JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

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Budget Implementation Report

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I. Status Report: Aged/Blind/Disabled (ABD) Enrollment in CCNC Medical Homes

Since August 2011, DMA and CCNC have been involved in a concerted effort to increase the enrollment level for ABD recipients (and all other Medicaid eligibility categories) with medical homes in the CCNC network. During this time period, the enrollment rate for ABD recipients has increased from 54% to a high of 72% in March 2012. Since that time the rate has leveled off at 70%. The rapid increase in ABD enrollment was the result of a joint effort with the Public Consulting Group (PCG) which developed an automated process that allowed the enrollment of a large number of beneficiaries in a relatively short period of time. It should be noted that approximately 46% of projected CCNC savings are associated with clinical management of the ABD population—these savings assume a 75% CCNC penetration rate for ABD recipients. It should also be noted that joint enrollment efforts involving DMA, CCNC and DMA contractors have served to increase CCNC enrollment of all other Medicaid eligibility categories to 93%. Given the fact that there are approximately 386,000 ABD recipients, increasing the penetration rate from 70% -75% requires the enrollment of an additional 19,000 ABD recipients.

The slight decrease in ABD enrollment in CCNC (from 72% in March 2012 to 70%) is principally due to an increase in the volume of beneficiary calls seeking to "opt out" of CCNC after being automatically assigned to a primary care provider. Since March 2012, the number of dually eligible beneficiaries choosing to opt out has increased by 20% (5,280 individuals).

In an effort to reinvigorate the statewide ABD enrollment process DMA/CCNC are implementing the following strategies:

- Conduct a joint weekly meeting to discuss enrollment strategies and issues. (CCNC/DMA)
- Work with the networks to recruit Carolina Access I providers into CCNC. There are approximately 550 Carolina Access I (CAI) providers with approximately 60,000 enrolled Medicaid recipients. (N3CN/CCNC).
- Facilitate a DMA webinar on enrollment (scheduled for October 9th) to members of the Adult Care Home Provider Association: (CCNC)
    - There will be two separate webinars that day;
    - CCNC is developing a list of CCNC providers for dissemination to all ACH providers.
- Distribute a flyer (developed by CCNC/approved by DMA) for use at a booth that CCNC will man at the NC Association of Long Term Care Facilities: (CCNC)
    - A state-wide meeting will be held on September 18th;
    - Flyer provides information about CCNC and CCNC providers.

- Reinstate the automatic enrollment process under the DMA contract with PCG. (DMA)
- Identify additional staff resources to provide information and counseling to ABD recipients seeking to dis-enroll ("opt out") from CCNC. (CCNC/DMA)
- Increase communication with County Departments of Social Services regarding the requirements of CCNC enrollment. (CCNC)
- Identify a target list of high risk/high cost recipients who are not enrolled in CCNC—efforts will be made through MCOs and behavioral health providers to enroll these recipients with CCNC. (CCNC)
- Identify ABD recipients who are receiving services from a CCNC physician but not enrolled in CCNC. (CCNC/DMA)
- Increase outreach efforts to ABD beneficiaries who become eligible for Medicaid through the Social Security Administration SSI Program—these individuals are automatically given a system generate exemption code. Recently the number of recipients with this exemption code has increased significantly—up 125% (5,500 recipients since March 2012. Given the fact that 100% of these recipients are classified as ABD, enrollment efforts targeted at this population should be productive. (CCNC/DMA)

II. Update: DMA State Medicaid Plan Amendments (SPAs)

See attached list.

III. Update: 1915 (i) SCU Application

Session Law 2012-142 (Section 10.9E.(a)) requires the development of a 1915(i) application due to CMS by September 15, 2012. The 1915(i) will provide services for individuals who are typically served in special care and memory care units that meet the criteria of the State-County Special Assistance Program and have been diagnosed with a degenerative, irreversible disease that attacks the brain and results in impaired memory, thinking and behavior.

DMA is currently in the final stages of developing the 1915(i) Application. Comments on the proposed application and its development process include the following:

- The process has been characterized by extensive discussions (both formal and informal) with key stakeholders and industry representatives. A final draft of the Application is currently under review and comment by stakeholders. Note: the September 15th submission deadline represents an extremely difficult application development time frame.
- The Application seeks to respond to legislative direction and address the needs of residents in Special Care Units (SCU) while controlling the woodwork effect and cost implications of extending services to individuals in in-home settings.
- Services delivered under the 1915(i) must be comparable across all settings and consumer-eligibility criteria must be the same regardless of service setting.
- The Target Population for the 1915(i) includes individuals over the age of 21 with at least one of seven diagnoses associated with Alzheimer's disease or a related disorder. Members of the Target Population must also be approved to receive State-County Special Assistance.

- To be eligible for benefits under the 1915(i), beneficiaries must meet each of the following eligibility criteria:
    1. have a physician-documented risk of wandering or disorientation to person or place;
    2. have a physician-documented need for a therapeutically secure environment, or, will benefit from the care provided in a secure environment in order to ensure the individual's safety and well-being; and
    3. require 24-hour caregiver supervision and care in a secure unit as attested by a physician.
- Eligibility for benefits under the 1915(i) will be subject to an independent assessment (IA).
- Services delivered under the 1915(i) must be delivered in keeping with Home and Community Based Standards (HCBS)—meeting HCBS within a secure setting has the potential to present a significant CMS approval concern.
- DMA's efforts to cost-model the 1915(i) fiscal impacts are currently underway—to a large extent these costs are driven by woodwork estimates and increases in Special Care Unit beds. The current expenditure level for Special Care Unit services is $76 M.
- Beneficiaries served is projected to be 7466 in Year 1. Annually, SCU residents total approximately 4000, with monthly averages totaling 2700 beneficiaries. Woodworking is anticipated from Medicaid recipients in private residences who meet eligibility criteria and do not receive any Home and Community Based Services. Estimated cost due to woodworking is $18-20 million. This estimate continues to be under further analysis.
- Services funded under the 1915(i) may not be provided by relatives and/or legal guardians of the service recipient.
- The implementation of the 1915(i) brings with it significant demands in the service-planning and QI arenas.
- The Application proposes a daily rate across all settings—this daily rate assessment will require clear documentation requirements for the in-home service providers.

IV. Status Report: NC Medicaid Non-Emergency Medical Transportation (NEMT)

Background Information:

- Federal law requires states to ensure necessary transportation for recipients to and from Medicaid providers (42 CFR 431.53).
- The NC NEMT Program expenditures for FY 11-12 were approximately $44 million with $15.7 million in State dollar expenditures. Approximately 260,000 recipients were provided 1.4 million trips during this time period.
- Federal law requires states to use the least expensive mode of transportation available that is appropriate for the needs of the recipient. Medicaid only pays for transportation to a qualified Medicaid provider for the provision of a Medicaid covered service.
- North Carolina's NEMT is administered by the State's 100 counties who employ such tools as mileage reimbursement, gas vouchers, volunteers, public transit, and private and non-profit vendors to provide services.

Recent Federal (CMS) Audits of the NEMT Program:

CMS audited North Carolina's NEMT Program during 2007 and 2011. These audits cited the State for a lack of sufficient oversight of the NEMT program. Recurring errors noted in the audits included the following:

- No proof that a Medicaid covered service was received;
- Individual not authorized for Medicaid on date of transport;
- Medical necessity for out-of-county trip not verified;
- No valid vehicle registration/inspection/driver's license.

In response to the issues raised in the CMS NEMT audits, DMA initiated the following:

- Initial discussions regarding the possibility of issuing an RFP to hire a Statewide Broker to manage the NEMT Program. These discussions included informal information sessions with potential contractors.
- Discussion with counties and current transportation vendors who expressed a strong interest in working to address problems in the current system.
- DMA also worked with a stakeholder group comprised of county DSS Directors, county transportation supervisors, public transit and other vendor representatives to develop a revised Medicaid NEMT Policy for North Carolina. This new Policy was implemented in January 2012, with the following revisions included:
    - Documentation of trips from request through completion;
    - Self-audits of 2% of all trips each month;
    - Transportation file to include above documentation and driver/vehicle credentials.
- DMA hired the KFH Group, a firm that performs audits for the NC Department of Transportation, to perform NEMT compliance reviews in all 100 counties. KFH has completed reviews of 25 counties and expects to have all 100 counties finished by January 2013. These performance reviews measure county compliance with the revised NEMT Policy. Compliance reports from the first 25 counties showed a 10.8% administrative error rate, as well as billing errors totaling $9,200. Preliminary findings showed counties out of compliance with NEMT Policy in the areas of oversight of vendors, safety and risk management, recipient eligibility, and trip eligibility and tracking.

Legislative Requirement for RFP:

Session Law 2012-142 (Section 10.7) requires that the Department of Health and Human Services (DHHS), in consultation with the Department of Transportation (DOT), to develop and issue a request for proposals (RFP) for the management of NEMT. The Departments are also directed to submit a written report to the Legislature by September 15, 2012. The report must contain an analysis of nonemergency transportation brokerage services implemented in other states, an assessment of the current coordination of human services transportation within North Carolina, and the potential impact of brokerage services on transit system funding and operation, as well as a cost benefit analysis of implementing a statewide NEMT brokerage model for Medicaid recipients.

- In an effort to insure that this report adequately addresses the legislative requirements, the report will be submitted no later than October 15, 2012.
- DMA has formed an internal stakeholder group and is also using the existing external NEMT stakeholder group to address the legislative reporting requirements. NCDOT representatives are participating in both workgroups.
- DMA has solicited information from all 50 states regarding the management and delivery of Medicaid-funded transportation services and has engaged in detailed conversations with several states regarding NEMT program management.
- The proposed date to issue this RFP is October 15th.

V. UPDATE: PHARMACY STATE PLAN AMENDMENT (SPA)

- Session Law 2012-142 (section 10.48(a) & 10.48 (b)) require DHHS to achieve an additional pharmacy savings by :
  1. Lowering the dispensing fees paid to pharmacies and
  2. Implementing a specialty pharmacy program and
  3. Seeking to encourage the use of 340b pricing for hemophilia drugs.

- **PHARMACY SPA—GENERIC DISPENSING FEES**

DMA is preparing a state plan amendment (SPA) that will be submitted to CMS by September 15, 2012 designed to achieve approximately $5.3 million in savings under pharmacy services. CMS approval for the generic dispensing fee structure that was implemented in February 2012 was received in August 2012. With the approval of that SPA, DMA can move forward with submission of the dispensing fee SPA, which will include the following revised dispensing fees for both brand and generic drugs to meet the SFY 2013 pharmacy budget requirements related to this portion of the legislation. Please note that this SPA contains two different dispensing fee structures—the first designed to achieve the required savings between October 1, 2012 and June 30, 2013, and a second fee structure designed to achieve the required savings on a go-forward basis beginning in SFY 2014. These fee models have been reviewed with stakeholders.

October 1, 2012 (Effective Date):

Brands: $3.00

Generics:

Generic Dispensing Rate (%)	Fee ($)
≤ 72%	$3.00
72.1% - 77%	$4.00
77.1% - 82%	$6.50
> 82%	$7.75

July 1, 2013 (Effective Date):

Brands: $3.00

Generics:

Generic Dispensing Rate (%)	Fee ($)
≤ 69.9%	$3.00
70% - 74.9%	$4.00
75% - 79.9%	$6.50
≥ 80%	$7.75

Hemophilia Specialty Pharmacy Program

DMA has drafted a proposed policy for a hemophilia specialty pharmacy program with approximately $1.4 million savings driven primarily through the use of 340B priced drugs and implementation of standards of care for dispensing pharmacies. A state plan amendment (SPA) is not required for this program. North Carolina Medicaid spends more than $50 million annually for services provided to 294 beneficiaries with hemophilia. These beneficiaries receive hemophilia services from 15 pharmacies. The combination of the standards of care and reimbursement changes will improve the care that our hemophilia patients receive and allow DMA to meet the SFY 2013 savings requirements ($1,391,906).

Mandated savings for SFY 2013 will be generated in two ways:

1) DMA will establish standards of care for pharmacies providing hemophilia services. These standards will increase the level of care beneficiaries receive and decrease costs by about 5% of total expenditures through better management and decreased product utilization under assay management protocols. The standards of care have been through DMA's policy development process and have received the approval of the Pharmacy and Therapeutics committee and the N.C. Physicians Advisory Group. DMA is sharing the draft policy with stakeholder groups this month, prior to posting for the 45-day comment period. These standards of care will require changes to the N.C. Administrative Code.

2) DMA will implement new payment methodologies for 340B and non-340B providers designed to increase access to 340B drug pricing through public providers serving hemophilia beneficiaries. This change does not require a SPA. These changes will be implemented as state upper limits similar to the Enhanced Specialty Discount Program (mandated by SL 2008-107, Section 10.10(e)). The State upper limits for 340B providers will be increased to encourage utilization of 340B priced drugs in a shared savings model based on acquisition cost + 21%. This model is used under other state Medicaid programs and represents a win-win for both Medicaid programs and 340B providers. The state upper limits for non-340B pharmacy providers will be reduced to acquisition cost + 15%. Both reimbursement methodologies include sufficient gross margins to cover provider costs in addition to the drug cost.