North Carolina Medicaid Reform and Transformation

HEALTH ACCESS COALITION — **BRIEF**

February 2016

INTRODUCTION

This brief will examine the content of the Medicaid Reform Bill, House Bill 372, that was passed on September 22, 2015. It also will highlight the potential implications and pitfalls of the legislation along with the North Carolina Justice Center's recommendations to ensure that Medicaid reform improves health outcomes and protects patients.

What Problem Does House Bill 372 Address?

Like many health care programs, North Carolina's Medicaid program is experiencing growth in spending and enrollment. To address the increased demand and cost, the General Assembly passed a Medicaid reform bill that aims to accomplish four goals:

1. **Ensure budget predictability through shared risk and accountability.**
2. **Ensure balanced quality, patient satisfaction, and financial measures.**
3. **Ensure efficient and cost-effective administrative systems and structures.**
4. **Ensure a sustainable delivery system.**

What Does House Bill 372 Say?

On September 23, 2015, the Medicaid Reform Bill or House Bill 372 was signed into law by Governor Pat McCrory. The most significant component of the bill is the transformation of the Medicaid payment model. North Carolina's Medicaid system will transition to a shared risk capitation payment model. This system attempts to improve care by moving away from the current fee-for-service payment model, which pays medical providers per visit and procedure. In contrast, in a capitated system, managed care entities receive one risk-adjusted payment per enrollee. In a shared risk system, providers are eligible to share in savings realized in service delivery and may be exposed to penalties for exceeding certain budget targets.

In addition to changing the payment model, HB 372 mandates new methods for administering and delivering Medicaid services. Medicaid reform in North Carolina will move towards a hybrid model that combines the use of outside insurers or managed care organizations (MCOs) and state-based provider led entities (PLEs). Currently, local management entities, referred to as MCOs or LMEs oversee payments for mental and behavioral health care. With reform, North Carolina will now join 39 other states that rely on MCOs for delivery of comprehensive Medicaid services. While MCOs and PLEs will help with Medicaid delivery, North Carolina, and more specifically the Department of Health and Human Services (DHHS), will be charged with oversight and administration of Medicaid. It is important to note that Medicaid beneficiaries covered by LME/MCOs for behavioral health will continue under the current system for at least four years after managed care companies begin overseeing physical health spending. The reform bill creates a new Division of Health Benefits (DIB) within DHHS to oversee the implementation of Medicaid transformation in addition to entering into contracts with the MCOs and PLEs. The General Assembly will continue to determine the criteria for Medicaid eligibility and will monitor Medicaid reform through a Joint Legislative Oversight Committee on Medicaid.

To implement reform, DIB will enter into three contracts with either MCOs or PLEs for statewide administration and/or delivery of Medicaid. DIB will also enter into up to ten regional contracts with PLEs to deliver health care services. DHHS has additional responsibilities such as writing the application for a Medicaid demonstration waiver or State Plan Amendment to authorize the reform plan and submitting the reform plan to the federal government for approval. DHHS will be responsible for designating Medicaid and NC Health Choice Providers as essential providers. These providers will be identified as essential providers if they are the only provider offering services that make health care accessible or if they already see a significant number of patients in an area. Other categories of essential providers are: federally qualified health centers, free clinics, local health departments, and rural health centers.

HB 372 also outlines the timeline for Medicaid reform in the state. The key date to note is that on June 1, 2016, DHHS is

responsible for submitting the Medicaid reform plan to the federal government for approval. However, the bill outlines that DHHS will report the reform plan to the Joint Legislative Oversight committee on Medicaid and NC Health Choice by March 1, 2016. Eighteen months after the reform plan gains approval from the federal government, DHHS will enter into contracts with MCOs and PLEs. The contract between DHHS and Community Care of North Carolina (CCNC) will be renegotiated by July 1, 2016. While the bill outlines the frequency of reports to various oversight committees and the General Assembly in addition to other benchmarks, the total time to implement reform is two years.

Unintended Outcomes

Given the accelerated timeline and the additional layers of complexity added to the Medicaid system, there are many risks that reform will not achieve the four goals outlined in HB 372. By dismantling the well-established and respected primary care case management system operated by CCNC and introducing outside insurers there is a danger that quality will suffer and that fewer physicians will choose to participate in Medicaid. These disruptions could cause more, not less, fragmentation in our health care delivery system.

We also know that without proper safeguards insurance companies may delay care to patients, slow payments to providers, or pull out of contracts early. Many major insurers have faced regulatory actions and fines for failing to make claims payments to providers in a timely fashion or establishing burdensome barriers to accessing care for patients. These harmful practices have led some states to rethink privatization and caused many regulators to levy hefty fines against Managed Care Organizations[1].

NCJC Recommendations

Patient Protection: As NC DHHS drafts the waiver, we urge them to include a detailed description of how Medicaid beneficiaries will be protected from being denied or delayed care. Further, language needs to be included to ensure that health care is accessible. Protocol for monitoring prior approval wait times, examining provider networks to ensure patients have adequate access, holding companies to their contract terms, establishing a complaint system to track problems, and adding employees to pursue fines and file lawsuits needs to be included. There should also be a formal advisory committee consisting of patients and patient advocates to provide input to DHHS about the implementation of managed care.

Close the Medicaid Coverage Gap: The reform bill ignores the fact that there are 500,000 people who could directly benefit from expanding health insurance coverage. We also know that extending coverage to more people would produce savings for state and local government and boost rural hospitals. Many states have capitalized on the opportunity to reform and expand at the same time as money from the federal government can help pay for reform. Many conservative states have gained approval for demonstration waivers that package reform and expansion in order to develop state-specific plans that include patient requirements like cost-sharing, wellness programs, and job training. Since 2014, six states (Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire) have sought comprehensive Medicaid demonstration waivers from the federal government[2]. All of these demonstrations included expansion and all of the waivers were approved.

We know that Medicaid expansion helps slow state Medicaid spending growth, which in turn helps achieve program sustainability and improve budget predictability. Despite Medicaid enrollment increasing by 18 percent[3], survey results shows that Medicaid expansion states only saw a 3.4 percent increase in state Medicaid spending growth compared to non-expansion states, including North Carolina, which experienced on average a 6.9 percent increase[4].

1. http://khn.org/news/jury-out-on-managed-care-of-medicaid/
2. http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/
3. http://www.npr.org/sections/health-shots/2015/10/15/448729327/states-that-declined-to-expand-medicaid-face-higher-costs?utm_source=twitter.com&utm_campaign=science&utm_medium=social&utm_term=nprnews
4. http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/