



## 2015 Medicaid and NC Health Choice Reform

Legislative Brief

February 29, 2016

### EXECUTIVE SUMMARY

Session Law 2015-245, An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Program, became law on September 23, 2015. The legislation requires transformation of the Medicaid and Health Choice programs in the following ways:

- Requires transition of the current Medicaid and NC Health Choice service delivery system to **capitated contracts with Prepaid Health Plans (PHPs)**.
- Creates a **new Division of Health Benefits** within the Department of Health and Human Services (DHHS) to plan and implement reform of the programs.
- Creates a **new Joint Legislative Oversight Committee on Medicaid and NC Health Choice** (Medicaid Oversight Committee) to oversee the programs and the transformation process and outlines specific dates for DHHS to report to the Committee.

Key components of the transition to capitated contracts with PHPs include the following:

- The entities eligible for a PHP contract are **provider-led entities (PLEs)** and **commercial plans (CPs)**. Both PLEs and CPs must meet solvency criteria developed by the Department of Insurance to be eligible for a capitated PHP contract.
- PHPs will receive **capitated per-member per-month payments** to provide all covered services for their enrolled beneficiaries. In a capitated payment system, a health care provider or managed care organization is paid a *set* amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care. In a fee-for-service payment system, the provider receives payment for *each* service provided to an enrollee.
- Geographical coverage of PHPs will include **three statewide plans and up to 10 regional PLE plans** operating in 6 regions, which will be defined by the Division of Health Benefits and cover the entire State.
- Populations covered by the PHPs will include **all Medicaid and Health Choice beneficiaries, except beneficiaries who are dually eligible** for Medicare and Medicaid.
- **All services** will be covered by the PHPs, **except for dental services, and except that local management entities/managed care organizations (LME/MCO) services will be provided through existing arrangements during the first 4 years of capitated PHP contracts**. The primary care case management function provided by North Carolina Community Care Networks, Inc. (NCCCN) will transition to PHPs.
- The timeline for implementation requires that capitated payments under **PHP contracts will begin 18 months after approval of the plan by the federal government**, with submission of documents to the federal government required by June 1, 2016.

This legislation became effective September 23, 2015, except that the new law requiring a reemployment cooling-off period for certain DHHS employees became effective November 1, 2015 and the new law pertaining to the appointment process and term of office for the Director of the Division of Health Benefits becomes effective January 1, 2021.

The General Assembly appropriated \$5,000,000 in both years of the biennium to fund the cost of reforming the Medicaid and NC Health Choice programs during FY 2015-17. The General Assembly also established a Medicaid Transformation Fund in order to reserve \$75,000,000 nonrecurring in FY 2015-16 and \$150,000,000 nonrecurring in FY 2016-17 to be used for funding the cash flow transition from a fee-for-service payment system to a capitated payment system.

## 2015 Medicaid and NC Health Choice Reform

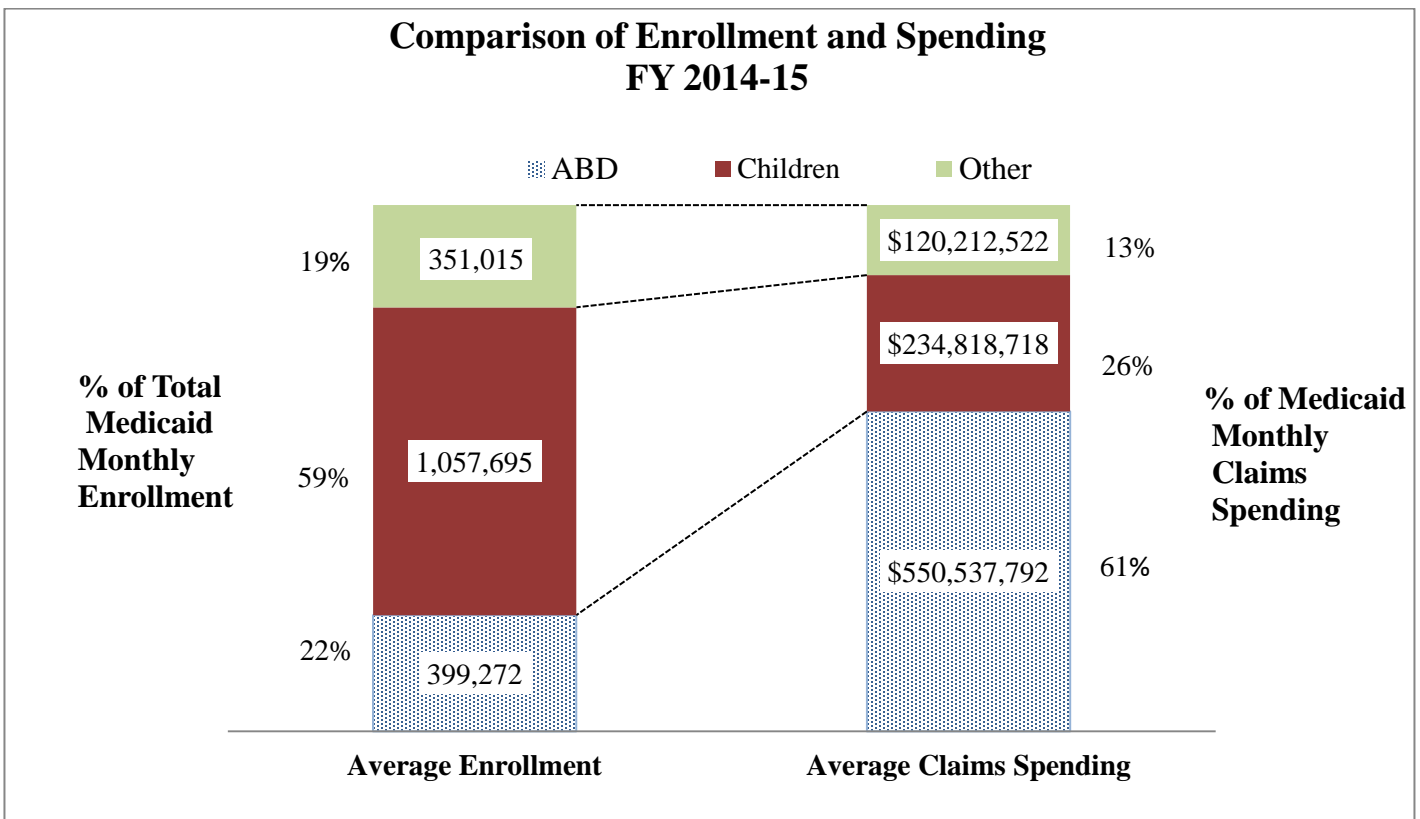
This brief summarizes the 2015 Medicaid reform legislation and provides a brief history of prior Medicaid and NC Health Choice reform initiatives in North Carolina. All reform efforts focused primarily on the Medicaid program and subsequently applied the same policy decisions to the NC Health Choice program; therefore, detailed information on the NC Health Choice program will not be provided in this brief. Section I of this brief provides program background, and Section II summarizes the 2015 Medicaid reform legislation.

### I. Program Background

Medicaid is a federal entitlement program created in 1965 as Title XIX of the Social Security Act for the purpose of providing health coverage to certain individuals and families with low income or resources. The program is a cooperative venture funded jointly by the federal and state governments. While federal law sets the parameters of the program, states administer individual programs and set the eligibility standards, covered services, and payment rates for their state program.

#### *Program Spending*

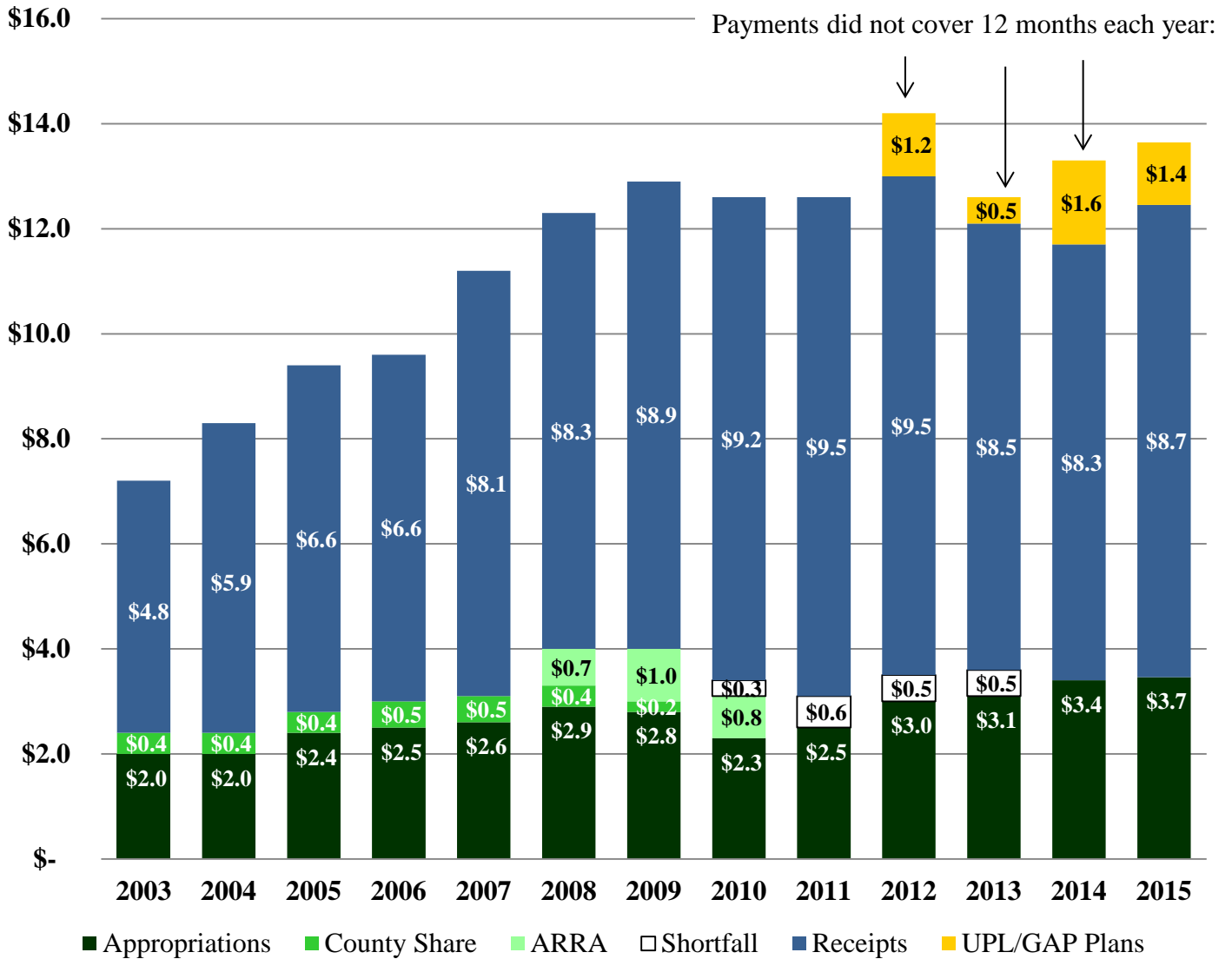
The major drivers of Medicaid expenditures include; the number of people enrolled in the program, the mix of services and recipient eligibility categories, the utilization of services, and price. The chart below demonstrates the relationship between enrollment and cost. The Aged, Blind and Disabled (ABD) category represented only 22% of the average monthly enrollment in FY 2014, but accounted for approximately 61% of the expenditures. Although children represent the largest enrollment category at 59%, they are responsible for only 26% percent of the average monthly Medicaid expenditures.





The legislative debate related to reform frequently centered on the growth in the overall Medicaid budget. The federal government funds the majority of the Medicaid program. In FY 2015 the State paid approximately 23.6% of total Medicaid expenditures, the federal government covered 59.7%, and the remaining 16.7% in spending was covered by drug manufacturer rebates, intergovernmental transfers, provider assessments and other receipts or transfers. The following chart represents the trend in total Medicaid expenditures since 2003.

### Historical Medicaid Expenditures





## ***Historical Budget Issues***

Budget writers were confronted with significant budget gaps in the State's Medicaid budget for several years, as shown in the following chart.

<b>State Fiscal Year</b>	<b>Amount of the Shortfall (Net State Appropriation)</b>	<b>Key Considerations:</b>
2009-10	\$335 million	
2010-11	\$601 million	\$222 million was associated with an unknown federal match rate at the time the budget bill passed. The budget bill included a contingency plan to cover a portion of the shortfall.
2011-12	\$507 million	\$132 million was associated with shifting a liability one month into the next fiscal year.
2012-13	\$488 million	*Details on next page.

In FY 2013 the shortfall was due to increased enrollment and utilization, a one-time State reimbursement of federal drug rebate payments, and a miscalculation of federal receipts. To ensure adequate funding through July 2013, the General Assembly passed S.L. 2013-56, Medicaid/2012-13 Additional Appropriations (H.B. 980), authorizing \$451 million, and S.L. 2013-184, Continuing Budget Authority (H.B. 336) authorizing \$45 million, for a total of \$496 million in additional Medicaid funding. The total amount of the shortfall was \$488 million for FY 2012-13.

Additional budget issues that contributed to Medicaid budget gaps included unachieved budget reductions. The Appropriations Act of 2013, S.L. 2013-360, reduced the Medicaid budget by \$147.3 million and the Health Choice budget by \$15.6 million. The Fiscal Research Division estimated that the Division of Medical Assistance would not achieve \$63.6 million of those reduction items by the end of FY 2013-14.

Based on continued budget issues, difficulty in projecting base budget requirements and the projected impact of the Medicaid budget on other areas of the State's budget, the General Assembly began addressing program reform in 2013.

## ***Early Reform Initiatives***

**2011** Session Law 2011-264, Statewide Expansion of 1915(b)/(c) Waiver, introduced statewide capitated payments for Medicaid behavioral health services. The legislation transitioned local management entities to Local Management Entity/Managed Care Organizations (LME/MCOs) and converted the payment structure for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders from fee-for-service to a single capitated payment. Under the LME/MCO model, all Medicaid behavioral health services expenditures, except for pharmaceuticals are paid on a capitated basis.

**2013** Session Law 2013-360, Appropriations Act of 2013, Section 12H.1, required DHHS, in consultation with a Medicaid Reform Advisory Group, to create a detailed plan to reform the Medicaid program. DHHS was prohibited from implementing Medicaid Reform without legislative approval. The plan was required to accomplish the following goals:

- (1) Create a predictable and sustainable Medicaid program;
- (2) Increase administrative ease and efficiency for Medicaid providers; and
- (3) Provide care for the whole person by uniting physical and behavioral health care.

DHHS's plan was presented to the General Assembly for consideration in a report dated March 17, 2014.



**2014** Session Law 2014-100, Appropriations Act of 2014, Section 12H.1, continued the legislature’s reform efforts and stated the intent of the General Assembly to develop a detailed Medicaid reform plan during a special session in November 2014. However, on August 20, 2014 the General Assembly adjourned sine die and did not return in November for a special session.

S.L. 2014-100 required DHHS to continue to consult with stakeholder groups, study, and recommend options for a Medicaid reform plan intended to provide greater budget predictability until the enactment of Medicaid reform legislation. S.L. 2014-100 specifically prohibited DHHS from:

- Implementing initiatives that would commit the State to any particular Medicaid reform plan;
- Submitting any reform-related State plan, amendments, waivers, or grant applications; and,
- Entering into contracts related to implementing Medicaid reform.

Also during the 2014 Session, the House and the Senate each passed versions of H.B. 1181, North Carolina Medicaid Modernization, containing a Medicaid reform plan; however, a final version of the legislation was not enacted.

**2015** H.B. 372 was introduced during the 2015 Session, continuing Medicaid reform efforts. The bill was enacted on September 23, 2015 as S.L. 2015-245.

## **II. S.L. 2015-245 Reform and Reorganization of the NC Medicaid Program**

### ***Role of the General Assembly***

The role of the General Assembly in the reform and operation of the Medicaid and NC Health Choice programs is to:

- (1) Define the overall goals of transformation and the structure of the delivery system.
- (2) Monitor the development of transformation plans and implementation of reform.
- (3) Define and approve eligibility and income standards for the programs.
- (4) Appropriate the annual budget for the Medicaid and NC Health Choice programs.
- (5) Confirm the Director of the Division of Health Benefits.

### ***Timeline for Medicaid Reform***

The timeline for key benchmark activities defined in S.L. 2015-245 are:

When act became law (September 23, 2015)	<ul style="list-style-type: none"> <li>• Division of Health Benefits in DHHS created</li> <li>• Joint Legislative Oversight Committee on Medicaid and NC Health Choice (Medicaid Oversight Committee) created</li> <li>• Division of Health Benefits to begin development of the 1115 waiver and any other State Plan amendments and waivers necessary</li> </ul>
March 1, 2016	Report due to Medicaid Oversight Committee on plans and progress of reform
On or before June 1, 2016	DHHS submission of waivers and State Plan amendments for federal approval
18 months after federal approval	Beginning of capitated contracts and completion of initial beneficiary enrollment



## ***Structure of the Reformed Delivery System***

The following are key components of the reformed Medicaid delivery system:

<b>Eligible Entities</b>	<ul style="list-style-type: none"> <li>• Contracts will be awarded to Prepaid Health Plans (PHPs), which may be either a provider-led entity (PLE), or a commercial plan (CP).</li> <li>• A PLE is an entity whose majority ownership interest is held by Medicaid providers and who has physicians, physician assistants, nurse practitioners, or psychologists as a majority of the entity's governing board.</li> <li>• A CP is any entity that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis.</li> <li>• Both types of PHPs must meet solvency standards established by the Department of Insurance that are similar to the solvency standards for similarly situated regulated entities.</li> </ul>
<b>Geographical Coverage</b>	<ul style="list-style-type: none"> <li>• There will be 3 statewide contracts with PHPs.</li> <li>• There may be up to 10 regional contracts in 6 regions determined by the Division of Health Benefits with PLEs.</li> <li>• The six regions must be composed of whole contiguous counties. Together, the six regions must cover the entire State.</li> </ul>
<b>Capitated Payments</b>	<ul style="list-style-type: none"> <li>• PHPs will receive capitated per-member per-month payments for their enrolled beneficiaries.</li> <li>• Capitated rates will be risk-adjusted based on the category of enrolled beneficiary (e.g., aged, child, pregnant women, etc.)</li> </ul>
<b>Populations Covered</b>	<ul style="list-style-type: none"> <li>• All Medicaid and Health Choice beneficiaries, except beneficiaries who are dually eligible for Medicare and Medicaid, will enroll with a PHP.</li> </ul>
<b>Services Covered</b>	<ul style="list-style-type: none"> <li>• PHPs will provide coverage for all current Medicaid and NC Health Choice services except as specifically excluded.</li> <li>• PHPs will not cover dental services.</li> <li>• PHPs will not cover LME/MCO services during the first 4 years of capitated PHP contracts. LME/MCO services will be provided through existing arrangements during that period.</li> <li>• The primary care case management function provided by NCCCN will transition to PHPs effective on the date of the new capitated contract.</li> </ul>



<p><b>Contract Requirements</b></p>	<ul style="list-style-type: none"> <li>• <b>Performance Measures and Goals</b> – The new delivery system and capitated PHP contracts shall be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component shall be subject to specific accountability measures, including penalties.</li> <li>• <b>Administrative Functions</b> – PHPs shall be responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, claims processing, care and case management, grievances and appeals, and other necessary administrative services.</li> <li>• <b>Managing Medicaid Spending Growth</b> – PHPs shall be responsible to keep risk-adjusted cost growth for its enrollees at least two percentage (2%) points below national Medicaid spending.</li> <li>• <b>Medical Loss Ratios</b> – Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services will be required, with the components of the numerator and denominator to be defined by the Division of Health Benefits.</li> <li>• <b>Provider Networks</b> - PHPs must develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS.</li> <li>• <b>Rate Floors</b> – PHPs must establish appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.</li> <li>• <b>Drug Spending</b> – DHHS will develop a single drug formulary and ensure that there is a requirement that PHP spending for prescribed drugs, net of rebates, represents a net savings for the State.</li> </ul>
<p><b>Planning and Reporting</b></p>	<ul style="list-style-type: none"> <li>• By March 1, 2016 the Division of Health Benefits must submit a report to the Joint Legislative Oversight Committee on Medicaid and Health Choice that includes the proposed waiver, required statutory changes, the timeline for issuing requests for proposals (RFPs) for PHPs, and a plan for the transition of service features of the contract with North Carolina Community Care Networks, Inc. (NCCCN) to the new delivery system. Complete details of the reporting requirements contained in the legislation can be found in <u><i>Attachment A - Medicaid Reform Reporting Requirements</i></u>.</li> <li>• All PHPs and Medicaid and NC Health Choice providers shall be required to submit data through the Health Information Exchange Network, as part of the Medicaid reform plan.</li> </ul>



## ***Reorganization***

- The Division of Health Benefits is created within DHHS to plan and implement reform of the Medicaid and NC Health Choice programs.
- The Division of Medical Assistance will operate the current Medicaid and NC Health Choice programs until the transition to PHPs is completed.
- The Division of Medical Assistance and all positions remaining in DMA will be eliminated 12 months after capitated PHP contracts begin or at an earlier time upon notice to the Office of State Budget and Management.
- Beginning in 2021, the Director of the Division of Health Benefits will be appointed by the Governor and confirmed by the General Assembly to serve a four-year term.
- The new Division of Health Benefits has increased responsibility to keep program spending within the budget set by the General Assembly, to engage in budget forecasting, and to publish data.
- DHHS is given full authority to administer and operate the programs within their budget and set all program components except for eligibility categories and income thresholds.

## ***Legislative Oversight***

- A new Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created to oversee the planning and implementation of the Medicaid reform process.
- The existing Joint Legislative Oversight Committee on Health and Human Services will no longer oversee issues related to Medicaid and Health Choice except that they will continue to oversee the LME/MCOs and mental health matters.
- Both oversight committees will oversee mental health issues.

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## Attachment A – Medicaid Reform Reporting Requirements

Reports due to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by S.L. 2015-245, include the following:

Due date	Agency Reporting	Authority for Report	Content of Report
3/1/16	DHB	§5(12)	<p>Plans and progress of Medicaid reform, including:</p> <ul style="list-style-type: none"> <li>a. The proposed waiver application.</li> <li>b. The expected time frame for the submission of the proposed waiver to CMS.</li> <li>c. Proposed statutory changes required.</li> <li>d. Status of staffing of the Division of Health Benefits, including a description of staff's key competencies and expertise.</li> <li>e. Anticipated distribution of regional capitated PHP contracts.</li> <li>f. Plans for recipient enrollment.</li> <li>g. Recipient access standards.</li> <li>h. Performance measures.</li> <li>i. A plan for the proposed inclusion of the following features as part of Medicaid and NC Health Choice transformation:               <ul style="list-style-type: none"> <li>1. Rate floors in addition to those required by subdivision (5) of Section 5 of this act.</li> <li>2. Antitrust policies.</li> <li>3. Protections against the exclusion of certain provider types.</li> <li>4. Prompt pay requirements.</li> <li>5. Uniform credentialing requirements.</li> <li>6. Good-faith negotiations.</li> </ul> </li> <li>j. Time line for issuance of RFP and solicitation of bids.</li> <li>k. Measures for sustainability of the transformed system.</li> <li>l. A plan for transition of features of the contract with the North Carolina Community Care Network, Inc., (NCCCN) to the new delivery system, including a plan for utilizing, at the appropriate time, the Health Information Exchange Network to perform certain functions presently being performed by NCCCN's Informatics Center in conjunction with the primary care case management program.</li> <li>m. A plan to stabilize the Division of Medical Assistance during the transition of the Medicaid and NC Health Choice programs to the Division of Health Benefits.</li> <li>n. A plan that will ensure continuity of services for individuals in foster care and adoptive placements in the transformed Medicaid and NC Health Choice programs.</li> </ul>
3/1/16	DHB and DOI	§4(6a)	<p>Review the applicability of Chapter 58 of the General Statutes to PHPs and report on:</p> <ul style="list-style-type: none"> <li>a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.</li> <li>b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.</li> <li>c. Proposed statutory changes necessary to implement this subdivision.</li> </ul>



3/1/16	DOI	§6	<ul style="list-style-type: none"> <li>• Recommended solvency requirements that are similar to the solvency requirements for similarly situated regulated entities and recommended licensing procedures that include an annual review by the Commissioner and reporting of changes in licensure to the DHB, developed in consultation with the Director of the DHB.</li> <li>• Proposed fees to offset the cost of licensure.</li> <li>• Any necessary statutory changes.</li> </ul>
5/1/16	DHHS	§8	<p>Program design and budget proposal for creating a Medicaid and NC Health Choice Transformation Innovations Center within the DHB with the purpose of assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:</p> <ol style="list-style-type: none"> <li>(1) Learning collaboratives, peer-to-peer networks.</li> <li>(2) Clinical standards and supports.</li> <li>(3) Innovator agents.</li> <li>(4) Council of Clinical Innovators.</li> <li>(5) Community and stakeholder engagement.</li> <li>(6) Conferences and workshops.</li> <li>(7) Technical assistance.</li> <li>(8) Infrastructure support.</li> </ol>
1/31/17	DHB	§5(11)	<p>Recommend a long-term strategy to cover dual eligibles through capitated PHP contracts, developed upon the advice of the Dual Eligibles Advisory Committee of the DHB.</p>

**DHB** = Division of Health Benefits of the Department of Health and Human Services

**DHHS** = Department of Health and Human Services

**DOI** = Department of Insurance