Nothing Compares
NORTH CAROLINA

Joint Legislative Oversight Committee
on Medicaid and NC Health Choice
March 1, 2016

Department of Health and Human Services Review of Medicaid Reform Report and Section 1115 Waiver Application

Years of hard work and collaboration

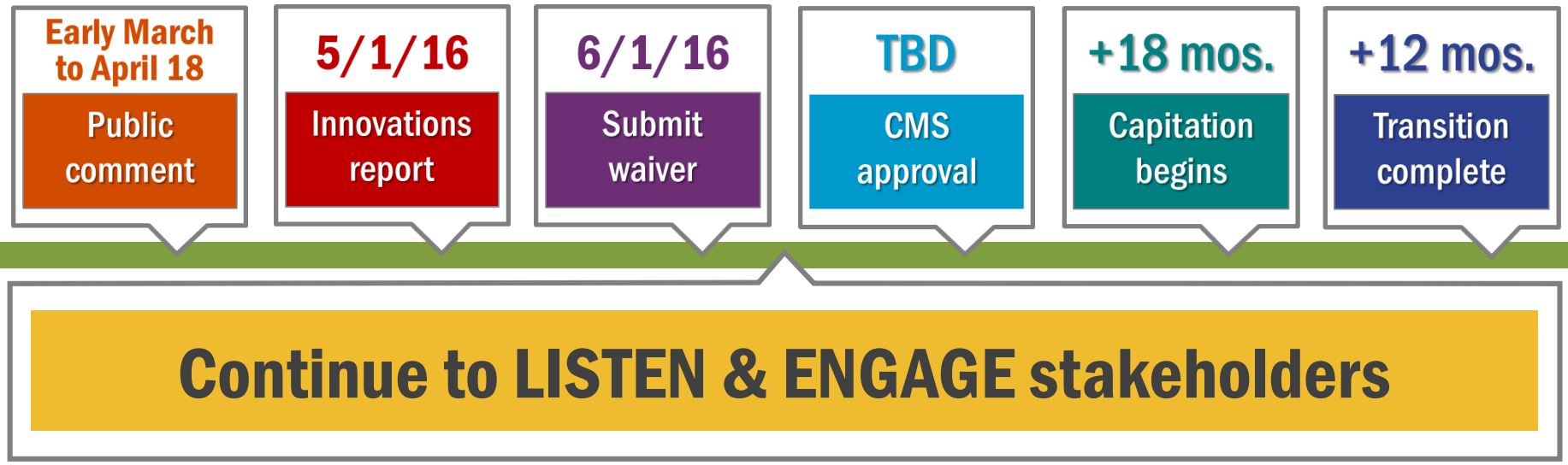
Legislation provided the frame

Session Law 2015-245 directives

- Ensure budget predictability through shared risk and accountability;
- Ensure balanced quality, patient satisfaction, and financial measures;
- Ensure efficient and cost-effective administrative systems and structures; and
- Ensure a sustainable delivery system through the establishment of two types of prepaid health plans (PHPs): provider-led entities (PLEs) and commercial plans (CPs).

Significant external stakeholder engagement

A process built on collaboration



Vision builds on the uniqueness of North Carolina

Improve access to, quality of and cost effectiveness of health care for our 1.9 million Medicaid and NC Health Choice (Children's Health Insurance Program, or CHIP) beneficiaries by:

- Restructuring care delivery using accountable, next-generation prepaid health plans
- Redesigning payment to reward value rather than volume
- Planning toward true "person-centered" care grounded in increasingly robust patient-centered medical homes and wrap-around community support and informatics services

Overview of 1115 demonstration waivers

Section 1115 waivers provide states an avenue to test and implement coverage approaches that do not meet federal program rules

- **Secretary of Health and Human Services authority to waive provisions of major health and welfare programs authorized under the Act, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules.**
- **Section 1115 Medicaid waivers can allow for broad changes in eligibility, benefits, cost sharing, and provider payments.**
- **Section 1115 waivers are intended to be research and demonstration projects to test and learn about new approaches to program design and administration.**

Key Takeaways

1. This reform is historic and brings innovation and new tools to meet the unique needs of North Carolina. A North Carolina solution.
2. Meets the goals set forth by the Governor and General Assembly.
3. Provides broad-based, system-wide innovation for beneficiaries, communities and providers while promoting budget stability.
4. Stakeholder input has been and will continue to be crucial to this waiver process.

Agenda

- Draft waiver review
  - Quadruple Aim (Dr. Warren Newton & Dave Richard)
  - Legislative Changes (Dave Richard)
  - Financing (Trey Sutten)
  - Next Steps (Rick Brajer)

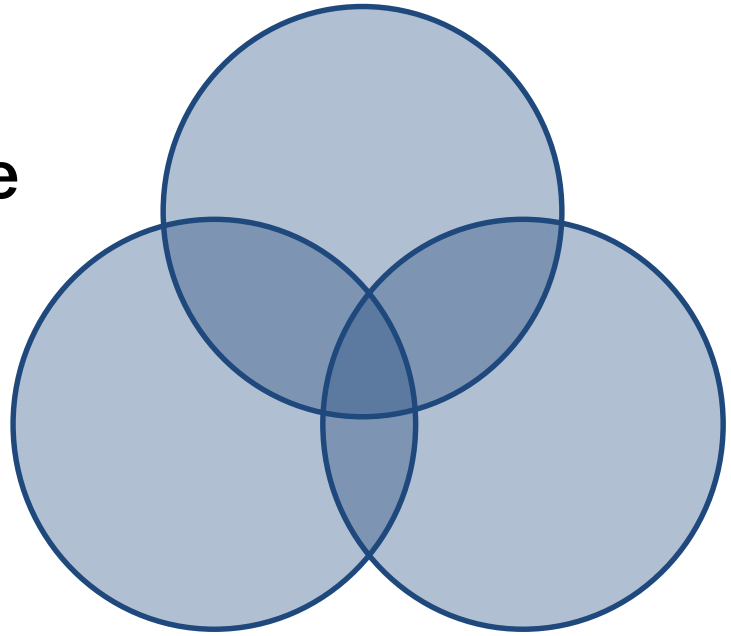
- Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice
  - Section 5(12) of SL 2015-245/HB 372 (Dee Jones)
  - Next steps (Dee Jones)

The Triple Aim

Better patient experience

Better health

Lower cost

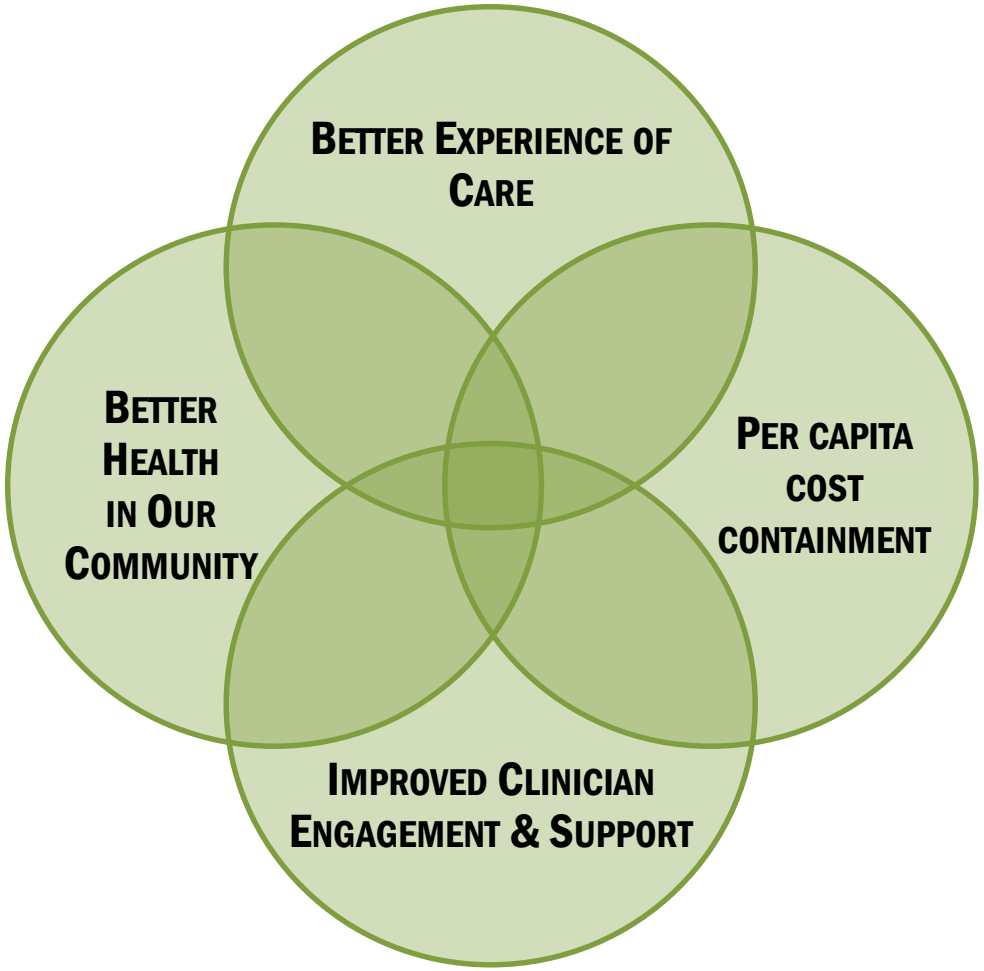


1115 Demonstration Waiver Rationale

The waiver provides broad-based, system-wide innovation for beneficiaries, communities and providers while promoting budget stability.

Our waiver proposals will support the goals of the Quadruple Aim.

North Carolina's Quadruple Aim



AIM #1

Better experience of care

- Choice of medical home and PHP
- Person-centered care
- Better connections with other social services
- Self care and involvement in care delivery by patients and families
- Evolving and robust PCMH as foundation for transformation to person-centered health communities
- Long term services and supports for Medicaid-only individuals

AIM #2

Better health in our community

- Build advanced patient centered medical homes
- Establish person-centered health communities in PHP provider networks
- Further integrate behavioral health
- Improve rural health access, outcomes and equity
- Enhance outcomes for children in foster care
- Address actionable social determinants of health
- Leverage health information exchange (HIE) and analytics to improve health

AIM #3

Improved clinician engagement & support

- Provide practice support for quality improvement and transformation
- Create Innovations Center to spread best practices
- Strengthen health information exchange (HIE) to drive practice improvement and efficiency
- Support clinicians and providers through statewide analytics tools
- Create the workforce necessary for reform (community residencies, community health workers, etc.)
- Ease administrative burden for clinicians and providers

AIM #4

Per capita cost containment and funding stability

- Ensure budget predictability through capitation
- Incentivize clinicians and hospitals through payments for better outcomes
- Maintain funding for safety net providers

Performance measures

- North Carolina priorities, aligned with national measures
- Transparency to legislature, clinicians and the public
- Accountability for performance
- Used to drive improvement

Legislative changes to support program

- Exclude from waiver
  - Populations with short eligibility spans (e.g., medically needy and populations with emergency only coverage)
  - PACE
  - Local Education Agency (LEA) services
  - Child Development Service Agencies (CDSAs)
- DHHS is exploring alternative solutions for the Eastern Band of Cherokee Indians (EBCI) and members of other federally recognized tribes
- Maintain eligibility for parents of children placed in foster care system

Supplemental payments

- NC providers receive approximately $2 billion annually in payments through a complex and vital set of funding streams
- Transitioning to prepaid health plans presents risks to these funds
- Redesigning them requires a thorough and deliberate process in partnership with impacted providers
  - Public, Private, and Teaching Hospitals
  - State Schools of Medicine
  - Local Health Departments
  - Public Ambulance Providers
  - Local Education Agencies
  - Others

Supplemental funding under reform

Supplemental funding under reform is preliminarily envisioned to be structured in five ways:

- Uncompensated Care Pools
- Delivery System Incentive Reform Payments (DSRIP)
- Direct Payments to certain providers
- Directed Value Based Payments
- Base Rates

Some of the existing funding will remain intact and outside of the waiver:

- Disproportionate Share Hospital Payments
- Graduate Medical Education

Budget neutrality

- Waiver must cost the federal government no more than what would have been spent otherwise
- Budget neutrality proposal will be based on historical and projected aggregate expenditures and enrollment
  - Without Waiver (WOW): Projection of what the federal government would theoretically pay absence the demonstration.
  - With Waiver (WW): Costs of the demonstration initiatives. For initial applications, these are projections.
  - Budget neutrality means that WW expenditures ≤ WOW expenditures
- Budget neutrality is not a calculation that reflects state budget impact

Looking ahead

DHHS finance team has a number of priorities before the June 1 waiver submission to CMS

- Continue engaging clinicians and providers on structure of incentive program
- Develop initial set of goals and associated measures for incentive payments
- Engage providers and legislators on funding amounts for supplemental payments
- Refine projections for budget neutrality section of the waiver
- Begin planning for PHP rate setting methodology

Hypotheses

- Building Person-Centered Health Communities will improve patient experience, care, and efficiency
- Measuring outcomes and paying for them appropriately will improve care and the experience of clinicians and beneficiaries
- Our hybrid model will create a learning network to develop and evaluate innovations in the context of the quadruple aim
- Improving supports for children in foster care will reduce unnecessary heath care spending and shorten the length of out-of-home placement

1115 draft waiver

Next Steps

- Planning for 12 listening sessions across the State
- 30+ day public comment period (early March to April 18)
  - Comments can be submitted via Medicaid Reform website www.ncdhhs.gov/nc-medicaid-reform
- 60-day Tribal consultation
- Recommend language for statutory changes
- Continued engagement with stakeholders
- Finalize and submit draft to CMS on June 1

Listening sessions

Asheville*

Boone

Charlotte (2)*

Elizabeth City*

Greensboro*

Greenville*

Lumberton

Raleigh

Sylva

Wilmington*

Winston-Salem

* Confirmed

Dee Jones, Division of Health Benefits

Key accomplishments

- Established design and draft waiver team
- Proactively engaged stakeholder community
- Identified and secured expertise to support development of the 1115 waiver and JLOC report
- Established Division of Health Benefits per S.L. 2015-24
- Delivered JLOC Report and draft 1115 waiver on schedule

JLOC report overview

Waiver application

Time frame for waiver submission to CMS

Proposed statutory changes required

Status of staffing of the Division of Health Benefits

Anticipated distribution of regional PHP contracts

Plans for recipient enrollment

Recipient access standards

Performance measures

Plan for the proposed inclusion of provider provisions

Timeline for issuance of PHP RFP

Measures for sustainability of the transformed system

Plan for transition of CCNC / N3CN features

Plan to stabilize Division of Medical Assistance

Plan to ensure continuity of services for individuals in child welfare system

Agenda

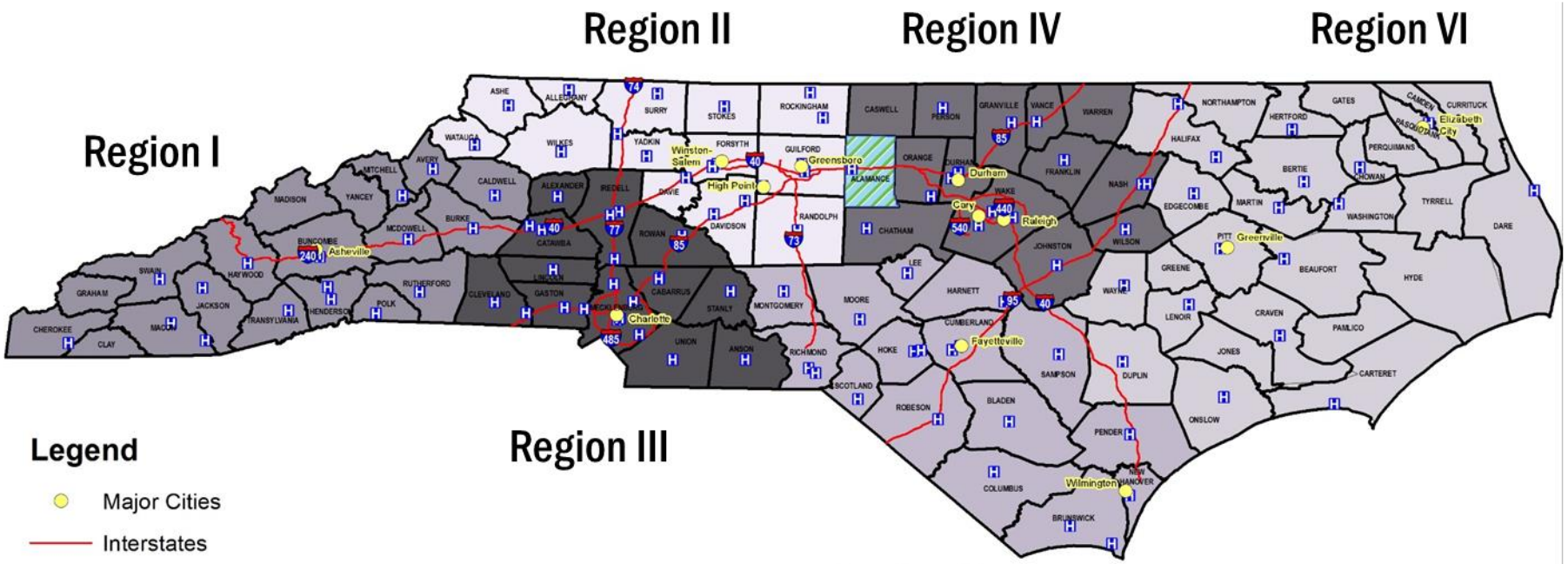
- Core programmatic activities
- Administrative activities
- Next steps

Regional capitated PHP contracts

Anticipated distribution

- DHHS focused on:
  - Reflecting existing beneficiary utilization and provider referral patterns
  - Sufficient enrollment to support at least one PLE per region
- DHHS requests flexibility to allow up to 12 regional PLE contracts
- Maximum number of PHPs per region based on number of eligible Medicaid beneficiaries in the region

Proposed regions



Region	Population*
I	165k
II	280k
III	410k
IV	299k
V	291k
VI	230k
II & IV	29k

*Population estimated from June 2015 enrollment data.

Application of Insurance Statutes

PHP licensure and applicable Chapter 58 provisions

- PHP Licensure
  - Required by S.L. 2015-245
  - Requirements under development with DHHS and DOI
- Solvency standards
  - Recognize levels of risk assumed by PHP
- Other consumer and provider protections
  - Chapter 58 will apply to PHPs through DHHS regulations or PHP contract

Beneficiary enrollment in prepaid health plans

- Contract with enrollment broker to provide:
  - Beneficiary education, outreach and enrollment
  - Assistance with plan selection and primary care provider selection, if necessary
- Auto-assignment (for those who do not select a PHP)
  - Preserve existing PCP, other provider relationships and family linkages
  - Will consider overall program goals, such as plan quality and balancing PHP enrollment
- Other
  - Modified process for Eastern Band of Cherokee Indians
  - Designated statewide PHP for foster care children

Beneficiary access standards

- DHHS will establish and enforce access and availability standards for PHPs
  - Must comply with pending Medicaid managed care rule
  - Will consider:
    - Time and distance standards
    - Appointment availability and office waiting time
    - Variation for rural versus metropolitan/urban areas
    - Findings from the development of the access monitoring review plan (AMRP)
- Expect additional stakeholder engagement

Foster care and adoptive placements care

Goal: Enhance outcomes for children and families in the child welfare system

- Proposal #1: Designation of statewide PHP tailored to the needs of foster care children
- Proposal #2: Expansion of Fostering Health NC
- Proposal #3: Maintenance of coverage for parents of foster care children

Proposed inclusion of provider provisions

- Rate Floors
- Essential Providers
- Good Faith Negotiations
- Protections against exclusion of certain provider types
- Anti-trust policies
- Prompt pay requirements
- Uniform credentialing requirements

Performance measures

- Continuous performance improvement at multiple levels (including program, PHP and provider levels)
- Align PHP and LME-MCO performance measures
- Common set of measures for provider accountability
- Leverages extensive work already completed
- Data and strong data analytics capacity are key

Sustainability measures

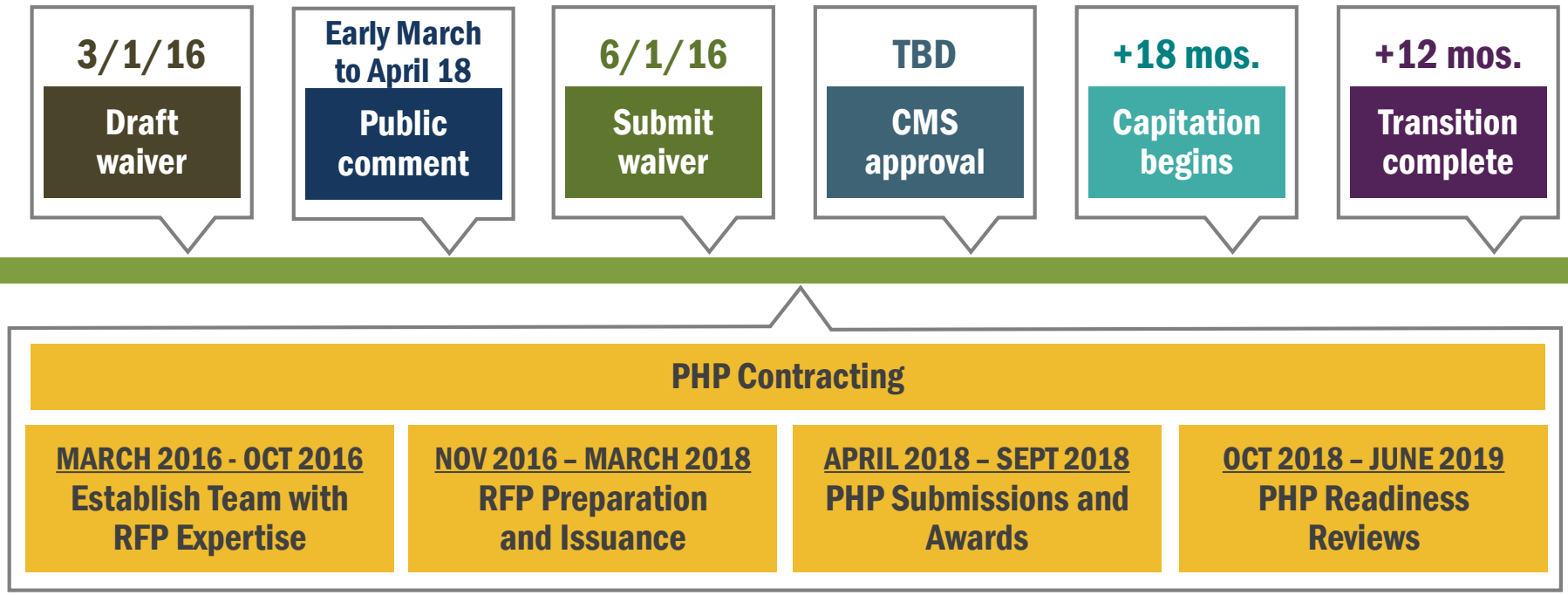
- General framework for sustainability measures includes:
  - Financial sustainability
  - Stakeholder engagement
  - Clinical quality
  - Organizational sustainability
- Issues can be identified early and corrections implemented in a timely manner
- Ensure programs are accountable to stakeholders for delivering efficient and effective care

NC Community Care Network contract

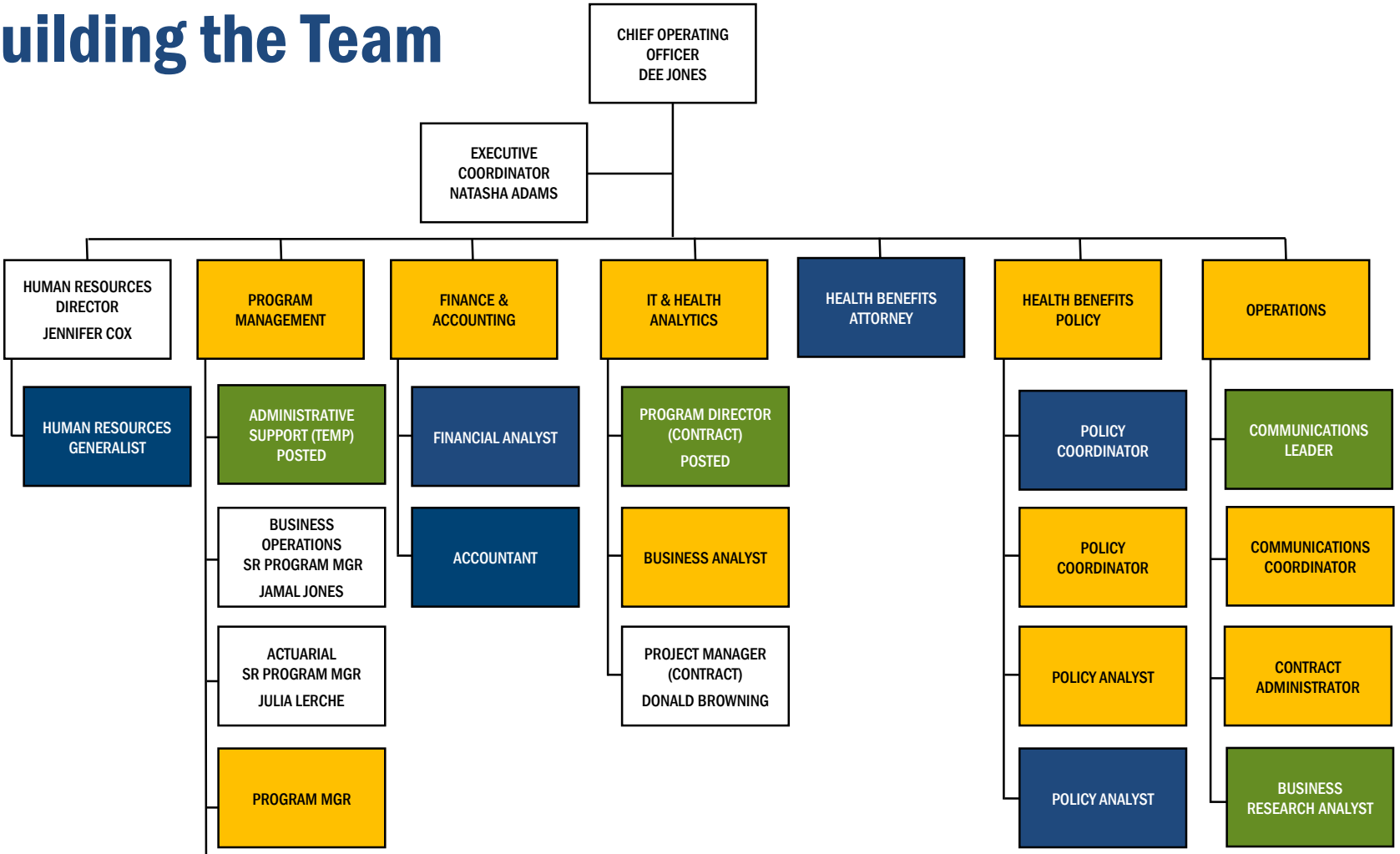
- New contract will define a transition plan
- Transition plan will depend on waiver concepts under development and consistent with S.L. 2015-245
- DHHS and N3CN are collaborating to ensure a smooth transition

Timeline for PHP Contracting

- Complex, time critical processes
- Substantial planning required to build Statement of Work
- PHP contracts timeline assumes CMS approval in January 2018



Building the Team



TIME FRAME	FTEs
Oct. 2015 - June 2016	22
July 2016 - June 2017	6
Total DHB Project Staff	28

DMA stabilization during transition to DHB

- Managing change and developing leadership
  - Emphasis on training/retraining, transition planning, timing, and change management
  - Medicaid Leadership Institute support until September 2016
  - Will also work with third party consultant on new organization structure and transition
- Division of Health Benefits (DHB) and Division of Medical Assistance (DMA) working together
  - Developing waiver and report
  - DHHS Human Resource staff developing support plans for transition
  - Focusing on continuity of DMA services along with continued improvement initiatives

Statutory changes

Administrative

- Recognize DHHS has operational authority for Medicaid, rather than through Division of Health Benefits
- Ease cooling off period requirements for staff without leadership role or contract decision making authority

Near term next steps

- Begin public comment period and conduct listening sessions
- Recommend language for statutory changes
- Finalize Innovations Center report by May 1
- Submit 1115 waiver by June 1
- Continue building the Division of Health Benefits team

Questions