Proposal to Reform North Carolina's Medicaid Program

Report to

North Carolina General Assembly

Pursuant to

Session Law 2013-360, Section 12H.1

March 17, 2014

North Carolina Department of Health and Human Services

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

March 17, 2014

Speaker Thom Tillis
North Carolina House of Representatives
16 W. Jones Street, Room 2304
Raleigh, NC 27601-1096

Senate President Pro Tempore Phil Berger
North Carolina Senate
16 W. Jones Street, Room 2008
Raleigh, NC 27601-2808

Dear Speaker Tillis and President Pro Tempore Berger:

Section 12H.1 of Session Law 2013-360 requires the Department of Health and Human Services to submit a detailed plan for significant reforms to the State's Medicaid program by March 17, 2014. The Department is pleased to submit the attached plan to the General Assembly.

The Department's plan for Medicaid reform is realistic and achievable. It has been produced with extensive input from stakeholders across the state, and we believe it is the right plan for North Carolina.

This plan puts patients first, improves whole person care, increases budget predictability, and helps create a sustainable Medicaid program, all while building on what we have in North Carolina. In addition, the Department will apply strong benchmarks to monitor the progress of the reform in three critical areas: access, cost, and quality.

Together we are dealing with the hardest questions that we face as a society. We have an obligation – an obligation we have willingly accepted as a state – to help those in need. And we must at the same time be good stewards of taxpayer resources. We believe this plan is responsive to both those obligations.

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We look forward to working with you on this critical issue. Please contact me if you have any questions about this plan for Medicaid reform.

Sincerely,

Aldona Wos, M.D.
Secretary

Attachment

cc: Governor Pat McCrory
Representative Justin Burr
Senator Ralph Hise
Representative Mark Hollo

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Executive Summary

Session Law 2013-360, Section 12H.1.(a) requires the Department of Health and Human Services to create a detailed plan for, but not implement, significant reforms to the Medicaid program that shall accomplish the following: (1) Create a predictable and sustainable Medicaid program for North Carolina taxpayers; (2) Increase administrative ease and efficiency for North Carolina Medicaid providers; and (3) Provide care for the whole person by uniting physical and behavioral health care.

Section 12H.1.(b) of the same law set forth specifications for the reform proposal. This report fulfills the requirements of that section.

This proposal was developed with the benefit of extensive input from Medicaid stakeholders from across the state and under the guidance of the Medicaid Reform Advisory Group that was created pursuant to Section 12H.1.(e) of the law.

The reform plan's design consists of three components. The first pertains to the delivery of **physical health care**. Reform will introduce a provider-led accountable care model that will improve efficiency and quality without placing undue administrative burdens on the provider community. For the first time, providers in the physical health domain will share with the State in gains and losses, which not only promotes value but adds a degree of budget predictability.

Payment of these accountable care organizations (ACOs) will be based on fee-for-service with the potential to pilot payment reforms such as episode bundles. ACOs are assigned an annual budget based on risk-adjusted claims history, and claims are debited against the budget. ACOs share in any savings or losses realized, with the outcome tied to ACOs' performance on quality measures. Over time, ACOs will be asked to assume progressively greater degrees of risk.

The second component covers **services for mental health, substance abuse, and intellectual and developmental disabilities**. The proposed reforms build upon progress that North Carolina has already made in this area and ensure both stability and increased statewide standardization for providers. North Carolina's ten Local Management Entity Managed Care Organizations (LME-MCOs) will consolidate to four strong organizations and will undergo tighter contract performance monitoring while receiving added technical assistance.

DHHS is committed to re-evaluating the entire system as it relates to mental health, developmental disability and substance abuse (MHDDSA) services to ensure that improvements are meaningful and result in higher quality and more efficiency, regardless of funding source.

The third part addresses **long-term services and supports**, which is composed of services for individuals having functional limitations and chronic illnesses who need assistance with routine daily activities. The proposed reform brings a new unified and holistic approach to needs assessment, care planning and case management. There will also be a concerted long-range

planning effort to craft more comprehensive solutions that will meet the needs of the growing portion of the population that is aging and increasingly disabled.

MEDICAID REFORM RECOMMENDATIONS

PHYSICAL HEALTH

Recommendation 1: North Carolina Medicaid services for physical health will be coordinated through accountable care organizations (ACOs) that share savings and losses with the State and are responsible for quality.

Recommendation 2: ACOs' coverage of the population and financial accountability will rise progressively; DHHS will benchmark progress.

MENTAL HEALTH, INTELLECTUAL/DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Recommendation 3: Enhance the state's Medicaid mental health, substance abuse and intellectual/developmental disability service delivery system.

LONG-TERM SERVICES & SUPPORTS (LTSS)

Recommendation 4: Streamline and strengthen coordination of care for long-term services and supports.

Recommendation 5: Shape the ultimate direction of LTSS.

Whole-person care is an essential feature of the Medicaid reform proposal. Currently, physical health care service delivery is structured in a fee-for-service system while behavioral health services are managed under a separate capitated system. The proposed model will begin to align financial incentives for more team-based approaches to whole-person care and will enable physical and behavioral health care providers to collaborate in new ways. Co-location of providers, tightly coordinating services and sharing risk for drug spending are all methods by which the ACOs and LME-MCOs will move toward whole-person care.

People who receive long-term services and supports will also benefit from this integration as primary care physicians who align with ACOs will have more resources to better manage the total care of those individuals.

The reforms build on what is working in North Carolina and on models showing promise in other states. The State must continually evaluate progress and the impact of this innovative approach. Benchmarks will be set on the key performance dimensions of **access**, **cost** and **quality**. DHHS will report periodically to the Governor and to the General Assembly on the progress toward realization of goals. If goals are not met, DHHS will make needed changes that are within its authority, or it will propose course corrections that require new legislative authorization.

The Department engaged the services of independent consultants to estimate the cost impact of proposed reforms. They produced a five-year forecast using a start date of July 2015. The effects of reform are expected to accumulate over time. After a start-up year in which an estimated $8 million of combined federal and State dollars would be expended, overall Medicaid savings in Year 1 are estimated at $15 million. Year 5 savings are estimated to be $329 million. Total Medicaid savings of just under $1 billion are projected across Years 1-5, and a State share savings of approximately $325 million.

ESTIMATED SAVINGS DUE TO MEDICAID REFORM
($ Millions)

Program Area	2015-16	2016-17	2017-18	2018-19	2019-20	5-Year Total
MEDICAID OVERALL						
Physical Health (ACO)	20	75	136	197	209	637
MHDDSA (LME-MCO)	0	51	63	76	81	271
LTSS	-5	4	14	26	39	79
TOTAL	**15**	**130**	**213**	**299**	**329**	**987**
STATE APPROPRIATIONS						
Physical Health (ACO)	6	25	45	66	70	212
MHDDSA (LME-MCO)	0	17	21	26	27	92
LTSS	-3	0	4	8	13	22
TOTAL	**3**	**42**	**70**	**100**	**110**	**326**

The Department believes these reforms are realistic and will have lasting benefit for North Carolina's Medicaid beneficiaries, health care providers and taxpayers. The entire team responsible for leading and administering the Medicaid program looks forward to working with the General Assembly on implementation.

I. The Importance of Reform for North Carolina's Medicaid Program; Principles and Processes

A. Case for Reform

North Carolina's Medicaid program is the nation's tenth largest. Of the state's nearly 10 million residents, approximately 2.3 million received Medicaid coverage for at least part of 2013. The state's average Medicaid enrollment at any one time is approximately 1.8 million. Total 2013 expenditures were $13 billion, roughly double the amount expended in 2003. On a per capita basis, North Carolina's Medicaid program spends 14 percent above the U.S. average.[1] However appraised, Medicaid in North Carolina is no longer affordable in light of the state's fiscal outlook and other pressing priorities for state funds such as education.

Even though the rate of Medicaid per capita cost growth has slowed somewhat in the last few years, North Carolina's program is not financially sustainable. Much of the flattening in the cost trend is attributable to provider payment rate cuts imposed by the General Assembly, to demographic shifts, and to broad declines in health care consumption nationwide associated with the recession that began in 2008. These cost suppressors are unlikely to continue.

What is more, while North Carolina is rightly proud of some aspects of Medicaid program performance, such as access to primary care, in general North Carolina's Medicaid beneficiaries could receive better quality of care and improvements in health status for the level of public investment being made. Further, the State and taxpayers continue to pay for care that is based upon a pure fee-for-service model that does not reward efficiency or healthy outcomes.

North Carolina today has the opportunity to capture more value for its spending on Medicaid. Instead of paying for medical services on a purely fee-for-service basis that merely rewards volume and intensity of services, the State can redesign payment and care coordination models to reward advances in quality and patients' health outcomes.

By altering the current payment model to one that holds providers accountable for meeting budget targets and quality goals, North Carolina can ensure that Medicaid beneficiaries receive care that is more prevention-focused, integrated across physical, behavioral and long-term care domains, and well-coordinated as patients move among settings of care.

In designing and implementing reforms to Medicaid, North Carolina can benefit from the experiences of other states that have progressed further along this path. North Carolina will also take advantage of existing assets in the state that are functioning well and will take care not to destabilize the more fragile parts of the state's health care infrastructure.

[1] Menges Group analysis of CMS MSIS data; 2010 data, the latest year for which comparable figures are available. For comparability, state data have been adjusted for differences in mix of population across eligibility categories.

B. Legislative Charge

The General Assembly directed that reforms made to the Medicaid program shall:

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

In crafting a reform proposal, the Department of Health and Human Services (DHHS) addressed each of these directives.

The reform plan, through adoption of a value-based system in physical health, will produce greater predictability and stability for the Medicaid budget. The Division of Medical Assistance (DMA) is being restructured to enhance cost forecasting and quality measurement of health services delivery. Utilizing a provider-led accountable care model will ensure that no undue administrative burdens are placed on the provider community. The mental health, developmental disability and substance abuse (MHDDSA) system reforms ensure increased statewide standardization for providers. Aligning financial incentives for both behavioral health and physical health providers is an important step toward coordinating and integrating care for the whole person. Last, DHHS will act to ensure that care of beneficiaries requiring long-term services and supports (LTSS) is the most appropriate cost-effective care for each patient.

C. Principles Guiding Medicaid Reform

In addition to incorporating the legislative charge into the reform proposal, the Department is committed to ensuring that Medicaid reform efforts incorporate these principles:

- **Put patients first: Improve quality of care and health outcomes for Medicaid beneficiaries-and incorporate quality performance into the payment framework**
    - Incentivize providers to improve quality of care and health outcomes for Medicaid beneficiaries. To this end, primary care physicians are pivotal, in partnership with the patient, to medical home and care plan development functions. Patients will also be engaged in their own health improvement.
- **Secure budget predictability and cost savings for the Medicaid program-to this end, risk-based solutions are essential**
    - Produce the best achievable health outcomes for a reasonable amount of money, rewarding results rather than merely treatment activity.
    - Localize accountability for costs and outcomes to those providers and facilities rendering care to the beneficiary. At present, responsibility for healthy outcomes is diffuse, and risks for cost over-run is borne by the state and taxpayer. This model is not in the best interest of the state, taxpayer or beneficiary.

- **Build on what we have in North Carolina: Partner with North Carolina's health care community as the first line strategy for achieving the above – providers will lead the new organized systems of care, and LME-MCOs and CCNC will have key roles**
    - Effect change quickly and broadly but recognize that all participants need time to adapt their practices and technologies to tailor the reformed approach to local circumstances. Minimizing disruption of the system while changes are made is pivotal to the success of the reform plan and reflects one of the charges of the legislation: the reform shall not increase administrative burdens on the providers.

D. Medicaid Reform Planning Process

The reform effort, called the Partnership for a Healthy North Carolina, began with Governor McCrory's recognition that the current Medicaid system is not functioning well. The Governor's bold vision for reform, coupled with a mandate from the General Assembly, led to the Partnership.

In February 2013, the Department issued a Request for Information (RFI) inviting comments and ideas on Medicaid reform. More than 160 responses were from provider groups and associations, individual providers, families, insurance companies and other interested parties. The data gleaned from an analysis of the RFI responses yielded valuable insights about how the goals of reform may be met.

All along, DHHS has recognized that having input from all of North Carolina's Medicaid stakeholders is crucial to the success of reform. The model selected evolved over time as the Department listened to and engaged with stakeholders. The evolution of the model is a testament to the spirit of collaboration that has informed this process.

DHHS leadership and staff devoted hundreds of hours of meeting time to listening to stakeholders' ideas. Diverse groups such as beneficiary advocates, medical associations, behavioral health providers, health system executives from both urban and rural areas, county health departments, rural health experts and providers, representatives from teaching hospitals and medical schools, community health center directors, pharmacists, representatives from long-term care facilities and others have contributed valuable input to the development of this proposal. In addition, Department leaders have engaged publicly concerning Medicaid reform with standing committees whose purpose is to advise DMA.

DHHS Secretary Wos participated in a many of these encounters. Governor McCrory also hosted two meetings so that he could interact directly with health care leaders on this topic of vital importance to the state.

In concert with these activities, the General Assembly in S.L. 2013-360, Section 12H.1(e) called for the formation of the Medicaid Reform Advisory Group. This body is comprised of five members. Three members are citizens appointed by the Governor. Two are legislators appointed by their respective chamber leaders.

- Dennis Barry (Guilford), Advisory Group chair. CEO emeritus of Cone Health, a multihospital system serving the Piedmont region
- Peggy Terhune, Ph.D. (Randolph). Executive Director/CEO of Monarch, working with people with disabilities for over 35 years
- Richard Gilbert, MD, MBA (Mecklenburg). Former chief of staff for Carolina's Medical Center and chief for its Department of Anesthesiology for 20 years
- Representative Nelson Dollar (Wake County). Appointed by House of Representatives Speaker Thom Tillis
- Senator Louis Pate (Lenoir, Pitt, Wayne). Appointed by Senate President Pro-Tempore Phil Berger

The role of the Medicaid Reform Advisory Group is "to provide stakeholder input in a public forum and ensure the transparency of the process of developing the reform proposal."

The Advisory Group met three times: December 2013, January 2014 and February 2014. Each meeting was open to the public. Approximately 180-200 people attended each meeting and media were present. All presentations and materials were posted on the Department's website.[2]

At December's meeting, DHHS gave the Advisory Group an overview of the Medicaid program and a statement of the problem it faces. A DHHS consultant presented information on other states' efforts to reform Medicaid and described a possible vision for North Carolina reform to begin the dialogue.

January's meeting was a lengthy session devoted to hearing from stakeholders and other interested parties. Forty-eight people spoke and took questions from the Advisory Group. They ranged from individual Medicaid consumers to major health care industry groups.

In between meetings, members of the Advisory Group individually conveyed questions, comments and suggestions to the DHHS team coordinating the reform process.

At February's meeting, DHHS representatives presented elements of the reform proposal and elicited feedback from Advisory Group members. All of the Advisory Group members made positive comments about the plan as outlined. DHHS took note of any reservations or concerns they expressed and has addressed them in producing this report.

The Medicaid Reform Advisory Group members have also had an opportunity to preview this report and submit written comments in advance of publication. Their remarks appear in **Appendix 1**.

During the implementation phase of Medicaid reform, Secretary Wos remains committed to having DHHS engage with stakeholder groups for feedback and guidance. Historically, health care leaders in North Carolina have collaborated to achieve needed reforms and improvements to the system. This will continue.

[2] http://www.ncdhhs.gov/medicaidreform/

E. Existing Features of NC Medicaid to Be Preserved and Enhanced

North Carolina has developed a number of mechanisms that work to the advantage of Medicaid beneficiaries, providers and taxpayers. Most notable are the following:

- Community Care of North Carolina (CCNC) operates North Carolina Medicaid's primary care case management program. With 14 regional networks and a central guiding body, CCNC works with participating primary care providers to support better quality. CCNC delivers an array of care coordination and data analysis services to support providers' patient care efforts. CCNC also helped to establish patient-centered medical homes throughout North Carolina. CCNC does not have a role as intermediary in Medicaid health cost transactions.

- Ten regional "local management entity-managed care organizations" (LME-MCOs) are contracted to organize, manage and pay for behavioral health care and services for the intellectually and/or developmentally disabled (I/DD) for most Medicaid beneficiaries. The LME-MCOs receive a fixed capitation from the State for each enrollee and bear the risk for costs of mental health, I/DD and substance abuse services incurred by enrollees in their respective catchment areas.

- North Carolina has secured programmatic waivers from the federal government intended to reorient Medicaid resources to more productive purposes. For example, one waiver program substitutes home- and community-based services for institutional care for long-term care patients who will benefit from the alternative service configuration.

- Hospitals and other health care providers partner with the Medicaid program, contributing both non-cash and cash support to help maximize the impact of state funds by ensuring a full level of federal government investment.

The reform plan seeks to incorporate these well-established assets – and to strengthen them – in the next generation of Medicaid in North Carolina.

F. Rationale for Design Selection

The Governor's and the General Assembly's shared vision of a reformed Medicaid program for North Carolina has remained consistent from the outset. Patient-centeredness, cost predictability and sustainability, and whole-person care are the goals that have driven the reform planning process.

DHHS has explored many alternative approaches to Medicaid reform. This effort entailed researching other states' approaches to enhancing value in their Medicaid programs, hearing from many organizations that offer proprietary solutions to aspects of the Medicaid management challenge, and, as already noted, listening extensively to stakeholders from across the state.

Types of reforms that DHHS considered range from making modest adjustments to small parts of the Medicaid program to outsourcing Medicaid management for whole sub-populations to private sector companies that would accept responsibility for quality performance and full risk for per capita cost outcomes.

DHHS has chosen a realistic course that will fulfill the aims of reform in a manner that suits North Carolina. This pragmatic course will materially broaden accountability for Medicaid program performance to an array of in-state stakeholders. Yet it will avoid the undue disruption that could result from a radical shift of responsibilities and an abrupt transition to new modes of managing and financing Medicaid services.

G. Benchmarking Performance

The proposed model builds on what is working in North Carolina and what is showing promise in other states. Because it is an innovative solution, the State must continually evaluate the progress and impact of Medicaid reforms. DHHS will report periodically to the Governor and to the General Assembly on the progress toward realization of goals. If defined goals are not met, DHHS will make needed changes that are within its authority or it will propose course corrections that require new legislative authorization.

Dimensions of performance to be measured include **access**, **cost** and **quality**. There will be many ways of evaluating performance on these dimensions, but just a small handful of core measures will be used as sentinels of overall program performance so as to give clarity on the main goals.

- **Access** – The core access measure will be the extent to which Medicaid beneficiaries become associated with ACOs. In Year 1, DHHS expects 40 percent of Medicaid beneficiaries who are deemed eligible for ACO assignment to be linked to ACOs. In Year 2 the goal will be 60 percent and in Year 3 the goal will be 80 percent. In Year 4 and beyond the goal will be 90 percent. For all years, the distribution of ACO assignment should span all applicable Medicaid eligibility categories in equal proportions.

- **Cost** – The core cost measure will be the percentage reduction in the Medicaid cost trend. Specifically, by the second year of implementation (expected to be SFY2016-17) reform should diminish the rate of growth in Medicaid physical health costs by two-fifths.[3] That is to say, if the projected cost growth trend is 5 percent, the growth rate after reform is implemented should be 3 percent.

- **Quality** – The core quality measure will be the fraction of ACOs that achieve quality scores sufficient to make them eligible to receive increasingly higher shares of any savings they may produce. DHHS will devise a matrix of target quality scores, by year of implementation, and the population-weighted percentage of ACOs that must meet them.

[3] The specific cost measure is per capita physical health care claims costs, net of any shared gain/loss distributions, adjusted for any changes in beneficiary population demographics and changes in covered benefits.

The above benchmarks all pertain to physical health care services, which is the part of Medicaid that is due to undergo the most significant change in the near term. The LME-MCOs are already subject to a variety of performance measures and they will continue to be monitored and evaluated accordingly. Most significant will be to complete the consolidations on schedule.

The changes proposed in the near term for long-term services and supports do not lend themselves to a specific measurement regime. In completing the strategic plan for LTSS, DHHS will define appropriate benchmarks and an evaluation approach.

II. Reform Plan Elements

The reform plan's design consists of three components. The first pertains to the delivery of physical health care, which consists of preventive, acute and therapeutic care for conditions affecting the body. The second component covers services for mental health, substance abuse, and intellectual and developmental disabilities. The third is long-term services and supports, which is composed of services for individuals with functional limitations and chronic illnesses who need assistance with routine daily activities, though not including those with primarily intellectual and developmental disabilities.

These three service delivery components comprise the framework around which the Medicaid reform proposal is designed. A fourth part of this section addresses considerations for oral health and outpatient prescription drugs.

A. Introducing Accountable Care for Physical Health Services

DHHS intends to work with accountable care organizations (ACOs) for the coordination of physical health services for Medicaid beneficiaries.

DHHS's aim in working with ACOs is to engage organized groups of health care providers in improving health care quality and cost efficiency within a payment arrangement that builds upon fee-for-service but that shifts incentives away from volume toward value. A key building block for ACOs that already exists in North Carolina is the network of patient-centered primary care medical homes serving Medicaid beneficiaries. ACOs go beyond medical homes, though, by linking primary care providers with specialty care practitioners and hospitals to address the full continuum of care and by adding financial incentives for meeting quality and cost-savings goals.

ACOs are a relatively new phenomenon, having first been proposed in the academic literature in 2007.[4] DHHS agrees with the vision of effective ACOs articulated by the National Committee on Quality Assurance (NCQA), a key health care standard-setting and accrediting body:

> "Today, most health care is organized around a site of care and the services provided there. ACOs should transcend the boundaries of particular sites to care for populations over time and across settings. The key tools needed for this approach will be excellent analysis of patterns of care to identify high-risk populations and opportunities for improvement and targeted resources devoted to care management. These will help drive out waste and unnecessary care by identifying and addressing unwarranted variation. Successful organizations will have committed leaders who set aligned goals and incentives across the diverse providers who care for patients."[5]

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[4] Fisher, *et al*, "Creating Accountable Care Organizations," *Health Affairs*, January 2007, vol. 26, no. 1, pp.44-57. http://content.healthaffairs.org/content/26/1/w44.long

[5] NCQA Accreditation of Accountable Care Organizations," 2013, at http://www.ncqa.org/Portals/0/ACO%20Press%20Conference/ACO%20White%20Paper%20Feb.%202013.pdf

The federal Affordable Care Act (ACA) formally recognizes ACOs and includes them in the Medicare fee-for-service system by way of the Medicare Shared Savings Program (MSSP).[6] DHHS intends to model its use of ACOs on MSSP, though with many adaptations to suit North Carolina's Medicaid program and its health care community.

Presuming that the General Assembly enacts enabling legislation in its 2014 session and CMS does not require North Carolina to seek special waivers that would take a long time to obtain, DHHS intends to solicit applications from ACOs by late 2014 and to make ACOs effective at the beginning of the 2015-16 fiscal year in July 2015.

The framework is organized into the following sections:

1. Eligible Organizations
2. Key ACO Functions
3. Provider Participation in ACOs
4. Beneficiary Assignment to ACOs
5. Data Sharing
6. Value-Based Payment Provisions
7. Quality Measurement
8. Relationships Between ACOs and Other Entities in Medicaid
9. Procurement and Contracting

1. Eligible Organizations

a. Eligible Providers

DHHS defines an ACO as a legal entity recognized by the State and composed of certified Medicaid providers. These participants work together to coordinate care for a defined population of Medicaid beneficiaries and have an established mechanism of shared governance that assures appropriate control over the ACO's decision making.

ACOs may be constituted by any of the following: (1) professionals (i.e. physicians and other clinicians) in group practice arrangements; (2) joint venture arrangements between hospitals and professionals; (3) networks of individual professional practices; and (4) hospitals employing professionals. Safety net organizations such as critical access hospitals (CAH), federally qualified health centers (FQHC) and rural health clinics (RHC) may participate in, or form their own, ACOs.

Other health care providers – for example, home health agencies or diagnostic centers – may participate in ACOs by partnering with eligible provider groups.

b. Legal Entities

An ACO that wishes to participate as a North Carolina Medicaid ACO must be a legal entity such as a corporation, partnership, limited liability company, or foundation recognized by the

[6] See the MSSP ACO rule (42 CFR Part 425) at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf

State. It must be capable of: receiving and distributing shared savings; repaying shared losses; establishing, reporting and ensuring that all participating providers comply with program requirements, including quality performance standards; and performing other requisite ACO functions as set forth in statute and regulation.

Existing entities that meet the legal definition can participate without forming a new legal entity. For instance, a hospital employing professionals is eligible and would not have to form a new entity. However, an ACO created by otherwise separate participants – such as two medical groups and a hospital – must form a new entity distinct from its participants.

An ACO legal entity may have as a minority owner or member a non-provider such as a management services organization or a health insurance company or health plan, as long as health care providers control the governance of the ACO. ACO sponsors may look to such non-provider entities to furnish capital or know-how or technology to administer the ACO.

c. Governance Requirements

An ACO must have a governing body – such as a board of directors – with adequate power to execute the statutory functions of the ACO. The governing body is to be majority comprised of provider representatives. Any non-provider involved in ACO governance cannot have reserved powers. The governing body must be vested with broad responsibility for the ACO's administrative, fiduciary and clinical operations. An ACO should also have community representation on the governing body.

2. Key ACO Functions

a. Leadership and Management

An ACO must have a leadership and management structure that includes clinical and administrative systems. The ACO must meet the following criteria:

- Operations are managed by an executive who must certify that all ACO participants are willing to be accountable to, and report on, quality and cost of care for Medicaid beneficiaries assigned to the ACO. The executive must be subject to appointment and removal by the governing body. The ACO's leadership team must have demonstrated ability to effectively direct clinical practice and improve processes and outcomes.
- Clinical management and oversight is led by a senior-level medical director who is a board-certified physician licensed and residing in North Carolina.
- Providers participating in the ACO must make a meaningful commitment – a financial or in-kind (labor) investment – to the ACO's clinical integration program.

An ACO wishing to propose an alternate structure must demonstrate that it can meet the same goals.

As part of its application to DMA, the ACO must describe how it will establish and maintain an ongoing process for quality assurance and quality improvement, overseen by an appropriately qualified health care professional.

b. Processes Pertaining to Beneficiary Health Care Management

In its application, the ACO must document how it plans to: (1) promote evidence-based medicine; (2) promote beneficiary engagement; (3) report internally on quality and cost metrics; and (4) coordinate care, including that of specified LTSS beneficiaries. DMA will monitor ACOs' approaches on these matters to ensure that they do not impede the ability of beneficiaries to seek care outside the ACO's network.

The ACO must also exhibit an emphasis on patient centeredness. This includes developing individualized care plans – based on the person's unique needs – that are regularly evaluated and updated. Care should also be integrated with community resources that beneficiaries require to maintain well-being. Beneficiaries, along with family members or caregivers, should be encouraged to be partners in care and should have access to their medical information to make informed choices about their care. The ACO should support transitions of care among providers in the ACO as well as between ACO providers and non-ACO providers and, where appropriate and feasible, providers of services not covered by Medicaid.

ACOs must also contribute to fulfilling the aim of whole-person care. ACOs are well positioned to provide comprehensive primary care services, including coordination with dental services, attention to social and environmental needs, and mental health and substance abuse screening, brief intervention, brief treatment, and referral when specialty care is needed. They will attain better patient outcomes, and presumably savings, by paying attention to the behavioral health and lifestyle needs of their population.

Including behavioral health professionals in the primary care team can yield efficiencies in physician productivity; increase follow-through with specialty MH and SA referrals; improve coordination with specialty MH, DD and SA services; divert and prevent some individuals from needing specialty behavioral care though screening and early intervention; and improve patient compliance and outcomes through disease self-management and healthy lifestyle behaviors.

Given the potential cost and quality benefits of integration, ACOs should choose to invest in integration up front. They could realize savings and meet quality goals because of that tightly integrated team-based care, with the patient at the center.

Specific expectations of ACOs pertaining to patient-centeredness, to be described in the application, include the following:

- A beneficiary survey to evaluate patient experience and inform care process improvement. This survey will also be used as part of the ACO performance assessment. DMA will require all ACOs to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

- Measures to ensure that the ACO governing body receives, evaluates and acts upon substantive input from ACO-assigned Medicaid beneficiaries.
- A process for evaluating the health care needs of the assigned Medicaid population, including considerations for ethnic and cultural diversity.
- Systems to identify high-risk individuals across the spectrum of chronic conditions and processes to develop individualized care plans.
- Mechanisms for care coordination, such as through care coordinators or enabling technology.
- Processes for communicating clinical information to beneficiaries in an understandable way. Such processes should allow for beneficiary engagement and shared decision-making.
- A process to allow beneficiaries (or parent or guardian) access to their medical records.
- Systematic means of measuring clinical and service performance by professional clinicians in the ACO; use of the results to improve care and service over time.

c. Program Integrity

Each ACO must have a compliance plan that addresses how the ACO will meet applicable legal requirements. The plan must include: (1) a lead compliance official who reports to the governing body; (2) mechanisms for identifying compliance problems; (3) a way for ACO providers, employees or contractors to report suspected problems; (5) compliance training; and (6) a requirement to report suspected violations to the appropriate law enforcement agency. The ACO must also have a conflict of interest policy.

DHHS recommends that the ACO coordinate its compliance program with those of its participating provider groups.

DMA will screen ACOs and participating providers for any history of program integrity concerns.

3. Provider Participation in ACOs

a. Voluntary Provider Participation

Upon initiation of the program in July 2015, health care providers will not be required to participate in ACOs in order to be Medicaid participating providers. Yet it is the State's goal that all, or nearly all, eligible Medicaid beneficiaries will be cared for through ACOs. Therefore, over spans of time, if DMA finds that too few Medicaid beneficiaries are assigned to ACOs due to lack of capacity and/or geographic breadth, DHHS will be authorized to take measures to ensure that ACOs are available to the preponderance of beneficiaries. Such measures shall be set forth in statute and may include reducing fees paid to non-ACO-participating providers.

These are the annual goals DHHS has established for ACO coverage of the ACO-eligible Medicaid population:

Time	ACO Coverage
End of Year 1	40 percent
End of Year 2	60 percent
End of Year 3	80 percent
Later Years	90 percent

Not only is the fraction of the population covered to be considered, the distribution of the population by eligibility categories and other factors reflective of the diversity of the Medicaid population will be taken into account as well.

b. Primary Care Providers

Each ACO shall include a number and distribution of primary care providers (PCPs) capable of serving a sizeable and diverse Medicaid population that includes infants and young children, adolescents, adults and aged individuals, many of whom are physically or developmentally disabled.

ACOs may take advantage of the Medicaid PCP arrangements already in place thanks to the primary care medical home program administered by Community Care of North Carolina (CCNC) and its 14 regional networks. ACOs may choose to contract with one or more CCNC networks to obtain participating PCPs as long as the agreements entered into appropriately bind the ACO and individual primary care practices to the terms that the State requires of ACOs and participating providers. ACOs are not, though, required to use the CCNC networks if they prefer to establish direct relationships with PCPs.

None of this would preclude a CCNC network from reconfiguring itself to become an ACO on its own. However, a CCNC network reconfigured as such cannot require a physician's participation in its ACO as a condition of participation in the regular primary care case management program. Furthermore, should CCNC networks evolve in this fashion, they must take care to avoid conflicts of interests.

c. Capacity Minimum

Each ACO must have sufficient PCP capacity to serve at least 5,000 assigned Medicaid beneficiaries at all times. If the number of assigned beneficiaries falls below 5,000 during any contract year, DMA will issue a warning and place the ACO on a corrective action plan. An ACO that cannot sustain a population of at least 5,000 Medicaid beneficiaries may have its contract terminated.

d. Primary Care Provider Exclusivity

Each beneficiary will be linked to a specific PCP who will both render primary care and guide the patient to specialty care providers and other referral services. Given the special role of the PCP and the fact that beneficiary assignment to an ACO will be based on PCP selection (see below), each PCP must be affiliated with only one ACO at any point in time.

Providers other than PCPs may belong to more than one ACO at a time.

4. Beneficiary Assignment to ACOs

a. Assignment Based on Primary Care Provider Selection

In North Carolina's Medicaid program today, most beneficiaries are required to enroll formally with primary care providers. This will continue when ACOs are functioning. (Some beneficiaries living with chronic conditions rely on specialty care providers for routine care. Notwithstanding the benefits of such arrangements, DHHS will still expect all beneficiaries to align with general care PCPs to ensure that the full array of preventive care is rendered. Access to appropriate specialty care will not be hindered.) The beneficiary's selection of PCP will be the basis for assigning the beneficiary to an ACO.

If a beneficiary fails to enroll with a PCP within 30 days of gaining Medicaid eligibility, DMA will assign the beneficiary to a suitable PCP – one who is located close to the beneficiary's home and who, for example, takes care of children if the beneficiary is a child. With limited exceptions, such assignment will be made to PCPs who are affiliated with ACOs.

A beneficiary who actively chooses a PCP not affiliated with any ACO will be subject to care coordination in the traditional fashion as administered by CCNC. DMA will work with CCNC to design what may be thought of as a virtual ACO. The virtual ACO would link together PCPs not affiliated with ACOs for purposes of enabling shared accountability for costs and quality of care rendered to the population.

b. Changes of Primary Care Providers

Medicaid beneficiaries are allowed to change PCPs as often as once every 30 days in the current system. Beneficiaries will continue to have freedom of movement. To increase the potential for ACOs to impact beneficiaries' care-seeking behaviors; however, DMA will explore with the federal Centers for Medicare & Medicaid Services (CMS) whether it is permissible to lessen the frequency of PCP changes – to quarterly, semi-annual, or yearly.

c. Subgroups Not to Be Assigned to ACOs

DHHS's intention is that the vast majority of Medicaid beneficiaries are assigned to ACOs. However, certain eligibility classes have very limited Medicaid coverage and so will be excluded from the program due to the difficulty of systematically affecting their care. The classes that ***will not be assigned to ACOs*** are: Family Planning waiver participants, Breast and Cervical Cancer Control Program participants, and legal aliens.

DHHS is considering whether individuals who are dually eligible for Medicaid and Medicare coverage ought not to be assigned to Medicaid ACOs. It would be best for dual eligibles to receive the benefits of ACO care coordination and quality improvement efforts, but there are hurdles. First, Medicare is the primary payer for physical health services of dual eligibles. Medicaid only pays the required premiums, deductibles and coinsurance. This gives Medicaid limited power to affect provider or patient behavior. Second, within Medicare, dual eligibles may

enroll in private Medicare Advantage plans that receive capitation payments from CMS and become responsible for care management. Or, dual eligibles who remain in Medicare's fee-for-service system may become aligned with Medicare ACOs that must coordinate their care.

For this proposal, DHHS intends to include dual eligibles in the ACO program. As required by CMS, however, dual eligibles will be allowed to opt out.

DHHS does recognize the potential value of linking Medicaid care coordination with Medicare's. Following the launch of the ACO initiative, DHHS will explore longer-term opportunities to align the financing and care management of Medicaid and Medicare.

d. ACO Marketing to Beneficiaries

ACOs are not to engage in activities that prevent assigned beneficiaries from receiving the full range of Medicaid benefits to which they are entitled. ACOs also are not to promote themselves to beneficiaries as having been endorsed by the State. Toward these ends, ACOs must submit all marketing communication materials to DMA for review. After 30 days, if DMA has not disapproved the materials, the ACO may use them. All of an ACO's – and participating providers' – messages to beneficiaries must be clear and concise and at a 6th grade reading level.

ACOs are prohibited from offering gifts, cash or other remuneration to beneficiaries for choosing a particular provider or receiving services. As part of *bona fide* health education efforts, ACOs may supply certain items or services for free or below fair market value. Such items must either be preventive or advance a clinical goal for the beneficiary. DMA may institute a formal approval process for such practices.

5. Data Sharing

a. Data Required from ACOs

ACOs will be required to submit tax identification numbers (TINs) and national provider identification (NPI) numbers for all participating providers. This information will support beneficiary assignment and allow DMA to create data reports tailored to each ACO's population.

ACOs may also be required to share clinical data from electronic health records or other sources to permit quality measurement and to enable providers not directly linked to one another to see information on patients actively in their care.

b. Data for Use by ACOs

DMA will make available limited beneficiary identifiable data (name, date of birth, sex, ID number and PCP identity) on all assigned beneficiaries. The data will be updated monthly to reflect changes additions to and deletions from the ACO's roster.

ACOs will be able to receive claims data on assigned beneficiaries on a monthly basis. The data will be delivered in a standard format. The ACO must first explain how it intends to use the data to evaluate the performance of its providers, assess and improve quality of care, and conduct population-based activities to improve assigned beneficiaries' health.

DMA will also furnish periodic reports aggregating the health care usage and cost experience of the ACO's assigned beneficiaries.

6. Value-Based Payment Provisions

a. Overview

The ACO payment model is intended to reward those provider groups who enhance value – that is, produce greater quality and efficiency in the delivery of care – without materially changing the basic fee-for-service approach to paying for individual services.

A formal methodology will be developed with stakeholder input and independent expert validation. The discussion that follows is meant to explain the key concepts.

Each ACO will have a benchmark spending level for its assigned beneficiaries each year. If actual spending falls below the benchmark, the ACO will be eligible to share in the savings, provided that the ACO also meets predetermined quality performance standards. If spending exceeds the benchmark, the ACO will share in the overrun with the State.

The following elements of the payment model will be explained below:

- Medicaid-covered services encompassed in ACO formula
- Determination of spending benchmark
- Computation of savings and losses
- Impact of quality performance on payment
- Computation of amounts owed to, or by, the ACO
- Distribution of shared savings; repayment of shared losses

Much as this model aims to shift risk and reward to organized provider groups under ACOs, it does not at any point in time impose full risk on those provider groups. In that respect it is quite unlike capitation payment to managed care organizations.

b. Medicaid-Covered Services in ACO Formula

With the following significant exceptions, the whole Medicaid benefit package will be encompassed in the array of services for which ACOs share in gains and losses:

- Mental health, substance abuse and intellectual/developmental disability services that are covered under the capitation contracts with LME-MCOs

- Long-term services and supports, which are non-medical services such as personal care services and nursing facility services that some beneficiaries need to conduct activities of daily living[7]
- Dental care services, except oral care connected to treatment of a physical illness or injury
- Other services that are covered under a capitation contract with a private vendor, currently high-cost imaging procedures
- A portion of costs for outpatient prescription drugs (to be shared with LME-MCOs).

These services are excluded from the ACO formula because ACO providers would have limited impact on spending for these items.

Over the long term, some changes may be made to benefit definitions and accountable parties. Any such changes will need to be reflected in the budgeting and accounting for ACOs' risk.

c. Determination of Spending Benchmark

To establish a baseline, DMA, with the assistance of independent actuarial experts, will compute the historical average annual per capita spending for the services in the ACO service package described above. Costs measured will consist of claims costs only; non-claim payments to providers, generally referred to as supplemental payments, are not counted. Costs in the historical base associated with high-cost cases for which ACOs will not be at risk (discussed later) will be subtracted. The spending will be tallied separately for each of the major Medicaid eligibility categories. Then, the values will be trended forward to reflect changes over the span of time between the base period and the initial period of ACO performance.

The above computations are made without reference to the specific population assigned to any ACO. To ensure that the cost of care benchmark is set appropriately for each ACO, DMA will apply a risk adjustment formula that considers the health status of individual beneficiaries. Health status will be defined using disease state information contained in claims data for any Medicaid beneficiary having been covered prior to assignment to an ACO. On the basis of available health status and demographic factors, each beneficiary will be given a risk score using an established risk adjustment methodology, such as the CMS Hierarchical Condition Categories or the proprietary (3M™) Clinical Risk Groups. Risk scores are weighted so that the average score across the entire population in an eligibility category equals 1.0.

DMA may make global adjustments to risk scores to account for expected systematic differences between the data used for the calibration of the risk adjustment model and the base period data used to establish a population's risk score.

[7] Some services that may be delivered by LTSS providers will remain within the ACOs' scope of financial and care coordination responsibility. Examples include (a) post-acute care furnished by a skilled nursing facility or home health agency that is intended as short-term step-down care following hospital discharge; (b) durable medical equipment for use at home by a patient recovering from surgery; (c) and home infusion services.

The total cost of care benchmark for each ACO will then be constructed by summing the person-specific benchmark rates, computed as the category-specific base amount multiplied by the risk score of each ACO-assigned beneficiary. Units will be set in beneficiary-months (one beneficiary covered for one month) to take into account the fact that many beneficiaries will have Medicaid and/or be assigned to a particular ACO only part of the year.

The base costs underlying benchmarks will be reset at the end of the first three-year ACO contract period. After that point, the benchmarks may be revised as frequently as yearly and no less frequently than every three years. Any changes the State makes in payment rates for specific services will be factored into adjustments made to the benchmark.

d. Computation of Savings and Losses

Following the close of each performance year, with a three month lag to allow for claims run-out, DMA will tally total claims expenditures for each ACO's assigned population. (Considering that some claims may arrive more than three months past the dates of service, DMA will explore potential ways to adjust for the additional claims. The three month window is seen as a reasonable compromise meant to allow for prompt reconciliation.) This will include claims incurred with ACO participating providers as well as claims for services used by ACO-assigned beneficiaries at non-ACO providers.

As noted above, to protect the ACO against infrequent high-cost cases that could ruin the outcome despite the ACO's best efforts to control the use of services overall, a large share of so-called catastrophic costs will be subtracted. Specifically, for any ACO-assigned beneficiary, 90 percent of claims costs above $50,000 in twelve months will be excluded from the calculation.

These actual costs, net of the catastrophic case subtraction, will be compared to the ACO's benchmark to see if there is a gain or a loss. The ACO may then share with the State in either the gain or the loss as explained below. However, no sharing will occur if the actual spending is between 98 percent and 102 percent of the benchmark, because such a small difference very likely could be due to random fluctuations rather than true performance of the ACO. Once this plus/minus 2 percent corridor is surpassed, the ACO will share on all dollars of savings or losses, including those inside the corridor.

e. Impact of Quality Performance on Payment

To be eligible to be awarded a share of savings, an ACO must achieve the quality performance goals described in Section 7 below.

In the event of a loss, the share of the loss that the ACO owes the State will vary according to the ACO's performance on quality. Higher quality scores will reduce the amount owed, within a set range.

f. Computation of Amounts Owed to, or by, the ACO

The ACO's award for generating savings or its penalty for incurring a loss will be as set forth in the table below. As indicated, ACO savings/loss shares will rise over time. Total awards and

penalties will be capped at defined percentages of the benchmark spending amounts, with the maximum penalty always being lower than the maximum award.

	SAVINGS		LOSS	
YEAR	ACO's Share of Savings*	*Award Cap as % of Benchmark*	ACO's Share of Loss*	*Penalty Cap as % of Benchmark*
1	40-60%	*15%*	60-40%	*5%*
2	40-60%	*15%*	60-40%	*7.5%*
3	60-80%	*15%*	80-60%	*7.5%*
4	80-100%	*15%*	100-80%	*7.5%*
5	80-100%	*15%*	100-80%	*10%*
*Ranges reflect potential variability based on ACO quality performance. An ACO with better quality results will receive a higher savings share or owe a lower loss share.				

To illustrate the effects of both the pro rata sharing and the caps, suppose an ACO has 25,000 beneficiaries assigned and an annual benchmark of $100 million in Year 1. Here are examples of the different sharing transactions based on different outcomes, where A is the ACO's share and C is the cap:

Example 1: Savings = $10 million; Quality goals fully achieved

⇨ Award paid to ACO = Lesser of A or C = $6 million
A = $10 million x 0.6 = $6 million
C = $100 million x 0.15 = $15 million

Example 2: Loss = $10 million; Quality goals not achieved

⇨ Penalty paid by ACO = Lesser of A or C = $5 million
A = $10 million x 0.6 = $6 million
C = $100 million x 0.05 = $5 million

Example 3: Loss = $10 million; Quality goals fully achieved

⇨ Penalty paid by ACO = Lesser of A or C = $4 million
A = $10 million x 0.4 = $4 million
C = $100 million x 0.05 = $5 million

g. Distribution of Shared Savings; Repayment of Shared Losses

DMA will pay the shared savings award directly to the ACO legal entity.

ACOs starting in the first two years of the program will have an option for an interim payment calculation and possible early savings share distribution to enhance cash flow.

Each ACO must establish a self-executing method for repaying losses to the State. Options include recouping funds from ACO providers, reinsurance, surety bonds, credit line, reserves built from prior years' savings, or some other mechanism. ACOs must furnish documentation

annually demonstrating ability to repay up to 1 percent of the benchmark amount, using the prior year's benchmark as the basis.

Reconciliation payments owed either by the State to the ACO or by the ACO to the State will be payable within 90 days from the date the obligation is determined and notice given.

h. ACO Internal Incentive Arrangements

ACOs will be required to describe in their applications how they will incentivize participating providers to meet the goals of the program. ACOs will have wide latitude to decide how they will distribute shared savings awards or assess participants in the case of losses.

DHHS does expect that ACO participating providers will have financial incentives appropriate to their respective roles in the coordination and delivery of care for assigned beneficiaries. Incentives should be focused on those providers who actually influence outcomes. The incentives should reward improving efficiency and quality of care and elevating population health, and discourage growing the volume and raising the intensity of services. A distribution formula that simply apportions gains or losses based on each provider's claim dollar volume would be judged inadequate. Incentive arrangements that could have the effect of restricting beneficiaries' access to appropriate and necessary care would also be judged adversely.

i. Piloting of Alternative Payment Methods

DHHS will be receptive to proposals from ACOs that wish to explore arrangements entailing higher degrees of risk assumption sooner than is written above. Approval of any such pilot project will be based on expected economic benefit, quality enhancement, technical feasibility, and regulatory considerations such as possible requirements for federal waivers.

Separately, as part of the transition to value-based payment, DHHS intends to explore the use of episode bundled payments. These are payments that are fixed in advance for a specific episode of care that occurs with relatively high frequency. The bundle typically wraps in all professional and facility services arising from the beginning of the episode until a defined end. An example would be a major joint replacement surgery, where the bundle includes the hospital stay, the fees of the surgeon and other practitioners such as anesthesiologists, post-discharge rehabilitation, and any hospital readmissions and/or surgical revisions occurring within 90 days post-discharge. DMA would pay the single sum to a designated entity – possibly an ACO – and it would be that entity's responsibility to distribute the funds to the providers.[8]

Any bundled payments that are established will be paid as service units in the same manner as fee-for-service payments and will be counted in the measurement of ACO performance.

7. Quality Measurement

Any shared savings or shared loss payment is contingent on the ACO's performance against quality standards, regardless of the amount of savings or loss. This section presents a preliminary

[8] Medicare's "Bundled Payments for Care Improvement" initiative is a model that could serve as a starting point. http://innovation.cms.gov/initiatives/bundled-payments/

outline of the quality measurement plan. This plan is adapted from Medicare's ACO quality measurement protocol, with particular consideration of Medicaid-specific quality aims. DHHS will work with providers, other stakeholders and independent measure developers prior to implementation to build out and refine the quality measurement protocol.

a. Quality Measures and Data

DMA will require ACOs to report on a specified list of measures for performance year 1. After the first year, performance will be assessed based on actual measure results. The measure set will cover adult, maternity, and pediatric care and will include process, outcome, and patient experiences-of-care measures. **Appendix 2** displays measures from MSSP, the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, CMS Independence at Home Demonstration, and CCNC (Key Performance Measures), all of which will be considered in determining the final measure set.

The process for selecting the measures, yet to be established, will include consultation with the North Carolina Medical Society and specialty societies, other providers in the state as well as DHHS and external experts on measurement and reporting processes. DMA will consult with the national measure development community to ensure specifications are up to date.

Data sources for these measures will be specified in the formal quality measurement plan to be produced later in 2014. They are expected to include claims, surveys, and electronic health record data.

b. Scoring and Standards

The first year will essentially be a pay-for-reporting arrangement in order to allow ACOs an opportunity to ramp up and DMA an opportunity to learn about the process and establish improvement targets. Thus, ACOs will be eligible for shared savings if they report accurately on 100 percent of the measures, regardless of their actual performance.

After the first performance period, most of the measures will begin to be used on a pay-for-performance basis.

After the first performance period, a scoring system will be used to determine how much of the shared savings ACOs will receive. The measure-specific benchmarks ACOs must achieve for scoring purposes will be made known prior to the second performance year.

c. Public Reporting

Public reporting is important for holding ACO providers accountable for high-value care. Each ACO will be responsible for making organizational information available, including a list of all participants and members of the governing body, as well as a primary contact. In addition, quality performance scores and shared savings or losses paid must be reported. The information will need to be publicly available in a standardized format. DMA will issue guidance on public reporting of quality measures.

8. Relationships between ACOs and Other Entities in Medicaid

DHHS will expect ACOs to work constructively with other organizations or groups that impact the health care of Medicaid beneficiaries, as outlined below.

a. LME-MCOs

Evidence has shown that individuals with comorbid chronic medical conditions and mental illness or substance abuse are much more difficult to treat and more expensive. ACOs will need to collaborate with LME-MCOs and their participating providers of behavioral health and intellectual/developmental disability services. Such partnerships could take the form of shared care coordination or care management between ACOs and LME-MCOs, ensuring that one beneficiary has a single coordinator to manage the care and ensure communication and teamwork among specialists and primary care.

Some ACOs could choose to embed primary care providers in behavioral health clinics to ensure that their assigned beneficiaries have access to primary care and to facilitate a tight relationship among the care team. LME-MCOs could be more supportive of behavioral health providers embedded in ACO primary care clinics for prevention and early intervention with the entire panel population. These same embedded individuals could also help the ACOs meet their quality goals related to mental health and substance abuse, as well as increase follow-through with referrals to specialty mental health and substance abuse treatment.

ACOs will be expected to enter into cooperative agreements with local LME-MCOs that outline how they will partner to integrate care for the whole person.

b. Local Health Departments

North Carolina's 85 local health departments have long played a vital role in advancing the health of communities, whether by broad efforts to prevent the spread of disease or through the delivery of direct patient care not available from other sources.

The State supports local health departments with direct funding and by paying for Medicaid-covered services that they provide. The typical health department receives about one-fourth of its funding from Medicaid.

ACOs will be expected to identify their local health departments and indicate how they will engage with them, especially around prevention and population health management.

Ideally, over time, ACOs and health departments will enter into formal cooperation agreements and they will report to DMA on ongoing interactions that demonstrates their commitment to, and the effects of, such cooperation.

c. Other Providers of Services Not in the ACO Risk-Sharing Pool

Long-Term Services and Supports Providers: It will be important to integrate ACOs into the lives of Medicaid beneficiaries utilizing long-term care services. Today, primary care physicians often play a pivotal, but often detached role, in how Medicaid beneficiaries access long-term care

services. It is the intent of DHHS for the ACOs to participate in LTSS interdisciplinary team planning, for ACOs to help ensure access to all viable LTSS options, and for ACOs to engage in coordinating the care of high-risk LTSS beneficiaries.

Dental Care Providers: There is a link between dental health and general physical health, especially for many Medicaid beneficiaries. ACO providers therefore should be in communication with dentists in their communities to identify opportunities to coordinate care of patients they share in common.

d. CCNC

CCNC plays an important role in Medicaid and is expected to continue to do so. CCNC's role will evolve over time to best support the ACO model. Any such evolution, however, is expected to occur over a transition period as the ACO model is implemented, expanded and strengthened, so as not to undermine the benefits North Carolina receives from the primary care case management system.

CCNC offers a foundation of medical home expertise, care management, quality improvement initiatives and monitoring, and data analysis and sharing infrastructure. Under reform, ACOs will need to assume some of the care management responsibilities, which could entail using CCNC care management resources.

With the new structure bringing accountability closer to the primary care provider, CCNC in partnership with DHHS has acknowledged the need to thoughtfully rearrange their services to align well with the needs created by the new ACO system. Certain roles offered to CCNC would greatly change their structure. For example, an oversight role over ACOs using CCNC care management networks may cause a conflict of interest. Therefore, while CCNC certainly has a strong role to play under reform, the specific requirements of the relationships between CCNC and ACOs is currently being discussed/negotiated between DHHS and CCNC.

9. Procurement and Contracting

a. Solicitation of ACO Applications

In summer or early fall 2014, DMA will receive notices of intent from organizations planning to apply for ACO contracts. Notices of intent are a prerequisite for submitting an ACO application, though they are non-binding.

In late 2014, DMA will issue a request for applications (RFA) for organizations wishing to participate as Medicaid ACOs effective July 2015. The RFA will ask applicants to demonstrate how they will meet the provisions described in this document and will require attestations of commitment from ACO sponsors and participating providers.

DMA will evaluate ACO applications and will issue acceptances or notices of rejection. All applications that are complete and qualified will be accepted; there is no limit on the number of ACOs that may participate in the program. Any applicant receiving a notice of rejection will be

afforded an opportunity, within a limited time frame, to submit additional material necessary for DMA's reconsideration.

There will be an annual opportunity for new ACOs to enter the program. All contracts shall take effect on the July 1 following acceptance into the program.

b. Contracting

ACOs will be expected to enter into agreements with the State for three-year terms. During the term of agreement, both the State and the ACO will have latitude to make some limited changes. For example, DMA may make some changes to quality performance standards, and ACOs will be expected to comply with such changes. ACOs may add or subtract participating providers, though they must give DMA 30 days' notice of any changes. Changes by ACOs that materially weaken their capacity to serve a large population and/or to meet the State's requirements may result in termination of the contract.

B. Enhancing the Mental Health, Substance Abuse, and Intellectual/Developmental Disability Service System

In North Carolina the mental health, developmental disability and substance abuse service (MHDDSAS) system has been moving toward full-risk managed care since 2008. Since April 2013 the entire system has operated under a 1915(b)/(c) managed care waiver. Under this waiver, North Carolina's Local Management Entities, which once coordinated and offered publicly supported behavioral health care services, have become managed care organizations (LME-MCOs). Through a process of facilitated mergers, there are now ten LME-MCOs.

LME-MCOs' contracts with DMA call for them to: coordinate care; manage provider networks; ensure access to mental health and substance abuse treatment and supports for individuals with intellectual and developmental disabilities; monitor for fraud, waste, and abuse; and pay providers for services out of capitation income received from DMA for each enrollee.

LME-MCOs also perform functions not directly paid for by Medicaid. They manage state-appropriated funds and federal grants and pay for services and coordinate care for those without insurance or means to pay for services related to mental illness, substance abuse, intellectual/ developmental disabilities, and traumatic brain injury.

Although the MHDDSAS system has undergone great changes over the last several years, there is room to improve. As DHHS gathered public feedback, several themes emerged concerning the MHDDSAS system. Most important were the voices of consumers and families who agreed with whole-person integrated care, but warned that moving too fast with reforms could destabilize an already fragile system. They urged the State to assure that the value of specialty care is not lost in a new system. Almost all feedback encouraged change that incorporated gradual shifts and common sense approaches. Along with consumer, family, and provider feedback, reform efforts targeted at the MHDDSAS system follow the objectives articulated by the General Assembly.

First, North Carolina's MHDDSAS system is on a path of predictability and sustainability through capitation arrangements with LME-MCOs. Based on the performance of the first three

LME-MCOs to go live after Cardinal Innovations, the LME-MCO capitation rates for services have decreased an average of 10 percent ($14 on a per member per month basis) after the LME-MCOs' first year of managing services. State-funded administration was reduced by 9 percent this fiscal year.

Second, ensuring whole-person care and ease of use for beneficiaries and providers are also essential elements of reform proposed for the LME-MCOs. The reforms discussed herein are proposed to improve upon the system according to the guiding principles while ensuring that patients' access to providers and services is not disrupted.

While some of the reforms presented below are concrete, well-developed changes supported by stakeholders and beneficiaries that may already be underway, others are best stated as objectives that will require lengthier planning and coordination with beneficiaries and stakeholders. DHHS is committed to re-evaluating the entire system as it relates to MHDDSAS from the perspective of beneficiaries and providers as they move through the system, within each service array and between these services and other parts of the state system to ensure that improvements are meaningful and result in higher quality and more efficient services, regardless of funding source.

1. LME-MCO Improvements

a. LME-MCO Consolidation

To assure that the MHDDSAS managed care system is sustainable, DHHS has planned and is already acting to consolidate the ten LME-MCOs into a four-region LME-MCO model. The mergers will be final by July 2016 with intermediate benchmarks to be met at six-month intervals beginning July 2014. DHHS will closely monitor the consolidation in order to guarantee access to care for beneficiaries during network restructuring. DHHS will propose specific accountability standards and administrative criteria to assure the LME-MCOs meet quality standards appropriate for more integrated care management.

Consolidation will ultimately yield administrative savings for the State, decrease the provider burden involved in billing multiple LME-MCOs, and enable better standardization of processes and uniform application of resources and services across broad areas of the state.

In addition to consolidation, the deployment of resource allocation methodologies for determining I/DD service budgets will be expanded statewide in order to offer better budget predictability and more uniform application of resources.

b. Enhanced Contracted Processes and Outcome Expectations

Now that the LME-MCOs have been active under the 1915(b)/(c) waiver for at least one year, DHHS intends to revise their contracts and related expectations based on our shared experience and with input from the State's contracted managed care oversight experts. The following adjustments, in consultation with stakeholders including LME-MCOs, providers, beneficiaries and CCNC, will be made to the next round of contract renewals:

- Develop meaningful, more advanced outcome measures and performance measures with associated incentives and penalties.

- Ensure LME-MCOs are including the whole person in their service to their beneficiaries. A few ways in which whole-person expectations can be established include: clearer contract expectations for including physical health care and other individual-level needs in service plans; attention to the whole person in care coordination and utilization management functions; and provisions for shared accountability for the physical health care of their beneficiaries in need of access to medical services.
- Employ stronger, clearer contract language and requirements that correspond to objective measures of performance and outcomes. For example, care coordination functions need more details regarding best practice models available and requirements for this function, such as expected caseloads and minimum proportions of populations to be affected.
- Explicitly define expectations for elements of LME-MCO processes and services that must be standardized to ensure ease of access and use by beneficiaries and providers.

c. Increased Sophistication of DHHS Oversight, Monitoring, and Technical Assistance for LME-MCOs

With stronger, clearer contracts in place, DHHS will partner with the LME-MCOs to make them more effective and efficient managers of services through more sophisticated monitoring, oversight, and increased technical assistance supported by both staff and contracted expertise:

- LME-MCOs will be monitored not only on the aggregate, but with expectations for minimum standards county-by-county in order to ensure that counties with lower populations are not overlooked in favor of more populous areas in terms of access to service and outcomes.
- DHHS will intensify on-site monitoring of the LME-MCOs, reviewing all aspects of operation from provider network management to claims system performance, especially as related to any complaints received from the community.
- DHHS has been gaining internal expertise in Medicaid and publicly-funded managed care MHDDSA services through experience and through contracting and consulting with national experts. As such, more technical assistance will be offered across a broad range of areas where the state has noticed opportunities for significant improvement, especially with respect to upcoming larger entities:
    - Desired staffing patterns and appropriate talent management
    - Alternative payment methods to increase pay for performance, increase provider accountability, and facilitate improved quality
    - Assessing and addressing uniform access to services across geographic regions
    - Provider network monitoring, restructuring and rate-setting efforts that maintain or improve beneficiary access to an array of services
    - Care coordination best practices and functions, including how to identify and prioritize populations, models for intervention, how to integrate services, and measurement of outcomes

    - Improved consumer involvement
- Performance measures and results of monitoring and oversight will be more readily available to the public.

d. Realignment of Managed and Unmanaged Services to Encourage Whole-Person Care

The entire benefit package assigned to the LME-MCOs will be re-evaluated to ensure that individual services are allocated to the most appropriate coordinating entity, be it managed by the LME-MCOs or a risk-based responsibility under the ACOs.

The benefits covered by the LME-MCOs were set several years ago. Since then, the State has identified services covered by LME-MCOs that are likely better managed within physical health care/ACOs, such as developmental screenings performed in pediatric primary care clinics. Others have been identified that are not included in the LME-MCO benefit package, but would likely improve overall whole-person care if they were, for instance, personal care services for mental illness-related disability or others.

LME-MCOs are not currently responsible for pharmacy costs. DHHS will identify ways that they can share some of the responsibility for psychotropic medication costs with both the ACOs and the State through shared savings and loss arrangements that encourage all system actors to focus more attention on the quality and cost of prescribed medications (see D.2 below). Note this does not propose that the LME-MCOs will authorize or directly pay pharmacy claims.

Additionally, individuals with MH, SA, and I/DD service needs often experience silos of care within these services. One example is the exclusion of children ages zero to three from LME-MCO management. Many children requiring services in this age range receive care from Child Development Service Agencies (CDSAs) administered by the NC Division of Public Health. Needs are often driven by an intellectual/developmental disability. Yet the transition from CDSAs to the Innovations I/DD waiver under the LME-MCOs is ill defined and should be better managed. In partnership with LME-MCOs and community stakeholders, DHHS will address the silos identified for adults, children and families to promote continuity of services and to support the effectiveness and availability of quality interventions.

2. Service Improvements

In addition to improving the LME-MCOs, clinical policies will be adjusted to improve the services overseen by the LME-MCOs. These improvements affect not only the Medicaid populations, but those whose services are funded through state appropriations. Quality enhancements will also generalize to all providers, regardless of payer source.

Until recently, under the fee-for-service system, MHSA services had to be revised in piecemeal fashion; the only substantial protections against fraud, waste, and abuse were tighter regulations. Now that North Carolina has implemented the 1915(b) waiver with the LME-MCOs, and now that a great deal more evidence is available to recommend effective services, it is opportune to revisit the entire service array and ensure that an adequate and evidence-based continuum of care is supported.

This analysis of available and needed services will maintain budget neutrality through more efficient levels of care and a focus on prevention and recovery, decreasing unnecessary crisis and hospitalization utilization. DHHS will identify an ideal service array that emphasizes care at the lowest levels for much of the population through preventing the need for higher levels of care and smooth transitions across levels of care, provides prevention services, and offers more flexibility to providers and LME-MCOs.

Gaps have already been identified in service arrays, such as services for Innovations waiver participants and a lack of services for those on the Innovations waiting list; gaps in the crisis services continuum; a lack of attention to transitions between levels of care and missing levels of care across adult and child policies; a lack of services for individuals with traumatic brain injury; and inadequate attention to more preventive services.

Listed below are a few of the MH, I/DD and SA service reforms that are being considered:

- DHHS will assess the feasibility of obtaining an additional 1915(c) waiver in order to offer services to individuals with I/DD currently facing a long waiting list for services. Opening additional waiver slots capped at a lower rate ($20,000) could shrink the waiting list and make services available to beneficiaries who have been waiting for years.
- I/DD services may need to include more flexible services that place the person's needs related to their goals at the center of their care plan rather than focusing on their needs defined by their disability or deficits.
- The crisis services continuum is already being analyzed for improvements in partnership with the LME-MCOs and the Crisis Solutions Coalition.
- Current 1915(b)(3) services, subject to available funds through planned LME-MCO savings, will be revised to better meet the needs of our beneficiaries.
- Service definitions will include provisions and flexibility for co-occurring disorders such as substance abuse and mental illness.
- Service definitions will include more expectations of coordination with needs of the whole person, including service planning that addresses medical, dental, social, and environmental needs.
- Services that support social as well as physical integration within the community are being prioritized. Efforts to discharge individuals as part of "TransITions" have highlighted the need for improved home-based supports for those with the highest need.

3. Integration / Whole-Person Care

Although the MHDDSAS system does interface with CCNC locally, and there is a contractual requirement that the LME-MCOs monitor primary care access for their beneficiaries, more must be done to strengthen the MHDDSAS system's commitment to whole-person care.

Some level of accountability for the medical and dental health care of LME-MCO enrollees receiving specialty MH, SA, or I/DD services must be included for the LME-MCOs in order to

encourage tight partnerships with the providers of other services needed by these beneficiaries. Most of this will be accomplished through performance and outcome measures and contractual expectations and developed through stakeholder input. Service definitions will be rewritten to place more emphasis on whole-person care. Requirements for person-centered planning continue to be revised, and training is occurring to ensure a cultural shift toward attention to the person and the whole array of his or her individual needs.

Development of partnerships between the LME-MCOs and the ACOs will likely require technical assistance and careful planning to foster well-coordinated care. DHHS and other local and national resources can offer assistance to forge effective partnerships. Some potential approaches include the following:

- A primary care clinic with a number of individuals experiencing serious and persistent mental illness or I/DD might choose to embed either a care manager or a primary care provider in an MH, SA, or I/DD agency to increase access to primary care or better affect disease self-management for their patients.
- Primary care providers embedded in MHSA agencies or practices might join ACOs, aiming to enhance the value of care for people with dual diagnoses.
- LME-MCOs and ACOs could choose to jointly support care coordinators for high risk populations, designating one individual as the "quarterback" for their beneficiaries' care rather than two care coordinators from two different systems.
- LME-MCOs could also help foster relationships between local MH, SA, and I/DD providers and ACOs to establish high quality referral paths and efficient communication and coordination, in part through contractual expectations and payment reforms that emphasize such coordination with physical health care.

As extra incentive to engage in whole-person, integrated care, DHHS will investigate the possibility of adding an array of Health and Behavior codes only for those providers working under an ACO. Other options for fostering integration will also be considered.

These reform efforts do not only affect Medicaid beneficiaries. Improvements of the entire MH, SA, and I/DD system are relevant across payers as changes to Medicaid services and provider expectations apply to services funded solely by state appropriations. Additionally, reform that results in better quality services is likely to generalize beyond payer-specific outcomes and influence the quality of overall services throughout North Carolina.

4. MHDDSA Reform Implementation Timeline

The table below presents an illustration of potential system enhancements, by time period.

Time Frame	Reform Action
2014 -15	○ Create an additional 1915(c) waiver for adults with IDD that is capped at $20,000 to address the IDD waiting list. Include in the waiver increased responsibility for managing physical health needs ○ Continue and evaluate current LME-MCO and CCNC data sharing efforts to increase coordinated care
2015-16	○ Require LME-MCOs to include at least one pilot that creates shared risk with providers around health care coordination ○ Include capitation for Medicaid PCS for those individuals with mental illness and I/DD ○ Add the CAP-C program to the LME-MCO capitation in order to increase responsibility for preventive care for children ○ Create incentive payment processes that allow for provider agencies to establish co-location integrated care models for people with MHDDSA ○ Initiate LME-MCO shared risk for outpatient prescription drugs, along with ACOs
2016-17	○ Add the Resource Allocation process to all LME-MCOs for I/DD that includes provisions for integrated care ○ Add additional incentives for shared risk pilots
2017-18	In contract require LME-MCOs to have at least 25% of provider contracts as sub-capitated arrangements that address integrated care
2018	Evaluate success and begin new reforms

C. Strengthening the Delivery System for Long-Term Services and Supports

1. The Basis of LTSS Reform

North Carolina's Medicaid beneficiaries who receive long-term services and supports (LTSS) remain simultaneously one of the most vulnerable and least coordinated of all Medicaid beneficiary populations. As a consequence, individuals with long-term support needs face a confusing and sometimes conflicting array of service networks, which are often location-specific, with varied enrollment procedures and coordination practices.

To provide optimal long-term supports and services to Medicaid beneficiaries and to better integrate the care needs of the whole person, the essential aims of Medicaid reform as it relates to the LTSS population are:

- Beneficiaries receiving LTSS experience clear, responsive, user-friendly points of entry into the LTSS system
- Beneficiaries are informed about all available LTSS options
- The LTSS service delivery system facilitates opportunities to holistically support a person and strengthen coordination of care

- LTSS workforce competencies around case management, options counseling, transition planning and integrated care are elevated
- Information technology (IT) platforms effectively meet the short-range and long-term needs of the reformed LTSS system.

The importance of these components is well documented in both national literature (most recently in the bi-partisan Commission on Long-Term Care's *Report to Congress*)[9] and in North Carolina's own experience. Many of the elements of an effective North Carolina LTSS system have been identified for more than a decade.

However, precisely *how* these objectives are to be shaped for North Carolina's long-range context, will be determined through a year-long strategic planning process. DHHS will lead this planning effort and will engage stakeholders – beneficiaries and families, state agency staff, providers and advocacy groups – to establish a strategic direction for long-term services and supports in the state. **Appendix 3** outlines the proposed strategic planning process.

The Department's intent is to build on what is working in the state's LTSS system while also exploring all viable options for bettering the whole-person experience of the LTSS beneficiary. The importance of proper planning is well established regardless of the LTSS delivery model North Carolina pursues for the long range.

In the strategic planning process, it is helpful to reflect on the predominant sentiments from North Carolina's LTSS stakeholder community that were reflected in Department's report to the General Assembly submitted on October 1, 2013:

- Support and build a system that promotes consumer choice
- Establish a continuum of services and a variety of settings in which to receive them
- Develop systemic parity and flexibility in supporting choice among these options, with recognition that public funding streams and public policy have historically restricted these choices
- Recognize the key role family caregivers and other natural supports play in supporting an individual's long-term needs.[10]

These sentiments are also reflected in North Carolina law. Longstanding statutes related to LTSS require DHHS to "include a balanced array of health, social, and supported services that are well coordinated to promote individual choice, dignity and the highest practicable level of independence." Further, DHHS is expected to ensure that "all services shall be responsive and

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[9] See *Report to Congress*, Commission on Long-Term Care, September 30, 2013, specifically, see Service Delivery Principles, outlined on page 36. Available at: http://ltccommission.lmp01.lucidus.net/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf

[10] See Recommendation 3 of the *DHHS Findings and Recommendations in Response to Blue Ribbon Commission on Transitions to Community Living,* October 2013, p.5.

appropriate to individual need and shall be delivered through a uniform and seamless system that is flexible and responsive regardless of funding source."[11]

2. Fulfilling the Aims of LTSS Reform

a. Points of Entry into the LTSS System

North Carolina's LTSS stakeholders have long identified the need for uniform points of entry into the LTSS system. In 2001, the Long-Term Services Task Force, chaired by the North Carolina Institute of Medicine, recommended that "the state begin using uniform screening, level of service assessments and care planning instruments; and that the state identify or help develop a computerized information and assistance system that can be used statewide."

This unified point of entry in which people can access information about services is recognized by CMS[12] and the national literature as being a key component of coordinated LTSS system design.

DHHS proposes identifying and strengthening existing points of entry taking into account where individuals already obtain information about LTSS services. While hospitals and local Departments of Social Services are well-identified points of access, individuals often seek information through other, community-based organizations, such as Area Agencies on Aging.

DHHS also recognizes the value of creating stronger web-based portals for accessing information and conducting "self-screens" for those beneficiaries and their families who prefer to access information in this way.

b. Informing Beneficiaries about All Available LTSS Service Options

In its consumer-driven recommendations, the Stakeholder Engagement Group formalized the sentiment of many in the North Carolina LTSS community by recommending that reform efforts include employing "a person who helps me enroll and has nothing to gain from my choice of services." To accomplish this goal, DHHS intends to explore building a function that will be referred to as an "usher." This function would be housed in existing and newly developed LTSS points of entry and is modeled after an options counseling function that is increasingly recognized as a being a key component of an effective LTSS system.

Supplemented by improved web-based tools, the usher will be available to assist beneficiaries in need of LTSS to understand and consider both Medicaid and non-Medicaid options available to them. While the duration of the usher's involvement may be revised with further analysis, DHHS's initial proposal is to ensure each usher can effectively serve as the beneficiary's point of contact until he or she is effectively linked with services.

The concept of LTSS options counseling is widely accepted, with every state having some sort of options counseling mechanism. While the usher functions will be tailored to North Carolina's

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[11] N.C. Gen. Stat §143B-181.5; N.C. Gen. Stat. §143B-181.6

[12] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html

specific service-delivery landscape, numerous states (examples include Connecticut, Maryland, Massachusetts, New Hampshire, Oregon, Vermont, Washington and Wisconsin) with various Medicaid funding mechanisms are working to strengthen the options counseling role.

Throughout its strategic planning process, the Department will learn from other state partners about building a conversation-based options counseling screening practice based on North Carolina's current options counseling efforts. Further, this usher role would be developed in a manner that is consistent with national options counseling standards.

c. Opportunities to Holistically Support a Person and Strengthen Coordination of Care

Supporting the whole person is a key tenet of Medicaid reform. The current experience of a North Carolina LTSS beneficiary clearly reflects our current system's fragmented approach to meeting the individual's LTSS, behavioral and medical/primary health care needs. If care management is available, it does not follow the LTSS beneficiary across settings and often does not effectively coordinate the comprehensive needs of the individual.

Under reform, DHHS seeks to strengthen this coordination of care and better ensure continuity across long-term care settings. Two key elements include:

1. Uniform screening and assessment tools
2. Integration of the beneficiary's primary care provider into the LTSS delivery design.

1. Uniform, Holistic Screening and Assessment Tools Used for Access to LTSS Services

More than a decade ago, the North Carolina Long-Term Care Task Force recommended that the state "begin using uniform screening, level of service assessment and care planning instruments."[13] The importance of uniform assessment tools and this recommendation was echoed in subsequent state-level efforts.[14] The value of uniform assessments has been codified in federal statute,[15] is reflected in the national literature[16] and used by other states such as Washington and Wisconsin.

2. Strengthened Integration of the LTSS Beneficiary's Primary Care Provider

There is currently no comprehensive practice that fully integrates primary care case management functions with the LTSS population across all settings. Additionally, while current referral

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[13] See Issue Brief *A Long Term Care Plan for North Carolina, Institute of Medicine Final Report,* 2001, p.3 Available at: http://www.nciom.org/wp-content/uploads/2001/01/ltcbrief.pdf

[14] See Recommendation 3 of the *DHHS Findings and Recommendation in Response to Blue Ribbon Commission on Transitions to Community Living Recommendations* October 2013; also Recommendation 4.1: Requiring Standardized Preadmission Screening, Level of Services and Assessment Instruments in Adult and Family Care Homes and 122C Facilities, *Short and Long-Term Solutions for Co-Location in Adult and Family Care Homes: A Report of the NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes*, NCIOM 2011. Available at: http://www.nciom.org/wp-content/uploads/2011/01/AdultCareHomes_wcover.pdf

[15] See Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

[16] See, for example, Commission on Long-Term Care, Report to Congress, September 30, 2013, pg. 43, Available at: http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf

mechanisms all require physician's orders, at present there is no expectation that this physician become integrated into the LTSS interdisciplinary care team.

To strengthen this integration under reform, DHHS will explore through its strategic planning process the viability of the following four integration concepts:

- Ensuring the LTSS beneficiary's primary care provider is central in the referral process for those patients who are seeking LTSS services and stays involved in coordinating care if the beneficiary moves to a facility-based setting
- Having the ACO become the usher for hospitalized LTSS beneficiaries, relying upon the ACO to coordinate post-acute care in a way that streamlines and potentially minimizes the need for ongoing LTSS services
- Enabling ACOs to provide holistic care coordination services for those LTSS beneficiaries who experience high Medicaid expenditures, co-morbidities or do not receive case management under the existing LTSS service delivery structure
- Establishing performance measures under the ACO model that target health care needs of LTSS beneficiaries.

In examining the full array of options for improving care coordination – and especially to address the General Assembly's directive to improve Medicaid budget predictability – DHHS would be remiss if it did not also explore the potential viability of managed care for LTSS, or MLTSS. Just as North Carolina already does with LME-MCOs for MH, SA and I/DD services, MLTSS, if adopted, would entail contracting with organized networks on a capitation payment basis. At least half of all other states are actively using or moving toward MLTSS. DHHS will appraise those other states' experiences, along with the facts and circumstances of this state's LTSS delivery system, to determine if MLTSS would add value to North Carolina's Medicaid program.

3. Additional Opportunity to Pilot Innovative Whole-Person Care Models

The need for better supporting the whole person is often most apparent in the lives of individuals with traumatic brain injury (TBI).

To effectively address the needs of the beneficiary with TBI requires essential coordination of the behavioral health, LTSS and primary care. To this end, DMA and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services will co-facilitate an effort through 2014 to develop a pilot program that works to effectively and holistically address the support needs of this population.

d. Elevating LTSS Workforce Competencies in Case Management, Options Counseling, Transition Planning and Integrated Care

For North Carolina to build the competencies required to effectively implement these proposed elements, DHHS recommends providing competency-building efforts on identified functions essential to the success of LTSS reform efforts. The current LTSS workforce needs to become

more expert in care and transition coordination and options counseling. North Carolina's primary care case management networks (CCNC) and ACOs will need to understand and effectively coordinate the social and functional needs of the LTSS population.

e. IT Platforms and the LTSS System

An essential element of LTSS reform is the need for a robust, cohesive IT platform that enables North Carolina LTSS systems to effectively communicate with each other and ensure streamlined, appropriate, and effective data sharing. As part of reform, DHHS will examine its current IT platforms utilized for LTSS services and determine the capacity needed to implement the technical elements proposed under Medicaid reform.

D. Considerations for Oral Health and Outpatient Prescription Drugs

1. Oral Health

The North Carolina Medicaid program for dentistry covers about one million low-income children and 460,000 adult beneficiaries in addition to 170,000 dually eligible individuals. The continued coverage of adult North Carolina Medicaid dental benefits beyond emergency services demonstrates the value placed on oral health by stakeholders who understand the importance of good oral health to a person's overall physical well-being. Poor oral health can exacerbate medically compromised patients' chronic medical conditions. Pain from dental disease can affect a low income child's quality of life and ability to function well in school.

Since 2008, state oral health policymakers have been diligent in making policy and program changes to maintain a balance between access to and utilization of oral health services, preservation of an adult dental benefit and the need to be fiscally responsible.

Since SFY 2009, overall spending for dentistry has remained flat. In fact, as Medicaid enrollment has grown, dental care as a percent of the overall budget has declined from 3 percent to 2.5 percent. In the U.S. population at large, 5 percent of health care expenditures go toward oral health. Medicaid beneficiaries include many medically fragile children and adults whose dental health needs could easily account for a far greater percentage of the total Medicaid budget.

DMA has instituted a variety of cost savings measures such as lowered reimbursement for multiple fillings for a single tooth, modifying rates paid for fillings on back teeth and others. Participating dentists have also emphasized preventive oral health services.

While keeping overall costs for the Medicaid program flat, DMA's dental program has still raised access to dental services. In CY2010, HEDIS data indicated that approximately 60 percent of North Carolina Medicaid children received an oral health service. CMS and Pew report that the average utilization rate for children in private dental benefit plans is 58 percent.

In SFY2013, approximately 44 percent of adult beneficiaries who were eligible for dental services (excluding dual eligibles) received at least one dental benefit service. This rate exceeds

the national average of 38 percent for private dental benefit plans as reported by the American Dental Association. Additionally, since FFY 2010, more unduplicated North Carolina Medicaid-eligible children ages 0-20 have received an annual oral health service than have received a medical screening visit.

DMA estimates that between 45-50 percent of the active licensed dentists in North Carolina are rendering providers on at least one Medicaid paid claim each year. Since 2008, the DMA dental program has continued to maintain a network that meets the needs of a growing beneficiary population. However, access to care remains a problem in certain rural sections of the state, most notably northeastern and far western counties. These areas continue to lack participating providers and specialists such as oral surgeons and orthodontists.

In light of the relative success of the dental program and low proportion of spending devoted to oral health care, DHHS does not consider dental care a high priority for reform. More urgent challenges will command attention in the near term. This is not to say, though, that there is no room for improvement in Medicaid oral health benefits, especially with there being pockets of poor access.

Therefore, DHHS will remain vigilant in exploring ways to further improve the value of taxpayers' investment in Medicaid dental benefits. By the end of the 2015-16 fiscal year, DMA will evaluate whether the types of measures other states have pursued would be appropriate and beneficial for North Carolina. Generally, other states are either folding dental care into the responsibilities of full-service health plans or separately outsourcing the management of dental care. Contracts are either for administrative services only, or they fold the payment for dental care into a capitation that transfers risk to the contractor.

Any consideration of potential reforms in the management of Medicaid dental benefits must and will involve a diverse group of stakeholders.

2. Outpatient Prescription Drugs

Prescription drugs used in outpatient settings account for more than one-tenth of North Carolina's Medicaid expenditures. This is roughly the same share of spending that goes toward inpatient hospital services or physician services. Pharmaceutical manufacturers' rebates do cut the net cost of prescribed medications by more than one-half, though rebates are accounted for as revenues, not as offsets to claims costs, so the expense line item remains significant.

With the advent of new high-cost specialty biopharmaceuticals, spending on prescription drugs is expected to climb markedly, even as older brand-name oral medications shift to generic status. For instance, one national report found that while Medicaid spending per beneficiary on specialty medications was one-third that of spending on traditional medicines, the rate of growth in spending on specialty drugs was three times higher – 15.9% versus 5.3%.[17]

[17] Express Scripts *Drug Trend Report* 2013 http://www.drugtrendreport.com/medicaid/total-trend

North Carolina has over the years instituted a variety of measures to stem the rise of drug costs. Tightening the Preferred Drug List and expanding the set of drugs requiring prior authorization have contributed to DMA's ability to control spending. Using a tiered system for pharmacy reimbursement has helped increase the percentage of prescriptions dispensed as generics. However, more tools are needed to combat new cost challenges.

Considering that ACOs will be introduced to coordinate physical health services and that LME-MCOs are now fully in charge of coordinating mental health, I/DD and substance abuse services, DHHS believes the opportunity exists to incorporate prescription drugs into the financial accountability mechanisms for both types of organizations. Fostering better awareness of cost through shared accountability while maintaining quality standards should help to hold down cost growth without the need to tighten the already-cumbersome authorization process.

Accountability for pharmaceutical costs must be shared across the system. Prescription medicines will be classified as "generally psychiatric" – roughly defined as primarily used for the treatment of mental illness or substance abuse – or non-psychiatric – all other drugs. DMA will set target budgets for both groups based on prior spending, using a method similar to that used to establish the ACOs' benchmark budgets.

The LME-MCOs, ACOs, and the State will share in any savings or cost overruns in the psychiatric medications budget. For the non-psychiatric medications, savings and losses for pharmaceutical spending will be shared between the ACOs and the State. The *pro rata* shares of risk for both LME-MCOs and ACOs will be kept low in the initial stages to allow for experience to be gained and the method to be refined.

III. Reform Implementation

This section addresses matters of implementation, ranging from state legislative authorization and federal government approvals to agency readiness and expected impacts on Medicaid beneficiaries and providers.

A. State Legislative Authorization

Each of the three components of reform will need legislative authority granted by the General Assembly. Listed below is a synopsis by service delivery category of the legislative authority DHHS believes may be needed.

1. Physical Health Services; ACOs

- Authority to pursue state plan amendments and/or Section 1915(b) waiver as may be required
- Administrative licensing or regulatory scheme will need to be enacted (created in statute) or authorized (allow DMA to make rules) in 2014; if the rulemaking route is chosen, an exemption from Chapter 150 will be needed to ensure rules are in place in time for the market to organize, perhaps instead setting up a committee with various appointments to represent stakeholders
- Expansion budget item to pay for changes to NCTracks to allow for this monitoring and payment to occur
- Expansion budget item to pay for vendors to perform the independent benchmark setting and to appraise objectively ACOs' performance
- Potential rate cuts for providers who do not enroll in ACOs – exact effective date to be determined but July 1, 2016 is seen as most likely implementation date
- Authorization to pilot or otherwise implement payment reforms such as episode bundles
- Establish a non-reverting trust fund into which we can deposit funds returned by providers, beginning the creation of a Medicaid Reserve Fund
- New positions in DMA to oversee the regulation and administration of the ACOs

2. Mental Health, Substance Abuse and Developmental Disabilities Services; LME-MCOs

- Any outstanding items on LME-MCO consolidation
- Authority to submit state plan amendments or 1915(b)/(c) waiver amendments to further integrate care, and possibly to allow for pilot programs

3. Long Term Services and Supports

- Authority to issue an RFP to perform assessment and/or case management functions
- Expansion item for new positions and/or funding at DMA to write the RFP and design the new system of uniform, holistic needs assessment and care planning for beneficiaries.

B. Federal Government Approval

The federal authority needed to implement most aspects of reform will likely be state plan amendments. Since the reforms will not restrict beneficiaries' freedom of choice, it is unlikely that Section 1915(b) program waivers would be needed. However, it is conceivable that the risk-sharing arrangements contemplated for ACOs could lead CMS to suggest that a program waiver is warranted. DMA will explore this question with CMS promptly.

As DHHS explores solutions to the I/DD waitlist, an additional 1915(c) waiver may also be required.

DHHS believes that a Section 1115 demonstration waiver is not needed to authorize the reform as described. At a future date, should the General Assembly wish to change the payment model for physical health services – and possibly also for long-term services and supports – to full capitation, a Section 1115 waiver may be needed. Absent such a waiver, it would be very difficult for North Carolina to continue to make safety net supplemental payments to providers.

C. Medicaid Agency Administration and Budget Forecasting

The success of proposed Medicaid reforms will depend in no small part upon the ability of the state Medicaid agency to implement the changes. DHHS has embarked upon a restructuring plan that will strengthen DMA's capabilities to perform all of the functions demanded of it.

The General Assembly has expressed particular interest in seeing DMA improve its ability to forecast Medicaid expenditures and revenues. In recent years, North Carolina's Medicaid program has experienced significant budget shortfalls. These events have required emergency action on the part of the General Assembly. Audits conducted by the State Auditor and Ernst & Young confirmed that DMA's methodology for forecasting needs improvement.

To that end, the following measures have been taken:

- DMA ended the practice of carrying the federal share of drug rebates into the next state fiscal year. A new system has been developed which repays CMS its share of drug rebates weekly, thereby eliminating the state's being a month behind on payments and ending the fiscal year in debt.
- Many Medicaid claims have different federal medical assistance percentages (FMAP rates). In years past, DMA used historical data to estimate a blended FMAP for the entire population of beneficiaries. During SFY 2013, DMA implemented a new cash model to verify and track federal receipts throughout the fiscal year. Receipts are now forecasted

and budgeted at the actual FMAP for category of service rather than using a blended historical estimate.

- DMA has improved budget and cash flow predictability by instituting timely settlement of over- or under-payments to specific providers. In years past, over- or under-payments were often settled over a multi-year time frame, which at times resulted in cash flow shortages for DMA. Currently, claims are paid more efficiently, leading to fewer swings in cash flow.
- DMA ended the practice of grouping multiple service and programs into one fund. Doing so led to inefficiencies and difficulty monitoring expenditure levels of individual initiatives. Beginning SFY2013, separate funds within the Medicaid budget were established, leading to greater transparency and enabling better monitoring.
- DHHS is building a new forecasting model with the help of a nationally recognized firm, Alvarez and Marsal. The new model will improve forecasting methodology and address the deficiencies identified in the Ernst & Young report. The following are specific examples of improvements that will be made going forward:
    - DMA will add new personnel to the budgeting and forecasting team to increase capacity and enhance expertise.
    - DMA will replace spreadsheet tools with more advanced forecasting software.
    - Program area managers will now be directly involved in the forecasting process to ensure that projections appropriately reflect program realities and needed changes.
    - Alvarez and Marsal will provide oversight and quality control of the forecasting and budgeting processes and outputs.

  DHHS understands the importance of data integrity in forecasting. In March 2014, the State reached a significant milestone for receiving critical data to forecast. DHHS will continue to dedicate significant resources to ensuring that correct and useful data is being pulled from the NC TRACKS system.

D. Reform Plan's Impact on Beneficiaries and Providers

In framing the reform plan, DHHS took great care to consider the impact on beneficiaries and providers in terms of enrollment, access, quality and payment. For beneficiaries, DHHS is committed to ensuring continued access to care. By utilizing provider-led ACOs without mandatory enrollment – except continuation of the primary care provider enrollment expectation – beneficiaries' access to care will remain stable or perhaps expand.

The table below summarizes the impacts expected for both beneficiaries and providers.

	ENROLLMENT	ACCESS	QUALITY	PAYMENT
	Beneficiaries			
Physical Health Services	Enrollment with PCP continues, is used to link beneficiary with ACO	Access increased as providers under ACOs become more efficient	Quality improves due to provider gain sharing or loss based upon quality measures	Copayments remain unchanged
MHDDSA	No change	Investigate expanding access to those on Innovations waiting list No change for MH or SA access other than improvements expected through enhanced monitoring and technical assistance for the LME-MCOs	Improved quality through enhanced performance measures, incentives, and more sophisticated, targeted monitoring Improved service array	No change
LTSS	No change	Improved access as a result of improved technology resources and establishing clear, options counseling sites based on where people already seek LTSS information.	Quality improves because of: 1. Fuller integration of ACO/primary care into LTSS planning/ enrollment processes and ACO's provision of care management for identified LTSS beneficiaries. 2. Increased competencies of case management and other LTSS functions. 3. Better ability to communicate across services and settings thanks to stronger information-sharing options.	No change

	ENROLLMENT	ACCESS	QUALITY	PAYMENT
	Providers			
Physical Health Services	Providers participate in ACOs voluntarily; State may penalize non-participation if insufficient ACO capacity develops	N/A	Providers render quality care due to payment incentives; DMA oversees quality performance of ACOs	Providers continue to be paid fee-for-service; enhanced payments for quality and efficiency
MHDDSA	Improvements in standardization across LME-MCOs	N/A	Quality monitoring for providers is undergoing improvements under partnership between DHHS, LME-MCOs and providers	As LME-MCOs consolidate, payment should be simplified (fewer LME-MCOs per region to bill)
LTSS	No change to enrollment initially. Credentialing may impact some current providers to participate in the future.	N/A	New credentialing structure for care managers, transition coordinators and others related to the LTSS coordination process will improve competencies.	No change.

IV. Projection of Reform's Fiscal Impact

DHHS commissioned the independent Medicaid-focused consulting firm, The Menges Group of Arlington, Virginia, to provide technical assistance to the reform planning effort. Working with the principal DHHS consultant, Bob Atlas, The Menges Group projected the fiscal impacts of the proposed Medicaid reform activities. The analysts sought to be conservative in every respect.

This section presents these estimates and describes how the projections were derived.

It begins by setting a baseline of current and projected costs of the unreformed Medicaid program. It then describes projections for the impacts of reform in the three main domains: physical health services; mental health, developmental disabilities and substance abuse (MHDDSA) services; and long-term services and supports (LTSS). The discussion closes with a tally of the total projection.

An important caveat is warranted. These projections are estimates. There is considerable uncertainty surrounding both the projection of costs without reform and the potential effects of future interventions and programmatic changes.

A. Baseline Costs and Projected Costs of Current Program

DHHS supplied The Menges Group with detailed cost and coverage information on each Medicaid beneficiary encompassing calendar years 2011 and 2012. Data for 2013 were not fully developed in time for this analysis. Summary Medicaid enrollment and cost information, grouped by major eligibility category, is presented in Exhibit 1. The term "Covered Person Months" refers to one person covered for one month. Costs are health claims costs only.

Exhibit 1. Baseline Cost and Covered Population Figures by Major Eligibility Group, CY2011 and CY2012

	Covered Person Months		Average Covered Persons		Total Costs	
Eligibility Group	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Dual Eligible	3,878,627	3,821,002	323,219	318,417	$3,145,735,025	$2,933,917,546
NCHC (SCHIP)	2,015,580	1,964,297	167,965	163,691	$174,362,772	$328,067,634
Blind Disabled non-duals	1,939,374	2,028,419	161,615	169,035	$2,917,963,482	$3,070,351,289
Work First	873,645	919,634	72,804	76,636	$239,332,740	$262,482,024
Families and Children	2,863,617	2,754,816	238,635	229,568	$1,058,000,027	$1,080,149,516
Family Planning	856,045	758,764	71,337	63,230	$103,573,197	$63,098,991
Infants and Children	8,254,493	9,113,292	687,874	759,441	$1,462,726,849	$1,704,312,780
Pregnant Women	409,493	400,289	34,124	33,357	$191,156,136	$209,971,134
Foster Care	230,708	231,513	19,226	19,293	$183,511,054	$202,256,797
Total	**21,321,582**	**21,992,026**	**1,776,799**	**1,832,669**	**$9,476,361,284**	**$9,854,607,711**

Baseline costs were derived for three Medicaid reform program components as described below and portrayed in Exhibit 2:

- Physical health costs, which will fall under the purview of various accountable care organizations (ACOs), were derived by subtracting MHDDSA costs, nursing home costs, and personal care services costs from total costs.
- MHDDSA costs – also labeled as "Behavioral" – were identified through screening for claims with a primary diagnosis in the ICD-9 range of 290–319, or any capitation payment made to a LME-MCO.
- Long-term care costs were identified as payments to nursing homes and payments for personal care services.

These distinctions provide reasonable, albeit imprecise, estimates of the costs that each reform program will strive to address. For example, temporary step-down admissions to a nursing facility have been included in the estimate of LTSS costs when such services will in fact fall under ACO cost management in the physical health program. More precise actuarial work will be needed to establish the cost targets for each program and to calculate actual savings against these targets.

Note also that some North Carolina Medicaid costs were not included in the tabulations, such as non-claims-based special payments to hospitals (e.g., disproportionate share payments), and costs in some minor eligibility categories.

Exhibit 2. Baseline Costs by Major Reform Program Component, CY2011 and CY2012

	MHDDSA		LTSS		Physical (ACO)	
Eligibility Group	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Dual Eligible	$906,053,875	$874,055,664	$1,301,774,780	$1,291,427,064	$937,906,370	$768,434,818
NCHC (SCHIP)	$36,805,393	$72,698,451	$0	$0	$137,557,379	$255,369,183
Blind Disabled non-duals	$855,994,262	$907,223,188	$130,615,721	$144,326,135	$1,931,353,499	$2,018,801,966
Work First	$49,961,563	$61,094,019	$9,588	$31,301	$189,361,590	$201,356,705
Families and Children	$132,427,362	$138,182,815	$179,492	$200,523	$925,393,174	$941,766,177
Family Planning	$6,003,842	$3,190,538	$0	$10,571	$97,569,355	$59,897,882
Infants and Children	$324,282,957	$400,154,770	$2,290	$0	$1,138,441,602	$1,304,158,010
Pregnant Women	$5,012,922	$6,330,496	$0	$0	$186,143,214	$203,640,638
Foster Care	$121,931,029	$137,170,606	$0	$0	$61,580,025	$65,086,191
Total	**$2,438,473,205**	**$2,600,100,548**	**$1,432,581,871**	**$1,435,995,593**	**$5,605,306,208**	**$5,818,511,569**

The CY2012 covered population and cost figures were trended through State Fiscal Year 2019-2020, using the following annual trend assumptions:

- A one percent annual increase in the Medicaid population in each eligibility category.
- A five percent annual increase in per capita medical costs in each eligibility category.

Savings for each program component were estimated across a five-year period extending from July 2015 through June 2020. Estimates were aligned with the state fiscal year, July 1 to June 30. Projections were prepared for each of the five fiscal years.

B. Physical Health Savings Projection

The savings estimates and assumptions used for the physical health (ACO) program are summarized in Exhibit 3. The medical cost estimates take into account the following factors:

- The trended Medicaid costs for the population that ACOs will be invited to serve.
- A downward adjustment in these costs of approximately 8% to reflect the fact that ACOs will be accountable for only 10% of Medicaid claims costs above $50,000 for any given beneficiary. This 8% factor was derived based on actual beneficiary claims cost distributions for physical health services during CY2011.
- The percentage of the statewide ACO-eligible population that ACOs are expected to serve in each year. This is estimated to grow from 40% in Year 1 to 90% in Year 5 as ACOs continue to develop and meet state requirements.
- The percentage savings the Medicaid program will realize, on average, after the claims are tallied relative to projected targets and ACOs are paid any bonuses for which they qualify – or pay any debts associated with cost overruns. The savings are estimated at a modest but rising savings percentage, beginning at 1.0% in Year 1 and rising to 3.0% in Years 4-5. Factors considered in developing these estimates included the modest average savings that Medicare ACOs have achieved in their initial years of operation, the fact that North Carolina's Medicaid ACOs – unlike most Medicare ACOs at present – will be placed at risk for cost overruns and thus ought to be well motivated to achieve cost savings and quality improvements, and the fact that some ACOs will be newly formed entities with little or no track record in achieving medical cost savings.
- Medical cost savings were depicted in total (Federal plus State share), as well in terms of State funds savings. A federal matching rate of 66.09%, the rate for the coming fiscal year was used to derive State share estimates.

In addition to the medical savings projections, several offsetting costs have been factored into the physical health program. These include preliminary estimates of the nature and level of costs required to administer the ACO program, as well as a projection that 25% of the initial pharmacy cost savings from the ACO program will be negated by a decrease in drug rebate revenue.

There will also be some start-up costs for the ACO program, such as for actuarial consultation, IT enhancements and the like. These costs are estimated at $6.5 million total and $3.25 million of State dollars in SFY 2014-15, as shown in the column labeled "Year 0" in Exhibit 3.

Through these assumptions, a Medicaid savings of approximately $635 million is projected across the first five years of ACO operations. The State appropriations savings across this five-year timeframe are estimated to total $212 million.

Exhibit 3. Physical Health Savings Estimates

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total, Years 1-5
	July 2014 - June 2015	July 2015 - June 2016	July 2016 - June 2017	July 2017 - June 2018	July 2018 - June 2019	July 2019 - June 2020	July 2015 - June 2020
BASELINE COSTS PROJECTIONS							
ACO Persons (covered months divided by 12)	1,552,393	1,567,917	1,583,596	1,599,432	1,615,426	1,631,581	1,599,590
ACO Dollars Including Catastrophic	$6,583,698,713	$6,982,012,485	$7,404,424,240	$7,852,391,907	$8,327,461,617	$8,831,273,045	$39,397,563,295
Annual Cost Per Full-Year Person	$4,241	$4,453	$4,676	$4,909	$5,155	$5,413	
ACO Dollars Excluding Catastrophic	$6,056,504,145	$6,422,922,646	$6,811,509,466	$7,223,605,789	$7,660,633,939	$8,124,102,292	$36,242,774,131
% of Potential Target Population Served by ACOs		40%	60%	80%	90%	90%	
Dollars in ACO Risk Pool		$2,569,169,058	$4,086,905,680	$5,778,884,631	$6,894,570,545	$7,311,692,063	$26,641,221,976
ACO PROJECTED SAVINGS							
Medicaid Medical Cost Savings (%)		1.0%	2.0%	2.5%	3.0%	3.0%	
Medicaid Medical Cost Savings ($)		$25,691,691	$81,738,114	$144,472,116	$206,837,116	$219,350,762	$678,089,798
Federal Match Rate		66.09%	66.09%	66.09%	66.09%	66.09%	66.09%
State Share of Net Medicaid Medical Savings		$8,712,052	$27,717,394	$48,990,494	$70,138,466	$74,381,843	$229,940,251
OFFSETTING COSTS							
Cost of Administering ACO Program							
Actuarial -- Set Targets, Reconcile Actual Costs	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Information Systems Modifications	$2,000,000	$500,000	$500,000	$500,000	$500,000	$500,000	$2,500,000
Consulting to Develop/Support/Monitor ACO Program	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
State Staff to Support/Monitor ACO Program	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Quality Measurement	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Other	$500,000	$500,000	$500,000	$500,000	$500,000	$500,000	$2,500,000
Subtotal	$6,500,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$25,000,000
State Share of Admin Costs (50%)	$3,250,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$12,500,000
Revenue Reduction in Pharmacy Rebates		$613,628	$1,952,258	$3,450,617	$4,940,161	$5,239,041	$16,195,706
State Share of Rebate Reduction		$208,081	$662,011	$1,170,104	$1,675,209	$1,776,559	$5,491,964
NET MEDICAID SAVINGS (FEDERAL AND STATE SHARES)	**-$6,500,000**	**$20,078,062**	**$74,785,855**	**$136,021,499**	**$196,896,955**	**$209,111,721**	**$636,894,093**
STATE FUNDS SAVINGS	**-$3,250,000**	**$6,003,971**	**$24,555,384**	**$45,320,390**	**$65,963,257**	**$70,105,284**	**$211,948,287**

C. MHDDSA Savings Projection

The savings estimates and assumptions used for the behavioral health (LME-MCO) program are summarized in Exhibit 4. Because the LME-MCO program is ongoing, only marginal savings are projected from enhancements to this program. The enhancements anticipated are largely tied to a consolidation of LME-MCOs from ten entities to four, which should yield some improvements in the average utilization management capabilities of the LME-MCOs as well as yield some administrative savings through improved economies of scale. No new administrative costs are projected beyond existing resources dedicated to program support and oversight.

This consolidation is expected to occur in early 2016; therefore no meaningful savings are likely to occur until Year 2, which runs from July 2016 through June 2017. The projected savings increase from 1.5% in Year 2 to 1.75% in Year 3, and reach 2.0% in Years 4 and 5. Across the full five-year timeframe, Medicaid savings of $270 million are projected, of which $92 million are State appropriations savings.

Exhibit 4. MHDDSA Savings Estimates

	Year 1	Year 2	Year 3	Year 4	Year 5	Total, Years 1-5
	July 2015 - June 2016	July 2016 - June 2017	July 2017 - June 2018	July 2018 - June 2019	July 2019 - June 2020	July 2015 - June 2020
BASELINE COST PROJECTIONS						
LME MCO Dollars	$3,193,577,779	$3,386,789,235	$3,591,689,984	$3,808,987,228	$4,039,430,955	$18,020,475,181
Percentage Savings From Reform						
Consolidation & Increased Sophistication of LME MCOs -- Utilization Savings Plus Economies of Scale	0.00%	1.50%	1.75%	2.00%	2.00%	
SAVINGS PROJECTIONS						
LME MCO Dollars Under Medicaid Reform	$3,193,577,779	$3,335,987,397	$3,528,835,409	$3,732,807,483	$3,958,642,336	$17,749,850,404
Medicaid Savings	$0	$50,801,839	$62,854,575	$76,179,745	$80,788,619	$270,624,777
Federal Match Rate	66.09%	66.09%	66.09%	66.09%	66.09%	66.09%
State Fund Savings	$0	$17,226,903	$21,313,986	$25,832,551	$27,395,421	$91,768,862

D. LTSS Savings Projection

The LTSS savings are estimated to be derived from a combination of two factors:

1) An enhanced assessment process, with LTSS needs assessments on average being more comprehensive and occurring earlier in the person's Medicaid coverage trajectory

2) Improved care coordination efforts taking appropriate actions based on the findings from the comprehensive assessment process.

It is estimated that these process enhancements will not be firmly in place until 2016. Savings are therefore projected to occur beginning in Year 2 (July 2016 – June 2017). On a percentage basis, savings of 0.5% are projected in Year 2, increasing by 0.5% each year thereafter as the financial benefits of averting lifelong institutionalization compound favorably.

Additional administrative costs of approximately $5 million per year are projected to implement the enhanced assessment and care coordination activities. Pre-implementation costs of $1.5 million are also included for starting up these functions.

Across the full five-year timeframe, Medicaid savings of approximately $80 million are projected, of which $23 million are State appropriations savings.

Exhibit 5. LTSS Savings Estimates

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total, Years 1-5
	July 2014 - June 2015	July 2015 - June 2016	July 2016 - June 2017	July 2017 - June 2018	July 2018 - June 2019	July 2019 - June 2020	July 2015 - June 2020
BASELINE COSTS PROJECTIONS							
LTSS Dollars	$1,663,143,755	$1,763,763,952	$1,870,471,671	$1,983,635,207	$2,103,645,137	$2,230,915,668	$9,952,431,635
% MEDICAL SAVINGS FROM REFORM							
Utilization Reduction Through Improved Assessments and Improved Care Coordination		0.00%	0.50%	1.00%	1.50%	2.00%	
MEDICAL SAVINGS PROJECTIONS							
LTSS Dollars Under Medicaid Reform		$1,763,763,952	$1,861,119,313	$1,963,798,855	$2,072,090,460	$2,186,297,355	$9,847,069,934
Medicaid Savings		$0	$9,352,358	$19,836,352	$31,554,677	$44,618,313	$105,361,701
Federal Match Rate		66.09%	66.09%	66.09%	66.09%	66.09%	66.09%
State Fund Savings		$0	$3,171,385	$6,726,507	$10,700,191	$15,130,070	$35,728,153
COSTS OF ADMINISTERING PROGRAM							
More Frequent & Comprehensive Assessments	$1,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$25,000,000
Information Systems Modifications	$500,000	$250,000	$250,000	$250,000	$250,000	$250,000	$1,250,000
Subtotal	$1,500,000	$5,250,000	$5,250,000	$5,250,000	$5,250,000	$5,250,000	$26,250,000
State Fund Cost (at 50% Match Rate)	$750,000	$2,625,000	$2,625,000	$2,625,000	$2,625,000	$2,625,000	$13,125,000
NET MEDICAID SAVINGS (FEDERAL AND STATE SHARE)	**-$1,500,000**	**-$5,250,000**	**$4,102,358**	**$14,586,352**	**$26,304,677**	**$39,368,313**	**$79,111,701**
STATE FUNDS SAVINGS	**-$750,000**	**-$2,625,000**	**$546,385**	**$4,101,507**	**$8,075,191**	**$12,505,070**	**$22,603,153**

E. Total Savings Projection

The savings are projected to grow significantly each year, following a start-up year (SFY 2014-15) in which an estimated $8 million (or $4 million of State appropriations) will be expended. While overall Medicaid savings in Year 1 are estimated at $15 million, Year 5 savings are estimated to be $329 million.

Total Medicaid savings of just under $1 billion are projected across Years 1-5, and a State share savings of approximately $325 million.

Exhibit 6. Overall Savings Estimates

Program Area	Year 1 July 2015 - June 2016	Year 2 July 2016 - June 2017	Year 3 July 2017 - June 2018	Year 4 July 2018 - June 2019	Year 5 July 2019 - June 2020	Total, Years 1-5 July 2015 - June 2020
OVERALL MEDICAID SAVINGS						
Physical Health (ACO Model)	$20,078,062	$74,785,855	$136,021,499	$196,896,955	$209,111,721	$636,894,093
MHDDSA (LME MCO)	$0	$50,801,839	$62,854,575	$76,179,745	$80,788,619	$270,624,777
LTSS	-$5,250,000	$4,102,358	$14,586,352	$26,304,677	$39,368,313	$79,111,701
Total	**$14,828,062**	**$129,690,052**	**$213,462,426**	**$299,381,377**	**$329,268,653**	**$986,630,570**
STATE FUNDS SAVINGS						
Physical Health (ACO Model)	$6,003,971	$24,555,384	$45,320,390	$65,963,257	$70,105,284	$211,948,287
MHDDSA (LME MCO)	$0	$17,226,903	$21,313,986	$25,832,551	$27,395,421	$91,768,862
LTSS	-$2,625,000	$546,385	$4,101,507	$8,075,191	$12,505,070	$22,603,153
Total	**$3,378,971**	**$42,328,672**	**$70,735,884**	**$99,871,000**	**$110,005,775**	**$326,320,301**

Appendix 1: Written Comments from Medicaid Reform Advisory Group

Dennis R. Barry

To: Aldona Wos, MD. , Secretary, DHHS

From: Dennis R. Barry, Chair, Medicaid Reform Advisory Group

Subject: Comments Regarding Draft Proposed Medicaid Reform Plan, 2014

INTRODUCTION

In the main, the draft of the Proposed Plan to Reform Medicaid in North Carolina is a good and thoughtful plan. It clearly makes the case and need for Medicaid Reform with which I concur. Further the proposed plan has been developed in order to build on the existing strengths of the current care systems operating in NC. Given some more minor comments below, I fully endorse the proposed Medicaid Reform Plan.

It is important to recognize that the transition from a largely fee-for-service system to a more value based system is not an easy transition and therefore it will take time, especially as it relates to creating the needed Medicaid Accountable Care Organizations (ACO's). It will take a number of years to develop new organizations that deliver care, align incentives, monitor quality and take risks in order to more effectively serve the Medicaid beneficiaries of North Carolina.

The Advisory Group's role in development of this plan has been an interesting journey and I would be remiss if I did not thank the members of the group (Senator Louis Pate, Representative Nelson Dollar, Dr. Peggy Terhune, and Dr. Richard Gilbert, MD) for their many contributions and devoted service to this effort. Also, having witnessed the tremendous effort that has been put forth by DHHS staff and Mr. Bob Atlas, consultant, in creating this proposed plan, I would like to thank them for their effort and leadership as well.

Finally, as part of these introductory comments, please be advised that the Advisory Group did not have the opportunity to review the projected estimated cost savings of this Reform Plan. Therefore, I will not have any comments regarding this section of the report.

Accountable Care for Physical Health Services (ACO's)

The following are comments regarding this first section of the proposed plan:

1. The definition and/or description of "organized groups of healthcare providers" must clearly indicate that such groups include a broad array of primary and specialty care MD's, hospital care, and many other related groups and services who are willing to

come together to share risk, align incentives, measure and improve quality and manage the care of Medicaid beneficiaries.

2. Given the initial organizational costs and stated administrative functions of an ACO, it is clear that initial start-up capital will be required. Yet there is no provision for funding start-up capital in this plan. Some consideration should be given for start-up capitalization in the form of a loan, under certain situations in which private financing is unavailable.

3. Although I'm impressed with the stated ACO coverage goal for year 5 at 90% of the applicable Medicaid population, I do believe that the goal should be, virtually, 100%. All beneficiaries should have the opportunity to access the available ACO system(s) in all geographic area of the state by the end of the fifth year.

4. The minimum number of Medicaid beneficiaries is stated at 5,000. Although this minimum goal is okay for the initial implementation phase, I certainly hope and suggest that the minimum size needs to be increased over time, reaching at least 25,000 by the end of the fifth year.

5. Primary Care provider exclusivity: The report states that primary care MD's can only be part of one ACO, although specialty MD's are allowed to belong to more than one ACO. The exclusivity provision may be appropriate for the initial years of development, however, a more flexible policy regarding PCP exclusivity should be considered for out years(beyond year 2) in order to provide PCP's the ability to belong to more than one ACO. This is especially needed when you have potentially competing ACO's, or PCP organizations that cover a sizable amount of geography.

6. Frequent changes of primary care physicians (every 30 days) are highly problematic as currently required by CMS. Having a primary care home is vitally important, especially over time. Therefore, the frequency of the ability to change a medical home should be every 6 months or once a year versus every 30 days, as is now the case. Such a change would be beneficial to the care of the patient.

7. Dual Eligible: It is very important to align the financing and care management programs between Medicaid and Medicare. Dual Eligible beneficiaries are some of the most ill and costly of all Medicaid patients. The differing parameters of the 2 programs have frustrated the creation of a more efficient delivery and care management structure for these patients. Given the development of ACO's, it will more possible to work with LTSS

and MH, SA and I/DD systems in creating better solutions for this special population of patients. Consideration for including such potential solutions and related financing in future required waiver's, is important.

8. Savings and Losses: There should be some ability toward accelerating the mix of savings and losses over time, if an ACO desires and is qualified to assume more risk with DHHS approval.

Mental Health, Substance Abuse and I/DD System

The following are comments regarding the Mental Health section of the report:

1. Although consolidation of 10 LME/MCO's into 4 is highly desirable, I cannot stress too much the need for standardization across many administrative areas. One of the key criticisms that I heard throughout the State is the variability of dealing with differing LME/MCO systems, including billing, credentialing, quality reporting, etc. Therefore I strongly encourage all efforts to standardize similar process across LME/MCO organizations.

2. The Mental Health, Substance Abuse, I/DD System in NC. Historically has been considered an institutional centric system. Tomorrow's system must be more community based in both the array and capacity of needed services. Toward that goal, we should minimize or eliminate the 1915(c) waiver program waiting list by creating a significant number of additional waiver slots, thereby reducing the overall cost of caring for the special needs and I/DD population in NC.

Long Term Care and Supports System

The following are comments regarding the LTSS system section of the report:

1. One of the most persistent problems in long term care is the continuation of the relationship between the beneficiary and their PCP if they move to a long term care facility. Sometime the facility is some distance away from the PCP and at other times it simply is not an efficient use of the PCP to see the patient outside their office. Exactly what the solution(s) is for this problem is, at best, elusive. However, this is one of those problems that must be considered as part of the strategic planning effort. Whether continuation of this historic relationship is feasible or not and to what extent ACO's involvement will be desirable, are key questions that need to be explored.

2. In the LTSS arena, there are a variety of new programs that have a more flexible funding base than traditional services and are community based. Programs such as PACE and Adult Day Care to name several. Like Mental Health, we should move our traditional array of LTSS services toward a more community based model of needed services. Such a trend would be highly desirable.

Outpatient Prescriptions

The proposed plan of Reform proposes to make the cost of outpatient prescriptions more accountable to both ACO's and LME/MCO's, which I support. However, to the extent that the current system of accounting for rebates does not reflect the actual net cost of the prescription drug within the Medicaid system, then this needs to be changed. This is especially the case if rebates differ amongst drugs and brands. We must use net cost when holding both ACO's and LME/MCO's accountable.

Dennis R. Barry, Chair
Medicaid Reform Advisory Group

Cc:
Senator Louis Pate
Representative Nelson Dollar
Dr. Peggy Terhune
Dr. Richard Gilbert, MD

Representative Nelson Dollar

NC House District 36

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March 17, 2014

TO: Aldona Wos, M.D.
Secretary, N.C. Department of Health and Human Services

Dennis Barry
Chair, Medicaid Reform Advisory Group

RE: Comments on the Department's Proposal to Reform North Carolina's Medicaid Program

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I want to thank my fellow members of the Advisory Group and the staff and consultants at DHHS for their important and insightful contributions toward reforming our Medicaid program.

North Carolina's Primary Care Medical Home (PCMH) model was first developed under Governor Jim Martin and since has become a nationally recognized model of reform that other states have sought to emulate. The PCMH model has contributed significantly to controlling the growth of Medicaid claims spending while improving our State's healthcare outcomes. As echoed in this proposal, it is vitally important to build on the strengths of our system.

True Medicaid reform must be transformative and incremental in order to ensure success. Provider upside and downside risk is an essential component of the next stage of any reform effort. However, the transition to risk must be in such a way that current levels of patient access and quality of care in North Carolina are improved, not interrupted. I support this Medicaid reform plan's use of Accountable Care Organizations (ACO) if we build upon the current foundation of the primary care medical home model that exists in all 100 counties. Other states developing Medicaid ACOs are looking to our PCMH model as the foundation of their medical neighborhoods.

The proposal endorses and recommends refining the Behavioral Health Reforms initiated by the General Assembly in 2011. I believe the ongoing consolidation of LME/MCOs operating the 1915(b) and (c) waivers is in the best interest of the state, consumers and their families. Once consolidation is achieved these systems, with governance boards appointed from and answerable to their communities, will be in a position to significantly improve the quality of care and close the gaps in our Mental Health System. Working with the LME/MCOs we will be able to achieve coordination of care between a person's behavioral health home and their medical home.

The majority of direct long-term care services funded by Medicaid fall under two major categories; Skilled Nursing Facilities and Medicaid's optional Personal Care Services (PCS). Skilled nursing in North Carolina has been a stable and reliable part of our healthcare continuum for many years. However, the PCS program (provided in adult-care homes and in-home) has undergone extensive reworking by the General Assembly and the Department in recent years to address a range of difficult issues. These and pressures from the USDOJ and others have led to instability and uncertainty in the long-term care industry. The proposal's recommendation to take more time for additional study of long-term care services and supports is prudent and appropriate.

The Department should consider submission of the pending federal grant proposal for dually eligible individuals (those qualifying for both Medicaid and Medicare services). This proposal, developed by the full range of stakeholders, could provide immediate improvements to the coordination and integration of care, as well as, save state and federal resources.

Information and data are the keys to significant improvements in our Medicaid system. As discussed in the proposal, the Department also needs to successfully institute reforms in the leadership, management, and operations of the Division of Medical Assistance, while providing staff with the best available tools and support to achieve the program's goals and objectives.

North Carolina is blessed to have world-class medical centers and research institutions with a wealth of knowledge across the full range of medical and behavioral health. As the Medicaid Reform process moves forward, we must marshal the considerable talent, knowledge and resources available in our State. Healthcare is a complex endeavor which requires the sustained engagement of all stakeholders. The best solutions will be found by fully engaging our State's extensive resources. By doing so we can create a system that will serve our citizens well into the future.

These comments and recommendations are not intended to be an exhaustive response to the Department's Medicaid Reform Proposal. Additionally, the Medicaid Reform Advisory Group did not convene to discuss and make recommendations as a group. The Proposal itself is a broad outline which envisions and will require considerable additional engagement and work once the General Assembly has completed its review and determined the most appropriate course.

This proposal does represent an important and historic reform as we move away from paying only for quantity of services provided and move toward value-based purchasing that rewards health care providers for delivering high quality care in a cost-effective manner.

cc: Richard Gilbert, M.D.
Peggy Terhune, PhD
Senator Louis Pate

Richard L. Gilbert, M.D.

To: Aldona Wos, M.D., Secretary, and DHHS

From: Richard L. Gilbert, M.D., MBA, Member, Medicaid Reform Advisory Group

RE: Draft Proposal to Reform North Carolina's Medicaid Program ('Proposal')

Date: March 14, 2014

I applaud the goal of Governor McCrory, The General Assembly, Secretary Wos, and DHHS to make meaningful reform to the North Carolina Medicaid Program. This reform will transform Medicaid to enhance quality of care, assure patient access, attain cost effectiveness, and achieve fiscal predictability.

It has been a privilege to serve with my colleagues on the Medicaid Reform Advisory Group, Chairman Dennis Barry, Senator Louis Pate, Dr. Peggy Terhune, and Representative Nelson Dollar. Chairman Dennis Barry has done a most admirable job providing leadership and guidance throughout this process. Many thanks to Bob Atlas, Mardy Peal, Matt McKillip, and the DHHS staff for their dedication, commitment and outstanding work in developing this 'Proposal'. Importantly, this process has positively engaged and extensively sought input from patients, providers, the community and other stakeholders. Notwithstanding the comments and recommendations which follow, I endorse this Proposal to Reform North Carolina's Medicaid Program.

Page 12- b 'Processes Pertaining to Beneficiary Health Care Management' Suggest – 5) develop a statistically valid audit process to validate quality outcomes reports; 6) develop a continuous quality improvement process which measures, reports and improves individual practitioner performance, but primarily focuses on identifying and improving systems issues.

Page 13- Specific expectations of ACOs - Suggest - Specific education and training of Providers and Staff to enhance the Patient Experience.

Page 15- Primary Care Provider Exclusivity Suggest Adding - PCP assignment to an ACO should be based upon the PCP NPI number rather than the practice TIN number.

Beneficiary Assignment to ACOs - Suggest Adding - In order to promote proactive population health management including but not limited to chronic disease management and preventive care measures, the ACO and PCP must know beneficiary assignments at the beginning of the enrollment year; assignment should not be made retroactively. From an actuarial risk taking perspective, is a minimum of 5,000 beneficiaries for an ACO adequate?

Page 16 – b. Changes of primary care providers - Agree that effectively managing beneficiaries in an accountable care environment will be difficult if beneficiaries can frequently change ACOs. Suggest - beneficiaries may be able to change PCPs every 30 days but only to PCPs within the same ACO for a given year.

Page 20 – 'Catastrophic costs' - Appreciate the intent to mitigate impact of catastrophic costs by 'excluding from calculation 90% of claims costs above $50,000 in a twelve month period'. Expect that ultimate policy determination will be made based upon actuarial data and analysis.

Page 21 - Suggest adding to the list of metrics which should receive financial incentives: patient satisfaction scores (patient experience), patient safety initiatives, lower costly medical complications, ACO implementation of data driven quality improvement programs, cost effective use of pharmaceuticals including but limited to maximizing use of generic drugs, implementation of evidence-based medicine.

General - "If you can't measure it, you can't manage it" has been attributed to the legendary management consultant, Peter Drucker. The degree to which Medicaid Reform is deemed successful will in part be based upon achieving both financial and quality performance benchmarks. To that end, it is important that the veracity of the data is assured so that all parties share a similar vetted data set. This will enable all stakeholders the inputs to evaluate as to whether performance targets have been achieved.

The following is suggested to be incorporated into this 'Proposal' - Financial Audit - An annual independent financial audit/review will be conducted to provide structured and transparent financial performance outcomes, assumptions and comparatives to the ACOs, DHHS, the Governor's Budget office and the Fiscal Research Division.

Quality Audit - An annual independent audit of designated Quality Measures ("Quality Performance Balanced Scorecard") will be conducted to provide structured and transparent quality performance outcomes, assumptions and comparatives to the ACOs, DHHS, the Governor's office and Legislature.

Respectfully Submitted,

Richard L. Gilbert, MD, MBA

Richard L. Gilbert, MD, MBA
Chief Medical Officer
American Anesthesiology

North Carolina General Assembly
Senate

SENATOR LOUIS M. PATE, JR.
DEPUTY PRESIDENT PRO TEMPORE
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HEALTH CARE – CO-CHAIR
PENSIONS, RETIREMENT AND AGING
STATE AND LOCAL GOVERNMENT

March 17, 2014

Dear Secretary Wos,

The current administration has been handed a monumental challenge in reforming North Carolina's broken Medicaid program. I appreciate the considerable amount of time and effort that has gone in to evaluating ways to fix this chronically ignored crisis and am grateful for the opportunity to offer feedback on this proposal.

Mismanagement by former state leaders created a host of operational and budgetary problems that have fallen to you and your department to fix. In the past four years alone, the General Assembly has had to fill Medicaid shortfalls totaling nearly $2 billion – money that could have been used for critical state priorities like education, infrastructure and public safety.

Unfortunately, Medicaid's upward spending pressures show no signs of abating. In fact, the nonpartisan Fiscal Research Division (FRD), using a 5.8 percent national growth rate estimate, projects that the state's Medicaid appropriation will grow by more than a billion dollars over the next five years. It is against this backdrop of years of mismanagement and ongoing shortfalls that I must evaluate the Department of Health and Human Service's proposed Medicaid reform plan, which FRD estimates will still require an additional $840 million over the same five-year period.

To address that key challenge, while also improving the quality of care Medicaid offers, the General Assembly and Governor McCrory clearly outlined in the state budget a vision of Medicaid reform achieving three critical objectives: 1) budget predictability and sustainability 2) administrative ease and efficiency for providers and – most importantly – 3) whole person patient care that unites physical and behavioral health.

In its current form, the proposal does not completely achieve any of these objectives. Instead of providing a comprehensive plan, the proposal presents a list of tentative steps that may move us in a new direction, but collectively fall short of the vision and goals of true reform this group was tasked with developing.

Furthermore, I am concerned that the proposal creates a new, complex administrative structure to manage a reworked version of the existing, chronically over-budget fee-for-service payment model.

Years of Medicaid shortfalls have left the General Assembly weary of finding places to cut, and eager for comprehensive reform. It concerns me that this proposal keeps us on the path of using provider rate reductions as one of the only solutions for cost containment in the Medicaid system. That is an undesirable outcome.

I hope the department will revisit the idea of reform and develop a proposal that meets the objectives set forth by the General Assembly and the Governor of delivering quality, whole-person care, with the Medicaid budget stability that allows the state to make necessary investments in other areas of state government.

Sincerely,

Louis M. Pate, Jr.

Peggy S Terhune, Ph.D., MBA, CEO Monarch

To: Aldona Wos, MD. , Secretary, DHHS

From: Peggy S. Terhune, member, Medicaid Reform Advisory Group

Subject: Comments Regarding Draft Proposed Medicaid Reform Plan, 2014

INTRODUCTION

As an expert in MH/DD/SA services in NC, I have found the process of development of this plan to be an exciting opportunity to assist in creating a plan for Medicaid Reform in North Carolina that is based on research and stakeholder input while being innovative and creative. This plan builds on national existing and emerging best practices to create a daring and viable plan that will allow NC to once again lead the nation. As our General Assembly seeks to be fiscally prudent with tax payer dollars, I applaud this effort to ensure that stakeholder input has been solicited and listened to, and strongly urge the state to continue these efforts going forward.

My comments are primarily related to my experience as a provider of MH/DD/SA services in NC as well as my background in policy development. They are comments based on my knowledge of the current system and the tremendous amount of information that I was privileged to review from stakeholders who wanted to ensure that they could find their voice in this report. Like you, I believe that everyone will find something to like in this report, and something they disagree with. However, I feel that for the most part, it sets a direction for North Carolina that can be fiscally prudent while meeting health care needs for our citizens.

I appreciate and respect the views and dedicated hard work from the rest of our committee (Dennis Berry, Chair; Senator Louis Pate; Representative Nelson Dollar; and Dr. Richard Gilbert, MD.) as well as that of the staff and consultants. It has been an honor to serve with these knowledgeable and esteemed colleagues.

Finally, as part of these introductory comments, please be advised that the Advisory Group did not have the opportunity to review the projected estimated cost savings of this Reform Plan. Although I will not have any specific comments regarding this section of the report, I wish to highlight some thoughts.

The last of the LMEs became managed care entities only a year ago. The experience of the initial MCO, Cardinal innovations, demonstrated that savings in PMPM occurred *over time*. Learning how to maximize savings while improving quality is not easy – there is no recipe or one "right" way to do this. It is based on decisions made one by one, working with individuals before any sort of aggregate savings can occur. Only with experience and history will we gain savings. Based on the stellar performance of MCOs in reducing cost and increasing quality, even in their first full year of operation, I believe that the ACO model will eventually create huge savings. However, a very large ship takes time to turn, and our legislators and administrators will have to be patient as the learning curve develops.

I also caution the department against moving too quickly to reduce PMPMs for MCOs and expected savings from ACOs. I would encourage the department (and the legislature, through its budget) to allow

the system to work. Greater savings will be achieved in the long run if there are sufficient funds allocated up front to allow MCOs and ACOs to try creative practices to reduce cost. In addition, cuts that directly affect providers and their constituents can affect an already shaky system.

Those who have read the entire report and these comments are to be commended for their interest. At the end of the day, however, it is legislators who must now take up the challenge to improve access, cost, and quality in our Medicaid services. I would implore them to put aside disagreements between and among parties, and truly consider the potential impact of these decisions on the vulnerable citizens of NC. Many of us have not been homeless, or experienced a child's death by suicide, or dealt with the loss of home and family when placed in long term care. We cannot rely on our own experiences to make decisions. We must listen carefully to the individuals affected by and working within the system. Only in this way can we create a Medicaid Reform that will be meaningful, person centered, and effective.

Comments regarding the proposal in general

1. The legislative mandate has been clear, and has been kept at the forefront of our minds. "Patient-centeredness, cost predictability and sustainability, and whole-person care are the goals that have driven the reform planning process." (Medicaid Reform Proposal Draft, 2014, p. 8). Yet I feel our proposal can only go so far given the timeframes and the restrictions that a short legislative session dictates. Although this draft is peppered with comments about patient centeredness, we must NOT lose this focus going forward.

2. Integrated care is something for which everyone has their own definition. The recommendations in this report begin the process of integration between behavioral health and physical health via suggestions about co-location, but as we move forward, I hope to see even more emphasis on creating comprehensive integrated person centered health homes that coordinate all care and ensure effective communication, lack redundancy or extra procedures, and provide quality driven care. The reader should not assume that this process is more about cost containment than person centeredness. The true way to save money is to make this about the person. It is my hope that as we begin at the beginning, we make a commitment to continuous improvement of our system.

3. North Carolina has received national recognition for our care management CCNC model. Like any system, CCNC provides benefits at a cost. The data management system that CCNC uses is excellent and helpful in many ways. However, this system only includes primary care, so in its current state cannot serve as the comprehensive model needed for integrated care. In this report, recognition is given to CCNC, and comments are made about its use and need for modification. From an MH/DD/SA point of view, the current information that providers can access from CCNC is significant, powerful, and reduces cost while allowing for provision of higher quality care. If CCNC is expected to continue in some form, however, accountability must occur for expenditure of funds. If CCNC determines that it chooses to morph into some other type of entity, then ACO systems must consider allowing access to medical record data for behavioral health and I/DD providers to continue the good work that was started by CCNC to measure trends, use of EDs, and other vital pieces of information.

Accountable Care for Physical Health Services (ACO's)
The following are comments regarding this first section of the proposed plan:

1. I completely support the concept of ACOs. There are several in North Carolina that are working with Medicare and have demonstrated that the model is cost effective and quality driven. I would caution, however, that in every system, there is never one model that accurately fits all people. My concern is for people who have severe and persistent mental illness (SPMI). Research has demonstrated that these individuals die on average 25 years sooner than their average life expectancy is due to lack of medical care. Given the nature of the mental illness and at times homeless status, these individuals simply do not get medical or preventative care or treatment. Blood pressure or Diabetes that goes unchecked results in high expense to the system and poor quality of life for the individual.

2. I applaud the department's suggestions for potential co-location settings and recommend that ACOs pilot programs with various models that could enhance the system without taking away from the ACO concept. SPMI and I/DD health homes are being piloted nationwide with excellent results.

3. I strongly suggest that the department look at lessons learned from MCOs. Population expectations for 5000 participants may be fine for the first year or two, but will not be large enough to sustain the types of savings needed in these organizations. Start-up funding will be essential, as a review of MCO start-up expenses can again predict some of the investment costs needed.

Mental Health, Substance Abuse and I/DD System
The following are comments regarding the Mental Health section of the report:

1. My first comment pertains to a significant expense in the plan. While the ACOs are to be monitored on access, cost, and quality, the MCO section details much more oversight, reporting, and monitoring. I have noted that in the past this burden is at times not "value added". It is compounded by the fact that these burdens are passed to providers who again duplicate cost for non-value added activities. The state has a choice. Hold MCOs accountable for access, cost, and quality such as ACOs, or continue to dictate many additional data and reports that can be reviewed and discussed. While such hand holding is admirable at best and intrusive at worst, it is not cost effective. Create standards on access, cost, and quality and eliminate anything else that is state driven and not needed for federal reporting. Build accountability into the standards and *hold ACOs and MCOs accountable.* Do not create a system where there is not a way to eliminate a poor performing group. This is unfair to the others of that group, and ultimately unfair to both consumers and the taxpayers who support the system.

2. I am encouraged that NC is willing to look at the list of people waiting for services in MH and DD, currently about 9,500 individuals. These numbers will only increase as elderly parent caregivers die and baby boomers age. There have been many discussions during the development phase of this report about what other states are doing and have done to eliminate their waiting lists. I would encourage the department to review CMS priorities for community living and move those legacy models of service into new evidence based supports that have been demonstrated to deliver lower cost and improved quality. This can provide the cost savings to serve many more NC citizens.

3. One of the frequent comments I have heard is, "The devil is in the details". The overarching and philosophical tenets in this plan are excellent, but the plan will succeed or fail based on the details. The North Carolina Council on Developmental Disabilities worked with a group of stakeholders from all types of disabilities and all parts of the state to identify the values that will guide the underpinnings of reform. I recommend that as details are developed, the state follow the adage "Nothing about me, without me" for consumers, providers (BH and primary health care), hospitals, and others. I also suggest that the value statements developed by the NCCDD workgroup be continually referred to as decisions are made, whether decisions are to be made about fiscal matters such as PMPMs, quality measures, or access into the system. In this way, all stakeholders can be part of the solution. In addition, we have brilliant and person focused university researchers and policy developers in NC who can help the department craft these details.

Long Term Care and Supports System

The following are comments regarding the LTSS system section of the report:

1. I agree with the intentions to study the long term care system via a group of involved stakeholders. I encourage the department to consider new and community based options over legacy type services. People should be allowed to "age in place" and retain the dignity they have enjoyed in their lifetimes even as disease and consequences of age advance. Research tells us that the baby boomers will require and demand community services and supports far greater than bricks and mortar health care options can provide. We must look to new community based models if we are to avoid collapse of the system as baby boomers age.

2. Although not described specifically in this report, individuals who age are also members of the first two population groups discussed. As we try to break down silos to gain economies of scale for fiscal and quality improvements, we must not forget that the I/DD system also provides intermediate care facilities (ICF) of a slightly different nature. There are many areas where the aging system could work with the I/DD system to save cost and improve quality. While this is something that many people in both fields talk about, I am not aware of any visible pilot initiative to enhance coordination and collaboration between these systems. Both groups want the same values in systems that are delineated in this section of the Medicaid Reform Report.

Outpatient Prescriptions

The following are comments regarding the Prescription section of the report:

The proposed plan of Reform proposes to make the cost of outpatient prescriptions more accountable to both ACO's and LME/MCO's. MCOs actually already review this data, and provider physicians have access to excellent databases to give information that can result in more appropriate prescribing. This has made a difference in behavioral health prescription costs. That is not to say that this can be improved, although it should be noted that this already occurs on some level.

Peggy Terhune
Medicaid Reform Advisory Group

Cc Senator Louis Pate; Representative Nelson Dollar: Dr. Peggy Terhune: Dr. Richard Gilbert, MD

Appendix 2: Sample Quality Measures

Medicare Shared Savings Program Quality Performance Measures for ACOs			
Domain	**Measure Name**	**Measure Steward**	**NQF #**
Patient/ Caregiver Experience	CAHPS: Getting Timely Care, Appointments and Information	AHRQ	5
	CAHPS: How Well Your Providers Communicate	AHRQ	5
	CAHPS: Patients' Rating of Provider	AHRQ	5
	CAHPS: Access to Specialists	AHRQ	5
	CAHPS: Health Promotion and Education	AHRQ	5
	CAHPS: Shared Decision Making	AHRQ	5
	CAHPS: Health Status/Functional Status	AHRQ	6
Care Coordination/ Patient Safety	Risk Standardized All Condition Readmission	CMS	1789
	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	AHRQ PQI	275
	Ambulatory Sensitive Conditions Admissions: Heart Failure	AHRQ PQI	277
	Percent of Primary Care Physicians Who Qualify for EHR Incentive Payment	CMS	NA
	Medication Reconciliation	AMA-PCPI, NCQA	97
	Falls: Screening for Future Fall Risk	NCQA	101
Preventive Health	Influenza Immunization	AMA-PCPI	41
	Pneumococcal Vaccination for Patients 65 and Older	NCQA	43
	Body Mass Index Screening and Follow-Up	CMS	421
	Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	28
	Screening for Clinical Depression and Follow-Up Plan	CMS	418
	Colorectal Cancer Screening	NCQA	34
	Breast Cancer Screening	NCQA	31
	Screening for High Blood Pressure and Follow-Up Documented	CMS	NA
At-Risk Population – Diabetes	Diabetes Composite: Diabetes Mellitus: Hemoglobin A1c Control (< 8 percent)	MN CM	729
	Diabetes Composite: Diabetes Mellitus: Low Density Lipoprotein Control	MN CM	729
	Diabetes Composite: Diabetes Mellitus: High Blood Pressure Control	MN CM	729

Medicare Shared Savings Program Quality Performance Measures for ACOs			
Domain	**Measure Name**	**Measure Steward**	**NQF #**
	Diabetes Composite: Diabetes Mellitus: Tobacco Non-Use	MN CM	729
	Diabetes Composite: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication for Patients with Diabetes and Ischemic Vascular Disease	MN CM	729
	Diabetes Mellitus: Hemoglobin A1c Poor Control	NCQA	59
At-Risk Population – Hypertension	Hypertension: Controlling High Blood Pressure	NCQA	18
At-Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease: Complete Lipid Panel and LDL Control (< 100 mg/dL)	NCQA	75
	Ischemic Vascular Disease: Use of Aspirin or Other Antithrombotic	NCQA	68
At-Risk Population – Heart Failure	Heart Failure: Beta Blocker Therapy for Left Ventricular Systolic Dysfunction	AMA-PCPI	83
At-Risk Population – Coronary Artery Disease	Coronary Artery Disease Composite: Lipid Control	CMS AMA-PCPI	74
	Coronary Artery Disease Composite: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	CMS AMA-PCPI	66

AHRQ: Agency for Healthcare Research & Quality; AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CAHPS: Consumer Assessment of Healthcare Providers and Systems®; CMS: Centers for Medicare & Medicaid Services; MN CM: Minnesota Community Measurement; NA: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; PQI: Prevention Quality Indicators

2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP

Measure Name	Measure Steward	NQF #
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHC) Medication	NCQA	108
Ambulatory Care – Emergency Department (ED) Visits	NCQA	NA
Adolescent Well-Care Visit	NCQA	NA
Behavioral Health Risk Assessment (for Pregnant Women)	AMA-PCPI	NA
Child and Adolescents' Access to Primary Care Practitioners	NCQA	NA
Chlamydia Screening for Women	NCQA	33
Childhood Immunization Status	NCQA	38
Pediatric Central-line Associated Bloodstream Infections-Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC	139
CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA	NA
Cesarean Rate for Nulliparous Singleton Vertex	CMQCC	471
Developmental Screening in the First Three Years of Life	OHSU	1448
Frequency of Ongoing Prenatal Care	NCQA	1391
Follow-Up After Hospitalization for Mental Illness	NCQA	576
Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA	1959
Immunization Status for Adolescents	NC QA	1407
Live Births Weighing Less Than 2,500 Grams	CDC	1382
Medication Management for People with Asthma	NCQA	1799
Percentage of Eligibles that Received Preventive Dental Services	CMS	NA
Timeliness of Prenatal Care	NCQA	1517
Percentage of Eligibles that Received Dental Treatment Services	CMS	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	24
Well-Child Visits in the First 15 Months of Life	NCQA	1392
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA	1516

AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CAHPS: Consumer Assessment of Healthcare Providers and Systems®; CMQCC: California Maternal Quality Care Collaborative; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; NA: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OHSU: Oregon Health and Science University.

CCNC Key Performance Indicators

- Inpatient Admission Rate (per thousand member months)
- Emergency Department Usage Rate (per thousand member months)
- Potentially Preventable Readmission Rate
- PM/PM expenditures

- Pregnancy Medical Home
  - Primary cesarean section rates among term patients with a singleton, vertex fetus.
  - Rate of low (<2,500 grams) and very low (<1,500 grams) birth rate basis babies delivered

- Care Coordination for Children (CC4C)
  - Rate of hospital admission of Medicaid Children birth to less than 5 years
  - Rate of hospital re-admissions of Medicaid Children birth to less than 5 years
  - Emergency Department usage rate of Medicaid Children birth to less than 5 years

Independence at Home Quality Measures

- Number of inpatient admissions for ambulatory-care sensitive conditions per 100 patient enrollment months
- Number of readmissions within 30 days per 100 inpatient discharges
- Number of ED visits for ambulatory-care sensitive conditions per 100 patient enrollment months
- Contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED
- Medication reconciliation in the home
- Patient preferences documented
- Beneficiary/caregiver goals

- Screenings/assessments
- Symptom management
- Medication management
- Caregiver stress
- Voluntary disenrollment rate
- Referrals
- Patient satisfaction

Appendix 3: Strategic Planning Process for the Future of Long-Term Services and Supports

Medicaid Reform: LTSS Strategic Planning Framework

Facility, Home & Community Based Services

Overview of Project Effort

Engagement of DMA program staff with other DHHS agencies involved in delivering long-term services and supports (LTSS), Community Care of North Carolina (CCNC), provider representatives, advocacy groups, beneficiaries, and those who support them, in a year-long strategic planning initiative for each program under the DMA Facility, Home & Community Services section.

This planning will focus in two areas:

a. Planning for how current programs and services can better meet the goals of Medicaid Reform
b. Building a service delivery design that solidifies the mechanisms for accomplishing the "essential aims" outlined in the LTSS portion of the Medicaid reform plan.

By December 31, 2014, the Department will have the following information prepared:

- A formalized, detailed work plan for implementing those elements identified through Medicaid reform and through the strategic planning process.
- A proposed budget for each element, including anticipated cost implications and cost savings.
- Recommendations about identified rate, licensing and administrative changes that may be required to fully implement LTSS Medicaid reform.
- Anticipated timeframes for accomplishing each part of the work plan.

Strategic Planning Format for Each Program/Service

In the interest of unifying the strategic direction of these programs, DMA proposes gathering stakeholders of different programs into a coordinated strategic planning effort. To balance the need for full stakeholder inclusion with the need for effective group size (typically no larger than 30), DMA anticipates having two planning groups: one that focuses on the strategic direction of long-term care services (Skilled Nursing Facility, CAP-DA, PCS, etc.) and a second that focuses on intermittent services provided under the Facility, Home & Community section (Home Health, Hospice, etc.).

DMA is committed to ensuring equity among stakeholder constituencies as well as diverse points of view. We intend to rely on recommendations from current stakeholders and provider associations to assemble participants. All meetings will be conducted face to face.

DMA will facilitate no less than four meetings for each stakeholder group. The strategic planning process for each group is anticipated to follow the sequence outlined here:

1. Setting the Stage
    - Update about the Medicaid reform effort
    - Purpose of strategic planning project
    - SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of the program/service
2. Analysis of SWOT
    - Use SWOT Analysis to identify goals and deliverables for the strategic plan
3. Analysis of funding, utilization and regulatory Issues for each program/service as supports or barriers to Medicaid reform
4. Formulation of program-specific recommendations

If it is determined to be feasible, all participants in the strategic planning effort may be invited to re-assemble to one group to review DMA's final plan. This would be contingent in part upon identifying funds to host a large group.

All meetings are anticipated to be two or three hours long and will occur on Dix Campus. Travel reimbursements will be available to participating Medicaid beneficiaries and their families.

Proposed Meeting Schedule

DMA will initiate Strategic Planning for the Long-Term Care Group in May 2014 and will conclude by November 2014. The Intermittent Services Group will begin meeting in July 2014 and will also conclude by November 2014.

Invitations/Strategic Planning Attendees

Incorporating guidance from others, DMA will extend targeted invitations to the following entities:

- Sister state agency representatives
- Relevant provider group representatives
- LTSS advocacy group representatives
- Beneficiary/family representatives.

Feedback Process

In addition to informal feedback, groups will be invited to submit feedback after each session on both the content discussed and the process used, through an online survey mechanism (i.e. Survey Max).

Posting Information

Notes from strategic planning efforts and final workplan will be posted on the DHHS website.