Annual Medicaid Quality Forum

Overview of NC’s Medicaid Managed Care Legislation & 1115 Waiver Application

Tuesday, October 4, 2016 • Morganton, NC
Thursday, October 6, 2016 • Raleigh, NC
Tuesday, October 11, 2016 • Greenville, NC

The Paratum Group, LLC

www.theparatumgroup.com

Disclaimer

I previously served as the director of NC’s Medicaid program, but I do not speak on their behalf. My opinions are my own and do not represent those of any elected or appointed policymaker.
Objectives

I.  Review the national & state Medicaid landscapes

II. Summarize HB 372 & SB 838

III. Provide an overview of the Department’s 1115 Waiver

IV. Identify unanswered questions & possible implications for LME/MCOs

Review US Landscape: Movement towards managed care

15 years ago: Majority of Medicaid payments were predominantly fee-for-service (FFS); small managed care presence

5-10 years ago: State budget overruns and the Great Recession triggered a noticeable and increased movement towards managed care - generally for healthier children & adults, some limited presence in long-term care

Currently: Majority of Medicaid programs are now under managed care (2011 – 58%; 2015 – 70+% est.), including both healthy and long-term care populations
Review US Landscape: *Current Managed Care Footprint*

**States Without Medicaid MCOs**
- Alabama *
- Arkansas
- Connecticut
- Idaho
- Maine
- Montana
- **North Carolina**
  - Oklahoma
  - Vermont
  - Wyoming

Review NC Landscape: *What’s involved and at stake?*

**Expends roughly $15 billion annually**
- $4 billion in state appropriations
- Outside of education, it is the largest source of state spending
- History of overspending; but has come in under budget for the last 3 years

**Covers roughly 1.9 million individuals**
- Represent nearly 25% of NC’s population; pays for almost half of all births in the state
- Two-thirds are children (and their parents), remaining third are the aged, blind & disabled
- Roughly two-thirds of the budget is spent on the aged, blind & disabled

**Has a moderate, but partial Managed Care presence**
- Behavioral health care services – LME/MCOs $2.6 Billion
- Primary Care Case Management (PCCM) – Community Care/N3CN $209.3 Million
- Program for the All-Inclusive Care for the Elderly (PACE) $44.4 Million
Summary of NC Medicaid Reform Legislation

Session Law 2015-245 (HB 372)

_ later amended by_

Session Law 2016-121 (SB 838)

Key Elements (changes due to SB 838 are struck-thru and/or underlined):

• Divides the state into six regions --- to be served by 3 statewide commercial plans (CPs) and up to 12 regional provider-led entities (PLEs).

• Excludes or “carves out” from managed care: (1) those dually eligible for Medicaid & Medicare; (2) qualified non-citizens who receive emergency medical services; (3) the Medically needy; and the (4) presumptive eligibles. Additionally, federally recognized tribal members have the option to enroll in managed care.

• Also carves out: (1) dental services; (2) school-based services such as audiology, speech, occupational, physical therapies and nursing services; (3) PACE; and (4) services provided by a Children’s Developmental Services Agency (CDSA).

• Shifts the current PCCM/medical home model from Community Care to the CPs/PLEs.

• Behavioral health services covered by LME/MCOs are excluded for the first 4 years of capitation.
**Summary of NC Medicaid Reform Legislation**

**More Elements** (changes due to SB 838 are struck-thru and/or underlined):

- Requires at least 88% of capitated payments be spent on direct health care services (also known as a “Medical Loss Ratio” or MLR).
- Requires a minimum reimbursement rate (or “rate floor”) to be paid by plans to in-network PCPs, physician specialists and for pharmacy dispensing fees.
- Identifies “essential providers” that every plan must enroll. At a minimum, essential providers must include FQHCs, Rural Health Clinics, free clinics, local Health Departments and State Veterans Homes.
- Requires the development of a single prescription drug formulary to be used by CPs.
- Requires the adoption of a uniform provider credentialing process.
- **Allows parents to retain Medicaid eligibility while their children are being served temporarily by the Foster Care program.**

**Summary of NC Medicaid Reform Legislation**

**Further Elements** (changes due to SB 838 are struck-thru and/or underlined):

- Establishes a new Division of Health Benefits (DHB) within NCDHHS, phases out current Division of Medical Assistance (DMA).
- Directs DHHS to form a “Dual Eligibles Advisory Committee” and to use the committee’s input to develop by January 2017 a long-term strategy & report as to how duals can be covered under managed care.
- Requires all Medicaid providers to submit data to the NCHIE twice daily.
- Caps Medicaid growth rate at 2% per year.
- **Notwithstanding other provisions of law, permits DHHS/DMA to adjust all Medicaid program components – excluding eligibility & income limits – provided that the proposed changes do not increase the overall Medicaid budget.**
- Directs DHHS to submit a 1115 waiver, other waivers and/or State Plan amendments to accomplish reform objectives and preserve supplemental funding to hospitals and others.
## Overview of NCDHHS’ 1115 Waiver

1. **Incorporates everything in HB 372 and SB 838, such as:**
   - Sets regions and number of CPs & PLEs
   - Carves-outs (people & services)
   - Essential Providers
   - Rate floors
   - Single Rx Formulary (PDL)
   - MLR
   - Creation of DHB
   - Extends Medicaid eligibility for parents with children in Foster Care

2. **Provides some early clues, direction and limited details about:**
   - Payment reform
   - Integrated care & population health
   - Provider satisfaction
   - Performance measures & NCHIE
   - DSRIP funding

---

The Paratum Group, LLC

[www.theparatumgroup.com](http://www.theparatumgroup.com)
Overview of NCDHHS’ 1115 Waiver

Payment Reform

- Capitated payments will be risk-adjusted (disease, age). They may also be adjusted to reflect geographic variances in health costs.
- Plan payments will be further adjusted – up or down – based on their performance against quality measures, health outcomes & enrollee satisfaction scores.
- Plans will be incentivized or required to incorporate value-based purchasing (VBP) concepts into how they pay their network providers. VBP is designed to lower unnecessary & avoidable expenditures and reward outcomes.
- Over time, plans will have to shift their provider payments away from FFS towards bundled payments, quality-based payments, shared savings & sub-capitated arrangements.
- Plans will also be encouraged to invest in cost-effective alternative services, such as the community paramedic programs.

Integrated Care & Population Health

- NC’s medical home program (PCCM) will continue, but responsibility for administration & delivery shifts from Community Care to the plans.
- Introduces the concept of person-centered health communities (PCHCs) – a kind of “medical neighborhood” – as the successor to, or next generation of, NC’s medical home program.
- Plans and PCHCs to be responsible for care management, integration of behavioral health & primary care, and identifying interventions to address social determinants of health and ensuring folks reach/maintain highest level of health.
- Plans to have a contractual expectation to engage with communities to address social determinants of health (e.g., housing and food insecurities) and improve health outcomes.
Overview of NCDHHS’ 1115 Waiver

**Integrated Care & Population Health, cont’d**

- Everyone receives an assessment of their physical & behavioral health and their need for LTSS and social determinants of health. Those with complex needs will have a comprehensive care plan and will be jointly care managed.
- All providers connected to the NCHIE, allowing medical records & care plans to be exchanged electronically.
- Allows for pilots that permit others to take on responsibility for primary care services (e.g., LME/MCOs, I/DD providers and specialists); allows for primary care physicians to serve those with mild-to-moderate behavioral health issues; and allows for modified special need plans.
- Seeks to expand the availability/access to health care in rural counties (70 of 100) through provider recruitment, telemedicine and use of community health workers.

Provider Satisfaction

- DHHS’ uniform credentialing process will include a standardized application to be used by all Plans and providers; verification to be handled centrally.
- Plans to be subject to the “prompt pay requirement” and will pay 18% interest for clean claims not paid within 30 calendar days.
- DHHS to develop/offer population management tools, clinical toolkits and quality improvement coaching to help providers meet expectations of PCHCs.
- New Health Transformation Center (within DHB) charged to assist providers and plans to achieve the multiple goals of Medicaid reform.
- Input from providers to be routinely sought to identify/spread new innovations.
- Seeks $163 million in federal funds over 5 years to match existing state dollars to increase participation in NC’s community-based residency programs.
Overview of NCDHHS’ 1115 Waiver

Performance Measurement & NCHIE

- DHHS to develop a comprehensive set of performance measures to evaluate the system, Plans, PCHCs and providers.
- A “metrics and scoring group” comprised of stakeholders and experts will be formed to offer input on those performance measures.
- Measures will reflect clinical priorities established by DHHS and address acute care, chronic care, specialty care and preventive care – early on, will lean heavily on pediatric measures.
- Number of measures to be limited and consideration will be paid to measure sets already in use and validated (e.g., HEDIS, PQRS, CMS).
- Primary care practices, LME/MCOs and others to be subject to incentive and performance-based payments that are tied to shared outcomes and performance measures.

NCHIE viewed as a crucial component to DHHS’ reform strategy, its 1115 waiver, and to support greater care coordination and improved health outcomes.

HB 97 (SL 2015-241) requires all Medicaid providers to be connected to the NCHIE by February 2018, all other state-funded healthcare providers (LME/MCOs, SEHP) to be connected by June 2018.

DHHS to assist providers with connecting to the NCHIE and with enhancing the capacity and functionality of the NCHIE.

Data within the NCHIE, coupled with paid claims and administrative data, allows for enhanced reporting and analytical capabilities, greater transparency around performance, and the ability to measure the effectiveness of new interventions or policies.
Overview of NCDHHS’ 1115 Waiver

Delivery System Reform Incentive Payment

- Originally focused on helping safety net hospitals increase revenue, DSRIP funds are now increasingly used to promote major payment & delivery system reforms, involving a wide swath of Medicaid provider types.
- DSRIP funding is only available through an 1115 waiver and is generally approved in 5 year increments.
- Funding is tied to meeting performance metrics that evolve over time, beginning with process measures aimed at infrastructure development & system redesign, and evolving to outcome measures that achieve specific clinical and population health improvements.
- Several states have used DSRIP funding as a means to preserve a portion of hospital supplemental funding under managed care expansions. FYI: NC hospitals receive $1-2 Billion annually in supplemental Medicaid funding to offset their uncompensated care costs.

Overview of NCDHHS’ 1115 Waiver

Delivery System Reform Incentive Payment, cont’d

- NC’s 1115 waiver is seeking $262 million over five years for 3 DSRIP projects: Hospital-based Incentive Payment Program $ 65 million Academic Health System Initiatives $ 98 million Local Health Department Incentive Payment Program $ 99 million
- Expected outcomes for hospitals and academic health systems include: (1) decreasing hospital admissions along with increasing medication management & specialty follow-up appointments post-discharge; (2) decreasing emergency department visits along with expediting behavioral health/substance use follow-up appointments post-discharge; and (3) increasing the hospital's role in identifying & addressing social determinants of health.
- Expected outcomes for local health departments include: (1) participating in the “Positive Parenting Program;” and (2) implementing a CDC-recognized Diabetes Prevention Program.
Overview of NCDHHS’ 1115 Waiver: Proposed Timeline

<table>
<thead>
<tr>
<th>KEY ACTIVITY</th>
<th>DATE (Assuming 1115 is approved Jan. 1, 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit demonstration application</td>
<td>June 1, 2016</td>
</tr>
<tr>
<td>Draft RFP (including contract)</td>
<td>October 2016–January 2018</td>
</tr>
<tr>
<td>CMS approval of the 1115</td>
<td>Jan. 1, 2018</td>
</tr>
<tr>
<td>Consult with Joint Legislative Oversight Committee on terms and conditions of the RFP</td>
<td>February 2018</td>
</tr>
<tr>
<td>RFP issued</td>
<td>March 2018</td>
</tr>
<tr>
<td>PHP proposals due</td>
<td>June 2018</td>
</tr>
<tr>
<td>PHP awards</td>
<td>September 2018</td>
</tr>
<tr>
<td>Readiness reviews</td>
<td>November 2018–June 2019</td>
</tr>
<tr>
<td>PHP go live</td>
<td>July 1, 2019</td>
</tr>
</tbody>
</table>

Unanswered Questions & Implications

Payment Reform: Possible spill-over effects?
- LME/MCO payments adjusted to reflect performance, outcomes and satisfaction scores
- Require LME/MCOs to shift provider payments from FFS and adopt forms of payment reform
- Embrace VBP goals as a means of lowering unnecessary and avoidable expenditures

Performance Measures & Increased Transparency on Performance
- New measures for LME/MCOs
- Shared outcomes/risk with primary care and the broader PCHC
- More data = further analytics = strengthened measures = great transparency & report cards
- NCHIE connectivity

Working with CPs & PLEs
- What’s the impact of varying reimbursement rates and clinical criteria/PA/UM?
- How well will providers navigate parallel systems – FFS (carve-outs) versus MC (all others)?
Unanswered Questions & Implications, cont’d

Pilots & Larger Roles
- LME/MCOs and/or I/DD providers taking responsibility for primary care
- Other unique pilots
- Serving as a PLE or partnering with others to do the same

November Elections
- Presidential
- Gubernatorial
- NC General Assembly – more specifically, the House

Splitting Managing Care from the 1115 Waiver
- Will this be a necessity . . . and what are the implications?

My Political Crystal Ball

<table>
<thead>
<tr>
<th>Trump</th>
<th>Clinton</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Managed Care moves forward</td>
<td>• Managed Care moves forward</td>
</tr>
<tr>
<td>• 1115 will need much more detail, easier path to approval</td>
<td>• 1115 will need much more detail, tougher path to approval</td>
</tr>
<tr>
<td>• Trump’s block grant proposal might be very appealing to NC</td>
<td>• Need to split into 2 or more waivers?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>McCrory</th>
<th>Cooper</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Managed Care moves forward</td>
<td>• Managed Care moves forward</td>
</tr>
<tr>
<td>• 1115 will need much more detail; easier path to approval</td>
<td>• 1115 will need much more detail, easier path to approval</td>
</tr>
<tr>
<td>• How will Cooper modify the waiver?</td>
<td>• How will Cooper modify the waiver?</td>
</tr>
<tr>
<td>• Need to split into 2 or more waivers?</td>
<td>• Is Medicaid expansion a possibility?</td>
</tr>
<tr>
<td>• Would a block grant be appealing?</td>
<td></td>
</tr>
</tbody>
</table>
Thank You *and* Questions

Mark T. Benton, Managing Partner
The Paratum Group, LLC
benton@theparatumgroup.com
Office Phone: 919-256-3985
Cell Phone: 919-985-6444