

Recent Medicaid Reform Ideas in N.C.

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Presentation Outline: Reform Ideas From Past Two Years

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- ▶ Statewide managed care
- ▶ Regional managed care
- ▶ Accountable Care Organizations
- ▶ Provider-led full-risk capitated health plans
- ▶ Provider-led and non-provider-led full-risk capitated health plans

Statewide Managed Care

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- ▶ “Whole person” care managed by “threeish” comprehensive care entities covering enrollees statewide
- ▶ Medicaid recipients would each choose their own plan from among the plans
- ▶ Completion no later than July 1, 2018
- ▶ Idea presented in April 2013 through press releases and in draft PCS to HB 398, “Partnership for a Healthy North Carolina”



Detailed Reform Plan Requested by General Assembly

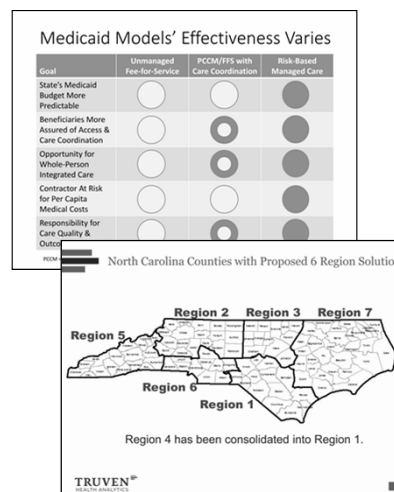
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- ▶ DHHS to work with Medicaid Reform Advisory Group to create detailed Medicaid reform proposal
- ▶ Required goals of reform:
 - ▶ Predictable and sustainable Medicaid program
 - ▶ Increase administrative ease and efficiency for providers
 - ▶ Provide care for the whole person by uniting physical and behavioral health care
- ▶ See Sec. 12H.1 of S.L. 2013-360, enacted July 2014

Regional Managed Care

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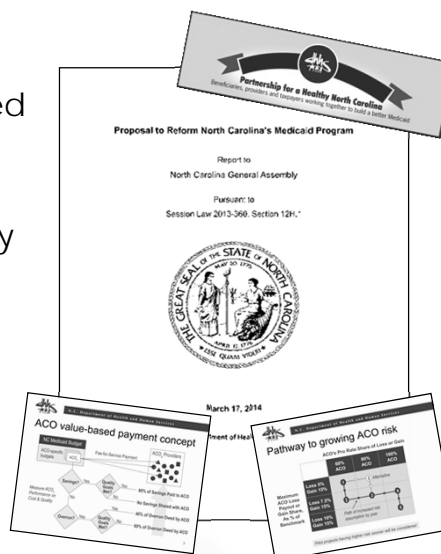
- ▶ Managed care, like in the comprehensive care entities proposal, but delivered through regions rather than statewide contracts
- ▶ Allow for regional differences and greater competition by regional/smaller participants
- ▶ Idea presented as option at December 5, 2013, meeting of Medicaid Reform Advisory Group (never recommended by Group)



Accountable Care Organizations

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- ▶ DHHS's Medicaid Reform Proposal recommended the use of provider-led Accountable Care Organizations (ACOs)
- ▶ Payments based on achieving quality and savings targets
- ▶ Providers share in savings and loss, subject to certain caps (limited risk)
- ▶ Care coordination among physical, behavioral, and long term care



Ideas from House Bill 1181

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- ▶ DHHS-defined Accountable Care Organizations (1st Edition)
- ▶ Provider-led full-risk capitated health plans (House's 3rd Edition)
- ▶ Provider-led and non-provider-led full-risk capitated health plans (Senate's 6th Edition)



HB 1181: High Level Comparison

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	House's Third Edition	Senate's Sixth Edition
Basics of reform	Provider-led full-risk capitated health plans	Provider-led <u>and non-provider-led</u> full-risk capitated health plans
Who conducts reform?	Existing Department of Health and Human Services	New Department of Medical Benefits

HB 1181: More Detailed Comparison

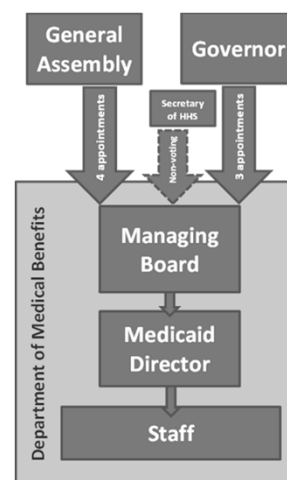
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	House's Third Edition	Senate's Sixth Edition
Basic Goal	"...transform the State's Medicaid program from a traditional fee-for-service system into a system that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need."	Same
Types of Plans	Full-risk capitated health plans	Same
Operators of Plans	Providers	Providers and non-providers
Medicaid Enrollees Covered	"...majority of the Medicaid population..."	"...all Medicaid recipients..."
Risk Implementation for Plans	Full risk by 2020	Full risk in 2016 for non-provider-led plans; 2018 for provider-led plans
Department to Implement Reform	Existing Department of Health and Human Services	New Department of Medical Benefits
Additional Plan Details?	Developed and reported back to General Assembly	Same

Additional Details on Proposed Department of Medical Benefits

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- ▶ Managed by compensated Board, whose duties include:
 - ▶ Administer and operate the Medicaid & Health Choice programs
 - ▶ Hire/fire Medicaid Director
 - ▶ Establish all components of Medicaid program, except for eligibility
 - ▶ Annual five year forecast with expected enrollment growth and reductions to program to keep costs from growing
- ▶ Existing Division of Medical Assistance (DMA) continues to operate program while new Department is set up



Additional Questions?

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