Nothing Compares
NORTH CAROLINA

NC TIDE
2016 Fall Conference

November 14, 2016

Department of Health and Human Services
NC Medicaid Reform Update

Agenda

- National Medicaid Landscape
- Medicaid Transformation in NC
- 1115 Waiver Process
- NC Health Transformation Center

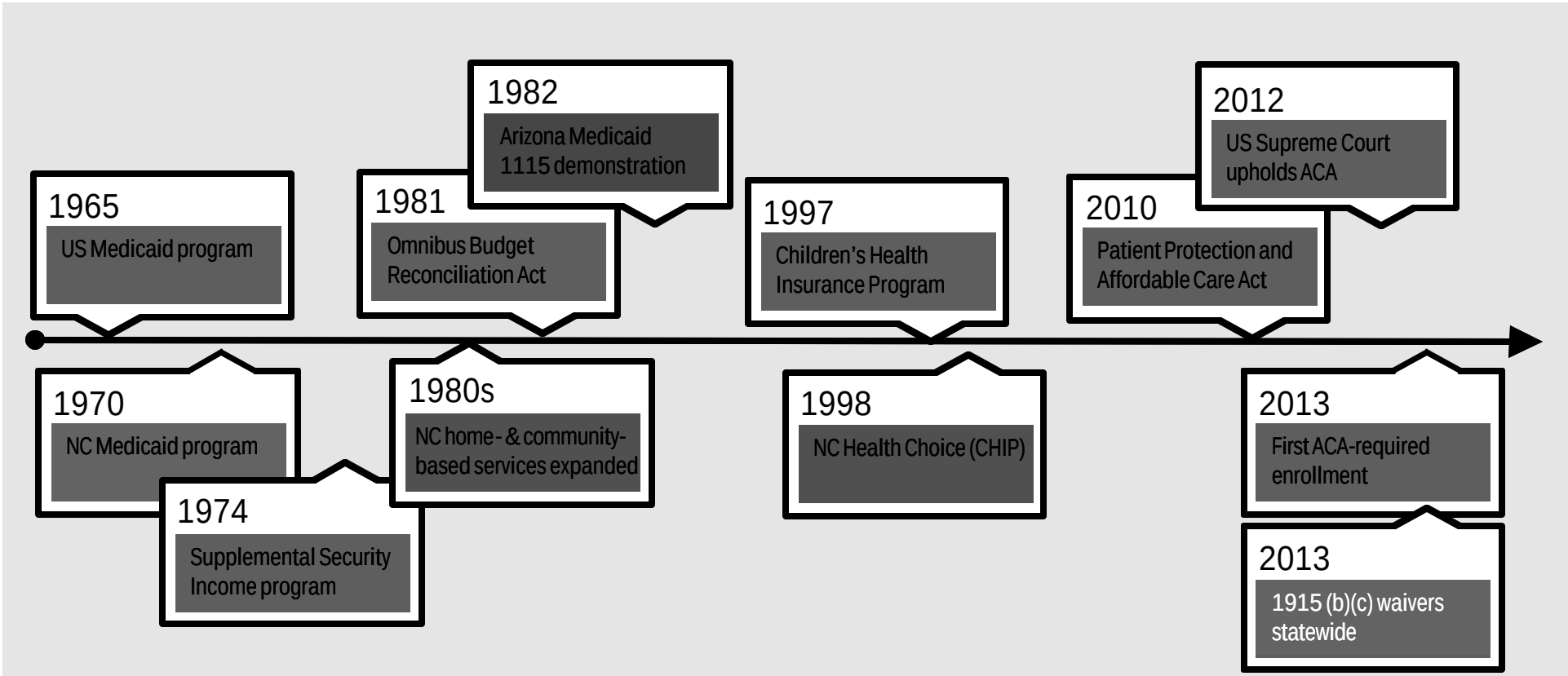
National Medicaid Landscape

Medicaid history

Title XIX of the Social Security Act of 1965

Originally an entitlement program to provide health care

- Certain aged, blind and disabled individuals
- Families qualifying for Aid to Families with Dependent Children



National push for health care system reform

Better Care.
Smarter Spending.
Healthier People.

Paying Providers
for Value,
Not Volume.

"Whether you happen to be a patient, a provider, a business, a health plan or a taxpayer, it's in our common interest to build a health care delivery system that's **better, smarter and healthier**– a system that **delivers better care**; a system that **spends health care dollars more wisely**; and a system that makes our **communities healthier**."

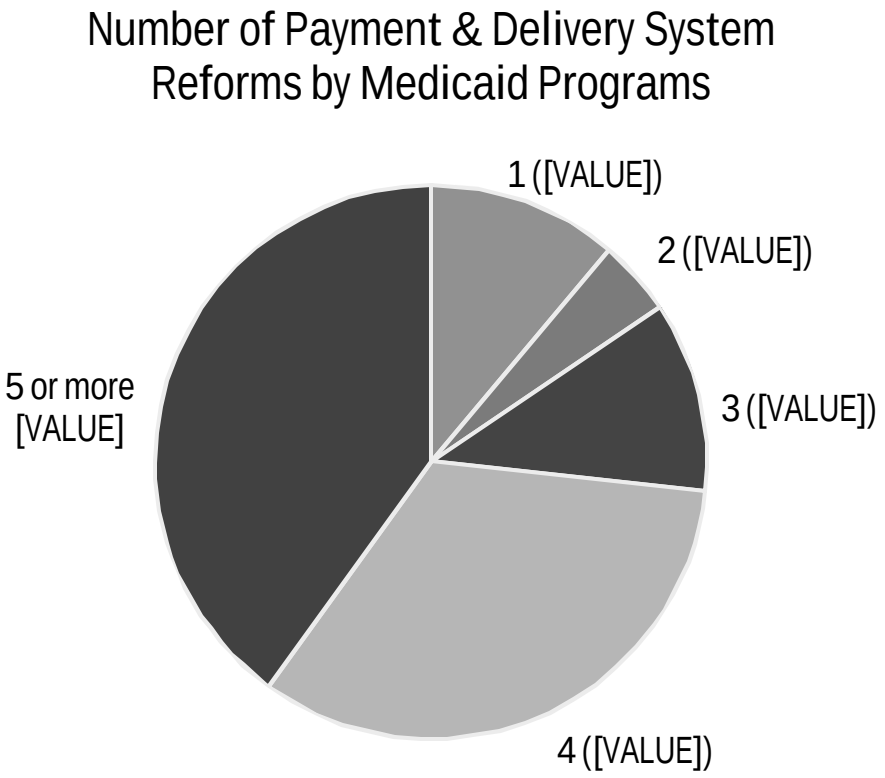
- Sylvia M. Burwell

The New England Journal of Medicine
January 26, 2015

National Medicaid priorities

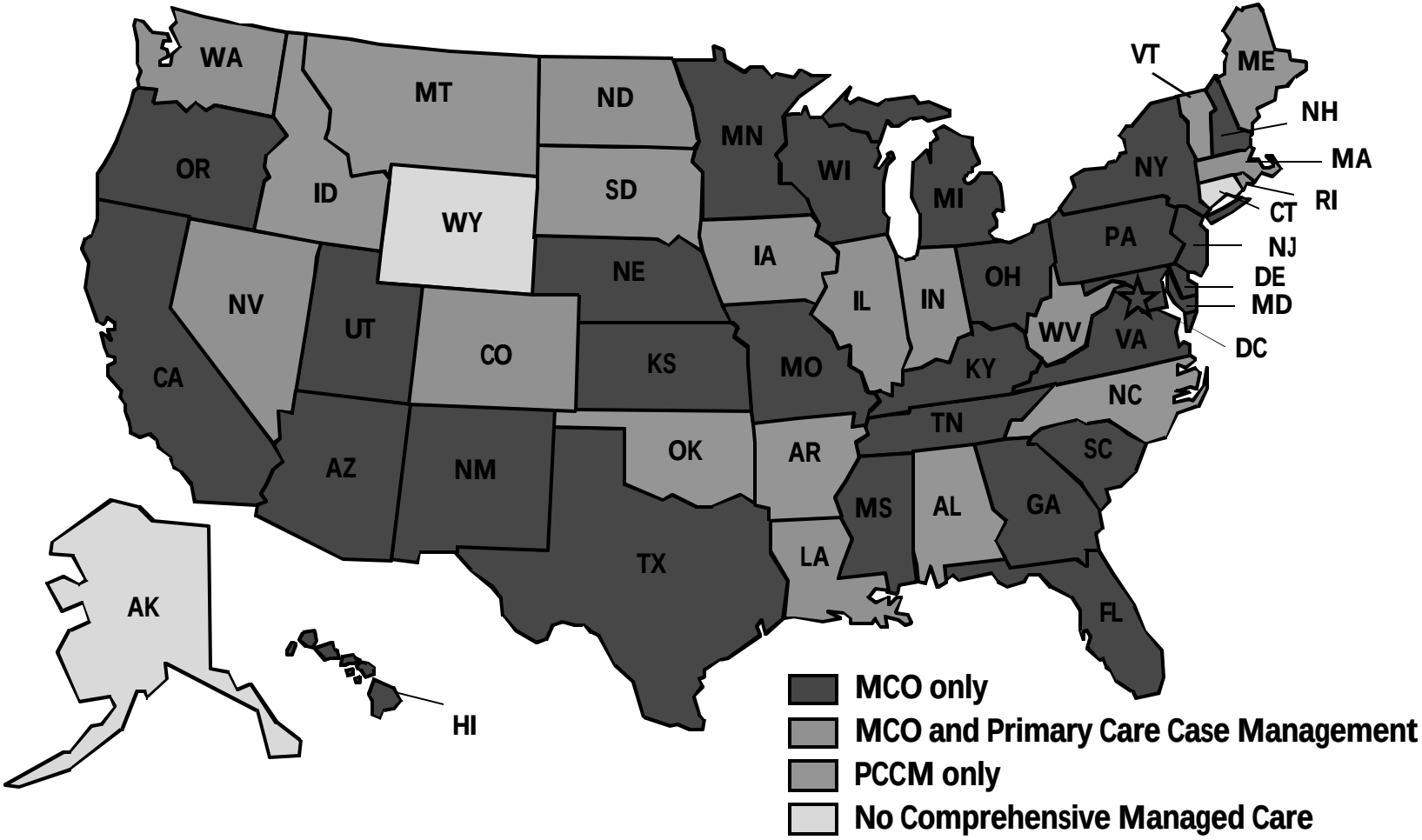
Medicaid programs driving broad-based quality improvement in health care system

- Nearly 3 out of 4 states are studying, planning or implementing 4 or more reforms
- Every state Medicaid program is engaged in some kind of reform effort
  - Managed care initiatives
  - Episodic payment
  - ACOs
  - Health homes
  - Long-term services & supports
  - Behavioral health integration
  - Super-utilizers initiatives



NAMD "State Medicaid Operations Survey: Third Annual Survey of Medicaid Directors," Nov. 2014

39 states use comprehensive MCOs



Source: Adapted from findings of Health Management Associates survey conducted for Kaiser Family Foundation, Oct. 2014

Why states go to Medicaid managed care

Cost management is only part of the reason

IMPROVED CARE COORDINATION

- Coordination across service delivery sectors
- Coordination across lifespan

CLEARER POINT OF ACCOUNTABILITY

- Increase ownership of cost and outcomes by plans and providers
- Clearer responsibility for coordination

IMPROVE POPULATION HEALTH

- Advance policy directions through payment, contract requirements and quality measures
- Increase preventive service
- Population-specific measures and outcomes

EXPAND INNOVATION

- Flexibility in how and where services are provided
- Enable ways to better address needs (e.g., social determinants) that are not easily/effectively addressed in FFS (housing, employment, etc.)
- Improve investment in preventive approaches

COST MANAGEMENT

- Medicaid health care costs are growing faster than state GDP
- Reduce inappropriate use of services
- Increase competition

CMS Medicaid managed care final rules

Effective July 5, 2016, with most provisions phased-in between now and July 1, 2019; PHPs in 2019 will need to comply

Broad-based requirements that will govern states and PHPs, including:

- Beneficiary information and support
- Enrollment and disenrollment protections
- Network adequacy and access to care
- Short-term IMD stays (optional)
- Continued services during appeals
- Medical loss ratio standard
- Delivery system and payment reform
- Quality of care
- Program integrity
- Encounter data

Managed care entities

Federal regulations and CMS identify various types

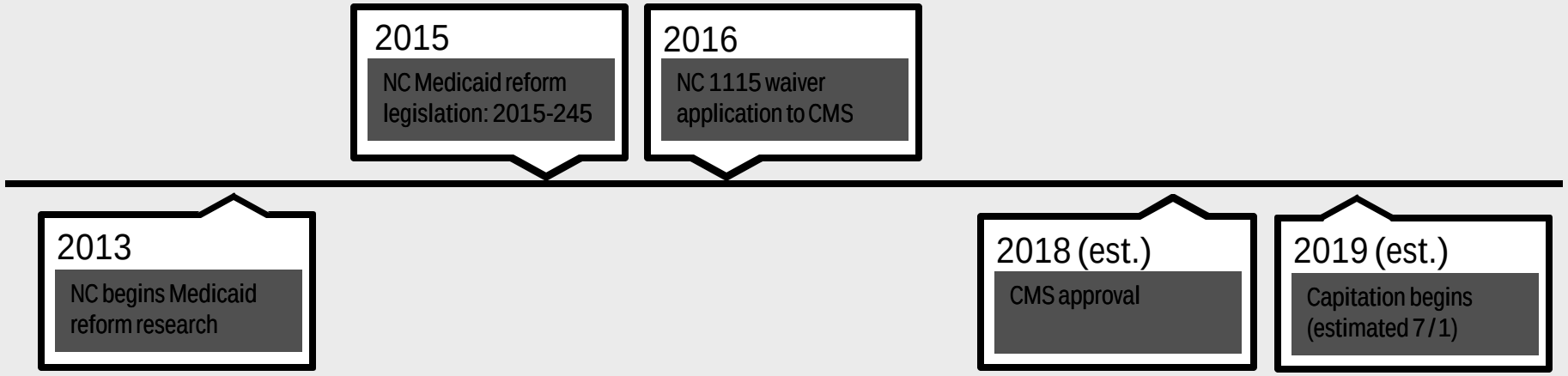
MCO	PCCM	PIHP	PAHP
Managed Care Organizations	Primary Care Case Management	Prepaid Inpatient Health Plan	Prepaid Ambulatory Health Plan
Comprehensive benefit package Payment is risk-based / capitation	Primary care case managers contract with the state to furnish case management (location, coordination, and monitoring) services Generally, paid FFS for medical services rendered plus a monthly case management fee	Limited benefit package that includes inpatient hospital or institutional services (example: mental health) Payment may be risk or non-risk	Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation) Payment may be risk or non-risk

Source: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

Medicaid Transformation in NC

NC Medicaid reform history

Medicaid reform is the result of extensive collaboration among beneficiaries, providers and other stakeholders, McCrory administration and NC General Assembly



Why reform Medicaid in NC?

Improve access to,
quality of
and cost effectiveness
of health care for
most of our 1.9 million
Medicaid and
NC Health Choice
beneficiaries

- Redesign payments to reward value rather than volume
- Restructure care delivery using accountable, next-generation prepaid health plans
- Plan toward true person-centered care grounded in increasingly robust patient-centered medical homes and wrap-around community support and informatics services

SL 2015-245 & SL 2016-121: Key components

Feature	Reform Component
Timeline	Approx. 3 years (est. July 1, 2019)
Capitation	Full capitation
Excluded populations and services	• Dual eligible beneficiaries • Dental • LME/MCOs (continue under existing waivers) • Program of All-inclusive Care for the Elderly (PACE) • Local Education Agency (LEA) services • Child Development Service Agencies (CDSAs) • Populations with short eligibility spans (e.g., medically needy and populations with emergency-only coverage) • Periods of retroactivity and presumptive eligibility
Health plans	• Up to 12 Provider Led Entities (PLEs) in 6 regions • 3 statewide Commercial Plans (CPs)

Session law 2016-121: Other changes

Legislative changes to support program transformation

- Maintain eligibility for parents of children placed in foster care system
- Include state veterans homes as an essential provider
- Allow members of the Eastern Band of Cherokee Indians (EBCI) to opt in to the managed care program
- Clarify cooling-off period requirements for staff without leadership role or contract decision making authority
- Recognize DHHS has single state agency authority for Medicaid, rather than through Division of Health Benefits

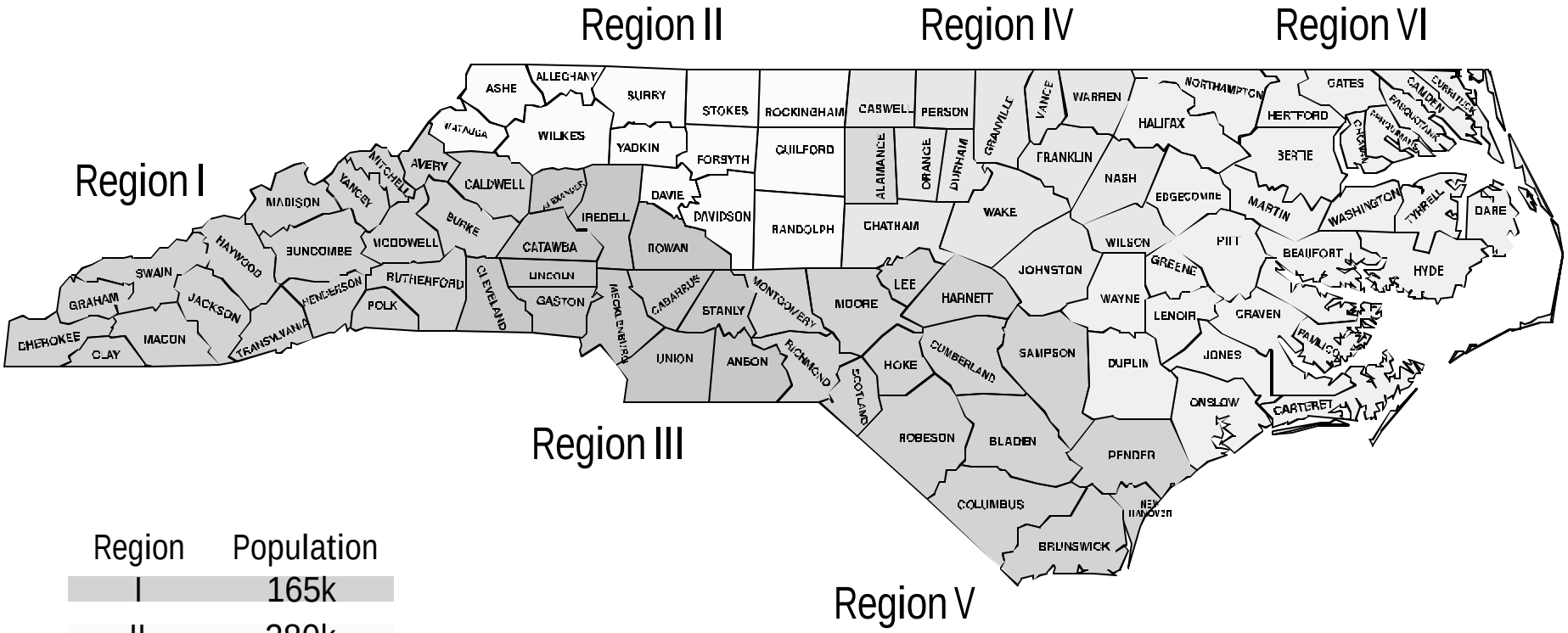
Key differences: Current (FFS) vs. Future (managed care)

	CURRENT	FUTURE
Financial risk	State government (with federal match)	Insurance Plan (CP / PLE)
Medical management	Currently focused on and / or around primary care	Comprehensive
Care coordination for LTSS	Reliant on more services but remain the least coordinated group	Expanded coordination of care across services and / or delivery systems
Innovation	Limited flexibility because FFS can only pay for services provided	Encourages flexibility of reimbursement to providers

Key Differences: Current (FFS) vs. Future (Managed Care)

	CURRENT	FUTURE
Network of care	Providers fragmented	Providers contract with CP or PLE
Provider Reimbursement	Provider paid per visit or procedure; rewards volume & intensity	Plans may develop value-based payment approaches with providers
Enrollment	Beneficiary enrolls in Medicaid; uses providers who accept Medicaid	Beneficiary enrolls in Medicaid; selects or is assigned to CP or PLE
Access	Choose any provider, but limited to those accepting Medicaid	Choose provider within selected network; all network providers follow access standards

Proposed regions



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

Populations estimated from June 2015 enrollment data

Standards and protections

Beneficiaries

Must comply with new CMS Medicaid managed care rule

Expect additional stakeholder engagement

ACCESS
- Time and distance standards
- Variation for rural versus metropolitan/urban areas

QUALITY & SATISFACTION
- Services
- Outcomes

Providers

Rate floors

Essential providers

Good faith negotiations

Protections against exclusion of certain provider types

Anti-trust policies

Prompt pay requirements

Uniform credentialing requirements

1115 Waiver Process

Comparison of 1915 and 1115 waivers

Features	1915 (b)	1915 (c)	1115
Purpose	Allows mandatory enrollment in managed care on a statewide basis or in limited geographical areas; adequate access to quality services must be demonstrated	Provides home and community-based services (HCBS) to individuals meeting income, resource and medical (and associated) criteria, who otherwise would be eligible to reside in an institution	Authorizes US HHS to consider and approve experimental, pilot or demonstration projects likely to assist in promoting objectives of the Medicaid statute; provides significant flexibility to test new health care delivery or payment approaches
Requirements That May be Waived	Allows selected provider contracting and allows use of savings to provide additional services	• State wideness • Comparability • Community income rules for medically needy population	US HHS may waive multiple requirements under §1902 if waivers promote the objectives of the Medicaid law and program intent

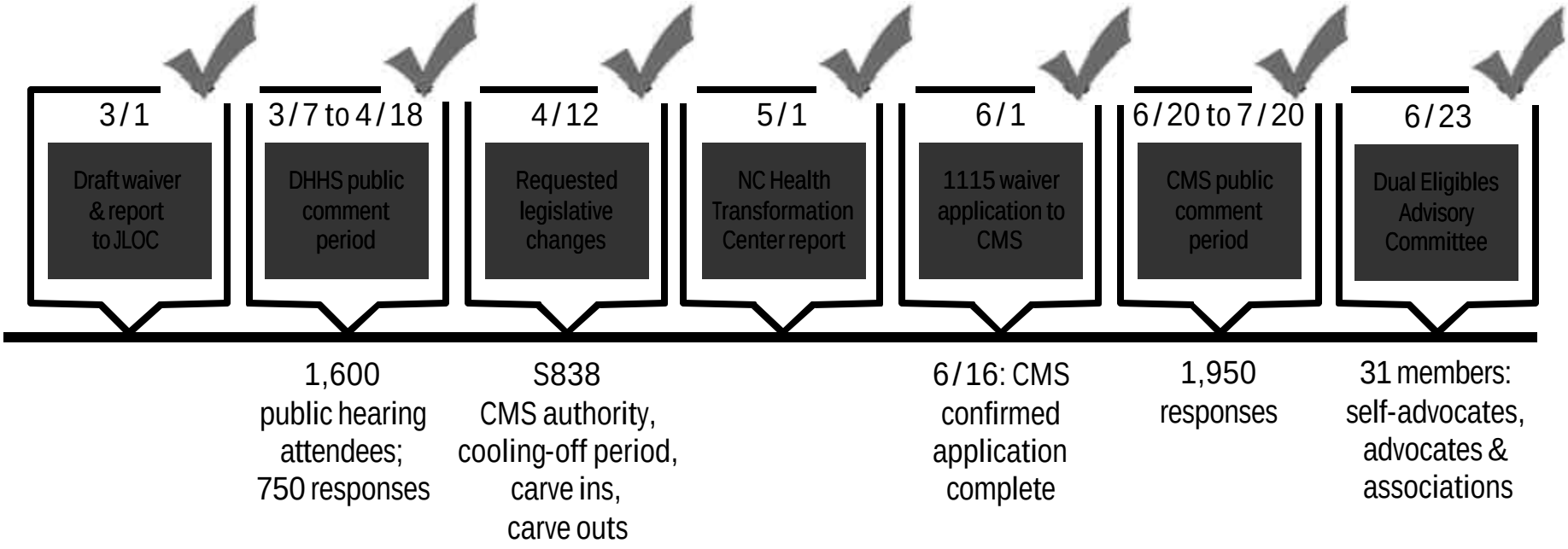
Comparison of 1915 and 1115 waivers

Features	1915 (b)	1915 (c)	1115
Approval Duration	Initial application: 5 years Renewal: 5 years	Initial application: 3 years Renewal: 5 years	Initial application: 5 years Renewal: 5 years
Cost Requirements	Must be cost-effective and efficient	Must be cost effective; cannot exceed average annual cost of institutional level of care	Must be budget neutral; aggregate cost with waiver cannot be more than without the 1115 waiver
Waiting Lists	Waiting lists not applicable	Waiting lists allowed	Waiting lists not applicable
Other State Requirements	Quarterly and annual progress reports	Annual reports	Waiver hypothesis and evaluation plan; monthly progress calls, quarterly and annual progress reports; significant public input

NC Section 1115 demonstration waiver basics

What Will Change	To be Transitioned	What Will Remain the Same
• Medicaid beneficiaries will enroll in their choice of health plans • Prepaid health plans receive capitated payments and incentive payments for quality care goals • LME-MCOs will need to integrate with PHPs	• Services provided by CCNC • Strategy to include dual eligibles (enrollees in both Medicare and Medicaid) • Behavioral health and Innovations Waiver (long-term)	• Dental services (FFS) • Program of All-inclusive Care for the Elderly (PACE) services (carved out of PHP scope) • Local education agency services (FFS) • Child development service agencies (FFS) • Short-term eligibility groups; e.g., emergency-only services (FFS) • BH and Innovations Waiver through LME-MCOs (for 4 years)

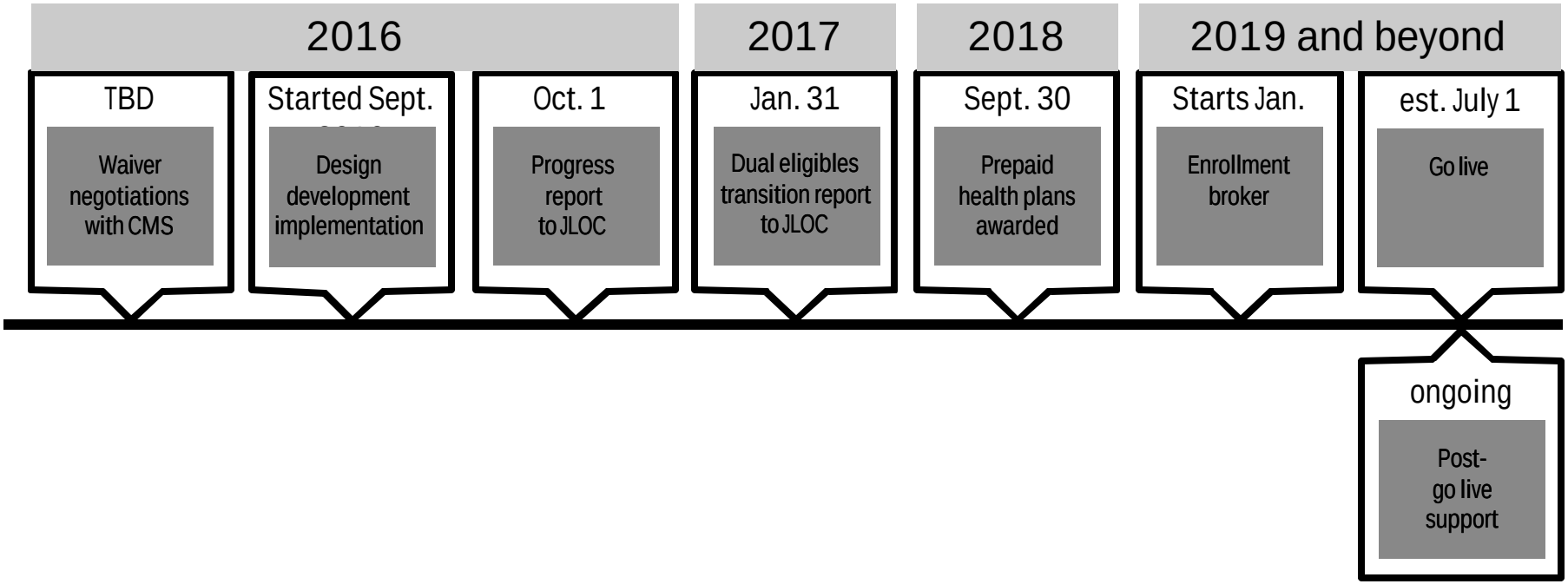
Medicaid reform completed milestones



Key stakeholder questions

- Why reform Medicaid? Why managed care?
  - Able to pay for social determinants, unlike fee-for-service
  - Providers can improve health for the person, not just the patient
- What will happen to care coordination?
- Is there a plan to provide whole person care?
- Will there be more administrative burden for providers?
- Why not expansion?

Recent and upcoming milestones



Dates for 2018 and beyond are contingent on CMS approval Jan. 1, 2018

Health Transformation Center

North Carolina Health Transformation Center

- Outward-facing support for Medicaid transformation
  - Spur innovative programs
  - Enable health care leadership transformation and development
  - Foster clinical information sharing
  - Disseminate grant funding and incentive payment programs
  - Provide collaboratives and technical assistance to providers and prepaid health plans
  - Measure prepaid health plan performance
  - Evaluate effectiveness of waiver program
- Build upon North Carolina history of innovations
- Robust data usage
- Work starts now for a phased implementation

Questions

Documents, reports, committee progress, presentations, updates

www.ncdhhs.gov/nc-medicaid-reform