

# *Medicaid Items from 2013 Appropriations Act (S.L. 2013-360)*

JOINT LEGISLATIVE OVERSIGHT COMMITTEE  
ON HEALTH AND HUMAN SERVICES

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**FISCAL RESEARCH DIVISION**  
A Staff Agency of the North Carolina General Assembly

## Presentation Outline

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## Medicaid Budget at a Glance

Increases in Medicaid Spending	Reductions in Medicaid Spending
<ul style="list-style-type: none"> <li>• Rebase</li> <li>• Affordable Care Act: <ul style="list-style-type: none"> <li>• Woodwork effect</li> <li>• DSH</li> <li>• Some NC Health Choice children moved to Medicaid (corresponding reduction in Health Choice funding)</li> </ul> </li> <li>• Contracts</li> <li>• Settlements</li> <li>• MMIS implementation</li> <li>• CCNC Study</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital outpatient payment reduction</li> <li>• Cost savings through drug adjustments</li> <li>• Rate freeze for services subject to automatic increases</li> <li>• Nominal copay increase</li> <li>• Service limitations: <ul style="list-style-type: none"> <li>• Rehabilitation set-up and training</li> <li>• Visits to physician office per year</li> </ul> </li> <li>• Enhanced federal match for Health Homes for Chronically Ill</li> </ul>

## Medicaid Budget Change Components

Structural Shortfall	\$ 272,200,000
Enrollment/Utilization Growth	191,000,000
ACA Woodwork and DSH Effects	49,700,000
ACA Health Choice to Medicaid	22,000,000
Non-Recurring IT	4,800,000
Budget Reductions	(143,500,000)
Non-Recurring Federal Payments	<u>(3,800,000)</u>
<b>TOTAL CHANGE</b>	<b>\$ 392,400,000</b>

## Hospital Changes

- Increased Hospital Provider Assessments
  - Previous: State retained a flat \$43M from hospital assessments
  - FY 2013-14 Budget: State retention converted to a percentage of total assessment collected.
  - Budget impact: \$50M annually (effective 7/1/13)
- Reduced Outpatient Payments
  - Changed payment rate from 80% of cost to 70% of cost
  - Budgeted savings:
    - \$23M in FY 2013-14 (effective 1/1/14)
    - \$48M in FY 2014-15
- Regional inpatient hospital rates
- Rate methodologies for acquired providers

## Rate Freeze for Services Subject to Automatic Increases

- Medicaid rate methodologies contain provisions for some provider rates to be adjusted based on cost increases, but budget freezes rates to those in effect 6/30/13 for selected provider categories.
- Budgeted savings:
  - \$17M in FY 2013-14
  - \$27M in FY 2014-15

## Cost Savings Through Drug Adjustments

- Changes to markup on brand and generic drugs:
  - Non-specialty brand: 102.7% of WAC
  - Specialty brand: 101% of WAC
  - Generic: 150% of SMAC
- Decreases in drug dispensing fees:
  - Brand dispensing reduced by \$1
  - Generic dispensing reduced by \$1 to \$2
- Budgeted savings:
  - \$15M in FY 2013-14 (beginning Jan 2014)
  - \$30M in FY 2014-15

## Shared Savings Plan

- Establishes a system to reimburse selected medical providers based on performance
- 3% payment withhold begins in FY 2013-14
- Shared savings payments to providers begin in FY 2014-15
- Budgeted savings:
  - \$27M in FY 2013-14 (beginning Jan 2014)
  - \$45M in FY 2014-15

## Medicaid Reform Plan (Sec. 12H.1)

- DHHS to create a detailed Medicaid reform plan
- Non-legislative Medicaid Reform Advisory Group to advise DHHS
- Plan to be submitted to General Assembly
  - Budget provision explicit that DHHS not implement plan without General Assembly authorization
- Legislation based on proposal and recommended by advisory group:
  - Eligible for introduction in short session
  - May contain appropriations and run prior to FY 2013-14 budget bill

### Section 12H.1 of S.L. 2013-360:

#### **DETAILED MEDICAID REFORM PROPOSAL TO BE PREPARED BY DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEDICAID REFORM ADVISORY GROUP ESTABLISHED**

**SECTION 12H.1.(a)** The Department of Health and Human Services, Division of Medical Assistance, (Department), in consultation with the Medicaid Reform Advisory Group created by subsection (e) of this section, shall create a detailed plan for, but not implement, significant reforms to the State's Medicaid Program that shall accomplish the following:

- (1) Create a predictable and sustainable Medicaid program for North Carolina taxpayers.
- (2) Increase administrative ease and efficiency for North Carolina Medicaid providers.
- (3) Provide care for the whole person by uniting physical and behavioral health care.

**SECTION 12H.1.(b)** The Department shall submit its detailed proposal of how to reform the State's Medicaid Program to the General Assembly. The report shall contain the following:

- (1) The details of the reform plan, including how the plan would accomplish the goals set out in subsection (a) of this section.
- (2) The Department's methodology for selecting the reform plan over alternatives.

- (3) Forecasts of the reform plan's potential to slow the growth of the costs of the Medicaid Program, including the assumptions and methodology used for the forecast, as well as an explanation of how the Department's forecast methodology has been improved to produce more accurate forecasting than in prior years.
- (4) The reform plan's impact, as compared to the existing Medicaid Program, on both providers and recipients in areas such as enrollment within the Medicaid system, access to services, quality of care, and payment methodologies, and any other areas of comparison to help the General Assembly evaluate the reform plan.
- (5) If regional demonstration projects, pilot projects, or similar projects will be used to test a proposal, how the Department will ensure that the test methodology is scientifically valid and consistent with social science research methods.
- (6) How financial risks will be allocated under the reform plan.
- (7) The mechanisms through which the Department and any contractors under the reform plan would be held accountable for the implementation and performance of the plan.
- (8) Short-term costs to implement the plan and expected long-term savings in future years from slowing the growth of costs.
- (9) A realistic time line for implementation.
- (10) Draft Medicaid State Plan Amendments, Medicaid waivers, amendments to State law, or other changes necessary to legally allow the Department to implement its reform plan.
- (11) Any other detailed information that would assist the General Assembly in evaluating the strength of the reform plan and the plan's ability to accomplish the goals set out in subsection (a) of this section.

**SECTION 12H.1.(c)** The Department is encouraged to and may submit draft Medicaid State Plan amendments, draft waiver applications, or other documents to the federal government to solicit feedback on the Department's proposal prior to reporting to the General Assembly. The Department shall not, however, submit any documents to the federal government to implement the reform plan without legislation authorizing the Department to implement the Department's reform plan.

**SECTION 12H.1.(d)** The Department shall submit its reform plan to the General Assembly no later than March 17, 2014, but is encouraged to submit its plan as early as it responsibly can.

**SECTION 12H.1.(e)** Advisory Group. – There is established the North Carolina Medicaid Reform Advisory Group (Advisory Group) in order to advise the Department of Health and Human Services in its development of its detailed plan to reform Medicaid. The Advisory Group shall meet in order to (i) provide stakeholder input in a public forum and (ii) ensure the transparency of the process of developing the reform proposal. The Advisory Group shall meet at the call of the chair. The Advisory Group shall consist of the following five members, and the appointing officer shall fill vacancies:

- (1) A Representative appointed by the Speaker of the House of Representatives.
- (2) A Senator appointed by the President Pro Tempore of the Senate.
- (3) Three persons appointed by the Governor, one of whom shall be designated as the chair.

Legislative members of the Advisory Group shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1. Non-legislative members of the Advisory Group shall receive per diem, subsistence, and travel expenses as allowed under G.S. 138-5 or, if the member is a State employee, lodging and travel expenses as allowed under G.S. 138-6.

The Secretary of Health and Human Services shall ensure adequate staff representation and support from the Department of Health and Human Services. The Advisory Group shall terminate on July 1, 2014.

**SECTION 12H.1.(f)** Eligibility of Legislation. – Legislation based on the Department's reform proposal and recommended by the Advisory Group shall be eligible for consideration when the 2013 General Assembly reconvenes in 2014, and G.S. 143C-5-2 does not apply to such legislation.

**§ 143C-5-2. Order of appropriations bills.**

Each house of the General Assembly shall first pass its version of the Current Operations Appropriations Act on third reading and order it sent to the other chamber before placing any other appropriations bill on the calendar for second reading. This section does not apply to the following bills:

- (1) An appropriations bill to respond to an emergency as defined by G.S. 166A-19.3.
- (2) An appropriations bill making adjustments to the current year budget.
- (3) An appropriations bill authorizing continued operations at current funding levels. (2006-203, s. 3; 2012-12, s. 2(w).)

## Changes to SPA Process (Sec. 12H.2)

- State Plan Amendments (SPAs) may not expand Medicaid program without legal authority
- Explicit triggers for submission of SPAs now provided in statute
- SPAs posted on DHHS website 10 days prior to submission to the federal government
  - Notice to members of HHS Oversight and Fiscal Research
- Timely submission of SPAs to federal government

### **New G.S. 108A-54.1A (enacted by Section 12H.2 of S.L. 2013-360):**

#### **§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) No provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

(b) The Department may submit amendments to the State Plan only as required under any of the following circumstances:

- (1) A law enacted by the General Assembly directs the Department to submit an amendment to the State Plan.
- (2) A law enacted by the General Assembly makes a change to the Medicaid Program that requires approval by the federal government.
- (3) A change in federal law, including regulatory law, or a change in the interpretation of federal law by the federal government requires an amendment to the State Plan.
- (4) A change made by the Department to the Medicaid Program requires an amendment to the State Plan, if the change was within the authority granted to the Department by State law.
- (5) An amendment to the State Plan is required in response to an order of a court of competent jurisdiction.
- (6) An amendment to the State Plan is required to ensure continued federal



financial participation.

(c) Amendments to the State Plan submitted to the federal government for approval shall contain only those changes that are allowed by the authority for submitting an amendment to the State Plan in subsection (b) of this section.

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division that the amendment has been posted. This requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.

(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section.

## Additional Medicaid Changes

- State Plan now has the force and effect of rules adopted pursuant to Chapter 150B (Sec. 12H.9)
- Changes to post-payment review and recovery audit contracts (Sec. 12H.16(b))
  - Contingent fees not paid until appeals complete
  - Contingent fees based on final overpayment, not amount first identified by contractor
  - Contingent fees may not exceed State share of amount actually recovered
- CCNC to set and pay per member per month (PMPM) payments to providers (Sec. 12H.22)

### **G.S. 108A-54.1B, as enacted by Section 12H.9 of S.L. 2013-360:**

#### **§ 108A-54.1B. Adoption of rules; State Plans, including amendments and waivers to State Plans, have effect of rules.**

(a) The Department is expressly authorized to adopt temporary and permanent rules to implement or define the federal laws and regulations, the North Carolina State Plan of Medical Assistance, and the North Carolina State Plan of the Health Insurance Program for Children, the terms and conditions of eligibility for applicants and recipients of the Medical Assistance Program and the Health Insurance Program for Children, audits and program integrity, the services, goods, supplies, or merchandise made available to recipients of the Medical Assistance Program and the Health Insurance Program for Children, and reimbursement for the services, goods, supplies, or merchandise made available to recipients of the Medical Assistance Program and the Health Insurance Program for Children.

(b) Rule-making authority granted under this section for particular circumstances or programs is in addition to any other rule-making authority granted to the Department under Chapter 150B of the General Statutes.

(c) Prior to filing a temporary rule authorized under G.S. 150B-21.1(a)(17) with the Rules Review Commission and the Office of Administrative Hearings, the Department shall consult with the Office of State Budget and Management on the possible fiscal impact of the temporary rule and its effect on State appropriations and local governments.

**(d) State Plans, State Plan Amendments, and Waivers approved by the**

**Centers for Medicare and Medicaid Services (CMS) for the North Carolina Medicaid Program and the NC Health Choice program shall have the force and effect of rules adopted pursuant to Article 2A of Chapter 150B of the General Statutes.**

**G.S. 108C-5.1, as enacted by Section 12H.16(b) of S.L. 2013-360:**

**§ 108C-5.1. Post-payment review and recovery audit contracts.**

The Department shall not pay contingent fees pursuant to any contract with an entity conducting Medicaid post-payment reviews or Recovery Audit Contractor (RAC) audits before all appeal rights have been exhausted. Any contingent fee for Medicaid post-payment reviews or RAC audits shall be calculated as a percentage of the amount of the final overpayment, as defined in G.S. 108C-2(5). The State share of the contingent fee paid for Medicaid post-payment reviews or RAC audits shall not exceed the State share of the amount actually recovered by the Department and applied to the final overpayment.

**Section 12H.22 of S.L. 2013-360:**

**COMMUNITY CARE OF NORTH CAROLINA TO SET AND PAY PER MEMBER PER MONTH PAYMENTS ON PERFORMANCE BASIS TO ENCOURAGE BETTER CARE MANAGEMENT**

**SECTION 12H.22.(a)** The Department of Health and Human Services shall contract with Community Care Networks, Inc. (NCCCN), to administer and distribute the funds currently allocated to per member per month (PMPM) payments for Community Care of North Carolina (CCNC) primary care providers. NCCCN shall distribute one hundred percent (100%) of the funds allocated to PMPM payments to primary care providers on a care management performance basis using criteria developed by NCCCN. In developing its pay for performance model, NCCCN shall (i) ensure an adequate statewide network of participating CCNC primary care providers and (ii) adopt a payment level of zero dollars (\$0.00) for providers who do not satisfactorily participate in CCNC care management initiatives. Performance-based payments shall begin on July 1, 2014.

**SECTION 12H.22.(b)** PMPM payments from the Department to CCNC primary care providers shall continue until the implementation of the performance-based payment system.

**SECTION 12H.22.(c)** The Department shall consult with the Joint Legislative Oversight Committee on Health and Human Services on the performance-based payment proposal from NCCCN to incentivize better care management from primary care providers. If the Department submits a report and requests a meeting for the consultation, but the Oversight Committee does not hear the consultation within 90 days of the request, then the consultation requirement shall be deemed waived by the Oversight Committee. The report submitted for consultation shall include the following:

- (1) Measureable elements that will be used to differentiate care management

performance-based payments from the existing PMPM payments.

(2) A comparison of the performance plan to other measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) or other national performance or quality measures.

(3) The specific structure of when payments would be made.

(4) An impact calculation of prospective payments under the performance-based payment plan and the current PMPM rates.

**SECTION 12H.22.(d)** Subsection (a) of this section is contingent upon both of the following:

(1) The Department's successful renegotiation of and modification to the existing contract or entering into a new contract with NCCCN to administer and distribute performance-based payments, as provided in subsection (a) of this section.

(2) The consultation required under subsection (c) of this section or an implied waiver of the consultation requirement, as provided in subsection (c) of this section.