HOUSE HEALTH COMMITTEE

NC Department of Health and Human Services

NC Medicaid Transformation Update

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NC's Transition to Medicaid Managed Care

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service to managed care.

The North Carolina Department of Health and Human Services (DHHS) collaborated with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates and other stakeholders to shape the program based in the following values:

1	**Whole-person care** - through the coordination of services addressing physical health, BH, I/DD, TBI, long-term services and supports (LTSS), pharmacy, and unmet health-related resource needs with the goal of improved health outcomes and more efficient and effective use of resources
2	**Buy health** - Uniting communities, providers and health care systems to address the full set of factors that impact health while deploying cost-effective resources that are needs-based and outcomes driven
3	**Local care management** - Overseeing a transition to provider-based care management at the site of care, in the home or in the community to promote in-person interaction with members
4	**Member experience** - Improving the Medicaid Managed Care member experience with a simple, timely, and user-friendly eligibility and enrollment process focused on high-quality, Culturally and Linguistically Appropriate Services
5	**Provider access** - Maintaining broad provider participation in NC Medicaid by removing or mitigating provider administrative burden from the health delivery system

NC Medicaid Enrollment Options

Phase 1 | Phase 2 | Phase 3

Standard Plan	EBCI Tribal Option	Medicaid Direct	Behavioral Health I/DD Tailored Plan	Child and Family Specialty Plan
Standard Plans will provide integrated physical health, behavioral health, pharmacy, and long-term services and support to most Medicaid beneficiaries, as well as programs and services that address other unmet health related resource needs.	**The Eastern Band of Cherokee Indians (EBCI) Tribal Option** will be available to federally recognized tribal members and their families, as well as IHS eligible beneficiaries for primary care case management and will be managed by the Cherokee Indian Hospital Authority (CIHA).	**Medicaid Direct** provides Medicaid and NCHC benefits through fee-for service (NCTracks), the LME/MCOs (behavioral health/ SUD/I/DD and TBI services operating as a PIHP) and CCNC (primary care case management services) for the Delayed, Excluded, and Exempt Populations.	**Behavioral Health I/DD Tailored Plans** will provide the same services as Standard Plans, as well as additional specialized services for individuals with significant mental health and substance use disorders, I/DDs and traumatic brain injury (TBI Waiver), on the Innovations Waiver, as well as people using state-funded services.	**Child and Family Specialty** will provide the same services as Standard Plans, as well as specialized care management services that aim to address many of the challenges children/youth in the child welfare system face today in receiving seamless, integrated and coordinated health care.

NC Medicaid Managed Care Eligibility

EBCI Tribal Option

- Federally Recognized Tribal members
- Indian Health Services eligible beneficiaries

Medicaid Direct

- Medicare/Medicaid Dual Eligible beneficiaries
- Beneficiaries engaged in the child welfare system (until launch of CFS Plan)
- Beneficiaries in Medically Needy eligibility category
- Beneficiaries enrolled in CAP/C, CAP/DA, PACE or HIPP
- Beneficiaries in an extended nursing facility stay (>90 days) or residing in state operated healthcare facility or Veteran's Home.

Behavioral Health I/DD Tailored Plans

- Beneficiaries meeting Tailored Plan clinical criteria
- Beneficiaries receiving services through the Innovation waiver, TBI waiver or Transition to Community Living

Standard Plans

- All other Medicaid beneficiaries

Enrollment	4,500	328,000	150,000 (estimated)	1,846,000

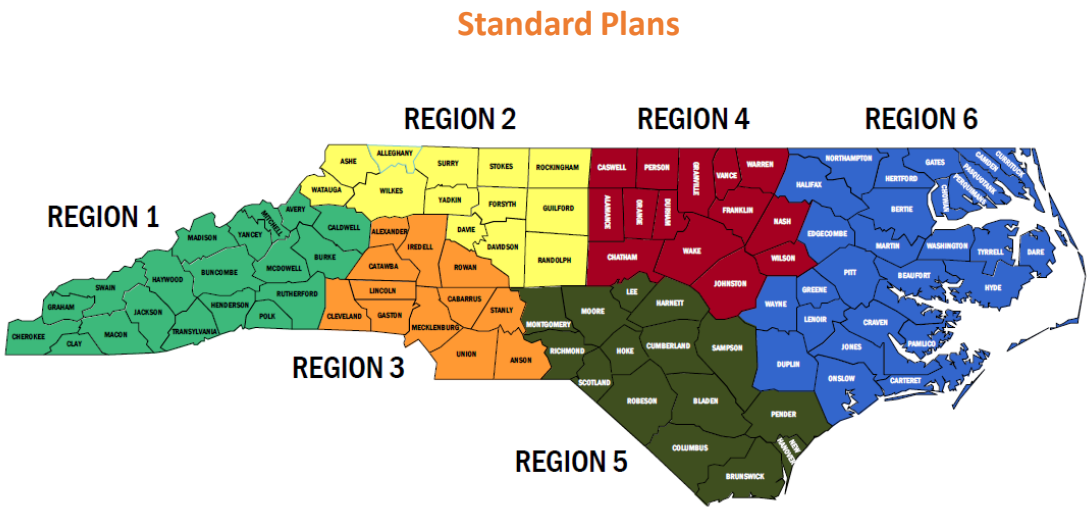
- **These enrollment estimates and eligibility categories do not included beneficiaries with limited benefits (i.e. family planning, COVID testing, incarcerated, partial duals, refugees, presumptive eligible)**

Managing Costs

- **Fee-for-service: DHHS reimburses physicians and health care providers directly based on the number of services provided or the number of procedures ordered.**
- **Managed Care: DHHS contracts with health plans who are paid a capitated rate, which is a pre-determined set rate per person to provide health care services.**
  - **Standard Plans are held to a minimum medical loss ratio (MLR) of eighty-eight percent (88%), meaning they must spend more than 88% of their capitation payments (less taxes) on health care services and quality improvement activities**
  - **All five Standard Plans were over the 88% minimum MLR in the first year of managed care**

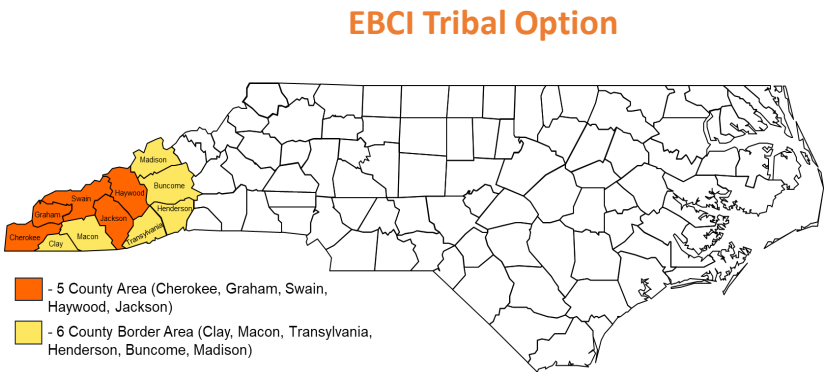
Standard Plans

- **Standard Plans** provide integrated physical health, behavioral health, pharmacy, and long-term services and support to most Medicaid beneficiaries
- **The following health plans are available in all regions:**
  - AmeriHealth Caritas of North Carolina
  - Healthy Blue
  - UnitedHealthcare Community Plan
  - WellCare
- Carolina Complete Health (A Provider Led Entity) is only available in Regions 3, 4 and 5.
- **Over 1.8 million Medicaid beneficiaries are enrolled in Standard Plans.**



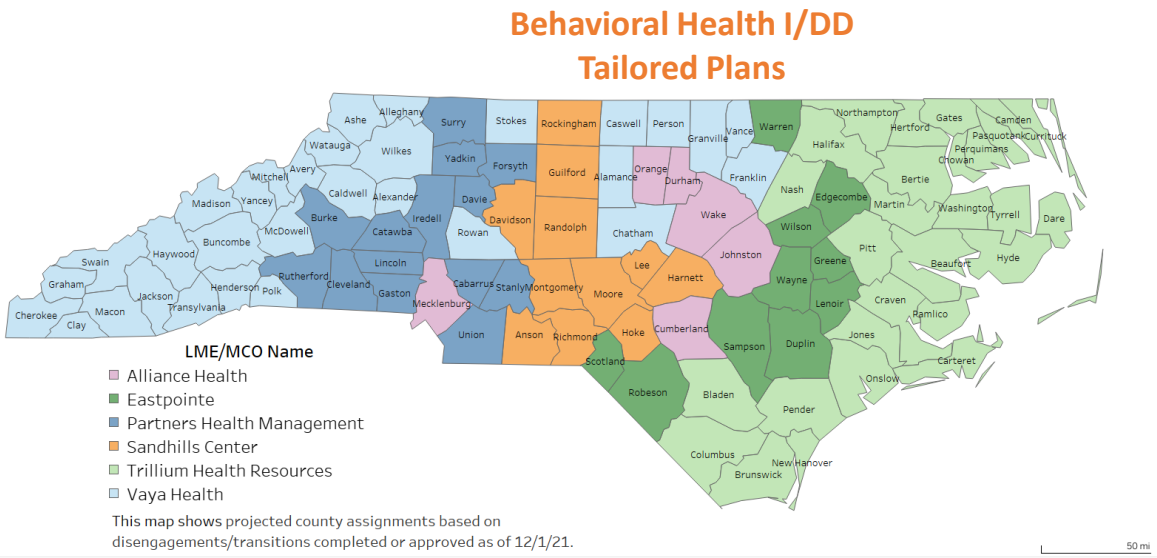
EBCI Tribal Option

- **The Eastern Band of Cherokee Indians (EBCI) Tribal Option is a Primary Care Case Management (PCCM) Entity** managed by the Cherokee Indian Hospital Authority (CIHA) to meet the primary care coordination needs of federally recognized tribal members and others eligible for services through Indian Health Service (IHS)
  - Only IHS-eligible beneficiaries associated with the EBCI can participate in this health care option
- **The EBCI Tribal Option is primarily offered in five counties:** Cherokee, Graham, Haywood, Jackson, and Swain
  - Eligible beneficiaries in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison, and Transylvania
- A Primary Care Case Management (PCCM) Entity responsible for managing the healthcare for the State's nearly **4,500 Tribal eligible Medicaid beneficiaries.**



Behavioral Health I/DD Tailored Plans

- **Tailored Plans** will provide the same services as Standard Plans, as well as additional specialized services for individuals with significant mental health and substance use disorders, I/DDs and traumatic brain injury (TBI Waiver), on the Innovations Waiver, as well as people using state-funded services.
- **The following regional health plans are available:**
  - Alliance Health
  - Eastpointe
  - Partners Health Management
  - Sandhills Center
  - Trillium Health Resources
  - Vaya Health
- Approximately **150,000 Medicaid** beneficiaries are expected to be enrolled in Tailored Plans when they launch



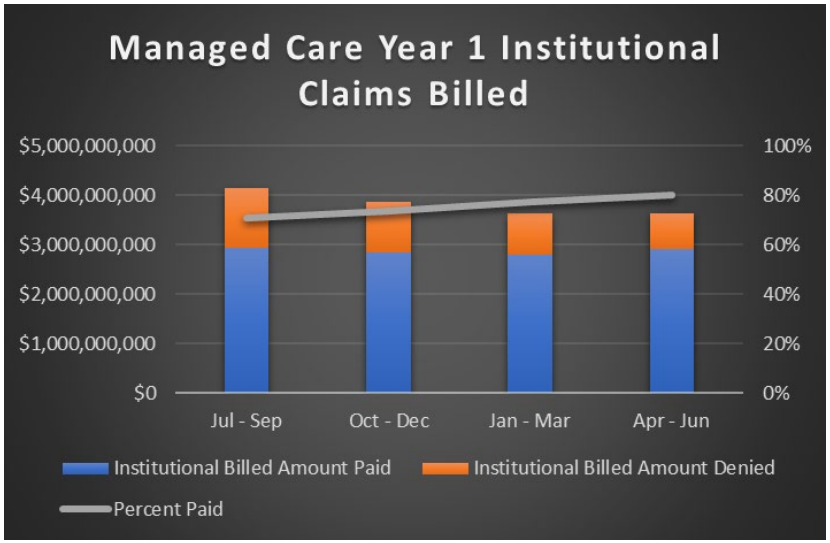
Early Successes

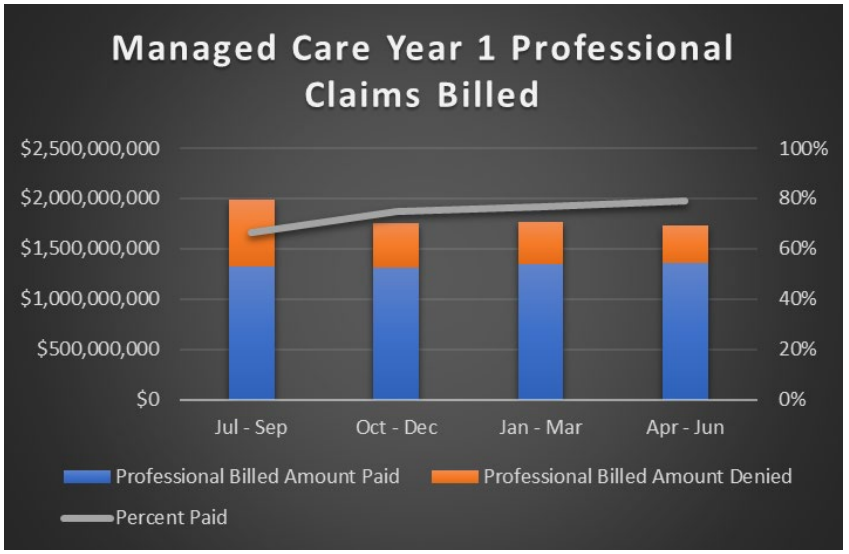
- At go-live, 97% Medicaid beneficiaries eligible for standard plans kept their primary care provider (PCP).
- Provider survey suggests increased access to behavioral health providers
- Since March 2022, Healthy Opportunities Pilots have provided over 36,000 services to Medicaid members

Challenges to Date

- **NEMT - Network adequacy challenges leading to beneficiaries having to postpone or reschedule treatment**
- **Skilled Nursing Facility admissions - Delayed determination of long-term care financial eligibility**
- **Claims processing – concerns regarding denial rates, timely payment & administrative burden**

Claim Payment Metrics





- **More than 70 million claims have been processed since the launch of Medicaid Managed Care**
- **DHHS Maintains a PHP Claims payment dashboard updated monthly (https://medicaid.ncdhhs.gov/reports/dashboards)**

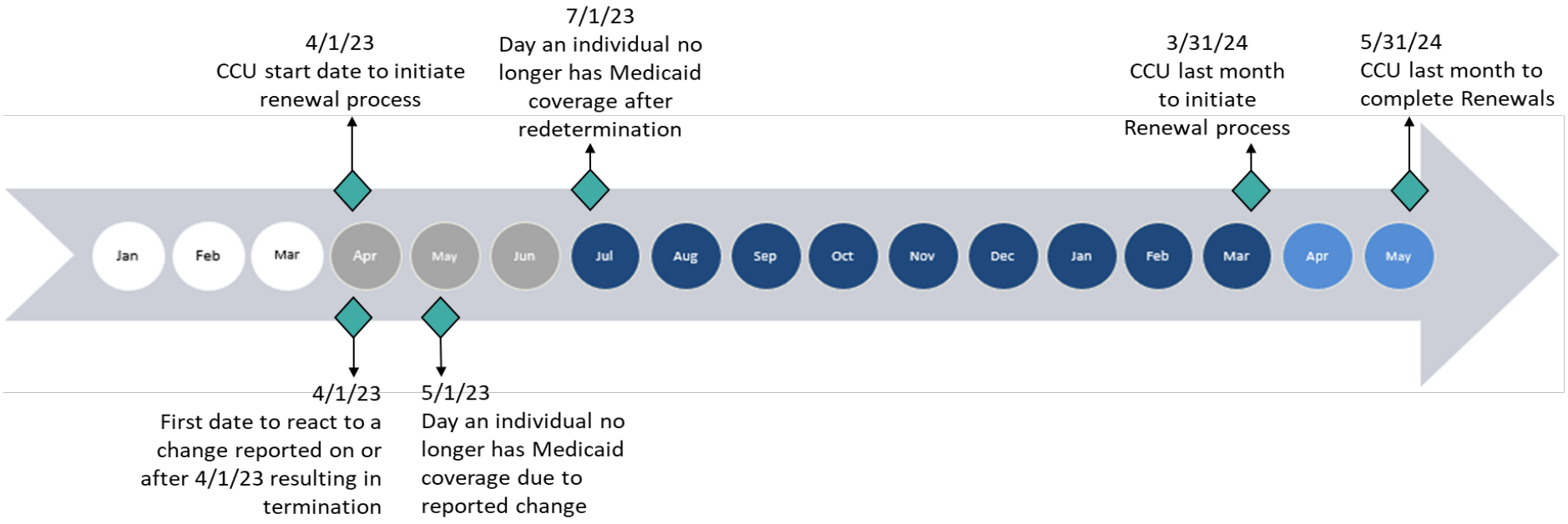
DHHS Claim Payment Actions

- Resolution of over 5K provider ombudsman cases (less than .01% of claims have resulted in help center cases)
- Enhancements to support providers in billing and claim disputes
- Added new billing requirements on PHPs to reduce provider administrative burden
- Extended prior authorization transition of care flexibilities after go-live
- Convened an ongoing, monthly clinical series with medical leadership from NCHA, health plans and DHB, to identify areas where our collaboration can improve health
- Claim audits of PHPs planned

Medicaid Continuous Coverage Unwinding

- **The 2023 Consolidated Appropriations Act (Omnibus Bill) decoupled the continuous coverage requirement from the Federal COVID-19 Public Health Emergency.**
- **This allows states to begin termination as early as 4/1/23. Due to the 90-day renewal process in NC, the first termination will be effective 7/1/23.**
- **States have 12 months to initiate renewals and 14 months to complete renewals.**

Continuous Coverage Unwinding (CCU) timeline



Improved Automation and Electronic Source Verification

The following verification sources are used in the NC FAST eligibility system to automatically verify attested information (e.g., citizenship, social security number, income). An Asset Verification System (AVS) is also used to verify resources.

System notifications from PARIS (Federal/VA benefits match) and DPH (date of death) are also used to update existing cases in NC FAST.

Planning for Potential Medicaid Expansion

- **Once fully implemented, expansion would ensure access to affordable health coverage for about 600,000 North Carolinians**
- **More than 400,000 of these beneficiaries are already in our system**
- **If Medicaid expansion were to launch by July 1, more than 100,000 beneficiaries who would lose coverage through the continuous coverage unwinding would retain coverage**

Support for Counties

- March refresher training on redeterminations
- Upcoming technology improvements:
  - Beginning in April, if a beneficiary is determined eligible for the same benefit level, based on electronic matches, they can be redetermined without a county worker touching the case
  - Automating NCFAST to use FNS income if it is more recent to determine Medicaid eligibility
  - Increased automation for new applications if a beneficiary is determined eligible, based on electronic matches

Ongoing Support for DSS

- **The Department continues to explore ways to support local DSSs with the increased workload as continuous coverage unwinds, such as:**
  1. **A centralized call center that can handle eligibility-related questions and changes to information (such as address). Would reduce the call volumes at the local DSS.**
  2. **Funding to support staffing. Could allow counties to increase wages to attract candidates or hire temporary staff to help with administrative tasks.**
  3. **Becoming a Federally Facilitated Marketplace (FFM) Determination state. This would prevent caseworkers from having to process applications that are submitted on Healthcare.gov – the eligibility determination would have been made at the FFM.**