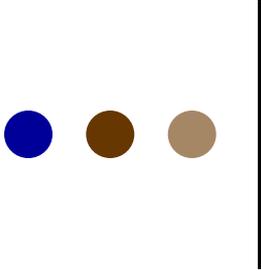
# Medicaid: HCBS

- The workgroup discussed possible ways to expand HCBS with little or no new state dollars.
  - The workgroup suggested options where the state could use existing state dollars and leverage it through the Medicaid program to serve more people. Examples:
    - Use existing state HCBS funds to pay for respite and adult day care services for individuals with incomes higher than traditional Medicaid
    - Use existing state funds for people with I/DD being served in 122C facilities (limit program initially to people in 122C facilities so as to limit potential state liability)
    - Provide HCBS to people who are currently being served through the Adult Protective Services system



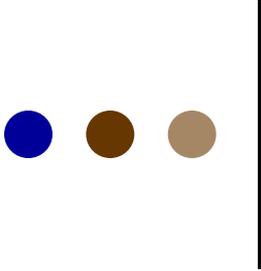
# New Models of Care

- The new models of care workgroup heard presentations on new primary care models that are being implemented in North Carolina that have led to improved health outcomes and/or reduced costs
- At the next meeting (this afternoon), the workgroup will begin to explore cost drivers
  - Services
  - Health conditions
  - Episodes of care



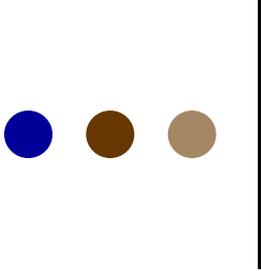
# New Models of Care: Focus on Costs

- The workgroup is going to continue to explore cost drivers in the commercial market, Medicaid and state health plan to help identify new delivery models that could help reduce health care cost escalation
- The workgroup is also trying to determine:
  - What are the metric we would use to measure the success of a new initiative
  - Whether NC needs to develop an infrastructure to support all different types demonstration programs



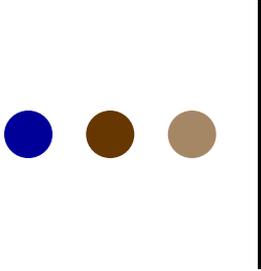
# Health Professional Workforce

- North Carolina was awarded a State Health Workforce Planning Grant in late September
- In October the Steering Committee met to figure out how the two groups- with similar overall missions and members- could work together without duplicating efforts
  - *Long-term Strategies:* 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
  - *Short-term Strategies:* the NCIOM workforce workgroup will focus its energy on 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.



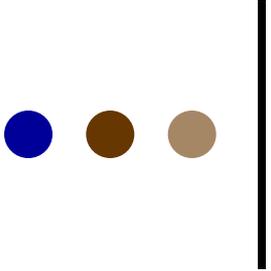
# Health Professional Workforce

- The NCIOM group will consider policy levers at various points in the health professional workforce pipeline including:
  - Early recruitment (particularly for allied health professionals)
  - Education (high school to advanced degrees)
  - Recruitment to health professional shortage areas
  - Retention of current health professionals
  - Ways to better meet the North Carolina's health needs
  - State and federal policies that impact the short-term size and distribution of health professionals in North Carolina



# Health Professional Workforce

- *November*: look at the coordination of the two groups and then focus on issues related to mental health providers
- *December*: focus on issues related to primary care and dental providers
- *January*: 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 group.



# Quality

- Gap analysis:

- Sub-committee met yesterday.
- Initial focus: Provisions with implementation dates through 2011
- Reviewing existing initiatives and efforts to provide information to providers.
- December Workgroup meeting will focus on gaps, legislation needs.