2017-2018

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

MINUTES

JT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE
2017-2018 Session

CHAIRS

Representative Nelson Dollar
Representative Donny Lambeth
Senator Ralph Hise

COMMITTEE ASSISTANTS

Candace Slate
Pan Briles
Susan Fanning

JT.OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

2017-2018 SESSION

Committee Clerks: Susan Fanning, Candace Slate, Pan Briles

Sen. Ralph Hise
Co-Chair

Rep. Nelson Dollar
Co-Chair

Rep. Donny Lambeth
Co-Chair

Rep. William Brisson
Member

Rep. Josh Dobson
Member

Rep. Verla Insko
Member

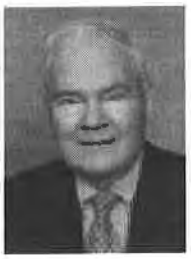
Rep. Bert Jones
Member

Rep. Greg Murphy
Member

Sen. Don Bishop
Member

Sen. Valerie Foushee
Member

Sen. Krawiec
Member



Sen. Louis Pate
Member

Sen. Gladys Robinson
Member

Sen. Tommy Tucker
Member

Sen. Angela Bryant
Advisory

Rep. Chris Malone
Advisory

Rep. Rodney Moore
Advisory

Rep. Beverly Earle
Advisory

Joint Legislative Oversight Committee on Medicaid and NC Health Choice
Members and Staff
2017

Member	LA	Room/Office	Phone
Sen. Hise, Co-Chair	Susan Fanning	312 LOB	733-3460
Rep. Lambeth, Co-Chair	Pan Briles	303 LOB	733-5747
Rep. Dollar, Co-Chair	Candace Slate	307 LOB	715-0795
Sen. Bishop	David Larson	2108 LB	733-5655
Sen. Foushee	James Spivey	517 LOB	733-5804
Sen. Krawiec	Brian Mooney	308 LOB	733-7850
Sen. Pate	Spencer Goodson	311 LOB	733-5621
Sen. Robinson	Phyllis Cameron	1120 LB	733-3042
Sen. Tucker	Joey Stansbury	300 LOB	733-7659
Rep. Brisson	Caroline Stirling	405 LOB	733-5772
Rep. Dobson	Julie Ryan	301N LOB	733-5862
Rep. Insko	Gina Insko	502 LOB	733-7208
Rep. Jones	Brenda Olls	416A LOB	733-5779
Rep. Murphy, MD	Anne Smith	632 LOB	733-5757
Advisory	**LA**	**Room/Office**	**Phone**
Sen. Bryant (Advisory)	Jacqueta Rascoe	516 LOB	733-5878
Rep. Malone (Advisory)	Ben Malone	1229 LB	715-3010
Rep. Moore (Advisory)	Charmey Morgan	402 LOB	733-5606
Rep. Beverly Earle (Advisory)	Ann Raeford	514LOB	715-2530
Staff	**Division**	**Room/Office**	**Phone**
Jennifer Hillman	Legislative Analysis	545 LOB	733-2578
Theresa Matula	Legislative Analysis	545 LOB	733-2578
Jason Moran-Bates	Legislative Analysis	545 LOB	733-2578
Steve Owen	Fiscal Research	619 LOB	733-4910
Denise Thomas	Fiscal Research	619 LOB	733-4910
Deborah Landry	Fiscal Research	619 LOB	733-4910
Amy Jo Johnson	Bill Drafting	401 LOB	733-6660
Leah Burns	Speaker Moore's Office	2305 LB	733-3451
Kolt Ulm	President Pro Tem's Office	300B LOB	301-1783
Committee Assistants			
Susan Fanning	Senator Hise	312 LOB	733-3460
Candace Slate	Representative Dollar	307B LOB	715-0795
Pan Briles	Representative Lambeth	303 LOB	733-5747

2017 ATTENDANCE

Joint Legislative Oversight Committee – Medicaid and NC Health Choice

MEMBERS	10/9/17					
Rep. Nelson Dollar, Co-Chair	✓					
Rep. Donny Lambeth, Co-Chair	✓					
Sen. Ralph Hise, Co-Chair	✓					
Rep. William Brisson	✓					
Rep. Josh Dobson	✓					
Rep. Verla Insko	✓					
Rep. Bert Jones	X					
Rep. Gregory Murphy, MD	X					
Sen. Dan Bishop	✓					
Sen. Valerie Foushee	✓					
Sen. Joyce Krawiec	✓					
Sen. Sen. Louis Pate	✓					
Sen. Gladys Robinson	✓					
Sen. Tommy Tucker	✓					
Advisory Member						
Rep. Chris Malone	X					
Rep. Rodney Moore	X					
Rep. Beverly Earle	X					
Sen. Angela Bryant	✓					
Committee Staff						
Jennifer Hillman, Legislative Analysis Division						
Theresa Matula, Legislative Analysis Division						
~~Jason Moran-Bates,~~ Legislative Analysis Division						
Steve Owen, Fiscal Research Division						
Denise Thomas, Fiscal Research Division						
Deborah Landry, Fiscal Research Division						
Amy Jo Johnson, Bill Drafting Division						

10.09.17

2017-18 ATTENDANCE

Joint Legislative Oversight Committee – Medicaid and NC Health Choice

MEMBERS	3-13-18					
Rep. Nelson Dollar, Co-Chair	✓					
Rep. Donny Lambeth, Co-Chair	✓					
Sen. Ralph Hise, Co-Chair						
Rep. William Brisson	✓					
Rep. Josh Dobson	✓					
Rep. Verla Insko	✓					
Rep. Bert Jones						
Rep. Gregory Murphy, MD	✓					
Sen. Dan Bishop						
Sen. Valerie Foushee	✓					
Sen. Joyce Krawiec	✓					
Sen. Sen. Louis Pate	✓					
Sen. Gladys Robinson						
Sen. Tommy Tucker	✓					
Advisory Member						
Rep. Chris Malone						
Rep. Rodney Moore						
Rep. Beverly Earle						
Sen. Angela Bryant	✓					
Committee Staff						
Jennifer Hillman, Legislative Analysis Division						
Theresa Matula, Legislative Analysis Division						
Jason Moran-Bates, Legislative Analysis Division						
Steve Owen, Fiscal Research Division						
Denise Thomas, Fiscal Research Division						
Deborah Landry, Fiscal Research Division						
Amy Jo Johnson, Bill Drafting Division						

2017-18 ATTENDANCE

Joint Legislative Oversight Committee – Medicaid and NC Health Choice

MEMBERS	4-10-18					
Rep. Nelson Dollar, Co-Chair	✓					
Rep. Donny Lambeth, Co-Chair	✓					
Sen. Ralph Hise, Co-Chair	A					
Rep. William Brisson	A					
Rep. Josh Dobson	✓					
Rep. Verla Insko	✓					
Rep. Bert Jones	A					
Rep. Gregory Murphy, MD	✓					
Sen. Dan Bishop	✓					
Sen. Valerie Foushee						
Sen. Joyce Krawiec	✓					
Sen. Sen. Louis Pate	✓					
Sen. Gladys Robinson						
Sen. Tommy Tucker	✓					
Advisory Member						
Rep. Chris Malone	A					
Rep. Rodney Moore	✓					
Rep. Beverly Earle	A					
~~Sen. Angela Bryant~~						
Committee Staff						
Jennifer Hillman, Legislative Analysis Division						
Theresa Matula, Legislative Analysis Division						
Jason Moran-Bates, Legislative Analysis Division						
Steve Owen, Fiscal Research Division						
Denise Thomas, Fiscal Research Division						
Deborah Landry, Fiscal Research Division						
Amy Jo Johnson, Bill Drafting Division						

2017 ATTENDANCE

Joint Legislative Oversight Committee – Medicaid and NC Health Choice

MEMBERS	10-10-17					
Rep. Nelson Dollar, Co-Chair	X					
Rep. Donny Lambeth, Co-Chair	X					
Sen. Ralph Hise, Co-Chair						
Rep. William Brisson	X					
Rep. Josh Dobson	X					
Rep. Verla Insko	X					
Rep. Bert Jones						
Rep. Gregory Murphy, MD						
Sen. Dan Bishop	X					
Sen. Valerie Foushee						
Sen. Joyce Krawiec	X					
Sen. Sen. Louis Pate	X					
Sen. Gladys Robinson						
Sen. Tommy Tucker	X					
Advisory Member						
Rep. Chris Malone	X					
Rep. Rodney Moore	X					
Rep. Beverly Earle	X					
Sen. Angela Bryant						
Committee Staff						
Jennifer Hillman, Legislative Analysis Division	X					
Theresa Matula, Legislative Analysis Division	X					
Jason Moran-Bates, Legislative Analysis Division	X					
Steve Owen, Fiscal Research Division						
Denise Thomas, Fiscal Research Division	X					
Deborah Landry, Fiscal Research Division	X					
Amy Jo Johnson, Bill Drafting Division						

2017 ATTENDANCE

Joint Legislative Oversight Committee – Medicaid and NC Health Choice

MEMBERS	11-14-17					
Rep. Nelson Dollar, Co-Chair	✓					
Rep. Donny Lambeth, Co-Chair	✓					
Sen. Ralph Hise, Co-Chair	✓					
Rep. William Brisson	✓					
Rep. Josh Dobson	✓					
Rep. Verla Insko	✓					
Rep. Bert Jones	A					
Rep. Gregory Murphy, MD	✓					
Sen. Dan Bishop	A					
Sen. Valerie Foushee	✓					
Sen. Joyce Krawiec	✓					
Sen. Sen. Louis Pate	✓					
Sen. Gladys Robinson	A					
Sen. Tommy Tucker	A					
Advisory Member	✓					
Rep. Chris Malone	✓					
Rep. Rodney Moore	✓					
Rep. Beverly Earle	✓					
Sen. Angela Bryant	A					
Committee Staff						
Jennifer Hillman, Legislative Analysis Division	✓					
Theresa Matula, Legislative Analysis Division						
Jason Moran-Bates, Legislative Analysis Division	✓					
Steve Owen, Fiscal Research Division	✓					
Denise Thomas, Fiscal Research Division						
Deborah Landry, Fiscal Research Division	✓					
Amy Jo Johnson, Bill Drafting Division	✓					

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

September 25, 2017

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Medicaid and NC Health Choice
FROM: Rep. Donny C. Lambeth, Co-Chair
Rep. Joseph Nelson Dollar, Co-Chair
Sen. Ralph E. Hise, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Medicaid and NC Health Choice** will meet at the following time:

DAY	DATE	TIME	LOCATION
Tuesday	October 10, 2017	1:00 PM	643 LOB

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Candace Slate at dollarla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

October 10, 2017 1:00 p.m.
Legislative Office Building - Room 643

I.	**Welcome & Opening Remarks**	Representative Nelson Dollar Presiding Co-Chair
II.	**Remarks from Department of Health and Human Services (DHHS) Secretary**	Mandy Cohen, Secretary, Department of Health and Human Services (DHHS)
III.	**Medicaid and NC Health Choice Enrollment**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS
IV.	**Medicaid and NC Health Choice Financial Update**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS
V.	**Status of 1115 Waiver and Work Plan for Medicaid Transformation**	Mandy Cohen, Secretary, DHHS Dave Richard, Deputy Secretary for Medical Assistance, DHHS Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS
VI.	**Appointment of Joint Health and Human Services and Medicaid Oversight Committees' Behavioral Health Services Subcommittee** (Sec. 12F.10, S.L. 2016-94)	Jennifer Hillman, Committee Staff, Legislative Analysis Division, NCGA
	Adjourn	

Article 23B.

Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except that initial appointments begin on the date of appointment. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment. (2015-245, s. 15.)

§ 120-209.1. Purpose and powers of Committee.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services.

(b) The Committee may make periodic reports, including recommendations, to a regular session of the General Assembly on issues related to Medicaid and NC Health Choice programs. (2015-245, s. 15.)

§ 120-209.2. Organization of Committee.

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge. (2015-245, s. 15.)

§ 120-209.3. Additional powers.

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice, while in discharge of official duties, shall have access to any paper or document and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly. (2015-245, s. 15.)

§ 120-209.4. Reports to Committee.

Whenever the Department of Health and Human Services, or any division within the Department, is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters relating to the Medicaid and NC Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. (2015-245, s. 15.)

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
MEDICAID & HEALTH CHOICE

Tuesday, October 10, 2017
1:00 p.m.
Legislative Office Building, Room 643

ATTENDEES:
Chairmen: Dollar, Lambeth

House Members: Brisson, Dobson, Insko, Malone, Moore, Earle
Senate Members: Bishop, Krawiec, Pate, Tucker

I. Welcome and Opening Remarks

Chairman Nelson Dollar presided and called the meeting to order at 1:20 p.m.

Chairman Dollar introduced Sergeant-at-Arms Staff assisting with the meeting and committee staff members.

II. Medicaid and NC Health Choice

North Carolina Secretary of Health and Human Services, Mandy Cohen, began by stating that North Carolina is the largest state in the nation that has not transitioned to managed care. North Carolina's proposed Managed Care Program design is based upon best practices from other states and builds upon the existing infrastructure in North Carolina. The end result is a program that is founded upon advanced high value care, improves health and supports providers while, at the same time, builds a sustainable program that focuses on the health of the whole person. The timeline for Phase I began May 2017 and is scheduled to *GoLive* during July 2019.

Secretary Cohen informed the committee that Congress allowed CHIP (Children's Health Insurance Program) coverage to lapse on September 30, 2017. She stated that North Carolina has sufficient funding to continue coverage through February 2018. In order to continue serving these North Carolina working families, Congress must reauthorize CHIP. More than two-hundred thousand North Carolina children are covered through CHIP and more than $450 million is paid for health care services to North Carolina's children each year.

According to Roger Barnes, CFO Medical Assistance Division, the reprocussions of this lapse in coverage equates to a disruption of one-hundred thousand children no longer having insurance coverage through the CHIP program.

III. Medicaid and NC Health Choice Enrollment

Dave Richard, Deputy Secretary for Medical Assistance, shared with the committee a chart depicting the forecast versus actual Medicaid enrollment figures over a four-year period beginning July 2014 through May 2018. A chart showing Medicaid enrollment broken down by county and program aid category was also provided to committee members.

IV. Medicaid and NC Health Choice Financial Update

Roger Barnes, Chief Finance Officer with the Department of Medical Assistance, provided SFY 2017 actual revenue distributions and a projected SFY 2018 budget. Through August 2017, Mr. Barnes reported that total Medicaid expenditures were $42.5 million or -1.9% favorable to the authorized budget.

Chairman Lambeth expressed concern regarding the high cost of pharmaceuticals, especially those prescribed for chronic conditions.

Dave Richard responded that medical doctors would be involved in the process of decision-making regarding generic drugs.

V. Status of 1115 Waiver and Work Plan for Medicaid Transformation.

Secretary Cohen introduced the agenda item stating that elements of the proposal need additional statutory authority from the General Assembly. The desired outcome is to build upon and maintain current infrastructure to promote quality, value and population health. A single set of quality measures would assess performance and drive progress. The North Carolina Institute of Medicine would comprise a taskforce charged with measure development.

Mr. Richard stated that appropriateness of care and incentives for prepaid health plans would be the framework for developing a value-based payment system. In the managed care arena, staff would look at what is working well today and factor in options for advanced medical homes and data analytics capabilities in the decision-making process.

According to Mr. Richard, support to providers in the way of education and training at regional centers lessens stress and offers support. Additionally, it centralizes the credentialing process, unifies policies, allows for a single electronic application and streamlines contract negotiations. This partnership ensures transparent and fair payments to providers, supports workforce initiatives, provides new tools to combat the Opioid crisis and supports telehealth initiatives.

A primary, desired outcome is *whole person care,* that is built upon best practices from across the country as well as what is already working in North Caroina's behavioral health system. A more streamlined service model that combines both physical and behavioral health needs was also discussed.

Jay Ludlam, Assistant Seretary for Medicaid Transformation, discussed with the committee proposed oversight of the plans. He stated that the department had looked at successful plans and that vendor accountability is key. In addition to being good stewards of the State resources, strong contract language will be required.

Mr. Richard reviewed legislative changes that are needed in order to run a successful Medicaid Program:

- Behavioral health integration and tailored plans
- Phased implementation plan
- Efficient benefit administration for family planning and inmates
- Supplemental payments
- Insurance regulation

VI. Appointment of Joint Health and Human Services and Medicaid Oversight Committees' Behavioral Health Services Subcommittee (Sec. 12F.10, S.L. 2016-94)
Chairman Dollar announced the following subcommittee appointments:

Behavioral Health Subcommittee

Senator Ralph Hise, Cochair	Representative Nelson Dollar, Cochair
Senator Valerie Foushee	Representative Verla Insko
Senator Joyce Krawiec	Representatve Gregory F. Murphy, MD

VII. Adjournment
The Joint Legislative Oversight Committee on Medicaid and NC Health Choice adjourned at 3:30 p.m.

Representative Nelson Dollar, Chair

Panthea Briles, Committee Clerk

Attachments: Agenda
Handouts (3)

JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid and NC Health Choice

Mandy Cohen
Secretary, Department of Health and Human Services

Oct. 10, 2017

Proposed Managed Care Program Design

- Based on best practices from other states and building on the existing infrastructure in NC
- Vision: Advance high value care; Improve health; Support providers; Build a sustainable program
- Key themes:
  - Focus on health of the whole person
  - Improve health and well-being of North Carolinians
  - Support providers in delivering high-quality care at good value
- Elements of the proposal need additional statutory authority from the GA

Transformation Timing

- May 2017 – Request for Public Input & listening sessions
- August 2017 – Proposed Program Design
- September 2017 – Kickoff meeting with CMS leadership
- **Fall 2017 – Requests for Information**
- **Fall 2017 –Waiver Amendment Submission**
- ***Spring 2018 – Waiver Amendment Approval****
- ***Spring 2018 – RFP Release****
- ***Fall 2018 – Contract Awardees Selected****
- ***July 2019 –Phase 1 Go-Live****

Children's Health Insurance Program (CHIP)

- Sept. 30, 2017: Congress allowed CHIP authorization to lapse
- North Carolina funding sufficient for now
- Congress must reauthorize CHIP to continue serving NC working families

CHIP IN NORTH CAROLINA

- **Covers children in families with income up to 211% of the federal poverty level or $52,000 for a family of 4**
- **More than 200,000 NC children covered through CHIP**
- **More than 90% of eligible NC children are enrolled**
- **More than $450M in health care services to NC children each year**

JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

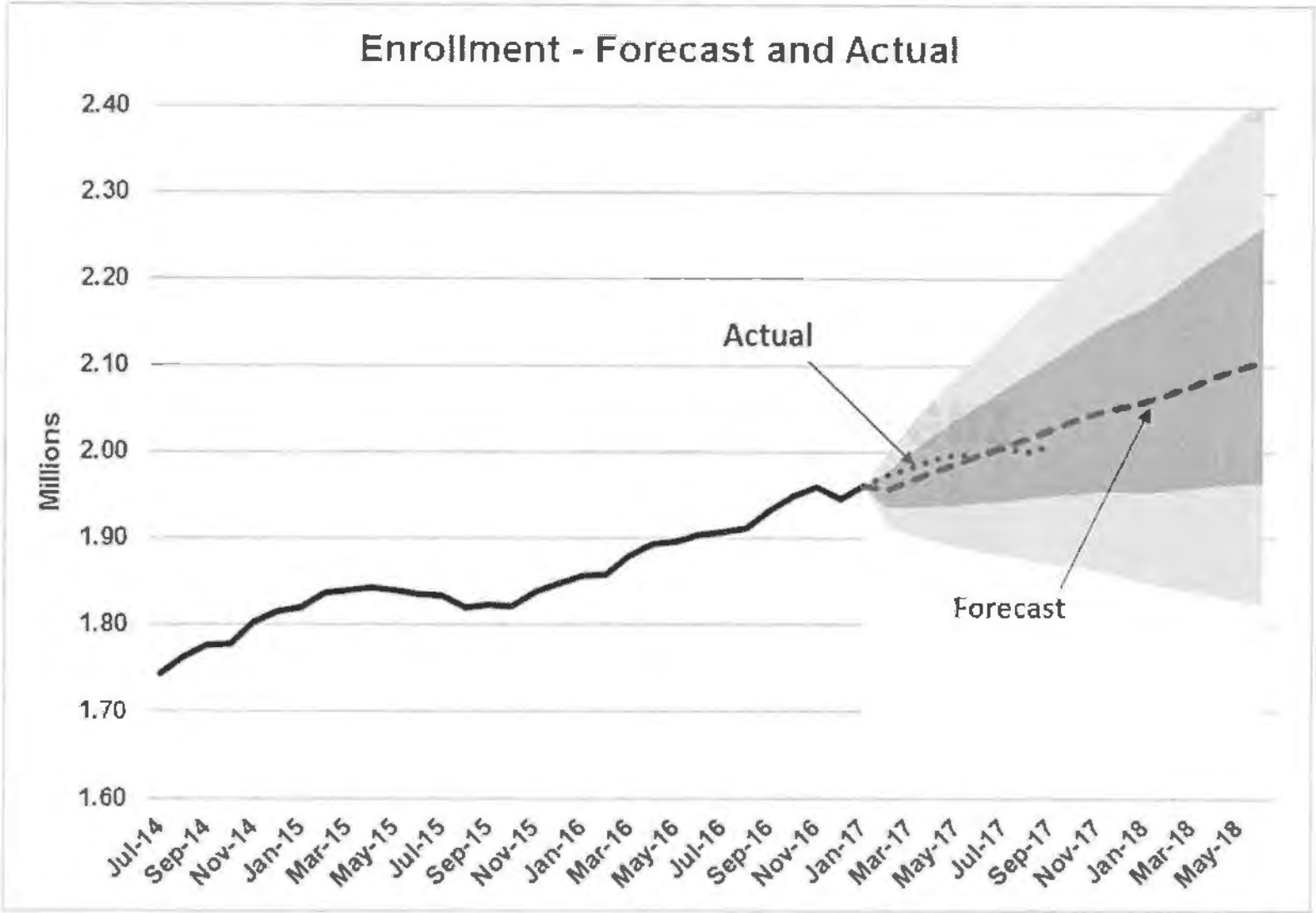
Medicaid Enrollment

Dave Richard
Deputy Secretary for Medical Assistance

Oct. 10, 2017

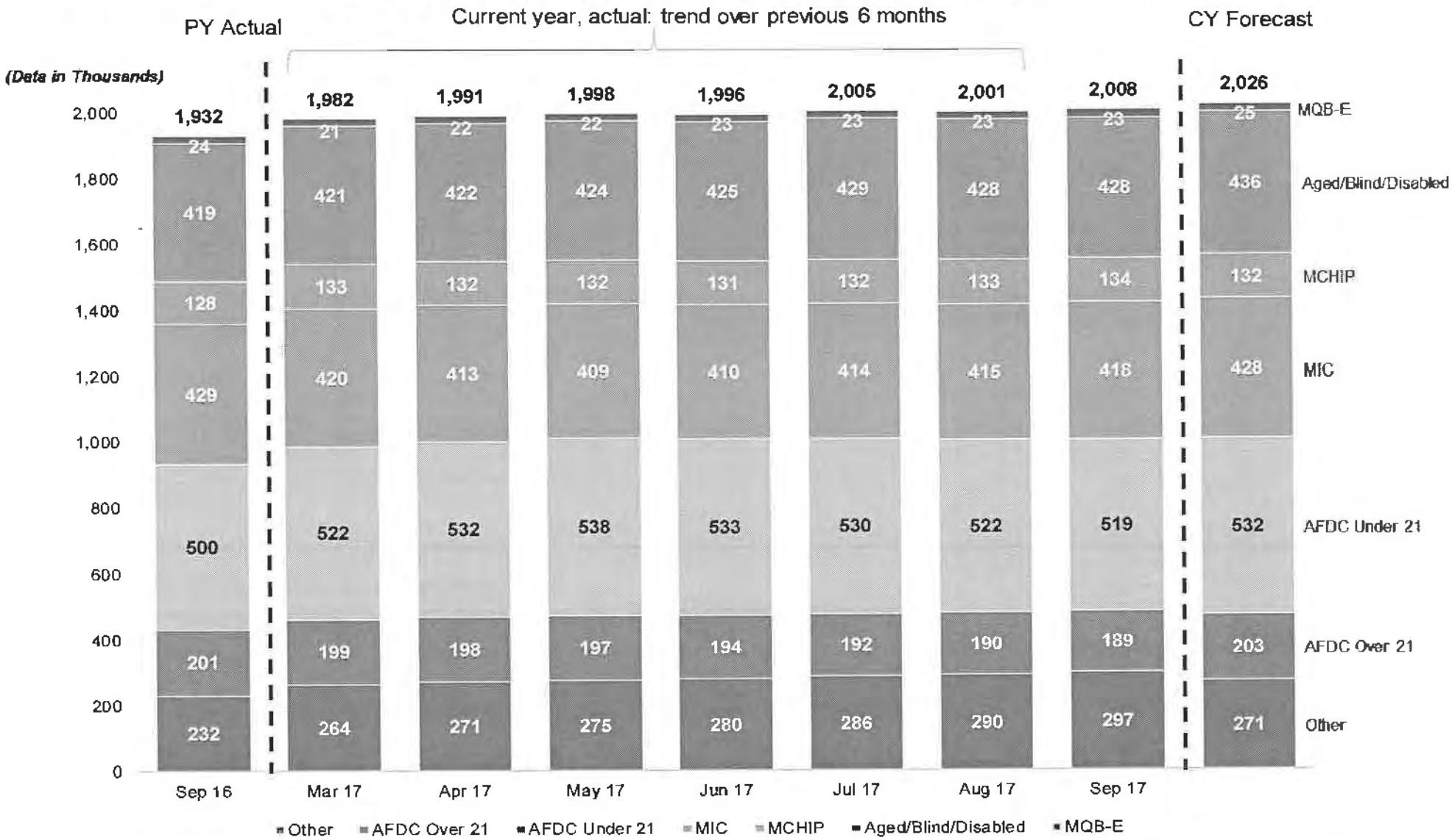
Medicaid Enrollment – Forecast vs. Actual

Medicaid enrollment has tracked roughly in line with DMA's expectations to date



Medicaid Enrollment by Program Aid Category

Enrollment year-over-year is 4% higher – Sept. 2017: 2.008M; Sept. 2016: 1.932M



Enrollment Dashboards – DMA Website

Home | Contact | Medicaid | Get Involved | Find A Doctor | Providers | Documents | Reports

North Carolina Medicaid and Health Choice Enrollment

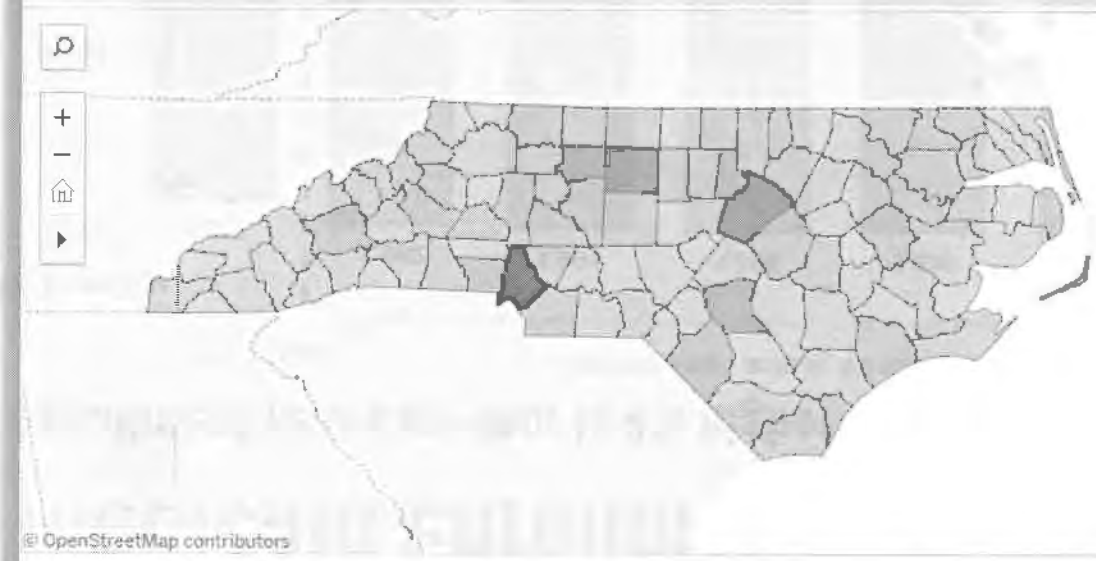
By County and Program Aid Category (PAC)

Navigation Guide:
Click on a county on the map to see that county's PAC enrollment in table.
Click on county again to clear the selection.
Select a PAC in the table to see distribution on state map and county rankings.
Click on PAC again to clear selection.

Select Date: September - 2017

Select Plan: (All)

County Enrollment - * PAC
September - 2017



976 — 210,949

PAC Enrollment - All
September - 2017

	Enrollment	% of Total
TANF (AFDC) 20 and Under	519,223	24.7%
Infants And Children	418,302	19.9%
Disabled	300,312	14.3%
Family Planning	201,183	9.6%
TANF (AFDC) 21 And Over	188,639	9.0%
MCHIP	133,862	6.4%
Aged	126,178	6.0%
MQBB	41,914	2.0%
MQBE	23,495	1.1%
Documented Aliens	19,781	0.9%
Pregnant Women	18,935	0.9%
MQBQ	8,145	0.4%
Other Child	6,138	0.3%
Blind	1,648	0.1%
BCC	450	0.0%
Refugees	247	0.0%
Undocumented Aliens	86	0.0%
Total	2,008,538	95.6%
Chip	92,500	4.4%
Chip Extended Coverage		
Total	92,500	4.4%
Grand Total	2,101,038	100.0%

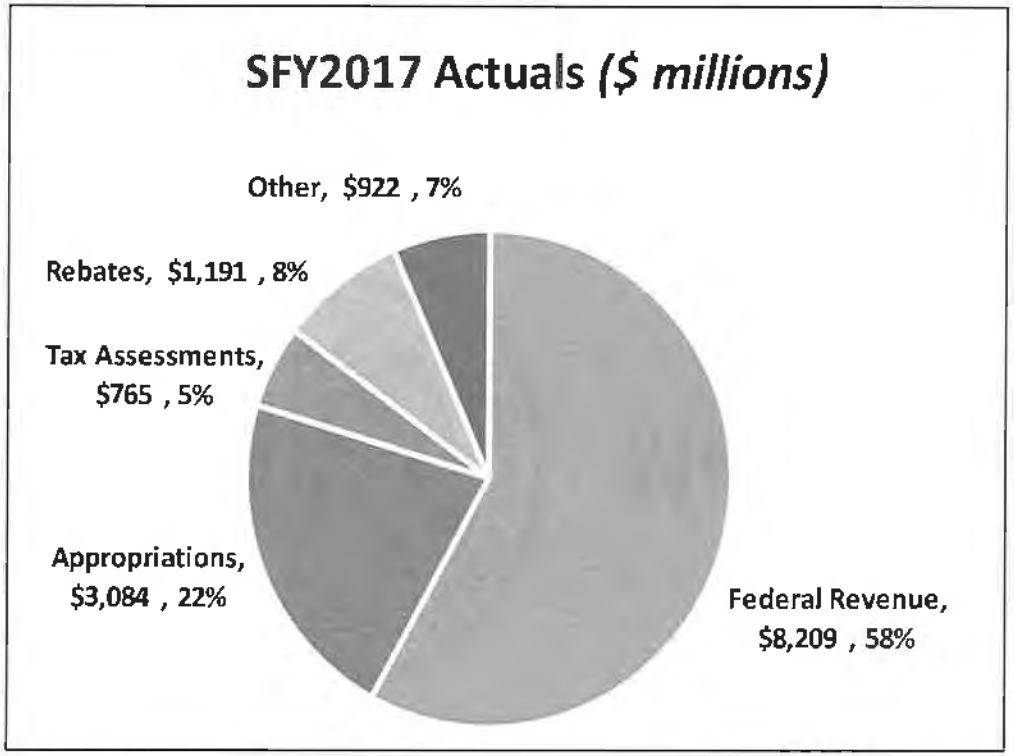
JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

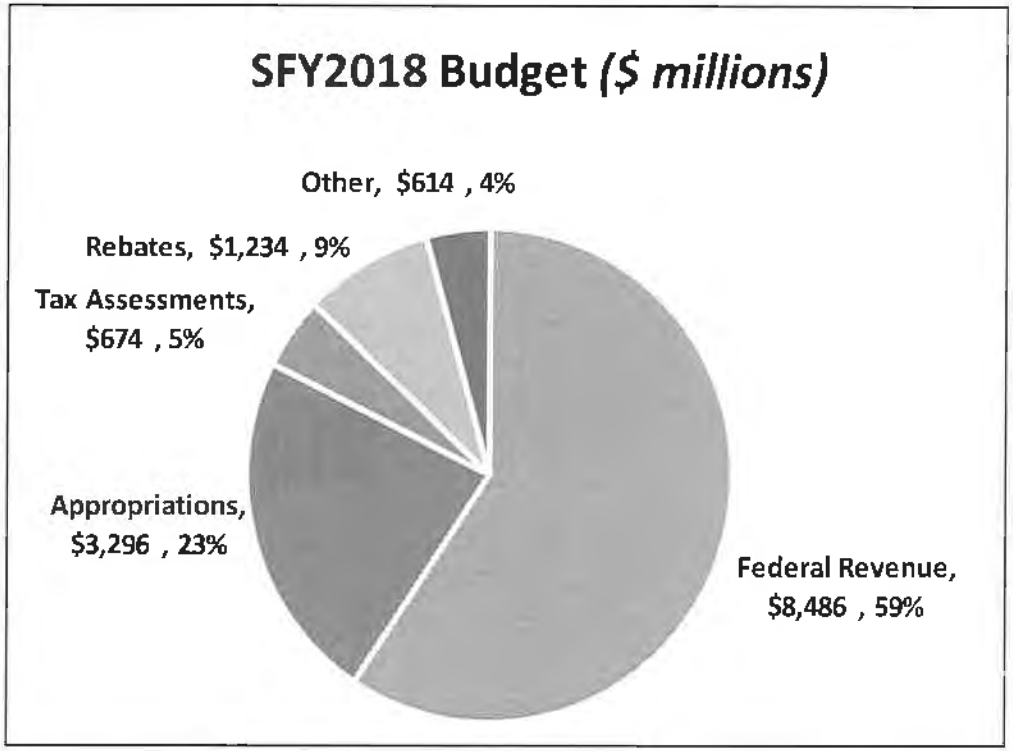
Medicaid Financing

Dave Richard
Deputy Secretary for Medical Assistance

Oct. 10, 2017

Medicaid Revenue Distribution





Medicaid SFY18 Actuals vs. Budget

Through August 2017, total Medicaid expenditures were $42.5M or 1.9% favorable to authorized budget

($ millions)

Fund Description	SFY2018B YTD	SFY2018A YTD	Variance (vs. Budget)	Variance %
Hospital[1]	$ 347.0	$ 364.0	$ 17.0	4.9%
Skilled Nursing Facilities	231.3	228.5	(2.8)	-1.2%
Physician	195.0	187.5	(7.5)	-3.9%
Pharmacy[3]	289.1	280.0	(9.0)	-3.1%
Other Claims	421.3	438.4	17.2	4.1%
Total Fee-For-Service Claims Exp.	**$ 1,483.6**	**$ 1,498.4**	**$ 14.8**	**1.0%**
Consolidated Supp. Hospital Payments	53.2	26.1	(27.1)	-50.9%
Cost Settlements	23.1	23.2	0.2	0.8%
Capitation, Premiums & Other Exp.[2]	701.8	671.4	(30.4)	-4.3%
Total Expenditures	**$ 2,261.6**	**$ 2,219.1**	**$ (42.5)**	**-1.9%**

Notes:

1. Hospital Expenditures include Inpatient, Outpatient, and Emergency Room Services.
2. Includes LME/MCO, PACE, High-Tech Imaging, and Buy-in/Dual Eligible Services.
3. Pharmacy Expenditures are net of rebates.

JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Transformation

Mandy Cohen, Dave Richard, Jay Ludlam
Department of Health and Human Services

Oct. 10, 2017

Proposed Managed Care Program Design

- Based on best practices from other states and building on the existing infrastructure in NC
- Vision: Advance high value care; Improve health; Support providers; Build a sustainable program
- Key themes:
  - Focus on health of the whole person
  - Improve health and well-being of North Carolinians
  - Support providers in delivering high-quality care at good value
- Elements of the proposal need additional statutory authority from the GA

Promoting Quality, Value and Population Health

- Statewide Quality Strategy
  - Single set of statewide quality measures to assess performance and drive progress
  - NC Institute of Medicine taskforce on measure development
- Value-Based Payment
  - Population health metrics, appropriateness of care
  - Incentivize prepaid health plans to use alternative payment models
  - Supplemental Payments
- Care Management
  - Build on what's working well today
  - Advanced medical homes
  - Data analytics capabilities

Supporting Providers

- Education and training through regional support centers
- Cut down administrative burden
  - Centralized credentialing process; uniform policies; single electronic application
  - Streamlined contract negotiations with standardized language for select sections
- Ensure transparent and fair payments to providers
- Support workforce initiatives
- New tools to combat the Opioid Crisis
- Support telehealth initiatives

Whole Person Care

- Built on best practices from across country & what is already working well in NC's behavioral health system
- Every person has one insurance card for both their physical and behavioral health needs
- Timing is important
- Standard Plans
  - "Primary care" behavioral health spend included in PHP capitation rate
  - Beneficiaries benefit from integrated physical & behavioral health services
- Tailored Plans
  - Specialized managed care plans targeted toward populations with significant BH and I/DD needs
  - Access to expanded service array
  - Delayed start

Oversight of Plans

- Plans are responsible for delivering to beneficiaries high quality care
- Plans are expected to act as good stewards of State resources
- Strong contract language is required
- Monitor health plan clinical, financial and operational activities

Transparency, accountability and outcome measurement are core components of a contracting strategy

Legislative Changes Needed to Run a Successful Medicaid Program

- Behavioral health integration and tailored plans
- Phased implementation plan
- Efficient benefit administration for family planning and inmates
- Supplemental payments
- Insurance regulation

October 10, 2017

Members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice:

G.S. 120-209.2(d) authorizes the Committee Cochairs to establish subcommittees of the Joint Legislative Oversight Committee Medicaid and NC Health Choice to examine issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services. Session Law 2016-94, Section 12F.10(c) directs the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Joint Legislative Oversight Committee on Health and Human Services to each establish a subcommittee on Behavioral Health Services. The two subcommittees are directed to meet jointly.

Pursuant to the authority provided in G.S. 120-209.2(d) and S.L. 2016-94, Section 12F.10(c), the Committee Cochairs are appointing a subcommittee to meet jointly with the Joint Legislative Oversight Committee on Health and Human Services to study behavioral health services. Below is an excerpt of the Session Law outlining the study requirements and the subcommittee appointments from the the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

S.L. 2016-94, SECTION 12F.10, STRATEGIC PLAN FOR IMPROVEMENT OF BEHAVIORAL HEALTH SERVICES

...

SECTION 12F.10.(c) The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice shall each establish a subcommittee on Behavioral Health Services. The subcommittees shall meet jointly to do the following:

(1) Oversee the Department's development of the strategic plan required by subsection (b) of this section.

(2) Review the strategic plan developed by the Department in accordance with subsection (b) of this section, including a review of all performance-related goals and measures for the delivery of mental health, developmental disabilities, substance abuse, and traumatic brain injury services.

(3) Review consolidated monthly, quarterly, and annual reports and analyses of behavioral health services funded by Medicaid and State-only appropriations.

The subcommittees shall jointly make recommendations about the areas of oversight and review described in subdivisions (1) through (3) of this subsection and report their findings and recommendations to their respective committees. In conducting the required oversight and review, the subcommittees may seek input from other states, stakeholders, and national experts as they deem necessary in conducting their examination and developing their recommendations.

Behavioral Health Subcommittee Members:

Senator Ralph Hise, Co-Chair	Representative Nelson Dollar, Co-Chair
Senator Valerie Foushee	Representative Verla Insko
Senator Joyce Krawiec	Representative Gregory F. Murphy, MD

Sincerely,

Representative Nelson Dollar, Co-Chair

Senator Ralph Hise, Co-Chair

Representative Donny Lambeth, Co-Chair

Article 23B.

Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except that initial appointments begin on the date of appointment. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment. (2015-245, s. 15.)

§ 120-209.1. Purpose and powers of Committee.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services.

(b) The Committee may make periodic reports, including recommendations, to a regular session of the General Assembly on issues related to Medicaid and NC Health Choice programs. (2015-245, s. 15.)

§ 120-209.2. Organization of Committee.

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge. (2015-245, s. 15.)

§ 120-209.3. Additional powers.

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice, while in discharge of official duties, shall have access to any paper or document and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly. (2015-245, s. 15.)

§ 120-209.4. Reports to Committee.

Whenever the Department of Health and Human Services, or any division within the Department, is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters relating to the Medicaid and NC Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. (2015-245, s. 15.)

October 10, 2017

Members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice:

G.S. 120-209.2(d) authorizes the Committee Cochairs to establish subcommittees of the Joint Legislative Oversight Committee Medicaid and NC Health Choice to examine issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services. Session Law 2016-94, Section 12F.10(c) directs the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Joint Legislative Oversight Committee on Health and Human Services to each establish a subcommittee on Behavioral Health Services. The two subcommittees are directed to meet jointly.

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SECTION 12F.10.(c) The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice shall each establish a subcommittee on Behavioral Health Services. The subcommittees shall meet jointly to do the following:

(1) Oversee the Department's development of the strategic plan required by subsection (b) of this section.

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The subcommittees shall jointly make recommendations about the areas of oversight and review described in subdivisions (1) through (3) of this subsection and report their findings and recommendations to their respective committees. In conducting the required oversight and review, the subcommittees may seek input from other states, stakeholders, and national experts as they deem necessary in conducting their examination and developing their recommendations.

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Senator Ralph Hise, Co-Chair	Representative Nelson Dollar, Co-Chair
Senator Valerie Foushee	Representative Verla Insko
Senator Joyce Krawiec	Representative Gregory F. Murphy, MD

Sincerely,

Representative Nelson Dollar, Co-Chair

Senator Ralph Hise, Co-Chair

Representative Donny Lambeth, Co-Chair

Department of Health and Human Services Responses to Fiscal Research Division Questions on Proposed Program Design

(Based on questions asked during the JLOC Medicaid & Health Choice Meeting 10-12-17)

The Fiscal Research Division posed a number of questions about DHHS's proposed program design for Medicaid transformation. Additional information on those questions is provided below. DHHS plans to release additional detail on several topics in coming weeks and months, including several of the items described below. DHHS looks forward to continuing dialogue and transparency with the NCGA.

Topics where DHHS presentation and explanation would be helpful

1) Discussion of opioid plan components and cost

Like many states, North Carolina is facing an opioid crisis that has worsened over the last decade. North Carolina's efforts to address this epidemic have intensified over time. Multiple agencies came together with community-based organizations to develop the State's Opioid Action Plan to reduce opioid addiction and overdose deaths. The recently passed Strengthen Opioid Misuse Prevention (STOP) Act and a federal grant of $31 million to expand access to prevention, treatment and recovery supports have also bolstered the state's efforts. Knowing that Medicaid can play a vital role in supporting North Carolina's statewide efforts to address the opioid crisis, the State has developed a Medicaid opioid strategy to build on the policies and programs that have been developed to address the opioid epidemic to date.

As part of this strategy, DHHS intends to ask CMS to waive the Institute for Mental Diseases (IMD) exclusion to expand access to inpatient services for individuals with short-term stays who need mental health or substance use disorder treatment. DHHS seeks federal flexibility to make these IMD payments either directly to IMDs (for FFS enrollees) or to plans. This will enable us to dramatically increase access to much needed IMD services and promotes parity between acute behavioral and acute physical health care.

This waiver request is part of a broader strategy that DHHS will be implementing, through a variety of non-waiver initiatives leveraging existing federal authority that are targeted at reducing the numbers of North Carolinians on the path to addiction. This includes reducing the permitted maximum daily dosage of opioids and requiring prior approval for certain prescriptions or supply sizes. DHHS is also exploring additional strategies to prevent new onset of SUDs (e.g., training physicians and pharmacists on prescribing best practices, assess risk of a beneficiary developing SUD) and treat existing SUDs (e.g., adding low intensity residential services as covered benefits). We look forward to sharing additional details as this work develops.

2) Discussion of proposed plan as a system of care or integration of care **2A) Regional Provider Support Centers (RPSCs) and CCNC similarities**

Regional provider support is an element of most states' managed care programs, especially during significant transitions. RPSCs would perform direct supports to primary care and other providers for training, education and quality improvement activities, conducted at the regional level. The RPSC entities will be organizations with substantial experience and/or current

capabilities delivering the types of practice support envisioned. RPSCs will also assist primary care provider practices in meeting Advanced Medical Home certification, providing support in reviewing quality reports and enhancing performance in evidence-based practice, and assisting practices in accessing and using any data and information systems designed to support their efforts. Small, rural and essential providers will be given priority in the delivery of RPSC services. While some of these provider support activities are similar to activities performed by CCNC today, RPSCs would not conduct local care management, population health management, or informatics.

2B) Social determinants of health and additional rural provider capacity

In designing its high-performing Medicaid managed care program and a sustainable Medicaid program, DHHS is committed to optimizing the health and well-being of all beneficiaries by improving coordination between our communities and the health care system and strengthening access to economic and social services that are critical to better health. Central to these efforts is a commitment to address the social determinants of health that have dramatic negative ramifications for enrollees' health and often for costs as well. Based on stakeholder feedback from across the State, we will target food insecurity, housing instability, and transportation challenges as crucial barriers to health. These and other social determinants disproportionately impact Medicaid beneficiaries, increase the risk of developing chronic conditions, detract from people's ability to work and contribute to community life, and drive cost.

DHHS will embed various strategies throughout the Medicaid managed care program to address social determinants of health, starting with its inclusion as a key initiative within the Quality Strategy. Additionally, the State will develop tools to enable North Carolina's PHPs and providers to better meet the full range of their enrollees' needs, including a standardized screening instrument with targeted questions on food insecurity, housing instability and transportation needs and a resource management database that captures information on community services and access points to services.

To complement and strengthen these non-waiver strategies, DHHS intends to seek federal flexibility and support for a limited set of public-private initiatives to scale, strengthen, and sustain their existing efforts to closely link the healthcare and social services systems, aiming to deliver better health for individuals and families and yield lower healthcare costs. DHHS will support evidence-based interventions in rural and urban areas and develop a rigorous evaluation protocol, including the development of metrics and requirements on data collection and reporting, to ensure demonstration projects' ability to measure and report their impact on health and cost outcomes.

Rural provider capacity: DHHS is focused on building health care capacity in rural and underserved areas. As a part of this effort, we will seek to continue existing loan repayment, community grant, and Area Health Education Centers (AHEC) residency programs. As part of its goal to build a multi-disciplinary workforce, DHHS plans to pursue other initiatives, including requiring that PHPs or Advanced Medical Homes (AMHs) deploy community health workers and other individuals performing similar functions to improve population health by delivering certain

preventive or health education services. These community health workers and others will expand the reach of the traditional healthcare workforce into the highest need communities.

2C) Maintain and expand best elements of today's care management and AMHs North Carolina's Medicaid program is characterized by high rates of primary care provider participation and investments in care management at the local level. These are key building blocks for driving efficient use of resources and increasing high value care, and the program design attempts to build on those features in the transition to managed care. This is one of the critical goals in the AMH design, and we are continuing to develop the details of this program. We intend to provide an update in the near future about this work.

2D) Role of LME/MCOs

In our proposed design for managed care, most beneficiaries would receive integrated physical health and behavioral health through a PHP beginning on the first day of managed care launch. A few special populations with unique health needs (individuals with serious mental illness, substance use disorder, or intellectual/developmental disability) would temporarily remain in their current arrangement, receiving physical services on a fee-for-service basis and behavioral services through an LME/MCO. After 1-2 years, these individuals would enroll in Behavioral Health I/DD Tailored Plans, which would cover both physical and behavioral health services, including waiver services. Tailored Plans would be selected through a competitive bid process and it is expected that some LME/MCOs could submit bids in partnership with a physical health plan to serve as Tailored Plans. This aspect of the proposed program design will need additional statutory authority from the NCGA to implement.

3) Supplemental Payment Plan

Federal rules prohibit the Department from continuing to direct supplemental payments outside those payments covered by capitation rates. The Department is working closely with the North Carolina Hospital Association to design a payment structure within Medicaid managed. While the specifics of this model are still being worked out, the new payment model will be costneutral to the State compared to the current model, it will only change the mechanism by which the funds are distributed.

The new structure will transition most supplemental payments into higher base rates (though the total amount of money will be the same), which will in turn be used as a basis for relevant contracting guidance (e.g., rate floors) between PHPs and providers. Some payments, such as Graduate Medical Education (GME) payments and DSH payments, will not be included in the new base rates and would continue to be paid directly by the State to providers as allowed under federal rules.

This aspect of the proposed program design will need additional statutory authority from the NCGA to implement. We intend to provide a more detailed update in the near future, and look forward to working with you on this issue.

4) Role and relationship of Carolina Cares (H.B. 662) to program design

The General Assembly is considering Carolina Cares. The program design describes features that would need to be implemented if the legislature acts, some of which will also need to be approved by CMS. This includes:

- Instituting premiums of 2% of income for most enrollees with incomes greater than 50% FPL, with select exemptions;
- Disenrolling beneficiaries for failure to make premium payment with a "lockout" period; and
- Establishing mandatory employment activities for most enrollees who are not already engaged in employment, training, or school (with select exceptions for certain caregivers, medically frail individuals, and individuals in substance use treatment).

As noted, this aspect of the proposed program design will need additional statutory authority from the NCGA to implement.

5) Medical Loss Ratio

The Department will require health insurance issuers to submit data on the proportion of capitation payment revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). CMS regulations and State legislation direct DHHS to establish the MLR for PHPs, and to require rebates if plans do not meet this standard. DHHS is still conducting the actuarial analyses necessary to establish the appropriate minimum MLR. Many features of the program design affect the MLR. For example, DHHS is working with hospitals on an approach to include hospital supplemental payments in the base rates and building those higher base rates into capitation payments made to PHPs; all else equal, this results in a higher MLR than if supplemental payments had remained outside of PHPs.

6) Maintain chronic pain and pregnancy home

The Chronic Pain initiative has shifted to become the Opioid Safety initiative, focusing on combatting the opioid crisis by addressing the prescription of opioids in pain management. The Pregnancy Medical Home (PMH) program is designed to improve the quality of maternal care and improve infant and maternal outcomes while reducing costs. It includes most maternity care providers in the state.

We are exploring how to leverage the general structure of these programs in managed care, and will provide an update to the General Assembly and other stakeholders as this work develops.

7) Eligibility and enrollment process streamlining and DHHS divisional roles

DHHS envisions streamlining the eligibility and enrollment process for Medicaid to promote timeliness and accuracy. For example, at some point in the future, if a person's point of entry was their county DSS office, we intend for many individuals to be able to apply for Medicaid, receive their complete eligibility determination, and select a PHP all at the same time.

8) How solvency standards for PHPs will compare to LME/MCO solvency standards and what constitute differences

PHPs will be held to solvency standards by the Department of Insurance (DOI) based on the financial risk that they are taking on. LME/MCO solvency is not regulated by the DOI today, but existing DHHS policies provider solvency standards for these entities. DHHS will provide an update to the General Assembly and other stakeholders as this work develops.

9) Definition of what legislative changes are needed to ensure smooth and successful transition for vulnerable populations and to enable PHPs to manage integrated and coordinated care

As discussed in the October 10, 2017 meeting of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the major areas of legislative change needed to run a successful managed care program are:

- Behavioral health integration and tailored plans
- Phased implementation plan
- Efficient benefit administration for family planning and inmates
- Supplemental payments
- Insurance regulation

We intend to provide additional detail on all of these areas in the near future.

10) Anti-exclusivity provisions

Exclusive contracts between PHPs and providers would threaten the success of the managed care program by jeopardizing the broad provider participation and strong network that North Carolina has historically enjoyed. Such provisions could also violate North Carolina's any willing provider rules regarding physician participation in Medicaid. DHHS intends to oversee PHP contracting to prevent anti-competitive behavior. While the details of this oversight are still being refined, forms of exclusivity that the Department will likely seek to prevent include:

- PHPs requiring providers to enter an exclusive arrangement with that PHP to preclude them from contracting with other PHPs.
- Provider-led or provider-affiliated PHPs refusing to negotiate to join the networks of other PHPs, preventing those PHPs from establishing adequate networks.

We look forward to continuing to work with you as we develop additional enforcement strategies.

11) How provider capacity fits with the network adequacy standards for time and distance

Network adequacy standards require plans to include a sufficient number of providers across all geographic areas to ensure all Medicaid beneficiaries have access to necessary services. They ensure that when plans begin enrolling individuals, the network is sufficient to meet the demand for medical services. The standards differ in rural and urban areas; plans are required to maintain a higher density of providers in areas with a higher density of beneficiaries. We anticipate offering a limited process by which plans can seek an exception if there is truly an absence of qualified providers in a given area; however, we expect this process will be used sparingly. Also, while the specific requirements are still under design work, the Department anticipates establishing requirements for plans around provider accessibility, including

consideration of provider capacity, to ensure that beneficiaries have actual adequate access to providers for covered services.

12) How realistic is the proposed time table

DHHS proposes managed care go-live would occur on 7/1/2019, 18 months after an anticipated waiver approval on 1/1/2018, consistent with the timeline laid out in S.L. 2015-245. The Department is in negotiations with CMS regarding the aspects of the waiver which require CMS approval and continues to anticipate submitting an amended waiver in late fall 2017. While DHHS is hopeful that the waiver can be approved by 1/1/2018 and believe this is a realistic turnaround time for waiver approval, we acknowledge that that timing is outside of our control, particularly given that there are several pending waivers from other states ahead of us in the CMS waiver review queue.

Significant items not covered in the proposed program design

Initial information on each of these topics is provided below. We intend to provide additional detail in the near future, and look forward to meeting with you to discuss these and other areas.

1) Internal infrastructure and administrative functions beyond IT

Consistent with the reorganization of the Medicaid and NC Health Choice programs described in S.L. 2015-245, the Division of Health Benefits (DHB) will become the division that administers the managed care program and the Division of Medical Assistance (DMA) will be eliminated. We will continue to work with the General Assembly as we prepare for this transition.

2) Who, when, and how outcome measures will be established and incorporated into contracts

Outcome measures will be incorporated into PHP contracts to ensure that PHPs are held accountable for both quality and value. DHHS intends to have a standard set of clinical quality goals and measures and to drive plan performance on desired outcomes. We intend to draw on the work done by the North Carolina Institute of Medicine (NCIOM), in alignment with national quality standards, and include measures that touch a wide variety of domains, including population health, chronic disease management, patient-centered care, and the Social Determinants of Health (SDOH) specific to the needs of North Carolina.

DHHS also intends to incorporate measures of value into PHP contracts, including measures to encourage the accelerated adoption of value-based payment (VBP) between PHPs and providers that tie to the Department's quality goals. While these measures have not been finalized, DHHS expects to draw on the Health Care Payment Learning and Action Network (HCP-LAN) framework to define value goals and measures. The Department plans to release additional detail on quality and value measures in coming months.

3) Cost implications of any proposed changes to the initial legislation

The proposed integration of physical and behavioral health services can reduce costs by preventing redundant care coordination and averting unnecessary service utilization through integrated, whole person prevention and shifting some care to lower-cost sites.

The exclusion of family planning program enrollees and inmates from the managed care program is expected to generate savings versus enrolling these individuals in managed care. These populations both receive a very limited benefit package and as a result have a much lower per-member-per-month (PMPM) cost than other Medicaid participants. As a result, there is limited opportunity for PHPs to manage care for these populations, but additional administrative costs to the State of designing, contracting, and regulating a separate capitated product for these unique benefit packages with little to no offsetting savings.

4) Cost implications for proposed program design **4A) Maintaining FFS for physical health for SMI, SUD, and I/DD populations**

DHHS proposes maintaining these populations in their current arrangement (behavioral health services covered by an LME/MCO and physical health paid fee-for-service) for up to two years before bringing these populations into managed care. Given that this is a continuation of the existing structure, this proposal is anticipated to be cost-neutral to the State.

4B) Variation of tailored plans for special/high cost population in smaller plans versus part of the risk for the larger group

DHHS and our actuarial consultants at Mercer are analyzing the financial implications of tailored plans. An important note is that DHB's rate setting methodology includes diagnosis-based risk adjustment, so a PHP would receive a higher capitation payment for managing a special/highcost individual than for someone with lower acuity needs regardless of whether that person is in a standard plan or a tailored plan. The risk-adjustment process is cost-neutral to the State.

5) How this program design impacts NC Health Choice Beneficiaries

NC Health Choice beneficiaries are treated like Medicaid beneficiaries in the Proposed Program Design, and generally the aspects of this proposal that are applicable to child population in Medicaid will also be applicable for the NC Health Choice population. NC Health Choice children will be a managed care mandatory population unless they are also a member of another population that is excluded or exempt from managed care.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kris Lance	PLA
Chip Baggett	NCMS
Dana Simpson	SA
Kara Weisland	SA
Doug Miskuly	PSG
J Perms	CSS
Joyce Peters	CSS
Jeff Horton	NCALTCF
Emily Ziegler	UNC REX
Dodie Ranfer	CCR
Jeremy Dodd	N/A

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Bain	Troutman Sanders
Taylor Griffin	NC Assoc. of Health Plans
Pearl Burris-Floyd	Partners BHM
Ryan Minto	UHG
Anita Bachmann	UHC
[illegible]	NCPA
[illegible]	[illegible]
Peggy Maynard	[illegible]
Jon Carr	Jordan Price
TJ Bugbee	NP
Caram Hunt	MVA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

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NAME	FIRM OR AGENCY AND ADDRESS
Wendy Kelly	Focus carolina
Lexi Gilman	JLF
Saran McQuillan	KOANC
Betsy McCorkle	KOANC
Rick Zechini	Williams mulle
Doug Heron	Dulce
Cody Hump	NCHA
Ryan Blackledge	Cone Health
Brenda Bloomer	CFVH
Christine Craig	WakeMed
Lindsey Dowling	FSP

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

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NAME	FIRM OR AGENCY AND ADDRESS
Mayc. May	OSC. SChina Maine
Sarah Grimsrud	OSBM
Pam Kilpatrick	OSBM
Paul M. Duck	Beacon Health Options
April Byrd	DHHS Div of Health Benefits (Beacon Health)
Marilyn Avila	self
Reg O'Donnell	CCME
Carla O'Briel	Care4Carolina
[illegible]	DP
Phoebe Handel	MW

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Frazier	SML
Josh Lanier	SML
Ben Kellman	AmeriHealth Caritas
Will Morgan	MFS
Becki Gray	John Locke Foundation
Barbara Foley	MAXIMUS
Sara Sutula	Real Facts NC
CAROL OFNITZ	TBI Advocate - BIANC
Pier Protz	TBI Advocate - BIANC
Jan Andersen	TBI Advocate BIANC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

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NAME	FIRM OR AGENCY AND ADDRESS
McCoy	NMRS
Ed Sinclair	BJP
Richard Edwards	CBC
My Bates	NC CoA
Shelly Parker	Parker Law
Cory Dunn	DRNC
Matt Gray	NC Child
Jim Harrell	B&H
Katie Mills	CFVH
Sarah Ball	Guidance/NSO

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rick Irby	T.B.I.
Jeannie Irby	ACFAC NCC TBI Advocate
James Whalen	Cynthia Ball
John Nash	The Arc of NC
DENISE Hobson	Liberty Healthcare of NC
Lyncka Judkins	Liberty Healthcare of NC
Kelly B. Garrison	Emtiro Health
Michealle Grady	Atromitos
DOUG PORTER	PORTER CONSULTING
Kevin Rich	OSBM
Karen Mclud	Benchmarks

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Haire	NC DMHDDSAS
Ann Rodriguez	NC Council of Comm Programs
Kari Barsness	Gateway Health
Katherine Hobbs Knutson	Alliance Behavioral Health
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
JEFF BARNHART	McGuireWoods
Greg Griggs	NCAFP
Elizabeth Hudgins	NCPCA
Ken Levin	NC AHP
	CS
Angela Boykin	Blue Cross NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice 10/10/2017

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Frank Hill	PSG
David Powers	PS, LLC
Chris Mclin	BB

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

October 27, 2017

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Medicaid and NC Health Choice
FROM: Rep. Donny C. Lambeth, Co-Chair
Rep. Joseph Nelson Dollar, Co-Chair
Sen. Ralph E. Hise, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Medicaid and NC Health Choice** will meet at the following time:

DAY	DATE	TIME	LOCATION
Tuesday	November 14, 2017	1:00 PM	643 LOB

Senator Hise, Presiding Co-Chair

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Candace Slate at dollarla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

November 14, 2017, 1:00 p.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Nelson Dollar
Rep. Donny Lambeth
Sen. Ralph Hise

Legislative Members
Rep. William D. Brisson
Rep. Josh Dobson
Rep. Verla Insko
Rep. Bert Jones
Rep. Greg F. Murphy, MD
Sen. Dan Bishop
Sen. Valerie P. Foushee
Sen. Joyce Krawiec
Sen. Louis Pate
Sen. Gladys A. Robinson
Sen. Tommy Tucker

Advisory Members
Rep. Beverly M. Earle
Rep. Chris Malone
Rep. Rodney W. Moore
Sen. Angela R. Bryant

I.	**Welcome & Opening Remarks**	Senator Ralph Hise Presiding Co-Chair
II.	**Remarks from Department of Health and Human Services (DHHS) Secretary**	Mandy Cohen, Secretary, Department of Health and Human Services (DHHS)
III.	**Overview of Medicaid Dashboards**	Steve Owen, Committee Staff Fiscal Research Division, NCGA
IV.	**Medicaid and NC Health Choice Enrollment**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS Michael Becketts, Assistant Secretary for Human Services, DHHS
V.	**Medicaid and NC Health Choice Financial Update**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS Roger Barnes, Chief Financial Officer, Division of Medical Assistance, DHHS
VI.	**Status of 1115 Waiver and Work Plan for Medicaid Transformation**	Mandy Cohen, Secretary, DHHS Dave Richard, Deputy Secretary for Medical Assistance, DHHS Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS
	Adjourn	
		NEXT MEETING: **December 12, 2017**

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE
November 14, 2017
Room 643

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice met on Tuesday, November 14, 2017, at 1:00 P.M. The meeting was held in Room 643. Senate members present were Valerie Foushee; Ralph Hise, Co-Chair; Joyce Krawiec; and Louis Pate. House of Representatives members present were William Brisson; Josh Dobson; Nelson Dollar, Co-Chair; Verla Insko; Gregory Murphy, M.D.; Donny Lambeth, Co-Chair; and Chris Malone. House of Representatives Advisory members Beverly Earle, Chris Malone, and Rodney Moore were present.

Legislative Services staff attending the meeting included Jennifer Hillman and Jason Moran-Bates from Fiscal Research Division; Steve Owen, Denise Thomas, and Deborah Landry from Fiscal Research Division; and Amy Jo Johnson from Bill Drafting Division. Committee Assistants in attendance were Susan Fanning, Candace Slate, and Pan Briles.

Serving as Sergeants-at-Arms were Jim Hamilton and Larry Hancock for the Senate; and Doug Harris, David Leighton, and Malachi McCullough for the House. See **Attachment 1 –Visitor Registration Sheet**.

Welcome & Opening Remarks

Sen. Hise, Co-Chair, presided. He welcomed everyone and then recognized Mandy Cohen, Secretary, Department of Health and Human Services to present agenda item **II. Remarks from Department of Health and Human Services (DHHS) Secretary**. See **Attachment 2 – NCTracks Enhancement to Prevent and Detect Fraud, Waste and Abuse**. Sec. Cohen spoke on the need for Congress to act on the Children's Health Insurance Program. She stated that the state continues to provide uninterrupted coverage, but that if the U.S. Senate doesn't take action in December, NC DHHS will need to come back to the Committee with a plan on dealing with the challenges, possibly an enrollment freeze. She spoke about the work that the Department is doing in moving forward with managed care and the need for different types of authorizing legislation to launch the most successful managed care program possible. She spoke on the General Assembly's charge to implement technology enhancement for dealing with provider or recipient fraud. She said that DHHS has identified those scenarios to focus on and is working with their vendors on implementation, and that the piece related to providers is currently being implemented and will have the first run by the month's end, while the piece related to the recipients is a bit more complex and will be online in April.

Sen. Hise then recognized Steve Owen, Committee Staff, Fiscal Research Division, NCGA, who presented agenda item **III. Overview of Medicaid Dashboards** and answered questions from Committee members. See **Attachment 3 – Medicaid Dashboards October 2017**.

Sen. Hise: Rep. Brisson

Rep. Brisson: Thank you, Mr. Chair. Steve, do you have numbers on how many applied and how many qualified?

Steve Owen: I do not, but that's one of the questions we need to look at as we look at those 26 counties.

Rep. Brisson: In the last couple years we've been doing some reevaluation with the local county offices and they spent a lot of time and overtime trying to get the changeovers, a caseworker could only do two or three a day. What were we overlooking? What's going on? Particularly in those counties where you said it's dropped so much.

Steve Owen: I don't think from the data I presented that you can really make that conclusion. There was a report on timeliness and accuracy that the Department provided, as well as the changes there and that might be something better for the Department to respond to.

Dave Richard: Rep. Brisson, we don't see that correlation between anything in terms of what was happening in timeliness and accuracy. We think there were some other factors that may be at play, including the overall population growth in those counties. We appreciate Steve's analysis of this and will continue to look at it, but we don't think that correlation is there.

Sen. Hise: Rep. Murphy.

Rep. Murphy: Thank you, Mr. Chairman. Steve, you said that it's $6 a month per person for family planning. The total numbers have gone down, but the cost has gone up 300%. Can you break that down into what those costs are generally; are medications the reason for the skyrocketing cost, or is it other ancillary services?

Steve Owen: Actually, the enrollment is what has grown by 340,000 so the number of people that are eligible for Medicaid for family planning services has increased over 300%. The cost really is limited to exams, screening, and treatment related to family planning activities, so they don't get a full range of services that Medicaid covers. The cost has actually remained fairly constant for the last few years. Actually, I think it's down a bit from what it was two years ago.

Sen. Hise: Rep. Lambeth, and then Rep. Insko.

Rep. Lambeth: Thank you, Mr. Chairman. Always as usual, good presentation, great data to look at. You might look at unemployment rates in all the counties and see if there is a correlation in unemployment rates. When I first came and it was running over budget, we attributed a lot of that over budget to the fact that unemployment was very high. Now unemployment is very low, a 17-year historical low, and there may be a correlation. Also, I find that one slide that shows the variance interesting in the scheme of things, we still don't have a major budget variance because we spent a lot of money on Medicaid, but it does jump out at me that dental and home health, the magnitude of dollar variance versus the spend is pretty significant. We obviously spend a lot of money on hospital and physician services. Home health

and dental as a proportion is very high as a percentage. Have you done any drill-downs into those? It's great that people are taking advantage of the dental services. I get a lot of questions about Medicaid dental, so maybe they're finding their way to those dental clinics.

Steve Owen: I think you're correct. I've not done any real drill down other than identify where the categories or variances are. The home health and DME as a percentage is probably the largest variation. I know there are some offsets with the CAP programs, but when you look at CAP, DME, home health together, there's still a variation that I don't know that I can explain or even understand at this point.

Sen. Hise: Rep. Dollar.

Rep. Dollar: You were talking about home health, so this is against what was budgeted, or what was assumed in coming up with the budget. Do you have numbers of what the actual change is in year over year?

Steve Owen: I do not have those with me, so I will get those to you. You're correct. This is the variation from what the Department expected to be spent. What I used here was the information that they provide through the rebase.

Rep. Dollar: In terms of the family planning component, is that just more people accessing birth control, or more procedures. Do we know what increasing services have been driving that as that line's been going up?

Steve Owen: When ACA was implemented there were changes in the way people were identified as eligible for this program. So people applied, either through the Exchange and then were transferred to the Department, or more people were determined to be eligible through NC FAST. At some point you would think equilibrium would resume and we would return to a more normal pattern. We just have seen this continuation of growth and I haven't been able to get an understanding of why that is. On the spending side, again because it is limited to examinations, treatment, and screenings, the services that are actually accessed are fairly consistent with what they were. This chart really reflects the growth in the number of people, the spending at $6 a person. Obviously, we would be over budget with that, but in the scheme of things it's not a huge number.

Rep. Dollar: These are individuals that would not have been, prior to the ACA, eligible, that are in the current environment eligible and so to a certain extent, we had been expanding Medicaid in a sense. Certainly in this category we have more people enrolled and that's been going up rather significantly over the past few years. Is that a correct analysis or not?

Steve Owen: I think that's part of it. These are individuals that probably have been eligible all along, but the process and the systems now identify them as eligible, where prior to the ACA, our system of implementation just didn't catch them. I don't know if that's a fair statement or not.

Dave Richard: That would be correct, yes, sir.

Sen. Hise: Rep. Insko.

Rep. Insko: I understand that there has actually been a drop in the number of children per family over the past 10 years. Have you seen those trends in the Medicaid population specifically? We're now down below two children per family.

Steve Owen: I have not looked at that. I'm not sure if the Department has.

Sec. Cohen: I believe that's because there are more child-only folks. If you look at the distribution there are fewer adults per child, but I think the number of total children has been fairly consistent, or consistent with where we were projecting. The number of children and their parents also being on the plan has decreased, so it's child-only.

Rep. Insko: So, do we have automatic enrollment or do you have to re-enroll every year with Medicaid? Or do they stay continuously enrolled until they fall off?

Dave Richard: Annually, there will be enrollment for the individuals in Medicaid, so, yes.

Rep. Insko: So have we seen a falloff in the enrollment?

Steve Owen: In terms of the numbers of children, as you see from this chart, prior to July 1st of this year, the numbers haven't necessarily declined. The expectation was that it would continue to increase, although we actually have seen through October 1st, an absolute decline in the number of children when you add together all the children categories, so we actually have seen less kids enrolled.

Rep. Insko: Can you break down where the increases are in home health service versus direct medical equipment?

Steve Owen: I can get that information for you. I don't have it with me today, unless the Department wants to answer.

Dave Richard: On home health we can go in and get the exact detail. We do know what is driving that. So, Steve suggested that you see an offset in the CAP programs. The entire offset doesn't equal the amount. We believe most of this is driven in their private duty nursing side, and there were several reasons for that. If you recall, we went through a long process of revising our CAP/C waiver, having to take the private duty nursing part of that outside of the waiver. It still counted for the entire population in terms of how we do budget neutrality and it's managed together, but it's now on a state plan service. That was because we had a similar state plan so we couldn't have it inside the waiver. That was a change that we had to make. When we made the change, what we'd committed to was that for those families who had

private duty nursing under the CAP/C waiver, when we moved it out to a place no longer in the fee-for-service side, no family would lose any hours in that process. To do that, we had to lessen some of the rules around the private duty nursing for the fee-for-service area. So that's part of what you see in here; we expected that to happen. We're watching it daily to make sure that we don't see this continued growth. We think it's going to level. There's also a little bit of this that includes having to do a retroactive payment for those people in the PDN that were on the CAP/C, the PDN was inside of CAP/C. We had to wait until we pulled it out to be able to do that retro payment, so some of that is in there also.

Sen. Hise: In slide 5, looking at the changes in enrollment in children, what have we seen corresponding in the CHIP plans – health insurance plans? Are they similarly declining? The economic shift may indicate that people are moving from one area to another.

Steve Owen: I can get you the exact information. What I recall is that the health choice plan has not seen a similar decline. Children here include what we call MCHIP, which are those kids that technically are funded under the SCHIP program, but we've always had them as Medicaid, at the 0 to 5 group. The MIC, which are basically the kids from age 5 to age 18, other children, AFDC under 21, so it is really the combination of all children. We saw so much movement between categories, I put them all together when I looked at the kid population.

Sen. Hise: And just to follow up on that, you showed the ACA and its changes in enrollment, but as best as I remember, the only change for children under the ACA was the shift from those who were on the Children's Health Insurance Plans to Medicaid and how that was paid. There were no other changes in services in enrollment implied to children through the ACA?

Steve Owen: The Affordable Care Act actually increased the threshold based on the federal poverty level up to 133, so what we saw is about 70,000 children on January 1st move from what we call NC Health Choice over to Medicaid. That's the bump you see around that green dotted line. If you remember, we were extending eligibility, people were past their normal one-year point. There were a number of issues going on that caused that continued rise, I believe.

Sen. Hise: Any other questions or comments? Thank you, Steve. I appreciate it.

Sen. Hise then recognized Dave Richard, Deputy Secretary for Medical Assistance, DHHS, to present agenda item **IV. Medicaid and NC Health Choice Enrollment.** Dave Richard, along with Michael Becketts, Assistant Secretary for Human Services, DHHS, presented agenda item IV. and answered questions from Committee members. See **Attachment 4 – Medicaid Enrollment Update.**

Sen. Hise: Questions for Dave. I just ask one that's more directly related to Michael, working with the county DSSs. How is the state emphasis, and I know what we're doing on Medicaid and others, balanced with ensuring timeliness, particularly for Food and Nutrition Services? We ran into that problem a little before you arrived. Are you seeing similar improvements across all areas of beaefits in the counties? How are you focusing on those?

Michael Becketts: I was the Director of Social Services in Durham County for 5 years and, while not at the state, I was subject to the monitoring of timeliness around Food and Nutrition Services. We're trying to make sure that our efforts do not create a deficit in other places, and so when we look at our timeliness rate for Food and Nutrition Services, we are as a state meeting that mark of 95% of timeliness and has been doing so rather consistently. While there are variations at the county level, overall our timeliness rate for Food and Nutrition Services is stable.

Sen. Hise: Just to follow up, the other variance we saw a lot, particularly in Medicaid enrollment, was not just timeliness, but accuracy. And we had some counties that came in at 50% accuracies and we had some come in with great numbers. Are you doing any monitoring? I know that we had provided to begin some auditing, but do you have any sense on what is happening with the accuracy of determinations?

Michael Becketts: I don't have that data in front of me. My general sense is that we are improving, but we can be more precise on the report.

Sen. Hise: Dave is going to continue for the financial update. Previewing this and looking at enrollment here was absolutely not information we had 3 years ago. The best we could get in the budget report 3 years ago was how many checks we had written at this point in the year, and how did how much we spent compare to the same number of checks written the previous year. That's really what we had, and to begin to break down enrollment information and spending, the dashboard's helpful. We have a long way to go still, but this is a night and day difference from what we were looking at a few short years ago. So, congratulations to everyone on that.

Dave Richards: Sen. Hise, thank you for that, and again, we believe this is a partnership as we do our forecasting and work with the General Assembly, and it is a large budget.

Dave Richard and Roger Barnes, Chief Financial Officer, Division of Medical Assistance, presented agenda item **V. Medicaid and NC Health Choice Financial Update** and answered questions from Committee members. See **Attachment 5 – Medicaid Finance Update**.

Sen. Hise: Any budget questions?

Rep. Dobson: Thank you, Mr. Chairman. The previous presentation, if I'm reading correctly, was $13 million over budget, and your presentation is saying 0.8% favorable. What am I missing?

Roger Barnes: This is as of the end of September. Steve's presentation is as of mid-October, and if I look at today, at this week's checkwrite, we're $11 million under budget, so what you're seeing is a normal variation from one checkwrite to the next, and as we go further out into our forecast to the annual part, we really want to make sure that we will meet our targets being under budget, and that's what we will do.

Steve Owens: Only thing I would add to Roger's comment is that actually what I was using was the checkwrites through the end of October, but it was only NCTracks. This is a complete picture of

Medicaid including rebates, administrative expenses, non-NCTracks service costs. This has got everything on it, versus just the claims processed through NCTracks.

Rep. Dobson: Thank you. That clears up the discrepancy that I had.

Sen. Hise: How is our recovery on fraudulent cases comparing at this point in the year with previous years? I know we did some additional personnel and others into the budget; just seeing when that utilization may occur.

Roger Barnes: Thank you for the question, Sen. Hise. I don't have that number on the top of my head, so I will need to go back and pull that information. I think we're on pace with the recoveries, however.

Sen. Hise: Rep. Lambeth.

Rep. Lambeth: Thank you, Mr. Chairman. Is there a quick answer to the supplemental payments being so far over, or is that just a timing issue?

Roger Barnes: Yes, it is just a timing issue. The majority of our payments would occur later in our state fiscal year.

Sen. Hise: Are there any other expected large expenditures that we may be in debt for to the federal government or other payments that you expect to be coming in this year that are not accounted for yet in the budget?

Dave Richard: We have constant things that go on in terms of audits and other things. We see nothing in the current year that will impact this budget that we would have to pay back to the Feds. Frankly, we're not looking at having anything that significant that would impact us at that level. If there is something, we will come to you, so you know ahead of time before one of these meetings, but right now we don't see something out there.

Rep. Dollar: So you're saying this is the fourth or fifth year we'll actually be under budget in Medicaid?

Dave Richard: I think it will be the fourth year; I may be wrong. This is the most aggressive rebase we've done in terms of our forecasting. We had a couple of years where it was significantly higher than we wanted to return to the General Assembly because, obviously, any dollars that are rebated at the end of the year the Governor nor the General Assembly have the ability to think about how to use for other programs. We were very tight in this effort, so we're optimistic that we'll finish that way. Sec. Cohen has been very clear we will not finish this year over budget. I don't think you can anticipate some large number of return to the general fund at the end of the year.

Rep. Dollar: You're correct as to what we want in the General Assembly. A couple of years there it was nice to have huge dollars coming back; we were able to use those for other things. But yes, it's much better to be right on budget, and for the fourth year we'll either be under budget or maybe right on budget, what we're looking to do.

Sen. Hise: Sen. Krawiec.

Sen. Krawiec: Thank you, Mr. Chairman. Mr. Richard, you remember last time I told you Sen. Tucker and I were rabid about fraud? Do we have someone specifically tasked with investigating frauds of these services?

Dave Richard: We do have an entire division, inside of Medicaid dedicated to that. It's our program integrity section, with multiple people responsible for that oversight and effort. We'd be happy to spend more time on that at some future presentation if you'd like.

Sen. Hise: Any other questions or comments?

Sen. Hise recognized Sec. Cohen for presentation of agenda item **VI. Status of 1115 Waiver and Work Plan for Medicaid Transformation.** See **Attachment 6 – Medicaid Transformation.** Sec. Cohen, Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS, and Dave Richard presented agenda item VI.

Sen. Hise: Rep. Dobson.

Rep. Dobson: Madam Secretary, you talked about the capitation rates. Normally, when an RFP goes out you go with the lowest bidder. If we're going to set the capitation rate before the RFP goes ont, what metrics will be used to determine who gets those 3 statewide contracts?

Sec. Cohen: We measure them against a standard of "can they deliver the services for our population?" We say we want you to deliver physical and behavioral health services and they have to prove to us they have a network of providers to do that. They'd have to show us how they are contracting with doctors and hospitals to have a statewide plan, for example. We'd ask them to show us how they're going to do care coordination, and they'd have to show us their plan for care coordination. It's a gamut of hundreds and hundreds of standards like that, and we will have a rubric, as Jay was mentioning, a scorecard to show you get 10 points for network, 10 points for care. We will have a rubric that will be very transparent; the RFP will say this is what will give you extra points. These are things that are non-negotiable. Either you have them or if you don't you don't even get to the next stage. The next stage will be things that are going to inch you up toward getting selected. You don't compete on price; you compete on quality. That is the way most states do it. Some states sometimes have a band of the capitation rates. Feedback from other states really didn't bear out in terms of either getting better costs or better quality for folks, so we're going through a process of really using the best actuarial science to build our capitation rate based on the historical data, and then asking folks to meet the standards that we've been articulating in our first paper

and in all of these technical documents. This is why I'm excited that Jay is on the team, someone who has been through this and supervised these kinds of bid processes before.

Rep. Dobson: Mr. Richard, on slide 9, you talk about non-Medicaid federal grant dollars will be managed by the tailored plans. So, only non-profit or governmental entities will be able to offer them because of that non-Medicaid federal grant dollars. What type of entities other than the LMEs could you imagine, not specific names or organizations obviously, but what type of entities could you envision perhaps taking this on?

Dave Richards: There are certainly health plans that are non-profit health plans. There are health systems that are non-profit health systems that could be a part of this. One of the right combinations would be a combination of a health plan or some other thing with an LME/MCO to be able to do this work. The idea of building upon what works in this system is something that we want to do. So those are potential options that, as we currently envision it, would be there. But again, that is the work we want to do with you.

Rep. Dobson: Thank you. On this same issue, if you envision this going forward through legislation or however we can get there, is that the permanent solution going forward for the tailored plans?

Dave Richards: Ultimately, the state of North Carolina will move to a system that requires that our managed care plans manage both behavioral health and the physical health needs of individuals, because it is ultimately the right way to get integrated care. You can do all the other things you want to do, but, eventually, if you don't have people responsible for the full cost of care from that visnal, the obstacles are significant to get there, and we know that's better care for individuals. So, for North Carolina at this point, this is the right answer because it builds on what we've done. I don't think we can ever say "never," that there wouldn't be another iteration, but I believe if we do this, we've set the course that we can build upon, continue to use to make sure that we get the best services. So, no guarantees that it's the last part, because we have had a lot of reform in mental health, I know, but I think if we make this step, then what we can do is stabilize the system, stick with it, make sure that we're continuing that process, and we should be able to do that hopefully for a long period of time.

Rep. Dobson: Thank you, and I would share that I think the sooner that we can get to as permanent as permanent can get solution so everyone would know the path forward I think the better. Thank you, Mr. Chairman.

Sen. Hise: Rep. Lambeth.

Rep. Lambeth: There was no mention in here of the development of metrics that will eventually reward through an incentive system. Is that in the process? You're developing those metrics, it was just an oversight in here?

Sec. Cohen: So there will be a separate paper on our quality strategy, as well as our care management, and that is where we will use some tools, both incentives and carrots and sticks, around incentivizing quality. Yes.

Rep. Lambeth: One additional question, Mr. Chairman. One comment had that would include statewide commercial plans and regional PLEs, and I believe the plan actually allows the statewide to be both commercial and/or PLE plans. You might want to make that correction on the slide.

Sec. Cohen: Good catch, yes, thank you.

Sen. Hise: Rep. Dollar.

Rep. Dollar: As you know, Madam Secretary, I'm not sold on all the changes that are being proposed here with respect to the LME/MCOs. The reason why I'm not is this is something that we've been investing six-plus years, actually six years prior to that in a pilot. Then when we passed the law in 2011 and then subsequent legislation, it keeps getting said, and I wish it would not be said "We have managed care and behavioral health now." The LMEs are local management entities managed care organizations. So, we have that now and we also have one card. I'm not sure what the magic of having one card is, but we have one card now. When the Department says "best practices from other states," do you have some specific best practices? Because I know that there are times when you go to another state and you talk to them, and they'll tell you a good story about their program. It's not necessarily what's going on on the ground. So, I'm particularly interested in which specific best practices as it directly relates to ID and DD services you're talking about.

Sec. Cohen: Arizona has done this work. The National Governors Association has now put together a collaborative on best practices in behavioral health and they've highlighted three states: Arizona, Michigan, and one other, validating to me that they are also looking at two of the three states that we looked toward for best practices. How do you think about the financing side to drive the results that you want on the delivery side? We've been able to connect with the Arizona team, and that is helpful. Importantly, we want to recognize the infrastructure that we have here. We are doing a version of utilization management or managed care in the behavioral health side. Folks do still have to have their physical health needs authorized by the state or, in the future, by another managed care entity, and so I think as we move into managed care, our responsibility is to look at what's going well in other states, but then adopt it to what is the reality here in North Carolina, and you see this plan that is unique. I think it is unique to North Carolina, because it builds on the capacities that we have here, and takes those principles and best practices in Arizona. It's not exactly the same. Arizona does not have governmental-type entities that would be part of these plans. That's not their governing structure; they didn't have the type of LME/MCO infrastructure before they made their change. We're trying to adopt to what we see here, yet still bring those same principles and the same structure.

Dave Richard: Sec. Cohen had said early on that many states that started out with a carve-out or, in their fully grown managed care, are trying to figure out how to make sure they integrate those populations.

You can't go to a conference with Medicaid directors without that being the topic. There is clear indication that the integration of behavioral health and physical health is not only the trend, it's the best practice for states going forward. I would add, because you mentioned the IDD population, our system works an awful lot like Michigan's. They're moving toward trying to integrate their current behavioral health DD system with physical health. We have this system that does really good things for certain parts of our population, but what it can't do is create that alignment between the physical health spend and the spend for behavioral health and development. And it creates quality issues in terms of how we do the work inside of that. But, what I'd say, Rep. Dollar, is that it is hard to find a state in the country that isn't trying to move toward an integrated model.

Rep. Dollar: We could debate more on that issue, in terms of quality and what's actually being done. Currently, we could bring up the LMC/MCOs and have countless examples of community investment. I'm talking about in the millions of dollars in community investment in facilities, in certain cases, and other cases services are provided for because of how we have designed the system in North Carolina. You all sent the additional paper at the end of the week so I haven't been able to fully analyze that. But, I have yet to see where you're going to generate the money, and how it's going to be generated specifically for community investment. We have serious problems in this state and in this country in terms of mental health, and mental disease and behavioral health issues. If we don't have some mechanism, the General Assembly, somebody, is going to have to come up with the money to do that. Where is that community investment in this plan?

Dave Richard: Rep. Dollar, one of the things I clearly anticipate is that if you are a tailored plan and you are responsible for the total spend of a population that has significant mental health needs, substance abuse needs, and developmental disability needs, you're going to be looking for your community investment. You will be doing community investment. Where we are going to get the best bang for our dollar is when people begin thinking about how to use the entire Medicaid dollar, along with those state dollars, to best serve the population. And the reality is that incentives work, right? So if we're creating a system where we are telling these organizations that you are responsible for the total spend of these individuals, you're responsible for the outcomes that we've put out for those folks, and if you don't meet those outcomes, we're going to either give you carrots or sticks as the Secretary's described it, then they're going to invest in the things that will make their outcomes better. That's what we want to see. They won't be silo investments, they will be investments that both address the physical health needs along with the behavioral and developmental disability needs.

Rep. Dollar: That all sounds real nice and good, but it's not the real world in many respects. I mean, you have to have specific facilities to address behavioral health needs, whether it's children or adults. Otherwise, the hospitals could do the whole thing, but they're not designed for that. Somebody's got to be able to make those specific investments, and, when you talk about the population, there may be some coming agreement on saying that mild to moderate services would be billed under the larger capitation. Obviously, a lot of physicians and others would like to be able to do that for a host of very good reasons, reasons of integrated medicine that I think everybody here supports. But, as a practical matter, you back those people out of the capitation as you mentioned, Mr. Richard, earlier, that means that that "capitation"

for the LME/MCO or tailored plan or whoever is going to go up greatly – a lot of the ID/DD folks, you're talking about a great deal of just fixed costs. And although I think they're doing an excellent job right now of trying to manage what people are receiving, we are taking away part of the area in there and the way that capitation works in which they are able to realize additional funds for that community development. And before somebody says "Well we don't think that's the way it'll happen." banks are going to have to show me numbers that that's not a legitimate concern with what we're talking about doing.

Dave Richard: Rep. Dollar, I appreciate all of your comments, because those are things we need to be able to respond to and give you great detail on and I think as you review the paper you'll see a lot of those thing addressed. We definitely want to continue that dialogue. Let me give you an example of the reason why integration makes sense. You're very familiar with the ICF program for people with developmental disabilities. Let's use the community side, mostly in group homes. The entire spend for the developmental disabilities services, except for medical, is included in the cost of that service. Right now, we pay a capitation rate to the LME/MCOs who then contract with the ICF providers based on a rate that they give to them. And that capitation rate is designed just to provide the service for the individual in the group home. When an individual in one of those group homes winds up in the hospital, and it happens often, the LME/MCO no longer pays for anything at that ICF, because the individual is now inside of a hospital where the Medicaid rate's being paid fee-for-service. While they're in the hospital they don't pay, but we continue to pay the capitation rate to the LME/MCO because that's how we have to do it to make the rates stand for those individuals. But if we had an integrated system, I'd actually show you how we can not only do what's right for the individual, but improve the cost outlook for how we do business. I don't think there is an LME/MCO in the state that thinks this way, but, right now, if I'm not paying for a person in a hospital, I have very little incentive to go buy an additional support for that group home or make sure that that individual gets out of the hospital quickly because, right now, it is being paid for by pure Medicaid fee-for-service. If we stay in a system we are in right now, it'll be paid for by a separate health plan. If we're all one total cost to care, I guarantee that the managed care organization that has the responsibility for that would be doing everything in the world to get the person out of the hospital quickly because the cost of living in that home is a lot less expensive than a hospital stay. It's better for the individual, and so we wind up aligning the actual financial incentives with quality incentives. And there are multiple places inside our system where we can show that. Now, again, I don't believe anybody at the LME/MCO system was trying to do a cost shift, but there is a natural cost shift that happens the way we do business today. So I think some of the things you're concerned about, in terms of that investment, actually get addressed in creating the right incentives with the financial and quality standards.

Rep. Dollar: With the current system, we control the capitation rates. So if you believe there needs to be an adjustment, you can do it on an annualized basis. You won't have that if you move to the system that you are talking about. You won't have the hands-on control nearly as much as we currently have with managed care in the public sector. When we talk about integration, particularly with behavioral health, it's not simply a matter of physical health plus whatever the behavioral health issues are, which can be quite a range. You're also talking about integration with public schools, juvenile justice, DSS, and a whole host of non-governmental agencies, private groups and the like that are all involved with

behavioral health at the community level. And we have a lot of integration and connections there that I'm just not seeing the valuing of in all these proposals. I keep seeing "we've got to get this money up here," but in behavioral health and mental health, if you don't have that network out there, and if we do things that take away folks that are trying to pull all of that together at the local level, we will have lost something very, very important in this state that goes back decades before even the LME/MCOs now, going back to the areas in the counties in terms of behavioral health. We need to make sure, in the pursuit of other, sometimes very worthy goals, that we take sight of what we might lose.

Sec. Cohen: Those are excellent points. What are the guardrails that we need to put on this, both from a governance structure as well as a spend, and the expectations of what these tailored plans would be expected to do in terms of partnership with local entities? I think that we are aligned there and it is a matter of "let's do the work" and articulating what those guardrails and parameters are that can take us to the next step. I think these are the kinds of issues that we want to get out on the table.

Rep. Murphy: When we're sending out the RFP for these companies and they're going to be told "this is how much it is going to cost," are we going to look at how their expenses are going to be done? In other words, we're now moving into managed care and now we're moving into an administrative cost that previously had not been heretofore, and 93% of the providers participate in Medicaid. I just want to make sure that all of a sudden we're not going to have an administrative blossom of costs and lose providers from the system.

Sec. Cohen: That is something that we think about a lot in terms of the burden on the doctors and other clinicians in the system as we make this change. Right now we have one payer. In the future we'll have more than one payer, and by design that means there's going to be more complexity in the system. So it's incumbent on us at the state to think through the ways we can reduce that burden as much as possible. There are a number of ways that we've been talking about, whether it's unified credentialing or a unified quality strategy, so every plan doesn't have a different quality metric. It's all the same. We have a standardized drug formulary, those kinds of things that have some standardization for our doctors and providers. We welcome feedback. We've been asking to help us prioritize what are the hardest, biggest pain points in terms of administrative burden. We're never going to be able to add everything, so help us prioritize. On the administrative cost side for a managed care entity, we do have specific structures as we build our rate methodology. We outline how we build the administrative dollars that will go into that capitation rate; we also cap how much a managed care entity can spend on administrative dollars versus clinical dollars. You have to spend at least 85% of the dollars on clinical services as opposed to admin. We both create a rate that reflects the need for administrative dollars to run the program but then we make sure that 85% of those dollars are going into clinical care.

Sen. Pate: Are we certain that we've covered all the bases? Are we going to suddenly find there's a group that hasn't been covered and suddenly they're locked out? Is there some way of getting them in? I'm specifically talking about TBI folks.

Sec. Cohen: We are trying to be as transparent as possible, down to the individual diagnoses codes, so that everyone is very aware of who's in what bucket and gives us feedback. This is the time; give us feedback if we are not recognizing service needs. We think we did a very thorough job, but always welcome additional feedback to say "You know what, this diagnosis really belongs in this category versus that." This is why we did it down to the individual diagnoses codes. We also outline a process, if we got it wrong and that will happen, to rapidly address that. We want to make sure that we are building processes that are as focused on those that we are serving as possible. There are a lot of competing thoughts, so we are trying to find the right middle ground to move the whole system forward, and then we'll adjust. That is my pledge to you – to continue to be transparent, to continue to look at data, to continue to be responsive to those we serve, and then if we need to, we'll adjust.

Rep. Insko: My concern has to do with maybe two groups of people. You said 120,000 people would stay on the tailored plans; I'm not sure how many people that carves out. What's going to happen to the uninsured? If we lose our LME/MCOs it all goes into standard plans. Eventually, they won't be covered. I don't know who will be responsible for them. I don't know whether we'll have people in the traditional plans that will want to provide housing for mentally ill people. A lot of that doesn't fit into our traditional health plans. Part of my concern is will we have state facilities? Who will take people to the emergency room and then to the state facility? I don't see how all of that eventually works together. Will the LME/MCOs eventually go away?

Dave Richard: We believe in this plan that we've put forward. There is the right pathway for the LME/MCOs to be a partner in this effort and one of the important ways in which we evolve this system. The word "tailored plan," actually is the exact right word. A lot of people used "specialized" or "specialty plans," but this is trying to design to be tailored around a population that you described. You're right. Housing is so important to people who have significant mental illness. It is important for the folks to have transportation. The reality is that the LME/MCOs today don't provide housing directly. They use contract agencies to do that work. The LME/MCOs still may transcend the community they live in. Our DOJ settlement requires responsibility for certain housing activities. But we have a great partnership with our housing finance agency to do that. We don't see that changing in the tailored plan – the responsibility to make sure people are inside of housing; that's part of how they do treatment and the other services. That'll be part of the tailored plan support. Right now, uninsured is paid by our single stream dollars and the other IPRSs, we used to call it. That is why we say state and federal monies will be with the tailored plans, because that is where that money should go. Those state dollars, at whatever level the General Assembly appropriates, need to be in those tailored plans because they are tailored and designed for those people with the most significant needs. So, we don't see that as something that will be part of the standard plans because it's for those individuals at that level. We would not be proposing something that we believe would not be better for those individuals that have those significant needs. The reason we suggest the tailored plan is because we want to make sure that the care management and care coordination is appropriate for this population, and that individuals do not get lost in the larger plan. So our goal is the same that you have, to make sure we continue with the good things that have happened while at the same time improve by creating a total cost-to-care model for these individuals so we address their physical health needs at the same time as the behavioral health needs.

Rep. Insko: I would like, specifically, to get more information on exactly what these other states are doing with these specialized populations and the evidence that they are actually doing better than what we would be doing now.

Dave Richard: Would be happy to do so.

Sen. Hise: When we talk about getting this waiver approved, we understand that there is a short timeline when the legislature needs to act in this process, but what is the value to CMS of integration? They're the ones we're going to ultimately have to negotiate with for approval for our system, and I know you, Secretary, have some pretty extensive experience there. They manage this nationwide. What do value do they see of integration of mental and physical health within a plan and how important is that to their ultimate approval of a plan?

Sec. Cohen: They have been extremely supportive and have given us good suggestions on how to further refine the work that we're doing, but definitely think that we are headed in the right direction in terms of integrating physical and mental health. They've been telling us stories of other states having to go back, amend waivers, or redo processes to bring these together now, and that it is hard and don't go down that path. I do not anticipate having any issue with them approving this piece. They've done it in other states and are encouraging. There are almost no states that aren't moving some part of their Medicaid program in this direction. If anything, they would caution us against not doing it. And again, that comes from both a clinical outcome and a budgetary outcome from their perspective. We've gotten a lot of support and good suggestions on how to just refine things at the edges.

Sen. Hise: I have felt from the beginning that it is important to move all of mental health under a single system as a covered service and put in responsibilities for overall plans. And those who fail the mental health population need to have at risk losing the entire population they serve and their contract to make sure they provide those services. I do understand the need to move quickly. And while this is not the gold star of where we ultimately need to be, I think it is an incredible step in the right direction. We have heard a lot of rosy things about the LME/MCOs, but having done the budget for the last couple years, there is another side to this. We talked a lot about investment in communities. Well, I've seen a lot of investment in fund balance with entities that build a fund balance larger than the state of North Carolina, and not until we begin to make significant cuts to that do we begin to see any plan for how those would be reinvested in the community. I am approached by advocates for different individuals with disabilities on a regular basis here that tell me how the system is currently failing them in handling and managing their services. I think we all know we can do better for the population with severe and persistent mental illnesses. Once we can bring all the dollars on the table to be able to manage their care, we are in a position to create a system with performance measures to ensure that occurs.

Secretary Cohen then presented the final slide titled Supplemental Payments: Context and Approach.

Sen. Hise: Does this, in effect, lock all hospitals into fee-for-service? How much can plans vary from the floors in order to put in incentive payments and maybe guarantee the overall dollars? How much flexibility do they have within those?

Sec. Cohen: So it'll create floors, hut it won't change your ahility to negotiate with the individual payer. There will be some restrictions in the first couple of years just to retain some stability, but then free up, on the latter half of our waiver period, more of that negotiation. This is where we are encouraging our future managed care entities to move to alternative payment models very quickly. Those are things that take a little hit of time to gel and get right over time, so I don't anticipate seeing those alternate payment models out of the gate day one, maybe we will, but I think year two, three, four, we'll start to see some of those alternative payment models and moving away from fee-for-service. In fact, I think this accelerates that process, it makes sense. Roger, do you want to add anything?

Roger Barnes: Sir, to what you're saying and why we put up there that the fee-for-service and the managed care rates would be the same; it is primarily to help administratively. Currently our hospitals' base rates are $2,704, but once you add in the supplemental payments, they can get as high as $7,000 per discharge. So, we did not want while we are transitioning from fee-for-service into managed care, to have some of those fee-for-service payments at the $2,704 and the managed care at the $7,000. We still have the carve-out populations that we will be dealing with. Now, all of this we are designing, working with the hospitals to make this as budget neutral as we possibly can. This is where we will be looking at possible legislative action, and that is, at what tax percentage rate would we want to look at, that we need to refine the hospital providers assessments legislation.

Sen. Hise: Any other questions, comments on supplemental payments?

There being no further business, the meeting adjourned at 3:17 P.M.

Senator Ralph Hise, Co-Chair

Susan Fanning, Committee Assistant

Joint Legislative Oversight Committee

On Medicaid and NC Health Choice

November 14, 2017 – Room 643 LOB – 1:00 PM

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NAME	FIRM OR AGENCY
Yvonne Copeland	CCME-Carolinas Center Medical Excellence
Pamela Shipman	Monarch
ROB Lemire	PCA
Marilyn Avila	Self
FRANK Hall	PSG
Ed Shirley	BSP
Daniel Patterson	Troutman Sanders
Sarah Bales	Brubaker's Assoc.
Jon Carr	Jordan Price
TJ Bugbee	NP
Sue Ann Forrest	NCMS
Katie Mills	CFUH
JOE CAVIOR	TROUTMAN
Ryan Blackledge	Core Health
Kara Weishaar	SA
Christine Cyrus	Wakemed
Daniel Vanhorn	Vidant Health

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On Medicaid and NC Health Choice

November 14, 2017 – Room 643 LOB – 1:00 PM

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[illegible]	MVA
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[illegible]	[illegible]
[illegible]	[illegible]
Andy Ellen	NCRMA
DOUG HEIRON	DUKE
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
JEFF BARNHART	MWC
[illegible]	CCS
Kelly Vogel	Aetna
[illegible]	[illegible]
[illegible]	Partners
David Powers	PSLLC

Joint Legislative Oversight Committee

On Medicaid and NC Health Choice

November 14, 2017 – Room 643 LOB – 1:00 PM

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Rick Irby	Family of TBI
Karin Suers	Carolina Collaborative Community Care
Phoebe Landon	McGuireWoods
Chris Egan	NC Council on Developmental Disabilities
Ann Rodriguez	NC Council of Comm Programs
Jennifer Alderman	UNC-CH School of Nursing
LISA WOODLEY	↓
MATT GRAY	NC CHIP
Jennifer Smith	pediatric resident
Matthew Cook, II	" "
Denise Hobson	Liberty Healthcare of NC
Jill Elliott	" " "
Kelly B. Garrison	Emtiro Health
Michelle Gadd	Atromitos
Paul M. Duck	Beacon Health Options
April Byrd	[illegible]
Maeve Gaden	GSC

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On Medicaid and NC Health Choice

November 14, 2017 – Room 643 LOB – 1:00 PM

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NAME	FIRM OR AGENCY
Michelle Frazier	SML
Katye Tobe	SML
Ben Kellman	Amn Health Care
Will Morgan	MFS
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[illegible]	WMRS
CS Hollis	CSH
Brad Christoph	none
Julia Adams Schweich	Duke City GR
Jennifer Mahan	ASNC
Karen McLeod	Benchmarks
Richard Edwards	Community Based Care
Pier Protz	Brain Injury Advisory Council
CAROL GRAITZ	BIANC Board
Jean Anderson	Brain Injury Adv Council
Jeanine [illegible]	Traumatic Brain Injury Mem

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On Medicaid and NC Health Choice

November 14, 2017 – Room 643 LOB – 1:00 PM

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Carla O'Neal	Care4Carolinas
Rob O'Connell	CCMC
Rachel Barker	RBLaw
Johanna Reese	NCACC
Whitney Christensen	Ward and Smith, P.A.
Dodie Reefer	CCB
Michael Watson	CAMPBELL
Pam Perry	Carolina Complete Health
S. Middlebrooks	NCAM - LAD
Mike Leighs	NCPE
Holly Watkins	The Arc of NC
Jan Nixon	The Arc of NC
[illegible]	CSS
Chris McClure	BP

Joint Legislative Oversight Committee

On Medicaid and NC Health Choice

November 14, 2017 – Room 643 LOB – 1:00 PM

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NAME	FIRM OR AGENCY
Iain Stauffer	Poyner Spruill
JOEL HAMMOND	GlaxoSmithKline
Janet Pitts	CSS
Ann Sloan	NCHCFA
LT McCrimmon	DHHS
Will Robinson	Nature Conservancy
Connie Wilson	NCOA

JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

NCTracks Enhancement to Prevent and Detect Fraud, Waste and Abuse

Dr. Mandy Cohen
Department of Health and Human Services

Nov. 14, 2017

Attachment 2

NCTracks Enhancement to Prevent and Detect Fraud, Waste and Abuse

- Enhancement goal: Identify scenarios that can be evaluated for action during claims adjudication
- Current identified scenarios addressed in this effort:
  - Providers with bankruptcies, judgments or liens
  - Providers with expired licenses
  - Providers identified as sex offenders
  - Deceased providers/recipients
  - Incarcerated recipients
  - Recipients living outside of North Carolina

Status

- Provider monitoring workflow is in place and reporting capabilities are being enhanced, implemented by the end of November.

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

Medicaid Dashboards October 2017

Steve Owen,
Fiscal Research Division

November 14, 2017

Attachment 3

Discussion Guide

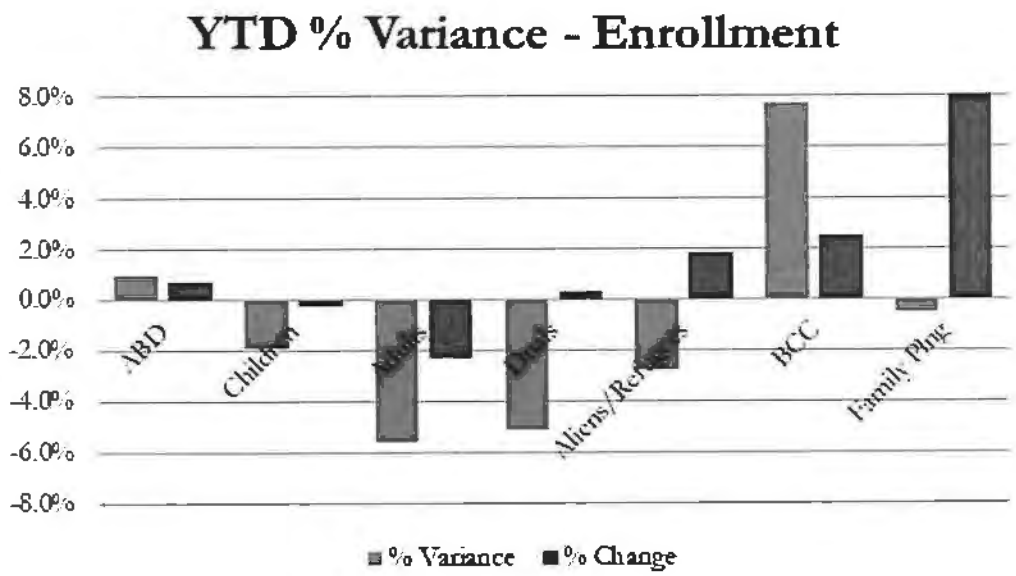
Dashboards should provide an insight into drivers of spending….*enrollment-mix-price-use*

- Overall trends in enrollment compared to budget
- Significant Program Aid Category trends
- Trends in County Medicaid enrollment
- Trends in Medicaid Spending
- Items for discussion or follow up

Objective: not a complete budget summary, but rather context prior to DMA presentation

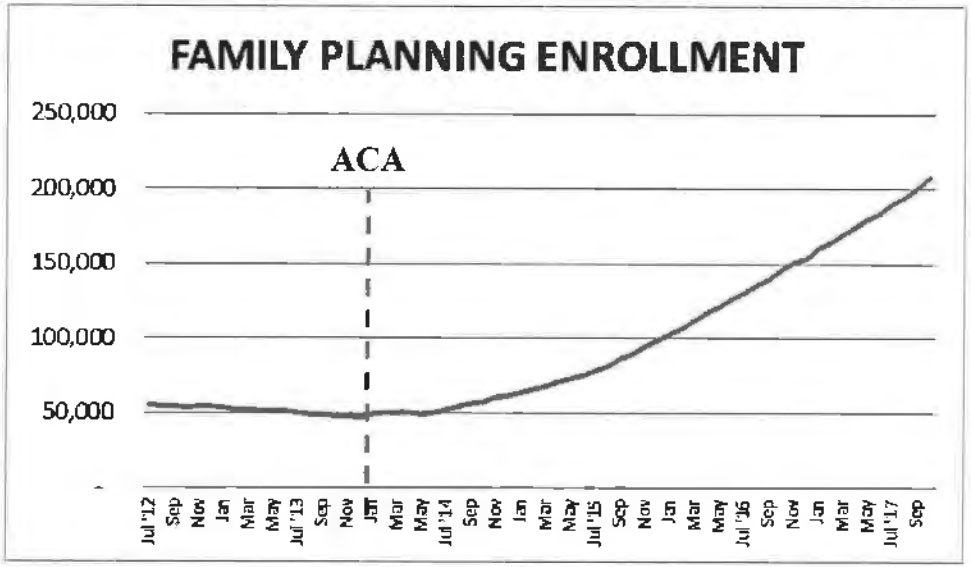
Enrollment Trends Compared to Budget

Medicaid enrollment at 10/1/17 was 2,014,249. This is 41,748 less than was budgeted and 18,553 higher than June 30, 2017. AFDC adults and children in all categories represented the areas with the greatest variance under budget for the number enrolled – *why, will this continue, what does mean?*



Program Aid Category Enrollment Trends

- Family Planning has reflected a significant increase in enrollment since the Affordable Care Act (ACA) began.

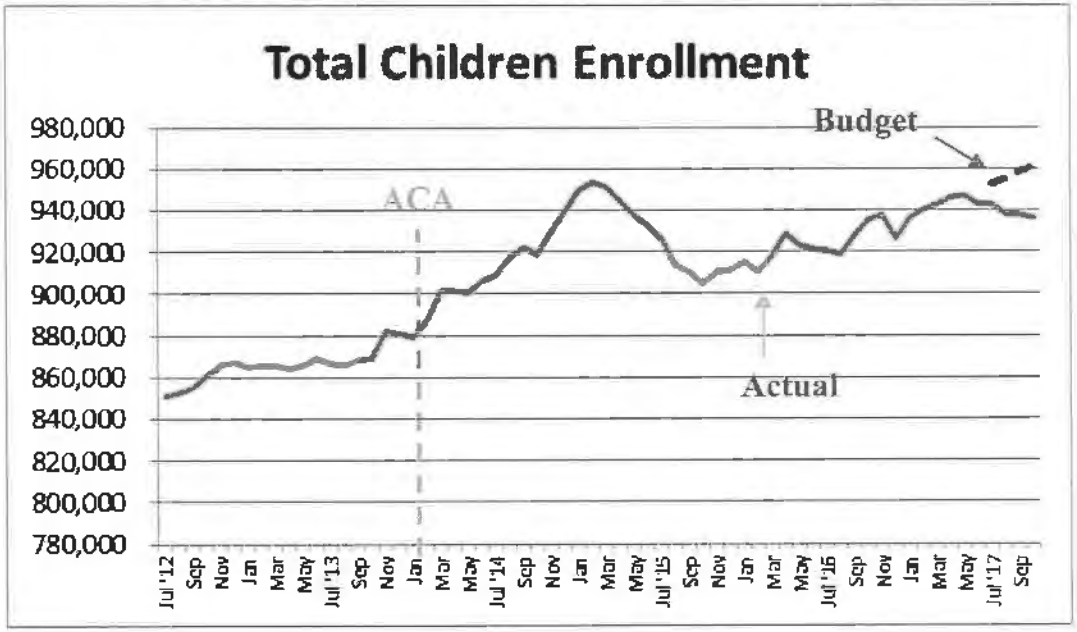


- Overall, Family Planning has increased 339.6% since December 2013, compared to the overall enrollment without Family Planning that has grown by 14.5%.

- Family Planning spending is less than $6 per person per month.

- There were process changes with the implementation of the ACA. The question is whether there is a point where family planning trends will return to similar patterns experienced before the ACA? Impact on births?

Trends in Child Enrollment



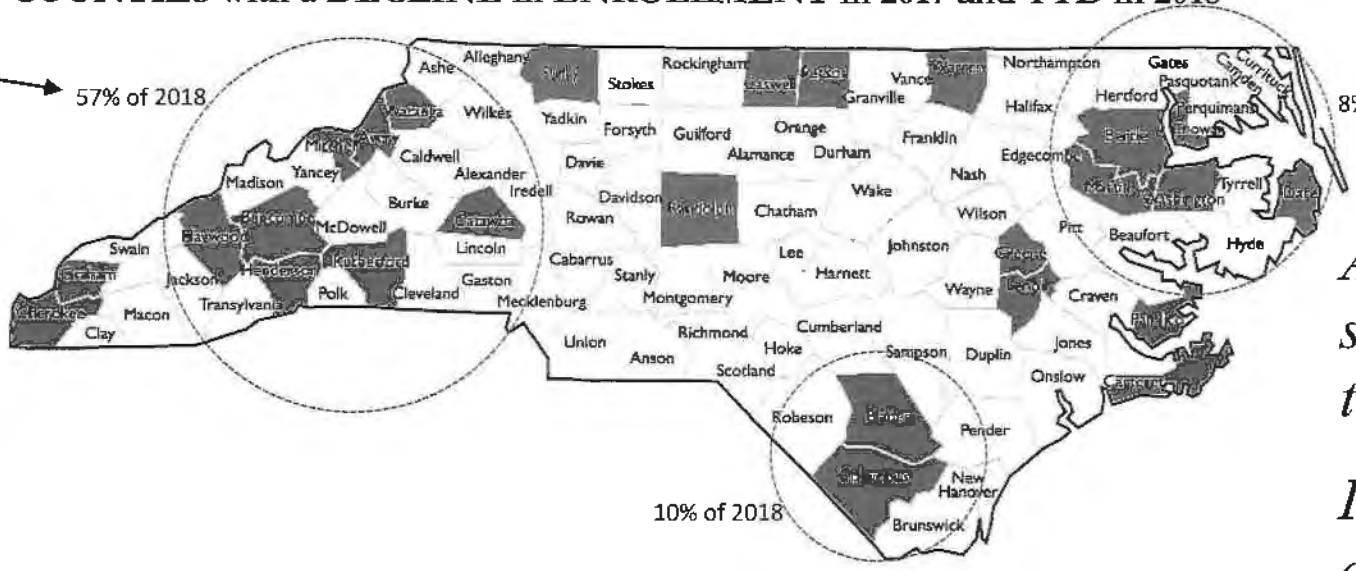
- Enrollment of children has been less than budget Year to Date through October 1st of 2017.
- Children cost per person per month is approximately half that of an average Medicaid enrollee.
- In 2018 children have declined .8% since June 2017, in the prior year children rose by 1.5% over the same period in the prior year *– can we identify the reasons? The value of variance analysis is once we know "why", then what should/could we do to alter the trends.*

Changes in County Enrollment

There are 26 counties that experienced a decrease in non-Family Planning enrollment in SFY 2016-17 and continue YTD in SFY 2017-18

COUNTIES with a DECLINE in ENROLLMENT in 2017 and YTD in 2018

% of total reduction in the 26 counties



Are there similarities in the drivers?

Is this expected?

Decrease in SFY 2016-17	(5,158)	Overall Change	33,501
YTD Decrease in SFY 2017-18	(2,640)	Overall Change	(4,948)

Other counties with significant decreases in 2018 –Cabarrus (224), Craven (254), Gaston (694), Harnett (513), Nash (568), New Hanover (263), Robeson (313), Rockingham (213), Union (337), Wake (1,555)

SFY 2017-18 Enrollment Trend Summary

- Family Planning continues to reflect a significant rate of growth in 2018 compared to all other categories – what has happened to birth rates.
- Child enrollment is 2.6% less than budget at 10/1/17 – is the mix or composition of the Medicaid eligible changing? Why?
- Aged and Disabled enrollment, two of the most costly categories, are .8% collectively over budget at 10/1/17.
- Based on the mix of enrollment and historical spending, year to date total spending would be expected to be $18 million under budget. Actual spending through 10/31/17 is $13 million over budget based on the DMA weekly checkwrite report.

Together these make up an effective $31 million claims spend above expected through 10/31/17.

SFY 2017-18 Claims Spending Trends

Overall Medicaid claims spending year to date through 10/31/17 was $4.033 billion compared to a budget of $4.020 billion. The primary areas with spending variances over budget are:

Hospital Services	*$26.0 million*
Physician Services	*$ 3.6 million*
Dental	*$ 8.0 million*
Home Health/DME	*$46.2 million*

These variances were offset with lower spending for PCS ($28 million), CAP programs ($18.9 million) and Drugs ($14.6 million).

SFY 2017-18 Claims Spending Trends

Another area of variance under budget was the spending for behavioral health services and other prepaid services which were $5.2 million less than budget through 10/31/17 for claims.

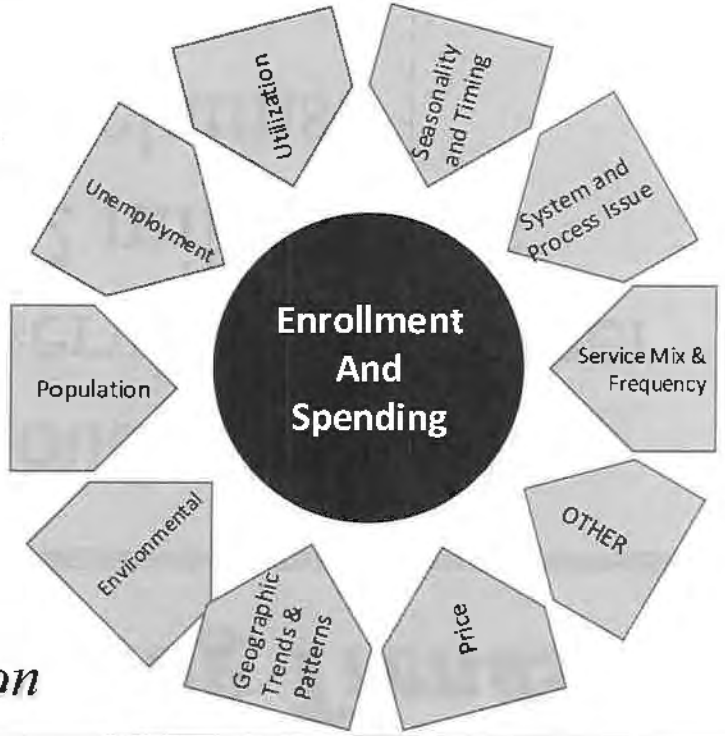
The combination of the mix of enrollment, the lower than expected overall enrollment and the budgeted capitation rate increases for the LME/MCOs contributed to this variance.

Key Considerations

- THE WHY'S *areas where we need more information*
  - Why are children and non-aged/disabled Adults less than budget
  - Why do family planning growth trends continue
  - Why have there been enrollment declines in 26 counties that have extended from June 2016
  - Why is there a $31 million spending variance – what are the drivers of hospital, physician, dental and home health/DME claims
- THE WHAT'S TO CONSIDER

  categories of explanation
- WHAT DOES IT MEAN

  what should/could we do now or in session



QUESTIONS

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JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

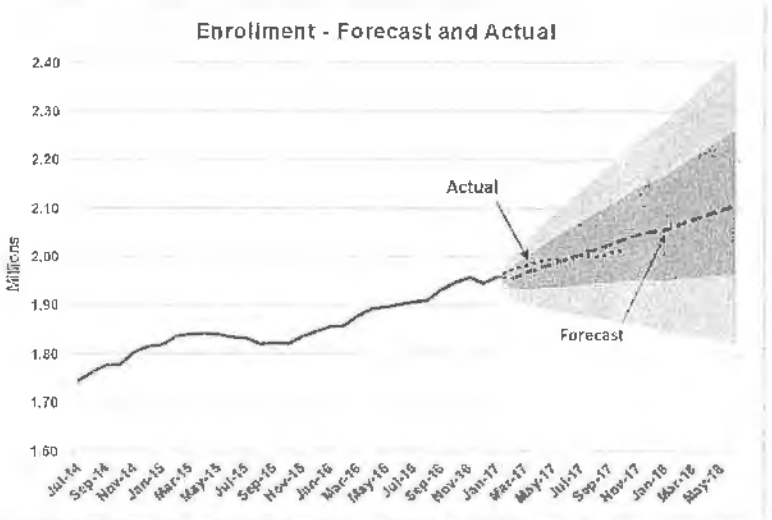
Medicaid Enrollment Update

Dave Richard and Michael Becketts
Department of Health and Human Services

Nov. 14, 2017

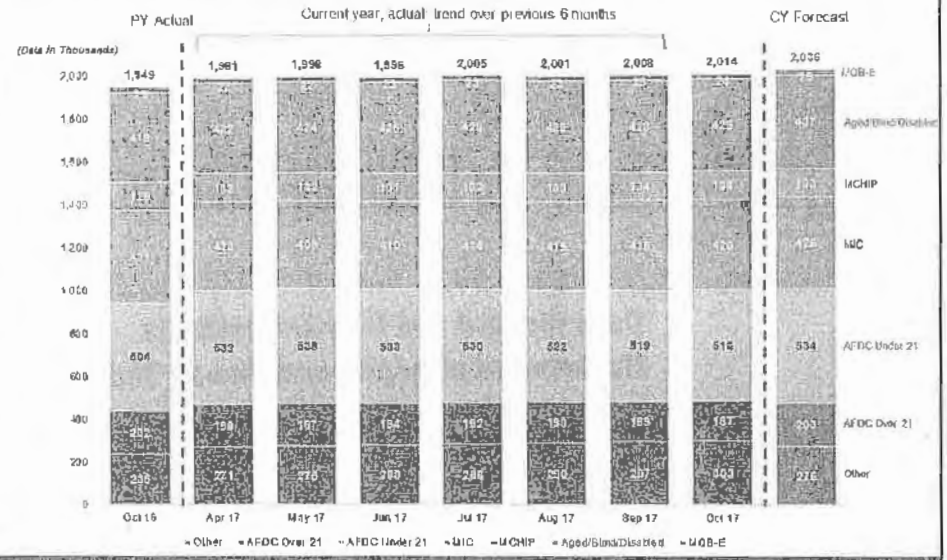
Medicaid Enrollment – Forecast vs. Actual

Medicaid enrollment has tracked roughly in line with DMA's expectations to date.

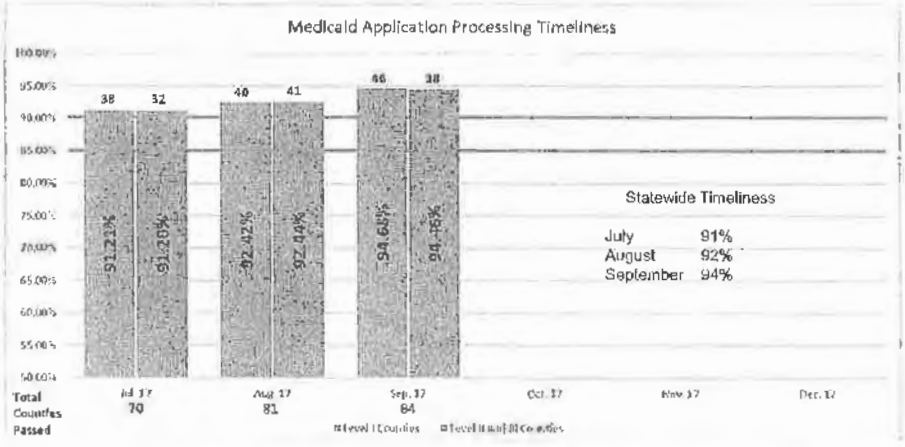


Medicaid Enrollment by Program Aid Category

Current enrollment at October 2017 of 2.014M is 3.4% higher than the one year prior 1.949M at October 2016



Medicaid Application Timeliness



- While the above graph represents average timeliness across counties, Each county must meet the 85% or 90% metric.
- Level I counties (52 smallest counties) are required to meet 85% timeliness on Medicaid/NCHC applications.
- Level II & III counties (48 largest counties) are required to meet 90% timeliness on Medicaid/NCHC applications.

Level I - Small (rural) Level II - Mid-size Level III - Large (urban)

Medicaid Application Timeliness

- Department experienced data issues in establishing the timeliness report card; resolved by July
  - High engagement with the Department and DSS leadership and Association
- Since July data were published, improvement noted monthly
  - September statewide results: 94%
- Department continues with actions:
  - Continue work with DSS Leadership workgroup
  - Provide technical support with individual counties that failed to meet monthly threshold
  - Provided training at DSS statewide meeting in August and October

Medicaid Eligibility Accuracy

- Department continues work with counties:
  - Implemented enhanced county second party review requirements and reporting
  - Coordinating with OST and NC FAST to develop policy training available in the NC FAST Learning Gateway
  - Revising to provide tracking for utilization
  - Developing enhancements to NC FAST to reduce potential income calculation errors
  - Developing county staffing model
  - Continued development of training and certification process for county staff
- Department recommends medical assistance programs be included with all other programs in the current social services reform efforts to drive comprehensive improvements across our social services system.

JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Finance Update

Dave Richard and Roger Barnes
Department of Health and Human Services

Nov. 14, 2017

Medicaid SFY18 Actuals vs. Budget

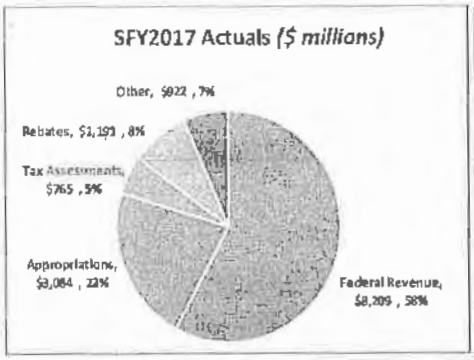
Through September 2017, total Medicaid expenditures were $30.7M or 0.8% favorable to the authorized budget.

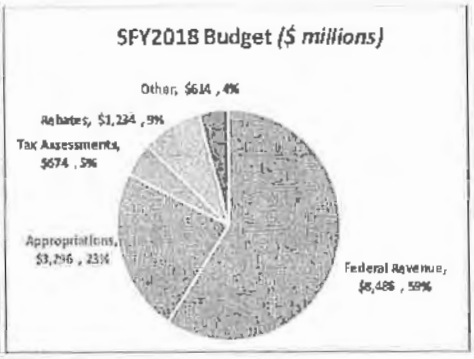
($ millions)

Fund Description	SFY2018B YTD	SFY2018A YTD	Variance (vs. Budget)	Variance %
Hospital[1]	$ 500.1	$ 508.7	$ 8.7	1.7%
Skilled Nursing Facilities	333.0	331.0	(2.0)	-0.6%
Physician	275.9	265.0	(10.9)	-4.0%
Pharmacy[3]	228.6	184.9	(43.7)	-19.1%
Other Claims	597.6	612.8	15.2	2.5%
Total Fee-For-Service Claims Exp.	$ 1,935.1	$ 1,902.3	$ (32.8)	-1.7%
Consolidated Supp. Hospital Payments	781.0	850.5	69.5	8.9%
Cost Settlements	49.3	28.4	(20.9)	-42.4%
Capitation, Premiums & Other Exp.[2]	1,070.6	1,024.1	(46.5)	-4.3%
Total Expenditures	$ 3,836.1	$ 3,805.4	$ (30.7)	-0.8%

Notes:
1. Hospital Expenditures include Inpatient, Outpatient, and Emergency Room Services.
2. Includes LME/MCO, PACE, High-Tech Imaging, and Buy-in/Dual Eligible Services.
3. Pharmacy Expenditures are net of rebates.

Medicaid Revenue Distribution





JOINT LEGISLATIVE COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Transformation

Dr. Mandy Cohen, Dave Richard, Jay Ludlam
Department of Health and Human Services

Nov. 14, 2017

Recap: Where We Are in the Transformation

- **Aug. 2017**: Published detailed Proposed Program Design
- **Nov. 2017**:
  - Released two Requests for Information (RFI)
  - Released a proposed PHP capitation rate setting methodology
  - Released concept paper with further detail on Behavioral Health I/DD Tailored Plans
  - Will soon submit amended 1115 waiver to CMS
- **Next 3-4 months**: Will publish several short, technical concept papers with more detail on specific topics
- **Feb. 2018**: Anticipated CMS approval of revised waiver
- **Spring 2018***: Release Request for Proposal (RFP)
- **July 2019***: Phase 1 of managed care goes live

* Assuming timely CMS approval and other activities

Pre-Paid Health Plan Procurement

- Releasing RFIs was the first step in PHP procurement process
  - Requested non-binding Letters of Interest
- In spring 2018, intend to release a Request for Proposal (RFP)
  - RFP will articulate standards PHPs are expected to meet across wide variety of program areas; e.g. plan administration, quality improvement, presence in NC
  - Potential plans will respond with detailed information on how they will meet these standards
  - DHHS will score results based on rubric established in RFP
  - DHHS will establish capitation rates that plans will be paid; all plans who win a bid will be paid using same formula

Behavioral Health Integration

- Consistent with principle of learning from best practices from other states while building on what is working in NC today
- Single point of accountability for care and outcomes; gives beneficiaries one insurance card
- Once managed care is fully implemented, Medicaid beneficiaries would receive coordinated physical and behavioral health services
- Most Medicaid beneficiaries would be enrolled in **Standard Plans;** a smaller number with significant BH or I/DD needs would be enrolled in **Tailored Plans**
- Time sensitive for NCGA action given timing of procurement process

Standard Plans

- Standard Plans would cover most beneficiaries in Medicaid managed care, including adults and children
- Most Medicaid beneficiaries would ultimately be in Standard Plans
- Integrated plan providing both physical health and behavioral services
- Would be expected to ensure that beneficiaries can access a network of providers for routine and some crisis BH services in addition to physical health services
- Would include statewide commercial plans and regional PLEs
- Would be selected through a competitive process
- Anticipated for Phase 1 of managed care in July 2019

Behavioral Health and I/DD Tailored Plans

- Specialized plans targeting ~120,000 beneficiaries with significant BH and I/DD needs; would have access to expanded service array
- Integrated plan providing both physical health and behavioral services
- Would be expected to ensure that beneficiaries can access a network of providers for the full, expanded array of BH and I/DD services (and physical health)
- Anticipate a phased rollout after launch of standard plans
  - Tailored plan population would temporarily remain in current arrangement (physical services in state administered fee-for-service, behavioral services authorized through LME/MCOs)
- Tailored Plans would be selected through a competitive process to ensure entities could meet requirements for both behavioral and physical health delivery
- Capitation rate setting formula will reflect enhanced risk of this population

Concept Paper on Behavioral Health and I/DD Tailored Plans

- Overview of covered populations in Standard Plans and Tailored Plans
- Detailed lists of ICD-9 and ICD-10 diagnosis codes associated with each population that would be in Tailored Plans:
  - Intellectual/Developmental Disability (I/DD)
  - Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)
  - Substance Use Disorder (SUD)
- Detailed list of BH and I/DD services covered only by Tailored Plans and list of services covered by both Standard Plans and Tailored Plans
- Enrollment processes for Tailored Plans include:
  - Processes for both legacy FFS beneficiaries and for new Medicaid applicants
  - Processes both before and after the launch of Tailored Plans
  - Mid-coverage year transitions and renewals

Behavioral Health and I/DD Services Available in Standard Plans and Tailored Plans

Covered by Both Standard and Tailored Plans	Covered Exclusively by Tailored Plans
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Partial hospitalization • Mobile crisis management • Substance abuse intensive outpatient program (SAIOP) • Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program • Psychosocial rehabilitation • Outpatient opioid treatment • Ambulatory detoxification • Non-hospital medical detoxification • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization • Substance abuse comprehensive outpatient treatment program (SACOT) • Research-Based Behavioral Health Treatment of Autism Spectrum Disorder *(pending CMS approval)* • Diagnostic assessments **EPSDT**	**State Plan BH and I/DD Services** • Residential treatment facility services • Child and adolescent day treatment services • Intensive in-home services • Multi-systemic therapy services • Psychiatric residential treatment facilities (PRTFs) • Assertive community treatment (ACT) • Community support team (CST) • Substance use non-medical community residential treatment • Substance abuse medically monitored residential treatment • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) • Diagnostic assessments **Waiver Services** • TBI waiver services • Innovations waiver services • 1915(b)(3) services **All State-Funded BH and I/DD Services** **State-Funded TBI Services** **EPSDT**

Further Work to Develop BH and I/DD Tailored Plans

DHHS intends to work closely with the NCGA to further develop additional components of Tailored Plans:

- Governance structure for BH and I/DD Tailored Plans
  - Non-Medicaid federal grant dollars will be managed by Tailored Plans; thus only non-profit or governmental (122C) entities will be able to offer them
  - Anticipate that some LME/MCOs would submit bids in partnership with a physical health plan to serve as a Tailored Plan
- Number of regions
- Whether or not to procure a statewide Tailored Plan

Supplemental Payments: Context and Approach

- Federal rules prohibit DHHS from making supplemental payments (other than DSH and GME) directly to providers for services covered under managed care
- DHHS is working closely with NC Hospital Association to design a payment structure within Medicaid managed care with the following goals:
  - Achieve cost-neutrality to the State
  - Result in similar reimbursement for hospitals
  - Continue direct DSH and GME payments
- Proposal uses hospital-specific rate floors to prevent disruption
- May need statutory authority from NCGA to implement
- Same rates will apply under managed care and remaining fee-for-service populations
- DHHS will release a white paper with technical details in next few weeks

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

February 14, 2018

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Medicaid and NC Health Choice
FROM: Rep. Donny Lambeth, Co-Chair
Rep. Nelson Dollar, Co-Chair
Sen. Ralph Hise, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Medicaid and NC Health Choice** will meet at the following time:

DAY	DATE	TIME	LOCATION
Wednesday	February 28, 2018	1:00 PM	643 LOB

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Candace Slate at dollarla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

February 28, 2018 1:00 p.m.
Legislative Office Building - Room 643

I.	**Welcome & Opening Remarks**	Representative Nelson Dollar Presiding Co-Chair
II.	**Remarks from Department of Health and Human Services (DHHS) Secretary**	Mandy Cohen, Secretary, Department of Health and Human Services (DHHS)
III.	**Family Planning Enrollment Update**	Steve Owen, Committee Staff Fiscal Research Division, NCGA
IV.	**Overview of Medicaid Dashboards**	Steve Owen, Committee Staff Fiscal Research Division, NCGA
V.	**Medicaid and NC Health Choice Enrollment**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS Susan Perry-Manning, Deputy Secretary for Human Services, DHHS
VI.	**Medicaid and NC Health Choice Financial Update**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS Roger Barnes, Chief Financial Officer, Division of Medical Assistance, DHHS
VII.	**1115 Waiver Amendment Submitted on 11/20/17 and Work Plan for Medicaid Transformation**	Steve Owen, Committee Staff Fiscal Research Division, NCGA Mandy Cohen, Secretary, DHHS Dave Richard, Deputy Secretary for Medical Assistance, DHHS Christen Linke Young, Deputy Secretary for Policy and Operations, DHHS
	Adjourn	**NEXT MEETING:** **March 13, 2018**

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
MEDICAID & HEALTH CHOICE

Tuesday, February 28, 2018
1:00 p.m.
Legislative Office Building, Room 643

ATTENDEES:

Chairmen: Hise, Dollar, Lambeth

House Members: Brisson, Dobson, Insko,
Senate Members: Bryant, Foushee, Krawiec, Pate, Tucker

I. Welcome and Opening Remarks

Chairman Nelson Dollar presided and called the meeting to order at 1:15 p.m.

Chairman Dollar introduced Sergeant-at-Arms Staff assisting with the meeting and committee staff members.

II. Remarks from Department of Health and Human Services (DHHS)

Secretary Mandy Cohen gave an overview of the day's reportings. She began by answering questions regarding the Department's efforts around fraud that were asked earlier in the day during the HHS meeting. She stated that the Department is on track for implementing its fraud/error work during the April timeframe. She expressed her appreciation to the Committee for allowing the Department to explain the status of the 1115 Waiver Amendment. She explained that looking at the Waiver in isolation does not provide a full understanding of the Department's intent regarding the Medicaid Program. Secretary Cohen referenced the comprehensive paper published during the summer of 2017 that outlined the Department's vision for managed care and provides an end-to-end look at what the Department desires to accomplish for Medicaid.

III. Family Planning Enrollment Update

Steve Owen, Fiscal Research Division, provided a visual that showed an approximately $200 thousand increase in family planning enrollment from July 2012 to January 2018. Mr. Owen noted two major factors that contributed to this increase: 1) A more accurate process of category determination through NCFAST; and, 2) A change in eligibility determination criteria to Modified Adjusted Gross Income through the Affordable Care Act. He noted that from 2012 to 2016, the birth rate for Non-Medicaid recipients increased while a decrease in birth rate over the same time period is noted for Medicaid recipients.

Mr. Owen reported that the percentage of males enrolled for Family Planning has increased by more than 10% since 2012 -- from 17.0% in 2012 to 27.8% during 2017. With regard to utilization and spending, data indicate that the percent of enrollees accessing services is 10% lower in 2017 at 15.2% compared to 25.2% in 2015. Per member/per month spending has also decreased slightly less than 10%: $14.23 in 2012 compared to $4.41 in 2017. According to Mr. Owen, trends in Medicaid birth rates have decreased as Family Planning enrollment increased.

Alarming data among Family Planning enrollees is the increase in low birth-weight in newborns who have received a NICU service -- from 6.0% in 2013 to 6.9% during 2016.

Representative Insko asked if the data regarding an increase in low birth-weight babies also applied to non-Medicaid recipients. Mr. Owen responded that the data presented applied only to Medicaid recipients; however, recent data reviewed also show the same trend in non-Medicaid recipients as well.

In response to this reporting, Secretary Cohen stated that the Department has seen a 900% increase in the number of newborns who were exposed to Opioid in the last six-to-seven years and require NICU and specialized care. Other factors include the mother's health and the mother's access to care. Secretary Cohen indicated that this data are not specific to Family Planning. She stated that the Department is looking at the high infant mortality rate in North Carolina. Nationally, it is approximately 5%; in North Carolina, 7%. In the rural areas of our state, it is between 12% and 13%. "This means that out of 100 infants, 12-to-13 will not live to their first birthday," she said.

IV. Overview of Medicaid Dashboards

Mr. Owen identified four drivers of Medicaid enrollment: Population; Unemployment; Birth Rates; and Uninsured/ACA enrollment. He stated that growth in Family Planning skews the trends in overall Medicaid enrollment. Since June 20, 2016 non-Family Planning enrollment has increased in the categories of ABD, Children (FPL) and Aliens and Refugees. Mr. Owen reported that 29 counties have experienced a decline in non-Family Planning enrollment since June 30, 2016; an additional 33 counties have experienced a decline in enrollment since June 30, 2017. Sixty percent of North Carolina counties are experiencing non-Family Planning enrollment declines in 2017-18. He indicated that unemployment is another driver in enrollment trends. "However, Medicaid is not always tied to the poverty rate," he added.

Mr. Owen suggested that the Committee look at higher-than-expected spending variance and areas with highest spending variance under budget, paying particular attention to how much is related to lower enrollment and how much is related to lower utilization. Program Integrity Recoveries was also reviewed by Mr. Owen. He reported that hospital and drugs represent 78% of the total recoveries in the current year. Current year recoveries as a percent of claims has remained fairly consistent for nearly all service

categories. "PCS/Home Care and Other Professionals are areas with the most significant rise in recoveries as a percentage of claims paid," he said.

Chairman Dollar requested data of non-Medicaid pregnancy numbers among young women aged 12 – 16 years of age. He also asked for an evaluation report of the Pregnancy Home Model reflecting its effectiveness over the past six years.

Chairman Dollar also pointed out that, if current predictions continue, 2018 will be the fifth straight year that Medicaid is projected to come in underbudget, including both Federal and State funds.

Representative Lambeth asked for a future report on the suggested follow-up categories:

- Trends in non-alien adults and average family size.
- Trends in alien and refugee enrollment – small in numbers, large in percentage
- Trends in 0-133% children vs 133-210% children
- Identification of changes in outlier counties: 1) Practices; 2) Policy; 3) Capacity; 4) Systems or Use of Systems; and 5) Environment/Demographic

Senator Hise requested data that addresses *assumptions* for future reporting.

V. Medicaid and NC Health Choice Enrollment

Dave Richard, Deputy Secretary for Medical Assistance (DHHS), reported that Medicaid enrollment has tracked roughly inline with expectations to date. As of January 2018, enrollment is approximately 3.6% higher at 2.032 million than enrollment in January 2017 at 1.961 million. Of those covered, the highest enrollment by program category is Aid for Dependent Children under the age of 21 years.

VI. Medicaid and NC Health Choice Financial Update

Roger Barnes, Chief Financial Officer, Division of Medical Assistance, provided SFY 2018 actual expenditures and the variance with the SFY 2018 budget. Mr. Barnes reported that year-to-date total Medicaid expenditures were $6.5 million or -5.9% favorable to the authorized budget.

Budgeted revenue distribution is: Federal Revenue, $8.486M (59%); Appropriations, $3.3M (23%); Tax Assessments, $0.7M (5%); Rebates, $1.2M (9%); and Other, $0.6M (4%).

Representative Dollar asked for clarification regarding the $408.8 million under budget as it differs from the amount reported by Mr. Owen previously. Mr. Barnes responded that the $408.8 million in his reporting includes all funds, both the claims as well as the administrative portion of the budget.

VII. 1115 Waiver Amendment Submitted on 11/20/2017 and Work Plan for Medicaid Transformation

Steve Owen, Fiscal Research Division, summarized the basics of North Carolina's Medicaid Reform Legislation:

Overview: Transition the Medicaid Program from a fee-for-service model to a managed care model 18 months following CMS approval of the 1115 Waiver.

Prepaid Health Plans (PHPs): 1) PHPs will receive a capitated payment to cover all services to the enrollee; 2) Both commercial plans and provider-led entities (PLEs) as defined in the legislation) will be considered PHPs. Commercial plans may only operate statewide contracts, and PLEs may operate statewide or regionally; and, 3) Three statewide contracts are required and up-to-12 regional PLE contracts are permitted across six regions that will be determined by the Department of DHHS.

Populations to be Covered: All populations except: dual eligible, medically needy, presumptive elegibles, HIPP enrollees, and emergency-only recipients. Participation by members of a Federally-recognized tribe is voluntary.

Services to be covered: All services except: 1) Behavioral Health services covered by LME/MCOs (for four years after the date capitated contracts begin); 2) Dental; 3) PACE; 4) Certain services provided in school pursuant to an IEP; 5) CDSA services; 6) Services provided prior to an eligibility determination; and, 7) Fabrication of eye glasses.

Department Role: The Department shall ensure sustainability of the transformed program and beginning in September 2015 was granted full authority to manage the Medicaid and Health Choice programs within authorized budgets, with the exception that the General Assembly shall determine eligibility categories and income thresholds.

Mr. Owen reviewed 1115 Waiver Amendment provisions that are not consistent with S.L 2015-245. Inconsistencies include:

1) Increase access through implementation of Carolina Cares, "if proposed State legislation is enacted;"
2) Request for up to $1.2 billion in increased spending over five years to fund implementation of targeted initiatives at a 50% match rate; "non-federal sharefunding not identified other than implied savings on traditional Medicaid and lower Carolina Cares cost;"
3) Tribal uncompensated care pool -- "100% federally funded;"
4) Carve out nursing home long stays, Family Planning populations, prisoners, CAP-C and CAP-DA populations;

5) Implementation of Carolina Cares premiums and work requirements; "If enacted by the State Legislature;"
6) Delay in enrollment of populations eligible for tailored plans until year three;
7) Delay in enrollment of TBI populations until year three;
8) Behavioral Health/Intellectual Developmental Disability Tailored Plans and Specialized Foster Care Plans; "Pending State legislative authority;"
9) The Waiver states that three commercial plans will be offered statewide/silent on PLEs;
10) Carves out costs for "fabrication, fitting, and dispensing" of eyeglasses;
11) Proposed schedule is phrased, "Begin launch of managed care" July 2019 (17 months after CMS approval); and,
12) PHPs will be charged a "premium tax' and the proceeds of that tax will be used to fund Medicaid programs; "if approved by the legislature."

Mr. Owen stated that the amended waiver application only includes the projected budget impact for Federal spending. The non-Federal share of the proposed spending is not included in the 1115 Waiver Amendment. Mr. Owen noted that the only way to estimate the maximum potential impact is to derive the non-Federal share using exhibits contained within the Waiver. "In doing so, the potential increased spending from the Waiver for FY 2019-2024 of non-Federal spending totals an estimated $206.2 million," he said.

Three additional provisions needing CMS approval were also noted by Mr. Owen: 1) Cost Settlement for safety net providers; 2) IMD services by Medicaid; and, 3) Carolina Cares work requirements and the premiums.

Mr. Owen shared several elements within the Waiver that need further explanation: 1) One stop credentialing and regional provider support centers; 2) Improvements to physical and behavioral health; 3) Public/private partnership desired outcomes and measures; 4) "Workforce Fund" or loan forgiveness program; 5) Telemedicine services and Home Healthcare Management; 6) Access and network adequacy assurance; 7) PHP capitation rate setting, enrollment and reimbursement assumptions for cost projections; and, 8) Assumptions for funding impact of new provisions.

Mr. Owen posed the question for committee members to consider: What is the implication for Federal funding if CMS approves the Waiver Amendment as filed and the Department is never authorized by the General Assembly to implement elements included in the 1115 Waiver.

Senator Bryant inquired if FQHCs would be affected by the Waiver. Deputy Secretary Christen Linke Young responded that FQHCs are not considered safey net providers for the cost settlement provision in the 1115 Waiver. In the Managed Care Transformation legislation, FQHCs are identified as essential community care providers which means special rules apply.

Based upon Mr. Owen's report, Chairman Dollar asked if the General Assembly would be responsible for the $206M short fall? Mr. Owen responded *yes* over a five-year period if all the assumptions and spending occurred as presented in the Waiver Amendment.

Chairman Lambeth addressed the Committee regarding Carolina Cares. He stated that he unveiled Carolina Cares as an opportunity for the State to provide a better service. He described the committee's discussion as helpful and extremely important. "I do not want to be a part of anything that adds a $206 million deficit to the State. I would love to say we are going to save $200 million and provide a better service." Chairman Lambeth added that a lot of work and a greater understanding are necessary to move forward. Chairman Lambeth concluded that the good news is we can continue our work as this is a long-term reform plan for Medicaid.

Chairman Dollar asked so is the implication for Federal funding if CMS approves the Waiver Amendment as filed and the Department is not authorized by the General Assembly to implement elements of the Waiver?

In response, Secretary Cohen stated that there is a fundamental misunderstanding regarding the budget. "We need maximum flexibility in making decisions, she said."

Chairman Dollar asked if there was a significant difference between how the numbers are put together for CMS and how the numbers are put together with respect to the budget. He expressed concern that all parties involved may not have the same level of understanding between these two propositions.

Secretary Cohen explained that the 1115 Waiver Amendment is submitted one time and if approved, it stands for five years. "But the most fundamental is that we are asking the Federal Government: If we show up with State share in hand (authorized by the General Assembly), will you match it?" There will be additional tools required by CMS. She assured the committee that all required documentation will be in accordance with State law. "We cannot spend money unless we are authorized," she concluded.

Christen Linke Young, Deputy Secretary for Policy and Operations (DHHS), reviewed the three primary tools available for modifying a state's Medicaid program:

- State Plan Amendments (SPA) that are used to change administrative aspects of a state's Medicaid program such as covered benefits and provider payments;

- 1915 Waivers that are used for certain narrow functions like coverage of home and community-based services and in other states, case management; and,

- 1115 Waivers that allow broader authority for states to pursue "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of Medicaid, but must be budget neutral for the Federal Government.

These waivers are generally used for large initiatives and granted for five-year terms and may be renewed.

Deputy Secretary Young informed the committee that DHHS held public hearings and released an eighty-page program design prior to submitting the amended waiver which included: 1) An end-to-end view of vision for all components of the managed care transition, including those not requiring waiver authority; and, 2) Detailed discussion of covered populations and timelines. The Department also released concept papers on specific topics: 1) BH IDD Tailored Plans; and, 2) Network Adequacy. She stated that other papers on specific topics would be released in the coming months.

Deputy Secretary Young reviewed the process for submitting the 1115 Waiver Amendment to CMS (Centers for Medicare/Medicaid Services) which grants broad authority for states to pursue *any experimental, pilot or demonstration project likely to assist in promoting the objectives* of Medicaid, but must be budget neutral for the Federal government. It is generally used for large initiatives and granted for five-year terms and may be renewed. The 1115 Waiver Amendment which was submitted during November 2017 covers only the components of our State's proposal that require special Federal authority; not a holistic picture of any Medicaid reform initiative. "In other words, it is a starting point for discussions with CMS," she stated..

CMS and the State agree on an amount of "savings" for the Federal government compared to Federal spending. Based on those savings, the State secures an agreement that CMS will provide matching funds up to certain amounts for certain activities not typically covered by Medicaid if the State conducts those activities. Budget neutrality cannot be renegotiated except under exceptional circumstances.

Some components of the Waiver require additional legislative authority to implement:

- Integration of Behavioral Health into PHP contracts;
- Creation of Tailored Plans for those with significant needs and delayed enrollment of Tailored Plan population;
- Exclusion of certain populations with limited coverage from managed care;
- Delayed enrollment of special populations;
- Minor changes to managed care coverage related to eyeglasses;
- Imposition of work requirements and premiums for potential future populations;
- Supplemental payment reform; and,
- MCO tax and revenue.

Any spending under the Waiver requires enactment of future year budgets. Examples include:

- Initiatives to develop the NC healthcare workforce;
- Initiatives to improve access to, use of, and efficiency of telemedicine services; and
- Public/private partnerships

Deputy Secretary Young informed the committee that DHHS has had ongoing weekly meetings with CMS subject matter experts since September to discuss Waiver components. Feedback received include:

- Changes to the process for cost-settling local health departments and other safety net providers in managed care (now using State Plan Authority, not waiver authority);
- Discussion continues on the scope of an Institution for Mental Disease (IMD) waiver based on guidance provided by CMS after the waiver was submitted; and,
- Ongoing budget neutrality conversations.

She stated that recent discussions have unearthed potential areas of disagreement.

Chairman Dollar called on committee members who had follow-up questions or comments.

Chairman Hise stated that he has issues with the inclusion of Carolina Cares in the Waiver. "It disturbes me that the first chance we have to talk with CMS, we have to put Carolina Cares into that budget. This GA has not authorized changes in the Medicaid population," he said.

Secretary Cohen responded that what is asked for in the 1115 Waiver is the permission of CMS to impose work requirements and premiums if the General Assembly decides to move toward a change in eligibility. She reminded the committee that this is the one and only chance within the next five years to ask for any savings related to anything the State is about to do.

Secretary Cohen reiterated the fact that she is not in favor of work requirements or premiums in the Medicaid Program. Secretary Cohen informed the committee that, at the time the Waiver was submitted, CMS had not approved any work requirements or premiums so asking that question was important. "Since that time, CMS has approved Kentucky which gives us a sense of parameters of what they would approve related to work requirements or premiums," she added.

"My goal is to maximize what the State can access from the Federal government over a five-year period and spread the additional savings across all funds," she said. She informed the committee that nothing is in the Waiver regarding eligibility.

In addressing Chairman Hise's concern about public/private partnerships, Secretary Cohen stated that the department will work through any issues and develop details during the next budget cycle. She assured the committee that those decisions will be a part of the budget process.

Senator Hise expressed his displeasure with the inappropriateness of asking ourselves how high can we run that number and what's the maximum amount of Federal funds can we potentially access when dealing with the Federal government and Federal taxes.

Deputy Secretary Young responded that the goal is to maximize flexibility in making future decisions. "Any spending under the Waiver will ultimately require an act under the State budget," she said.

In order to give the committee a sense of how the department looks at building cost neutrality into waivers, Deputy Secretary for Medical Assistance Dave Richard used the example of the North Carolina Innovations Waiver for people with disabilities. He stated that the department builds cost neutrality estimates of about $120K per person in services. He stated that in order for that waiver to be cost neutral at the aggregate level, the State spends between $60K to $70K per person. In the budget process, you look at what you could spend and what you appropriate. "I can tell you we have never spent the amount at CMS allows us to spend on the NC Innovations Waiver," he said.

For clarification, Chairman Dollar asked if it is the position of the department that CMS will approve future expenditures in the context of the 1115 Waiver without specific legislative approval in advance. Secretary Cohen responded *yes*. She stated that it is very common with CMS and its COO.

Chairman Dollar pointed out that the 1115 Waiver differs from the Innovations Waiver in that the Innovations Waiver is designated to a specific area. He asked if the General Assembly would need to take additional action for CMS to approve the 1115 Waiver Amendment?

Secretary Cohen responded that no additional action needs to be taken by the General Assembly for CMS to approve the 1115 Waiver. She added that additional legislation would be required in order to launch Managed Care.

Based on the information presented, Chairman Dollar asked if CMS is beginning to raise budget neutrality questions with respect to the 1115 Waiver. Deputy Secretary Young affirmed that CMS is raising questions but added that their questions pertain to calculations regarding Venture and predictions regarding historical drug spending as well as changes in the State's 2014 Medicaid enrollment.

Representative Dobson asked if the department expects a delay in approval of the 1115 Waiver due to CMS's concerns regarding budget neutrality?

Deputy Secretary Young replied that questions raised by CMS were unexpected. She informed the committee that Secretary Cohen would be meeting with CMS in the coming week to get feedback from them.

Secondly, Representative Dobson inquired if provisions would be in place so that RFPs for both sets of contracts would not be sent out simultaneously.

According to Deputy Secretary Young, a single RFP will cover the three statewide contracts which may be operated by any entity that meets the requirements for operating a statewide contract as well as the 12 regional contracts. She advised Representative Dobson that rules of the contract and how decisions are made regarding the awarding of the contracts are on the RFPs. Assurances are in place so that all 12 regional contracts are not in one region.

Representative Dobson responded that the expectation is for every bidder to be on the same playing field. "Will there be a provision in place that mandates bidding on either a PLE contract or a regional contract but not both?" he asked.

Deputy Secretary Young responded that the department anticipates entities would be able to bid on both. She stated that she welcomes further discussion to determine what changes may need to occur moving forward.

Senator Tucker began his comments by sharing conversations with Mr. Richard to remind Secretary Cohen that the word *expansion* is off limits. He asked the question: What impact does North Carolina's stand to not expand (on Medicaid) have on CMS's decision. What would be the impact on North Carolina should the Federal Government move in the direction of block grants?

In response to Senator Tucker's question, Secretary Cohen stated that a lot of discussion regarding block grants and per capata took place during 2017. She informed the committee that a review of various proposals reflected a large reduction in overall funding to North Carolina over the previous ten-year period which is concerning to DHHS staff. Secretary Cohen reported that nothing seems to be happening Washington. She stated that conversations taking place at the National Governors' Conference were directed to the Opioid crisis and moving money to address that issue. Additional conversations and questions centered around possible Federal funding to stabilize the individual market and additional dollars related to reinsurance.

Secretary Cohen is of the opinion that block grants, per capata caps have been a policy idea for quite some time, but will certainly not happen this year. "I think we will have to wait until after the next election to find out what the goal is, what Congress looks like, and what priorities will be at that time," she said.

In response to Senator Bryant's question regarding process, Chairman Dollar summarized the dialogue among DHHS staff and members of the committee stating:

> "The Genereal Assembly in 2015 authorized an 1115 Waiver to be developed and submitted based on HB 372. That was done under prior administration and an amendment to that Waiver, which in essence is the original Waiver with certain changes, was done on November 20, 2017. So that amended Waiver has been submitted. The questions that have been raised in large measure have been both budgetary assumptions as Mr. Owen presented and there are specific programs included or specific elements of that amendment as noted in the submission that require General Assembly approval.
>
> So the reason for the question I asked previously was that is it the department's position that the GA doesn't necessarily need to act on any of those items in order for CMS to approve the Waiver amendment. Their response at this point is: yes, they don't believe the General Assembly has to act even though there are significant elements of that Waiver Amendment that in order to be operationalized will require an act or acts of the General Assembly."

Chairman Hise added that CMS recognizes a single state agency, the DHHS Department. He stated that while CMS could have approved the Waiver, CMS could disapprove the Waiver as well, because CMS doesn't feel the Waiver could be implemented and one of the reasons could be because the General Assembly hasn't authorized everything that's part of it. So I don't really want to say that CMS couldn't act but "What I'm looking for at the end of the day (and the GA is looking for) is not action by CMS--I'm looking for a reformed Medicaid system that we can implement in this State," he said.

Chairman Hise outlined components of the Waiver that need to be addressed:

- Day Family Planning.
- There amout of $4.00 dollars that we spend per person;
- Eye glasses;
- Special needs plans; and,
- The Mental Health population -- which ones are included under capitated plan and which ones will be under the special needs plans.

Chairman Lambeth expressed his agreement with both Chairman Dollar and Chairman Hise. He stated that the committee has and have had discussions about a number of items on the list—several of them that we can come to full agreement. " Can we deal with those in the Short Session in order to narrow our number of differences," he asked. "Narrowing our differences will enhance our ability to get approval of the Waiver and roll out the implementation consistent with the Waiver submitted during November 2017."

Chairman Dollar asked at what specific point on the statutory timeline for approval and implementation of the 1115 Waiver are we currently.

Secretary Cohen responded that the Department continues to target July 1, 2019 as the first "go live" date for Managed Care. She added that staff has a number of issues that are causing us to wonder whether or not that date is a little more aspirational than when it was established. "We continue to work operationally within the department to continue to target that date and work towards it.

Secretary Cohen stated that operationally July 1, 2019 remains the target date. Although there are a lot of questions, the department is not targeting a new date.

Chairman Dollar stated that he had additional questions regarding the information in the powerpoints but would send them in writing and share the department's responses with members of the committee.

Representative Dobson asked if a slight delay in the process would be detrimental in order to resolve some of the issues in HB403.

The response from Secretary Cohen is that a lot of work has taken place to ensure that Managed Care is launched in the most successful way possible. "If a couple of extra months are needed to get it right, it's the right thing to do," she said.

As follow-up, Representative Dobson inquired about a target time or a change in the target time for the RFPs to go out.

Chairman Dollar responded that the 1115 Waiver must be approved before RFPs can go out.

VII. Announcements

Chairman Dollar announced that The next meeting date is March 13th, 2018

VIII. Adjournment

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice adjourned at 3:34 p.m.

Representative Nelson Dollar, Chair

Panthea Briles, Committee Clerk

Attachments: Agenda
Handouts (6)

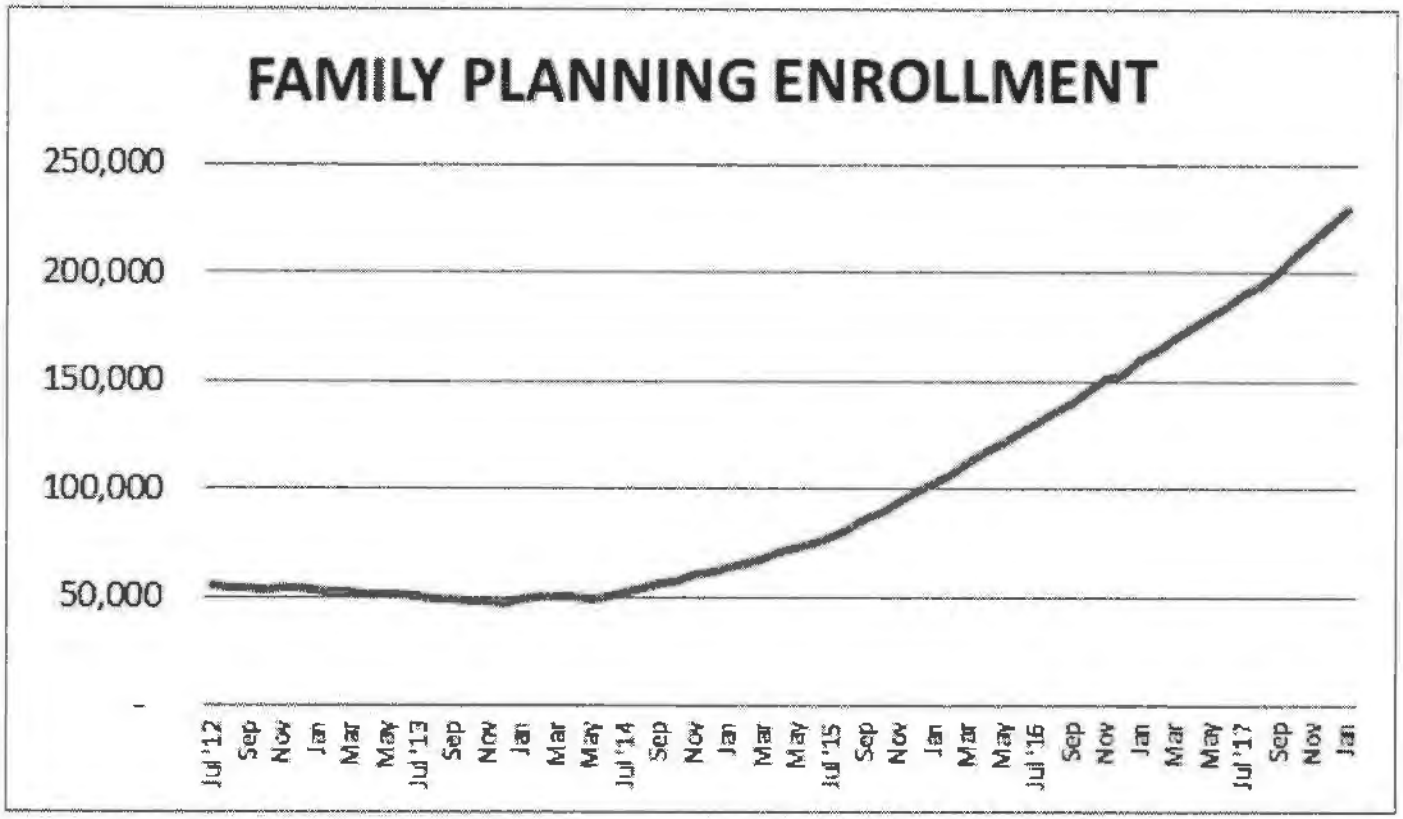
Joint Legislative Oversight Committee on Medicaid and NC Health Choice

Family Planning Enrollment

Steve Owen,
Fiscal Research Division

February 28, 2018

Trends in Family Planning Enrollment



WHY HAS THE ENROLLMENT TREND CHANGED AND WHAT IS THE IMPACT?

Changes in Eligibility Determination

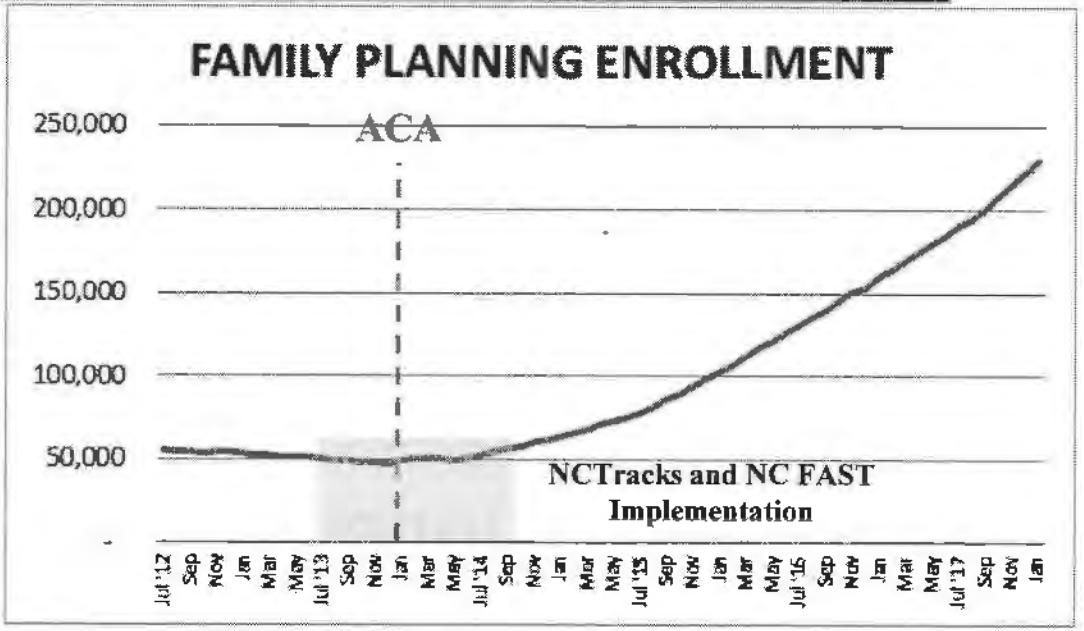
- Effective 1/1/14 the Affordable Care Act changed the income determination criteria to Modified Adjusted Gross Income

- Beginning in July 2013 NC Tracks and NCFAST were being implemented – *IMPACT was to automate the process of identifying the most appropriate eligibility category for each applicant*

Trends in Family Planning Enrollment

PRIMARY FACTORS DRIVING ENROLLMENT GROWTH:

- The process of enrollment through NCFAST resulted in category determination in a more accurate manner
- Since Family Planning income criteria is up to 195% of FPL individuals applying for Medicaid that did not meet other category eligibilities have been increasingly enrolled in Family Planning



Impact of Family Planning Trends

- Mix of enrollees
- Utilization
- Spending
- Birth Rate
- Other

Mix of Enrollees

- Increased proportion of males enrolled for family planning

	2012	*2013*	*2014*	*2015*	*2016*	*2017*
% of Enrollees	17.0%	17.0%	18.6%	22.1%	25.6%	27.8%

IMPACT would be a higher cost for procedures and lower cost for birth control; net decrease overall PMPM costs

Utilization and Spending

- % of Enrollees accessing planning services

FY 2015-16	*FY 2016-17*	*Est'd FY 2017-18*
25.2%	22.1%	15.2%

- PMPM Spending

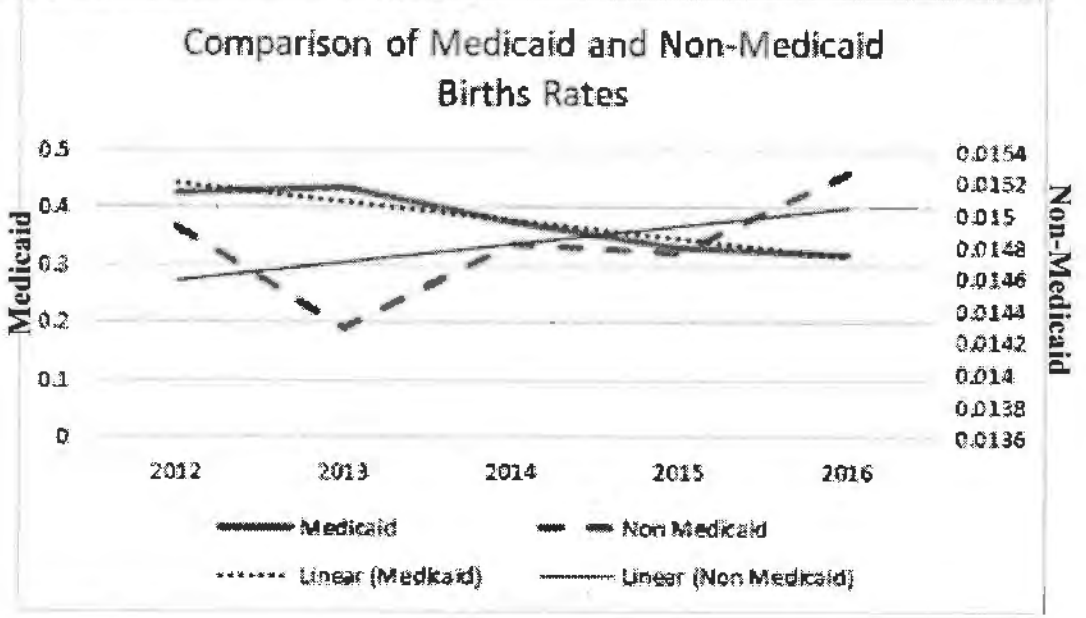
FY 2012-13	*FY 2015-16*	*FY 2016-17*	*Est'd FY 2017-18*
$ 14.23	$ 7.75	$ 5.87	$ 4.41

- Per Capita Spending

FY 2015-16	*FY 2016-17*	*Est'd FY 2017-18*
$ 369	$ 319	$ 348

Birth Rates

Changes in enrollment not determined to be causal for the changes in birth rate; but it is apparent that trends in Medicaid birth rates are different after Family Planning enrollment began to increase



- *The percentage of mothers that were previously in Family Planning increased each year from 17.1% in 2012 to 22.3% in 2017 - Months between family planning enrollment and birth increased each year from 21.3 months in 2012 to 31.6 months in 2017*
- *LARC Utilization: 1) Approximately 2% of the enrollees received LARC in 2017; 2) Less than 15% of LARC insertions or implants are for Family Planning enrollees; 3) Non-Family Planning inserts and implants declining; 4) Proportion of removals to insertions for Family Planning enrollees has doubled since 2012.*

Other Observations

- Births increasingly occurring at urban hospitals
- Births that have received a NICU service has increased each year since 2013

	2013	*2014*	*2015*	*2016*
	6.0%	6.4%	6.8%	6.9%
% <2,500g	*9.6%*	*9.7%*	*10.1%*	*10.6%*

- Given the rate of increase in Family Planning compared to other categories; it can skew the conclusions about trends and we should consider always presenting enrollment data with and without Family Planning when evaluating Medicaid

QUESTIONS

Steve Owen – steve.owen@ncleg.net
919-733-4910

Joint Legislative Oversight Committee for Medicaid and NC Health Choice

Medicaid Dashboards

Steve Owen,
Fiscal Research Division

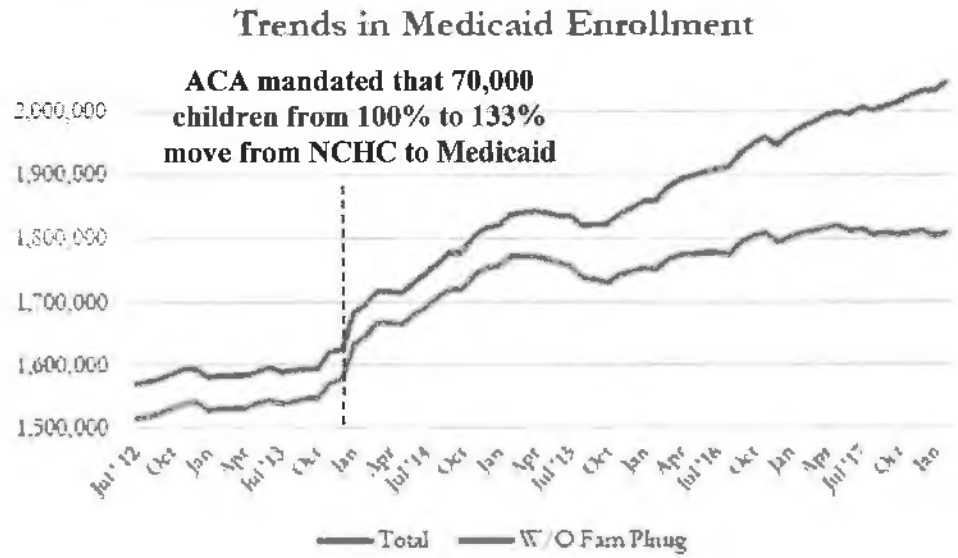
February 28, 2018

Discussion Guide

- **Enrollment**
- **Spending**
- **DMA Forecast**
- **Program Integrity**

Enrollment – YTD February 2018

- Family Planning growth skews the trends in overall Medicaid enrollment
- Drivers of Enrollment:
  - *Population*
  - *Unemployment*
  - *Birth Rates*
  - *Uninsured/ACA Enrollment*



- Since June 30, 2016 non-Family Planning enrollment changes have been:

	YTD 2/1/18	*FY 2016-17*
ABD	4,178 : *1.0%*	7,238 : *1.7%*
Duals	(1,160) : *(1.6%)*	(1,851) : *(2.5%)*
Children 0% -133% FPL	(5,593) : *(.6%)*	21,748 : *2.3%*
Children 133% - 210% FPL	9,354 : *7.1%*	5,795 : *4.6%*
Non-Alien Adults	(9,884) : *(4.6%)*	(5,464) : *(2.5%)*
Aliens and Refugees	1,154 : *5.8%*	6,035 : *44.0%*

Non-Family Planning Enrollment Trends

- Aliens and Refugees Growth– 20,910 at 2/1/18

2010	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*YTD '18*
7.4%	44.5%	17.1%	154.4%	22.2%	81.3%	5.9%	44.0%	5.8%

- Other non-ABD Adults

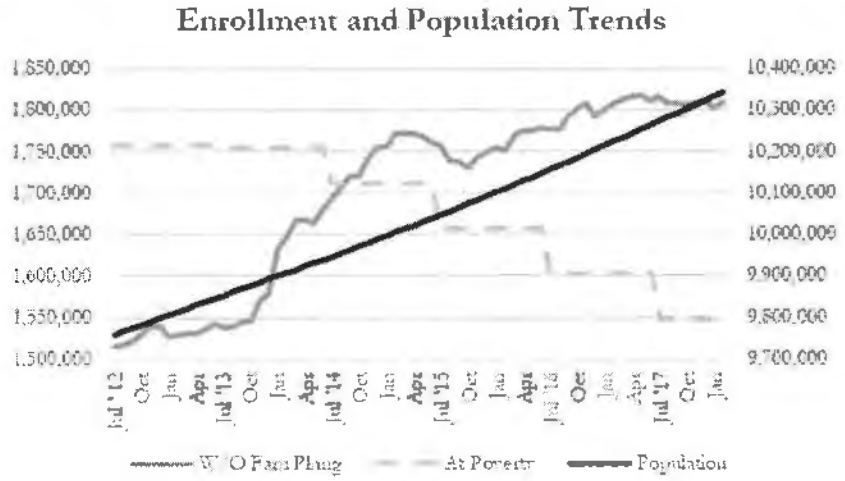
2010	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*YTD '18*
5.1%	4.1%	(1.9%)	(1.8%)	15.5%	18.3%	.4%	(2.5%)	(4.6%)

- Non MCHIP Children

2010	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*YTD '18*
7.0%	1.5%	9.1%	2.4%	4.3%	3.0%	(1.1%)	2.3%	(.6%)

Enrollment Trends

- The chart on the right compares the trend in non-Family Planning Medicaid enrollment with the trends in NC population at the population at or below 100% of the federal poverty level



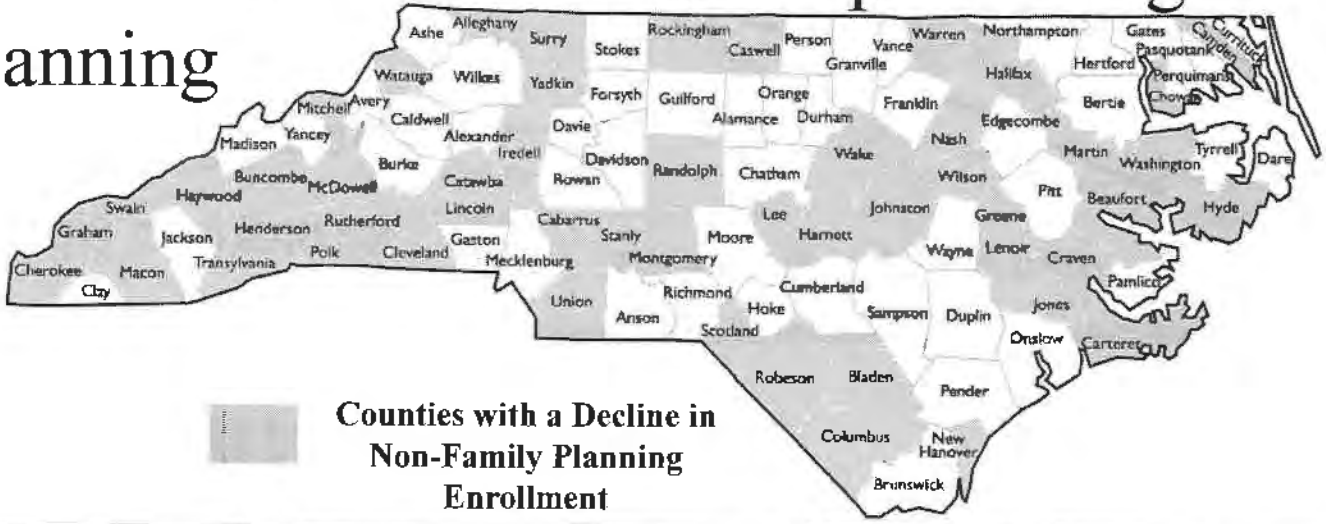
- Because the eligibility is not exclusively at or below 100% of FPL there is not an exact correlation for this driver
- Unemployment is another factor to examine as a driver

	2012	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
NC Unemployment	**9.7%**	**8.7%**	**6.9%**	**5.9%**	**5.3%**	**4.9%**	**4.2%**

Source: US Census website

Enrollment Trends – Counties

- 29 Counties have experienced a decline in non-Family Planning enrollment since 6/30/16
- Another 33 Counties have experienced a decline in enrollment since 6/30/17
- Over 60% have the counties in NC are experiencing non-Family Planning enrollment declines in FY 2017-18



Enrollment Trends – Counties

- Counties with non-Family Planning growth in FY 2017-18 have seen changes in the following categories:

	Counties	*Total*
– *ABD*	*3,361*	*4,178*
– *Children 0% - 133% FPL*	*2,738*	*(5,593)*
– *Children 133% - 210% FPL*	*4,267*	*9,354*
– *Non-Alien Adults*	*(2,884)*	*(9,884)*
– *Aliens and Refugees*	*582*	*1,154*
– *Duals*	*(299)*	*(1,160)*

Suggested Follow Up

- Trends in Non-Alien Adults and average family size
- Trends in Alien & Refugee enrollment – small in numbers, large in percentage
- Trends in 0-133% children vs 133-210% children
- Identify Changes in Outlier Counties
  - *Change in practices*
  - *Change in policy*
  - *Change in capacity*
  - *Change in Systems or Use of Systems*
  - *Environmental/Demographic Changes*

Forecast Comparison

- On January 24, 2018 DHHS reported that they expected a surplus in the current year of $28.1 million in State Appropriations
- DHHS expects Requirements to be $149.8 million over budget, but the $177.9 million in higher expected receipts more than offsets the spending variance to result in the surplus the Department reported

Forecast YTD Comparison

- For claims spending, DMA has reported a declining spending variance to budget over the past 2 months
  - *December* *($187.5) Million*
  - *January* *($155.0) Million*
  - *February 20, 2018* *($136.4) Million*
  - *Expected variance YTD February = ($66) million based on enrollment and mix*
- FRD has not been able to obtain data from the Department to assess the assumptions in the 1/24/18 estimate or what has caused the spending variance under budget to decline over the last 3 months

Suggested Follow Up

- Higher than expected spending variance
- Areas with highest spending variance under budget:
  - *Capitation Payments* *$59.1 million*
  - *PCS* *$42.1 million*
  - *Pharmacy* *$36.1 million*
  - *Home Health* *$15.4 million*
  - *Physician/Clinic/Hlth Chk* *$13.0 million*

  How much related to lower enrollment, how much related to lower utilization?

Program Integrity

Reporting of recoveries from third party payers when a recipient was covered by private health insurance during the time they were enrolled in Medicaid, estate recoveries; as well as, from providers where there is fraud, waste and abuse

Program Integrity Recoveries

	TOTAL RECOVERIES					
	SFY 2012-13	*SFY 2013-14*	*SFY 2014-15*	*SFY 2015-16*	*SFY 2016-17*	*YTD2018-Jan*
Hospitals	(65,593,151)	(39,836,464)	(44,685,721)	(43,505,391)	(45,502,676)	(32,564,853)
Prescribed Drugs	(39,429,019)	(13,759,631)	(29,112,916)	(34,841,466)	(31,918,131)	(15,279,321)
Physicians	(10,919,039)	(8,427,582)	(10,417,818)	(13,524,759)	(12,734,718)	(7,052,750)
PCS and Home Care	(2,692,551)	(1,081,588)	(1,168,118)	(1,930,519)	(2,315,596)	(2,240,965)
Mental Health Facilities	(381,452)	(426,618)	(476,758)	(615,336)	(1,345,882)	(153,175)
ICF-MR	(84,690)	(1,182,499)	(17,611)	(1,416)	-	-
Non-Physician Practitioners	(3,316,632)	(596,571)	(400,667)	(377,066)	(165,915)	(62,019)
Other Professionals	(962,318)	(1,055,773)	(851,379)	(1,792,361)	(1,803,548)	(1,397,132)
Diagnostic and Treatment	(17,597)	-	(48,011)	(2,443,850)	(679,125)	(158,016)
DME	(404,342)	(1,201,377)	(730,015)	(676,284)	(929,020)	(98,558)
Skilled Nursing Facilities	(1,041,985)	(250,736)	(118,980)	(137,325)	(102,925)	(7,382)
Ambulance	(176,129)	(126,711)	(41,299)	(4,258)	(9,916)	(19,827)
Clinics	(392,428)	(913,765)	(470,895)	(61,314)	2,080	(606)
Hospice	(49,029)	(198,844)	(424)	(18,759)	-	(124)
Other Services	18,477	(182,914)	(251,321)	(144,392)	(107,994)	(444,303)
TOTAL RECOVERIES	(125,441,884)	(69,241,073)	(88,791,932)	(100,074,497)	(97,613,364)	(59,479,029)

Annualized, on track for a comparable year

Source: NCAS BD701

Program Integrity Recoveries

	TOTAL RECOVERIES					
	SFY 2012-13	*SFY 2013-14*	*SFY 2014-15*	*SFY 2015-16*	*SFY 2016-17*	*YTD2018-Jan*
TOTAL RECOVERIES	(125,441,884)	(69,241,073)	(88,791,932)	(100,074,497)	(97,613,364)	(59,479,029)
	-	-	-	-	-	-
** January YTD Recoveries	(74,071,826)	(125,441,886)	(47,209,436)	(34,997,657)	(27,535,065)	(59,479,029)
TOTAL CLAIMS	10,648,418,547	10,762,525,171	11,684,674,590	11,786,239,232	12,049,741,694	6,188,165,672
Percentage of Claims	***-1.18%***	***-0.64%***	***-0.76%***	***-0.85%***	***-0.81%***	***-0.96%***
% without Behav Hlth	*-1.27%*	*-0.65%*	*-0.77%*	*-0.86%*	*-0.82%*	*-0.97%*

*** According to DHHS the variance in the YTD recoveries in 2018 is primarily a timing issue rather than a result of a significant increase in recoveries.*

Percent of Recoveries estimated by category:

	2013	*2014*	*2015*	*2016*	*2017*	*YTD 2018*
Third Party/Estate Recoveries	76%	65%	91%	73%	93%	82%
Fraud, Waste & Abuse	24%	35%	9%	27%	7%	18%

NOTES:

1) Changes in recoveries for Mental Health Facilities and ICF-MR's is significantly impacted by the fact that beginning in 2012 behavioral health services were shifted from Fee For Service to Capitation paid to LME/MCOs. Therefore, claims for these services that were paid by Medicaid were nearly eliminated and the recoveries from claims for services paid prior to the transition.
2) Claims spending does not include cost settlements, supplemental hospital or physician payments and transfers between funds.
3) Recoveries include both recoveries for fraud/waste/abuse and third party recoveries.

Program Integrity Recoveries

- Hospital and Drugs represent 78% of the total recoveries in the current year
- Current year recoveries as a % of claims has remained fairly consistent for nearly all service categories. "PCS/Home Care" and "Other Professionals" are areas with the most significant rise in recoveries as a percentage of claims paid.

	TOTAL RECOVERIES AS % OF CLAIMS PAID					
	SFY 2012-13	SFY 2013-14	SFY 2014-15	SFY 2015-16	SFY 2016-17	YTD 2018-Jan
Hospitals	-3.54%	-2.29%	-2.29%	-2.40%	-2.43%	-3.39%
Prescribed Drugs	-3.21%	-0.99%	-1.77%	-1.92%	-1.71%	-1.62%
Physicians	-0.93%	-0.74%	-0.80%	-1.12%	-1.04%	-1.16%
PCS and Home Care	-0.47%	-0.18%	-0.20%	-0.33%	-0.41%	-0.72%
Mental Health Facilities	-0.33%	-130.58%	-221.63%	-579.29%	-1027.66%	-504.14%
ICF-MR	-0.03%	-41.70%	-0.87%	-0.08%	0.00%	0.00%
Non-Physician Practitioners	-0.77%	-0.54%	-0.34%	-0.31%	-0.13%	-0.09%
Other Professionals	-0.26%	-0.30%	-0.22%	-0.46%	-0.46%	-0.69%
Diagnostic and Treatment	-0.02%	0.00%	-0.04%	-1.82%	-0.53%	-0.24%
DME	-0.26%	-0.70%	-0.38%	-0.32%	-0.44%	-0.09%
Skilled Nursing Facilities	-0.09%	-0.02%	-0.01%	-0.01%	-0.01%	0.00%
Ambulance	-0.36%	-0.30%	-0.09%	-0.01%	-0.04%	-0.14%
Clinics	-0.29%	-0.85%	-0.36%	-0.05%	0.00%	0.00%
Hospice	-0.07%	-0.31%	0.00%	-0.03%	0.00%	0.00%
Other Services	0.00%	0.00%	-0.01%	0.00%	0.00%	-0.02%
TOTAL RECOVERIES	-1.18%	-0.64%	-0.76%	-0.85%	-0.81%	-0.96%

QUESTIONS

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919-733-4910

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

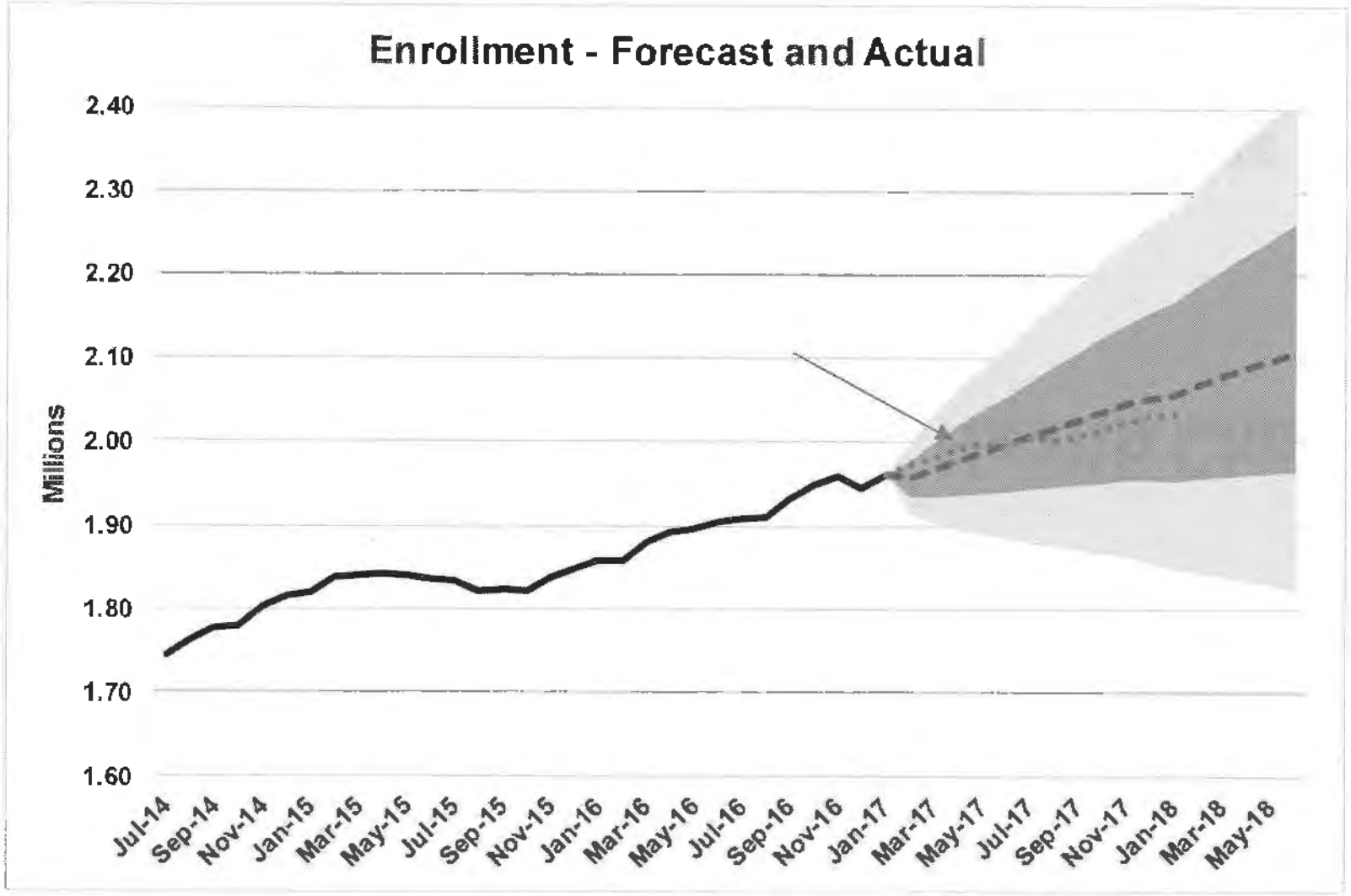
Medicaid and NC Health Choice Enrollment

Dave Richard, Susan Perry-Manning
Department of Health and Human Services

February 28, 2018

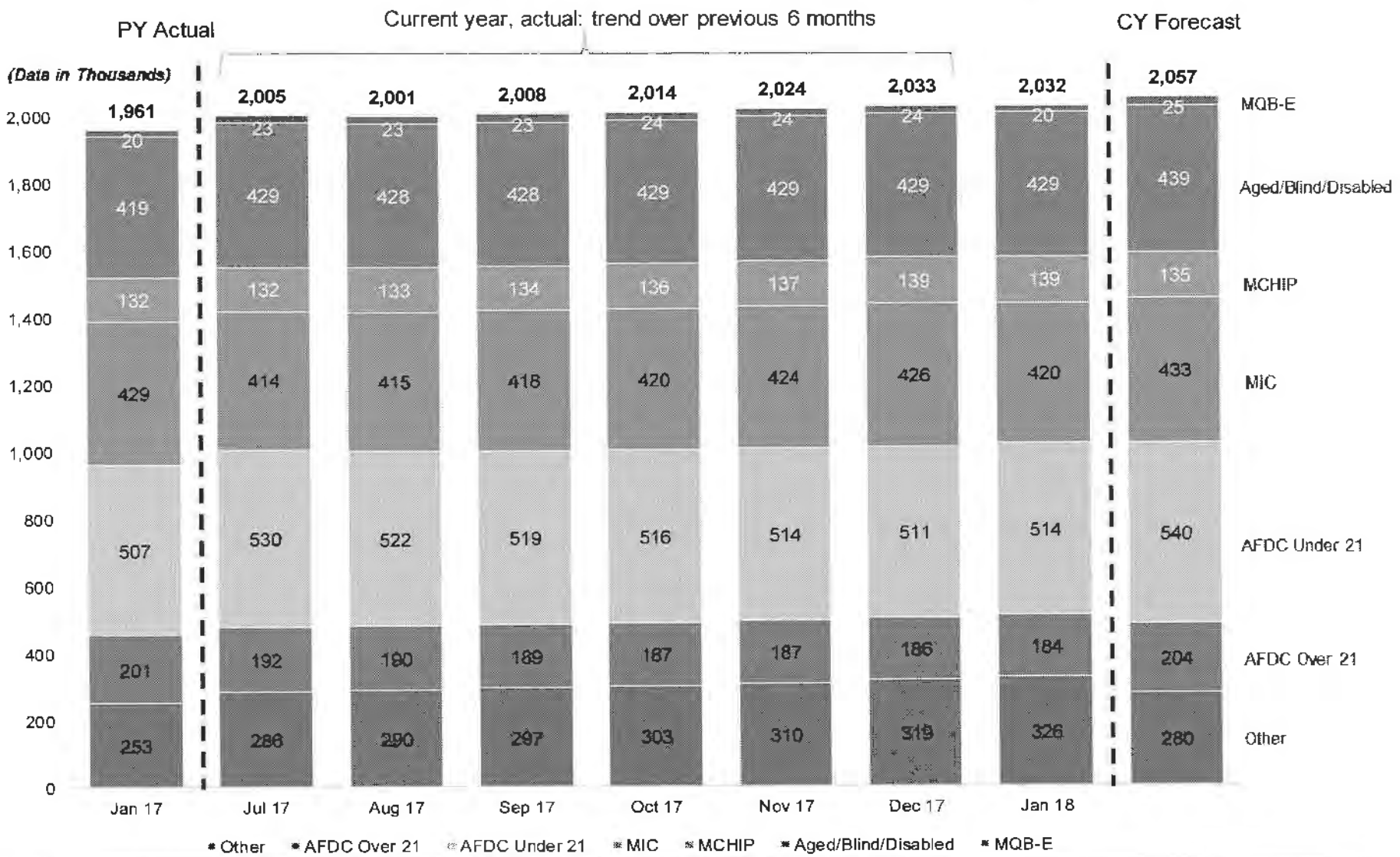
Medicaid Enrollment – Forecast vs. Actual

Medicaid Enrollment has tracked roughly inline with DMA's expectations to date



Medicaid Enrollment by Program Aid Category

January 2018 enrollment at 2.032M is 3.6% higher than one year prior at 1.961M on January 2017



JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid and NC Health Choice Financial Update

Dave Richard, Roger Barnes
Department of Health and Human Services

February 28, 2018

Medicaid SFY18 Actuals vs. Budget

Through December 2017, total Medicaid expenditures were $408.8M or 5.9% favorable to the authorized budget

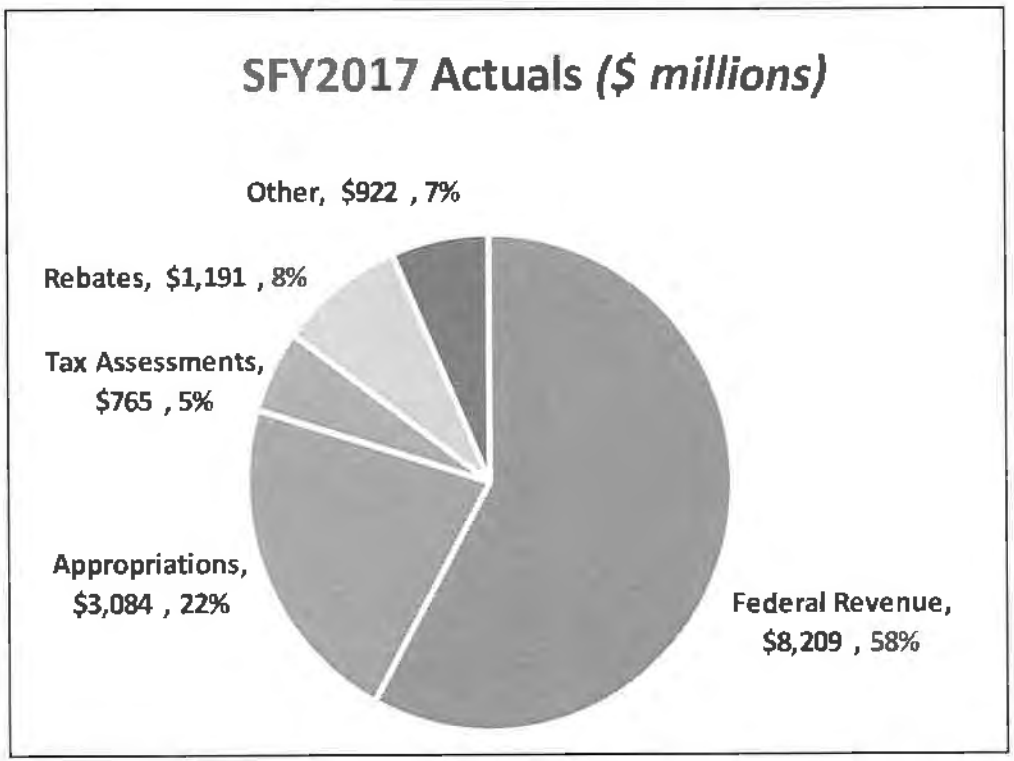
($ millions)

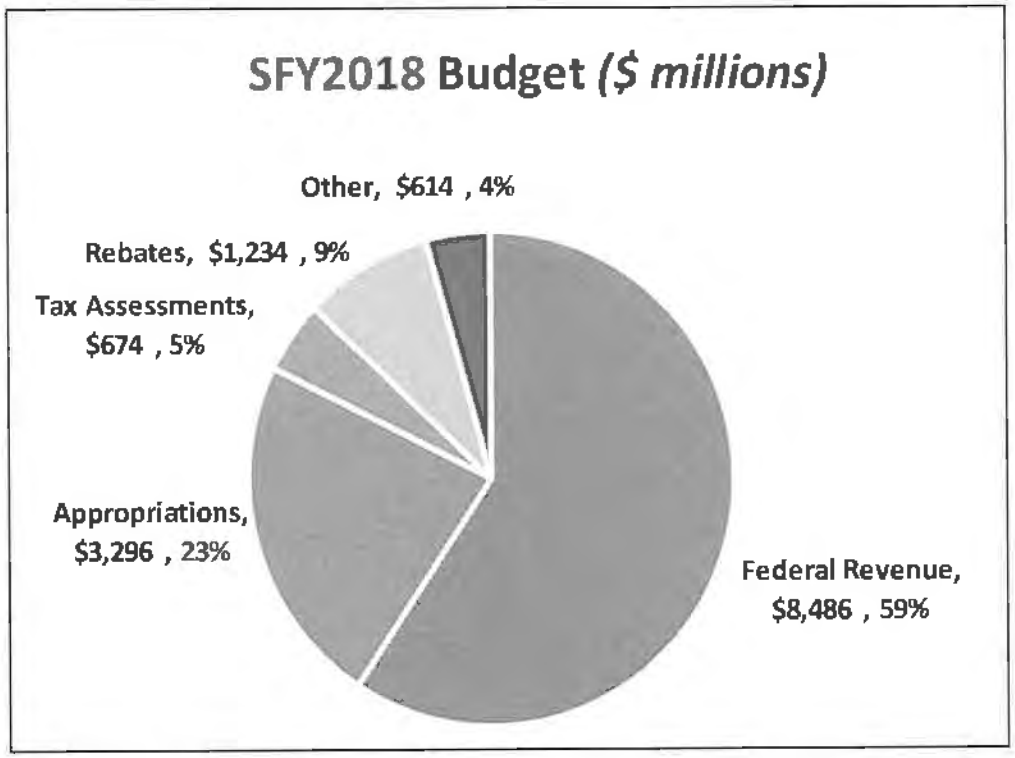
Fund Description	SFY2018B YTD	SFY2018A YTD	Variance (vs. Budget)	Variance %
Hospital[1]	$ 967.8	$ 963.6	$ (4.2)	-0.4%
Skilled Nursing Facilities	639.5	639.5	(0.0)	0.0%
Physician	549.3	510.6	(38.7)	-7.0%
Pharmacy[3]	381.9	316.0	(65.9)	-17.2%
Other Claims	1,184.3	1,134.9	(49.4)	-4.2%
Total Fee-For-Service Claims Exp.	**$ 3,722.8**	**$ 3,564.8**	**$ (158.0)**	**-4.2%**
Consolidated Supp. Hospital Payments	915.4	874.0	(41.5)	-4.5%
Cost Settlements	101.5	13.2	(88.3)	-87.0%
Capitation, Premiums & Other Exp.[2]	2,165.5	2,044.5	(121.0)	-5.6%
Total Expenditures	**$ 6,905.3**	**$ 6,496.5**	**$ (408.8)**	**-5.9%**

Notes:

1. Hospital Expenditures include Inpatient, Outpatient, and Emergency Room Services.
2. Includes LME/MCO, PACE, High-Tech Imaging, and Buy-in/Dual Eligible Services.
3. Pharmacy Expenditures are net of rebates.

Medicaid Revenue Distribution





Joint Legislative Oversight Committee for Medicaid and NC Health Choice

Review of Amended Waiver Application Provisions

Steve Owen,
Fiscal Research Division

February 28, 2018

Discussion Guide

- Amended Waiver provisions that are not consistent with S.L. 2015-245, as amended by S.L. 2016-121, Sec. 11H.17 of S.L. 2017-57, and Sec. 4 of S.L. 2017-186
- Funding Summary/Budget Neutrality
- Other provisions needing CMS approval
- Amended Waiver provisions needing additional explanation
- Considerations

Amended Waiver Application provisions that are not consistent with Medicaid Transformation Legislation S.L. 2015-245, as amended

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

02/28/2018

Inconsistencies with SL 2015-245, as amended

- Increase access through implementation of Carolina Cares; *"if proposed State legislation is enacted"* – Page 1.

- Request for up to $1.2 billion in increased spending over five years to fund implementation of targeted initiatives at a 50% match rate; *Non Federal share funding not identified other than implied savings on traditional Medicaid and lower Carolina Cares cost* – Page 2.

- Tribal uncompensated care pool; *100% federally funded* – Page 5

Inconsistencies with SL 2015-245, as amended

- Carve out Nursing home long stays, Family Planning populations, prisoners, CAP-C and CAP-DA populations – Page 14.

- Implementation of Carolina Cares premiums and Work Requirements *"If enacted by the State Legislature..."* – Page 14

- Delay in enrollment of populations eligible for tailored plans until year 3 – Page 18.

Inconsistencies with SL 2015-245, as amended

- Delay in enrollment of TBI populations until year 3 – Page 19.
- Behavioral Health/Intellectual Developmental Disability Tailored Plans and Specialized Foster Care Plans; *"Pending State legislative authority…"* – Page 21.
- Waiver states that 3 commercial plans will be offered state-wide/silent on PLE's – Page 28.

Inconsistencies with SL 2015-245, as amended

- Carves out costs for "fabrication, fitting and dispensing" of eyeglasses – Page 29.

- Schedule proposed phrased "Begin launch of managed care" July 2019 (17 months after CMS approval). Unclear what "Begin" means – Page 34.

Inconsistencies with SL 2015-245, as amended

- PHP's will be charged a "premium tax" and the proceeds of that tax will be used to fund Medicaid programs; *"if approved by the legislature"* – Page 41.

Proposed Federal Funding Summary

Budget neutrality is a basis for negotiating spending caps with CMS that will be the methodology used to determine that the demonstration does not cost the federal government more than it would had it not approved the demonstration.

IMPORTANTLY BUDGET NEUTRALITY ESTABLISES A CAP FOR FEDERAL PARTICATION IN SPENDING. MEDICAID SPENDING IN EXCESS OF THE CAP WILL RESULT IN NORTH CAROLINA FUNDING 100% OF THE AMOUNT OVER THE CAP, WITH NO FEDERAL SHARE.

Proposed Federal Funding Summary

- The Amended Waiver application only includes projected budget impact for federal spending

	*Total Requirements ***	*Federal ***
Workforce Initiatives	$ 45,000,000	$ 22,500,000
Public Private Partnerships	800,000,000	400,000,000
Tribal Uncompensated Care Pool	86,573,048	86,573,048
BH/IDD Care Management	150,000,000	75,000,000
Telemedicine	5,000,000	2,500,000
Telemedicine Innovation	80,000,000	40,000,000
Cost of Waiver Initiatives	$ 1,166,573,048	$ 626,573,048
Savings on Traditional Medicaid	$ (1,032,036,692)	$ (698,309,621)
Savings on Carolina Cares	(1,365,893,331)	(1,229,918,027)
POTENTIAL IMPACT REPORTED IN WAIVER	$ (1,231,356,975)	$ (1,301,654,600)

***** - Exhibits 3, 4, 5 and 6 from pages 55-58 of the Amended Waiver Application FY 2019-24***

Potential Estimated Total Funding Impact

The Non-Federal share of the proposed spending is not included in the waiver.

The only way to estimate the maximum potential impact is to derive the non-federal share using Exhibits in the waiver.

WAIVER ESTIMATED SPENDING IMPACT FY 2019-2024

	*Total Requirements ***	*Federal ***	*Non-Federal *****
Workforce Initiatives	$ 45,000,000	$ 22,500,000	$ 22,500,000
Public Private Partnerships	800,000,000	400,000,000	400,000,000
Tribal Uncompensated Care Pool	86,573,048	86,573,048	-
BH/IDD Care Management	150,000,000	75,000,000	75,000,000
Telemedicine	5,000,000	2,500,000	2,500,000
Telemedicine Innovation	80,000,000	40,000,000	40,000,000
Cost of Waiver Initiatives	$ 1,166,573,048	$ 626,573,048	$ 540,000,000
Savings on Traditional Medicaid	$ (1,032,036,692)	$ (698,309,621)	$ (333,727,071)
Savings on Carolina Cares	(1,365,893,331)	(1,229,918,027)	-
POTENTIAL IMPACT REPORTED IN WAIVER	$ (1,231,356,975)	$ (1,301,654,600)	$ 206,272,929
Potential Incremental Spending Increase	27,132,658,460	24,452,649,192	2,680,009,268
Potential Increase in Provider Assessment	-	-	(2,680,009,268)
Potential Increased Spending from Waiver	$ 25,901,301,485	$ 23,150,994,592	$ 206,272,929

***** - Exhibits 3, 4, 5 and 6 from pages 55-58 of the Amended Waiver Application FY 2019-24***

******* - May include sources of receipts not identified in the waiver that can impact potential State apporpriations.***

Other Provisions or Considerations from Amended Waiver Application

Other Provisions Needing CMS Approval

- Cost Settlement for safety net providers – Page 3
- Approval to cover IMD services by Medicaid immediately – Page 4
- Carolina Cares work requirements and the premiums- Page 1

Elements Needing Further Explanation

- One stop credentialing and regional provider support centers
- Improvements to physical and behavioral health
- Public-Private partnership desired outcomes and measures
- "Workforce Fund" or loan forgiveness program
- Telemedicine services and Home Health Care Management
- Ensuring access and network adequacy
- PHP capitation rate setting, enrollment and reimbursement assumptions for cost projections
- Assumptions for funding impact of new provisions

CONSIDERATION

What is the implication for federal funding if CMS approves the waiver as filed and the Department is never authorized by the General Assembly to implement elements included in the Waiver?

QUESTIONS

Steve Owen – steve.owen@ncleg.net
919-733-4910

7-B

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Overview of 1115 Waivers

Christen Linke Young
Department of Health and Human Services

February 28, 2018

State Tools for Modifying Medicaid Program

- Three primary tools for modifying a state Medicaid program:
  - State Plan Amendments (SPA) – used to change administrative aspects of a state's Medicaid program like covered benefits and provider payments
    - Usually covers a single discrete topic
    - Remains in effect until it is withdrawn and can be granted retroactively
  - 1915 Waivers – used for particular narrow functions like coverage of home and community based services and, in other states, case management
  - 1115 Waivers – broad authority for states to pursue "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of Medicaid, but must be budget neutral for the federal government
    - Generally used for large initiatives
    - Granted for 5 year terms and can be renewed

DHHS Preparation for 1115 Amendment

- 1115 waiver submission covers only the components of a state proposal that require special federal authority; not a holistic picture of any Medicaid reform initiative
- Prior to submitting the amended waiver, DHHS held public hearings and released 80-page program design
  - End-to-end view of vision for all components of the managed care transition, including those not requiring waiver authority
  - Detailed discussion of covered populations and timelines
- Also releasing concept papers on specific topics
  - BH IDD Tailored Plans
  - Network Adequacy
  - Other topics to be released in coming months

1115 Process

- State submits an application to CMS:
  - Defining the proposed demonstration project and how it meets the objectives of Medicaid
  - Asking for federal waiver of particular aspects of the Medicaid statute:
    - Programmatic authority, e.g. allowing DHHS to make managed care enrollment mandatory
    - Expenditure authority, which allows DHHS to claim a federal Medicaid match for activities that may be conducted in the future
  - Demonstrating how the waiver (including any proposed expenditure authority) is budget neutral for the federal government
- CMS and the state negotiate Special Terms and Conditions (STCs) that govern how the waiver will operate and the circumstances under which the state can claim federal match
- Waivers are granted for 5 year terms
- Waivers only cover items that require programmatic or expenditure authority

1115 Budget Neutrality

- Application serves as starting point for discussions with CMS
- CMS and the state agree on an amount of "savings" for the federal government compared to federal spending in the absence of the waiver
  - Specific formulas CMS prescribes for budget neutrality projections, which are very different from how DHHS projects the Medicaid budget
- Based on those "savings," state secures agreement that CMS will provide matching funds up to certain amounts for certain activities not typically covered by Medicaid if the state conducts those activities in the future
  - State share must still be provided at match rate appropriate for the activity (e.g. 50% for administrative activities or FMAP for medical services) under normal matching rules
  - State is under no obligation to conduct particular activities
- Budget neutrality cannot be renegotiated except under exceptional circumstances

DHHS 1115 Waiver Application

- Some components of the waiver require additional legislative authority to implement, which is made clear throughout the submission to CMS:
  - Integration of behavioral health into PHP contracts
  - Creation of Tailored Plans for those with significant needs and delayed enrollment of Tailored Plan population
  - Exclusion of certain populations with limited coverage from managed care (inmates of prisons, family planning enrollees)
  - Delayed enrollment of special populations (foster children, CAP-C and CAP-DA waiver enrollees, non-dual long-stay nursing home enrollees), coordinated with launch of specialized products to meet needs and manage budget
  - Minor changes to managed care coverage related to eyeglasses
  - Imposition of work requirements and premiums for potential future populations
  - Supplemental payment reform
  - MCO tax and revenue

DHHS 1115 Waiver Application

- *Any* spending under the waiver requires enactment of future year budgets
  - DHHS does not currently have funds to expend state share on any waiver activities, including even making capitation payments to PHPs at managed care launch
  - Future enacted budgets will define how Medicaid spends money
  - This may include items for which CMS has granted expenditure authority, if state funding is appropriated
  - Examples of these potential future "expenditure authority" activities include:
    - Initiatives to develop the NC health care workforce
    - Initiatives to improve access to, use of, and efficiency of telemedicine services
    - Public/private partnerships

Discussions with CMS

- DHHS has had ongoing weekly meetings with CMS subject matter experts since September to discuss waiver components
- Major areas of CMS feedback:
  - Changes have been made to the process for cost-settling local health departments and other safety net providers in managed care (now using state plan authority, not waiver authority)
  - We continue to discuss the scope of an Institution for Mental Disease (IMD) waiver based on guidance provided by CMS after the waiver was submitted
  - Budget neutrality conversations are ongoing; recent discussions have unearthed potential areas of disagreement
- Continue to work with federal partners

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Michealle Grady	Atromitos LLC
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Daniel Baum	Thornburgh Services
M Watson	Sandhills
Yvonne Copeland	CCME
Pam Shipman	Monarch
Hugh Johnson	NCHA
Kara Weishaar	SA
Ryan Blackledge	Cone Health
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[illegible]	[illegible]
Andy Ellen	NCRMA
Elizabeth Robinson	"
Mary King	"
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Wendy Kelly	Focus Carolina
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JOHN THOMPSON	TPG
Kelly Peterson	NASW NC

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Chris Egan	NCCAD
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CAROL ORNITZ	BIANC Board Member
Ken James	BIANC Executive Director
JEFF BARNHART	MWC
Brian Perkins	Alliance NC
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GINA BOCCETTI	League of Women Voters
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Rachel Beach	The Arc
Ashley Perkins	Perkins Law

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Will Morgan	MFS
Herb Weldon	AmeriHealth Caritas
Ben Kellman	AmeriHealth Caritas
Katie Hopkins	AmeriHealth Caritas
Michelle Frazier	SML
Logan Martin	Benchmarks
Karen McLeod	Benchmarks
TRACY GOLDARD	NCMHC
Jennifer Mahan	ASNC
Greg Briggs	NCAFP
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Ken Melton	KMA

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Kari Barbee	Gateway

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NAME	FIRM OR AGENCY AND ADDRESS
Ray O'Connell	Mark of Duke

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

March 1, 2018

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Medicaid and NC Health Choice
FROM: Rep. Donny Lambeth, Co-Chair
Rep. Nelson Dollar, Co-Chair
Sen. Ralph Hise, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Medicaid and NC Health Choice** will meet at the following time:

DAY	DATE	TIME	LOCATION
Tuesday	March 13, 2018	1:00 PM	643 LOB

Rep. Lambeth will preside.

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Candace Slate at dollarla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

March 13, 2018 1:00 p.m.
Legislative Office Building - Room 643

I.	**Welcome & Opening Remarks**	Representative Donny Lambeth Presiding Co-Chair
II.	**Remarks from Department of Health and Human Services (DHHS) Secretary**	Mandy Cohen, Secretary, Department of Health and Human Services (DHHS)
III.	**Status of Cardinal Innovations Healthcare LME/MCO**	Trey Sutten, Interim Chief Executive Officer, Cardinal Innovations Healthcare
IV.	**Report on Funding for GME Payments and Actions Taken to Achieve Flex Cut** – Section 11H.13 of S.L. 2017-57	Dave Richard, Deputy Secretary for Medical Assistance, DHHS
V.	**1115 Waiver Update and Work Plan for Medicaid Transformation**	Mandy Cohen, Secretary, DHHS Dave Richard, Deputy Secretary for Medical Assistance, DHHS Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS
VI.	**Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children** – Section 11H.14 of S.L. 2017-57	Dave Richard, Deputy Secretary for Medical Assistance, DHHS
	Adjourn	

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
MEDICAID & HEALTH CHOICE

Tuesday, March 13, 2018
1:00 p.m.
Legislative Office Building, Room 643

ATTENDEES:

Chairmen: Dollar, Lambeth

House Members: Brisson, Dobson, Insko, Murphy
Senate Members: Foushee, Krawiec, Pate, Tucker

I. Welcome and Opening Remarks

Chairman Donny Lambeth presided and called the meeting to order at 1:50 p.m.

Chairman Lambeth introduced Sergeant-at-Arms Staff assisting with the meeting and committee staff members.

II. Remarks from Department of Health and Human Services (DHHS)

Secretary Mandy Cohen gave an overview of the day's reportings. She began by answering questions regarding the Department's efforts around fraud that were asked earlier in the day during the HHS meeting. She stated that the Department is on track for implementing its fraud/error work during the April timeframe. She expressed her appreciation to the Committee for allowing the Department to explain the status of the 1115 Waiver Amendment. She stated that looking at the Waiver in isolation does not provide a full understanding of the Department's intent regarding the Medicaid Program. Secretary Cohen referenced the comprehensive paper published during the summer of 2017 that outlined the Department's vision for managed care and provides an end-to-end look at what the Department desires to accomplish for Medicaid.

Chairman Lambeth publically thanked Trey Sutten for the outstanding job he has been doing during the interim and called upon him for a status report.

III. Status of Cardinal Innovations Healthcare LME/MCO

Trey Sutten, Interim Chief Executive Officer, Cardinal Innovations Healthcare, provided a snapshot of activities over the past 120 days. To date, he has met with representatives from each of the Cardinal's internal departments and held regular meetings with the Department of Health & Human Services leadership, held Town Halls with healthcare

coordinators, and met with key CEOs of other LME/MCOs. Additional contacts include Mecklenburg and Alamance County officials, legislators, and key providers. Mr. Sutten also attended CFAC's retreat and Summit meeting, met one-on-one with employees and teams, as well as engaged in ride-alongs to meet members in their care settings.

In an effort to address trust issues, Mr. Sutten stated that the times and locations of Board meetings are posted and minutes of Board meetings are available to the public. He has begun weekly communications with all employees and a monthly newsletter is now being published. Mr. Sutten was pleased to report that employees are proud of their work and committed to Cardinal's mission and serving its members.

Mr. Sutten reported that community stakeholders are also committed. He and his team have conducted 200 listening and learning sessions and conducted 80 meetings with teams. His team has made it a priority to meet with DHHS on a regular basis, interact with CPAs, and spend time with care coordinators. Mr. Sutten thanked the new, reconstituted Board. Each of these efforts demonstrates a willingness to engage and return to where Cardinal needs to be.

Mr. Sutten identified a need for transparency in the new restructure of Cardinal. He stated that they began by working on mistrust issues and communicated the organizations commitment to its mission. Initiatives that target transparency include: 1) the launch of a new website; 2) weekly newsletters; 3) the launch of Project Future that includes eight initiaties to prepare the organization for next steps under reform; and, 4) the creation of a corrective action plan.

Audits of Cardinal were conducted by the Office of the State Auditor and the NC Department of Health & Human Services. Following the audits, DHHS requested that Cardinal develop and implement a Corrective Action Plan. Board activities, governance, personnel practices and spending were major issues identified. Mr. Sutten reported that action has been taken to address these areas: 1) Revised Board policies to have all meetings at appropriate locations in North Carolina with specific attention to costs; 2) Active and ongoing consultation with the North Carolina General Assembly and the Department of Health & Human Services; 3) Salary of the CEO is aligned with state law and employee compensation, incentive pay and benefits subject to Board approval and the policies on documentation for expense reimbursement have strengthened; and, 4) Inappropriate spending, e.g., first-class airfare, alcohol, and chartered flights.

Mr. Sutten described Community Reinvestment Initiative, a new, high-impact initiative that will positively affect Cardinals' members and its communities. He informed the committee that Cardinal will issue RFPs over the next 12 months to fund capital, equipment and/or programmatic needs. He announced that the Board of Directors will be

heavily involved in the review process and final approval will be given by the North Carolina Department of Health and Human Services. Eligible entities may include: counties, local public school systems and IHEs, municipalities, and well-established, non-profit organizations. The deadline to receive requests is May 1, 2018 and funds will be awarded for approved requests on June 29, 2018.

" Cardinal is committed to getting back on track," he concluded.

Senator Hise expressed his desire for the $3.8 million to be deployed by the end of the fiscal year.

Senator Tucker thanked Secretary Cohen for her courage in dealing with the takeover of Cardinal and Mr. Sutten for taking on the responsibility of leading the organization. Senator Tucker cited areas of concern that include: severance packages, recruitment/retaining employees; establishing a fair salary for the new CEO.

Representative Dollar recognized Board members Jean Andersen and Dan Brumitt who were in attendance. He asked Mr. Sutten of Cardinal's plans in using the unstricted funds portion of the $258 million fund balance. Mr. Sutten responded that funds would be used for state services, community reinvestments, and capital investments. He restated his goal was to maintain financial solvency.

Representative Dollar stated his pleasure with the investment in the Diversion Center initiative and the importance of a public managed care company dealing with Behavioral Health. Mr. Sutten responded that community representatives are out in the field, wellness centers available, care coordinators in homes – "the public mission aspect of our system is critical to the folks whom we serve," he concluded.

Representative Dollar thanked Board members for being present. "Public management of the Behavioral Health system is critical,"

Representative Insko asked for clarification. "As we move from fee-for-service to a managed care system, I assume there will be a surplus in the fund."

"In general, that is how it will work," Mr. Sutten responded.

Senator Tucker asked for clarification regarding the continuation of the law suit or OSHR to conduct a study. Mr. Sutten replied that he anticipates a cooperative conversation with OSHR. Secretary Cohen added that the Department's intention is to bring together behavioral health and managed care. "Work is very close to the 122C structure and the rules of the State HR office for salary in order to attract and maintain qualified personnel.

IV. Report on Funding for GME Payments and Actions Taken to Achieve Flex Cut
Section 11H.13 of S. L. 2017-57
Dave Richard, Deputy Secretary for Medical Assistance, Department of Health and Human Services, reported Medicaid actual spending SFY18 compared to the budget. Through January 2018, total Medicaid expenditures totaled $397.2M or 4.9% favorable to the authorized budget. Mr. Richard informed the committee that Medicaid's use of appropriations for Graduate Medical Education is $17.6M through January 2018. He indicated that reimbursement is expected to fall within the forecasted amount for the year. "Overall, current trends indicate that DMA will complete the State's fiscal year within budget," he said.

V. Work Plan for Medicaid Transformation and 1115 Waiver Update
Committee members were provided an update of the Medicaid Transformation efforts by Jay Ludlam, Assistant Secretary for Medicaid Transformation with the Department of Health and Human Services. He cited recent publications by the Department aimed at providing timely information. Since August 2017, ten articles ranging from *Proposed Program Design* to *Care Management & Advanced Medical Home* have been published. He stated that plans are to publish concept papers that address: Quality, credentialing, and PHP Licensure.

Mr. Ludlam provided a brief overview of the Department's operational progress starting with *As Is* and moving toward the desired *To Be* state. A plus in the new process is that beneficiaries will be able to choose a plan that fits their needs. Representative Murphy inquired if assistance would be provided to beneficiaries in choosing a plan? Mr. Ludlam responded that choice counselors and family physicians on the beneficiary's network would provide assistance. "We are committed to improving the medical experience to beneficiaries," he concluded. Representative Murphy stressed the importance of keeping providers in a state of knowing.

Mr. Ludlam informed the committee that DHHS has begun the procurement process and has issued RFPs to connect families and doctors to their health plans. He explained that the key component in the operation is changing how we do the work with managed care. "We will begin where we are and develop an impact analysis. The challenge will be how we define oversite," he said.

Mr. Ludlam presented a brief status report on the 1115 Waiver filed with the Center for Medicare and Medicaid Services. He stated that negotiations regarding program components and budget neutrality continue.

Mr Ludlam informed the committee that Secretary Cohen met with CMS Administrator's senior staff on March 12th to discuss the status of the Waiver. The next step in the process is to draft special terms and conditions. He reported that feedback received from CMS is that the most recent budget neutrality model shows improvement but continues to be negotiated to mitigate potential risk to the State. "Things are moving in the right direction," he said.

Secretary Cohen addressed the committee stating that the intent of the policy papers is to ensure that everyone is informed of the direction that the Department is taking. "We want no surprises as we move toward the RFP," she said. She informed the committee that great feedback had been received which will help in making final decisions. She reported that just a few issues remain with CMS. Secretary Cohen stated that CMS is pleased with the direction in which we are moving with budget neutrality. We have seen a second model from them and are expecting a third model that is even more favorable.

Representative Murphy inquired how beneficiaries would be assisted in choosing a plan. Mr. Ludlam responded that the enrollment broker function has been around for a number of years. He stated that Managed Care requires DHHS to hire choice counselors who connect families to health plans that have the family's doctor in their network. For beneficiaries who do not choose a plan, the default will be by auto assignment algorithm that most likely will serve a family in the network that will meet their needs. "We are looking to improve the beneficiary aspect,' he concluded.

In follow-up, Representative Murphy stated that providers are concerned about the process being overly burdensome. Mr. Ludlam responded that DHHS is looking to reduce the administrative burden placed on its providers by capturing additional information necessary for them to work with managed care. Representative Murphy expressed his appreciation for the department's attention.

Representative Dollar informed the Secretary that major concerns have been raised and inquired if the committee would know in advance of seeing the RFP which direction DHHS will take. Secretary Cohen responded that the Department would do that in the August paper and an opportunity for feedback would be available at that time.

Representative Dollar asked where the progress on clinical requirements fits into the schedule. Mr. Ludlam responded that clinical requirements are incorporated into the business requirements, gap assessment and impact analysis. Representative Dollar inquired about the *sticking points,* i.e., State vs CMS. Secretary Cohen replied, "Trends – what would the cost of the Medicaid population be if we don't have managed care versus what it would be if we have managed care.

Chairman Lambeth asked when the State may expect approval. "Are we *in line* or is it ongoing among many states?" In response, Secretary Cohen stated that North Carolina will be the first large 1115 Waiver that the current administration has approved and she reiterated that the State is moving in the right direction. "We are asking for some new ground; and hopefully, in the next several weeks we can come to some conclusion," she stated. Secretary Cohen informed the committee that she met with North Carolina's entire congressional delegation to inform them of the status of the Waiver. "We may potentially need their help. (It's been) a very collaborative effort. I'll keep you posted," she concluded.

VI. Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children

Deputy Secretary Dave Richard reported that the plan to provide Medicaid and NC Health Choice coverage for home visiting was delivered on January 24th, 2018 to the North Carolina General Assembly in accordance with Session Law 2017-57, Section 11H.14.(b). Additional requirements under the law are to provide an analysis of the fiscal impacts of the *enhanced* Medicaid coverage for home visits. The establishment of a timeline for implementation and any requirements for State Plan Amendments is also required. The targeted timeframe is July 2018 – June 2019. State funds will be used for the pilot.

The Pilot will be conducted within two counties, Cleveland County has been identified to implement Medicaid coverage for nurse visits of the Nurse Family Partneship model for all first-time mothers and their infants. Johnson County will implement coverage for home visits for all pregnant women at high-risk and their infants. This will be an enhancement to existing OBCM and CC4C services.

Mr. Richard further reported that the fiscal impact in State dollars is estimated at approximately $251 thousand for the Nurse Family Partnership Model and approximately $92 thousand for the Hybrid Model-Enhanced Visits Analysis.

"We are on track in the implementation process," he concluded.

Senator Tucker inquired how the Department will address North Carolina's high infant mortality rate. Mr. Richard stated that the Department will be studying how other programs targeted high-risk mothers/programs. The outcome is more healthy children and a reduction in infant mortality.

VII. Announcements

Chairman Lambeth announced that the next meeting date is April 10th, 2018

VIII. Adjournment

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice adjourned at 3:12 p.m.

Representative Donny Lambeth, Chair

Panthea Briles, Committee Clerk

Attachments: Agenda
Handouts (5)

Cardinal Innovations Update

Joint Legislative Oversight Committee

March 13, 2018

120 Day Snapshot

Cardinal Innovations HEALTHCARE

Over 200 listening and learning meetings with employees, providers and stakeholders since December 1

Met with representatives of all 19 internal departments	Over 80 feedback meetings with employees and teams	Town Halls with Care Coordination, IT, Finance and Utilization Management	Served breakfast to employees in Charlotte and Chapel Hill
Attended CFAC Retreat in Raleigh & CFAC Summit in Burlington	Meetings with legislatars	Regular meetings with DHHS Leadership	Meeting with Mecklenburg and Alamance County officials
Care Coardination Ride-alangs to meet members in their care settings	Meetings with Minarity Praviders, Provider Council and Coalition Executive Members	Meetings and calls with key providers	Meeting with the other LME/MCO CEOs

What I've Learned

Frustration with previous leadership decisions

Need for transparency, communication & inclusiveness

Culture of fear and mistrust

Know our members & how best to serve them

Proud of our work

Commitment to our mission

Looking for strategic direction

Want to build connections & have voices heard

Optimistic about the future & want to move forward

Project Future

Initiative	Project Description
Develop Strategic Plan	Create and share Cardinal's vision and strategic plan for the organization, and align our efforts, resources and investments accordingly
Corrective Action Plan	Implement policies, procedures and internal controls to address concerns related to the audit findings
Restore Credibility & Reestablish Trust	Create and execute strategies that demonstrate our ongoing commitment to our members
Recruit, Retain, and Develop Talent	Attract the right talent to fill top leadership vacancies while retaining and developing our employees
Super Measures	Develop plans that measure, monitor, meet and sustain high performance levels relative to DMA and DMH measures
Medical Team Strategy	Develop and implement clinical plan that encompasses medical team goals, performance measures, structure, processes and training plans
IT Transformation	Develop and implement a plan that builds IT skills to respond to changing needs
Cardinal Innovations Accelerator	Launch a Lean Six Sigma project that will streamline and improve key member and provider-related processes

Cardinal Innovations HEALTHCARE

Project Future is a series of initiatives that will address high-priority issues and enable us to better fulfill our mission and serve members.

Corrective Action Plan

- Following audits by OSA and DHHS, the Department requested that Cardinal Innovations develop and implement a Corrective Action Plan.
- Final Corrective Action Plan was approved by both the Cardinal Innovations Board of Directors and the Department
- 13 areas have been identified and addressed, and an internal audit of compliance will take place in 6 months

Identified Issues	Actions Taken
Board Activities	Cardinal Innovations and the Board have revised Board policies to have all meetings at appropriate locations in North Carolino with specific attention to costs
Governance	Active & ongoing consultation with NC General Assembly and DHHS
Personnel Practices	CEO Salary is aligned with state law; CEO-only perks have been eliminated; Policies regarding employee compensation, incentive pay, and benefits subject to Board approval; Policy on documentation for expense reimbursement has been strengthened and is actively monitored for compliance
Spending	Cardinal has amended it policies to exclude spending deemed inappropriate, including first class airfare, alcohol, chartered flights, etc.

Community Reinvestment Initiative

Currently soliciting proposals to fund high-impact initiatives that will positively affect our members and our communities.

Will be accepting Requests for Proposals (RFPs) to fund capital, equipment, and/or programmatic needs over the next 12 months with BOD heavily involved in the review process, and final approval by DHHS

Eligible entities may include:

- Counties
- Local Public School Systems/Districts and/or Higher Education Institutions
- Municipalities
- Well-established non-profit organizations

Key Dates	
February 1	Initiative launched, began accepting proposals
March 31	Deadline to submit questions
May 1	Deadline to receive requests
June 29	Funds awarded for approved requests

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

GME Payments and Actions

Dave Richard
Department of Health and Human Services

March 13, 2018

Medicaid SFY18 Actuals vs. Budget

Through January 2018, total Medicaid expenditures were $397.2M or 4.9% favorable to the authorized budget

($ millions)

Fund Description	SFY2018B YTD	SFY2018A YTD	Variance (vs. Budget)	Variance %
Hospital[1]	$ 1,162.4	$ 1,171.0	$ 8.6	0.7%
Skilled Nursing Facilities	771.1	771.0	(0.1)	0.0%
Physician	634.0	621.2	(12.9)	-2.0%
Pharmacy[3]	555.9	482.4	(73.5)	-13.2%
Other Claims	1,418.5	1,390.8	(27.7)	-1.9%
Total Fee-For-Service Claims Exp.	**$ 4,541.9**	**$ 4,436.4**	**$ (105.5)**	**-2.3%**
Consolidated Supp. Hospital Payments	936.9	874.0	(62.9)	-6.7%
Cost Settlements	92.7	7.5	(85.1)	-91.9%
Capitation, Premiums & Other Exp.[2]	2,518.5	2,374.8	(143.7)	-5.7%
Total Expenditures	**$ 8,089.9**	**$ 7,692.7**	**$ (397.2)**	**-4.9%**

Notes:

1. Hospital Expenditures include Inpatient, Outpatient, and Emergency Room Services.
2. Includes LME/MCO, PACE, High-Tech Imaging, and Buy-in/Dual Eligible Services.
3. Pharmacy Expenditures are net of rebates.

Medicaid SFY18 GME Reimbursement

Through January 2018, Medicaid's use of appropriations for Graduate Medical Education is $17.6M. This is expected to fall within the forecasted amount for the year.

Overall, current trends indicate that DMA will finish the state fiscal year within budget.

	Graduate Medical Education - Medicaid Reimbursement			Medicaid Program - SFY2018 Expenditures		
($ millions)	SFY2018A YTD	SFY2018F YTD	SFY2018F Annual	SFY2018A YTD	SFY2018F Annual	SFY2018B Annual
Total Requirements	$ 54.6	$ 52.7	$ 90.4	$ 7,692.7	$ 14,542.0	$ 14,382.2
Receipts	37.1	35.2	60.3	5,529.7	10,874.0	10,682.5
State Appropriations	$ 17.6	$ 17.6	$ 30.1	$ 2,162.9	$ 3,668.0	$ 3,699.7

A = Actuals

F = Forecast

B = Authorized Budget

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Transformation

Dave Richard and Jay Ludlam
Department of Health and Human Services

March 13, 2018

Recent Transformation Milestones

Medicaid Publications

- August 2017
  - Proposed Program Design
- November 2017
  - Amended 1115 Waiver Application
  - Tailored Plans
  - Supplemental Payments
  - Managed Care Operational and Actuarial RFIs
- February 2018
  - Network Adequacy
- March 2018
  - Enrollment Broker RFP
  - Benefits & Clinical Coverage Policies
  - Beneficiaries in Medicaid Managed Care
  - Care Management & Advanced Medical Home

Upcoming Concept Papers

- Quality
- Credentialing
- PHP Licensure
- Other topics under development

Operational Progress Summary

"As-Is" State	Current fee-for-service model
Business Requirements	Based on program requirements & operational considerations
GAP Assessment	Identified gaps are organized to support process change management, technology & workforce design
Impact Analysis	Impact of transformation on workforce and technology
Technology Implementation Plan	Based on technology strategy – roadmap, timelines and milestones
Technology Strategy	Based on identification of technology initiatives and approach
"To-Be" State	Based on program requirements & impacts on DMA of managed care

CMS Progress – Amended 1115 Waiver

- Negotiations regarding program components and budget neutrality continue
  - Recent calls: 2/28, 3/2, 3/8
- Secretary Cohen met March 12 with CMS Administrator Verma to discuss waiver status
- Next step is to draft Special Terms and Conditions (STCs)
- Most recent budget neutrality model from CMS is improved from past model but continues to be negotiated to mitigate potential risk to State

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children

Dave Richard
Department of Health and Human Services

March 13, 2018

Session Law 2017-57, Section 11H.14.(b)

Requirements:

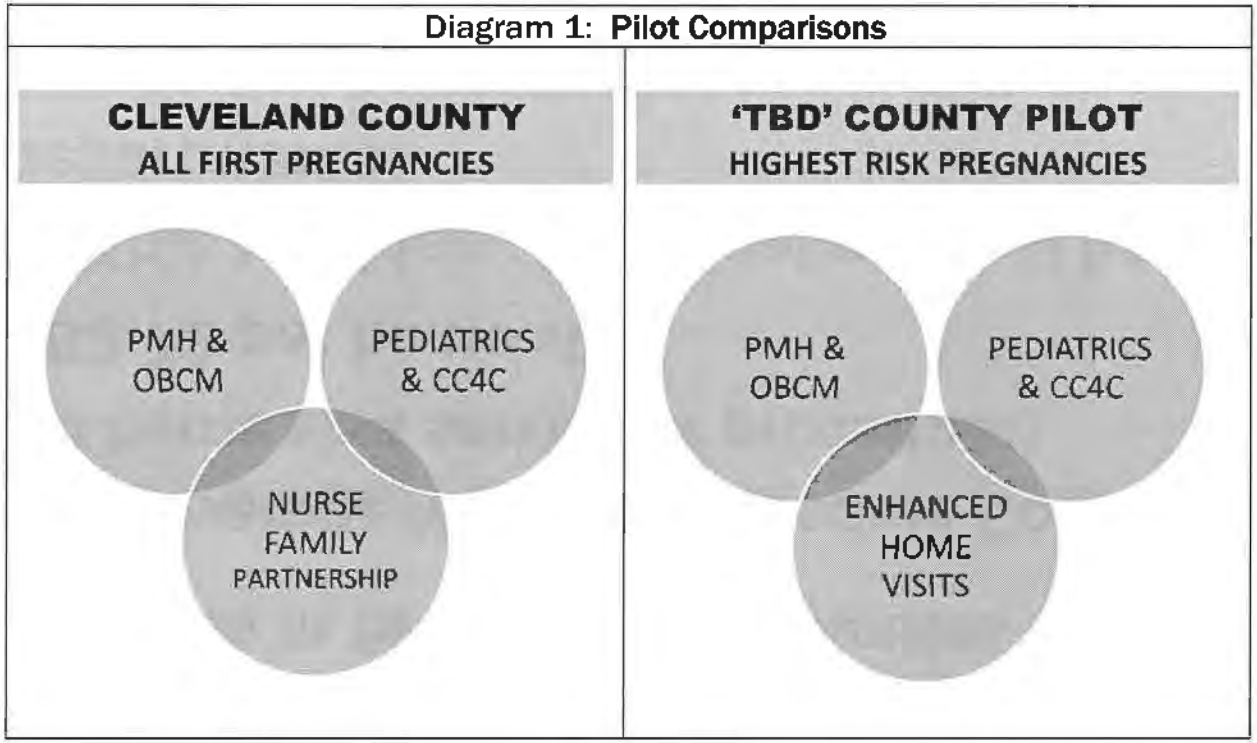
- Develop a plan or pilot program to provide Medicaid and NC Health Choice coverage for home visiting by July 1, 2018
  - *Plan delivered to NC General Assembly on January 24, 2018*
  - Focus: Evidence-based Home Visiting Models
- Provide an analysis of the fiscal impacts of "enhanced" Medicaid coverage for home visits.
- Establish timeline for plan implementation & any requirements for State Plan Amendments or Waivers
- Targeted timeframe: July 2018 – June 2019

Coverage Pilot Description

- Strong collaboration with DHHS Divisions of Medical Assistance, Public Health, Child Development & Early Education, Social Services and community partners
- Target population: Pregnant women and families with young children in two proposed counties
- Medicaid Coverage Method: Procedure Code 99600 (unlisted home visit service or procedure)
    - $83.72 per home visit
    - Eligible providers: Participating local health departments
- Funded with State dollars

Pilot Comparisons

Diagram 1: **Pilot Comparisons**



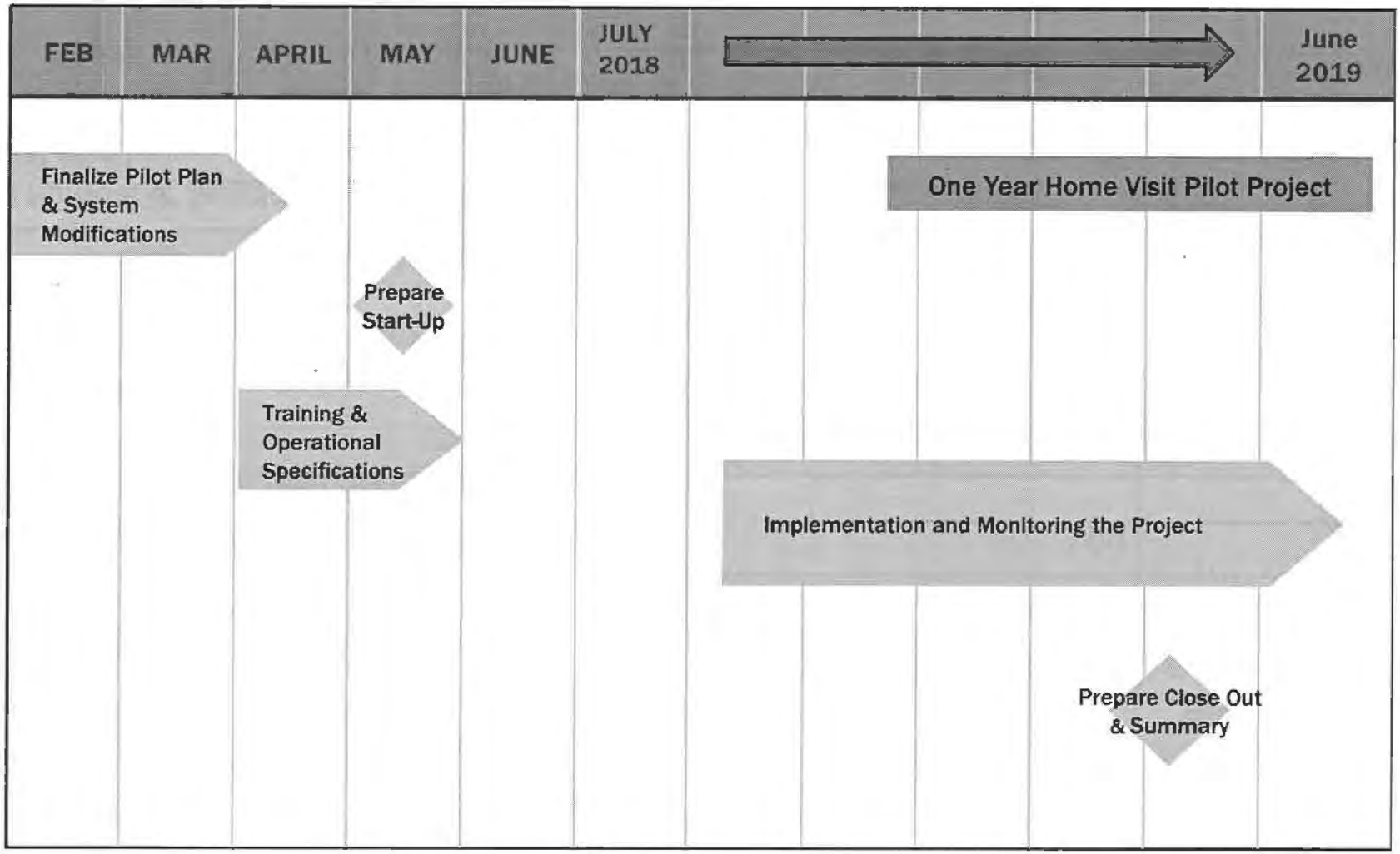
Cleveland County Pilot: Will implement Medicaid coverage for the nurse visits of the Nurse Family Partnership model for all first-time mothers and their infants.

'TBD' County Pilot: Will implement coverage for home visits for all pregnant women at high risk and their infants, as an enhancement to existing OBCM and CC4C services.

Fiscal Estimates

Summary	Cleveland County Nurse Family Partnership Model	'TBD' County Hybrid Model- Enhanced Visits Analysis
Illustrative Number of First Pregnancies per Year:	100	
Illustrative Number of High Risk Pregnancies per Year:		100
Fee for Service:		
CPT Code 99600 – Unlisted Home Visit Service or Procedure (Cost/Visit):	$83.72	$83.72
Total Number of Additional Home Visits per Pregnancy (1 Year Pilot)	30	11
Total Cost per Pregnancy	$2,511.60	$920.92
State Dollar Fiscal Impact (1 Year Pilot)	$251,160.00	$92,092.00

High Level Project Milestones



VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

3-13-18

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
AMES SIMMONS	EQUALITY NC
Doug Miskew	PSG
Tim Perkins	Deloitte
CAROL ORNITZ	BIAC Board
Jean Andersen	BIAC, Cardinal HS.
Will Morgan	MFS
Mary Gratton	GSK
Tracy Kimbrell	Parker Poe
Lisa Bacot	League of Women Voters
Laura Jane Nord	NC Rural Health Leadership Alliance
Tonya Horton	OSHR
John Hurst	MFS
Katie Hopkins	ARFC
Meg Bates	NCCOA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Baum	[illegible]
DAN BRUMMITT	VANCE CO. COMMISSIONER CARDINAL INNOV BRD OF DIRECTORS
Zane Stilwell	TSG
TAYLOR GRIFFIN	NCAHP
Katye Jobe	SML
Jocelyn Mitnaul	Wake County BOE Mentorship Program
Michelle Frazier	SML
Jodi Lee	CCH
CS Hollis	CSH
Mary Teague	NMRS
Jon Cecil	Jordan Price Law firm
Wayne Yancey	Dept of Justice / Medicaid Division
Jennifer Mahan	ASNC
David Collins	WellCare West
Ken Melton	[illegible]
Andy Chase	KMA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

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NAME	FIRM OR AGENCY AND ADDRESS
Sue Ann Forrest	NCMS
Kony Kiger	NCRMA
Mike James	DCP
Ben Popkin	Popkin Strategies
Carla Obioha	Care4 Carolinas
Pam Perry	Carolina Complete Health
Lori Krou	Novant Health
Jenna Mercer	Policy Group

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

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Lindsey Dowling	FSP
John Ganem	Powers Strategies
Pam Shipman	Monarch
TJ Bulpee	NP
Dodi Renfer	CCR
Ed Trulph	[illegible]
[illegible]	NCCMS
Rick Zechini	Williams Mullen
[illegible]	CSS
J Jenkins	OAPI
Daniel Van Liecam	Vidant Health
Ryan Blankenship	Cone Health
Lanier Hodgson	UNC HCP
Kari Barsness	Gateway Health
Rhaegan Jackson	Town Carolinian
Kara Weishaar	SA
PEYTON MAYNARD	GPH

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

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NAME	FIRM OR AGENCY AND ADDRESS
Leanna NYC	NSTC
JOE LANIER	TROUTMAN
Demetrius Delbatch	Troutman
Paige Bennett	Wake County Human Services
Paul M. Duck	Beacon Health Options
Regina Godette-Cranford	Regina Godette-Cranford
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
JEFF BARNHART	MWC
Sarah Grimsrud	OSBM
Erin Matteson	OSBM
Breeder Blackwell	CFVH
Justin Acuña	Governor
Matthew	[illegible]
Jillian Johnson	MWC

Candace Slate (Rep. Nelson Dollar)

From: Janet Black (Senate LA Director)
Sent: Tuesday, March 27, 2018 11:57 AM
To: Janet Black (Senate LA Director)
Subject: <NCGA> Joint Legislative Oversight Committee on Medicaid and NC Health Choice Meeting Notice for Tuesday, April 10, 2018 at 1:00 PM
Attachments: Add Meeting to Calendar_LINC_.ics

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

March 27, 2018

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Medicaid and NC Health Choice
FROM: Rep. Donny Lambeth, Co-Chair
Rep. Nelson Dollar, Co-Chair
Sen. Ralph Hise, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Medicaid and NC Health Choice** will meet at the following time:

DAY	DATE	TIME	LOCATION
Tuesday	April 10, 2018	1:00 PM	643 LOB

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Janet Black at janetb@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

April 10, 2018 1:00 p.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Nelson Dollar
Rep. Donny Lambeth
Sen. Ralph Hise

Legislative Members
Rep. William D. Brisson
Rep. Josh Dobson
Rep. Verla Insko
Rep. Bert Jones
Rep. Greg F. Murphy, MD
Sen. Dan Bishop
Sen. Valerie P. Foushee
Sen. Joyce Krawiec
Sen. Louis Pate
Sen. Gladys A. Robinson
Sen. Tommy Tucker

Advisory Members
Rep. Beverly M. Earle
Rep. Chris Malone
Rep. Rodney W. Moore
Sen. Angela R. Bryant

I.	**Welcome & Opening Remarks**	Senator Ralph Hise Presiding Co-Chair
II.	**Remarks from Department of Health and Human Services (DHHS) Secretary**	Mandy Cohen, Secretary, Department of Health and Human Services (DHHS)
III.	**Overview of Medicaid Dashboards**	Steve Owen, Committee Staff, Fiscal Research Division, NCGA Mark Collins, Committee Staff, Fiscal Research Division, NCGA
IV.	**Medicaid and NC Health Choice Enrollment**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS Michael Becketts, Assistant Secretary for Human Services, DHHS
V.	**Medicaid and NC Health Choice Financial Update**	Dave Richard, Deputy Secretary for Medical Assistance, DHHS Roger Barnes, Chief Financial Officer, Division of Medical Assistance, DHHS
VI.	**1115 Waiver Update and Work Plan for Medicaid Transformation**	Mandy Cohen, Secretary, DHHS Dave Richard, Deputy Secretary for Medical Assistance, DHHS Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS
VII.	**Efficacy of the Program for All-Inclusive Care for the Elderly (PACE) Study** – Section 11H.25 of S.L. 2017-57	Dave Richard, Deputy Secretary for Medical Assistance, DHHS
VIII.	**Plan to Implement Annual Audits of County Departments of Social Services for Compliance with Medicaid Eligibility Determination Accuracy Standards** – Section 11H.22(e) of S.L. 2017-57	Michael Becketts, Assistant Secretary for Human Services, DHHS
IX.	**Presentation of Committee Report**	Jennifer Hillman, Committee Staff, Legislative Analysis Division, NCGA
	Adjourn	

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE
April 10, 2018
Room 643

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice met on Tuesday, April 10, 2018, at 1:00 P.M. The meeting was held in Room 643. Senate members present were Dan Bishop; Joyce Krawiec; Louis Pate; and Tommy Tucker. House of Representatives members present were Josh Dobson; Nelson Dollar, Co-Chair; Verla Insko; Gregory Murphy, M.D.; and Donny Lambeth, Co-Chair. House of Representatives Advisory member Rodney Moore was present.

Legislative Services staff attending the meeting included Jennifer Hillman and Theresa Matula from Legislative Analysis Division; Steve Owen, Deborah Landry, and Mark Collins from Fiscal Research Division; and Amy Jo Johnson from Bill Drafting Division. Committee Assistants in attendance were Susan Fanning, Candace Slate, and Pan Briles.

Serving as Sergeants-at-Arms were John Enloe and Terry Barnhardt for the Senate; and Bill Bass, David Leighton, and Jim Moran for the House. See **Attachment 1 –Visitor Registration Sheet**.

Welcome & Opening Remarks

Rep. Lambeth, Co-Chair, presided. He welcomed everyone and then recognized Mandy Cohen, Secretary, Department of Health and Human Services to present agenda item **II. Remarks from Department of Health and Human Services (DHHS) Secretary**. See **Attachment 2 – DHHS Updates.**

Rep. Dollar: Is the Department saving back an amount of money from last year's budget, or is the anticipation that you're going to save back some money this year? Is that in any way going to impact any of the other programs, whether some of the past GME language that we have talked about in terms of being able to have funds sufficient to work on some of those issues or any of the behavioral health issues? Is this is going to have an impact on any other program moving forward?

Sec. Cohen: Thank you, Chairman Dollar, for the question. No, it won't have any impact. It was in last year's budget that we're carrying some of that funding forward, to be able to respond if there are any federal audit issues that do come up, but we do not see that impacting any of our other programs.

Rep. Dollar: The issue of licensure has yet to be resolved at this point. In terms of the PHP licensure, where are you with the Department of Insurance on that? Will PHP licensure be required prior to an entity bidding? Is there any entity currently operating in the state, under an HMO or other license, that would not be required to have that PHP licensure the same as any other bidder coming into the state?

Sec. Cohen: On licensure we've been working very collaboratively with the Department of Insurance. Our teams just had a big meeting in the last week and are finalizing details on how to put out a joint paper related to licensure before the short session starts. We know there is some additional legislative work that

needs to done in the short session, some around licensure. Those details are still being finalized, but I can say that plans are not going to need to be licensed in order submit the application to bid on the PHP contract, but they will need to be licensed before we go live. You'll see in the papers as we work through details that they have to be licensed before we award the contract. I think those are the details we are working through in terms of timing and workload for the DOI and our team.

Rep. Dollar: Could you win a bid and not yet be licensed, or you can only win a bid if you have a license at the time the winners are announced?

Sec. Cohen: We wanted to make sure everyone knew that they did not have to be licensed in time to respond to the RFP, but we do feel like we have the time we need to make sure we get through all of the work necessary for DOI to do their work and for us to do our work on the Department side. Those are the details we are still working through with DOI in terms of timing, but I'll look to my team if there's anything else.

Rep. Dollar: If someone has an HMO license, for example, is there any other licensure in the state currently that you are going to qualify as being a PHP?

Sec. Cohen: We want to make sure that folks have the capability to take on the risk of being an insurance company in the state and those are the details we are working through with the Department of Insurance and our goal is to have that paper out well ahead of the short session so you'll know exactly what types of legislative changes might be needed.

Rep. Dollar: It's a pretty big deal if we're saying someone doesn't have to have a PHP license, but can be licensed currently as an HMO in the state and be allowed to successfully bid, as opposed to having to go through the same standard plan. That is something I'd like to have answered sooner rather than later.

Rep. Lambeth then recognized Steve Owen and Mark Collins, Committee Staff, Fiscal Research Division, NCGA, who presented agenda item **III. Overview of Medicaid Dashboards** and answered questions from Committee members. See **Attachment 3 – Dashboards**.

Rep. Dollar: If I'm reading this chart correctly with the overall Medicaid spend, we are $206 million, federal and state, under budget?

Steve Owens: That is correct.

Rep. Dollar: As I understand it, $79 million of that you account for in terms of lower than expected population in terms of enrollees.

Steve Owens: That is correct.

Rep. Dollar: So that leaves that $127 million, federal and state money, in the final bullet point–variation in the frequency, duration, intensity of the services. So utilization and actual pricing, is that correct?

Steve Owen: That is correct.

Rep. Dollar: This is really a tremendous job by the provider community. We are in a fee-for-service system and I know we are moving to managed care for the major medical, but they're going to have a four or five year history or more of great management that they're going to have to live up to and we will see if they can perform at these same levels. In the behavioral area, again, we are operating under budget and that was significantly so, a far cry from what it used to be. Thank you very much.

Rep. Lambeth: Representative Dobson.

Rep. Dobson: Chairman Dollar covered it.

Rep. Murphy: With budget surpluses for the last four to five years under fee-for-service, it begs the question why we're moving to managed care, but that's a discussion that happened a few years ago. Anyway, Steve, could you define for me the criteria for people to have the family planning? That seems to be the one that went up the most, and what has happened with the cost of those individuals? Also, what benefits are provided to them in that specific category?

Steve Owen: I'll answer as much as I can, and defer to the Department if they want to add to it. Basically, my understanding is that anyone having an income below 185% of the federal poverty level is eligible for family planning. It is a limited set of services. This year, we're spending about $4.50 per month. If you go back to 2014 or 2015 it was about $14 to $15 per person. It's not that we are providing less services, it's just that you have smaller proportion of the enrolled population using services. As people get put into family planning because there's nothing else they're eligible for, they really don't come for family planning to start with, they come for Medicaid eligibility. They get thrown into that category and they really have no intention of using those services. Does the Department wants to add in terms of what services are covered?

Rep. Lambeth: Did that answer your question?

Rep. Murphy: No, actually it didn't. I would be happy to listen to the Department.

Dave Richard: I would ask Sandy Terrell to respond, she's our head of Clinical Operations.

Sandy Terrell: Those that come for Medicaid eligibility but don't meet eligibility are then automatically put into the family planning eligibility bucket, as Steve did mention. Many of those services are not covered, but are obviously focused on family planning and then any kind of preventative care such as HIV screening, etc. It's a very small array of services that are provided, but again, for those who do not

meet Medicaid eligibility, family planning is offered to them. They're put in that eligibility, but utilization is very low.

Rep. Murphy: I guess the term "family planning" is the part that I don't quite understand because as it was pointed out in this committee last year, over the 50 percentile part were infants born in the state; 52% are now Medicaid. If we're family planning and we are trying to help people plan families rather than a bunch of unexpected pregnancies, why are we using the term "family planning" if that's not really what we are doing?

Sandy Terrell: Sandy Terrell, Division of Medical Assistance. I certainly understand the misnomer; "family planning" is a federal label. Those that are increasing our rates, to your earlier comment, are those that are on Medicaid. So it is a distinction, from a service array, that the expenditures and then statistic that you mentioned is from our Medicaid population and not for those not meeting eligibility, but that fall into the family planning eligibility.

Steve Owen: If I could add one bit of information, there are a couple of things about family planning. Actually, the Medicaid birthrate has declined as a percentage of enrollment over the last three years, compared to the North Carolina non-Medicaid birthrate, which has risen. The other thing we saw was that the proportion of people having births, previously in family planning, is rising, and the length of time between the last birth and the current birth is extending. I can get you that detail from last month if that would help.

Rep. Lambeth: Was that helpful?

Rep. Murphy: Yes sir.

Rep. Lambeth: Representative Dollar.

Rep. Dollar: We know that the FMAP percentage is going to decrease; I assume that will begin October 1 or with the beginning of the next federal fiscal year. If the current budgetary trends hold for us until the end of our year, to what degree will those savings be calculated in or accrued to our advantage or lessen the amount that we may need next year in terms of rebase? I'm assuming the rebase, looking forward to next year is going to include the decrease of the reimbursement percentage we're getting from the federal government. Will the figure somewhere in the range of $250 million that will be required budget-wise, I was looking at a month or two ago, offset this sum, or to what degree will that be lessened if at all, if we stay on track with our current budget?

Rep. Lambeth: Mr. Owen.

Steve Owen: Again, I'll start the answer and let the Department pick it up. I believe that the overall impact of the reduced federal match is about $40 million a year. The rebase will consider not only that, it'll consider the fact that we have 46,000 less people, as well as the information we were looking at

previously about utilization. I know that the Department is forecasting the surplus this year. To what extent that carries forward to next year and offsets that, we'll have to let them respond to that.

Rep. Dollar: I know you're all working on the Governor's budget, or I'm sure Mr. Perusse is working on the budget now. What figure did you give him for rebase for next year?

Dave Richard: I don't think I can give the exact number on the rebase; I think we have to work through the process with the budget itself. But, I think you're absolutely accurate to assume that because we are running under budget this fiscal year, as we carry forward those trends, we'll continue in terms of what we will need for additional money for rebase. The $40 million for the FMAP will be included in the rebase obviously, and you know there are other program changes that happen throughout the year that we have to adjust for. As we work through this process relatively soon, fiscal research will have our rebase number, but I don't think I can tell you that at this point.

Rep. Dollar: Is it in the neighborhood of quarter of a billion dollars, less than that, significantly less than that? I'm trying to find out if that number's in the ballpark, or is it going to be significantly less than that?

Dave Richard: I think if a quarter of a billion dollars is what you're planning for I think you can feel comfortable that you won't have to plan for that, how's that?

Rep. Lambeth: No other questions, thank you all for sharing a lot of information with the Committee.

Rep. Lambeth then recognized Dave Richard, Deputy Secretary for Medical Assistance, DHHS, to present agenda item **IV. Medicaid and NC Health Choice Enrollment.** Dave Richard presented agenda item IV. See **Attachment 4 – Medicaid and NC Health Choice Enrollment**. There were no questions from Committee members.

For agenda item **V. Medicaid and NC Health Choice Financial Update**, Rep. Lambeth recognized and Roger Barnes, Chief Financial Officer, Division of Medical Assistance, presented the update. See **Attachment 5 – Medicaid and NC Health Choice Financial Update**. There were no questions from Committee members.

Rep. Lambeth recognized Jay Ludlam for presentation of agenda item **VI. 1115 Waiver Update and Work Plan for Medicaid Transformation.** See **Attachment 6 – Medicaid Transformation.** Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS, presented agenda item VI.

Rep. Lambeth: Dr. Murphy.

Rep. Murphy: One of the banes of our existence now in medicine is clicking buttons and treating the electronic chart rather than treating the patient anymore. I'm a little concerned about what 33 quality measures have been cooked up. Am I going to have click a box on somebody that comes in with a kidney

stone and have to worry about whether their grandmother died from a cancer of the ear? That's extreme, but again I get back to the point where it's overload. We're pulling away from patient care and treating the chart rather than the patient. I just always want us to be mindful of that. I think you guys have been listening, which I am deeply appreciative of. But I'm just interested, of the 33 quality measures, what are we talking about?

Sec. Cohen: We put this out for comment to ask is 33 too many, first of all. What are the things that are core to this program? I think the team was very creative in the way they tiered some of the quality metrics, so we have six that are really outcome measures and not the checking-box measures, We're trying to make sure that we are truly getting the outcomes that we pay for that are going to be our core, core measures. Then we had this next, next tier of measures that are still important. We want to make sure our folks are getting good care and there's no stinting in care. We look forward to feedback – is 33 the right number? And then there are other measures that don't have the validated data measurement yet, but are important as we think about the future of Medicaid and so we have other measures we would like to collect data on, from insurance companies, to help us understand the needs of our population better. We certainly hear your words of caution and look forward to feedback. The physician community has been very thoughtful at providing that feedback and we look forward to more of that.

Rep. Lambeth: Representative Dollar.

Rep. Dollar: There're lots of questions generated by these white papers and questions generated by what's presented. But we're not getting the answers or what's going to be done. My concern is from the last meeting – the response was that there wouldn't be follow-up white papers based on the changes, so are we not going to know what those are until the RFPs are issued? Can people respond to the answers to some of the questions? What's the final going to look like? Are we going to have an opportunity to work with that in some way, the General Assembly and the public, before those final things are just in the RFP so it's out there and being bid on? We have a lot of questions and issues. I'm not sure we're getting our hands on actual answers.

Sec. Cohen: We've tried to phase in a number of opportunities for folks to give feedback. All these opportunities are intended to be as transparent as possible while continuing to do our operational work and make sure that we're going to be able to launch the program on time. There is a lot of operational work to do. That is why we worked very hard until last summer to get out a high-level concept paper that let everyone know where we are going, then drill down on each of those to give even more detail. As someone who worked at the federal level and watched what states did across the country, this is a highly unusual level of transparency, but I think it is important because we want to get this right and really have appreciated the thoughtful feedback of our stakeholders. It is not something that is required of the Department and I appreciate the team coming along with me on this journey because it is a ton of work to

get these papers out, be responsive to the comments, but we will, in order to meet these deadlines, need the next turn of things to be the RFP that we put out. We hear all of the feedback and then we have to step back and say all of these things are interrelated; the supplemental payments impact the quality which impacts the network adequacy which impacts the care coordination. Then we have to sit back and take a look at it across all of those pieces and make the best decisions we can for the state of North Carolina. I thank you for empowering me in my role as Secretary and I have a great team doing the work here and we look forward to much continued feedback but we do need to move forward with the work.

Rep. Dollar: I appreciate the white papers and the transparency, but the General Assembly usually knows what the answers are going to be before a product is actually put out there to be bid on. That's normally the operational scenario in North Carolina and it's worked pretty well. We're going to have to get to that point one way or another. Can you give us an update of CMS approval of the 1115 Waiver and when do you anticipate approval of that waiver amendment?

Sec. Cohen: As Assistant Secretary Ludlam mentioned, it's been slower than we want. We are still waiting for a final budget model from them that helps us understand where our budget neutrality is. They keep saying "it will be here by the end of the week" and that's been three weeks now. I know how this goes. It is at OMB, which is a good sign. They have been doing a lot of work in the Medicaid space, as you can tell. Over the last number of weeks they've made some policy decisions, so we probably got caught up in terms of being behind some of those policy decisions they've been making. I'm hopeful to see a budget neutrality model soon; then we'll need to dig into it to make sure it incorporates the things we had concerns about. Then we'll be able to report back to the Committee on timing. It is our intent to keep the pace up here so that we meet operational deadlines.

Rep. Dollar: Will that budget neutrality model include factoring in savings from programs that have not been approved by the General Assembly?

Sec. Cohen: The budget neutrality model takes a projection of what our program would look like if there was no waiver. So the budget neutrality is really more dependent on what the program would look like if we had no waiver moving forward, and that is really what we are discussing with them, not about the things they are approving in the waiver. If you could imagine two sides of a graph, we are trying to negotiate on the top level of what the spend in Medicaid would have looked like if we did no waiver, if we did nothing. So the negotiation is not on the other side. What you're asking for is are we negotiating, but if we did physical health and behavioral health together, for example, is that part of this? We're not even negotiating on it, we are negotiating on what would the program have looked like if there was no waiver at all. We are waiting for a response back from CMS on that.

Rep. Lambeth: Follow up?

Rep. Dollar: Interesting answer, not at this time.

Rep. Lambeth: Sen. Tucker.

Sen. Tucker: What's the difference between care management and case management?

Jay Ludlam: Care management is more the whole person approach – looking at the clinical, behavioral health and physical health, the social determinant. It's working with the individual to ensure they get the transportation needed to get them into the appointments. It's the whole continuum of care ensuring that all the services are being done to care for the whole person. Case management is more administrative.

Dave Richard: Sen. Tucker and I have had a long history with case management and care management. Case management defined by CMS is often a targeted service through very specific populations, much more narrowly focused on how work happens. Care management is thinking about how you manage that entire population as a whole versus that very targeted approach. A third term is "care coordination," which happens at that higher health plan level, LME/MCO role, when they do care coordination which is making sure that people have access to service. The care management then ensures once they have access to service that they're getting the quality services they need and all of the accompanying things that relate to that. Case management is much more targeted to a very specific population.

Rep. Lambeth: You want a quick follow-up?

Sen. Tucker: I heard the secretary mention insurance companies. Back somewhat to Dr. Murphy's question, where will you get the data to know that our consumers are receiving quality care?

Sec. Cohen: It is actually an enormous piece of the operational work we are doing. Right now, we know about how services are delivered based on claims feed: a provider bills us and we pay it. In the future world of managed care, those claims essentially turn into encounter data. We take in that data, clean it, which is a lot harder than it sounds, and do analysis on that data to make sure that folks are getting the service in the right location, at the right time, all of that. That is a big lift and we are bringing in some experts to help us do this well because it is a new skill for us at the state, but it is a very important piece of work to make sure that we are able to run the program well.

Rep. Lambeth: Follow-up?

Sen. Tucker: And then where is this data plugged into the HIE, where's it all plugged into so it's useful after it's scrubbed or whitewashed or whatever you use?

Sec. Cohen: So HIE is clinical data pulled directly from an electronic health record as opposed to an encounter. It is a bit lagged and more related to the delivery of service. So there are two different types of

data, but the place we want to get to is where we can merge encounter and clinical data so it's actionable by a doctor or a nurse or a care manager at the time when a patient needs that care. Encounter is more of an opportunity to monitor the program. The HIE and clinical data is really to help doctors and nurses take care of persons sitting in front of them. And so they do serve different purposes, but I think for the future we are trying to build a strategic road map toward how you put that data together and get both.

Rep. Lambeth: Let me add a little bit to the quality of the discussion. Many indicators are already captured, whether it is for joint commission that accredits hospitals or for other organizations – Medicare, for example. In North Carolina, Medicaid does not capture any of those quality indicators, although they already exist. So to Dr. Murphy's point, is there added work that is going to be created? I would be surprised if there's added worked because many of these quality metrics or indicators are already part of the electronic medical records because of another entity, i.e., they have to capture it for joint commission to report to joint commission. Medicare requires certain information to get paid for Medicare or they're penalized. Thirty-three strikes me as a little on the high side, but not terribly surprising that that's what you all have looked at. But many of these metrics are not new; they already exist, we just don't capture them in the North Carolina Medicaid world and part of the process is to be able to compare and capture that going forward when we have a new reform plan. Rep. Dollar.

Rep. Dollar: If I'm understanding the slide, the PHPs will be able to essentially design their own benefit plans. In what way? To what extent would they be designing their own benefit plans?

Jay Ludlam: The health plans are required to cover the Medicaid benefit package; there's no change to that. They are going to be required to meet the same thresholds, benefit limitations, prior authorization requirements. The practical difference is we will use a clinical policy organization like Milliman or InterQual® that when a doctor seeks an authorization for a service there is evidence or certain conditions the doctor will have to document for the health plan to approve it. In the past, the Department would've established that criteria. Now the health plans will utilize InterQual® or Milliman and the providers will meet that policy definition and then get the authorization. So it's not like a wild west, there are evidence-based structures around this.

Rep. Dollar: Mme. Secretary, the anticipation was that the 1115 would be approved by now. That was amended in November, and we're awaiting approval and it was anticipated it was going to come soon, but it hasn't. The General Assembly is going to come in May and hopefully leave at the end of June or not long after that, and most members in here would probably appreciate that. What happens if we don't get approval on the 1115 amendment? I know that normally on such a thing they tell you go back and work again. Would a 1915 waiver be something that the state could drop back and take a look at? That's a manage care waiver regimen. Obviously it's not the same as an 1115, but would a 1915 or some other

pursuit be something the state should consider or at least given some thought to if the 1115 is not going to be approved?

Sec. Cohen: I'm not at all concerned that our 1115 won't be approved. It's a timing issue, so we're not concerned about the substantive issues that you would be taking up in the short session. So the things that we've been talking about that need legislative change related to licensure and supplemental payments, again those are not even in the waiver. I did not request any supplemental payment pools because we know we can't have them; it's not as if CMS needs to say yea or nay. There are no supplemental pools. We have to change the way in which we pay hospitals to move forward and to manage care. Same thing with licensure – they assumed that the DOI again has the authority to regulate licensure, and that that is a state function. They would just say you need to be licensed and want to see that as we work through our operational protocol, but that's not something that would hold up an 1115 approval. Nearly every state is moving toward behavioral and physical health integration. CMS is encouraging that. That is not an outstanding issue for them in terms of concern.

Rep. Dollar: Mme. Secretary, so am I understanding you correctly that the short session requires no action whatsoever on behalf of the General Assembly in order to move forward on the 1115?

Sec. Cohen: I think you heard me right. We have some work to do in the short session to make sure we can turn on managed care from an operational perspective around licensing, about how we pay hospitals. I don't want to make an exhaustive list because we will be sure that we are sharing with you all the provisions that are necessary to make managed care run and work appropriately, but I don't think it intersects with our ability to finalize and get an 1115 approval.

Rep. Dollar: So you're saying the 1115 would be approved even though there were elements in there that may not be acted on by the General Assembly or not likely to be acted on by the General Assembly?

Sec. Cohen: When we get CMS approval for expenditure authority, what they are basically saying is if you come to us in the future with state share and state authority, we'll let you do that. They are somewhat agnostic as whether or not there is state authority or even state share available at the moment because we know we don't have out-year budgets, so that is not a factor that goes into negotiations with CMS. For CMS, they want to capture what our spend would look like if there was no waiver and defining the parameters if we come back to CMS with the state share in hand, which obviously you all need to appropriate and we all work through, and with the authority, would they allow that expenditure authority and flexibility? Those are the details we are working through, so issues of state authority are not really ones that are top of mind to CMS. Obviously, they are trying to prioritize things to work through the waiver as quickly as possible, and get things started. We don't see that overlap in what we're doing in the 1115 negotiations and what we think needs to happen in the short session.

Rep. Dollar: So you're saying that the 1115 could be approved but you may not be able to move forward unless the General Assembly acts on other issues?

Sec. Cohen: That's right.

Rep. Dollar: And you're going to give us a list of those issues, is that correct?

Sec. Cohen: Correct.

Rep. Dollar: Sooner rather than later, that would be great.

Sec. Cohen: Very soon.

David Richard presented agenda item **VII. Efficacy of the Program for All-Inclusive Care for the Elderly (PACE) Study** and answered questions from Committee members. See **Attachment 7 – Efficacy of the Program for All-Inclusive Care for the Elderly (PACE) Study.**

Rep. Lambeth: I recall a few years ago there was a big budget issue regarding the PACE program, how did all that settle out? From the numbers I'm seeing earlier, it looks like it's well within their budget.

Dave Richard: Yes, Mr. Chairman. There was an issue where we had under-anticipated the amount of money it would cost for the PACE program and there was some growth that happened in there. We've been stable within the budget program and able to be very predictable for that, and so I think we're running about $70 million for the total cost of the program right now and feel good with that.

Rep. Dollar: Who does the assessment in terms of determining the individual's eligibility for PACE and is there any anticipation in changes recommended for the future in how that assessment process works?

Dave Richard: The PACE programs themselves do the assessments and we have no recommendations for changes in that at this time.

Rep. Dollar: So you're satisfied they're being done appropriately?

Dave Richard: Yes sir.

Rep. Dollar: At one time the thought was that PACE was a diversion for skilled nursing. Most of the skilled nursing in this state is pretty high acuity. It's probably more a diversion from other less acute assisted living or other living options. Is that the way the program operates in North Carolina in terms of the acuity level of the people in the PACE program?

Dave Richard: It clearly is still intended as a diversion from a nursing home and your point's well taken about the high acuity level. The PACE program allows for individuals to stay much longer in their homes, regardless of what an out-of-home home placement would look like. Because the PACE program itself, in the capitated model, is required to pay for those other services if they wind up going there. So yes, it is a diversion from adult care homes; it's also a diversion from nursing homes. There's a technical issue about that though. Because of the level of care at the adult care home, the PACE program itself is not technically designed to offset that. But it does allow for people to stay in communities much longer and I think that's what we're trying to achieve.

Rep. Dollar: Is the recommendation from the Department, as we move forward with the reform, to expand the PACE program and the support for it?

Dave Richard: Rep. Dollar, our recommendations are two-fold. There are things that we can do currently with available resources that we are working with the PACE organizations to make happen. I think that we've said PACE is a valuable program; it does do its job for those individuals. The decision is one the General Assembly will have to make in terms of the resources you would like to put into additional PACE sites. We certainly would not object to additional sites, but as it's a very small program at this point and is not statewide, it doesn't take on the magnitude that our managed care design is contemplating for managed care programs. No objection to the General Assembly wanting to expand size, but I think we left that up to you.

Rep. Dollar: Would it be the Department's judgment, if it was significantly expanded at some point or over a period of time, to be a net savings to the Medicaid program, taking into account where we're heading in terms of Medicaid transformation and the like?

Dave Richard: Rep. Dollar, in the way that we calculate the PACE program it clearly shows a savings against what a nursing home cost would be long-term for an individual. I think the question, as always, is how many people would end up in a nursing home? So in terms of giving you a net savings, if you put into the program $5 million would that give you a $5 million offset somewhere else? I don't think any of us comfortably could tell you that would happen during the fiscal year that you're doing that, or even in the coming fiscal years, because it's really a long-term offset. That's always been difficult to look at because if you expend the money in the PACE program it's not going to reduce your cost of nursing home costs anytime soon, because it's really a longer term view that you're taking.

Rep. Dollar: But if it didn't particularly offset most of the acuity levels that we have in skilled nursing, would it potentially offset it in terms of other costs, other care settings that the individual might be in, including just being in their home?

Dave Richard: Rep. Dollar I wouldn't feel comfortable answering that yet, but we can certainly get back to you. But, the key things I would like you take away from it is that we believe the PACE program works for individuals that are in PACE programs, and it is a quality program that makes a difference in lives and keeps people in their homes longer. Being able to give a dollar for dollar match, in terms of what you would be able to do if you expanded PACE and made reductions everywhere else, I don't think we're comfortable in giving you a number to do that.

Rep. Dollar: I wasn't necessarily asking for dollar for dollar. I mean there's quality of life as well and health outcomes and those kinds of things. So I wasn't necessarily looking for dollar for dollar, but I'm just talking about longer term impact. Thank you.

Dave Richard: Mr. Chairman, if I might add a reminder – this is a Medicaid and Medicare program so there is a blend of funding. So the return on investment for the state may not be as great as it might be for the federal government.

Rep. Dollar: But of course for the taxpayers it's federal and state.

Dave Richard presented Agenda item **VIII. Plan to Implement Annual Audits of County Departments of Social Services for Compliance with Medicaid Eligibility Determination Accuracy Standards** and answered questions of Committee members, following remarks from State Auditor Beth Wood. See **Attachment 8 – Audit of County Medicaid Eligibility Determinations**.

Rep. Lambeth then recognized State Auditor Beth Wood and her staff.

Auditor Wood: Thank you, Mr. Chairman. I am seeing a level of commitment at DHHS, since I've been state auditor, I've never seen before. I do lay out a couple of issues in my certification, one of them being that the training that was provided for eligibility determination on the new system for the counties was practically nothing. It's a very complicated system, so whatever plan we move forward with, one of the first things that has to happen is very detailed training on eligibility determination under NC FAST. In talking with and working with DHHS they are committed to that. The other piece of it is, we are reviewing their sample size determination. I haven't seen the underlying criteria that gets me to 200 items per county, but I am working with them and their stats person to be comfortable that 200 is adequate. The other piece – I think they have, for the first time since I've been state auditor, realized that some of the QA functions that they were doing were inadequate and they appear to have their arms around what was wrong with it. CMS provides some help, but it's always been inadequate. Everything is pointed in absolutely the right direction. The biggest piece is that this administration has taken responsibility for eligibility determination at the county level. So I'm feeling really good about where they're headed with this process and this new plan.

Rep. Lambeth: Thank you for those comments, now we will go to Sen. Tucker.

Sen. Tucker: Deputy Sec. Richard, what happened to those nine positions that were approved in the budget two cycles ago to go around to all one hundred counties and review the culture, the systems, and the overall audit? We funded about $700,000 and I received one report of about 32 counties. Wayne Black and Sherry Bradsher were here, and I received one report and haven't received one again. Where did those nine positions go? What are they doing and why can't they be used in some of the features required with the audit?

Dave Richard: Sen. Tucker, I'm going to have to get back to you with the exact details on what those positions are. I think as they were appropriated they were established inside the Division of Social Services, so we will make sure we connect and give you exact detail on where there at. I apologize for not having that.

Sen. Tucker: Well I've received no report in two or three years, I mean it just got absorbed in your 16,000 employees and you're asking for 19 and they're nine. You had trouble filling them but you did fill them with retired HHS workers or DSS workers to go around to check that. We're still funding those and we don't know what they're doing would be my question.

Dave Richard: Sen. Tucker I would say that we know what they're doing, I would say that I don't know at this point what they're doing. I want to get back to you on that, it's an appropriate point to make and we will do so.

Sen. Tucker: I heard Auditor Wood speak about training on a system, a data system for Medicaid eligibility, could you share with me what system that is again, please?

Dave Richard: Sen. Tucker that would be NC FAST.

Sen. Tucker: Isn't that the same system that we've been waiting on Child Protective Services for as well?

Dave Richard: Sen. Tucker, I suspect it is. Yes, sir.

Sen. Tucker: Since we're talking about eligibility and we're talking about funding, and you know I'm leaving here sooner rather than later, my question to you is on group home funding. We have done bridge funding for those folks time and time again since I've been here. I think we have funding for them in the short session, right? What has the Department done? Where are we on that issue? I don't want to see the paper come out and say that the General Assembly, like it did before, didn't fund it and we're going to be putting people on the streets. Are we going to do a study, or do we know what the answer is? This has been an ongoing issue and if we're talking about audits and those kinds of things, what are we doing for group homes? That's off the subject but real.

Dave Richard: I'm well aware of the conversation on the group homes. We've had several meetings with many of the constituents to talk about if potential options exist and the difficulty, from the Medicaid perspective, is that Medicaid itself can't pay for that housing so that we have to have state funds that allow us to do that work. I know you and others were so generous in appropriating funds for that. We continue to work with constituents to identify any other possible options. At the end of the day we're going to have to determine how much the General Assembly is willing to put in in terms of state funds, and how we connect that with the support services through the Medicaid program for those individuals. I wish I could tell you Medicaid could fund that directly and housing would be an appropriate thing Medicaid could do.

Sen. Tucker: Is some of the funding for the group homes coming from the single stream funding we used to do for the LME/MCOs?

Dave Richard: Yes sir.

Sen. Tucker: Mr. Chair, we get into this fire drill when we run out of money. These folks are not going away, they need some certainty in funding. I think this committee or one of the chairs needs to direct somebody to come up with a solution and some finality so there's some permanency in the budget structure to be able to fund these group homes. We've got them shutting down; some are closing. They haven't had any raises in a long time and it gets pretty hairy when they start putting people out on the street. I just bring that up since I got the higher-ups here to address that as well. Thank you.

Rep. Lambeth: Thank you Sen. Tucker. Senator Krawiec.

Senator Krawiec: Thank you, Mr. Chairman. Mr. Richard, thank you for the information. You mentioned Auditor Wood's audit that we had previously and the great job that Wilkes County had been doing, but, if I remember correctly, there was one county that had a 50 percent error rate. I think it was Guilford. Has that been reevaluated? Is Guilford County performing better now? Did you look at what was going on there and why that was occurring?

Dave Richard: I think it was 28 percent, but I could be wrong. We looked at Guilford, also other counties in terms of that, and we found, as Auditor Wood mentioned, that the training we were providing was not up to par. Also, inside of reviewing the process, there was another report that came out that required a certification process that we've submitted to you in terms of helping workers that do Medicaid eligibility meet that certification requirement that we'll be instituting with our partners at DSS and overseeing. Every county is different in how they do that work. Additional kinds of effort are needed to help those staff get there. If we create a certification process where people have to meet training standards then we should be able to get the workers across the state there. And I will also add that we are working closely with the county commissioners association along with the association of DSS directors to make sure that

we implement this in an appropriate way. But you were correct, there was one county that was an outlier in that.

Rep. Lambeth: Auditor Wood.

Auditor Wood: I would like to answer the senator's question also. One of the things we looked in our report was how many applications and renewals that each case worker did per year. We looked at Mecklenburg County, which is the largest, and they were processing something like 384 applications and re-certifications per year, per case worker. Wake County had about a 5% error rate and they were processing about 584. Guilford County had the highest error rate, it was in the low 20s, and that was the error rate where there were people that were eligible that should not have been, or they were rejected and they should've been in the program. It was around 50% when you add in the technical errors, where even when you corrected the errors they were still eligible. But they were processing over 800 applications per case worker, per year. One of our recommendations is that there should be some criteria or something put out there to say working at a normal pace you should be, on average, handling this many applications or reviewing and renewing or certifying this many applications per year. But I thought it interesting that of the top three counties, Guilford had the highest error rate and was processing over 800 applications. So if you're pushing them through too fast or you're not doing them appropriately, that's how you can push that many through so fast. So that may be some indication of why their error rate was so high, but again, our recommendation is that some criteria be put out there for approximately, on average, how many applications and renewals should a case worker be able to do in the course of a year.

Rep. Lambeth: Rep. Dollar.

Rep. Dollar: Thank you, Mr. Chairman. Do you have some proposals or do we need to come up with some proposals here in the General Assembly to do a better job of asset verification to make sure that people who are on the program are actually qualifying for the program?

Dave Richard: Rep. Dollar, thank you. Our system now is able to do a better job of that so we have been making improvements in our system to do that asset verification, and obviously we want to do that work on the front end so that we're not missing those things. That's part of the reason an automated system is where we want to be, along with making sure the workers are trained appropriately and that we have the right criteria the auditor mentioned, in terms of the number of workers that are required to do that. And as you know, and I was surprised that Sen. Tucker didn't ask this question. We also have a requirement from the General Assembly for a system that looks at fraud, waste, and abuse that will begin to be operationalized on April 29th. It's a back-end approach, but we have it in our system today, and I can get better detail for you. We have a better place in asset verification.

Rep. Dollar: Do we have any potential contractors that are working for HHS now that could do that kind of work? NC FAST is only going to have access to certain databases, but other groups have access to databases that could answer the questions. The systems that we have that are promised to be working sometime, may not be able to fully answer those questions even if they ever do become operational. But I know the private sector has tools that are out there currently, so I'm just wondering if maybe you have some vendors on board that could take a look at doing that for you, doing that for the state?

Dave Richard: Rep. Dollar, thank you for the suggestion. I don't know that I can answer your question right now.

Rep. Dollar: Thank you.

Rep. Lambeth: My feedback would be that you continue to work with Auditor Wood. I'm perfectly satisfied with a sampling approach, but I think this is a very important topic because as we move more toward Medicaid with a capitated system we need to make sure that we have the right people being determined that are eligible and vice versa. And so this is important for us to understand if we have a problem, and, if so, where are the areas we need to fix. So I would encourage you to continue to work with the audit team to make sure we are doing some auditing to verify whether we have problems in some counties and I think her observations are just spot on. If people are overworked they're going to make errors. There ought to be standards and a monitoring system that monitors how well they're doing.

Rep. Lambeth recognized Jennifer Hillman who presented agenda item **IX. Presentation of Committee Report.** See Attachment 9 – **Joint Legislative Oversight Committee on Medicaid and NC Health Choice Report to the 2018 Session of the 2017 General Assembly of North Carolina**.

Rep. Dollar: Before I make a motion I would point out one thing, and this is also something I wish I'd pointed out in the HHS Oversight. There's a committee that is jointly appointed, with HHS Oversight and Medicaid Oversight, and that is the Behavioral Health Subcommittee. Behavioral Health is obviously a huge spend in the billions of dollars and very important. I'm just extremely disappointed that we were not able to come to an agreement to have the LME/MCOs come and make a presentation and answer tough questions either before that subcommittee or before this committee or before the regular HHS Oversight Committee. I really do hope that, in the future, we'll right that and make sure we're including in our discussions hearing from the folks that are running our mental health and behavioral health system because I think they have some information they needed to share with us and I think there are tough questions we need to ask them to make sure they're doing what they need to be doing and that we understand what they're doing and understand where the gaps are. It is so incredibly important to this state. Hopefully, we'll be doing a better job of that in the future. Having said that I move that the Committee accepts the report as presented, directing staff to make any necessary technical changes.

Rep. Lambeth: You heard a motion. All those in favor, say aye. Any opposed? This will move forward to our short session. If there are no other comments, we appreciate the staff and the work you do to prepare this committee and the work you do every day. Thank you, again, for being here. This meeting is adjourned.

There being no further business, the meeting adjourned at 3:23 P.M.

Representative Donny Lambeth, Co-Chair

Susan Fanning, Committee Assistant

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Medicaid and NC Health Choice
April 10, 2018

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Amanda Donovan	KTS
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JT Leg Oversight Comm on Medicaid and NC Health Choice — 4/10/2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lyneka Juckins	kr Beery - Ljuckins@kberry healthcare
Steve Hess	Elderhaus 2222 S 17th St. Wilmington
AMES SIMMONS	EQUALITY NC
[illegible]	MA
Ed [illegible]	BP
Paul M. Duck	Beacon Health Options
Rachel Blanlie	RBLaw
[illegible]	Brain Injury Association of NC
Carol [illegible]	BIANC Board family member
Katye Jobe	SMM
Ashley Parkinson	Parkinson Law

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JT Leg Oversight Comm on Medicaid and NC Health Choice — 4/10/2018

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NAME	FIRM OR AGENCY AND ADDRESS
[signature]	MFS
Rick Zechini	Williams Mullen
Will Morgan	MFS
Will Robinson	TNC
Ken Lewis	NCAHP
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[signature]	CSS
[signature]	Amerigroup
[signature]	MVA
Kari Barsness	Gateway

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JT Leg Oversight Comm on Medicaid and NC Health Choice — 4/10/2018

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NAME	FIRM OR AGENCY AND ADDRESS
Breeden Blackwell	CFVH
Dick Carlton	Law Off. of Rick Carlton PLLC
Daniel VanLear	Vidant Health
Thom Mc	CGA
Rob Lummis	FLA
PEYTON MAYNARD	
Ben Popkin	Popkin Strategies
Yvonne Copeland	CCMLE
Pam Shipman	Monarch
Rhaegan Jackson	Focus Carolina
Emma Shelby	The Policy Group

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NAME	FIRM OR AGENCY AND ADDRESS
John P. Crowder	Crowder Consulting Co.
Adam Shola-	NCHCFA
Chris Spencer	Pitney Bowes
JOHN THOMPSON	TPG
Dan Miskin	PSG
Kirby Consier	Novartis
Kara Weishaar	SA
Cory Hood	NCHA
Lanier Hodgson	UNC HCS

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JT Leg Oversight Comm on Medicaid and NC Health Choice — 4/10/2018

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NAME	FIRM OR AGENCY AND ADDRESS
Brian Perlans	Alliance BHC
Sara Wilson	Alliance BHC email - [illegible]@aol.com
LINDA Jarrett	Invited to observe by Speaker Moore
Dodie Renfer	CCR
Laura Jane Ward	NC Rural Health Leadership Alliance
Jon Carr	Jordan Price Law Firm
Ken Melton	KMA

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JT Leg Oversight Comm on Medicaid and NC Health Choice — 4/10/2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maureen Darcy Carr	Women Birth + Wellness Center
Bo [illegible]	NWC
Johanna Reese	NCAOC

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

DHHS Updates

Mandy Cohen, MD, MPH
Department of Health and Human Services

April 10, 2018

Attachment 2

Background on Medicare Cost-Sharing Payments

- For most dual eligible beneficiaries, Medicare pays the majority of a claim, while Medicaid pays the portion that would otherwise be enrollee cost-sharing. In 2002, new state legislation changed methodology for calculating how much Medicaid would pay on each of these claims.
- Instead of basing the payment only on what Medicare paid for the service, DHHS's payment would also consider what Medicaid would have paid if the claim had originated as a Medicaid claim. Specifically, the Medicaid payment would be capped so that the total amount the provider received was no greater than the amount they would receive in Medicaid.
- This new legislation required providers to file special Medicaid secondary claims since Medicare did not provide all the necessary information (whereas before they had only needed to submit their Medicare claims to Medicaid).
- To minimize administrative burden, DHHS developed a "percentage table" to simplify the process and allow payment of the Medicaid payment to be calculated based on the Medicare claims. Initial table developed in 2004 and used through June 30, 2013.
- On July 1, 2013, NCTracks was programmed to make the calculation based upon the received Medicare claim, which now includes all the necessary information to make the calculation.

OIG Audit of Cost-Sharing Payments

- OIG began an audit of this payment process in 2016 and looked at claims from period prior to implementation of the new table in 2013
- In 2017 OIG concluded that any claim not paid based on the full Medicare claim was paid incorrectly, resulting in OIG finding an overpayment of $41 million.
- DHHS disagrees that these are overpayments and believes our methodology was appropriate
- CMS is still reviewing the OIG finding, and has not issued a demand letter; if a demand letter is issued DHHS will appeal
- DHHS has carried forward some funding to respond to any federal audit issues

Joint Legislative Oversight Committee for Medicaid and NC Health Choice

Dashboards

Mark Collins and Steve Owen,
Fiscal Research Division

April 10, 2018

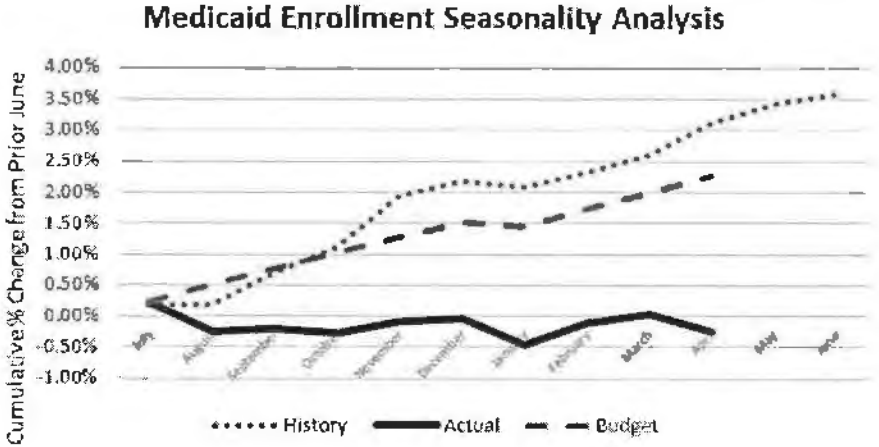
Discussion Guide

- Medicaid Enrollment
  - *Overall Enrollment trends*
  - *Follow up with selected Counties*
- Medicaid Spending and Variance Analysis
- Health Choice Enrollment
- Health Choice Spending

Medicaid Enrollment

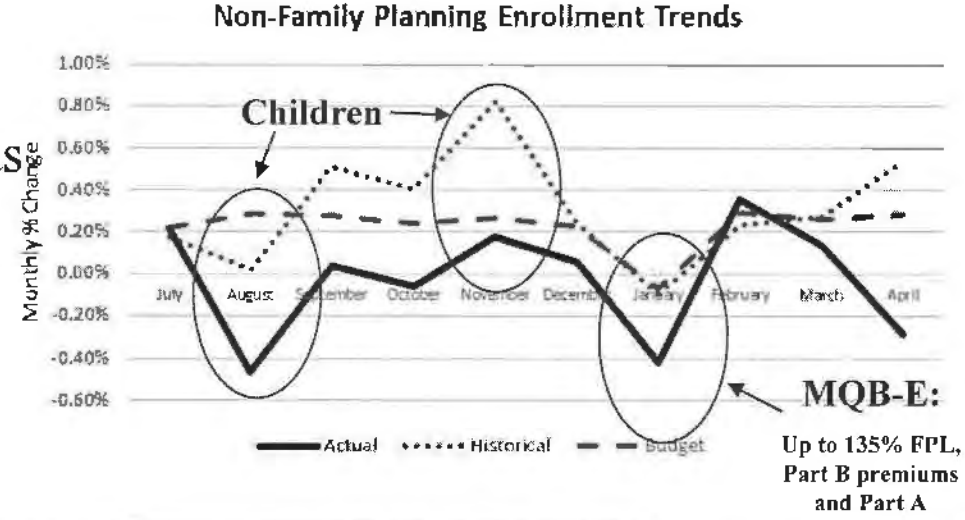
- Non-Family Planning Enrollment in April 2018 was 1,806,615, which was 4,577 lower than June 2017
- SFY 2017-18 non-family planning enrollment has averaged 45,500 less people per month than budget
- Family Planning enrollment was 250,509 in April 2018, which is 66,005 higher than June 2017 and 4,286 higher than the budgeted average

Medicaid Enrollment



Non-Family Planning trends in enrollment compared to budget and historical reflect that SFY 2017-18 has been stable

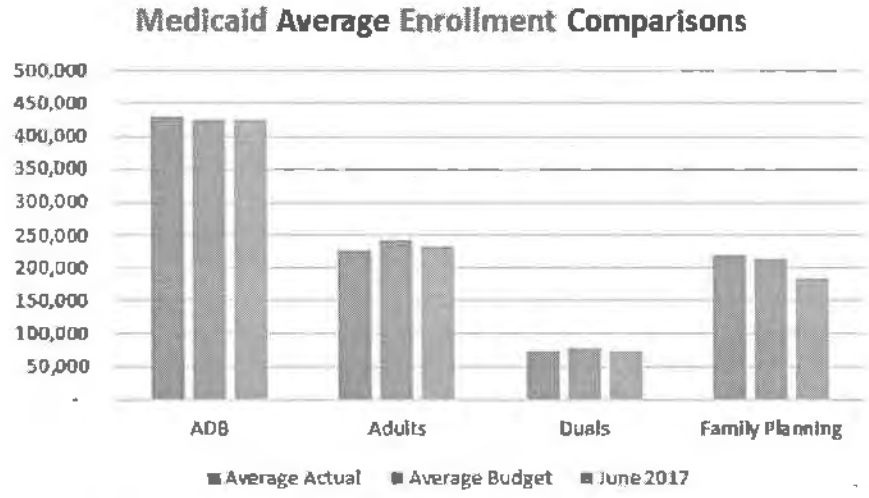
SFY 2017-18 monthly seasonality has reflected the same seasonal trends, though not to the same degree

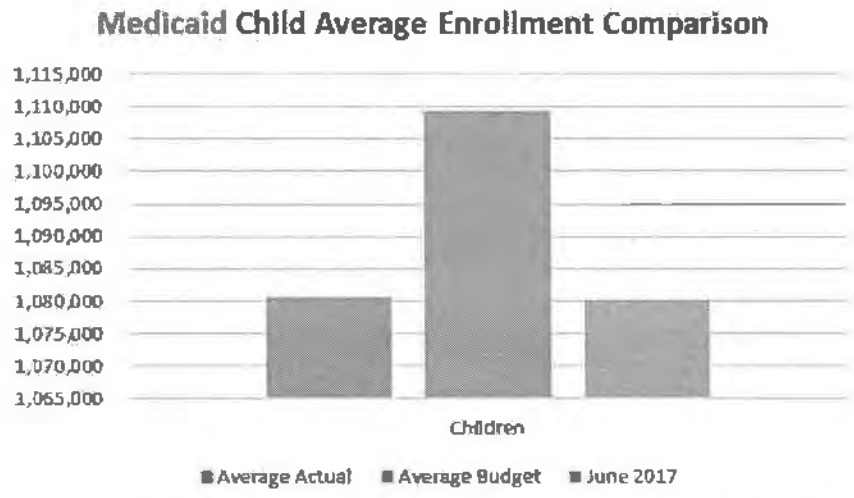


Medicaid Enrollment

- ABD and Family Planning only program aid categories not flat to declining in enrollment or under budget

	ABD	Adults	Duals	Family Planning	Children
Average Actual	428,749	226,099	73,248	218,937	1,080,473
Average Budget	426,017	241,777	76,922	213,794	1,109,316
June 2017	425,227	232,622	73,329	184,504	1,080,014





County Enrollment Notes

Mark Collins begins

- Spoke with local departments of social services in four counties about enrollment trends (excluding Family Planning)
  - three with enrollment declining more than the State average
  - one with enrollment increasing more than State average
- General impressions
  - Move to NCFAST has had an operational impact on trends; concerns that the implementation might still be having an effect
  - County responses and explanations for trends vary and were not necessarily formed from empirical analyses

County Enrollment Explanations

- Declining enrollment county explanations
  - *Extensive outreach to community during economic downturn - an improved economy results in fewer enrollees.*
  - *Culture in the area is 'do-it-yourself;' aversion to pursuing or accepting government assistance.* - Which counties?
  - *Students and retirees with second homes hold down enrollment.* ?
- Increasing enrollment county explanations
  - *Unemployment is down, but people remain underemployed.*
  - *Some areas have a combination of high wealth and working poor populations.*
  - *There is an increase in foster children due to opioid crisis.*
  - *Family sizes are larger.*

County Enrollment Conclusions

- Every county is different
- Changes in unemployment are not necessarily a predictor of enrollment changes
- Continued conversations with county departments can provide interesting and valuable insights
  - *The insights help to explain the current trends*
  - *While they provide limited value in predicting future trends for the State as a whole they can help identify trends that should be considered when forecasting enrollment*

Steve starts again

Medicaid Spending

Health Choice
covers 100,000 children

ANALYSIS OF MARCH YTD SPENDING

	ABD	Children	AFDC	Duals	Other	YTD Variance to Budget: Expected	YTD Variance to Budget: Actual	YTD Variance to Budget: Difference
Hospital Services	$ 4,190,884	$ (7,289,624)	$ (26,574,160)	$ (45,853)	$ 4,965,622	$ (24,753,131)	$ (7,910,000)	$ 16,843,131
Physicians	2,045,269	(6,709,004)	(18,574,342)	(29,773)	3,113,100	(20,154,750)	(23,180,000)	(3,025,250)
Drugs	5,233,442	(5,200,318)	(22,217,692)	(2,946)	968,482	(21,219,032)	(55,980,000)	(34,760,968)
Skilled Nursing	6,630,422	-	(20,107)	(10,873)	112,375	6,711,816	(1,050,000)	(7,761,816)
Capitation	10,815,037	(5,218,180)	(13,219,259)	(25,850)	652,056	(6,996,196)	(68,040,000)	(61,043,804)
Dental	381,883	(2,767,479)	(4,594,465)	(323)	(202,311)	(7,182,695)	(8,310,000)	(1,127,305)
PCS	2,220,781	(4,226)	(214,934)	(2,855)	6,331	2,005,096	(43,320,000)	(45,325,096)
Home Health	744,435	(98,268)	(260,963)	(12)	18,562	403,755	(18,790,000)	(19,193,755)
Lab and Xray	149,716	(200,422)	(3,331,823)	(177)	308,198	(3,074,508)	(10,580,000)	(7,505,492)
Hosp IP/OP Mental	91	-	13	-	5,729	5,832	15,190,000	15,184,168
DME	836,454	(415,980)	(1,048,244)	(7,247)	32,040	(602,976)	11,680,000	12,282,976
Pract/Nonphys	185,019	(1,081,093)	(684,512)	(509)	30,025	(1,551,070)	8,810,000	10,361,070
All Other	2,614,201	(2,199,379)	(3,885,873)	6,885	460,093	(3,004,073)	(4,940,000)	(1,935,927)
TOTAL	$ 36,047,634	$ (31,183,973)	$ (94,626,362)	$ (119,533)	$ 10,470,303	$ (79,411,931)	$ (206,420,000)	$ (127,008,069)

- Based on the variances in enrollment across the program aid categories through March 2018, it would be expected that total claims spending would be $79.4 million under budget through March 31, 2018
- There is an estimated minimal increase in spending that resulted from the recipient use rates – approximately $10 million
- The balance of the variance in spending is resulting from a variation in the frequency, duration, intensity and pricing in actual services and the budget

NC Health Choice

State will resume responsibility for a share of the costs by SFY 2019-20

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

NC Health Choice Program

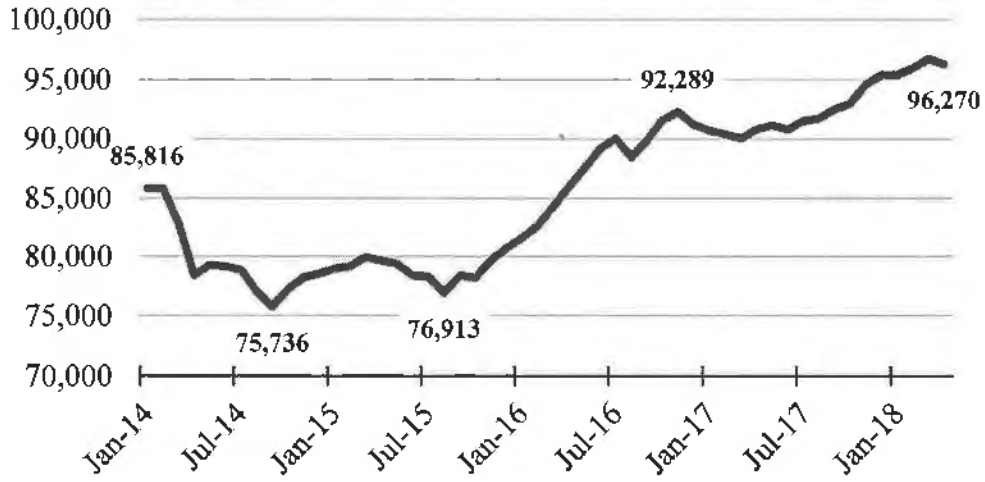
- Provides medical coverage to children ages 6 through 18 in households with income between 133% and 211% of the Federal Poverty Level
  - *$33,384 to $52,968 annually for a family of four*
- Benefits are similar to Medicaid
- Beneficiaries have higher copays and households with income over 159% of poverty *($39,910 for a family of four)* pay enrollment fees
- The NCHC population is nearly 100,000 children
- SFY 2017-18 budgeted total requirements: $195 million/ appropriations $-0- because of enhanced ACA FMAP

NC Health Choice Federal Match

- NC Health Choice falls under the federal Children's Health Insurance Program (CHIP)
- Unlike Medicaid, CHIP funding is an allotment not an entitlement
- Since October 2015 the federal government has provided an enhanced match for CHIP (+23 percentage points)
  - *With the enhancement, North Carolina's federal match is 100%, so no state funds are needed for the program*
- The enhanced match will phase down to 11.5 percentage points in October 2019 and is eliminated October 2020
  - This reduction in the federal enhancement will also impact over 100,000 children NC reports under Medicaid

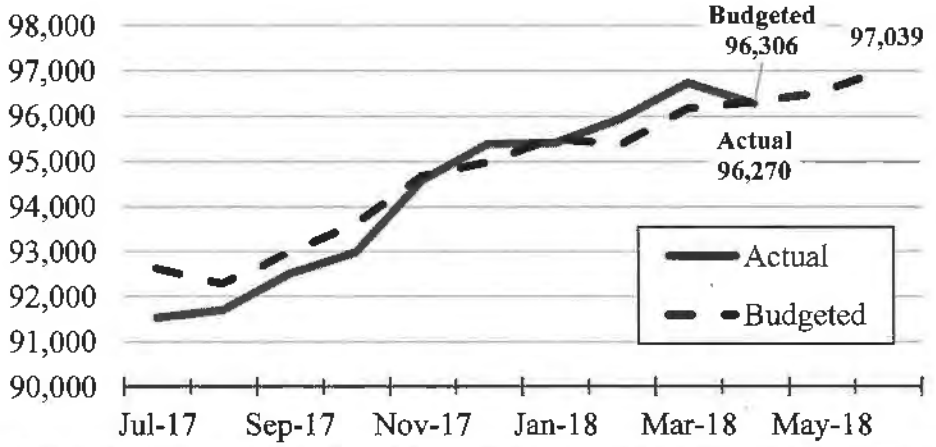
NC Health Choice Enrollment

NCHC enrollment has been increasing since SFY 2015-16, although growth has slowed in the last two fiscal years



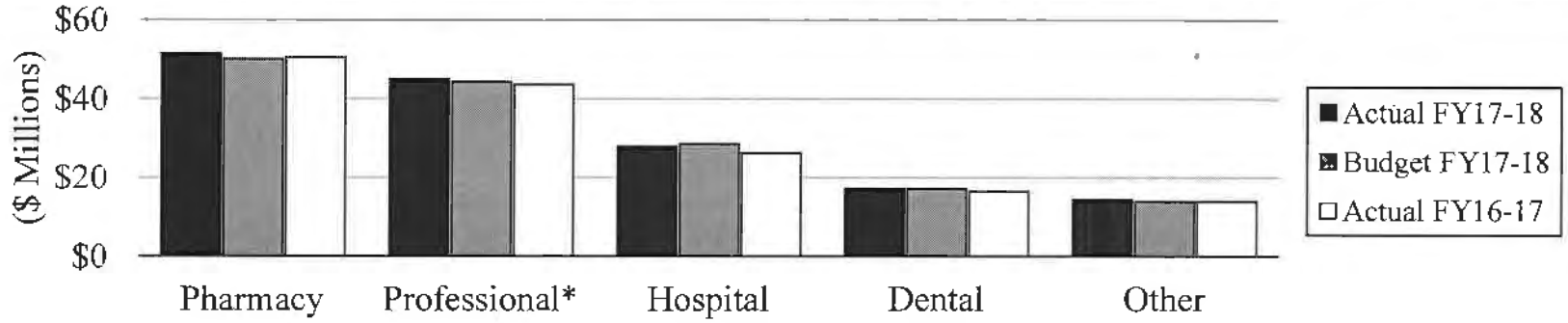
For current year, monthly enrollment has been relatively consistent with budget

SFY 2017-18 Enrollment



Health Choice Spending Year-to-Date Through April 3

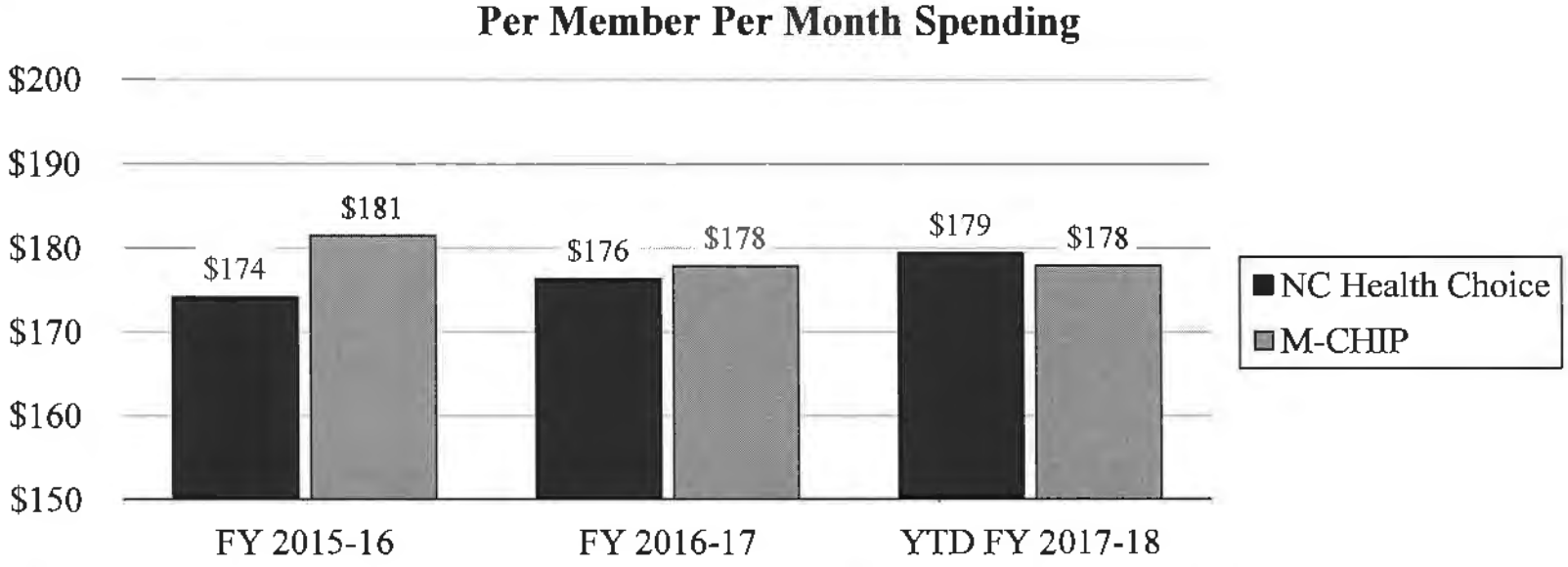
	SFY 2017-18 thru April 3 ($ Millions)			
Category	**Actual**	**Budget**	**$ Difference**	**% Difference**
Pharmacy	$51.3	$49.9	$1.4	2.7%
Professional*	44.9	44.2	0.7	1.4%
Hospital	27.9	28.6	(0.7)	-2.4%
Dental	17.1	17.1	-	0%
Other	14.3	13.9	0.4	3.1%
Total	**$155.5**	**$153.8**	**$1.8**	**1.1%**



*Professional includes physician and non-physician practitioner reimbursements

Spending Compared to M-CHIP

- Children ages 6 through 18 living in households with incomes between 100% and 133% of poverty are eligible for full Medicaid coverage under Medicaid-CHIP
- Costs are similar in the two groups



QUESTIONS

Mark Collins – mark.collins@ncleg.net
Steve Owen – steve.owen@ncleg.net
919-733-4910

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid and NC Health Choice Enrollment

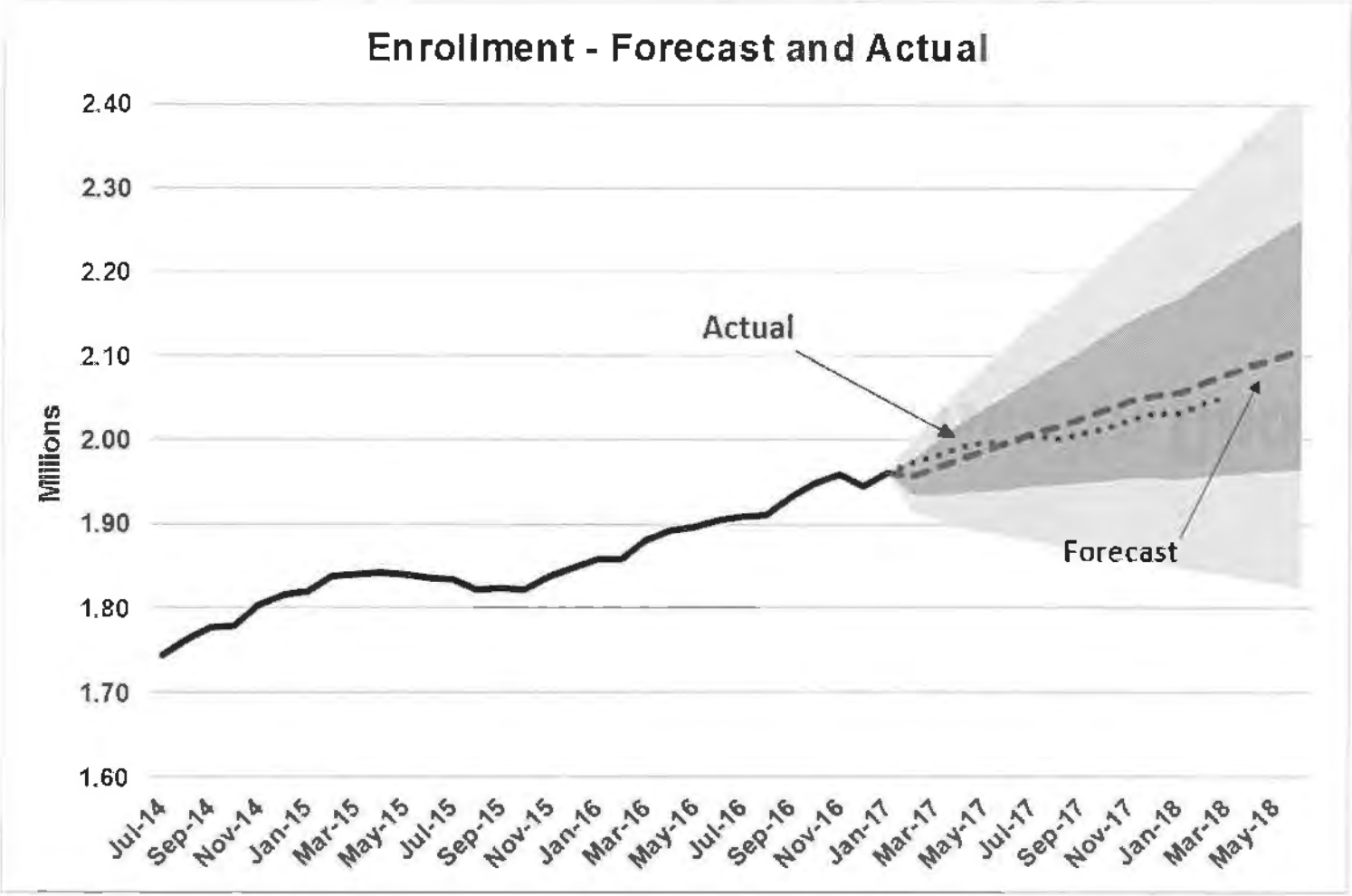
Dave Richard and Michael Becketts
Department of Health and Human Services

April 10, 2018

Attachment 4

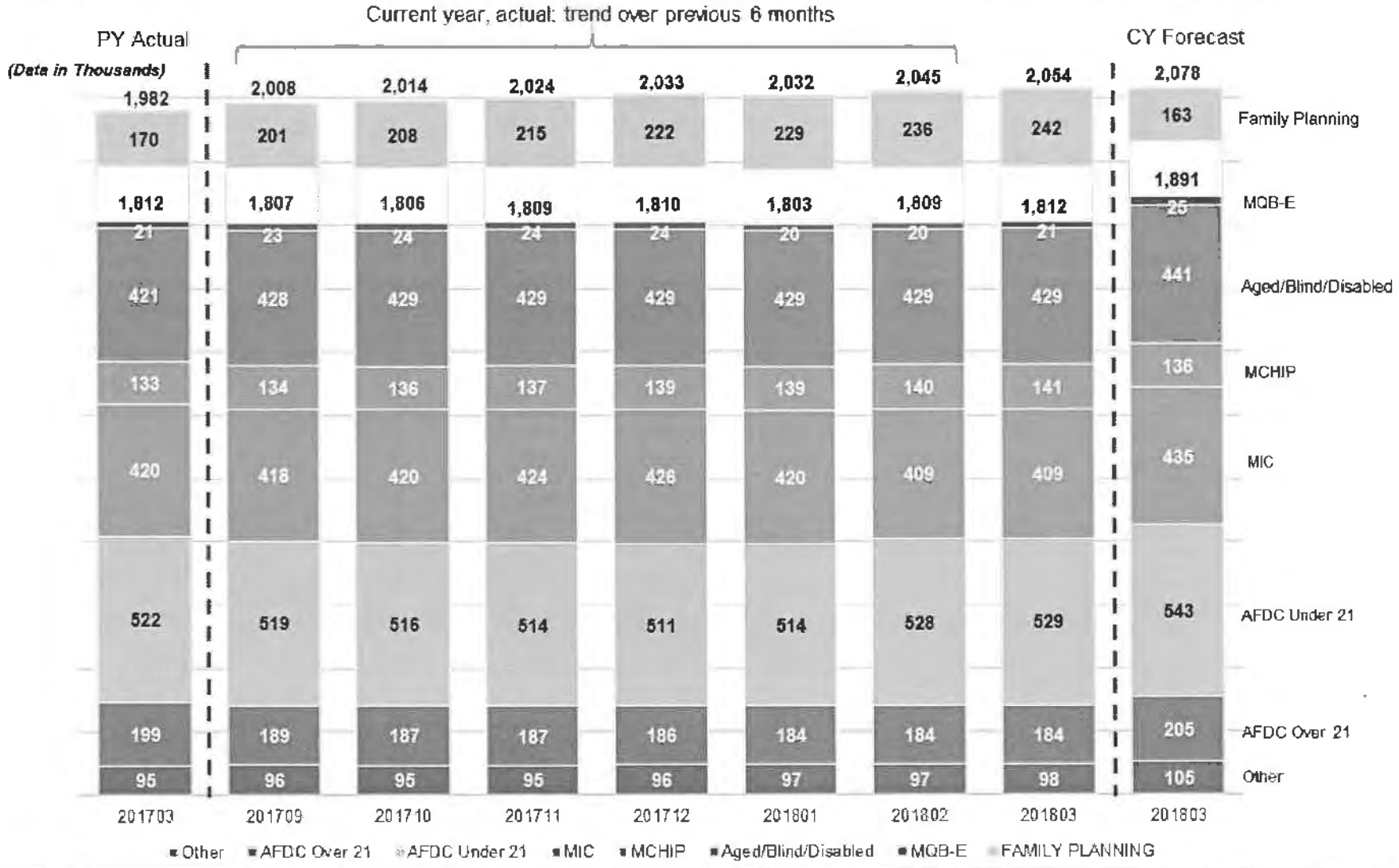
Medicaid Enrollment – Forecast vs. Actual

Medicaid Enrollment has tracked roughly inline with DMA's expectations to date



Medicaid Enrollment by Program Aid Category

March 2018 enrollment at 2.054M is 3.6% higher than one year prior at 1.982M on March 2017



	201703	201709	201710	201711	201712	201801	201802	201803	201803
Family Planning	170	201	208	215	222	229	236	242	163
MQB-E	21	23	24	24	24	20	20	21	25
Aged/Blind/Disabled	421	428	429	429	429	429	429	429	441
MCHIP	133	134	136	137	139	139	140	141	136
MIC	420	418	420	424	426	420	409	409	435
AFDC Under 21	522	519	516	514	511	514	528	529	543
AFDC Over 21	199	189	187	187	186	184	184	184	205
Other	95	96	95	95	96	97	97	98	105
Total	1,982	2,008	2,014	2,024	2,033	2,032	2,045	2,054	2,078
	1,812	1,807	1,806	1,809	1,810	1,803	1,809	1,812	1,891

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid and NC Health Choice Financial Update

Dave Richard and Roger Barnes
Department of Health and Human Services

April 10, 2018

Attachment 5

Medicaid SFY18 Actuals vs. Budget

Through February 2018, total Medicaid expenditures were $228.2M or 2.5% favorable to the authorized budget.

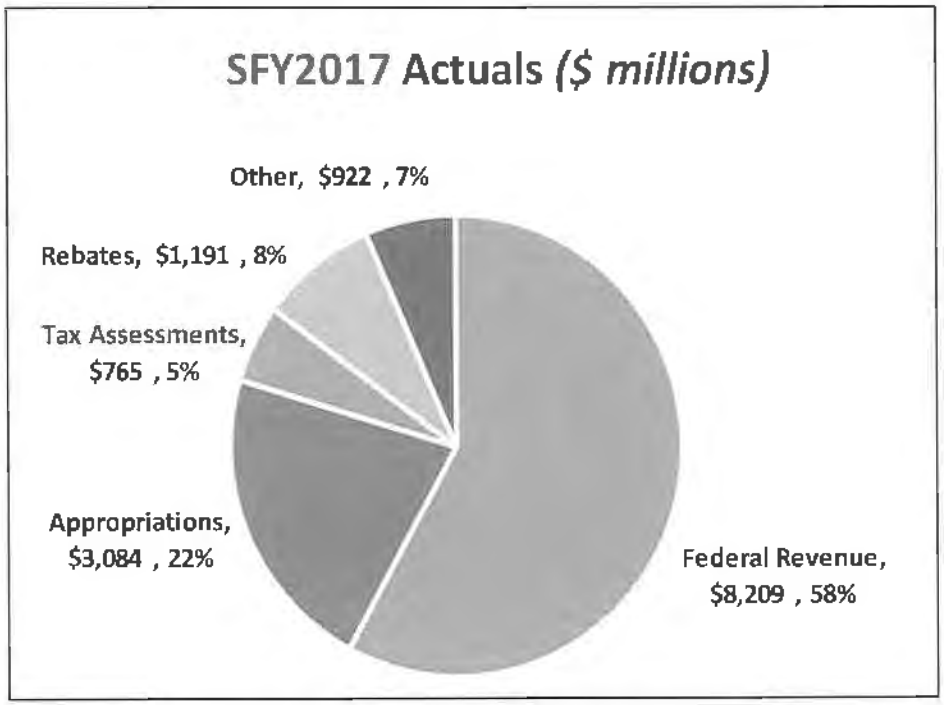
($ millions)

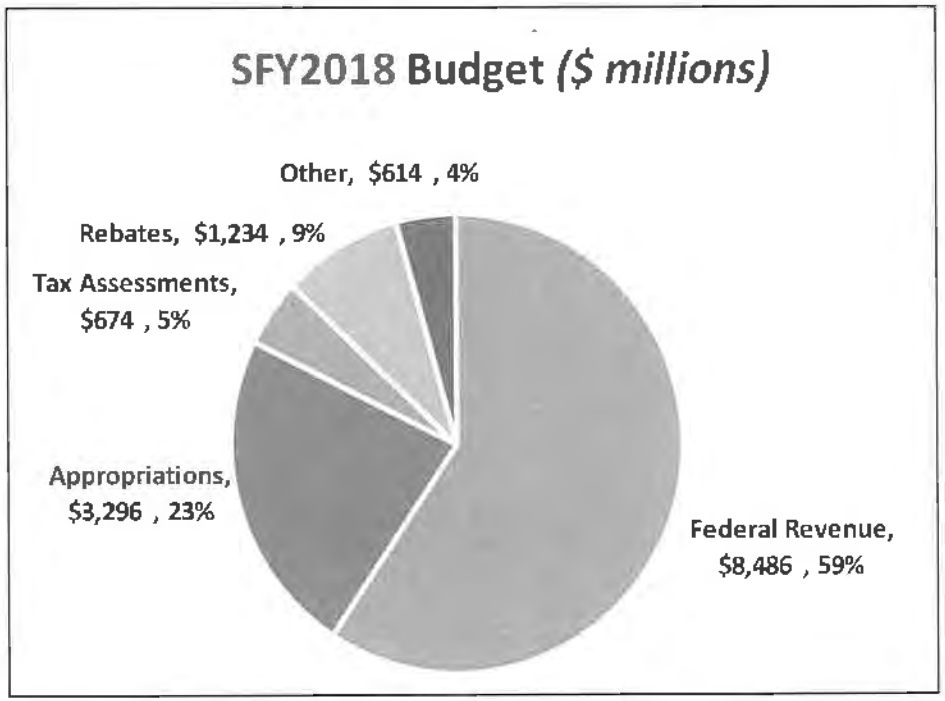
Fund Description	SFY2018B YTD[4]	SFY2018A YTD[4]	Variance (vs. Budget)	Variance %
Hospital[1]	$ 1,318.2	$ 1,337.4	$ 19.2	1.5%
Skilled Nursing Facilities	872.7	873.1	0.4	0.0%
Physician	722.8	719.3	(3.4)	-0.5%
Pharmacy[3]	689.6	627.5	(62.0)	-9.0%
Other Claims	1,609.2	1,583.7	(25.6)	-1.6%
Total Fee-For-Service Claims Exp.	**$ 5,212.4**	**$ 5,141.0**	**$ (71.4)**	**-1.4%**
Consolidated Supp. Hospital Payments	936.9	873.6	(63.3)	-6.8%
Cost Settlements	97.8	48.1	(49.7)	-50.8%
Capitation, Premiums & Other Exp.[2]	2,877.3	2,833.6	(43.8)	-1.5%
Total Expenditures	**$ 9,124.4**	**$ 8,896.2**	**$ (228.2)**	**-2.5%**

Notes:

1. Hospital Expenditures include Inpatient, Outpatient, and Emergency Room Services.
2. Includes LME/MCO, PACE, High-Tech Imaging, and Buy-in/Dual Eligible Services.
3. Pharmacy Expenditures are net of rebates.
4. Reporting as whole dollars (State + Federal Shares).

Medicaid Revenue Distribution





JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Transformation

Dave Richard and Jay Ludlam
Department of Health and Human Services

April 10, 2018

Attachment 6

Recent Transformation Milestones

Medicaid Publications

- August 2017
  - Proposed Program Design
- November 2017
  - Amended 1115 Waiver Application
  - Tailored Plans
  - Supplemental Payments
  - Managed Care Operational and Actuarial RFIs
- February 2018
  - Network Adequacy
- March 2018
  - Enrollment Broker RFP
  - Benefits & Clinical Coverage Policies
  - Beneficiaries in Medicaid Managed Care
  - Care Management & AMH
- March/April 2018
  - Quality Strategy
  - Quality – PHP Accountability
  - Credentialing
  - Vision for Long Term Service and Supports
  - SDOH Screening

Policy Paper: Supplemental Payments

- After managed care launch, DHHS will not have authority to make hospital supplemental payments
- DHHS and NCHA have engaged in collaborative process to revise payment structure so:
  - All payments move through "base rate" (i.e. payment for health care service delivered)
  - Plans are required to use these base rates for some period of time after managed care launch
  - Base rate is calculated so hospitals are "kept whole" for service delivery
- November 2017 concept paper laid out how these new base rates would be calculated
- Assessment mechanism will need technical updates to reflect new payment mechanism

Policy Paper: Network Adequacy

- DHHS will review PHP networks to ensure access to sufficient number of providers
- November 2017 concept paper discussed what DHHS would examine during these reviews – including draft numeric thresholds for various provider categories
- Oversight Focus will be on:
  - **Availability**: provider networks are sufficient to meet the needs of enrollees.
  - **Accessibility**: the proximity of providers to enrollees, based on geographic time and distance.
  - **Accommodation**: how provider's operating hours, appointment policies, language and cultural competencies, awareness, and communications meet enrollees' constraints and preferences
  - **Realized access**: enrollees' actual use of services
- PHP RFP will reflect final network adequacy standards

Policy Paper: Benefits and Coverage

- Today, DHHS defines covered benefits and the clinical policies that govern their use
  - Clinical coverage policies define the utilization management and other criteria that determine circumstances for beneficiary to receive service
- PHPs are required to cover all benefits that would otherwise be covered in FFS (unless carved out from managed care)
- PHPs cannot impose benefit limits more stringent than FFS, e.g. if FFS covers 10 physical therapy visits, PHPs must also cover at least 10 visits
- PHPs may generally design their own clinical coverage policies (that may be different from FFS and different from plan to plan)
  - Concept paper identifies a small number of services where DHHS policies will be required
- PHPs will use standard prior authorization forms to minimize provider burden
- PHPs will use DHHS prescription drug list and drug coverage criteria

Policy Paper: Care Management

- Today, care management is conducted by DHHS and CCNC
- Under manage care, PHPs will be responsible for care management
- March 2018 concept paper laid out vision for care management functions in managed care
- Primary care providers will continue to receive small payments from PHPs for supporting care management functions
- Primary care providers that wish to take on a more active role in care management can contract with PHPs to conduct this work
  - PHPs will be encouraged to contract with interested primary care providers
  - Primary care providers may perform care management functions directly (e.g., with staff that work in their offices or health systems) or may partner with other local primary care practices in clinically integrated networks
- PHPs will contract with local health departments for certain care management functions

Policy Paper: Quality

- In March 2018 DHHS published a concept paper describing our approach to health care quality in managed care as well as an official quality strategy for CMS
- Main aims of Quality Strategy:
  - Better Care Delivery/Access
  - Healthier People
  - Smarter Spending
- PHPs will be monitored on 33 quality measures against national benchmarks and state targets
- Small subset of measures will be linked to PHP Financial Withholds & Incentives
- DHHS will require that PHPs implement annual Quality Improvement Projects
- An External Quality Review Organization (EQRO) will also measure each PHP's compliance and quality annually

Policy Paper: Upcoming Work

- Additional policy papers forthcoming
- Continue conversations with CMS and are making progress to close down issues
- PHP RFP
- Existing DMA staff will change status and transition to DHB, consistent with requirements of SL 2015-245, on August 1
- Operational RFPs
  - Enrollment Broker responses are due April 13
  - Additional RFPs forthcoming

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Efficacy of the Programs of All-Inclusive Care for the Elderly (PACE) Study

Dave Richard
Department of Health and Human Services

April 10, 2018

Programs of All-Inclusive Care for the Elderly

- PACE is a capitated managed care program for frail, elderly adults who are enrolled in Medicaid, enrolled in Medicare, dually enrolled in Medicaid or Medicare, or able to pay privately.
- Program features a comprehensive service delivery system and integrated Medicare and Medicaid financing for beneficiaries enrolled in both programs.

PACE is a managed care model for the Elderly

- PACE organizations assume full financial risk for the costs of all medical care for their participants, including nursing home care, long-term care services, inpatient hospital services, outpatient hospital services, physician services, laboratory and radiology services, pharmacy, transportation, durable medical equipment (DME), and hospice services.

Program of All-Inclusive Care for the Elderly

- To be eligible for PACE an individual must:
  - 55 years of age or older;
  - Determined to need the level of care required under the Medicaid State Plan for coverage of nursing facility services;
  - Reside in the PACE organization's service area;
  - Able to live in a community setting at the time of enrollment without jeopardizing his or her safety; and
  - Meet any additional criteria set forth in the program agreement.
- 11 PACE Organizations with 12 sites
  - 36 counties have at least one zip code served by a PACE Organization
  - 64 counties have no PACE access at this time
  - Current enrollment is 2040 individuals

Next Steps for PACE growth in NC

- NC can consider expanding the capacity of existing PACE Organizations
  - Zip code expansion
  - Approval of alternative care setting
- Expansion of PACE to unserved and underserved areas in NC will require additional funding

Expanding PACE access

- Zip Code Expansion
  - Will allow existing PACE Organizations to enroll individuals residing outside their current service areas.
- Alternative Care Setting (ACS)
  - ACS allows PACE participants to receive some (but not all) PACE services at the alternative setting during usual and customary PACE center hours of operation.
    - Services at an ACS should supplement and not replace services provided at the main PACE center
    - Periodic visits to the main center are required

Next Steps for PACE regulatory reform

- Operationalize the recommendations that have been identified to address the duplication of regulatory monitoring by Centers for Medicare & Medicaid Services (CMS), Division of Medical Assistance (DMA), and Division of Aging & Adult Services (DAAS)
- Evaluate DMA and Division of Health Service Regulation (DHSR) rules regarding delivery of in-home services to verify duplication with CMS regulations

PACE Innovation Act Options

- Medicaid will investigate options for delivery of care under the PACE Innovation Act
- DMA will consult with CMS Coordination Office regarding the PACE Innovation Act
  - Discuss strategies to adapt the PACE model of care to serve populations currently ineligible for PACE and diagnostic criteria other than nursing home level of care

Recommendations

- Study the expansion of the Long-Term Care Ombudsman (LTCO) program to assist PACE participants.
  - LTCO assists residents of long term care facilities to exercise their rights and resolve grievances between the residents, families, and facilities
- Currently PACE participants and their families do not have comparable assistance to assist with grievances or complaints involving a PACE organization outside formal due process
  - PACE Organizations manage all care for individuals

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Audit of County Medicaid Eligibility Determinations

Dave Richard and Michael Becketts
Department of Health and Human Services

April 10, 2018

Objectives of SL 2017-57 Section 11H.22(e) Report

- Develop accuracy and quality assurance standards for eligibility determinations performed by county DSS
- Establish an audit methodology to measure counties' performance
- Establish an annual audit schedule to review counties' performance

Proposed Accuracy Standards

- Medicaid applicants approved for benefits when truly ineligible - 3.2% error rate threshold (derived from federal standard)
- Medicaid applicants denied benefits when truly eligible - 3.2% error rate threshold (derived from federal standard)
- Eligibility determination errors not impacting eligibility decision – 10% initial error rate threshold

Quality Assurance (QA) Standardized Processes

Counties completing these five items follow the established QA process:

- Standardized 2nd Party Review Procedures
- Standardized detailed review worksheet
- State-directed sample size by county
- Quarterly reporting to State on review results
- Results used to determine targeted training needs

Current Audits of Eligibility Determination

- Payment Error Rate Measurement PERM (CMS)
- Medicaid Eligibility Quality Control Reviews (CMS & Medicaid)
- Corrective Action Record Reviews (Medicaid)
- State Single Audit (OSA in conjunction with local CPAs)

Current Audits - Enhancements Underway

- Corrective Action Record Reviews (Medicaid)
  - Expanding number of cases reviewed and fine tuning review details and follow-up processes
- State Single Audit (OSA in conjunction with local CPAs)
  - State Auditor will dictate sample items to be reviewed
  - Review tool is updated by Department in consultation with OSA
  - State Auditor performing quality review of local CPA performance

Auditing 100 Counties Per Year

- Current legislation describes a new annual audit effort of all 100 counties.
- If funding is provided, based on work plan utilized by OSA in the performance audit issued January 2017, such an annual review would cost approximately $11.2 million

	Hours	Total Cost
Contractor Review	175,000	$7,875,000
DHHS Oversight (25% of audit effort)	43,750	$3,281,250
Total	**218,750**	**$11,156,250**

- Effort would entail reviewing 50,000 eligibility determinations at an average review time of 3.5 hours each
- Effort would also require approximately 26 additional DHHS staff to oversee the contractor's work in a timely manner.

Challenges with Auditing 100 Counties

- For DHHS to conduct efficient review of an eligibility determination
  - Reviewer must possess experience with eligibility determination process
  - Personnel with such experience are limited to retired and existing county and state workers
- OSA utilized a staffing contractor that was able to retain the expertise from available county workers with Medicaid experience

Proposed Alternative Audit Plan

- If funding is provided, DHHS could:
  - Follow Medicaid sampling methodology, use sample size of 200 cases per county
    (100 new applications and 100 re-certifications)
  - Rotate county audits over a three-year cycle
- Staffing options:
  - Contract with experienced vendor
    - Annual audit costs: $1.6M
    - Requires 5 additional DHHS staff for oversight
  - Hire DHHS permanent staff
    - Annual audit costs: $2.34M
    - Requires 19 additional DHHS staff

NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

REPORT TO THE 2018 SESSION of the 2017 GENERAL ASSEMBLY OF NORTH CAROLINA

APRIL 10, 2018

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TRANSMITTAL LETTER

April 10, 2018

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TO THE MEMBERS OF THE 2018 REGULAR SESSION
OF THE 2017 GENERAL ASSEMBLY

The JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE respectfully submits the following report to the 2018 Regular Session of the 2017 General Assembly.

Sen. Ralph Hise (Co-Chair)

Rep. Nelson Dollar (Co-Chair)

Rep. Donny Lambeth (Co-Chair)

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COMMITTEE PROCEEDINGS

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The Joint Legislative Oversight Committee on Medicaid and NC Health Choice met five (5) times between October 2017 and April 2018. This section of the report provides a brief overview of topics and presenters for each meeting and identifies any Department of Health and Human Services (DHHS) action items from each meeting. Detailed minutes and handouts from each meeting are available in the Legislative Library. Agendas and handouts for each meeting are available at the following link:

http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=284&sFolderName=\Meetings by Interim\2017-2018 Interim

Summary of Committee Proceedings and DHHS Action Items

October 10, 2017

- **Welcome & Opening Remarks**
  Representative Nelson Dollar, Presiding Co-Chair

- **Remarks from DHHS Secretary**
  Mandy Cohen, Secretary, DHHS

- **Medicaid and NC Health Choice Enrollment**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS

- **Medicaid and NC Health Choice Financial Update**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS

- **Status of 1115 Waiver and Work Plan for Medicaid Transformation**
  Mandy Cohen, Secretary, DHHS
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS

  DHHS ACTION ITEMS:
  - Provide a response to topics and issues identified by the Fiscal Research Division related to DHHS's Proposed Program Design for Medicaid Managed Care

- **Appointment of Joint Health and Human Services and Medicaid Oversight Committees' Behavioral Health Services Subcommittee** (Sec. 12F.10, S.L. 2016-94), Presiding Co-Chair

November 14, 2017

- **Welcome & Opening Remarks**
  Senator Hise, Presiding Co-Chair

- **Remarks from DHHS Secretary**
  Mandy Cohen, Secretary, DHHS

- **Overview of Medicaid Dashboards**
  Steve Owen, Committee Staff, Fiscal Research Division, NCGA

- **Medicaid and NC Health Choice Enrollment**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Michael Becketts, Assistant Secretary for Human Services, DHHS

- **Medicaid and NC Health Choice Financial Update**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Roger Barnes, Chief Financial Officer, Division of Medical Assistance, DHHS

- **Status of 1115 Waiver and Work Plan for Medicaid Transformation**
  Mandy Cohen, Secretary, DHHS
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS

February 28, 2018

- **Welcome & Opening Remarks**
  Representative Nelson Dollar, Presiding Co-Chair

- **Remarks from DHHS Secretary**
  Mandy Cohen, Secretary, DHHS

- **Family Planning Enrollment Update**
  Steve Owen, Committee Staff, Fiscal Research Division, NCGA

- **Overview of Medicaid Dashboards**
  Steve Owen, Committee Staff, Fiscal Research Division, NCGA

- **Medicaid and NC Health Choice Enrollment**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Susan Perry-Manning, Deputy Secretary for Human Services, DHHS

- **Medicaid and NC Health Choice Financial Update**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Roger Barnes, Chief Financial Officer, Division of Medical Assistance, DHHS

- **1115 Waiver Amendment Submitted on 11/20/18 and Work Plan for Medicaid Transformation**
  Steve Owen, Committee Staff, Fiscal Research Division, NCGA
  Mandy Cohen, Secretary, DHHS
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Christen Linke Young, Deputy Secretary for Policy and Operations, DHHS

March 13, 2018

- **Welcome & Opening Remarks**
  Representative Donny Lambeth, Presiding Co-Chair

- **Remarks from DHHS Secretary**
  Mandy Cohen, Secretary, Department of Health & Human Services (DHHS)

- **Status of Cardinal Innovations Healthcare LME/MCO**
  Trey Sutten, Interim Chief Executive Officer, Cardinal Innovations Healthcare

- **Report on Funding for GME Payments and Actions Taken to Achieve Flex Cut – Section 11H.13 of S.L. 2017-57**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS

- **1115 Waiver Update and Work Plan for Medicaid Transformation**
  Mandy Cohen, Secretary, DHHS
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS

- **Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children – Section 11H.14 of S.L. 2017-57**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS

April 10, 2018

- **Welcome & Opening Remarks**
  Representative Donny Lambeth, Presiding Co-Chair

- **Remarks from DHHS Secretary**
  Mandy Cohen, Secretary, Department of Health & Human Services (DHHS)

- **Overview of Medicaid Dashboards**
  Steve Owen, Committee Staff, Fiscal Research Division, NCGA
  Mark Collins, Committee Staff, Fiscal Research Division, NCGA

- **Medicaid and NC Health Choice Enrollment**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Michael Becketts, Assistant Secretary for Human Services, DHHS

- **Medicaid and NC Health Choice Financial Update**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Roger Barnes, Chief Financial Officer, Division of Medical Assistance, DHHS

- **1115 Waiver Update and Work Plan for Medicaid Transformation**
  Mandy Cohen, Secretary, DHHS
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS
  Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS

- **Efficacy of the Program for All-Inclusive Care for the Elderly (PACE) Study – Section 11H.25 of S.L. 2017-57**
  Dave Richard, Deputy Secretary for Medical Assistance, DHHS

- **Plan to Implement Annual Audits of County Departments of Social Services for Compliance with Medicaid Eligibility Determination Accuracy Standards – Section 11H.22(e) of S.L. 2017-57**
  Michael Becketts, Assistant Secretary for Human Services, DHHS

- **Presentation of Committee Report**
  Jennifer Hillman, Committee Staff, Legislative Analysis Division, NCGA

COMMITTEE MEMBERSHIP

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2017-2018

Senate Members	House Members
Sen. Ralph Hise, Co-Chair	Rep. Nelson Dollar, Co-Chair
Sen. Dan Bishop	Rep. Donny Lambeth, Co-Chair
Sen. Valerie P. Foushee	Rep. William D. Brisson
Sen. Joyce Krawiec	Rep. Josh Dobson
Sen. Louis Pate	Rep. Verla Insko
Sen. Gladys A. Robinson	Rep. Bert Jones
Sen. Tommy Tucker	Rep. Gregory F. Murphy, MD
Sen. Angela R. Bryant, Advisory	Rep. Beverly M. Earle, Advisory
	Rep. Chris Malone, Advisory
	Rep. Rodney W. Moore, Advisory

Committee Clerks	
Susan Fanning	Candace Slate
	Pan Briles

Committee Staff	
Fiscal Research Division:	
Steve Owen	Denise Thomas
Deborah Landry	Mark Collins
Legislative Drafting Division:	
Amy Jo Johnson	
Legislative Analysis Division:	
Jennifer Hillman	Jason Moran-Bates
Theresa Matula	

COMMITTEE CHARGE/STATUTORY AUTHORITY

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Article 23B.

Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except that initial appointments begin on the date of appointment. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment. (2015-245, s. 15.)

§ 120-209.1. Purpose and powers of Committee.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services.

(b) The Committee may make periodic reports, including recommendations, to a regular session of the General Assembly on issues related to Medicaid and NC Health Choice programs. (2015-245, s. 15.)

§ 120-209.2. Organization of Committee.

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees

in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge. (2015-245, s. 15.)

§ 120-209.3. Additional powers.

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice, while in discharge of official duties, shall have access to any paper or document and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly. (2015-245, s. 15.)

§ 120-209.4. Reports to Committee.

Whenever the Department of Health and Human Services, or any division within the Department, is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters relating to the Medicaid and NC Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. (2015-245, s. 15.)

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

November 2, 2018

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Medicaid and NC Health Choice
FROM: Rep. Donny Lambeth, Co-Chair
Rep. Nelson Dollar, Co-Chair
Sen. Ralph Hise, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Medicaid and NC Health Choice** will meet at the following time:

DAY	DATE	TIME	LOCATION
Monday	November 26, 2018	1:00 PM	643 LOB

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Candace Slate at dollarla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE

November 26, 2018 1:00 p.m.
Legislative Office Building - Room 643

I.	**Welcome & Opening Remarks**	Sen. Ralph Hise Presiding Co-Chair
II.	**Remarks from Department of Health and Human Services (DHHS) Secretary**	Mandy Cohen, Secretary, Department of Health and Human Services (DHHS)
III.	**Approved 1115 Waiver and Work Plan for Medicaid Transformation**	Mandy Cohen, Secretary, DHHS Dave Richard, Deputy Secretary for NC Medicaid, DHHS Jay Ludlam, Assistant Secretary for Medicaid Transformation, DHHS
IV.	**Medicaid and NC Health Choice Enrollment**	Dave Richard, Deputy Secretary for NC Medicaid, DHHS Roger Barnes, Chief Financial Officer, Division of Health Benefits, DHHS
V.	**Medicaid and NC Health Choice Financial Update**	Dave Richard, Deputy Secretary for NC Medicaid, DHHS Roger Barnes, Chief Financial Officer, Division of Health Benefits, DHHS
VI.	**NC Tracks Enhancements to Detect and Prevent Fraud, Waste, and Abuse**	Dave Richard, Deputy Secretary for NC Medicaid, DHHS
VII.	**Perinatal Quality Collaborative of North Carolina (PQCNC) Data Needs**	Martin McCaffrey, M.D., Director, PQCNC
	Adjourn	

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE
November 26, 2018
Room 643

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice met on Tuesday, November 26, 2018, at 1:00 P.M. The meeting was held in Room 643. Senate members present were Ralph Hise, Co-Chair; Joyce Krawiec; Gladys Robinson; and Tommy Tucker. House of Representatives members present were William Brisson; Nelson Dollar, Co-Chair; Verla Insko; Gregory Murphy, M.D.; and Donny Lambeth, Co-Chair.

Legislative Services staff attending the meeting included Jennifer Hillman and Theresa Matula from Legislative Analysis Division; Mark Collins, Deborah Landry, Steve Owen, and Denise Thomas from Fiscal Research Division; and Amy Jo Johnson from Bill Drafting Division. Committee Assistants in attendance were Susan Fanning, Candace Slate, and Pan Briles.

Serving as Sergeants-at-Arms were Frances Patterson and Hal Roach for the Senate; and Jonas Cherry, Terry McCraw, and Jim Moran for the House. See **Attachment 1 –Visitor Registration Sheet**.

Welcome & Opening Remarks

Sen. Hise, Co-Chair, presided. He welcomed everyone and then recognized Rep. Nelson Dollar for remarks.

Rep. Dollar: As everyone knows, I will not be back next year, certainly not in this role. I want to take the opportunity to thank the staff I've worked with over the years as one of the chairs of this Committee, and, also in the past, as one of the chairs of the HHS Oversight Committee: Dr. Porter who's worked with me over the years, certainly all the staff, folks from the Department of Health and Human Services, Madam Secretary, and Dave, I've known you in a number of roles. Certainly, I appreciate all my House and Senate colleagues, and House and Senate chairs on the oversight committee and all the great working relationships I've had with so many of the advocates and provider groups who are here today. Folks have worked in a tremendous way over recent years to address a number of very critical issues. The future of health care in this country and in North Carolina is a bright future. I think we're on the road to continuing to solve problems to make people's lives better. I have every confidence as we move through Medicaid transformation, this Committee will do tremendous work, along with the Department, to ensure that both providers and patients make it through that process in good shape and we have the results and outcomes everyone is hoping for. I will always give a shout-out to behavioral health and continuing to work with our public managed care system to make it stronger. Mr. Chairman, I appreciate the opportunity to express my thanks to everyone and wish everyone Godspeed for the holidays and good luck as you move through transformation over the next several years.

Sen. Hise thanked Rep. Dollar for his comments and for his service, and then recognized Mandy Cohen, Secretary, Department of Health and Human Services, to present agenda item **II. Remarks from Department of Health and Human Services (DHHS) Secretary**.

Sec. Cohen thanked the chairs and then discussed the recovery efforts related to Hurricane Florence regarding food assistance programs and housing, and temporarily extending redetermination timelines to help keep people enrolled in Medicaid. She spoke on the Department's provision of additional medical supplies, and temporarily waiving some of the provider enrollment requirements to temporarily allow physicians and other health professionals with out-of-state licenses to enroll as Medicaid providers of service. She noted that three areas still need additional state investment: 1) emergency mental health needs due to disaster trauma; 2) Back Home program that assists storm victims in shelters who do not have stable housing arrangements; 3) child welfare and adult protective services, due to stress of displacement that impacts some children and elderly.

Sec. Cohen, along with Dave Richard, Deputy Secretary for NC Medicaid, DHHS; and Jay Ludlum, Assistant Secretary for Medicaid Transformation, DHHS, then presented agenda item **III. Approved 1115 Waiver and Work Plan for Medicaid Transformation.** See **Attachment 2 – CMS Approves North Carolina's Innovative Medicaid Demonstration To Help Improve Health Outcomes** and **Attachment 3 – NC Medicaid Transformation Section 1115 Demonstration Waiver**. Following their presentation, they answered questions of Committee members.

Sen. Hise: Thank you very much. We'll start with some questions and begin with Chairman Lambeth.

Sen. Lambeth: Thank you, Chairman Hise. When you started the meeting, you said a lot's been done since we last met, and it's obvious you folks have been working very hard and you've accomplished a lot. We appreciate all the efforts to get us to this point and obviously a lot of work still to be done. We will continue to follow your progress and our progress as we go through this. I understand that CMS has issued a proposed rule that would actually support hospital supplemental payments in the transition from the fee-for-service to our managed care option. You mentioned the supplemental payments and you've been working on some options. That's certainly an issue we hear and have talked a lot about; we'd like to find a good solution. How does the proposed rule that CMS has actually proposed fit into your thinking? Is that a solution, potentially, that would get us where we need to be?

Sec. Cohen: Thanks, Chairman Lambeth, for the question. Yes, it is a proposed rule. As we watched proposed rules in the past related to Medicaid and managed care, it's often several years until it gets to a final, which would mean we would be past the point of our implementation date for managed care. But recognizing that we are certainly looking at our options, and could we pivot if the rule would become final. I think it doesn't get us around the fact that CMS, as evident by some of the things that CMS turned down in our waiver, is not favorable toward uncompensated care pools or pools generally. They want money tied to Medicaid beneficiaries and I understand that. It's the way you can track quality; it's the way you track value. And so our waiver's consistent with their thinking on that. I think there are new opportunities, potentially, for us – how we think about glide paths. What's proposed in the rule would be for a three-year period only. We need to be changing anyway. But we can think about what that three-year period looks like and that's some of what Dave is alluding to and some of this new work that we're working on with the hospitals and want to come to you with the proposal. Either way, I recognize a big change for the hospitals going into managed care as well as this change around supplemental payments.

And we want to find the right glide path that will work for folks, and make sure they're going to take care of our beneficiaries in the best way possible.

Sen. Lambeth: Follow-up? While you're working on these various options you'll bring back to us, do you have a timeframe to bring some options back to us to consider?

Sec. Cohen: We know we need to ahead of the next session because that's where we have to lock these things down, so I think we'll try to do that as quickly as possible.

Sen. Lambeth: We got a lot of emails in the last few weeks about the CAP/C program and the independent assessment process for the children currently receiving CAP/C funding. I know those parents and individuals are very concerned about potential changes. I though this might give you an opportunity to comment because you've actually been very responsive to my emails and you've followed up with a lot of individuals. But I thought I'd give you an opportunity to give an update on where you are and the solutions you're looking at that people will actually be pleased with.

Dave Richard: Rep. Lambeth, thank you very much for the chance to respond to that. CAP/C is for a waiver program that provides in-home supports for families who have medically fragile children. It is a really important program for North Carolina and the beneficiaries of those services are people that go through an awful lot. So we want to make sure the services are meeting their needs. Inside of Medicaid, we are constantly trying to respond to changes at the federal level, as well as make our program more efficient. As you all are aware, we worked with the General Assembly multiple years back to create an independent assessment of our PCS program, so that when people entered the program there was no question about whether they were eligible for the program itself. As we're looking at the future of our non-managed care waivers that are going into the behavior health space right now, we're looking at a concern that CMS has raised around independent case management. We're looking at the efficiency of the program – ensuring that as we're bringing people into the program we provide independent assessment for efficiency and getting things done. I would take full blame for this – not quite at the level needed for families that wanted to move in this direction. There was confusion about what that proposal was. They responded us, the Secretary, to you, with their concerns about it. We have had multiple meetings with stakeholders including an advisory committee that was set up for this purpose some years ago for us to work with CAP/C family members. For the compromise, we're looking at some other proposals they gave us this week. We hope to get out by the end of the week a finalized proposal to the families and others that we would do the independent assessment when we first start the eligibility for the program. One of the concerns of families was having multiple people come into their homes – the independent assessment agency and also the independent case management agency, which would bring two different folks in there. We believe in doing the independent assessment with a group that's not the case management agency to establish that they are eligible for the program. For the annual assessment that would happen afterward, the case management agency would continue to do those assessments. There's little risk we see that once a person is on the program they would not continue that eligibility and we believe we can do that monitoring by a process ensuring that the assessments are consistent across the board. We share that with many of the stakeholders. I don't think everybody is happy or thrilled with that, but there seems to

be an understanding that that approach would work for many of the stakeholders and would be one that meets the needs for the state of North Carolina.

Sen. Hise: Chairman Dollar, followed by Rep. Murphy, Rep. Brisson, Sen. Robinson, Sen. Krawiec, and Sen. Tucker.

Rep. Dollar: It's my recollection that there were some amendments to the RFP during the process once it was originally put out for response. Could you go over what the amendments were to the RFP?

Sec. Cohen: I'll turn it to Jay Ludlam to answer. But, yes, one RFP amendment was technical changes.

Jay Ludlam: The RFP amendment would have been technical changes. I think there was one place where 21 pages were the same text as the 21 previous pages. We also needed to amend the RFP when we changed the response due date from the 12th to the 19th. I'm not aware of any substantive changes that have been made to the RFP.

Rep. Dollar: If there happens to be a protest on the RFP awards, how will the Department address that? As someone alluded to a moment ago, this is how it looks if everything goes along. Of course, everybody knows it's not just going to follow along the script, necessarily. I don't know of any other state that's just followed the script. What plans do you have to address any protest? We're inviting any, obviously, but we've had some of those in past major procurements in North Carolina.

Sec. Cohen: Well thank you for the question, Chairman, and given that this is the biggest procurement in the Department's history — $6 billion a year, we've obviously been putting a lot of emphasis on ensuring our process is as clean as possible. We're documenting things and have an evaluation committee. We have lots of lawyers' eyes looking at this. But we know that in anything like this, protest is possible and there's a number of ways in which we work through that from a legal perspective. Jay, do you want to go into some of the details? We can report back to you the process that our legal team would work through in terms of merit of those protests and how quickly they can be disposed of or whether or not we actually need to go into court to settle those.

Rep. Dollar: Mr. Chairman, I'd like to ask one other question to you, Mr. Richard, because you mentioned it. You were talking about changes to 122C, 108A, and 105. There was a report due to the General Assembly a few weeks ago about specific statutory changes. When do you anticipate that those specific request recommendations for statutory changes will be in the General Assembly's hands?

Dave Richard: Rep. Dollar, we are working on that report. We had read it as being at the end of November to report back. I don't think we'll meet that deadline for the formal report, because as we walk through these more and more things become apparent. We hope to be sharing with staff over here the things that we're seeing ahead of time so that we're not waiting until the final report. Our intention is to begin doing that as soon as next week.

Rep. Dollar: So staff can be anticipating working with you all on that?

Dave Richard: I think that's the best way were going to get this done.

Rep. Murphy: Thank you, Mr. Chairman. Jay, this may be directed toward you or to the Secretary. Throughout this entire process, I've been very keen to how managed care is going to affect our providers in the state, and whether people will elect to continue in Medicaid given the fact that most of them lose money on Medicaid. You made mention, on page 14 of your project, that you were going to work on incentivizing providers to be in networks. Can you flesh that out a little bit? What kinds of things are you thinking about? The Secretary and I went back and forth that the pay scale, pay rates, are going to be stabilized. But what are we going to do to help ease the providers in – to say, hey this not a bad thing that you're coming into, it's something that we want you to continue?

Sec. Cohen: First, Dr. Murphy, thank you for continuing to advocate for the providers that are in the Medicaid program and making sure to hold us accountable to what they're going through, because this is a big change. And we need to be sensitive to that and we very much are. I've appreciated our team really thinking through the ways in which we can try to minimize this. We can't get over the fact that we're moving from one payer to multiple payers. We can't erase that complexity, but what we have tried to do are things like centralizing credentialing, for example, so that you don't have to credential with every different insurance plan. And, if you're enrolled right now, there's a no-touch – you don't have to re-enroll at the start of managed care. You stay on your normal cycle for re-enrollment with the program. We're trying to do things like standardize forms, whether contracts or prior authorization forms. We do have standardized pharmacy formulary, which I think will be helpful and standardized plan to plan. So folks may have different utilization management components on top of it, but at least the pharmacy formulary will be consistent plan to plan. Jay, if there are others, do you want to add?

Jay Ludlam: Again, thank you for the advocacy for our providers. As the Secretary said, we can't eliminate the added administrative burden of having multiple health plans replace a single state agency. So that is a focus for us. We have looked at different strategies, trying to standardize as much as possible across the health plans while still allowing them to do innovations. In order to support some of the providers, or at least protect them from health plans, we have put into the contract with the health plans that they would be expected to pay providers interest and penalties if they have late payment or deny inappropriately. We don't want our providers to absorb administrative costs that managed care companies might shift to them. We also looked at potentially doing liquidated damages but that money would come back to the state and that wouldn't serve us. So we wanted the money to cover the providers' added administrative burden if they got inappropriate denials or underpayments. The question on incentivizing providers to participate was related to our waiver ask. We expected that by doing a workforce study, and understanding where the major potential network gaps would be for our providers and our beneficiaries, that we would then be able to develop programs to incentivize provider participation in those specialty types or in those geographic locations. And that's actually what CMS turned down for the time being. We will continue to work with them and negotiate something that allows us to have that study as well as put together the programs to incentivize the participation.

Rep. Murphy: I appreciate what you all are doing because I think we've been on the same page about the folks that provide care for Medicaid patients in the state. They do it, not because they want to do it. They do it because either they have to do it, or out of a good heart, because it just doesn't pay the bill. You're seeing people retire early, move out of state, join hospital systems, where we all know that the cost of care then skyrockets. So I appreciate your efforts. It's a difficult time because there's so much pressure and regulatory burden being put on our providers that are good folks. I fear for them to be staying in medicine. We don't want second-class medicine in the state.

Sec. Cohen: If I could just add one more aspect to that. I hope a lot of our independent position practices are going to take a look at what we've tried to put in place – a pretty innovative model of looking at care coordination in the Medicaid program – trying to keep care coordination as local and practice-based as possible, to have those funds flow directly to practices to be able to take on the care management and care coordination responsibilities. It's work to take that on, but opportunity for resources in a world with a lot of change, wanting to think about how we open up avenues for practices to take on that work. They're often doing a lot of care coordination to begin with. How do we get them the resources to do it in a formalized way? I'm hoping a lot of practices are going to look at our advanced medical home model and hopefully move to a place where they would consider being a Tier 3, which is working with a clinically integrated network and doing that care coordination. Back to your point – it doesn't solve all the problems, but I hope one more piece of the puzzle.

Sen. Hise: Rep. Brisson.

Rep. Brisson: Thank you, Mr. Chair, my question would be to Dave. Just when would the regions you were talking about start up two and then go to four regions. What determining factors will be used to choose those first two regions to implement?

Dave Richard: Rep. Brisson, I think you're referring to the Healthy Opportunities Pilots, right? And we will have an RFI that will go out for response, and then an RFP for people to determine where best those regions will be. To be clear, they're not overlapping regions with the six regions that were described for the managed care programs. They have to be at county level regions and they can be multiple counties, but not necessarily at those. We haven't determined where they'll be. We're going to look for the field to help us determine that in our responses to the RFP.

Sen Hise: Sen. Robinson.

Sen. Robinson: Thank you, Mr. Chair and thank you, Madam Secretary and your staff for reporting. Some of you know the questions we've gotten from providers before in terms of delayed payment from our system. Do you expect that there's going to be additional delay in payment as we move to managed care or am I misinterpreting how that might look? I still have some providers who have problems in terms of delayed payment.

Jay Ludlam: One of the early key areas that the Department and the Division will be watching closely with the managed care companies is, of course, around transition of care, but once that's done it will be about provider payment. We will be looking for the health plans to be making those initial payments and making sure and verifying that they're accurate. One of the design changes is that we have also created an expectation that we want to see a copy of the denied claims as well as the paid claims. So we will be looking at both in order to verify that the health plans are actually adjudicating claims timely and correctly, and, if not, that they're making up for that with interest and penalty payments to providers.

Sec. Cohen: Just one thing to add is that we've also talked in our RFP process about having an ombudsman for providers, recognizing Dr. Murphy's point that this change is challenging. There will be a lot of new details. We want to have an entity within the Department to help folks navigate some of this that they can surface questions to and we can help to get the right answers. It will be a learning process and we're going to be needing to do a fair amount of technical assistance with our doctors and other providers to make sure everyone is understanding all of the details. Between Dave and myself, we talked to a lot of the physician organizations and now is the time for them to start to dig into these details about what managed care will mean. They're going to be signing contracts, potentially starting in the February timeframe once we select the managed care companies. This is the time where folks need to dig into those details to understand what this will mean for them and for their patients.

Sen. Robinson: Follow-up, Mr. Chair? What's the education process here? Beneficiaries are easily scared off from anything that's new. So what will be in place to educate beneficiaries about how you select a choice? What do you do, who do you contact, how do I get into this, and am I going to be lost, etc.?

Jay Ludlam: That's a very good question. In order to engage the beneficiary we're taking a couple of different approaches. One approach, of course, is through the enrollment broker. And if you look at that contract that we ask the enrollment broker to bid on it requires a tremendous amount of education. And in different forums – public forums, print, online – we're looking for a number different ways to reach the beneficiaries just through the enrollment broker. We are looking to bring on an ombudsman, a beneficiary ombudsman, who will also be tasked with educating, but also monitoring, to make sure that the enrollment broker and the health plans are doing their jobs and performing as we would expect them to and then reporting back. This will be an independent beneficiary ombudsman. And then there's just the work that many of us on staff at the Department are engaged in – working with advocacy groups, working with stakeholders directly, trying to reach beneficiaries where they are, answer their questions, try to get them engaged, help them understand how this new managed care program is going to work. I think another component of it is the 90-day without cause period. We will be offering up to 90 days for beneficiaries to change their health plan for any reason. So there's nothing like receiving a card for a health plan that you may not understand or know how you've arrived there. But then to have information guiding you back to the enrollment broker and/or the ombudsman to get you that education so now maybe that person who couldn't be engaged during the summer can be engaged during the fall and learn more about it. So these activities of educating our beneficiaries around managed care will continue not only through the soft launch or open enrollment but will continue throughout the program.

Sen. Hise: Sen. Krawiec.

Sen. Krawiec: Thank you Mr. Chairman. Sec. Cohen, thank you for being here. We appreciate your keeping us thoroughly updated and it's obvious a lot of work has been done thus far. As you recall, most of us envisioned broad participation by the managed care plans as well as the PLEs for regional plans. Based on responses to the RFP process, can you tell us how that's going? Has there been active participation with those PLEs? Can you just enlighten us a little bit on that?

Sec. Cohen: So I want to be careful here, because we're in the midst of the procurement process, so I'll probably just refer you to our website with the eight folks who have currently bid or asked for their application to be reviewed by our evaluation team. That is going on right now. And you would be able to know by those names, some of which are traditional commercial insurance companies, some of which are newer provider-led entities. We will have mix of both and they'll still go through that evaluation process.

Sen. Krawiec: Follow-up Mr. Chairman? Do you anticipate that we will have adequate competition with those providers? Do you see that as being adequate?

Sec. Cohen: I can't speak to the outcome yet, but I feel good with the strength of those, particularly in the commercial space, knowing their investment and involvement in Medicaid and other places and their success there. I do feel that we have good applicants. But we put a har pretty high of our expectations for serving our beneficiaries. And we want to make sure that everyone who participates as a partner with us meets those expectations, whether it's to do timely payment or to focus on care coordination. So that's the process we'll go through now to find the right partners to match up with those expectations.

Sen. Krawiec: Thank you, Madam Secretary. Thank you, Mr. Chairman.

Sen Hise: Let me follow up on that just a little differently to clarify it this way. The original legislation proposed for four statewide entities and up to twelve regional entities. How many of those are submitting for statewide and how many are submitting for region?

Sec. Cohen: That's not information I know, personally. That's something only the evaluation committee is privy to at this point. I can tell you what I've heard companies talk about, but I shouldn't speculate.

Sen. Hise: Sen. Tucker.

Sen. Tucker: Mr. Chairman, thank you. Mr. Ludlam, expound, if you would, please, on the enrollment broker. Some time back we found, I think in Guilford County, 800 or 8,000 applications for Medicaid in a drawer somewhere in a DSS office. Maybe it wasn't Guilford I don't remember, Sen. Robinson. But why are we employing an enrollment broker rather than using DSS like we always have?

Jay Ludlam: Thank you, Sen. Tucker for the question. We are required by federal regulation to hire an independent third-party enrollment broker. The enrollment broker vendor cannot be affiliated with a managed care organization nor can it be affiliated with the state. So it's a requirement of managed care that we hire an independent third party.

Sen. Tucker: Follow-up, sir?

Sec. Cohen: Let me clarify that the eligibility will continue to be done by the counties and the DSS offices. Eligibility is still going to happen the same way. Now they're going to have to do a second step – "Now you're eligible for Medicaid; now you have to pick a plan." It's the "pick a plan" that the enrollment broker does. Eligibility is still with DSS; then we have to do that warm handoff. We have to work on making sure that goes well so they have all the information they need to now pick the right plan for them and for their family.

Sen. Tucker: Follow-up, Mr. Chair? DSS is going to be handling that. So these folks, back to Sen. Robinson's question, are going to educate people about the health plan they have to help them choose it?

Sec. Cohen: The enrollment broker will do that education piece for the selecting of the plan portion of it. So the eligibility is still done, meaning the documentation, etc., by DSS. The "pick your plan" part, so that folks understand what doctors and network, etc., will be done by the enrollment broker.

Sen. Tucker: Thank you, ma'am, for that. Mr. Ludlam, you used a term "budget neutrality." That is a very incorrect word to use in government. I've never seen budget neutrality. It always costs more. When you state that, I understand that you have stated CMS requires a state not to spend any more dollars than they're already spending. Is that correct?

Jay Ludlam: That is correct.

Sen. Tucker: I see in this proposal, some of the milestones, and the things that you have listed here an opportunity to have to spend more money. Is there a hard and fast rule you cannot? Because I can pick a few things here out, if you wish, that cost money, spending over and above what you have allocated and agreed to with CMS. The reason I ask – I was here when the Medicaid budget was $500 million and $400 million over budget. I'm leaving and it's balanced and you folks have done a good job on that I'll give that to you, certainly. But I just don't want to see it get out of hand anymore. Help me with that.

Sec. Cohen: I think you're right in saying budget neutrality is a strange term – it's a federal term. It is not something that I would then bring over to our state budgeting process. Essentially, budget neutrality is, with the 1115 waiver, to spend at least the same or less than if you didn't have the waiver at all. Now we know the way health care costs go, they go up. Inflation goes up, medical costs go up. So, it's not saying we're going to stay the same in terms of amount of spending. It just means that if there was no waiver you'd spend on this line, and with the waiver you'd spend on that line. We feel very confident that even with these additional investments that navigate folks to the right setting for the right care at the right time,

managed care in of itself is meant to do some of that, to help us on the cost side. That's why CMS ultimately signed off on our waiver to say we are going to be budget neutral. That is different than what we need to do in terms of budgeting for the state. There's no getting around that we're going from one administrative cost structure with the state administering the program to multiple administrative cost structures. Managed care, as they go through their process, not in year one, not even in year two, but over the life of that five-year waiver, is looking to rein in the cost of the program and that's what we'll see over the life of the waiver.

Sen. Hise: Thank you, Sen. Tucker. Rep. Insko.

Rep. Insko: Thank you, Mr. Chairman. We have the DSS departments that our constituents are familiar working with. If I had a constituent who called DSS and said, "I've got this package here, but I don't really understand anything," will the DSS be required to send them to either your hotline that you have or to the broker?

Jay Ludlam: They would be required to send them to the enrollment broker, which will be the hotline. It will be one number and if the beneficiary comes in "through the long door," we are working on trying to get everybody on the same page so that they can send them to the right place, with a warm transfer.

Rep. Insko: Follow-up? I appreciate that you're taking steps to try to expand our provider base for mental health services. And we've all been concerned about too few providers. Should you just say that you had a proposal into CMS that has not been approved yet? That leads me to believe that you do not actually know where our provider gaps are. Do we know how too few providers we have and what kind of providers are where we need them? Do we have a map?

Jay Ludlam: I personally don't know if we have a map. I do believe we have a generalized understanding of where our provider gaps are. What we were seeking from CMS was a more targeted analysis of where our Medicaid provider gaps are. And that was what we were looking for – additional authority to investigate that.

Rep. Insko: I agree that you need to have that across the Medicaid population – behavioral health and physical health, too. So you don't really actually have the kind of picture you want to have?

Jay Ludlam: That's a better way to describe it. We don't have the picture that we want to have.

Rep. Insko: Follow-up? So, you're going to be making some changes to 122C?

Dave Richard: Yes, we'll be submitting to the General Assembly recommendations on changes to 122C. As you know, 122C is across-the-board for the mental health system. It is really complex, a lot of things that aren't related necessarily to transformation but are important. I think the General Assembly will make a decision on how deep they want to go into total changes in 122C.

Rep. Insko: As you move to tailored plans, do you know now whether or not the authority statute will be referenced? I'm concerned about losing the public system. Will that be changed or is it targeted?

Dave Richard: I think we have the authority to move to tailored plans in the legislation that was passed. Certain things about moving to tailored plans should be considered in terms of that, so we'll be submitting to you recommendations around larger issues. Recommendations will be about things that have to be changed in order to implement, and then broader questions about what the future of the system looks like.

Rep. Insko: Okay, thank you very much.

Sen. Hise: Chairman Dollar.

Rep. Dollar: Thank you, Chairman Hise. You were talking about the 90 days, how you think it's going to work. So, let's say, in that 90-day period, an individual finds out they were auto-enrolled in a plan, something happens to them medically, they go to a provider hospital, etc. They get treatment and, in this instance, they're going to have to have continual treatment of some sort for some period of time to come. But, this is in that 90 days and they decide they want to change plans. So they exercise their right, I assume, at that point, and they change to another plan. How does the liability fall for follow-up medical visits, and continuing treatments that were authorized when the individual was covered under, let's say Plan A, and now they're going to be enrolled at whatever date in Plan B. How does that follow? Does Plan A have to continue to follow through on that patient with regard to what happened to them and the subsequent therapies and treatments and all? Or when they change to the new plan choice their follow-up treatments become a part of the cost for the new plan?

Jay Ludlam: That's a great hypothetical that brings in a lot of different things to be considered. From a strict liability standpoint, and I'm somewhat speaking off the top of my head, I would have to refer to the actual contract that the health plans will agree to. The RFP outlines what we expect. I believe that physician costs are date-of-service driven and, therefore, the liability will fall with the health plan that the beneficiary is a member of on that day. For those costs that are inpatient costs, I believe until the individual is discharged, those liabilities will remain the liability of the original health plan. So that's just from the strict financial liability standpoint. Of course, there are transition of care considerations, working with both the physician as well as the new health plan. Ensuring care of the heneficiary is carefully managed during that transition is very important. And we have also outlined in our contract with the health plans those transition of care procedures and policies we expect them to follow.

Rep. Dollar: I think scenarios like that and a hundred variations are a major concern of a lot of the folks in this room and elsewhere in terms of how these various transitions are going to be managed. They're still lots of questions about how the variety of transitions are going to be managed and how they're actually going to operate in the real world. That's going to be a major challenge when plans go live.

Sen. Hise then recognized Dave Richard, Deputy Secretary for NC Medicaid, DHHS, who noted that a corrected slide deck had been distributed. Dave Richard presented agenda item **IV. Medicaid and NC Health Choice Enrollment** and answered questions from Committee members. See **Attachment 4 – Medicaid and NC Health Choice Enrollment.** Roger Barnes, Chief Financial Officer, Division of Health Benefits, DHHS presented agenda item **V. Medicaid and NC Health Choice Financial Update** and answered questions from Committee members. See **Attachment 5 – Medicaid and NC Health Choice Financial Update**.

Rep. Dollar: What are other revenues?

Roger Barnes: Other revenues come in with our supplemental payment plans, where we pick up additional dollars from the assessment tax that we have on the hospitals. Any of the other unidentified cash that isn't there immediately to identify is in other revenues, then once it's identified it will go against the proper account.

Rep. Dollar: But majority of that is the supplemental payments that we've had this part.

Sen. Hise: Let me just try to get why this is balancing differently because other revenues is a small portion. Why would expenditures in federal revenue, if it's a two-to-one match, only be moving 2.4 percent, yet state is moving 21 percent?

Roger Barnes: It is a timing issue, primarily. We also had a slight change in October which you will see at next year's or the next month's JLOC with your federal revenues. But majority of it is timing, our claims payment lag of coming in and paying off the expenditures in state appropriations.

Sen. Hise: So, ultimately is the state appropriation closer to the 2.4 percent the feds paid in, or the feds should be closer to a 21 percent decline?

Roger Barnes: I think the state appropriations would be closer to the 2-point percent.

Sen. Hise: Rep. Murphy.

Rep. Murphy: Thank you, Mr. Chairman. I've been down here three years and every year I've seen the Medicaid budget under budget when we haven't gone to managed care. And now that we're going to managed care what's going to happen to that $240 million that we're under budget if we go under budget again? Does that just go to the managed care organizations? Where does that go?

Sen. Hise: From what's designed in the program, other than potential changes in enrollment, it will be a flat-lined budget. It will come on much closer to what we predict. We pay a per member per month to the companies. So what the state expends will be consistent with what the state determines to spend, not hit by flu outbreaks or other things. As we see these expenditures grow or don't hit as we see expenditures

decline, all that's within the PHP. We will now pay a defined per member per month amount to the PHP, much more consistent with what do in other budgets across the state, for a very large percentage of our Medicaid recipients.

Rep. Murphy: Follow-up? Therefore, when in calculating exactly what per person payments will be, what type of variance is usually given to those?

Sec. Cohen: You're getting into how much we're paying per member per month to the insurance companies. In the RFP we put out very extensive rate tables that our actuaries built up, made some certain assumptions about costs and such. I'm happy to walk through how those assumptions came to be and how we made decisions about where we anchored those numbers. We make sure we cover costs for the insurance companies and you build in administrative costs, profit, those kinds of things, in addition to the medical expenditures, and we come up with a number. And the rate tables are out there right now. We are going to update those rate tables based on our next cycle of data. We have our actuary firm crunching those numbers right now. That's how we go about coming up with how much we are going to spend per member per month. And, of course, it's going to be a global number. Any time you do that it's going to be a global number where some people will spend a lot less than that number and some will spend more and, on whole, actuarially, that's the right way to cover the cost for the population. And if I could just say, Senator, you're exactly right in terms of the budgeting. I will say the next few years are going to be a mix. We're going to have fee-for-service payments continuing, as we will continue to have folks in fee-for-service in the state-administered component of Medicaid. We will have a lot in managed care, but not all. So, our budgets the next number of years are going to look different than our budgets have in the past. We're going to moving from the system that pays retrospectively – you bill us then we pay you back – to a prospective system where we're going to pay per month. At some period of time that means we're actually going be paying twice, because we have to pay the runout claims and we have to pay prospectively. But the General Assembly very much has known this and is saving for that sort of overlap period. The budgets will look very different in these next number of years because of that. So it's hard to take those numbers that you're seeing – 240 are we going to see 240. I just want put the marker out there that those numbers are going to look very different as we move forward.

Rep. Murphy: Flesh this out for me also, because I never really truly understand this. I understand the capitation part on a primary care-type physician, but, for example, somebody comes in with appendicitis you haven't contracted with a general surgeon to cover them. How does that work in a managed care environment? Or somebody comes in with a kidney tumor and I take care of it. That's not planned upon me. I'm contracted with me.

Sec. Cohen: We have said to the managed care companies, you must cover the things that Medicaid currently covers. And then you must show us you have a network that can allow for those kinds of services to be provided. And so it may not be with you, but they have to show us that there's going to be urologists in their network that can do both kinds of services to cover the benefits. And so that's the process that we are going through right now and saying here's the rate: "Who thinks they can do this job for this rate and provide this kind of network in order to provide the services?" It's exactly what we're

going through and is now the managed care company's job to say, "I need to build a network. I need to talk to all the urologists out there and make sure that we have who we need in our network so in case someone does come in with x, y, or z issue we can get it taken care of."

Sen. Hise: In talking about the budget part, we've anticipated putting aside about $300 million at opening, because anytime someone has a service they actually have up to twelve months to submit the claim, so if they had a service in December it can be a year before we actually pay it and that's not paid by the managed care company; that's still paid by the state, but now that we do this rollout it's going to be much longer than a year, as well, that a service could still be there. So, we'd originally anticipated to have about $300 million on January 1, to begin paying those claims. Now it looks like that process is probably spread out over two years and we'll probably need to look at breaking the budget into payouts for those claims and designating the funds those come to rather than this one-size-fits-all budget we've seen up to this point.

Rep. Dollar: Rep. Murphy, I think that you swerved into a really critically important point in the hundreds of millions of dollars. And that is if you looked at the Florida example after the first year, you had a number of the plans coming back to the General Assembly, asking for hundreds of millions of dollars more. There were lots of disputes as to how those claims were being calculated and I'm not picking sides in that dispute. If you go back and look at what happened in Florida, you had some real interesting dynamics between the initial expense of those plans and what they thought was appropriate and what they actually received and how the calculations were done. In California, the past year or two, they paid out too much money and MEDCAL was in the process of trying to recoup money from plans because they had actually overpaid in the hundreds of millions of dollars. So, trying to get the goldilocks scenario and get it right is going to be an incredibly difficult challenge for everyone – plans, the Department, General Assembly.

Sen. Hise: I think we kind of rolled into the fiscal budget side, just wanted to make sure we can cover the anticipated impact of implementing the IMD component of the waiver January 1, in the budget from one of the questions we'd submitted. Make sure we didn't miss that.

Dave Richard: We believe it's less than $1 million to implement that for the rest of the fiscal year, and we would require no additional dollars from the General Assembly to make that.

Sen. Hise: Rep. Dollar.

Rep. Dollar: And I hope that this isn't repetitive to what Chairman Hise just said. So when do you plan or do you already have available for the General Assembly the Medicaid transformation budget forecast? There was a budget forecast that was supposed to be presented to the General Assembly in this timeframe as I recall. Can you give us the status of that?

Sec. Cohen: Yes, we are definitely working on forecasting what the managed care program will look like. This is a hard number to come up with exactly what you were talking about here – the goldilocks thing

and we're trying to get it right. We know that managed care in the first number of years is actually going to cost more money, as I just mentioned. Not only are we paying both retrospectively and prospectively, we have to build in some additional administrative costs, a lot of operational expenses that we see early on. Now that we have finally put our pens down on the waiver, at least we know what components of that will be included. So I think the team is crunching numbers now to understand these. They're a slice in a moment in time. We will know now, but that will evolve over time as we start to get experience with managed care, and that will need to be continually updated as we move through the process.

Sen. Tucker: When you use budget neutrality, talking about this budget, when the Department makes application to CMS you always set those projection very high so that the managed care companies can always hit that number or will hit that number and look very positive. Don't you set those numbers very high?

Sec. Cohen: There are two different things we're talking about here. When we're negotiating with CMS for our budget neutrality room we, as a state, want to get the most favorable view possible from the federal government to give us the most flexibility. Then we come back here to the state to budget, figure out what are we going to spend on these managed care companies, and set those rates. I think they're two separate processes. I think we did our working with CMS, to say this is what we think the projections will be and the best deal for North Carolina. We come back to North Carolina to budget for managed care and build those rates, because it all comes back to those rates. What are we paying per person for that enrollment with a managed care company? We have our actuaries go through these complex actuarial tables and look at our current data and utilization patterns, trends in medicine, and take all of those things together. It's their whole job. And put that together to come up with a number to say this what we'll pay for the number of people you enroll in Medicaid. So, it was different than the federal budget neutrality work that we needed to do.

Sen. Tucker: Mr. Chairman, follow-up? Madam Secretary would you not know your baseline number when you project the high number for CMS in your application? Don't you already know your baseline number because the actuarial numbers you run parallel with them, what's the difference?

Sec. Cohen: So the short answer is yes, we do. We're projecting both what we would have spent if there was no waiver and what we would spend if there is a waiver. But that's not all of the components of managed care. That's what the confusion is. So, in the 1115 we had to show budget neutrality just for the 1115 component. But we know managed care transition is so much more than that and that's where it comes back to us needing to budget here to know how we are going to actually make budget year to year. It's just a little apples to oranges but what we would be happy to do is have some of our actuaries come and sit down, both with how did we go through the federal waiver budget neutrality piece and then how did we build the rates.

Sen. Tucker: Just one more question. Is there any correlation between the flatline on Medicaid enrollment and low employment in the state? And do you correlate that number at all? Because if people are going to work and not be dependent upon Medicaid and they get benefits at an employer, do you have

any correlation between that and does that over a pattern of years, if the unemployment ticks up like it was at one time, does that mean more people are going to be on the rolls? If it goes down like it has doesn't that mean less people on the rolls?

Dave Richard: Sen. Tucker, I think intuitively we believe that's correct and we've also worked with your staff in trying to take a look at some of these things, sorting it by county-by-county enrollment trends, it doesn't necessarily equate. So we think there's something there, but we haven't been able to figure out the exact correlation to that.

Sen. Hise: Any other questions?

Sen. Hise recognized Dave Richard who presented agenda item **VI. NC Tracks Enhancements to Detect and Prevent Fraud, Waste, and Abuse,** and answered questions from Committee members.

Dave Richard: A kind of quick, high-level reminder that the General Assembly had directed us to use a process by which we added Pondera Solutions to look at the eligibility system in the Department's program, to make determinations, through an analytics process, of people that were no longer eligible for Medicaid that would show up on rolls, people that may be in prisons or moved out of the state, as a key, high-level concept around that. We would use that with our existing vendor – CSRA, which is an NCTracks program, to review those efforts. In the implementation of it, we found places in which we had to make changes in the CSRA system to be able to add into this. That supported some of the delay in our efforts to move forward. As we go through this process, I think we're going to get better at determining how to manage it, but we also were going to use this as a way to find out how well our current system works, and whether or not we were actually seeing whether people should off the rolls because of these other reasons. And we figured there would be an overlap there and then it would be actually that group of folks that we didn't catch through regular system issues that the Pondera system did. That would be the place where we would see the potential benefit on it. So what you'll see in our letter in response to a letter from Sen. Tucker is that we had some delays in this. And the delays were in systems issues, and secondarily, helping our partners at DSS – because they have a responsibility in this work also – to make sure that they're able to respond back to us, whether or not individuals were already caught or whether off the rolls, and those other areas. And that, in itself, also created some time delays in this effort. We're getting significantly better with our DSS partners, and, as you know, some DSS agencies have more resources than others. So we're working with them to figure out how to manage this in the best way possible. But the short answer to the list of questions is that we did find, as we went through the rolls, that there are people that have died that are still on the Medicaid rolls, more than were identified through the DSS process. So the number that we were able to submit for this latter period of time is that were about 15,000 people verified as deceased. Our existing tools caught about 11,000 of those folks, which means there was another 4,000 folks that we were not catching through that process that we currently use. But in this situation, and I'm going to make a distinction about our future system and how that will work, what's also important is that we get those folks off the roll. But it's also important to note who used benefits, if somebody that wasn't on the roll used benefits. And there are some cases that someone may have been deceased, but because of delayed claims, we would see a claim come in later. Of that group, we find that

106 of those beneficiaries, identified as deceased, actually were shown as overpayments to somewhere and we're in the process of recouping that. There were a total of ten beneficiaries that should not have had claims submitted and there was about $5,000 on this period that we're recouping on that side. On the incarcerated beneficiaries there were 4,500 recipients that were verified as incarcerated. Our existing tool caught 3,700 of those individuals, and the Pondera system caught another 850, uniquely identified. Of that, 11 beneficiaries for a total of about $3,000 in potential overpayments, which we're investigating. A total of $16,000 in claims were denied for 17 beneficiaries. So we did have that impact.

On the out-of-state beneficiary count, when people leave the state or if let us know they're leaving, if we've indicated that, there were 1,700 recipients that were verified as residing outside of North Carolina. We'd caught 1,600 of those. About 150 individuals were out-of-state, in which we found ten beneficiaries that received services for a little over $200. And there were potential overpayments we're investigating that could be up to $27,000. Now those numbers are small and I want to be clear in terms of the dollar amounts and the total Medicaid program we have. But where you'll see a benefit for us as we're moving to managed care, for instance, is as we pay a per member per month on those individuals. So anybody we find in this process that helps us pay the proper payment for our managed care claims will help us based upon that PMPM. It's not going to be based on claims at that point because we will have paid the managed care company the money upfront. And we'll continue to do this work with Pondera to make sure that we are getting the best benefit out of this for our current system because there'll still be a lot of folks that are not inside of managed care that will want to make this work, and as we make sure that we're getting the best use out of it. So the message I want to make sure I give to the Committee is that the work is really important to us. We have done the changes inside our systems. We're working with our locals DSSs to ensure we can provide the support they need. We'll continue to use this system and continue to try to improve on it as we move into our managed care system.

Sen. Hise: Any questions Sen. Tucker may have about his favorite contract?

Sen. Tucker: Thank you, Mr. Chairman. And I just want to share with the Secretary and Deputy Secretary Richard the comments I made earlier about how intelligent and bright and wonderful you folks are. I really meant those, even after this line of questioning. I think it's worth going down the history road here and this all started out of a comment that Secretary Richard made when he said to us, some three years ago, that the DHHS did not chase claims below $150. And I asked him at that time how much money or what the guesstimate was and he stated to me that it was probably about $250 million a year. Is that correct Secretary Richard?

Dave Richard: Senator, I don't recall saying the dollar amount. but it is correct about the amount the claims that we did not go after because of the cost of going after those claims.

Sen. Tucker: May I ask this line of questioning without doing a follow-up? Sir, do you remember that after you made that statement I said I wanted to start a business and that I would only take ten percent of what I collect and at that juncture I could make $25 million dollars a year? You obviously don't remember that, correct?

Dave Richard: Sen. Tucker, I remember you making that statement, but my recollection was also after an auditor report.

Sen. Tucker: Okay, alright. So he made that statement and I went to NCTracks because we had problems with NCTracks. And while talking to the vendor, they told me that there was a set software that scrubbed the Medicaid rolls in California called Pondera. I brought that idea back to you. Is that correct, sir?

Dave Richard: Yes sir, that is correct.

Sen. Tucker: So I brought that idea back to him and then after two years we finally have it implemented or a year, or a few months – it doesn't matter. But let me just share with the public that there was an opportunity for DHHS not to spend one dime on this software. And it's my understanding that you spent about $750,000 implementing that. Would that be correct?

Dave Richard: I don't have the exact number but that sounds correct Sen. Tucker.

Sen. Tucker: Right, we spent $750,000, but we had a game share program where the software manufacturer whatever they found in fraud, waste, and abuse they would take one-third, the vendor with NCTracks would take one-third, and the State would take one-third. DHHS chose not take the free option. And my point – the reason you didn't take the free option is because you could not control the criteria of which the rolls were researched by the Pondera software. Now, Mr. Richard, I have a great deal of respect and we've gone round and round for eight years, but, surely, you don't think the public and I and this Committee are naïve enough to think that something that has never been done to 1.6 million enrollees can only generate $49,000 worth of fraud, out of 1.6 million. Then you mentioned today your existing systems found 3,700 and Pondera only found 800. Well, where in the hell has your system been the last twenty years if you all were scrubbing the rolls and doing what you're supposed to do. I do not think that you folks really want to know how bad it is. The game share program would have been the cheapest way and we could have really researched these vendors to see if they were committing fraud – 127 fraudulent claims only generating $49,000, out of 1.6 million recipients. Ridiculous, ridiculous! And then there's no mention of the double-dipping that may be going on with LME/MCOs. I have no idea about that. I'm a taxpayer and I really will be a taxpayer in about thirty more days. And I leave here with this: we can't spend this money: $750,000 to get $49,000 back. No business person in the world would do that deal. And I'm just disgusted with the lack of what we found. And then I hear the Medicaid expansion train coming down the track. I hear it loud and clear with the last election and everything else. And we can't find out who's doing fraud in this state at a bigger number than 127 cases and $49,000? And you expect to put 600,000 more people on the Medicaid rolls. Your system can't handle it. You can't handle it. And that's just the way I feel about it. And you know you can respond any way you want to. I'm leaving here, so you won't have to hear my chime again. But I can tell you that we owe more to the public by finding fraud, waste, and abuse because that's thrown around on the federal level and it's thrown around on the state level. Here we have an opportunity to turn the balance up on software to get at who is abusing the system and we refuse to do it. Thank you, Mr. Chairman.

Dave Richard: Mr. Chairman, I would like to respond just briefly. Again, Sen. Tucker I do have great respect for you and your role and what you're trying to do with this. I'd like to add a couple things. One – what we responded to is very specifically what the Pondera system has done. It doesn't mean that the state isn't doing more work and significant work around fraud, particularly around provider fraud which we think is where the ability to find more dollars would be than the beneficiary side. We have implemented and continue to implement more analytic systems there. We can certainly come back to you with the kind of work that we're doing. When you do that on a provider side, you actually prevent fraud by the way we do it. So we do, as you know, post-payment reviews and it requires a very significant amount of work from providers to do that. We believe we offset a lot of potential fraud when we do that work. Again, I appreciate your point and your concern about this, but this is not the only method that the agency uses to detect fraud. And we do a reasonably good job at avoiding those fraudulent claims that come through, especially on the provider side. We don't think there's any beneficiary fraud, in terms of the way this system works. You're not going to find a significant amount of dollars from there. We do think in managed care this will be a helpful tool, a broader tool. If we find people that shouldn't be on the rolls early, we will take them off those rolls. Related to any other conversation about what happens in the future of our program, I think that we have demonstrated over the years that we have the ability to manage it and continue to do that. And that the question about who's eligible and how that works, we continue to implement the programs that we've all agreed to with the state auditor and what we're doing with the local DSSs. Those programs have paid dividends. We will continue to work with Pondera and with CSRA to make sure that we make the adjustments that are necessary to continue to use this system at the best of its ability.

Sen. Tucker: Follow-up? If we've generated $49,000 in fraudulent claims and you talk about the system and you know we had that posterity or program or whatever we spent all that money on, I don't remember. The guy was supposed to check on fraud, he's not here anymore. We only generated $49,000. Your existing system has generated what to catch fraud? How many dollars?

Dave Richard: Sen. Tucker, I do not have the number for you, but we will come back.

Sen. Hise: Identifying individuals who aren't in the system is much more important moving into managed care. Can you identify for the programs anyone who's had no expenditures within a year? If you have someone, for example, in the aged, blind, disabled category who's had no expenditures within a year under our Medicaid that may be an additional indication that they have moved states or left, or other things. Hopefully, we can weed out some of those before we get to our per member per month cost.

Dave Richard: Sen. Hise, your question is as we look at our beneficiary list, can we cross-reference that with any claims that we would have on behalf of that beneficiary? Yes we can.

Sen. Hise: I'm interested in that kind of number and investigating those individuals a little more to make sure they should be in, before we start paying so much a month for them. Any other questions or comments?

Sen. Hise recognized Martin McCaffrey, M.D., Director, PQCNC, who presented agenda item **VII. Perinatal Quality Collaborative of North Carolina (PQCNC) Data Needs** and answered questions from Committee members. See **Attachment 6 – Remarks to Medicaid Oversight Committee.**

Sen. Hise: Thank you, Dr. McCaffrey. Have you had any conversation with the HIE yet, Health Information Exchange?

Dr. McCaffrey: No, we have not.

Sen. Hise: Is it the classification of your organization under UNC that creates the problem?

Dr. McCaffrey: We are in UNC. I'm not sure where necessarily the problem is. What we have been told, especially by public health, is that we are not recognized as a state agency that's acceptable to receive this data. Although the Medical Care Act looks like other types of folks beyond the state agents receive this data if you're doing the right type of work.

Sen. Hise: I think it's probably easiest if I ask Madam Secretary if you can coordinate a conversation with them and the HIE and your Department and come back to us with specific recommendations?

Sec. Cohen: Sure, as you know we don't run the HIE so I don't want to speak for them in terms of the data pieces, but I'd be happy to facilitate a conversation.

Sen. Hise: We can get them at the table, I'm pretty confident. Sen. Krawiec, any questions?

Sen. Krawiec: I think I read somewhere in your information, Dr. McCaffrey, that we are only one of two states where this information is not available. Is that correct?

Dr. McCaffrey: Yes ma'am. There are 22 states right now that are AIM States, and we are one of the two that do not have access to this data.

Sen. Krawiec: Follow-up, Mr. Chairman? I read the act also and it seemed clear to me what your charge was and that the information should be available to you. It seems simple, like a very simple ask, and I can't believe the complications that you've had to go through to try to get information that you are in my opinion already able to do. I'm so glad you're here today when we have all these fine folks here that maybe can help us figure out what the solution might be. So thank you for being here.

Rep. Dollar: I'm sure you've done some work on this in the past – low birthweight. That's an issue that has been a challenge for the state for a number of decades, actually. And there have been initiatives at different times to try to get birthweights up. I'm just curious in terms of the work that you've done in terms of birthweight and, more broadly, infant mortality.

Dr. McCaffrey: Thank you, Representative. I would move beyond birthweight; I'd say prematurity. Birthweight is one issue, but prematurity is a second issue as well. A project we worked on in the past included the 39 Weeks Delivery Project, looking at reducing late preterm. We expect we will see a similar probable reduction in late preterm deliveries as we work on the Primary Cesarean Section Project. We just completed a project we called CMOP, Conservative Management of Preeclampsia. And with that project, we reduced numbers of non-indicated preterm deliveries less than 37 weeks, for mother with hypertensive disorders of pregnancy by about 70 percent in the groups that participated. So we've done some pretty good work with this. That project, in particular, was extremely successful but we had 25 centers. We had about 40 percent of the hospitals doing deliveries in the state in that project. So we didn't have what we have for participation right now with AIM. The reason we think AIM is so important is that obstetricians have really rallied around AIM; it's sponsored by ACOG, their flagship organization. And they are very willing to pursue quality improvement through AIM. So we're trying to use that as the carrot to try and get folks engaged in the work we're doing. Otherwise, we've got volunteer folks. In the projects we're doing there are the models. California, for instance, has said that if you want to get Medi-Cal maternal or newborn payments you've got to belong to the CPQCC or the CMQCC, the California collaboratives for perinatal and maternal care. We haven't had a hammer like that to wield, but we have had a coalition of the willing. We've had folks who really want to do this work, and that's one of the reasons we've been very successful in the work that we've undertaken. But we haven't had quite the spread that we would like to have. It's increased with AIM; it's going to get better, but we hope for even more down the line.

Sec. Cohen: Since the Committee is spending some time on the importance of early childhood health, I want to point out that right now the Department has released an early childhood action plan on health, safety, and learning and I'd encourage folks to take a look at it. It's in draft form now and we're taking comment on it.

One of three pillars, childhood health, is about infant mortality, preterm birth, and low birthweight. Sen. Krawiec, I know you've been taking a look at that as an advocate for kids and families. I think that will be a really important document to help us all in the state align our resources and our time to make sure that we're doing the right investments that we need for kids and families, because I do think that kind of investment is not only right for the kids in the moment, but our future workforce. Think about that from a jobs perspective as well.

Dr. McCaffrey: Reducing the preterm birth rate is really challenging due to so many factors. Ohio has really done this pretty well – demonstrated, written, and published on it. The Ohio Perinatal Quality Collaborative ran a project looking at 17-hydroxyprogesterone, which we know is a great treatment for, moms who have had prior preterm birth, 30 to 40 percent prevention of a future preterm birth. So it's a relatively small number who are eligible for this, but it can have a huge impact. Ohio demonstrated that

they were able to actually drop the true, real preterm birthrate by executing a statewide project looking at 17P, 17-hydroxyprogesterone. It took a lot and the people at the table here are capable of doing this. We have done 17P in North Carolina through a couple of different projects that run through the Child Fatality Task Force. UNC has attempted to really run with this and get 17P introduced across the state. We haven't as a state taken it on as a statewide QI project, and I think that's something that's right for us. It is challenging in the sense that it's inpatient and a lot of outpatient. It is challenging that you get into access to care issues, because for moms to get 17P it's a shot every week, starting at about 16 weeks through 34 weeks or so. So how do you get folks to the doctor to get a shot every week? Are there innovative way that we can make that happen? That's another potential project for us to tackle, which we have not because there are other interest that have been engaged in that.

Sen. Hise: Sen. Tucker.

Sen. Tucker: My last meeting, I got to get it all out. Madam Secretary where do we rank in comparison to other states in infant mortality and in low birthweight? Where are we in 50 states available? I think President Obama said 53. Which one of those, where do we rank?

Sec. Cohen: Infant mortality is an interesting statistic. We rank about 37th out of 50 in terms of infant mortality. But the important part of looking at infant mortality is to break that down by county, because there's such a variation county to county. We're doing pretty well here in Wake, okay in Mecklenburg. It's where we get to the rural parts of our state, particularly those that are African-American in the rural parts of our state. Those two confounding pieces together are really bad. The infant mortality rate overall for the nation is around five. Which means five in 1,000 births don't make it to their first birthday. In North Carolina, it's about seven babies in 1,000 who don't make it to their first birthday. If you live in rural western or eastern North Carolina, it's about 18. So that's African-American and rural together. That's not acceptable; it's why one of my major focuses has been on early childhood. We're trying to put together all of the collective resources. There is no one silver bullet; there is no one project that's going to fix this. It's a very complex issue, and there are a lot of lessons to learn from around the country and around the world on how they've made improvements in this space. USA Today had an extensive article about maternal mortality and it speaks to what's going on in infant mortality as well, clearly room for improvement here. We know that infant mortality has a lot to do with moms' health and moms' access to care. The opioid crisis is certainly further straining our ability to make progress in this area and that's why we're doing a significant investment in maternal space for opioid treatment.

Sen. Tucker: Mr. Chairman, I think near and dear to you would be expansion for nurse practitioners, PAs, and those folks willing to go to the rural communities and work, which could certainly help with this particular issue, even in Pitt County.

Sen. Hise: Specifically nurse midwives in this area.

Sen. Krawiec: Thank you, Mr. Chairman. I would ask Dr. McCaffrey if he would touch base with us in three months. Advise us as to what kind of progress you're making; come back and let us hear from you.

Dr. McCaffrey: Yes ma'am. Absolutely.

Sen. Krawiec: Thank you. If that's okay with Mr. Chairman.

Sen. Hise: It will probably be a regular meeting versus oversight because the session is getting ready to start. For his last request, Sen. Tucker wants to ask about the child welfare program.

Sen. Tucker: Thank you, Mr. Chairman. I think I preempted this question in talking to Deputy Secretary Richard or whomever they had with NC FAST last week. I received a text from Sen. Barringer that stated, and correct me, NC FAST asked for $500,000 - $1,000,00 to test whether the child welfare module of NC FAST will work or not. Is that true?

Sec. Cohen: No, I don't believe that's true. We did ask for some additional funding to make sure that we could roll out NC FAST in the way I think we both want it to be done. And I think we both shared our frustration with the system – that it is not perfect. We've taken a pause on further implementing it, while we can make enhancements. We found that within our own budget. This about trying to get everyone on a system where we can share data across counties because we know families move and children move and we want to be able to share that information to protect kids across county lines – why you all went down this path in the first place and I think it's very important that we get there. We have taken a step back and really done a re-look at NC FAST and how it works. But as you well know, sir, we have a hundred counties doing a hundred different mechanisms for child welfare. It's not just a technology issue. That is certainly a large component of it, but this is also that everyone's doing their business a hundred different ways and so we have to not only change the technology which is hard, but we also have to change everyone's business processes which is hard, and I'm very sympathetic to that. And I don't want children and families to suffer while we're fixing our end. So we're very much trying to keep our eye on the ball there. But I think we're making slow but steady progress.

Sen. Tucker: Thank you Mr. Chairman, just one comment. First of all, I'm a child of abuse, I grew up in an alcoholic home, so this is near and dear to me just like the foster care is. In 2015, Sen. Hise, Sen. Barringer, and I put in the budget to take an off-the-shelf software program that was already implemented in Indiana, bring it off the shelf, and have a child welfare protective services. I'm from the county where the child had the chicken around its neck and was burned with an electrical wire by the child protective services supervisor from DSS in my county. And we still have, after four years, NC SLOW as I call it. I know you inherited this, but, ladies and gentlemen, these are children that don't vote, that don't give money, and after four years in this agency, DHHS and Sherry Bradsher begged me not to put it in the budget and we all agreed to take it out. And here we are four years later and she's gone to work for a

company that told us it doesn't work. We had articles from Great Britain about it. We had articles from Ontario, Canada about it. We are the guinea pig for IBM. Somebody needs to go back and look at all those contracts, scrub those dates, and, damn it, if they missed something we ought to sue the pants off IBM. Because while we're here, children and DSS social workers walk into trailers and have no idea what they're walking into, because in 2018 we don't have a child welfare system that's real time for them. Guys, if you all can't get this done how in the hell are you going to expand Medicaid?

Sec. Cohen: I'm going to miss you – I will. I don't think anyone is as fierce an advocate for our kids in North Carolina as you are, and I'll really miss you. We need you to keep the fire on this and I hope that you will continue to do that in your other roles. You and I share that same frustration here. But every day I have to make the decision – do you throw away what we've done already and start again? That means more time and more money, and I don't know that our kids can afford that either. I hear you about holding IBM accountable, and I do want to say they have stepped up to the plate and made a lot of enhancements to the underlying product at their own cost, which they should. I'm not carrying their water here. But we will continue to hold them accountable and I think we've learned a lot of lessons about how to do that better and it never feels good to be the guinea pig on any new piece of software. But I do want to say, it's not just technology here. A lot of business improvement processes and how people spend their time needs to be improved upon as well, and I think that's equally as hard. And we will be working in partnership with the counties. I think the counties have incredibly hard jobs in doing the child welfare and we want to be partners with them in service of kids. And I truly will miss your advocacy here. But we are making slow and steady progress, and I don't want anything to take away from our ability to get more folks access to care if we can get it.

Sen. Tucker: Mr. Chairman, sine die.

Rep. White: I really wanted to pass, because I think we need to just leave here keeping Sen. Tucker's words in our hearts and minds. But since you called on me, I will respond. The infant mortality rate in North Carolina has improved. We do have a long way to go, but in the 1980s to the early 2000s it was 14 per 1,000, so great strides have taken place. We have a long way to go, but I thank those entities, public health, DHHS for the efforts they've made. We've reduced it by 50 percent in twenty years or so.

Rep. Lambeth: Thank you, Mr. Chairman. I want to publicly thank both Sen. Tucker and Rep. Dollar for their advocacy, their commitment, and their passion. And I've been through these meetings now for about six years and they're not always a picnic or a bowl of cherries. We have our challenges, but these two individuals are and have been committed to making North Carolina and the people that we serve a better state. And for that I appreciate what both of them have done and how they've done it. They're both going to be missed and I will miss both of them.

Sen. Krawiec: Thank you, Mr. Chairman. I just wanted to follow up with something my colleague said. In a social services working group this last week, we had a long conversation about NC FAST. One of our local, county DSS directors there shared with us that they had to hire extra personnel to input the data into the system so the county had taken on a lot more expense. He also shared that one entry took 16 hours. Sen. Barringer and I questioned, and Sen. Tucker, you mentioned that the Canadian government was using this system. They finally decided that they were spending so much money patching it, and patching it, and patching it that they were just going to throw it out and start over. And I know we have done, I think, nearly a billion dollars in those two systems but there comes a time when it's not doing what it's supposed to do. And if we can't get it to that point after all these years, to take care of our children, I join our colleague in saying when is enough going to be enough? At some point, we have to make sure that our children are protected – that's number one. So we really have to get it fixed or we have to find something that works for that purpose.

There being no further business, the meeting adjourned at 3:37 P.M.

Senator Ralph Hise, Co-Chair

Susan Fanning, Committee Assistant

NAME OF MEETING : LROC on Medicaid

DATE: 11/26

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Connor Jones	MVA
Rick Zechini	Williams Mullen
Doug Heron	DUKE
Lexi Gainer	JLF
Hugh Johns	NCMCC
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Christine Cray	WakeMed
Marie Gardner	GSK
Tracy Kimbrell	Parker Poe
Dodie Renfer	CCR
Brady Young	OSA
John Hardin	MTS
Sarah Patterson	WM
Leah Byers	Civitas
Rob Robinson	Alliance
Sara Wilson	Alliance
Brian Parker	Allante
Christine Wilson	ACS CAN

NAME OF MEETING : LRDC on Medicaid

DATE: 11/26

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Rhaegan Jackson	Focus Carolina
Demetrius Deloatch	Troutman Sanders
Tiffany Gladden	NC Rural Center
David Powers	DS, LLC
[illegible] Vogel	Amergroup
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Jenna Nye	VHSA
Lori Kroll	Novant Health
Sue Ann Forest	NCMS
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Andy Ellen	NCRMA
Rob [illegible]	RCA
Dana Simpson	SA
Kara Weisbaar	SA
Kirby Consier	Novartis
David Misken	PSG
Frank Hill	PSG

NAME OF MEETING: LRDC on Medicaid

DATE: 11/26

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David Kalbacker	NC Board of Nursing
Ben Popkon	Popkon Strategies
Sarah Poplin	Popkon Strategies
Michelle Lewis	NC NAMI
Kay Castillo	NASW-NC
Cory Dunn	DRNC
Melissa Evans	DRNC
Tracie Hanson	Coastal SE United Care
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John Nash	The Arc of NC
Paige Bennett	Wake Co Human Services
[illegible]	CSS
Joyce Peters	CSS
Will Morgan	MHTS
Holly Perkins	Perkins Law

NAME OF MEETING : LROC on Medicaid

DATE: 11/26

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Reggie Holley	Longmire Group
TAYLOR GRIFFIN	NC AHP
DANIEL BAUM	TS
LINDSEY DOWLING	TS
JOE LANIER	TS
David Farrell	NP
Mary Bethea	NC Coalition on Aging
Andy Chase	KMA
Stephen Kaiba	KMA
Amanda Donovan	KTS
Josh Lanier	CSH
Elizabeth Hudgins	NCHA
Sarah Bales	Brubaker & Assoc.
Deb Clary	NCSP

NAME OF MEETING: LROC on Medicaid

DATE: 11/26/18

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Brendan Riley	NC Justice Center
[illegible]	NC Child
John Thompson	TPG
[illegible] Chetnut	Atty at LAW
Jackson Stawcil	JJC
[illegible]	[illegible]
John Cooper	Connect C
Dick Carlton	Law Off of RHC
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CMS Approves North Carolina's Innovative Medicaid Demonstration To Help Improve Health Outcomes

Seema Verma

OCTOBER 24, 2018 DOI: 10.1377/hblog20181024.406020

At CMS we are working with states to make Medicaid a stronger and more sustainable program that delivers better results on behalf of its 75 million beneficiaries and the American taxpayers. This is a critical

objective given the program's goal of serving the health needs of our nation's most vulnerable populations, including children, pregnant mothers, people with disabilities, and the elderly.

But too often states have been stymied by outdated regulations and rigid federal rules in their efforts to find creative new ways to deliver better care. That's why we believe that the best thing that CMS can do is create a fertile ground for states to fulfill their role as the laboratories of innovation in Medicaid policy. To do this, we've expanded opportunities for states to seek demonstrations to test new and exciting reforms. Today, I'm pleased to announce another example of that commitment through our approval of North Carolina's innovative Medicaid reform demonstration.

Through this demonstration, North Carolina will shift their program toward one that delivers better value with a more predictable budget through the transition from fee-for-service to a managed care delivery system. Leveraging best practices and the experiences of other states, this demonstration will allow the state to partner with health plans to target and better coordinate care for high-need Medicaid populations, including plans for beneficiaries with behavioral health, intellectual and developmental disabilities diagnoses, and specialized plans for current and former foster care youth.

The North Carolina demonstration will also allow the state and CMS to test innovative new approaches to address a broader range of issues that can have a direct impact on an individual's health. We know that behaviors and other determinants of health – like where we work, live, learn, and grow – are all factors in our overall health and wellbeing. As we seek to create a health care system that truly rewards value, we must consider the impact that factors beyond medical care have in driving up health costs. That's why many states are beginning to think

about ways to better address the root cause of chronic illness. As part of this demonstration, North Carolina will implement a groundbreaking program in select regions to pilot evidence-based interventions addressing issues like housing instability, transportation insecurity, food security, and interpersonal violence and toxic stress.

More specifically, the state will pilot enhanced case management (ECM) services based on evidence-based interventions for individuals with certain diagnoses and risk factors, all with the goal to improve health outcomes and lower costs. In the pilot regions, health plans will identify and target populations of high-need Medicaid beneficiaries and determine a specific package of services tailored to that individual's need. Health plans will work with local organizations to deliver these tailored case management and support services through a network of qualified providers.

North Carolina is the first state in the country to embed a program like the ECM pilots into its Medicaid managed care delivery system. We've worked with the state to design the program in a way that will ensure that there is strong accountability for this investment. Over the course of the five year demonstration, North Carolina will increasingly link payment for ECM pilot services to outcomes as we collect and analyze data to understand which interventions are having the anticipated impact on outcomes and costs. What will begin with financial incentives for meeting certain target metrics in the early years, will evolve toward financial withholds for exceeding utilization targets and shared savings for achieving reductions in the total cost of care.

As with all demonstrations, this will be an important opportunity to test new ways of delivering services that needs to be thoroughly evaluated. We will hold North Carolina accountable by tracking their progress and ensuring they meet reporting requirements throughout the pilot.

Additionally, North Carolina will conduct rapid cycle assessments (RCAs) that will provide timely information on service effectiveness, allowing the state to discontinue low-effectiveness services and redeploy resources to more valuable strategies. I am excited to follow this closely and to see the results, which will serve as an important learning opportunity for all states.

We are committed to collaborating with states like North Carolina, and the many others whom we've approved demonstrations for already, and I appreciate our continued partnerships.

While states have different ideas and approaches to serving the needs of their beneficiaries, we can all agree that one of our prominent goals should be to help individuals live healthier more complete lives by addressing the whole human need. We should keep exploring ways to achieve this goal so that we can identify best practices and replicate them.

Ultimately, the best ideas, attuned to the distinct needs of local communities, come from those communities – not from Washington, D.C. That's true too for North Carolina, and I look forward to continuing our work together so that state innovation, like what we've approved today, drives improvements in services and outcomes.

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JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

NC Medicaid Transformation
Section 1115
Demonstration Waiver

Mandy Cohen, Dave Richard and Jay Ludlam
Department of Health and Human Services

November 26, 2018

Attachment 3

Agenda

- Vision and background
- Summary of key provisions of approved waiver:
  - Behavioral Health Integration and Tailored Plans
  - Opioid Strategy
  - Healthy Opportunities Pilots
- Additional Demonstration Details: Budget Neutrality and Evaluation
- Next steps:
  - Milestones for implementing transformation
  - Next steps for completing pending waiver components
  - Next steps for RFP award process
- Plan for submitting legislative changes needed prior to implementation
- Anticipated changes to 1915(b) and (c) waivers as a result of 1115 waiver

Medicaid Transformation: Vision

"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both medical and non-medical drivers of health."

Medicaid Transformation: Background

- The North Carolina Department of Health and Human Services (DHHS) has collaborated extensively with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates and other stakeholders to shape the program, and is committed to:
  - Creating an innovative, integrated and well-coordinated system of care
  - Supporting clinicians and beneficiaries during and after the transition
  - Promoting access to care
  - Promoting quality and value
  - Ensuring a successful managed care program

1115 Waiver Approval is Key Milestone

Receiving waiver approval is a key milestone in the effort to pursue North Carolina's broader Medicaid transformation goals

- DHHS recently received approval from the federal Centers for Medicare and Medicaid Services (CMS) for the State's 1115 Demonstration Waiver, which:
  - Provides North Carolina with authority to implement its Medicaid managed care program
  - Allows the State to incorporate innovative features into its new managed care delivery system that require federal waiver authority

Summary of Key Provisions of the Approved Waiver

1. Behavioral Health Integration and Tailored Plans
2. Opioid Strategy
3. Healthy Opportunities Pilots

1 Behavioral Health Integration and Tailored Plans

Description

North Carolina will integrate physical, behavioral and pharmacy benefits into both Standard Plans and Tailored Plans. Tailored plans will provide:

- Integrated physical, behavioral and pharmacy benefits to people with a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/ developmental disability or a traumatic brain injury
- A specific, more intensive set of behavioral health benefits that are not available in Standard Plans (as approved in the 1115 demonstration waiver)*
- Care management through a specialized behavioral health home model designed to meet beneficiaries' complex needs

Impact

Supports the State's goal to provide managed care beneficiaries seamless access to coordinated care and benefits through one managed care plan and to ensure those with serious behavioral health conditions get the care they need.

**Individuals eligible for Tailored Plans may elect to enroll in either Standard Plans or Tailored Plans, but will only have access to the more intensive behavioral health benefits in the Tailored Plans*

2 Opioid Strategy

Description

As part of the State's comprehensive strategy to address the opioid crisis, North Carolina will (1) increase access to inpatient and residential substance use disorder treatment by beginning to reimburse for substance use disorder services provided in institutions of mental disease (IMD), and (2) expand the substance use disorder service array to ensure the State provides the full continuum of services.

Impact

Strengthens the State's approach to improving care quality and outcomes for patients with substance use disorders, including by decreasing the long-term use of opioids and increasing the use of medication-assisted treatment (MAT) and other opioid treatment services.

3 Healthy Opportunities Pilots

Description

- North Carolina will implement within its Medicaid managed care program a groundbreaking pilot program in two to four regions of North Carolina to improve health and reduce health care costs.
- Working with managed care plans, these pilots will identify cost-effective, evidence-based strategies focused on addressing Medicaid enrollees' needs in five priority areas that drive health outcomes and costs: housing, food, transportation, employment and interpersonal safety.
- The State will increasingly link pilot payments to improvements in health outcomes and efficiency.
- North Carolina will use a rigorous rapid-cycle assessment strategy to evaluate pilot performance and tailor service offerings to those with demonstrated efficacy.

Impact

Up to 80% of a person's health is determined through social and environmental factors and the behaviors that are influenced by them. The Healthy Opportunities pilots leverage federal funding to ensure the most efficient and effective managed care program and to strengthen work already underway in communities to improve population health.

CMS Administrator Seema Verma on NC Pilots

"As we seek to create a health care system that truly rewards value, we must consider the impact that factors beyond medical care have in driving up health costs. That's why many states are beginning to think about ways to better address the root cause of chronic illness. As part of this demonstration, North Carolina will implement a groundbreaking program in select regions to pilot evidence-based interventions addressing issues like housing instability, transportation insecurity, food security, interpersonal violence and toxic stress."

Budget Neutrality

- CMS policy requires that 1115 waivers be budget neutral to the federal government, meaning that the State not spend more than the State projected to spend without the waiver.
- In granting the waiver, CMS has agreed that North Carolina's waiver will not increase Medicaid spending for the populations and services authorized through the waiver.

Evaluation Strategy

North Carolina will conduct a rigorous evaluation of the waiver to ensure the State is achieving its goals.

Evaluation Strategy

- Consistent with standard waiver practice, North Carolina will arrange for a third-party entity to conduct an independent evaluation of the waiver.
- The State will submit to CMS two publicly available reports prepared by the independent evaluator: one in the middle of the demonstration and one after the five-year demonstration period ends (2019-2024).

Milestones for Implementing Transformation

- PHP Award and Enrollment Broker Readiness (February - June 2019)
- Open Enrollment (June – October 2019 / September 2019 – January 2020): when beneficiaries pick PHPs
  - "Soft launch" (June 2019/September 2019): Enrollment packages sent to beneficiaries; Enrollment Broker website and call center educating beneficiaries & enrolling into PHPs
  - Open Enrollment (July 2019/October 2019): formal period which will last ~60 days
  - PHP readiness activities begin and continue after go-live
- Transition of Care (October 2019/January 2020): transmitting data to the PHPs
  - Auto Assignment to PHPs: Beneficiaries who don't actively choose a PHP will be assigned a PHP based on where they live, historic PCP relationship, etc
  - Transition of Care: Information which will assist AMHs and PHP care management and facilitate smooth transition of beneficiary care will be sent to PHPs (e.g., Prior Auths, historic claims)
- PHP go-live and post go-live (November 2019/February 2020)
  - After go-live PHP members have 90 days to change health plans
  - Continued monitoring of PHP and program performance

Next Steps for Completing Pending Waiver Components

CMS and North Carolina agreed to finalize a first set of activities under the approved 1115 waiver authority while continuing to negotiate pending requests over the upcoming months.

Pended Items

Uncompensated Care Pool for Tribal Providers

- North Carolina's waiver application included a request for expenditure authority for an uncompensated care pool to address the high burden of uncompensated care borne by the Cherokee Indian Hospital Authority.

Workforce

- North Carolina proposed to invest in building its Medicaid provider network through an Innovation Workforce Fund. The Fund would support loan repayment and recruitment bonuses for critical Medicaid provider types targeted to fill identified gaps in the Medicaid provider network.

Behavioral Health Home Capacity Building Funds

- North Carolina is working with CMS to secure funding that will support upfront investment in the development of a strong health home care management model to ensure at launch the health homes can meet the needs of people with intellectual/developmental disabilities or significant behavioral health needs.

Next Steps in the RFP Award Process

- PHP Request for Proposal Responses were submitted on Friday, October 19.
- Evaluation process:
  - DHHS will first review offers to determine that they are in the proper form and include all required documents.
  - The Evaluation Committee will then screen the offers to determine if the minimum qualifications have been met.
  - The Evaluation Committee will evaluate proposals meeting the minimum qualifications and develop consensus ratings, ultimately developing an award selection that is aligned with state law, and will provide supporting documentation for their selection.
  - DHHS will submit the contracts to the federal Centers for Medicare & Medicaid Services for its approval.
- Award contracts in February 2019.

Legislative Changes to Launch Managed Care

- Chapter 105: PHP Premium Tax
- Chapter 108A: Hospital Assessment and Supplemental Payments
- Chapter 122C: Tailored Plans
- Other Technical Corrections

Anticipated changes to 1915(b) and (c) Waivers

- Technical amendments to (b) waiver for launch of Standard Plans
  - Amend covered populations
  - Update Capitation Rate
  - Update Cost Projections
- 1915 (c) waivers run concurrent with 1115

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

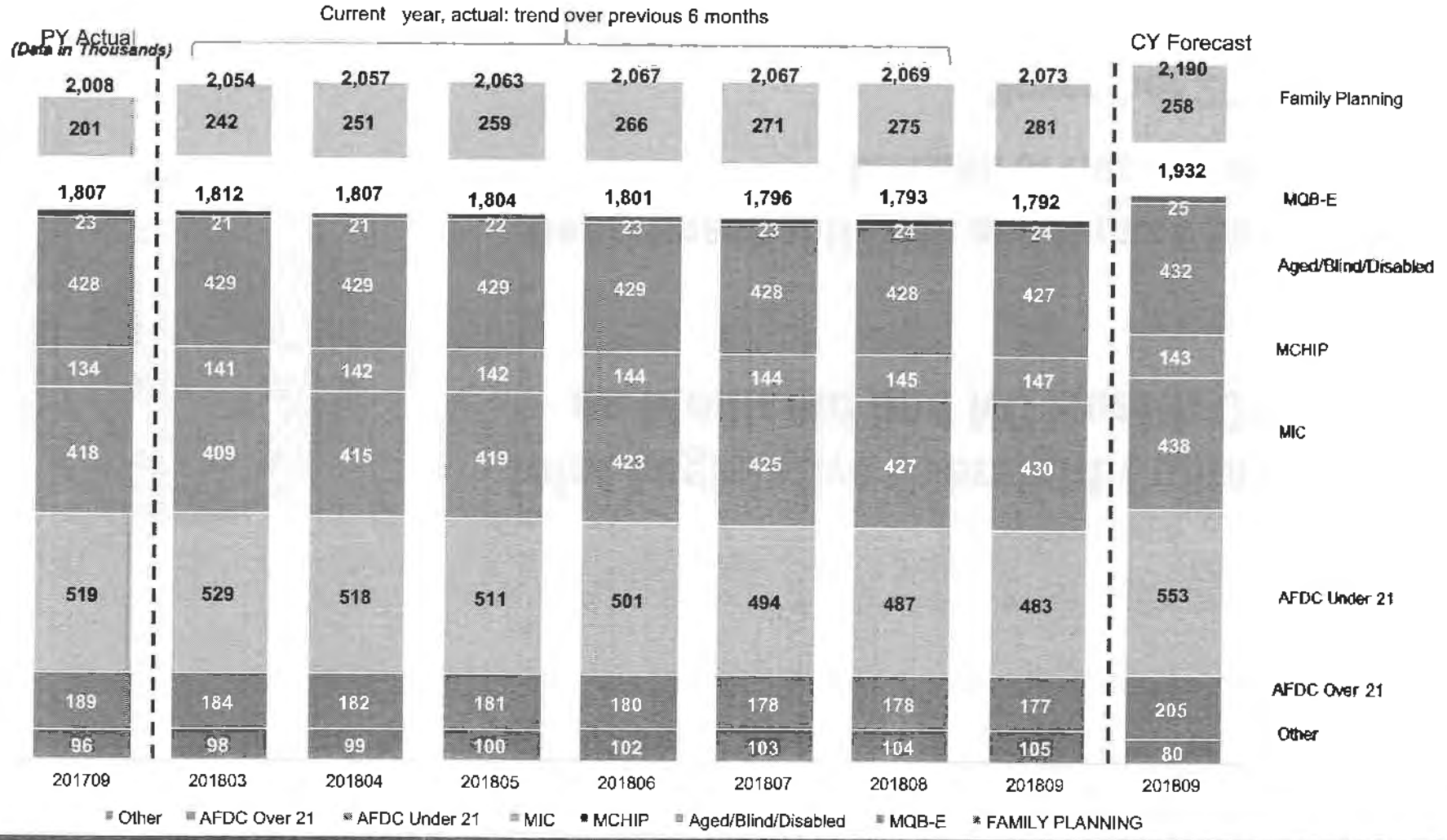
Department of Health and Human Services
Division of Health Benefits

November 26, 2018

Attachment 4

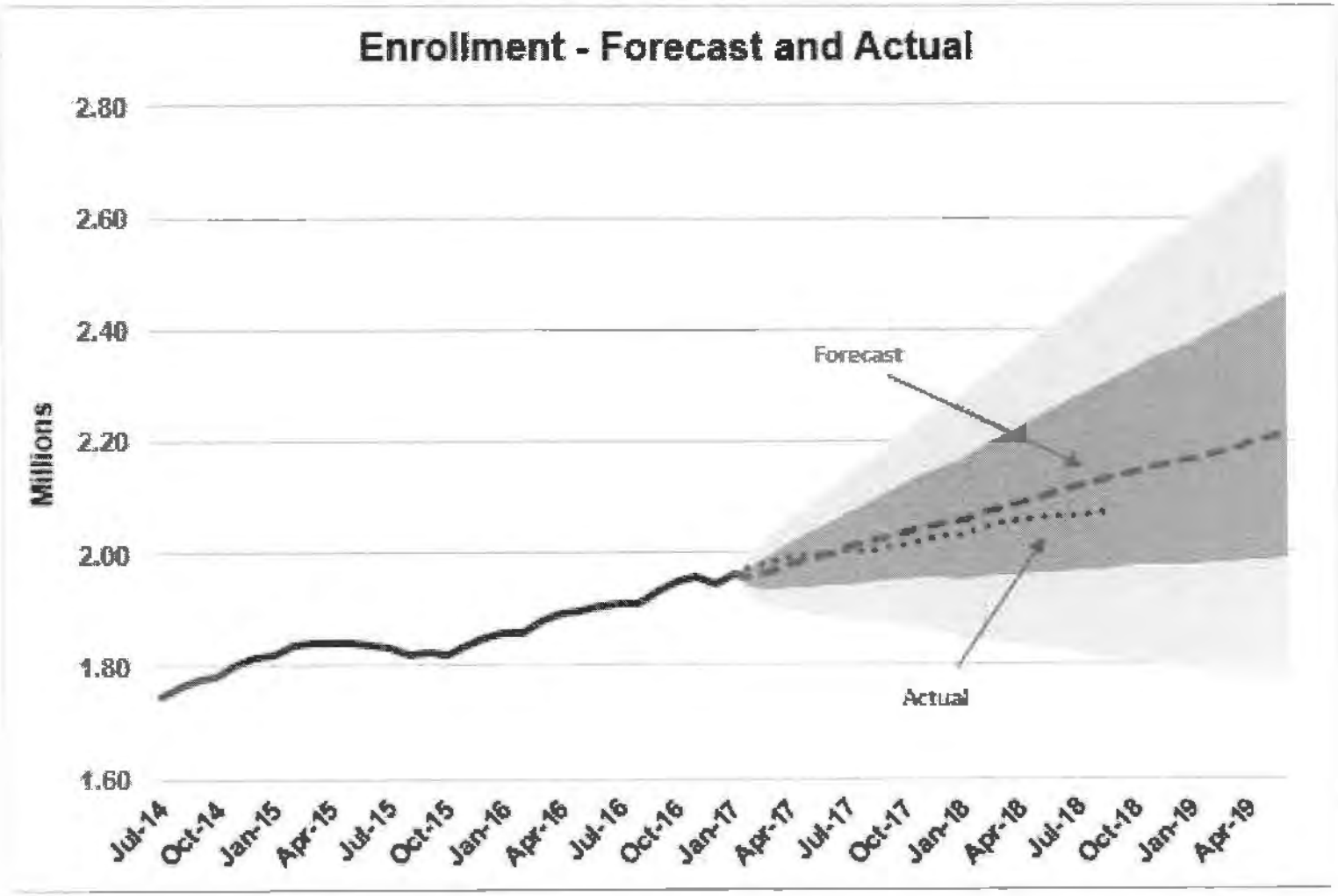
Medicaid Enrollment by Program Aid Category

September 2018 enrollment at 2.073M is 3.2% higher than one year prior at 2.008M on September 2017



Medicaid Enrollment – Forecast vs. Actual

Medicaid enrollment has tracked roughly in line with DMA's expectations to date.



JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid and NC Health Choice Financial Update

Dave Richard and Roger Barnes
Department of Health and Human Services

November 26, 2018

Attachment 5

Medicaid SFY19 Actuals vs. Budget

Through September 2018, Medicaid's use of appropriations was $240.3M or 21.9% less than budgeted for this point in the year.

MEDICAID SUMMARY at 9/30/2018 ($ millions)				
	SFY2019B YTD	SFY2019 YTD	VARIANCE $	%
Expenditures	$4,043.2	$3,953.6	($89.6)	-2.2%
Federal Revenues	$2,478.0	$2,538.3	$60.3	2.4%
Other Revenues	$469.7	$560.2	$90.5	19.3%
State Appropriations	**$1,095.4**	**$855.1**	**($240.3)**	**-21.9%**
			#	%
Avg. Enrollment (*millions*)	**2.085**	**2.070**	**(0.015)**	**-0.7%**

Remarks to Medicaid Oversight Committee:

1. PQCNC history
    a. 15 statewide projects since 2009
    b. Working currently in 65 hospitals
    c. Hospitals voluntarily participate in PQCNC initiatives
    d. Make North Carolina the best place to give birth and be born

2. Current AIM leadership in NC
    a. Team includes NC Ob GYN, NC ACOG, NCHA, NC AWHONN, DPH, BCBS, DMA
    b. All support PQCNC's request to have access to this data

3. Why AIM important for state QI
    a. Clear national and state OB/maternal provider support
    b. Light on data
    c. State level hospital discharge abstract data
    d. 5evere Maternal Morbidity indicators (ACOG and CDC endorsed)
    e. Multiple states: 22...we are one of 2 with no data access

4. Why State Level Data Critical
    a. Already collected
    b. Flow to PQCNC for reporting to AIM...works this way in 20 other states
    c. Data reported back to hospitals (see individual data) from AIM benchmarked against like facilities nationally and the state
    d. Never public reporting

5. In 1995 the Medical Care Data Act addressed the collection and availability of such data. http://www.ncleg.net/EnactedLegislation/Statutes/pdf/ByArticle/Chapter_131E/Article_11A.pdf

    The intent of this legislation seems well described in the stated purpose of Article 11:

    "The purposes of this Article are as follows:

    a) To ensure that there is an information base containing medical care data from throughout the State that can be used to improve the appropriate ond efficient use of medical care services and maintain an acceptable quality of health care services in this State.
    b) To ensure that the necessary medical care data is available to university researchers, State public policymakers, and all other interested persons to improve the decision-making process regarding access, identified needs, patterns of medical care, charges, and use of appropriate medical care services.
    c) To ensure that a data processor receiving data under this Article protects patient confidentiality.

These purposes are to be accomplished by requiring that all hospitals and freestanding ambulatory surgicol facilities submit information necessary for a review and comparison of charges, utilization patterns, and quality of medical services to a data processor that maintains a statewide database of medical care data and that makes medical care data available to interested persons, including medical care providers, third-party payors, medical care consumers, ond health care planners. (1995, c. 517, s. 39(b).)"

6. PQCNC funding over years...NCGA, Medicaid Transformation Grant, DMA last two years
    a) PQCNC is a state agent
    b) We are committed to improving care at the state level
    c) Sole purpose is to support hospitals in improving their maternal-newborn care

7. State Center for Health Statistics has the necessary data and if given permission could supply info needed by PQCNC for AIM reporting

8. This request for data access is not just for PQCNC...no doubt other state partners could benefit from access to this data as described in the Medical Care Data Act

Contact for Supporters

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Kate Menard, MD, MPH. Vice Chair for Obstetrics and Director of Maternal Fetal Medicine and Co-Director of the Center of Maternal and Infant Health at the University of North Carolina School of Medicine.