LEGISLATIVE REPORT
TRANSFORMATION AND REORGANIZATION OF NORTH CAROLINA'S MEDICAID AND NC HEALTH CHOICE PROGRAMS

SESSION LAW 2015-245, SECTION 5(12)

FINAL REPORT

State of North Carolina

Department of Health and Human Services

Health & Human Services

March 1, 2016

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I. INTRODUCTION

In September 2015, thanks to the leadership of Governor Pat McCrory and the efforts of the General Assembly, North Carolina enacted legislation for historic reform of its Medicaid program.

Medicaid is a state and federal program providing medical coverage for low-income and disabled citizens. It covers more than 1.9 million citizens, or roughly one of every five North Carolinians. More than 55 percent of all births in the State are to mothers receiving Medicaid benefits. The program also provides a variety of additional supports including long term care and behavioral health services.

Session Law 2015-245 (also known as House Bill 372) seeks to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This legislation directs the North Carolina Department of Health and Human Services (DHHS) to design Medicaid and NC Health Choice to achieve the following goals:

- 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
- Ensure a sustainable delivery system through the establishment of two types of prepaid health plans (PHPs): provider led-entities (PLEs) and commercial plans (CPs).

This report and the Section 1115 demonstration draft waiver application builds on what works in North Carolina by bringing innovation and new tools into the health system to ensure the system puts people first, and rewards health plans and providers for making beneficiaries healthier while containing costs. It meets the goals of the legislation by creating a North Carolina solution for Medicaid beneficiaries. A draft of the waiver is attached to this report.

In preparation for implementing Medicaid Reform, DHHS has proactively sought input from, and listened to, key stakeholders from across the state – including physicians, beneficiaries, beneficiary advocates, provider associations, hospitals, and many more. In fact, DHHS met with more than 50 stakeholder groups multiple times and collected written feedback for consideration in the development of this report and the Section 1115 draft waiver application.

Session Law 2015-245 requires specific deliverables, as described in Section 5(12), which directs DHHS, through the Division of Health Benefits, to:

Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016. At a minimum, this report shall include:

a. The proposed waiver application.

b. The expected time frame for the submission of the proposed waiver to CMS.

c. Proposed statutory changes required.

d. Status of staffing of the Division of Health Benefits, including a description of staff's key competencies and expertise.

e. Anticipated distribution of regional capitated PHP contracts.

f. Plans for recipient enrollment.

g. Recipient access standards.

h. Performance measures.

i. A plan for the proposed inclusion of the following features as part of Medicaid and NC Health Choice transformation:

1. Rate floors in addition to those required by subdivision (5) of Section 5 of this act.

2. Antitrust policies.

3. Protections against the exclusion of certain provider types.

4. Prompt pay requirements.

5. Uniform credentialing requirements.

6. Good-faith negotiations.

j. Time line for issuance of RFP and solicitation of bids.

k. Measures for sustainability of the transformed system.

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.

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.

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.

The report reflects DHHS' consideration of, and in some cases, recommendations on how to address each of the above items. While there are a number of decisions yet to be made, DHHS is dedicated to working with diverse stakeholders to develop a balanced, North Carolina-specific approach. DHHS is prepared to meet the timelines and outcomes defined in the legislation and to assure the successful implementation of Medicaid reform.

We look forward to working with the legislature and all stakeholders as we improve health care for North Carolina citizens.

II. PROPOSED WAIVER APPLICATION

Section 5(12)(a) of SL 2015-245 requires the report to the JLOC to include the "*[p]roposed waiver application.*"

A. Overview of Waiver Application

Accompanying this report is a draft of the application that DHHS proposes to submit to CMS for a waiver pursuant to Section 1115 of the Social Security Act. The waiver application includes an overview of transformation goals and the hypotheses to be tested. Consistent with CMS instructions, the waiver application also identifies:

- Individuals eligible for the waiver
- Services included in the waiver
- The proposed payment and delivery system using PHPs
- Demonstration financing and budget neutrality
- An overview of plans for implementation
- An estimate of expenditures and enrollment
- A description of the waiver financing
- The legal authorities being requested to accomplish the goals of the waiver.

The next step DHHS must take with the draft waiver application will be to complete the public notice requirements, including posting the application for public comment, holding public hearings and conducting Native American tribal consultation. These steps are required by CMS rules, before the application may be submitted to CMS for review.

B. Summary of Proposed Waiver

The draft application conveys the DHHS vision for next-generation prepaid health plans supporting advanced, comprehensive medical homes called "person-centered health communities (PCHCs)" and adoption of value-based payment driving improved outcomes. The waiver also indicates future plans to explore models for persons dually eligible for Medicaid and Medicare ("dual eligibles"), and integrating local management entity/managed care organization (LME/MCO) services to achieve this vision. However, proposals for later stage models are not included in the draft application. CMS will expect details on these later stage models to be submitted through an amendment to the waiver once program design features are available.

Section 9 of SL 2015-245 directs DHHS to "work with CMS to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved." Furthermore, "if such Medicaid-specific funding cannot be maintained as currently implemented, then the Division of Health Benefits shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation."

DHHS is proposing to CMS a program called Care Transformation through Payment Alignment. This initiative is a blended approach to preserve funding levels, and relies on a combination of continued direct funding to providers[1] through uncompensated care payments and a delivery system reform incentive payment (DSRIP) program. DSRIP is a federal-state partnership initiative authorized as part of broader Section 1115 waivers that allows federal matching dollars for project-driven milestones in order to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.

The waiver also will contemplate the possibility of building portions of the current supplemental payments into the PHP capitation rate to target provider efforts aimed at improving health outcomes and achieving overall Medicaid goals while helping to preserve funding.

Transitioning payments by way of the Care Transformation through Payment Alignment initiative will not only require careful consideration of the impact on providers, but also whether the funding source can be transitioned to the new funding model. DHHS will work closely with the provider community and other financing sources to further develop this proposal, including specific recommendations of funding levels dedicated to each payment arrangement. In addition, DHHS fully expects this proposal to be a primary focus of the waiver negotiations with CMS. If the approach is altered significantly, CMS may require an additional public notice period; for instance, to develop the initiatives under the DSRIP. See the fourth demonstration initiative in the draft waiver application for more description of the DSRIP proposal.

C. State Plan and Other Waiver Amendments

Section 1115 waivers often require amendments to the state plan (SPAs) and existing Section 1915(b) or 1915(c) waivers to fully implement the program goals. However, it is not until further into waiver negotiations when both the state and CMS will determine the changes that will be needed when these amendments are submitted. Based on our current understanding, DHHS will likely need to submit the following amendments to existing authorities:

- Section 2703 SPA for Medicaid Health Homes – terminate this state plan authority upon implementation of PHPs.
- Section 1932(a) SPA – terminate the North Carolina Community Care Network (N3CN) SPA pursuant to SL 2015-245, Section 7.
- Community Alternatives Program for Children (CAP-C) and Community Alternatives Program for Disabled Adults (CAP-DA) Section 1915(c) home- and community-based services (HCBS) waivers – reflect the capitated PHP delivery system.
- Amendment to Title XXI CHIP state plan to reflect changes from enrollment in N3CN to PHPs.

[1] Disproportionate Share Hospital (DSH) payments, and hospital graduate medical education payments will remain outside of the waiver.

D. 1115 Waiver Budget Neutrality

North Carolina must show that the new initiatives under the 1115 waiver will not cost the federal government more than it would without the waiver. DHHS will negotiate a "budget neutrality" agreement with CMS. Some general features of this agreement will be:

- North Carolina will be at risk for the state match if it exceeds expenditure limits established in the waiver. This is new to North Carolina.
- Once agreement is reached with CMS on budget neutrality, it is much more challenging to reopen this agreement than it is in Section 1915(b) and 1915(c) waivers that DHHS has now.
- CMS has its own rules for developing estimates for budget neutrality. They are not the same as those used for the state budget estimates. The state budget estimates and waiver projections are likely to appear different.

DHHS must live within the estimates that it agrees to with CMS. Therefore, it is very important that North Carolina negotiate the most favorable agreement with CMS, and that future spending decisions are considered in light of the budget neutrality agreement.

For the March 1, 2016 draft waiver application for public comment, CMS only requires aggregate historical enrollment and expenditure information, and aggregate annual projected enrollment and expenditure information for the five-year projected waiver period. Once DHHS has received public input, including input on the Care Transformation through Payment Alignment proposal, DHHS will prepare a detailed budget neutrality submission that will accompany the June 1 waiver application to CMS.

III. EXPECTED TIMEFRAME FOR SUBMISSION OF THE PROPOSED WAIVER TO CMS

Section 5(12)(b) of SL 2015-245 requires the DHHS report to the JLOC on Medicaid and NC Health Choice to include "*[t]he expected time frame for the submission of the proposed waiver to CMS*."

DHHS intends to submit the 1115 waiver application to CMS to implement the transformation of Medicaid and NC Health Choice on June 1, 2016 after conducting the federally required public notice and comment period, and 60-day tribal consultation period.

The federal requirements for public notice and comment specify the timing and logistics of the notice and comment process, and require states to summarize and respond to the comments received during the public comment period. To comply with the federal public notice and comment requirements, and meet the statutory deadline of June 1 for submission of the waiver application, DHHS is releasing the draft waiver application for public comment concurrently with the submission of the draft application to the JLOC and will accept public comments starting no later than March 7 and through April 18. The tribal consultation period is expected to occur from March 2 through April 30.

IV. PROPOSED STATUTORY CHANGES

Section 5(12)(c) of SL 2015-245 requires the report to the JLOC to include *"[p]roposed statutory changes required."*

A. Recommendations Regarding Licensure of Prepaid Health Plans

Background

Section 6 of SL 2015-245 adds a new scope of responsibility to the North Carolina Department of Insurance (DOI):

> "*The transformed Medicaid and NC Health Choice system shall include the licensing of PHPs based on solvency requirements established and implemented by the Department of Insurance. The Commissioner of Insurance, in consultation with the Director of the Division of Health Benefits, shall develop 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 Division of Health Benefits. …"*

Recommendations

DHHS has reviewed multiple options for licensure of PHPs and consulted with DOI. Staff of the two agencies jointly recommend that:

- PHP solvency requirements be similar to the solvency requirements in the Health Maintenance Organization (HMO) Act (N.C.G.S. §58-67). This includes the existing formula for capital/solvency requirements, which recognizes the amount of risk the PHP assumes – for instance, the number of lives covered – and the degree the PHP retains or limits its risk – such as paying providers by salary or capitation, or by purchasing reinsurance. This allows PHP funding structures to be different, and provides equitable application of reasonable standards intended to protect the interests of those impacted by the actions of the PHPs: enrollees, providers and the taxpayers financing the program.
- PHP licensure and DOI regulatory oversight will focus on solvency and liquidity requirements; DHHS will regulate the non-financial aspects of the PHP (e.g., covered services, provider network, member services, quality improvement) through regulations and the PHP contract. DHHS will also conduct financial monitoring, with DOI as the primary regulator of PHP finances.
- Chapter 58 be amended to specify the licensure requirements for PHPs, the applicable financial requirements, and the regulatory authority of DOI and DHHS with respect to PHPs.
- PHP licensing process build on existing processes and be efficient for both DOI and organizations seeking PHP licensure.

B. Application of Chapter 58

Background

Section 4 of SL 2015-245 requires that Medicaid and NC Health Choice programs be organized according to certain principles. Section 4(6a) specifies that:

> *"To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act, PHPs shall comply with the requirements of Chapter 58 of the General Statutes. The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:*
>
> *a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.*
>
> *b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.*
>
> c. *Proposed statutory changes necessary to implement this subdivision*."

Recommendation

DHHS and DOI recommend that, except for the financial requirements specified for PHP licensure, PHPs be exempt from Chapter 58 of the General Statutes. DHHS will instead incorporate key protections from Chapter 58 in its PHP regulations and/or the PHP contract. DHHS and DOI make this recommendation in the interests of administrative efficiency, ensuring compliance with federal Medicaid requirements, and consistency with the recommendation above to have DOI regulate the financial attributes of PHPs and DHHS regulate the non-financial components of PHPs.

Rationale

A review of Chapter 58 identified a few dozen non-financial provisions setting forth member or provider protections. These provisions are primarily outlined in the following articles: Article 3, General Regulations for Insurance; Article 50, General Accident and Health Insurance Regulations; and Article 51, Nature of Policies. However, many of these provisions are related to coverage (e.g., coverage for hearing aids), which are not applicable to PHPs because Medicaid coverage is governed by North Carolina's Medicaid state plan and Section 1915(c) waivers for home- and community-based services (HCBS).

Some other provisions (e.g., treatment discussions not limited, prohibition on managed care provider incentives, provider directories, direct access to obstetrician-gynecologists, grievance procedures) are not applicable to the PHPs because they are controlled by federal Medicaid law and regulation. The federal government requires its Medicaid-specific provisions to be included

in contracts with managed care organizations (MCOs).[2] Since the PHPs will be required to comply with the federal terms, the corresponding provisions in Chapter 58 do not apply to PHPs.

Other provisions (e.g., notice of claim denied, selection of a specialist as a primary care provider, identification card) are not controlled by federal Medicaid law but are typically addressed in Medicaid managed care contracts, and DHHS intends to include similar provisions in the PHP contract. Additionally, DHHS proposes to include any remaining provisions in Chapter 58 that might be applicable to PHPs (e.g., health plan fee schedules, direct access to pediatricians for minors) in the PHP contract, as long as they are not inconsistent with federal Medicaid requirements.

C. Proposed Amendments to SL 2015-245

Amendments Related to Eligibility and Services

While developing the waiver, DHHS identified proposed amendments to SL 2015-245 related to eligibility and services, and a few areas for clarification. Section 4(5) of SL 2015-245 provides that all program aid categories, except beneficiaries who are dually eligible for Medicaid and Medicare ("dual eligibles" or "duals"), be enrolled in a PHP. DHHS interprets the statutory language regarding exclusion of dual eligibles from PHP enrollment to mean all dual eligibles, including beneficiaries with disabilities who also have Medicare and those who are "partial duals" – beneficiaries eligible only for assistance with their Medicare cost-sharing.

Based on careful consideration during program design discussions, DHHS recommends that the statute be amended to exclude from PHP enrollment these additional Medicaid beneficiary categories:

- **Medically needy beneficiaries**
- **Beneficiaries who are eligible only for emergency services**
- **Members of federally recognized tribes**, including the Eastern Band of Cherokee Indians, who could opt to enroll voluntarily in PHPs.

Nationwide, medically needy individuals are generally excluded from capitated contracts (for example, in Florida and Virginia). These beneficiaries are enrolled in Medicaid for only short periods, which limits the plan's ability to effectively manage the beneficiaries' care. In state fiscal year 2015, there were 20,000 beneficiaries who were classified as medically needy, but most of these beneficiaries (approximately 85 percent) were eligible only for three to four months of coverage. The remaining beneficiaries had an average duration of 5.6 to six months.

Similarly, DHHS proposes to exclude a small number of beneficiaries who are eligible only for emergency services. These beneficiaries also are enrolled in Medicaid for short periods, and PHPs will not be able to directly manage their activity or costs.

[2] CMS uses the term "managed care organization (MCO)" in reference to entities that the North Carolina General Assembly has elected to call prepaid health plans, or PHPs.

Based on initial conversations with the Eastern Band of Cherokee Indians (EBCI), DHHS recommends that members of the federally-recognized tribes be permitted to enroll in PHPs on an opt-in basis, but not be required to enroll in a PHP. EBCI members who voluntarily enroll may disenroll without cause at any time.

The EBCI has also expressed an interest in developing a sub-regional specialty PLE for the Cherokee community in North Carolina. DHHS will work with the EBCI to explore this option during and after the tribal consultation period.

While DHHS does not believe that an amendment to the statute is required, it proposes to exclude the following from PHP enrollment:

- **Individuals who are presumptively eligible for Medicaid.** These individuals are only presumptively eligible for a short time and must apply to continue Medicaid eligibility beyond the presumptive eligibility period.
- **Months when a beneficiary is retroactively eligible for Medicaid.** Since costs during retroactive eligibility occur before enrollment with a PHP, the PHP will have no opportunity to manage those costs; therefore, periods of retroactive eligibility are typically excluded from capitated managed care.
- **Refugees.** While refugees receive the Medicaid package of services, they are 100% federally funded, and are eligible for only up to eight months of coverage.

Section 4(4) of SL 2015-245 provides that PHPs shall cover all Medicaid and NC Health Choice services excluding LME/MCO services (applicable to Medicaid but not NC Health Choice beneficiaries) and dental services. However, DHHS recommends that the statute be amended to exclude Program for All-Inclusive Care for the Elderly (PACE). There are approximately 1,200 beneficiaries in PACE, and approximately 3% of PACE beneficiaries are not dual eligibles. In addition, PACE beneficiaries are in a separately capitated program.

DHHS recommends the exclusion of, services provided by local education agencies (LEAs),[3] and services provided by Children's Developmental Services Agencies (CDSAs).[4] These services are provided in accordance with the Individuals with Disabilities Education Act (IDEA), and the state share of these services comes primarily from certified public expenditures (CPE), making the transition to capitated PHPs difficult and potentially disruptive to the delivery of these services.

[3] Local Education Agencies (LEAs) enrolled with Medicaid provide treatment and assessment services to Medicaid-eligible children through a child's Individualized Education Program (IEP) pursuant to Part B of the Individuals with Disabilities Education Act (IDEA). Services include audiology, speech/language therapy, occupational therapy, physical therapy, nursing services and psychological/counseling services.

[4] There are 16 regional Children's Developmental Services Agencies (CDSAs) located across the state that are available to help families, caregivers and professionals serve children with special needs through the Infant Toddler Program. The program offers early intervention services for children from birth through 36 months of age with a developmental delay or disorder. Services include evaluation, treatment, service coordination and consultation services. Administered by the NC Division of Public Health, this program delivers services as outlined in federal law under Part C of the IDEA.

In addition, based on initial conversations with the Eastern Band of Cherokee Indians (EBCI), DHHS proposes to permit Indian health care providers (IHCPs) to choose whether or not to participate in a PHP's provider network and to allow IHCPs to continue to be reimbursed on a fee-for-service (FFS) basis for services they provide as a non-participating provider.

Other Amendments to SL 2015-245

Section 4(6)(b) of SL 2015-245 provides that DHHS can have up to 10 regional contracts with provider-led entities (PLEs). Thus, if DHHS contracts with one PLE in each of the six regions, there will be only four contracts remaining. Some regions may have enough population to support more than four contracts. DHHS would therefore like the flexibility to contract with additional qualified PLEs where appropriate. Specifically, DHHS requests an amendment to allow up to 12 regional contracts with PLEs.

The legislative intent is clear that DHHS is the single state agency and DMA continues to manage the Medicaid program until DHB assumes operations. In several places, however, the legislation requires DHHS to act through DHB prior to the change taking place. For example, Part 1 section 3[3] indicates that DHHS, through DHB, shall submit the waiver application. Since DHHS is the single state agency and DMA is listed in the state plan as the operational agency for Medicaid under DHHS; submitting the waiver through DHB would conflict with the state plan. DHHS recommends making changes to SL 2015-245 to clarify that until DHB is in place – through a SPA – DHHS is the entity named to take action. These clarifications will not change legislative intent relating to the transition to the new DHB.

SL 2015-245 Section 14(a) requires a six-month cooling off period for certain DHHS employees. Some of these individuals will not become DHB employees, but have skill sets that will be in great demand by PHPs. This could have the unintended consequence of key staff leaving DMA early to avoid the cooling off period. DHHS legal counsel is preparing proposed language that will meet legislative intent and the needs of the Medicaid program.

D. Changes to Other Statutes

With respect to existing statutes relevant to Medicaid, DHHS has identified at least 21 provisions in Chapters 108A and 108C that will need clarifying language to reflect the system changes made by SL 2015-245. They are: NCGS §§ 108A-55, 108A-57, 108A-59, 108A-64.1, 108A-65, 108A-68, 108A-70, 108A-70.5, 108A-70.9A, 108A-70.9B, 108A-70.9C, 108A-70.11, 108A-70.12, 108A-70.18, 108A-70.21, 108A-70.27, 108A-70.29, 108C-2, 108C-3, 108C-4 and 108C-14.

As an example, GS 108A-55 speaks to provider reimbursement and states that the "Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes." While this would be true for rates for services in the remaining fee-for-service programs, the reimbursement framework will change under the PHP structure.

Other potential changes may include clarity to GS 108A-57, which sets out the state's subrogation rights. While DHHS will remain the single state agency, and collection of third-

party resources may, in theory, be dealt with in contract, it will be beneficial to revise certain language within the statute to facilitate collection of third-party resources by PHPs. As currently written, GS 108A-57 sets out notification requirements and payment requirements solely related to DHHS, with no reference to DHHS vendors, contractors or agents. A revision clarifying the rights of PHPs to pursue third-party resources in the transformed system will be helpful to ensure maximum recovery of third-party funds. In addition, statutory changes may be required to implement the recommendation in Section XV of this report to allow parents to retain their Medicaid eligibility while their children are being served temporarily by the foster care program.

V. STATUS OF DHB STAFFING

Section 5(12)(d) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include *"[s]tatus of staffing of the Division of Health Benefits, including a description of staff's key competencies and expertise*."

A. Overview and Creation of the Division of Health Benefits

DHHS is taking a tactical approach to planning for and hiring the Medicaid transformation project team. This team will work with internal and external stakeholders, along with appropriate and necessary third-party assistance, to plan, design and implement Medicaid reform in North Carolina. Through the Medicaid Leadership Institute sponsored by the National Governors Association and the nonprofit Center for Health Care Strategies, DHHS has access to change management and leadership development support until September 2016.

Part II of SL 2015-245 reorganizes the Medicaid and NC Health Choice programs in the following manner (at a high level):

- Division of Medical Assistance will manage the state Medicaid and NC Health Choice programs until 12 months after the capitated PHP contracts begin (or earlier, as determined by the DHHS Secretary).
- Division of Health Benefits is created within DHHS to plan the transformation and ultimately manage the state's Medicaid and NC Health Choice programs.

B. Staffing Plans

DHB has begun hiring key staff and contractors to support organizational start-up, 1115 waiver development and transformation planning. As of March 1, DHB has five full-time employees and one full-time contractor. Additional hires are expected over the coming months (see organizational structure in section V.C). Key skill sets for members of the initial team include:

- Finance
- Analytics/actuarial
- Technical
- Operations/organization leadership
- Project management
- Contract management
- Program knowledge (Medicaid, managed care and health care)
- Legal and regulatory
- Clinical and quality measurement

These skill sets are specific to each job and outlined in a job description, and will evolve for future roles needed to fulfill agency functions.

DHB intends to contract with a consultant later in 2016 to assist DHB in developing a long-term staffing and transition plan.

To ensure that DHB has the appropriate staff to manage the new capitated managed care programs and remaining FFS programs, DHB will focus on:

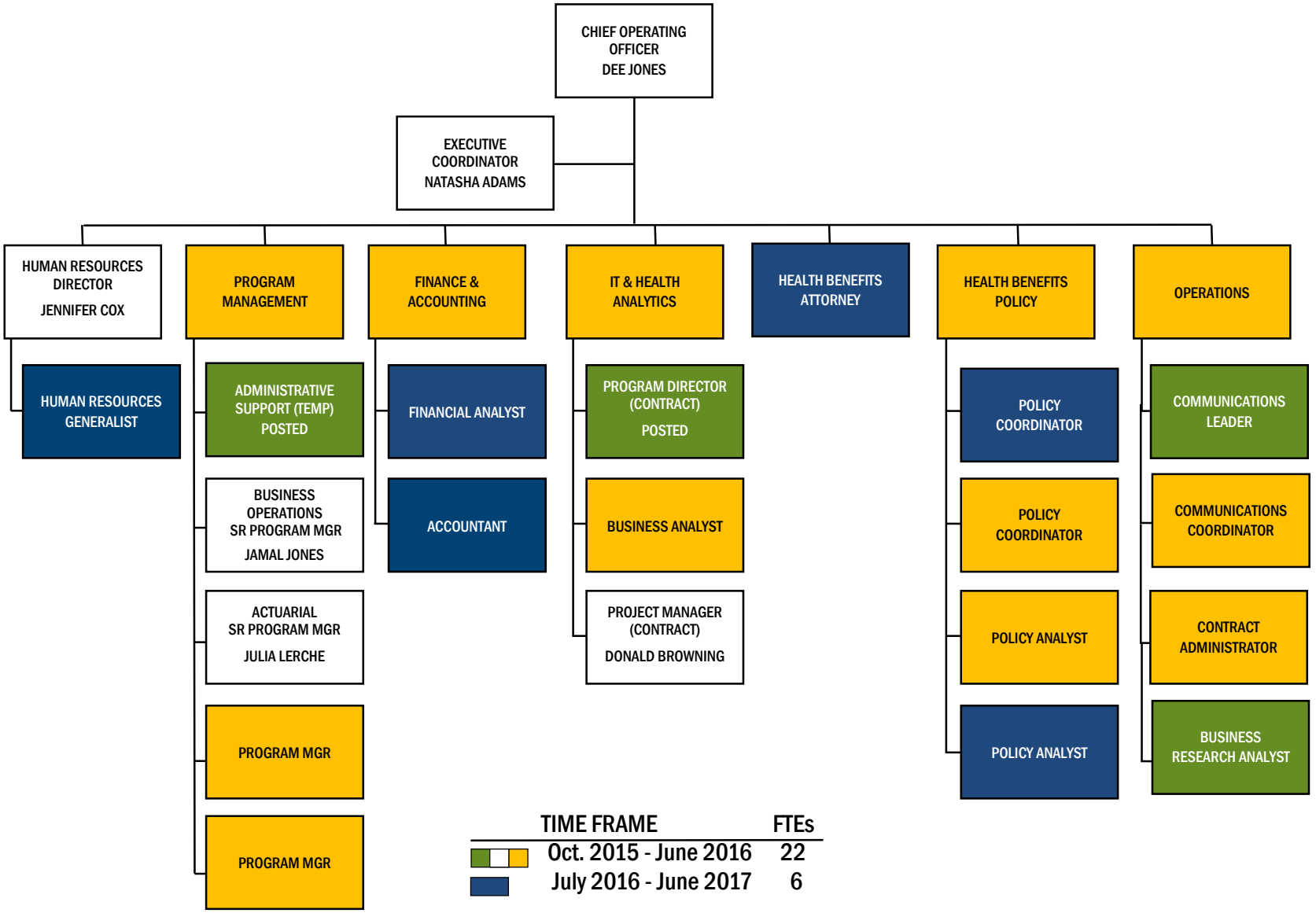
- Balancing requirements of state and federal partners (see below).
- Building key skillsets to support the planning, design and development of the Medicaid reform program.
- Developing policies and procedures.

C. Transformation Planning Project Organizational Structure

The transformation planning project team organization structure is a functional structure that enables development of expertise in each area. Based on discussions with another state that went through a similar transition, this was determined to be an effective structure.

The organization chart below depicts the anticipated structure and staffing level for the first one to two years. Positions requiring full-time workloads will be filled with full-time individuals, employed by DHHS and located within DHB. One-time or seasonal tasks will be performed by contractors or consultants.

Transformation Planning Project Organizational Structure



D. Approach to Benefits and Compensation

Per Section 13.G of SL 2015-245, employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in NCGS 126-5(c1)(31). The exemption from the Human Resources Act enables DHB to retain current, highly skilled talent, and attract new skill sets to the state.

Given this exemption, DHB has prepared an employment agreement for current hires until employment policies are developed. Following is a general comparison of the provisions of the DHB short-term employment agreement with the state Human Resources Act.

Similarities with NCGS Section 126	Differences with NCGS Section 126
• Frequency of salary payments • Paid time off • Retirement plan • Benefits	• At-will employment • Recruitment • Performance-based pay • No longevity pay

After the initial DHB start-up phase, there will be a review and further discussion of benefit plan opportunities and options. At this time, participation in the State Retirement system (6 percent contribution) is required by NCGS Chapter 135.

CMS Expectations

As indicated earlier, in developing employment policies for DHB employees, DHHS must find a balance between state and federal expectations. CMS has specific tenets related to defining merit-based employment that must be met to claim administrative match on employee salaries. With the exemption from the North Carolina Human Resources Act, and the requirement that DHB policies become effective for staff hired on or after October 1, 2015, DHHS must ensure that CMS understands and accepts its policies around merit-based employment requirements.

VI. ANTICIPATED DISTRIBUTION OF REGIONAL CAPITATED PHP CONTRACTS

Section 5(12)(e) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice include *"[a]nticipated distribution of regional capitated PHP contracts*."

A. Regions

Section 5(2) of SL 2015-245 requires DHHS to define regions in which provider-led entities (PLEs) may operate. DHHS shall "define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State…" and include all counties. Section 4(6)(b) provides that "[e]ach regional contract shall provide coverage throughout the entire region…."

DHHS used the following guiding principles to design the proposed regions:

- Minimize traffic between regions based on existing beneficiary utilization and provider referral patterns.
- Match (when possible) with existing provider networks and health care systems to ensure access to quality, coordinated health care within the region.
- Consider geographic limitations and boundaries to ensure physical access to providers.
- Promote beneficiary choice of PHP models by ensuring that each region can support at least one regional PLE in addition to the three statewide PHPs.
- Align (where possible) with various state-based regional maps (e.g., State Medical Facilities Plan, Public Health Department regions).

A map of the proposed regions may be found in the Appendix.

DHHS will ensure the defined regions assure beneficiaries of access to quality health care and that each region represents a competitive environment that encourages efficiency, quality and innovation. Beneficiary access to quality health care includes ensuring that beneficiaries have a choice of multiple PHPs and each region is composed of counties that contain a sufficient number of quality health care providers that can deliver the full array of covered services in a nearby setting and in a coordinated manner. It is important for PHPs to have adequate membership to be financially viable and for each region to be able to sustain PLEs participating in the region.

DHHS gathered analyses and input on potential regions from stakeholders with an emphasis on the intersection of beneficiary location and the location of providers used by the beneficiaries as a key consideration of region formation. This approach acknowledges there is some natural migration of beneficiaries to distant places for care, but looks to cluster counties in such a way that migration outside of the region is minimized. Such an approach contributes to efficient, consumer- and provider-friendly construction of regional provider networks.

One county, Alamance County, shows alignment with two regions, because the county is served by several major health systems. DHHS proposes that beneficiaries in Alamance County have the option of selecting PHPs in either Region II or Region IV.

Although there are considerations related to differing costs within or across regions, DHHS can address these considerations through the rate structure and rate setting methodology. The rate structure will consider the historical cost and utilization for the counties within a region to develop an actuarially sound reimbursement approach. Thus, geographic per capita cost variation has not been a focus of the current regional analysis. Rather, the focus has been on traditional care consumption patterns to ensure beneficiaries have access to an appropriate choice of providers within the geographic area.

DHHS plans to post the proposed regional map to its website and will solicit public comment to ensure that the region designations best meet the needs of beneficiaries. The timing will coincide with the public comment period for the draft 1115 waiver application. DHHS will consider adjusting the proposed regions based on the feedback provided.

B. Distribution of PHP Contracts

Section 5(12)(e) of SL 2015-245 requires that the report to the JLOC include the "anticipated distribution of regional capitated PHP contracts." DHHS interprets this section as requesting the anticipated number of PHP contracts – both commercial plans (CPs) and PLEs – per region, understanding that the three CPs called for in the law will be statewide, not regional.

The number of PHPs in a region requires balance. Too few or too many PHPs will pose problems. For instance, if there are only two PHPs in a region and one fails or terminates its contract, then according to federal Medicaid law requiring beneficiary choice of plans, DHHS will no longer be able to require beneficiaries to enroll in a PHP.

Conversely, too many PHPs in a region may leave each plan with too few enrollees. That will require paying higher capitation rates to sustain the higher per capita fixed administrative costs, and cover the contingencies of high-risk variability in a small enrollee base. Having too many PHPs also may reduce the state's ability to effectively monitor the PHPs. Many states place a cap on the number of health plans that can participate in a region to ensure there is sufficient enrollment to support the number of plans awarded and to allow the state to perform effective oversight within available resources.

When issuing the PHP contract solicitation, DHHS plans to specify the maximum number of PHPs with which it intends to contract in each region. This limit will be determined based on the number of eligible Medicaid beneficiaries in the region and an estimate of enrollees needed to make each PHP financially viable. While the number of Medicaid enrollees needed to make a PHP financially viable depends on many factors – including the characteristics of the population, covered services and payment rates – DHHS proposes a minimum of approximately 50,000 eligible beneficiaries per regional PLE, and 33,000 to 40,000 beneficiaries per region for each statewide CP. Therefore, DHHS estimates a minimum base of 150,000 to 170,000 eligible beneficiaries per region to support four PHPs in a region (three statewide CPs and one regional PLE).

While it is possible that, based on region development, a couple of the regions will lack sufficient enrollment to support more than one regional PLE (in addition to three statewide CPs),

others may support two or more PLEs. However, Section 4(6)(b) of SL 2015-245 specifies a maximum of 10 contracts with PLEs. As indicated in Section IV, DHHS is requesting the flexibility to have up to 12 regional PLE contracts.

VII. PLANS FOR BENEFICIARY ENROLLMENT INTO PHPs

Section 5(12)(f) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include *"[p]lans for recipient enrollment*."

DHHS plans to use an enrollment broker and an auto-assignment process to support beneficiary selection and enrollment in PHPs. This is separate from the Medicaid eligibility determination and Medicaid enrollment process, which will continue to be a function of the county DSS.

A. Enrollment Broker

As most states do to support the successful transition to capitated health plans, DHHS will contract with a neutral, experienced enrollment broker to provide education, outreach and enrollment activities to help beneficiaries first select a primary care provider/practice – if they do not already have one – and then choose and enroll in a PHP with consideration for current provider relationships. The enrollment broker will be selected through a competitive procurement, and will be required to meet the independence and conflict of interest requirements in federal regulations (42 CFR 438.10).

The enrollment broker will conduct choice counseling, including helping beneficiaries select a primary care provider/practice if they do not have an existing one, answering questions and providing information – in an unbiased manner – on available PHPs, and advising on the factors to consider when choosing among the PHPs. The enrollment broker also will distribute and process enrollment materials, and enroll beneficiaries in a PHP.

The EBCI has expressed an interest in being able to assist tribal members who elect to voluntarily enroll in a PHP with their evaluation of PHPs. DHHS will explore this concept further with the EBCI during the tribal consultation period.

DHHS recognizes the importance of ensuring that beneficiaries, particularly beneficiaries in need of long-term services and supports (LTSS) through the PHPs, receive conflict-free education, enrollment/disenrollment assistance, and advocacy. DHHS plans to leverage its enrollment broker and engage with stakeholders to ensure that this support is highly visible, accessible, uniform, meaningful and beneficiary-friendly.

Proposed federal regulations would require DHHS to provide a beneficiary support system that includes assistance to beneficiaries in understanding managed care, choice counseling, training for network providers on community-based resources and supports that can be linked with covered benefits, and functions specific to LTSS. DHHS will further define its plans for enrollment support when the proposed federal rules are made final.

B. Auto Assignment Process

Section 5(8) of SL 2015-245 requires DHHS to:

> *"[d]evelop and implement a process for recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician*."

While DHHS, through the enrollment broker, will emphasize and support beneficiary selection of a PHP, there will be beneficiaries who do not select a PHP within the specified period for selection. Consistent with federal requirements, beneficiaries who are required to enroll but do not choose a PHP will be assigned to one. Current federal regulations on assignment apply only to managed care programs authorized under a 1932(a) state plan.

In June 2015, CMS issued a proposed Medicaid rule (which may be made final as early as May 2016) that includes requirements for assignment to a health plan (enrollment by default) that apply to all mandatory managed care programs. The proposed rule provides that to be qualified for default assignment, the health plan must not be subject to suspended enrollment and must have capacity to enroll beneficiaries. As in the current federal rule, the process must seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries. If this is not possible, the state must distribute the beneficiaries equitably among the plans available to enroll them. Consistent with the practice of many states, the rule also provides that the state "may consider additional criteria to conduct the default enrollment process, including the enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, and other reasonable criteria related to a beneficiary's experience with the Medicaid program."

DHHS proposes that the process for beneficiary assignment to PHPs first consider beneficiary factors, with a focus on preserving existing primary care provider relationships. These factors will include whether the beneficiary's current or historical primary care provider is participating with a PHP, whether another of the beneficiary's providers (including LTSS providers) is participating with a PHP, whether a family member is enrolled with a PHP, and, after implementation, previous history of enrollment with a PHP. After consideration of beneficiary factors, DHHS will consider other program goals, such as balancing PHP enrollment. In particular, at least during the first year, DHHS intends to assign beneficiaries to help PHPs each achieve a minimum enrollment as needed to ensure financial viability.

As described in Section XV of this report, DHHS also is proposing to designate one of the statewide PHPs to provide specialized services to children and youth in the foster care program. This will be considered in the auto-assignment process.

DHHS proposes to review the assignment process after the first year to determine whether the assignment process should consider PHP quality; for example, to reflect the results of selected performance measures. DHHS proposes that PHP quality performance be considered secondarily, after beneficiary factors. Thus, if beneficiary factors result in two or more PHPs being rated similarly, the beneficiary will be assigned based on PHP performance. The highest-rated PHP will receive more auto-assignments than the next rated plan, and so on. By rewarding higher-rated PHPs with more enrollees, DHHS expects quality overall to rise.

It is important to note that, pursuant to federal Medicaid regulations, whether beneficiaries choose a PHP or are assigned to a PHP, they may change PHPs for any reason within 90 days after the date of enrollment.

VIII. BENEFICIARY ACCESS STANDARDS

Section 5(12)(g) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include *"[r]ecipient access standards*."

The CMS proposed Medicaid managed care rule issued in June 2015 included prescriptive access standards for Medicaid managed care plans. DHHS expects these provisions to appear in the final rule. The proposed standards below reflect this expectation.

DHHS will ensure that all PHP covered services are available and accessible to PHP enrollees in a timely manner. DHHS will do this by specifying, monitoring, and enforcing access and availability standards for PHPs. DHHS anticipates that standards will include, at a minimum, time and distance standards for specified provider types (e.g., primary care, specialty care, hospitals, pharmacies and LTSS).

Additional standards may include appointment availability and office waiting time. For example, the current LME/MCO contract specifies a travel/distance time of 30 miles or 30 minutes, or 45 miles or 45 minutes in rural areas; appointment availability times for emergency, urgent and routine care; and office wait times for scheduled visits, walk-ins and emergencies. DHHS will consider adopting similar requirements for PHPs.

Development of access and availability standards is a key design component of the PHP program, and the ability of a PHP to meet those access standards will be a critical milestone in the state's determination that a PHP is ready to enroll beneficiaries. Post-implementation, DHHS will monitor and evaluate access and availability, and will revise the standards as necessary to ensure that beneficiaries have timely access to covered services.

The access and availability standards may vary for rural versus metropolitan/urban areas, and will reflect findings from the development of the access monitoring review plan (AMRP) required by the federal Medicaid FFS access rule, which became effective January 4, 2016. When developing North Carolina's standards, DHHS will also consider model network requirements, including CMS requirements for Medicare Advantage and qualified health plans (QHPs), requirements from other states, and recommendations from Medicaid advisory groups.

Given the rural nature of certain areas of the state, North Carolina has already implemented telemedicine and telepsychiatry solutions to address unmet needs. DHHS is interested in exploring the continued role of telemedicine and telepsychiatry in closing access gaps and ensuring availability in geographic regions where results of the AMRP determine certain provider types or specialty capacity are not as robust as they could be.

When establishing the beneficiary access standards, DHHS will take into consideration potential competition between PLEs and commercial plans to ensure all players are properly incented to build viable networks aligned with the state's transformational goals. Some of these related issues around rate floors, antitrust and good faith negotiations are discussed in Section X. DHHS also will designate certain providers as "essential providers" for PHP networks. Additional information on essential providers is provided in Section X.B.

IX. PERFORMANCE MEASURES

Section 5(12)(h) of SL 2015-245 requires the report to the JLOC to include *"[p]erformance measures*."

A. Overview

As discussed in Section I of this report, DHHS intends to move beyond the triple aim – better experience of care, better health in our communities and per capita cost containment – by adding a fourth aim: improved provider engagement and support. This fourth aim recognizes the provider community as a crucial partner in driving the success of our state's Medicaid transformation efforts and aligns with the medical home philosophy that it the foundation of the care delivery system. DHHS will identify performance measures to assess whether the quadruple aim is being met at all levels – including the overall system, PHPs and providers – and to hold PHPs and providers accountable for their performance.

B. Guiding Principles for Measure Selection

Guiding principles that will govern performance measure selection include:

- **Importance**: Measures will be specifically relevant to the Medicaid and NC Health Choice population, with regard to prevalence of the condition being addressed; impact on health outcomes, costs or beneficiary experience; and opportunity for improvement.
- **Soundness**: Measures will have clear technical specifications to ensure validity and reliability of results, and will be evidence-based, consensus-built measures, such as those defined by the National Committee on Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and the NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Measures will ensure applicability to specialized populations and that optimal performance on the measure can be expected to improve the outcome.
- **Alignment**: Measures will support federal Medicaid reporting guidance for Adult and Pediatric Measurement sets and performance measures established by Medicare and other payers. For example, DHHS will consider the core set of quality measures recently released by CMS and America's Health Insurance Plans (AHIP), which were developed to achieve standardization across programs, thus minimizing the administrative burden on providers. When possible, DHHS will align measures with LME/MCO performance metrics.
- **Usability**: Ability to link measures to improved health outcomes, including looking at the result of a test, not just whether a test was performed, and information will facilitate the quality improvement process.
- **Feasibility**: Consideration of the ease, accuracy, cost and complexity of collecting and reporting performance data; striking the right balance between administrative (claims-based data) and medical record information (including data collected from electronic health records).

- **Reliability**: Standardized clinical and financial measures and reporting requirements routinely tracked and validated against other sources as available and appropriate. Measures will track PHP financial health and performance, and identification of quality/utilization/cost outliers for the PHPs.

C. Process for Selecting Performance Measures

The process of selecting measures for assessing the system, PHPs and providers will include:

- Application of the guiding principles
- Identification of performance standards and benchmarks
- A transparent process
- Being relevant to Medicaid and NC Health Choice programs
- Active stakeholder engagement (e.g., providers, members, advocates).

DHHS has done extensive work identifying clinical performance measures – for the enhanced PCCM program, previously proposed Medicaid accountable care organizations, LME/MCOs and integrated care measures and intends to leverage that work to identify the clinical measures for the transformed program. DHHS also will identify clinical measures for services included in the PHPs for which it has not previously identified measures (e.g., pharmacy and LTSS). Clinical measures will be used to assess the system, PHPs and providers. DHHS also will identify non-clinical measures for assessing system performance (e.g., member and provider satisfaction, claims payment and network adequacy). Performance measures are expected to evolve as the program matures and new initiatives are identified.

D. How Performance Measures Will Be Used

DHHS will use performance measures to better understand and improve the performance of PHPs, providers, and the system as a whole. These measures also will hold PHPs and providers accountable for their performance. At the system level, performance measures will be used for monitoring and evaluation: quality assessment and performance improvements. Performance measurement also will be used for monitoring and evaluation of PHPs, including comparisons among PHPs. In addition, some performance measures will be tied to rewards for exceeding benchmarks and contract sanctions for PHPs that fail to meet minimum thresholds. Rewards for PHPs may include additional payments and receiving a higher share of beneficiaries who do not choose PHPs (through the auto-assignment process).

For providers, performance measures will be used for monitoring and evaluation, and to support value-based payments. To ease the administrative burden on providers, DHHS proposes that providers be held accountable for meeting a common, simple set of measures.

E. Data and Reporting

A hallmark of a strong performance measurement system is the consistency with which the results can be calculated and the robustness of the data used to calculate the measures. N3CN's Informatics Center plays a significant role in performance measurement today, and DHHS will

ensure that this functionality is continued and expanded into a statewide system that applies to all of Medicaid. This will include leveraging the statewide health information exchange (HIE), a secure, standardized electronic system in which providers can share important beneficiary health information, and developing a robust data analytics capability.

X. A PLAN FOR THE PROPOSED INCLUSION OF CERTAIN FEATURES

Section 5(12)(i) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include:

> *A plan for the proposed inclusion of the following features as part of Medicaid and NC Health Choice transformation:*
>
> 1. *Rate floors in addition to those required by subdivision (5) of Section 5 of this act.*
> 2. *Antitrust policies.*
> 3. *Protections against the exclusion of certain provider types.*
> 4. *Prompt pay requirements.*
> 5. *Uniform credentialing requirements.*
> 6. *Good-faith negotiations.*

A. Rate Floors

Section 5(5)(b) of SL 2015-245 requires DHHS to establish "*appropriate rate floors" for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees*.

Capitated health plans typically pay network providers based on mutually negotiated payment terms. Negotiations are governed by market dynamics and influenced by the state's programmatic policies, such as the designation of essential providers, network adequacy standards and other policies that may encourage value-based purchasing arrangements. Even within a single type of provider, such as primary care physicians, a plan may choose to contract at different payment levels or use different compensation methodologies among its network providers. An established rate floor will require a PHP to pay no less than the amount that the rate floor will have produced.

Rate floors, by their nature, have the potential to constrain PHPs from negotiating the most cost-effective provider payment while still ensuring the Medicaid beneficiaries have acceptable levels of access to high quality care, as measured through contractual access and quality standards. While rate floors do not necessarily require PHPs to use a payment method that mirrors the floor structure, compliance with the rate floors may discourage the use of innovative, value-based payment methodologies. Thus, DHHS intends to limit the use of rate floors to those circumstances where they are critical to achieve transformation goals, and establish levels no higher than required to ensure that smaller providers with less negotiating leverage can be reasonably competitive.

DHHS does not anticipate establishing rate floors for providers other than those itemized in SL 2015-245. This decision may require revisiting, depending on the outcome of negotiations with CMS regarding retention of funding historically provided through supplemental payments. Programmatic changes arising from the recommendations of the Dual Eligibles Advisory Committee may also produce the need to include rate floors for other provider types in the future (e.g., nursing facilities).

DHHS expects to establish primary care and specialist physician rate floors that are expressed as a percentage of the effective Medicaid fee schedule. Use of the Medicaid fee schedule as the benchmark has the advantage of being logical, within control of DHHS and reasonably straightforward to operationalize. DHHS expects to continue to publish fee schedules for all provider types even after capitated payment is implemented, as some claims will continue to be paid FFS for populations excluded from enrollment with a PHP or newly eligible prior to enrolling in a PHP.

In determining the appropriate percentage of the Medicaid fee schedule to use for rate floors, DHHS expects to consider historical patterns of care, proposed network adequacy standards and the capitation rate setting approach. DHHS also will consult with stakeholders to identify the percentage that balances cost effectiveness goals with quality, access and provider inclusiveness.

DHHS is continuing to study options with respect to the requirement to establish a rate floor for pharmacy dispensing fees. Dispensing fees are the component of a prescription drug cost designed to cover the professional expense of filling a prescription. In a capitated environment, plans typically contract with pharmacy benefit managers (PBMs) to manage their outpatient pharmacy benefits, which includes negotiating pharmacy ingredient costs and dispensing fees. A requirement in the PHP contract establishing a dispensing fee rate floor will insert a new element into that negotiation. The requirement is further complicated by the way dispensing fees relate to the methodology for generating the ingredient cost component of the prescription.

DHHS recently received approval from CMS for a state plan amendment to implement an Actual Acquisition Cost Reimbursement using CMS-determined National Average Drug Acquisition Cost plus a dispensing fee based on a Cost-of-Dispensing Study. This new cost-based payment structure is estimated to save the state approximately $29 million in state fiscal year 2017. Evaluation is necessary to determine whether, if the rate floor is established at or near current Medicaid FFS levels and applies to all prescriptions, PHPs will pay higher prescription drug prices than the market demands.

DHHS is reviewing options that establish rate floors that ensure Medicaid beneficiaries have access to prescription drugs, which is vital to the success of the program. DHHS will work with key stakeholders to explore options and develop rate floor criteria.

B. Essential Providers

Designating certain providers as “essential” and requiring PHPs to contract with them is a policy mechanism to preserve the role of, and beneficiary access to, providers that have traditionally been crucial to low-income, underserved populations. When network adequacy standards are carefully crafted, the essential provider designation is not required to ensure that a particular service is available, but rather that a particular *type of provider* is available even when other network providers might be able to render the service. Often, these are providers that have more difficulty competing on price, and serve disproportionate numbers of uninsured North Carolinians and Medicaid beneficiaries. An essential provider designation helps these providers maintain sufficient volume of insured beneficiaries to sustain service availability.

Section 5(13) of SL 2015-245 specifies that at a minimum, federally qualified health centers (FQHCs), rural health centers (RHCs), free clinics and local health departments be designated as essential, and prohibits designation of physicians as essential. DHHS is provided authority to designate additional types of essential providers as long as they meet certain criteria. In addition to the statutorily designated essential providers, DHHS proposes to designate state veterans' homes as essential providers.

DHHS also will consider adopting an essential provider policy that requires PHPs to make at least a good faith effort (see below) to contract with all essential providers in their regions; however, an essential provider will not be required to participate with all – or even any – PHPs in its region. DHHS also expects to prohibit a PHP from having an exclusivity clause in a contract with an essential provider.

C. Protections Against the Exclusion of Certain Provider Types

Federal regulations (42 CFR 438.214(c)) prohibit discrimination against particular providers that serve high-risk populations or that specialize in conditions that require costly treatment. This language must be included in the DHHS PHP contracts.

Section 5(6)(d) of SL 2015-245 incorporates a policy limiting exclusion of providers "except for failure to meet objective quality standards or refusal to accept network rates." DHHS will work with PHPs and the provider community to identify the quality standards that may be used as a network exclusion, and will include appropriate language in the PHP contracts to carry out this requirement. To the greatest extent possible, the metrics and standards will be aligned with the program's performance measures.

D. Good Faith Negotiations

When state policies are an advantage to certain providers or provider types, such as with designated essential providers, it is appropriate to consider whether other policies are required to provide equitable opportunities or to prevent unintended consequences that work counter to programmatic goals. For example, if PHPs are required to contract with all essential providers in their regions, but essential providers are not required to do so, an essential provider declining to contract may cause a PHP to be non-compliant with its DHHS contract or unable to bring its program up in a region.

DHHS has determined that it is not appropriate to require essential providers to contract with all PHPs, although many may do so to maintain their beneficiary levels. DHHS is continuing to evaluate options and will work with the provider community and potential PHPs to develop specific policies that balance the need to support safety net providers through this transition with the need to avoid skewing negotiation leverage in a manner harmful to the program. Options under consideration include 1) establishing the concept of "good faith negotiations" by PHPs, paired with demonstrations of alternate solutions to beneficiary access in cases where essential providers decline to participate, and 2) establishing rate ceilings that will apply when non-participating essential providers provide services to PHP enrollees after declining a good faith offer.

Some elements of one or both of these options may be incorporated to establish the appropriate incentives while allowing providers the freedom to participate with fewer than all plans. For example, consistent with an approach used successfully in other states to balance interests, if a PHP demonstrates a good faith effort to contract with an essential provider, but the provider declines to participate in the PHP's network and is necessary for network adequacy, payment for out-of-network services furnished to that PHP's enrollees may be capped at Medicaid fee levels, or some discount to Medicaid fee levels. However, this approach is likely to be less effective with provider types that DHHS proposes to cost-settle outside the prepaid plan arrangement.

E. Antitrust Policies

The new capitated program is most likely to succeed when beneficiaries have a selection of PHPs from which to choose, and providers also have a choice of PHPs with which to contract. DHHS is considering whether policies are required to ensure that PLEs and commercial plans (CPs) do not exert undue influence over the others' ability to compete and succeed in the program. Specifically, there may be circumstances or locations where providers affiliated with a PLE may be able to undermine a CP's ability to compete successfully by charging significantly higher than market rates or declining to participate in the CP's network, leading the CP to fail to meet network adequacy requirements. Alternatively, CPs may attempt to undermine a PLE's network formation by using a combination of high rates and exclusivity contracts to keep key providers from contracting with a PLE.

DHHS is evaluating the use of policies that mitigate these undesirable actions, such as prohibiting exclusivity clauses, requiring providers affiliated with PLEs to charge CPs no more than the PLE pays for the same service, and evaluating PHP network adequacy compliance at a sub-statewide level. The latter option will allow a CP with a statewide contract, but regional network deficiencies, to operate in the areas where it may demonstrate an adequate network.

None of these policy options is sufficient to prevent a regional monopoly if a PLE controls scarce provider specialties that produce network adequacy deficits for competing PHPs.

DHHS will continue to work with stakeholders to define antitrust policies that support the objectives of reform. Additionally, in recognition that PHP network standards and contracting is pivotal to the program's success, DHHS will dedicate staff to monitor and enforce program requirements in these areas.

F. Prompt Pay Requirements

Background

Pursuant to federal regulations (42 CFR 447.45 and 447.46), PHPs must:

- Pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt.
- Pay 99 percent of all clean claims from practitioners within 90 days of the date of receipt.
- Pay all other claims within 12 months of the date of receipt, except in certain circumstances (e.g., provider under investigation for fraud or abuse, court order).

Pursuant to North Carolina's current insurance statute, 58-3-225, prompt claim payments under health benefit plans:

(b) An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) Payment of the claim.

(2) Notice of denial of the claim.

(3) Notice that the proof of loss is inadequate or incomplete.

(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.

(5) Notice that coordination of benefits information is needed in order to pay the claim.

(6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. …

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. …

Recommendation

Since the federal Medicaid timeframes and Chapter 58 timeframes are not the same, DHHS proposes to require PHPs, through regulation or PHP contract, to process 100 percent of clean claims (pay, deny or provide notice consistent with 58-3-225) within 30 calendar days of the day of receipt. Consistent with 58-3-225, claim payments that are not made according to this requirement shall bear interest at the annual percentage rate of 18 percent beginning on the date following the 30th calendar day of receipt. However, to account for potential issues during initial implementation, DHHS will not require interest payments during the first six months after PHP implementation.

G. Uniform Credentialing Requirements

Background

Credentialing refers to the process health plans use to ensure that providers are qualified to render services to enrollees. Each health plan completes the credentialing process for its providers, even if they are already enrolled with Medicaid or contracted with other health plans. The credentialing process is detailed, but generally includes the following key steps:

- Completion of an application (credentialing form) by the provider.
- Primary source verification to ensure the provider has the legal authority to practice, and the relevant training and experience.

- Review of appropriate databases for sanctions, debarment and evidence of malpractice.
- Entry of the provider's credentialing information into the PHP's credentialing database.
- Decision by the credentialing committee to accept or reject the provider's application.
- Ongoing monitoring of sanctions, complaints and quality issues, including site visits.
- Re-credentialing every five years.

Credentialing is the front line of quality assurance and also is a tool to mitigate risk. Yet, the credentialing process is generally considered an administrative burden for providers and is costly for health plans since it requires significant labor, systems investment and file storage.

To ease the burden on providers to complete multiple applications, many states, like North Carolina, have established uniform health care practitioner credentialing applications for use by commercial health plans through the Department of Insurance. Many health plans also use the universal provider data source available through the national Council for Affordable Quality Healthcare (CAQH) to obtain all necessary credentialing information from a central location and require that providers have a complete and up-to-date profile in the CAQH system as part of the enrollment process, as a way to reduce its burden and the burden on providers. In addition, many health plans delegate primary source verification to a credentials verification organization.

The recognized accrediting bodies NCQA, Joint Commission and URAC have established strong credentialing and re-credentialing standards. DHHS will use these standards as the foundation for the PHP credentialing requirements. However, the commercial standards do not address all Medicaid provider types, particularly those that are not licensed by the State. Examples from North Carolina Medicaid include Section 1915(c) HCBS waiver providers, such as adult day health care and personal care aides.

The lack of commercial credentialing standards means DHHS must define the requirements for those providers, which generally mirror the state's Medicaid provider requirements. For example, adult day health care providers must be certified as adult day facilities by the North Carolina Division of Aging and Adult Services.

In addition to the health plan credentialing process, according to federal law, the state must screen and enroll Medicaid providers and revalidate provider qualifications at least every five years. In general, DHHS must verify that a provider meets applicable federal and state requirements, conduct licensing verifications, and conduct federal database checks, including confirming that the provider is not excluded from participating in Medicaid. If the provider type is categorized as a "moderate" or "high" risk of fraud, waste or abuse to the Medicaid program, DHHS is required to conduct site visits and/or criminal background checks as part of the screening process.

Currently, in states with capitated health plans, these processes often occur separately. However, according to the CMS proposed Medicaid managed care rule, DHHS will need to screen and enroll providers before a PHP can contract with the provider. DHHS also will need to revalidate provider qualifications of PHP network providers at least every five years.

The requirement for the State to conduct its screening and enrollment process prior to the PHP contracting with a provider has the potential to slow down the provider contracting process. Also, given the overlap in activities conducted by the State for provider screening and enrollment and the PHP credentialing process (e.g., licensure verification and database checks), having both entities perform these functions is inefficient.

Recommendation

DHHS proposes to devise a uniform credentialing approach that meets the following objectives:

- Comply with federal Medicaid requirements, including the final Medicaid managed care rule when issued.
- Minimize the burden on providers (all types).
- Minimize the burden on PHPs.
- Streamline the process.
- Ensure a timely process.
- Leverage existing data and tools.
- Allow PHPs some flexibility in establishing and verifying credentials for their providers.

To meet these objectives, DHHS is considering an approach where the state will screen and enroll providers, but also will conduct primary source verification and database checks (potentially through a contactor) needed for the PHP credentialing process. Information from the state's activities will be available to the PHPs through an online system, and the PHPs will use the information from the state and any other information collected by the PHP to make credentialing decisions.

This approach will meet the objectives, including minimizing the burden on providers and PHPs. However, DHHS will be assuming credentialing responsibilities and will need to ensure the accuracy and timeliness of this process. The State also will need to identify a funding source for these activities, potentially a fee paid by the PHPs.

XI. TIMELINE FOR RFP ISSUANCE

Section 5(12)(j) of SL 2015-245 requires the report to the JLOC to include *"[t]imeline for issuance of RFP and solicitation of bids."*

Based on DHHS's understanding of the CMS review process and timeline, CMS approval will occur Jan. 1, 2018, which is approximately 18 months following the June 1, 2016, waiver application submission. Additionally, SL 2015-245 requires that capitation begin and beneficiary enrollment be complete within 18 months following CMS approval. Based on these key milestones, DHHS has developed a proposed timeline.

DHHS will begin preparing the PHP solicitation and contract later in 2016. The process will rely on feedback from key stakeholders in the state as well as CMS. The process will begin with a competitive procurement to identify experienced consultants to assist with requirements specification and stakeholder engagement. Work streams will run concurrently with the CMS review of the 1115 waiver application.

Key Activity	Proposed Date Assuming 1115 Waiver Approved Jan. 1, 2018
1115 waiver submission	June 1, 2016
DOI starts accepting applications for PHP licensure	TBD
Implementation Consultant(s) procured	March 2016 to October 2016
Draft PHP RFP (including contract)	October 2016 to January 2018
CMS approval of the 1115 waiver (assumed)	January 1, 2018
Consult with JLOC on terms and conditions of the RFP	February 2018
PHP RFP issued	March 2018
PHP proposals due	June 2018
PHP awards	September 2018
PHP readiness reviews by DHHS	November 2018 to June 2019
PHP go live	July 1, 2019

XII. MEASURES FOR SUSTAINABILITY OF THE TRANSFORMED SYSTEM

Section 5(12)(k) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include *"[m]easures of sustainability for the transformed system*."

The transformation process offers a unique opportunity to optimize the efficiency and effectiveness of the Medicaid delivery system, but it also presents risks. Such risks include declining rates of provider participation that impact access and availability; decreases in beneficiary and advocate satisfaction and engagement; disruption in beneficiary-provider relationships; stagnation of clinical quality improvements; disruption in payment and funding mechanisms; and ineffectiveness of program operations, which hinders the continued transformation of North Carolina's health care delivery system.

One of the four primary goals of SL 2015-245 is to ensure a sustainable delivery system over time. From a high-level perspective, delivery system optimization and system sustainability are synonymous, but the meaning of those terms will vary substantially depending on the audience. While many of the system design decisions will impact the final selection of measures, the general framework for measures of sustainability is proposed below:

- **Financial sustainability.** Measures in this domain will capture budgetary impacts, including federal funding, non-federal funding sources, and PHP financial performance. Tracking cost growth as compared to national averages, as required in SL 2015-245, will be part of the financial sustainability metrics, as will be PHP financial performance.
- **Stakeholder engagement sustainability.** Measures in this domain include whether the voices of beneficiaries, advocates, individual providers and other key stakeholders are being heard. Measures under consideration include enrollee and individual provider satisfaction, network composition, individual provider retention, access standards, and timeliness and accuracy of credentialing and claims payment.
- **Clinical quality sustainability.** Measures in this domain include delivery of preventive services, diagnosis and management of chronic disease, and over- and under-utilization. Attention must be given to key measures by age group and for special populations, such as pregnant women and persons with behavioral health diagnoses and I/DD.
- **Organizational sustainability.** These measures will focus on assessing the State's ability to implement, monitor and drive steady advancement within the Medicaid and NC Health Choice programs, as envisioned in SL 2015-245. This will include staff recruitment and retention, ongoing staff training and skills development, and robust data and data analytics capabilities. Adequacy of funding for these activities, including those of contractors and the Innovations Center, will be included in this domain.

Collectively, the measures in these domains will define and monitor whether the program is accountable to its stakeholders for delivering efficient and effective care. Sustainability comes from the ability to monitor the right measures at the right frequency so that issues can be identified early and corrective actions are timely. DHHS anticipates that some of the measures for sustainability will be drawn from the general performance measures discussed in Section IX.

XIII. PLAN FOR TRANSITION OF CERTAIN N3CN CONTRACT FEATURES

Section 5(12)(l) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include:

> *"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."*

A. Overview

NCCCN (also referred to as "N3CN") has played an important role in North Carolina's Medicaid/NC Health Choice programs and has assisted the State in carrying out a member-centric, provider-friendly medical home transformation effort.

To comply with Section 5(12) of SL 2015-245 and meet the goals of the waiver, DHHS recognizes that certain key features of N3CN will need to continue. The accomplishments of N3CN's efforts on behalf of the State must continue to evolve into the next generation of medical home. This next generation of medical home, known as the "Person-Centered Health Community" (PCHC) will build upon the existing medical home foundation and will seek to integrate a more holistic view of beneficiary care and more fully integrate all provider types across the different settings and continuum of care. To smooth the transition process, DHHS has developed the following guiding principles:

- **Ensure continuity of care for beneficiaries**: DHHS will determine how to ensure beneficiaries receive effective care management during and after transition to the new delivery system.
- **Minimize disruption to individual providers and practices**: Providers currently interface with one Medicaid body, N3CN, for practice supports, care management and data/reporting. Under the new PHP model, providers may interface with multiple PHPs. To ensure high levels of continued provider engagement – plus access and availability – administrative burden and process standardization must be key considerations during and after transition to the new delivery system.
- **Promote behavioral health integration**: DHHS, LME/MCOs and N3CN have taken steps toward "whole person" care delivery. Transition efforts must continue to support behavioral-physical health integration, including data sharing.
- **Continued emphasis on data analytics and reporting**: N3CN currently provides the data analytic and reporting engine that powers the enhanced PCCM program. Data analytics must continue in the new PHP environment as they deliver necessary information to providers, care managers and DHHS, to sustain care management activities, continuous quality improvement efforts and required reporting.
- **Continue other key clinical initiatives** that improve health outcomes including pregnancy medical homes, pharmacy programs, initiatives to integrate behavioral health

services into primary care, chronic pain management and proper opioid prescribing, and appropriate emergency department utilization.

B. Transitioning Medical Home to Person-Centered Health Community

DHHS will build upon the successful medical home model in place today, which emphasizes the provider-beneficiary connection. This next generation medical home, referred to as the Person-Centered Health Care Community (PCHC), will use the current medical infrastructure and proven population management performance as a foundation, and extend care management activities beyond the current enhanced PCCM program.

The PCHC model will advance the approaches of successful care management programs, such as Transitional Care and the Pregnancy Medical Home, and include provider and PHP incentives and value-based payments. The clinical scope of care management will grow to include care management for other beneficiaries, including individuals receiving home- and community-based services, non-waiver behavioral health and substance abuse care, and children in foster care.

Delivery system reform is not sustainable without payment reform, and DHHS will leverage value-based payment models. DHHS will provide incentives to PHPs to support PCHCs, and will require the PHPs to provide funding, including value-based payments, to support the PCHC care delivery model.

N3CN has historically provided tools to support enhanced PCCM as practice supports, care management activities and information systems. The new PCHC care delivery model will require similar infrastructure, and DHHS is defining how to supply this infrastructure, including the role of the future Innovations Center. DHHS will make determinations about transition activities based on the guiding principles outlined above.

C. Practice Supports

Practice supports bolster a medical home model of care and will help expand medical homes to the new PCHC model of care. N3CN's practice supports to medical homes included helping medical homes become recognized by NCQA as Patient-Centered Medical Homes; development, distribution and use of population management tools and clinical toolkits; quality measure reporting with peer comparison; quality improvement coaching; behavioral health integration; and workflow analysis. N3CN also provides some practice supports to pharmacies and hospitals.

DHHS values these activities as pivotal to the success of medical homes, and they will continue under the new program as part of the responsibilities of the State and/or PHPs. In general, the DHHS philosophy is to standardize the approach used to provide practice supports while advocating innovation and excellence at the PHP and practice level.

D. Care Management and Related Activities

N3CN provides data-driven, community-based care management activities statewide through its existing NCQA-recognized community networks or through contracts with local case management entities. These activities include intensive care management provided by an inter-

disciplinary team for beneficiaries at risk for future cost and higher utilization, transitional support for beneficiaries being discharged from inpatient care, disease management, and population management.

DHHS will require, as part of the procurement and subsequent contracts, that PHPs support community-based care management and related activities consistent with those provided by N3CN. This includes engagement with local health departments and other programs similar to Care Coordination for Children (CC4C)[5] and Pregnancy Care Management.[6]

Regarding the DHHS focus on improving specialty care and integration, North Carolina has had several initiatives funded by CMS that include specialty care. DHHS views this as a clear opportunity to continue promoting CMS priorities while enhancing the medical home delivery model. These grants include:

- **Child Health Accountable Care Collaborative**. A Center for Medicare and Medicaid Innovation (CMMI) grant for a pilot program to improve the health and life quality of children with complex medical conditions through better care coordination.
- **Community Pharmacy Enhanced Services Network.** A CMMI grant to CCNC to develop a network of pharmacies that provide enhanced services, such as synchronization of a beneficiary's chronic medication fill dates, adherence monitoring and coaching, compliance packaging, and home delivery.
- **CMS Medicare Shared Savings Program (MSSP)**. Many of North Carolina's MSSPs have specialty management initiatives for conditions that require specialty care; e.g., cardiovascular services, gastroenterology, and hip and knee replacements.
- **Practice Transformation Network**. A CMMI multi-organizational grant to help primary and specialty clinicians achieve large-scale health transformation through peer supported comprehensive quality improvement strategies.

To support ongoing care management activities, promote integration of behavioral health and facilitate information exchange, N3CN has developed the Case Management Information System (CMIS), a web-based application used for centralized care management activities and capture of the member's individualized plan of care. Expanding access to the CMIS for appropriate staff at the LME/MCOs and community care management entities has resulted in stronger integration across physical and behavioral health care managers, and has facilitated information exchange across the system. Continuing this type of system integration and information exchange is an

[5] CC4C is a focused care management program for children from birth to 5 years of age with special needs or otherwise in need of care management. The CC4C program is administered as a partnership between N3CN and DHHS. CC4C employs care managers through local health departments.

[6] Pregnancy care management (also called ObCM) is a care management model for pregnant beneficiaries who receive care in a pregnancy medical home and are identified as being at high risk for poor pregnancy outcomes, such as low birth weight or preterm birth. Pregnancy care management is delivered primarily by local health departments, as stated in the NC State Plan.

area of interest for DHHS when developing the new model of care management. DHHS is exploring options such as:

- Creation of a standardized beneficiary profile to be made available through the HIE or other HIPAA-compliant portal.
- State development of a "CMIS-like" interface, either through the Innovations Center or a contractual relationship to provide a uniform care management record.

E. Informatics Center

The N3CN Informatics Center supports today's enhanced PCCM operations, supplying data mining and analytics capabilities along with reporting mechanisms to DHHS, participating providers and, to a more limited extent, LME/MCOs. DHHS recognizes the key role of data and reporting in the success of PCHC. Data and reporting is used to improve medical decision-making and coordination of care, which improves health outcomes and helps control costs.

To successfully transition this essential feature, DHHS will need access to data from the PHPs and the data analytic capacity to translate the data into actionable information. This will include a key role for the North Carolina HIE and potentially the Innovations Center. DHHS understands that transitioning these functions and building the necessary capacity and functionality will require significant planning, and must be coordinated with the transition of other N3CN functions.

XIV. PLAN TO STABILIZE DMA DURING TRANSITION TO DHB

Section 5(12)(m) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include: "*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*."

DHB and the DMA are working together to identify the optimal way to ensure continuity of services at DMA along with continued improvement initiatives.

Through the Medicaid Leadership Institute sponsored by the National Governors Association and the Center for Health Care Strategies, DHHS has access to change management and leadership development support until September 2016. This support will target DHHS and DMA leadership during the initial phase of transition. The DHHS Human Resources team is working with DMA leadership to develop plans for DMA support during the transition.

DHHS anticipates engaging a consultant in late summer 2016 to assist in the design, development and implementation of the new organizational structure, and to plan for the transition from DMA to DHB. This effort will include a substantial emphasis on change management, timing, training/retraining, retention of key staff and transition planning.

XV. PLAN TO ADDRESS CONTINUITY OF CARE FOR INDIVIDUALS IN FOSTER CARE AND ADOPTIVE PLACEMENTS

Section 5(12)(n) of SL 2015-245 requires the report to the JLOC on Medicaid and NC Health Choice to include: "*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*."

A. Overview

DHHS has begun to develop a plan specifically to ensure continuity of care for children and youth in foster care and adoptive placement as they transition to PHPs, and to address the State's legal responsibility for children and youth in foster care and their special health care needs. The plan recognizes and addresses the complexity of this population's health care needs, the challenges to providing coordinated care and their high health care costs.

In partnership with county DSS offices, DHHS has identified several opportunities for enhancing outcomes for the children and families served by the child welfare system. North Carolina plans to implement the following strategic initiatives focused on improved outcomes for children and families in the child welfare system:

- Extension of coverage to parents of children in foster care
- Expansion of Fostering Health NC
- Designation of a statewide PHP for children in foster care

DHHS will work with stakeholders to further define these initiatives and specify requirements in the PHP contract that focus on strengthening continuity of care, promote appropriate training and support to providers.

B. Extension of Coverage for Parents of Children in Foster Care

When child maltreatment has been identified, but does not necessitate the removal of the child from the home, Medicaid services are provided to ameliorate the behaviors and conditions that may have led to the maltreatment. Often this includes the provision of comprehensive health services. When efforts to prevent removal are unsuccessful or unsafe, the child(ren)/youth may require foster care services, and parents may lose Medicaid eligibility. Foster care is a temporary living arrangement and, in most cases, the plan is to reunify the child(ren) to preserve the family unit. When efforts to prevent removal are unsuccessful or unsafe, children may require foster care services. Foster care is a temporary living arrangement. In most cases, the plan is to reunify children to preserve the family unit.

DHHS is proposing to the NC General Assembly and CMS (through the waiver) to allow parents to retain their Medicaid eligibility while their child is being served temporarily by the foster care program. DHHS seeks to ensure that parents are provided with appropriate and effective comprehensive health services, including behavioral health and substance use disorder (SUD) services, to increase the likelihood of successful reunification of the child and family. This will promote the overall health of our children and families and our communities, and potentially avert long-term costs to Medicaid.

C. Expansion of Fostering Health NC

Fostering Health NC began as one pilot under a CMS Children's Health Insurance Program Reauthorization Act (CHIPRA) Demonstration that was awarded to DMA. Fostering Health NC is transitioning to a statewide program and is currently jointly funded by DHHS and the Duke Endowment. It is focused on improving health outcomes for children and youth in foster care. This effort, which is led by the North Carolina Pediatric Society, is working to ensure every child in foster care has a medical home and that they receive services in accordance with standards recommended by the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA) for health care for children in foster care and standards developed by Fostering Health NC such as "Best Practice for Medication Management."

Fostering Health NC is focused on building and strengthening medical homes for children and youth in foster care through integrated communications and coordination of care through a partnership among local DSS office, the primary care practice's team, N3CN care manager, the school, the child, and the child's family.

Having a medical home is particularly important to foster and adopted youth because the health care provided prior to and during their time in care is often fragmented, which exacerbates their already high health care needs. Frequent check-ups help identify and treat issues early, mitigating the negative effects of their trauma. A medical home is also important when these children and youth experience a change in placement as it can further assist caregivers to take action to prevent a medical or behavioral health crisis. DHHS will work with Fostering Health NC and its partners to identify methods to maintain and expand this program with the PHPs and PCHCs.

An important component of Fostering Health NC is the ability of county directors of social service to access Medicaid claims data. DHHS across multiple divisions addressed privacy laws to facilitate the exchange of information which is operationalized via Technology Enabled Care Coordination Agreement (TECCA). This provides the care team contact information, office visit and hospital stay histories, current and past medications (along with information on whether/where prescriptions were filled), and immunization records. County DSS use this information to fill information gaps, coordinate care, and identify potential problems early. DHHS plans to maintain county DSS access to this type of data and will address this feature as part of the transition of N3CN, as addressed in Section XIII.

D. PHP Contracting Approach

DHHS has considered three potential alternative contracting approaches for PHP enrollment of foster children:

1. Contract with all PHPs to provide services to this population.
2. Contract with a subset of PHPs that meet enhanced standards specific to this population (e.g., medical homes, care coordination and quality).
3. Contract with one statewide PHP to offer a plan to provide services tailored to this population.

Under all three options, all PHPs will continue to be available to this population.

DHHS supports the third option, to contract with one of the statewide PHPs to provide specialized services to foster care children, but continue to offer a choice of PHPs to this population. Under this option, DHHS would:

- Develop requirements for a PHP for children served by the foster care program
- Select the statewide PHP that is most qualified to provide services to children and youth in foster care
- Require the selected PHP to comply with specialized requirements for this population, including provider network and training requirements
- Hold that PHP accountable for providing high-quality, coordinated care specifically tailored to this population.

Parents or county DSS would be able to select from among all PHPs serving the applicable region, but there would be one plan tailored to this population. Thus, a county DSS could choose the designated plan for all or most of the children in its custody, which would reduce the county DSS's administrative burden. Significantly, children and youth enrolled in the designated plan would not need to change PHPs in the not-infrequent instances when they move across regions. This will greatly enhance the continuity of their care.

DHHS is considering whether to also include children in adoptive placement and children receiving in-home services as part of this option.

XVI. OTHER CONSIDERATIONS

When a state Medicaid program converts from fee-for-service to capitation, there is a period when capitation prepayments are made at the same time providers are being paid for services rendered before the capitation effective date. This generates a one-time budget impact, which is largest in the first three months of capitation and typically diminishes over one year.

Assuming that PHPs launch July 1, 2019, DHHS roughly estimates that most of this isolated budget impact will occur in state fiscal year 2020.

Given the extent of the populations and services in the Medicaid and NC Health Choice programs, the fiscal impact will be significant. In the 2015 session, the General Assembly allocated non-recurring appropriations of $75 million for state fiscal year 2016 and $150 million for state fiscal year 2017 to be deposited into the Medicaid Transformation Fund.

As program details are developed and capitation estimates refined accordingly, DHHS will perform modeling to assess the available funding and, if applicable, request additional funds.

APPENDIX: Map of Proposed Regions