Nothing Compares
NORTH CAROLINA

House Health Committee
June 1, 2016

Department of Health and Human Services
Medicaid Reform 1115 Waiver Submission

Agenda

- Overview, milestones and vision
- Alignment with session law
- Public comments
- Waiver changes from 3/1 to 6/1
- Finances
- Proposed legislative changes
- Next steps

Overview

Session Law 2015-245

- Medicaid reform was signed into law by Gov. McCrory in September 2015, after extensive engagement with the General Assembly, providers, beneficiaries and other stakeholders throughout the state.
- Outlined in SL 2015-245 (HB 372), Medicaid reform, once approved by the Centers for Medicare & Medicaid Services (CMS) will transform North Carolina Medicaid and NC Health Choice programs through system-wide innovation for beneficiaries, communities and providers while promoting budget stability.
- SL 2015-245 required DHHS to submit an 1115 Demonstration Waiver to CMS by June 1, 2016, to support reform goals.

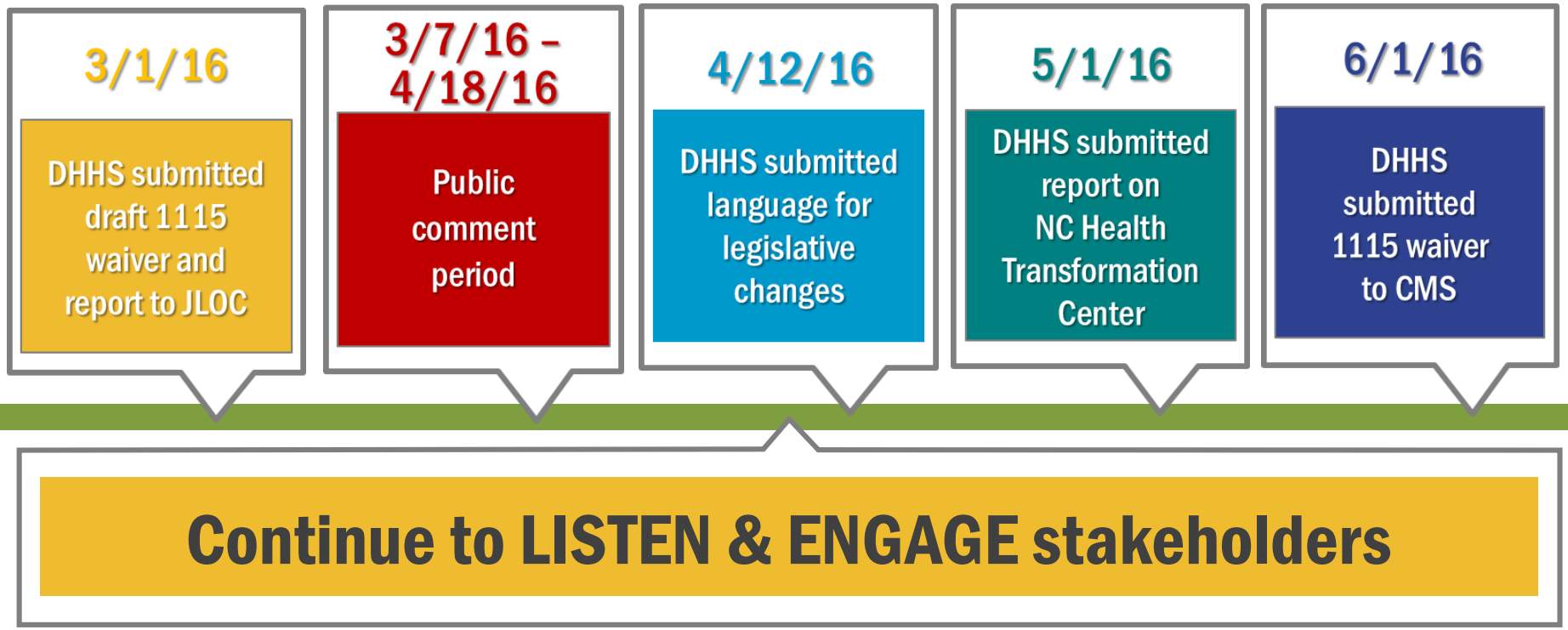
Overview of 1115 demonstration waivers

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

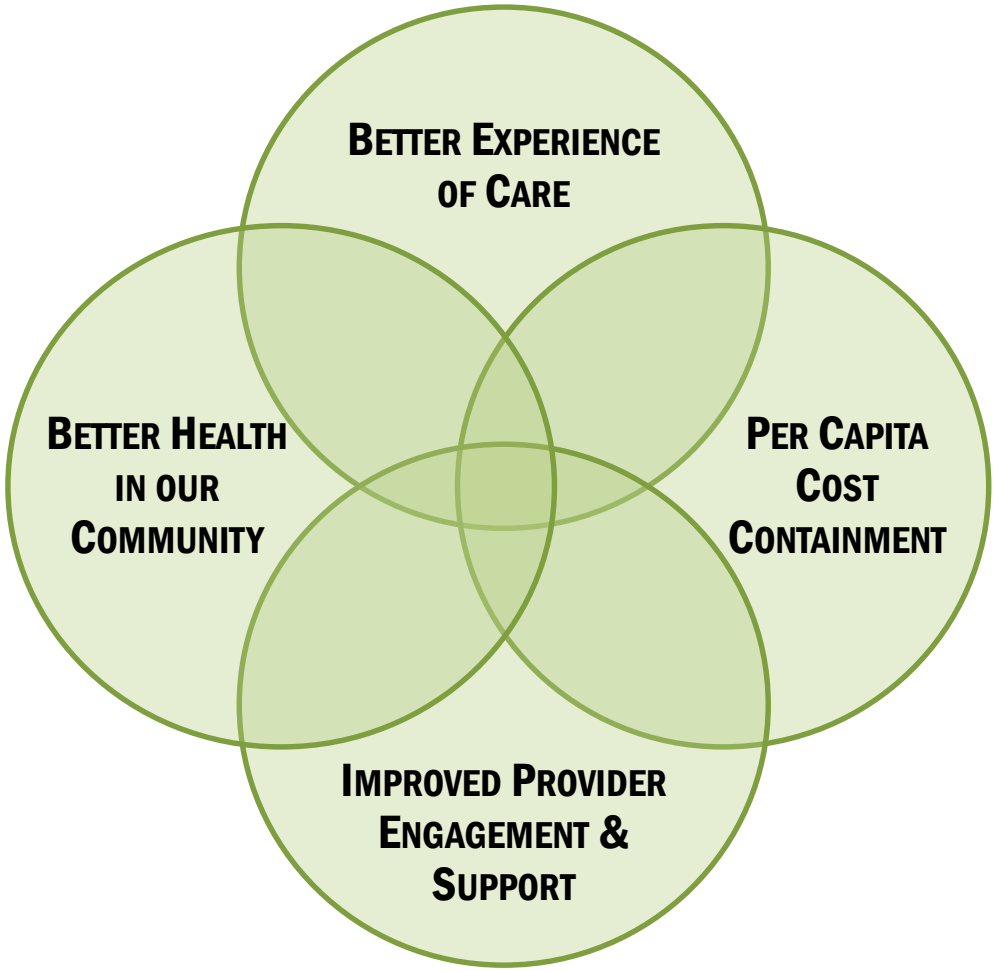
- Secretary of Health and Human Services has authority to waive certain Medicaid requirements and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules
- Allow for broad changes in eligibility, benefits, cost sharing and provider payments.
- Intended to be research and demonstration projects to test and learn about new approaches to program design and administration

Milestones

A process built on collaboration



Vision builds on our foundation of innovation



Improve to improve health care access, quality and cost efficiency for our 1.9 million Medicaid and NC Health Choice beneficiaries

North Carolina waiver initiatives

- Build a system of accountability for outcomes
- Create Person-Centered Health Communities (PCHCs)
- Support providers through engagement and innovations
- Connect children and families in the child welfare system to better health
- Implement capitation and care transformation through payment alignment

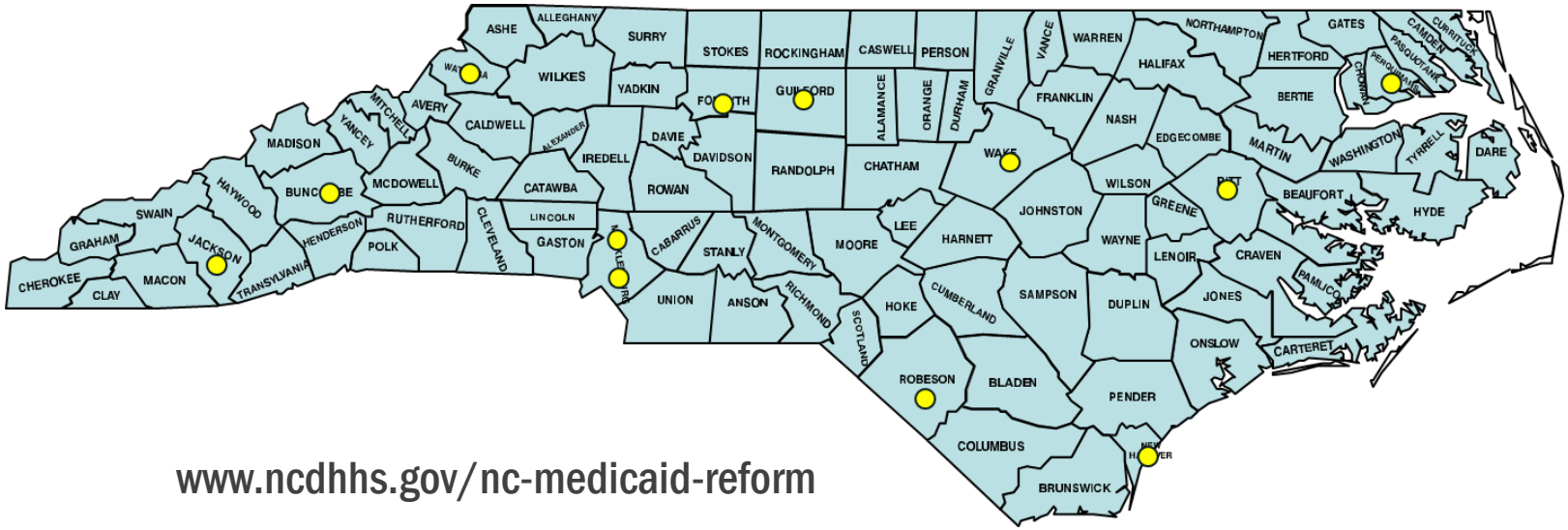
Alignment with session law

S.L. 2015-245 REQUIREMENT	IN WAIVER APPLICATION – Y/N
Part I, Section 4: Structure of Delivery System	
4.1 DHHS authority. DHHS has full authority to manage NC Medicaid and NC Health Choice; DHB is responsible for planning and implementing Medicaid transformation	Yes
4.2 Prepaid health plan. Commercial plans and provider-led entities, which will operate a capitated contract for delivery of services	Yes
4.3 Capitated contracts. DHB will enter into capitated contracts with PHPs, as a result of RFPs and submission of competitive bids	Yes
4.4 Services covered by PHPs. PHP capitated contracts will cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, LTSS and NC Health Choice behavioral health services; LME/MCOs are excluded until 4 years after capitated contracts begin; dental services are excluded	Yes, with exceptions requested by DHHS
4.5 Populations covered by PHPs. PHP capitated contracts will cover Medicaid and NC Health Choice program aid categories except dually eligible recipients; DHB will develop a dually eligible long-term coverage strategy	Yes, with exceptions requested by DHHS
4.6 Number and nature of PHP contracts. 3 statewide contracts; 10 regional contracts; initial PHP capitated contracts may be staggered in duration of 3-5 years	Yes
4.6a PHPs will comply with General Statutes Chapter 58. Joint review by DHHS, DHB and Department of Insurance	N/A; reflected in 3/1 JLOC report
4.7 Defined measures and goals. Delivery system and contracts will be built on defined measures and goals for health outcomes, quality of care, patient satisfaction, access and cost	Yes
4.8 PHP administrative functions. PHPs are responsible for administrative functions for enrolled recipients, including claims processing, care and case management, and grievances and appeals.	Yes, details will be included in contracts
4.9 LME/MCOs. LME/MCOs will continue to manage behavioral health services for enrollees under existing waivers for 4 years after PHP capitated contracts begin; DHB will negotiate rates and make payments directly to LME/MCOs during the 4-year period	Yes

Alignment with session law

Part 1, Section 5: Role of DHHS	IN WAIVER APPLICATION - Y/N
5.1 Section 1115 waiver application to CMS. Submit 1115 waiver, and any other waivers and plan amendments as necessary	Yes, 1115 has been submitted; plan amendments will be submitted if and when identified
5.2 Regions. Develop 6 regions that reasonably distribute populations across the state	N/A; reflected in 3/1 JLOC report
5.3 PHP contract performance. Oversee, monitor and enforce	N/A; part of PHP contracting
5.4 Transformed Medicaid and NC Health Choice programs. Ensure sustainability	Yes
5.5a-c Set rates. Actuarially sound capitation rates that are risk-adjusted and include a portion at-risk for quality and outcome measures, and value-based payments; appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees; fee-for-service rates	N/A; part of program design and PHP contracting
5.6a-e PHP standardized contract terms. Through RFPs and competitive bids, DHB will develop standard contract terms including risk-adjusted cost growth of 2% for enrollees; use of same prescription drug formulary; minimum medical loss ratio of 88%; include providers in coverage area designated as essential providers; assign enrollees a PCP if one is not elected	Yes, with details part of PHP contracting
5.7 RFPs for PHP capitated contracts. Consult with JLOC/Medicaid and NCHC before issuing RFPs	Yes
5.8 Recipient assignment to PHPs. Develop and implement process, including at least family unit, quality measures and primary care physician	Yes
5.9 Program integrity. Define methods against fraud, waste, abuse	N/A; part of program design
5.10 Health Information Exchange. Require PHPs and providers to submit data through HIE	Yes
5.11 Dual eligibles. Develop advisory committee; develop long-term strategy; report strategy to JLOC/Medicaid and NCHC	Yes
5.12a-n JLOC/Medicaid and NCHC reporting. March 1: Provide draft waiver, report, statutory changes, DHB staffing, contract distribution, etc.	N/A; completed
5.13a-d. Designate essential providers. Include federally qualified health centers, rural health centers, free clinics and local health departments	Yes

12 Public Hearings – 1,600 citizens participated



www.ncdhhs.gov/nc-medicaid-reform

March 30 – Raleigh, 6–8 p.m.
March 31 – Monroe, 2–4 p.m.*
March 31 – Huntersville, 6:30–8:30 p.m.
April 5 – Sylva, 4–6 p.m.

April 6 – Boone, 12–2 p.m.
April 6 – Asheville, 6:30–8:30 p.m.
April 7 – Greensboro, 6:30–8:30 p.m.
April 8 – Winston-Salem, 2–4 p.m.

April 13 – Wilmington, 6–8 p.m.
April 14 – Greenville, 2–4 p.m.
April 16 – Elizabeth City, 10–12 p.m.
April 18 – Pembroke, 3:30–5:30 p.m.*

* Dial-in option available.

Public comment process

750 commenters

1,700 comments

General public comment themes

- **Beneficiary concerns.** Ensure beneficiaries continue to have a voice through work groups; ensure adequate patient access to providers
- **Provider concerns.** With possibility of working with up to five plans, the state must standardize processes to reduce administrative burden; ensure independent appeals process, rate adequacy, and support for local health departments, HIV specialists and psychiatry
- **Expansion.** Strong advocacy for expansion by attendees
- **Case/care management.** Ensure continuation of care management, provider supports and analytics
- **Supplemental payments.** Ensure levels of funding are maintained for providers (LHD, EMS, hospitals, etc.)
- **Behavioral health.** Favorable feedback around integrated care

Waiver changes based on public comment

March 1 Draft version to June 1 Submission

PUBLIC COMMENT THEME	CHANGE TO DRAFT WAIVER
Medicaid expansion requests	• No change made to waiver.
Provider concerns related to working with multiple PHPs and requests for standardization / centralization	• While no significant changes were made to the waiver, DHHS indicated its intent to work with stakeholders to minimize the administrative burden on providers. This will include working with stakeholders to maximize standardization, centralize functions where feasible, and reduce unnecessary requirements.
Concerns over beneficiary access	• DHHS clarified that network and access standards would comply with new federal regulations with additional details determined as part of program design and PHP contracting.
Cost settlement for public ambulance providers	• Added public ambulance providers and state facilities as eligible for wrap-around cost settlements.
Request to cover community paramedic programs	• Added that DHHS supports the use of cost-effective alternative services by PHPs, such as community paramedic services.
Carved out populations	• Excluded people enrolled in NC Health Insurance Premium Payment (HIPP) program from enrollment in prepaid health plans (PHPs).
Preservation of current patient-centered medical home / enhanced primary care case management model	• Waiver clarifies that these models are the foundation of person-centered health communities. Existing functionality will continue with responsibilities shared by PHPs, providers, and/or DHHS.
Requests for clarification	• Added language regarding Person-centered Health Communities and included a conceptual illustration. • Removed language that S.L. 2015-245 requires integration of physical and behavioral health services within a single capitated system. • Clarified that waiver will change delivery but not coverage of the state plan and Community Alternative Program for Children (CAP/C) or Disabled Adults (CAP/DA) services for Medicaid-only beneficiaries eligible for long-term services and supports (LTSS). • Clarified that provider-led entities are managed care organizations as defined by CMS, and that all PHPs will be required to comply with federal Medicaid managed care requirements. • Clarified that DHHS intends to contract with three statewide plans, as required by SL 2015-245. • Reference to I/DD health homes was removed with clarification that DHHS intends to support I/DD providers to enhance their ability to provide primary care for individuals with I/DD and to increase the capacity of primary care providers to better meet the needs of individuals with I/DD.

Waiver changes based on public comment

March 1 Draft version to June 1 Submission

RATIONALE FOR CHANGE	CHANGE TO DRAFT WAIVER
EBCI requests through tribal consultation	• Clarified that PHPs may include a tribal/Indian managed care entity. • Added EBCI proposal regarding supplemental payments for uncompensated care and alternative services. • Added various assurances requested by EBCI.
CMS Public Notice Requirement	• Added summary of public notice process (e.g., website, public hearings). • Added summary of tribal consultation process. • Added summary of public comments and DHHS responses.
Additional Details Needed for Financing Section	• Added sample Delivery System Reform Incentive Payment (DSRIP) initiatives. • Added information regarding workforce initiatives. • Included projected expenditures for Medicaid Uncompensated Care Payments, DSRIP, workforce initiatives, and tribal supplemental payments for uncompensated care and alternative services.
Budget Neutrality Addition	• Added narrative and completed budget neutrality forms.
Reflection of Medicaid Managed Care Final Rule	• Added provider network standards. • Added requirements for enrollees who need long-term services and supports. • Added beneficiary support system. • Added value-based payments.
North Carolina Health Transformation Center	• Changed “Innovations Center” to North Carolina Health Transformation Center. • Reflected May 1, 2016, report to JLOC/HHS (copy of report will be attached to June 1 waiver application).
Structural Changes to Improve Readability and Flow	• Initiatives are no longer organized by Quadruple Aim elements; however, including an illustration of how each initiative aligns with each aim. • Changed order of some initiatives and items (e.g., foster care proposals included as their own initiative; moved provider administrative ease to first item of provider engagement and support initiative). • Strengthened waiver rationale and executive summary.
Eligibility Chart Required by CMS	• Added a chart of populations included or excluded from waiver and PHPs.

Other waiver changes

March 1 Draft version to June 1 Submission

- Modification to improve flow and readability, and reflect the CMS audience
- DHHS' internal review, discussion and clarifications
- Final Medicaid managed care rule inclusion, as feasible (published May 6, 2016)
- Addition of financing and budget neutrality section, and appendices

Supplemental payments

- NC providers currently receive approximately $2 billion annually in payments through a complex set of funding streams
- The transition to reform presents risks to these essential funds
- Waiver proposes supplemental payments be structured in four ways:
  - Uncompensated Care Pools
  - Delivery System Incentive Reform Payments (DSRIP)
  - Direct Payments to certain providers
  - Directed Payments through Base Rates
- Waiver does not reflect payment options provided in recently released final Medicaid managed care rule
- Funding for Disproportionate Share Hospital Payments and Graduate Medical Education will continue outside the waiver

Budget neutrality

- Waiver must cost the federal government no more than what would have been spent otherwise
- Budget neutrality is the basis for negotiations with CMS and is not a calculation that reflects state budget impact
- Preliminary estimates suggest reform will drive over $400M in savings over five years
- DHHS intends to reinvest a significant portion of the savings as incentives payments to improve health outcomes
- Final budget estimates, savings, and reinvestment amounts are subject to negotiations with CMS and OMB

Legislative changes to support program

Changes

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

Enable DHHS to contract with up to 12 Provider Led Entities (PLEs)

Allow members of the Eastern Band of Cherokee Indians (EBCI) to "Opt In" to the managed care program

Maintain eligibility for parents of children placed in foster care system

Changes continued

Include State Veterans Homes as an "essential provider"

Exclude from Prepaid Health Plans:

- Populations with short eligibility spans (e.g., medically needy and populations with emergency only coverage)
- PACE program
- Local Education Agency (LEA) services
- Child Development Service Agencies (CDSAs)
- Periods of retroactivity and presumptive eligibility

Near-term next steps

- Press conference 6/1/16 at 11:00 a.m.
- Submit 1115 demonstration waiver application 6/1/16
- Begin discussions and negotiations with CMS
- Continue stakeholder engagement

Appendix

CMS managed care rule

What is in the Managed Care Final Rule?

- Broad-based changes to the federal rules that will govern PHPs, including:
  - Beneficiary information and support, network adequacy, quality of care, appeals and grievances, LTSS, program integrity, encounter data, medical loss ratio, and capitation/provider payments.
  - July 5, 2016, effective date, with most provisions phased-in between now and 2019; PHPs in 2019 will need to comply.