Nothing Compares
NORTH CAROLINA

NC TIDE SPRING CONFERENCE
April 26, 2017

NC Department of Health and Human Services
Medicaid Transformation and the 1115 Waiver

Agenda

- Medicaid Landscape
- NC Medicaid Transformation
- Supporting Legislation
- NC's 1115 waiver application
- Comparison of 1915(b)(c) and 1115 waivers
- Primary and Behavioral Health Integration
- Current Transformation focus

National Landscape

New Leadership at Federal Level

ACA Repeal

Block Grants

Other State Approaches

Why States go to Medicaid Managed Care

Cost management is only part of the reason

COST MANAGEMENT

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

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

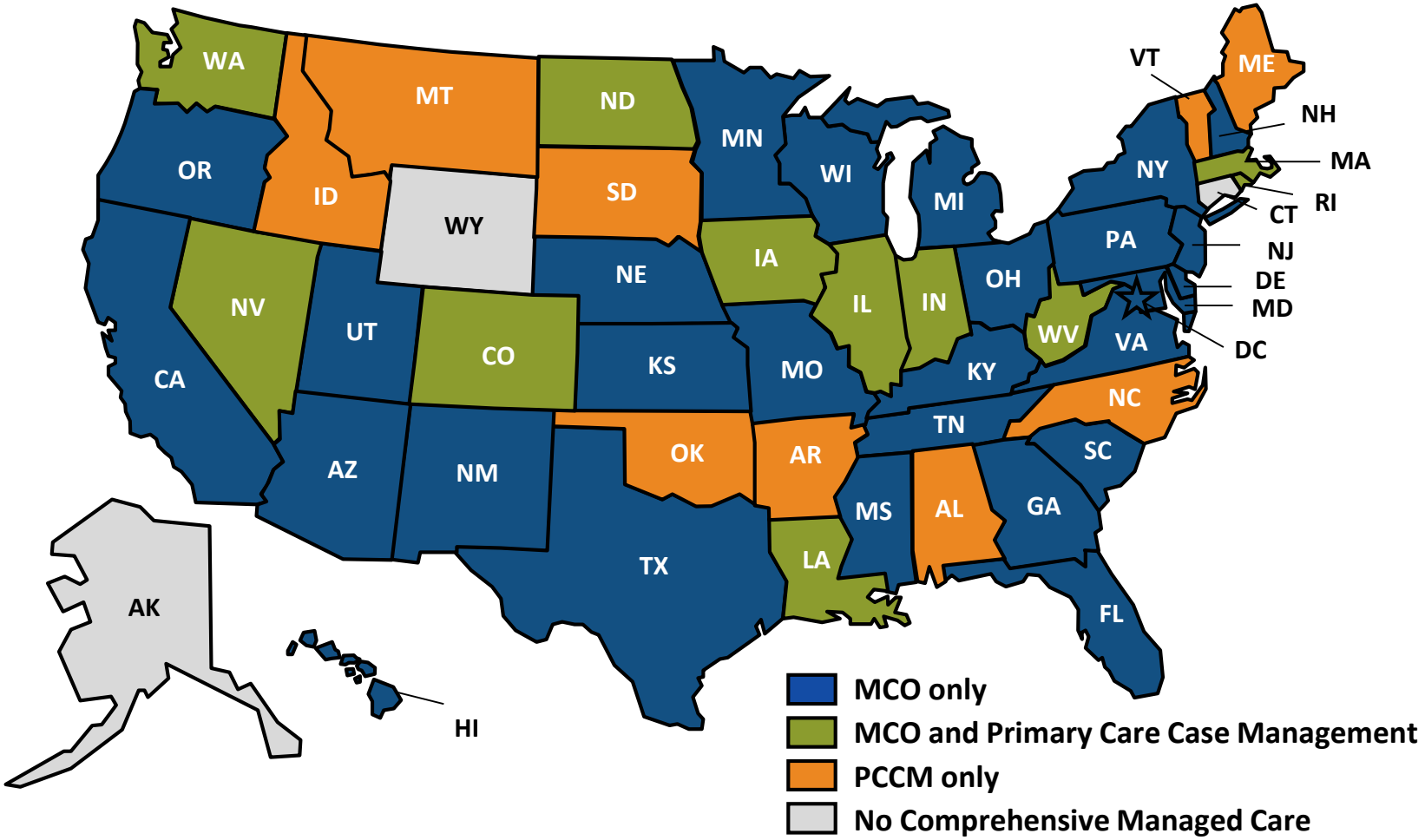
IMPROVE POPULATION HEALTH

- 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

39 States Use Comprehensive MCOs



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

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 NC waiver proposes 2 types - MCOs and PLEs	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 NC LME MCOs are PIHPs	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

Most States Reform Incrementally

Progression over 20-25 years not uncommon

- Coordination agreements layered onto FFS
- Full-risk MCOs in limited areas
- Voluntary enrollment in MCO
- Confined to “moms and kids” Medicaid population
- Carve-outs from MCO services: Behavioral/Rx/LTSS/Dental

- Widen MCO-covered territory
- Mandate enrollment
- Add harder-to-manage populations
- Capitate carved-out benefits

- FFS/PCCM mostly eliminated
- Full-risk MCOs everywhere
- Mandatory enrollment in MCO
- All Medicaid aid categories in MCO
- MCO contracts span all services

TANF = Temporary Assistance for Needy Families

Other State Approaches

- Arkansas
  - Private option
  - Medicaid covers premiums for private coverage
- Kentucky
  - Sliding scale premiums
  - Employment activities
  - Waiving NEMT for expansion adults
- Indiana
  - HIP 2.0
- 1115 Waivers in other states
  - Seven (7) states used 1115 waivers to expand Medicaid

NC Landscape

Governor's Budget

DHHS Priorities

Proposed Legislation

NC Landscape

Goals of Reform

Existing managed care in N.C.

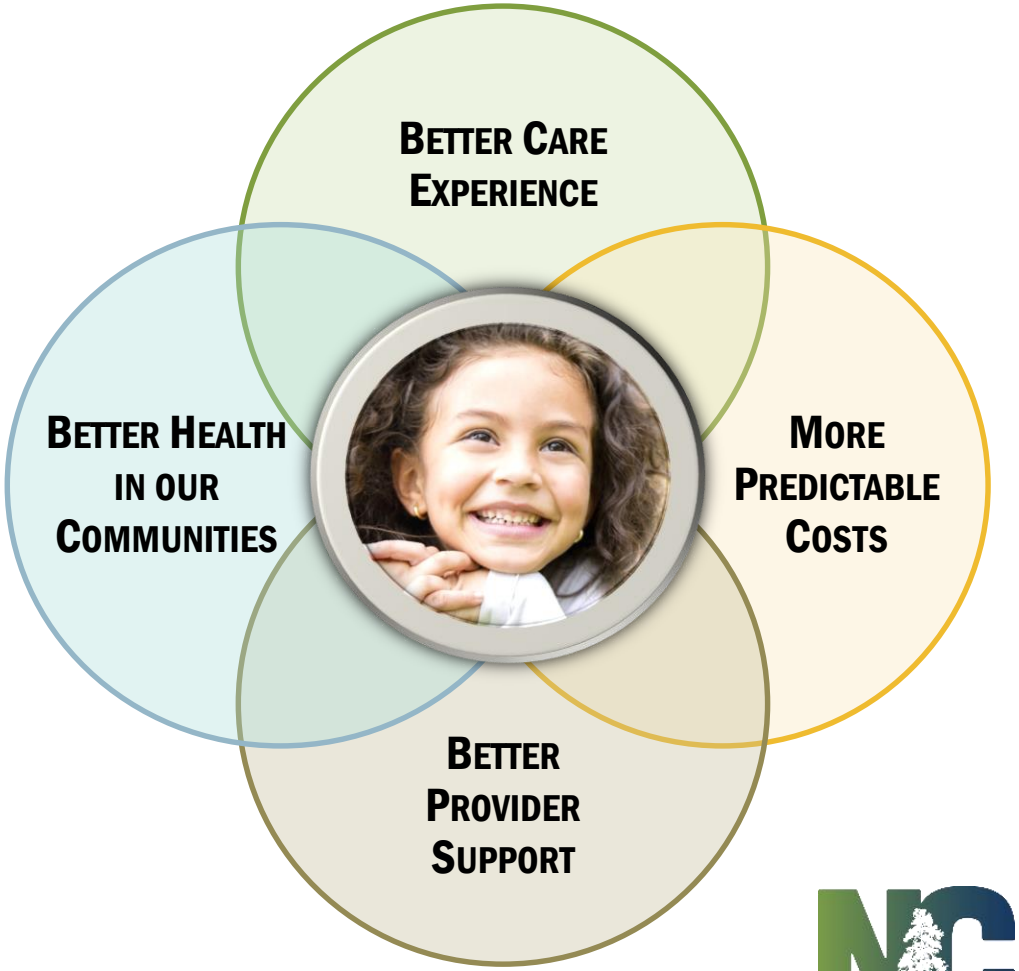
What will not change

Recent Legislation

Medicaid Reform: A North Carolina Solution

Medicaid & NC Health Choice Reform is about People

- Better health in our communities: Quality of life
- Better care experience: Quality of care
- Better engagement & support for providers
- More predictable costs



Medicaid "Managed Care Entities" Already Exists in NC; Reform Moves State Toward a More Comprehensive Model

What North Carolina Has Now

PRIMARY CARE CASE MANAGEMENT (CCNC)

- Primary care provider-based
- State pays additional fee to provide care management

PACE

- Comprehensive, capitated
- 55 years old and older
- Available in certain areas, not currently statewide

BEHAVIORAL HEALTH PREPAID HEALTH PLAN

- Cover specific populations and specific services
- Provides care coordination for identified and priority groups

What Medicaid Reform Will Bring

MCOs will take two forms:

- Commercial Plans
- Provider-Led Entities

Participating plans will be responsible for coordinating all services (except services carved out) and will receive a capitated payment for each enrolled beneficiary

Transformational principles that guide future state

- Pay for health outcomes
- Focus on social determinants of health
- Drive toward population health
- Engage stakeholders
- Enhance quality
- Improve access
- Simplify administrative processes
- Integration of physical and behavioral health

Proposed Bills http://www.ncleg.net/

Proposed Bills that may impact behavioral health

- ❑ H 386 Intensive Family Preservation Service Funds
- ❑ H 403 LME/MCO Claims Reporting/Mental Health
- ❑ H 478 Required Experience for MH/DD/SA QPs
- ❑ H 560 / S 608 I/DD Services Waiting List Transparency
- ❑ H 593 Increase PCS rates
- ❑ H 608 Family / Child Protection & Accountability
- ❑ H 631 Reduce Admin. Duplication/BH Providers
- ❑ H 679 Restore Direct Allocation of Funds to ADATCs
- ❑ S 334 (20172018) MH/SA Central Assessment & Navigation Pilot
- ❑ S 383 Behavioral Health EMS Transport
- ❑ S 422 Eligibility Reform/Medicaid/SNAP
- ❑ S 424 Increase Funding for Behavioral Health Svcs
- ❑ S 472 Streamline CAP/CDSA Services Pilot
- ❑ S 546 Accuracy/Medicaid Eligibility Determinations

House Bill 662 Carolina Cares

Provide health coverage to NC residents ineligible for Medicaid

Background

- Primary Sponsors - Representatives Lambeth, Murphy, Dobson, and White
- Specifies covered population
- Outlines covered services

Major shifts

- Participant premiums
- Work requirements

Funding Sources

- Federal (FMAP)
- Premiums
- State – hospital assessments

http://www.ncleg.net/Sessions/2017/Bills/House/HTML/H662v0.html

Reform Supporting Legislation

Session Law 2015-245

Session 2016-121

Proposed Regions

Special Populations

Medicaid Transformation Overview

Supporting Session Laws: 2015-245 & 2016-121 Key Features

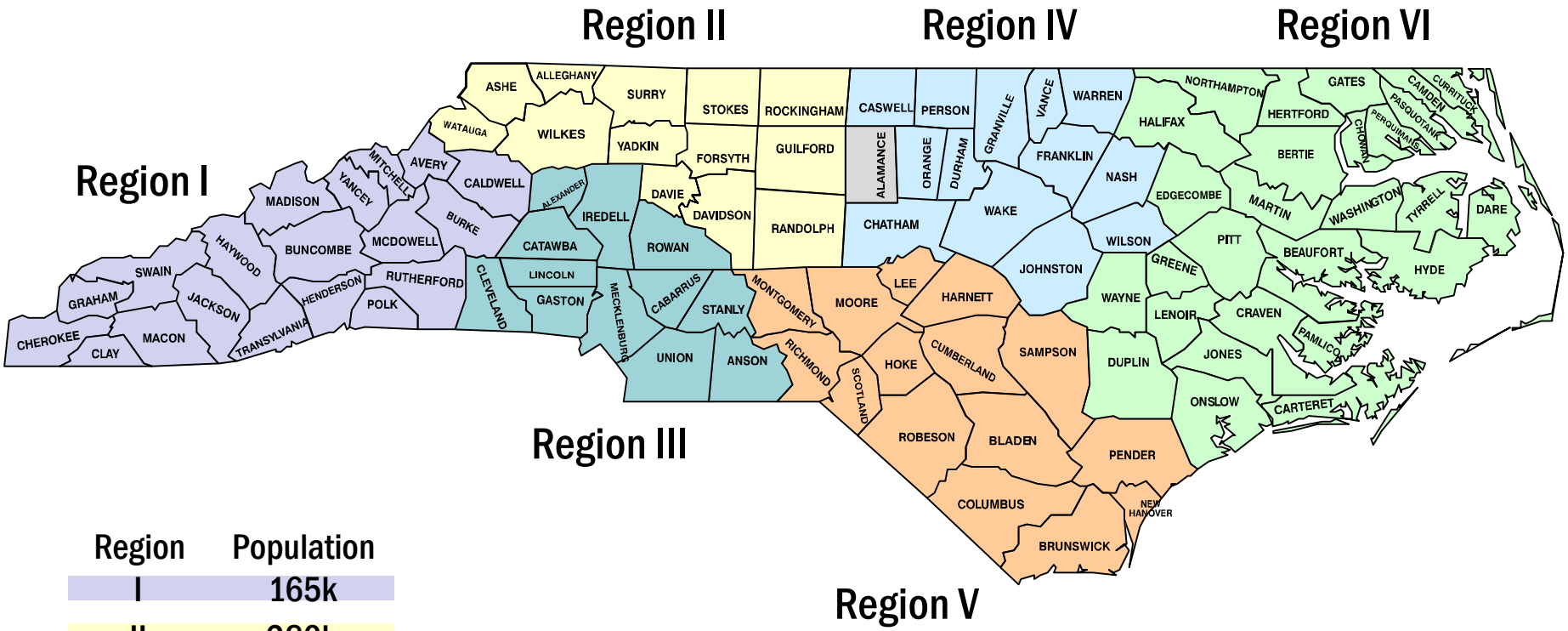
Feature	Reform Component
Oversight	• Established Division of Health Benefits • Clarified single Medicaid agency for CMS
Capitation	• Full capitation
Excluded populations and services	• Dual eligible beneficiaries • Dental • LME/MCOs (continue under existing waivers for 4 years) • Program of All-inclusive 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

Medicaid Reform Overview

Supporting Session Laws: 2015-245 & 2016-121 Key Features

Feature	Reform Component
Timeline	• Approximately 3-4 years*
Prepaid Health Plans	• 3 statewide MCOs (commercial plans) • Up to 12 PLEs in 6 regions*
Other	• Maintain eligibility for parents of children placed in foster care system • Essential providers identified • Allow members of Eastern Band of Cherokee Indians (EBCI) to “Opt In” to the managed care program

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

The 1115 as a Tool for Transformation

What is an 1115 demonstration waiver?

Rationale/benefits of this approach

5 demonstration components

NC Health Transformation Center (NCHTC)

Section 1115 Demonstration Waiver

What is an 1115 waiver?

- Refers to section of Social Security Act which gives Sec. of HHS authority to
  - waive certain provisions of major health and welfare programs under the act
  - approve experimental, pilot or demonstration projects
  - allow states to use Medicaid funds in ways not otherwise permissible under federal rules

Why use an 1115 waiver?

- Gives states additional flexibility to design and improve programs
- Provides authority and regulatory path for payments to safety net providers
- Provides opportunity to demonstrate and evaluate policy approaches
- Supports use of innovative delivery systems to improve care, increase efficiencies and reduce cost

Effective 1115 demonstrations

- Increase access to, stabilize and strengthen providers and networks which serve beneficiaries
- Improve health outcomes
- Increase efficiency and quality of care through initiatives which transform the service delivery system.

The NC 1115 Waiver Application

Demonstration Initiatives

- ❑ Build system of accountability (manage care entities)
- ❑ Creating Person-Centered Health Communities
- ❑ Supporting providers through Engagement and Innovation
- ❑ Connect Children and Families in the Child Welfare System to Better Health
- ❑ Implement Capitation and Care Transformation through Payment Alignment

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

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

	CURRENT	FUTURE
Financial risk	State government (with federal match)	Insurance Plan (MCO/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

Comparison of 1915(b)(c) and 1115 waivers

Purpose

Requirements that can be waived

Duration

Waitlist

How 1915(b)(c) and 1115 waivers line up in N.C.

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
What this means for NC	All individuals with behavioral health needs covered by waiver automatically enrolled. Eligibility for Medic	All individuals with behavioral health needs covered by waiver automatically enrolled	Proposed covered populations, excluded populations. Some services excluded

How 1915(b)(c) and 1115 waivers line up in N.C.

Features	1915 (b)	1915 (c)	1115
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
What this means for NC	NC LME/MCOs have closed networks, not required to take all providers	1915b waiver network rules apply	NC PHPs will contract with all providers except for quality and rate reasons
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

Primary and Behavioral Health Integration

- National Level
  - SAMSHA Grant
    - Promote care models for adults w/ SMI & children w/ SED
    - $2 million per year for 5 yrs.
    - Collaboration with community programs
- NC Efforts
  - Co-location and Reverse co-location models
  - Behavioral Health Integration Initiative grants
  - Pilot Demonstrations

Current Transformation Efforts

PHP Policy Requirements

Technology Assessment

North Carolina Health Transformation Center

Questions