North Carolina Medicaid Transformation
Seven-Year Forecast Legislative Report

North Carolina Session Law 2018-5, Section 11H.9

Report to

North Carolina General Assembly
Joint Legislative Oversight Committee on
Medicaid and NC Health Choice, and the Fiscal Research Division

By

North Carolina Department of Health and Human Services

April 9, 2019

Reporting Requirements (S.L. 2018-5)

MEDICAID TRANSFORMATION SEVEN-YEAR FORECAST

SECTION 11H.9. By November 1, 2018, the Department of Health and Human Services shall submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division a detailed seven-year forecast for Medicaid Transformation, as required by S.L. 2015-245, as amended. The seven-year period for this forecast should include an annual budget detailing anticipated requirements, receipts, and appropriations for each fiscal year beginning with fiscal year 2018-2019 and ending with fiscal year 2024-2025. At a minimum, the following information for each fiscal year shall be addressed in the detailed seven-year forecast:

(1) Forecasted enrollment by program aid category and the assumptions used in each forecast.

(2) Forecasted claims run-out, and associated costs, for populations transitioning from a fee-for-service system to a managed care system and the assumptions used in developing this forecast.

(3) Assumed capitation rates and fee-for-service per member per month costs, including at least all of the following components of those assumed rates and costs:

a. Changes in utilization by service type for each program aid category compared to fiscal year 2017-2018, including what assumptions were used to forecast those changes.

b. New programs or changes to existing programs.

c. Any new reimbursement rates or methodologies proposed as part of Medicaid Transformation.

(4) The assumed Federal Medical Assistance Program (FMAP) percentage.

(5) Additions, changes, consolidations, and eliminations of administrative staff, Department functions, or contracts that occur as a result of Medicaid Transformation.

(6) All anticipated infrastructure funding needed, including IT funding, and the FMAP assumptions and time line for receipt of funds from an enhanced FMAP rate associated with those needs.

(7) A forecast of expenditures and receipts from cost settlements, program integrity, rebates, supplemental payments, Disproportionate Share Hospital (DSH) payments, intergovernmental transfers, assessments, and fees.

(8) By line item or category, any recurring or nonrecurring Medicaid Transformation transition cost that is not otherwise addressed under this section, including costs associated with the elimination of the Division of Medical Assistance.

(9) Any savings anticipated as a result of the transition from a fee-for-service system to a managed care system and the source or reason for the identified savings.

Executive Summary

Background

North Carolina Session Law (S.L.) 2015-245 directed the "Transformation" (transition) of Medicaid from a fee-for-service structure to a managed care structure featuring contracted commercial Prepaid Health Plans (PHPs). The NC Department of Health and Human Services' (the Department's) Division of Health Benefits (DHB; also known as NC Medicaid), after extensive consultation with the North Carolina General Assembly (NCGA), the Centers for Medicaid & Medicare Services (CMS), and many stakeholders, will begin the multi-phased rollout of managed care on Nov. 1, 2019.

This report meets the directive of S.L. 2018-5 Section 11H.9 by providing a detailed, seven-year financial forecast (Forecast) for the transition to Medicaid managed care from state fiscal year (SFY) 2018-19 to SFY 2024-25. The Forecast assumes only currently authorized Medicaid eligibility groups; **it does *not* include Medicaid expansion** proposed in the Governor's budget.

Forecast

The Forecast is the product of NC Medicaid's existing financial model, along with data and analysis provided by a contracted actuarial firm, Mercer Government Human Services Consulting (part of Mercer Health & Benefits, LLC).

Highlights of the Forecast include:

1. **Implementing managed care, including Premium Tax on PHPs, will create savings for the State.**

    a. **Managed care is expected to reduce expenditures for health care services over time; after the first contract year, those reductions will almost completely offset the added cost to the State of PHP administration (including profit).** The first row in Exhibit 1 on page 2 illustrates expected reduction in health care services-related expenditures (relative to fee-for-service) for populations enrolled in the Standard Plan PHPs for each of the first four years of the contracts. The reduction comes predominantly from reduced service utilization rather than reductions in provider reimbursement levels. The overall reduction grows over the initial years of the contract and then levels off as the program matures. *Before consideration of the Premium Tax benefit (discussed below)*, the reductions in service-related costs eventually almost completely offset the added non-benefit (i.e., administrative, profit) costs built into PHP capitation rates (see Sections 3 and 9 of report for further detail).

    b. **Premium Tax is net neutral to the PHPs, and generates a net gain to the State; the Tax receipts will enable the State to realize overall net savings from managed care from year one forward.** The tax is net neutral to the PHPs, as the amount they owe is built into the capitation payments they receive from the State. The net gain to the State for the Standard Plan PHP comes from federal dollars (approximately 67% share) in the capitation payments to the PHPs for the tax then coming back to the State. Factoring in these additional receipts further offsets the administrative costs of managed care, thereby enabling the State to realize overall net savings from managed care even in the initial contract year.

EXHIBIT 1. Expected Cumulative Budget Effects of Managed Care (Compared to Fee-for-Service) for Standard Plan Populations

ELEMENT OF MANAGED CARE BUDGET EFFECT	STANDARD PLAN CONTRACT YEAR			
	YEAR 1 SFY 2019-20[1]	YEAR 2 SFY 2020-21	YEAR 3 SFY 2021-22	YEAR 4 SFY 2022-23
Reduced Expenditures for Medical Services due to Managed Care	-7.1%	-9.8%	-11.0%	-11.1%
Added Expenditures due to Managed Care (i.e., administrative cost + profit)	+10.6%	+11.7%	+11.5%	+11.6%
Subtotal of Managed Care Impact Compared to Fee-for-Service Equivalent ***(before** any Premium Tax Benefit)*	+3.5%	+1.8%	+0.5%	+0.5%
Premium Tax Impact[2]	-3.8%	-3.7%	-3.7%	-3.7%
Net Managed Care Impact Compared to Fee-for-Service, *Including Premium Tax Benefit[2]*	**-0.3%**	**-1.9%**	**-3.2%**	**-3.2%**

2. **Many factors separate from the move to managed care influence the budget outlook.** The overall budget pattern reflects the transition to managed care, but expenditure levels are also affected by the following key factors:

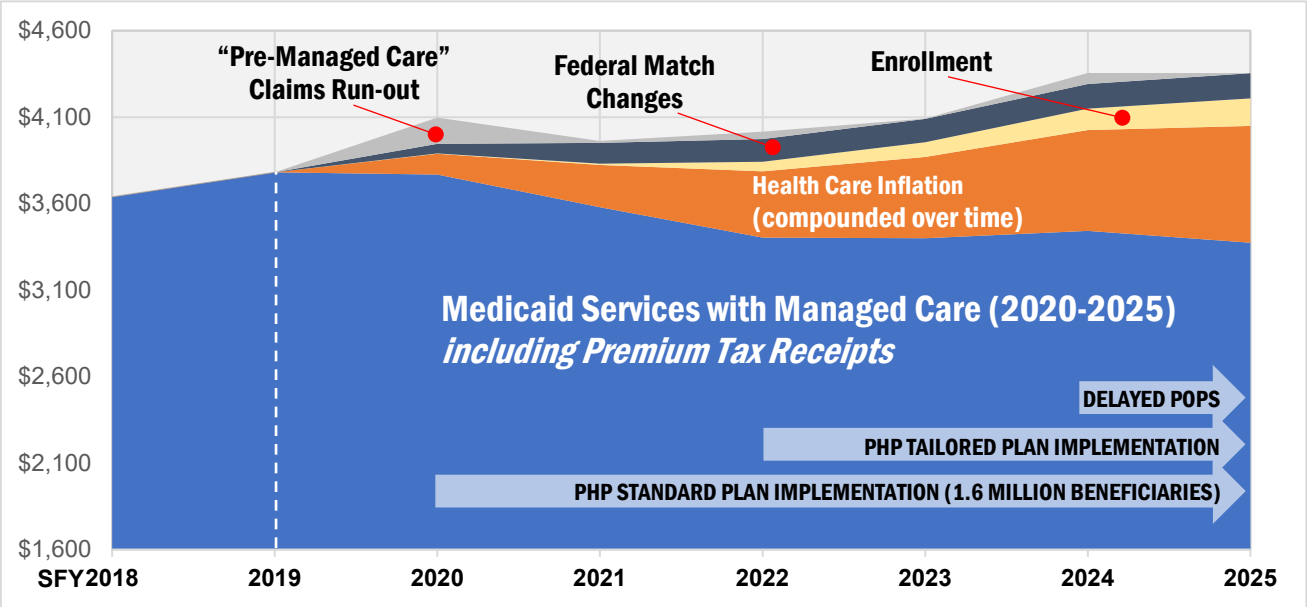
    - **Health care inflation**, consistent with national trends
    - **Enrollment growth**, which is expected to be less than 1% per year
    - **Federal match rate changes**
    - **Fee-for-service claims run-out,** as described in section 2 of the report

    Exhibit 2 on page 3 illustrates how each of these components contributes to the overall projected State expenditures for Medicaid (described in more detail in Section 7 of the report). The "Medicaid Services with Managed Care" budget trend (the base in the chart) reflects the **impact of managed care** *before* accounting for the factors listed above (and including the collection of Premium Tax, as described above). The Medicaid Services with Managed Care budget trend also reflects the multiple phases of managed care rollout (indicated by the arrows in the chart and described in detail in Section 9 of the report).

[1] Standard Plans will be implemented in two phases: a limited rollout in two regions on Nov. 1, 2019, and the remainder of the state on Feb. 1, 2020. Savings in year one is a blend of savings in Phase 1 regions and Phase 2 regions and must be pro-rated to account for partial first year.

[2] Calculations do not account for initial lag in collection of Premium Tax receipts. The net impact to the State of the premium tax application is approximately 1.2% of gross premiums, or 3.8% of non-federal share, which is the difference between the State share of the 2.0% premium tax and regulatory charge built into premiums (which is jointly funded by the State and federal government) and the 1.9% premium tax receipts collected by the Department of Revenue.

EXHIBIT 2. Medicaid[3] 7-Year Budget Forecast (in millions), *including Premium Tax Receipts*



Key Forecast Assumptions

Key assumptions regarding the **timeline for managed care rollout** are summarized below (with further detail provided in the body of the report).

- *Standard Plans* begin Nov. 1, 2019, in two of six regions and Feb. 1, 2020, in the remaining four regions
- *Behavioral Health Intellectual/Developmental Disability (I/DD) Tailored Plans* begin July 1, 2021
- Foster care population enrolls in managed care beginning July 1, 2021
- Managed care for other delayed populations [full Medicare/Medicaid dual-eligible, beneficiaries in a nursing facility for more than 90 days, and beneficiaries enrolled in Community Alternatives Program/Children (CAP/C) and CAP/Disabled Adults (CAP/DA)] waivers begins July 1, 2023
- Healthy Opportunities Pilots (plan still in development) are projected to begin service delivery Jan. 1, 2021
- Behavioral Health Health Home (BH Health Home) initiative (requires final approval by CMS) is projected to begin implementation July 1, 2021, concurrent with launch of the Behavioral Health I/DD Tailored Plans.

The Forecast is built on many other assumptions regarding aspects of managed care implementation; these assumptions, as well as limitations of the analysis, are discussed in detail in the body of the report.

[3] Medicaid *service-related* expenditures only; does not include State Administration (Division of Health Benefits), which is addressed in Sections 5 and 6 of this report.

Detailed Seven-Year Forecast for Medicaid

Summary of Assumptions

The detailed seven-year forecast for Medicaid (Forecast) is built on many assumptions regarding aspects of managed care implementation. Key assumptions are highlighted below (with further detail provided in relevant report sections).

- Managed care rollout timeline:
    - *Standard Plans* begin Nov. 1, 2019, in two of six regions and Feb. 1, 2020, in the remaining four regions
    - *Behavioral Health I/DD Tailored Plans* begin July 1, 2021
    - Foster care/adoptive population enrolls in Managed Care beginning July 1, 2021
    - Managed Care for other *Delayed populations* [full Medicare-Medicaid dual-eligible, beneficiaries in a nursing facility for more than 90 days, and beneficiaries enrolled in Community Alternatives Program/Children (CAP/C) and CAP/Disabled Adults (CAP/DA)] waivers begins July 1, 2023
    - Note: The following *Excluded populations* **will not move into Medicaid Managed Care**, consistent with State legislation and the current approved federal waiver:
        - Family Planning only (approximately 75% of the Excluded group)
        - Eligible for Medicare, but not full Medicaid benefits, including Medicaid cost-sharing
        - Program of All-Inclusive Care for the Elderly (PACE)
        - NC Health Insurance Premium Program (HIPP)
        - Medical Emergency Services only
        - Medically Needy
        - Prison Inmates
- Annual trend projections are applied to expenditures in both Medicaid Fee for Service and Medicaid Managed Care to account for expected changes in service utilization and unit costs in the absence of other program changes.
- Expected Medicaid Managed Care impacts are based on projections from NC Medicaid's actuarial consultant, Mercer Government Human Services Consulting (part of Mercer Health & Benefits, LLC).
- Enrollment projection is based on historical enrollment data and economic trends
- Behavioral Health I/DD Tailored Plan enrollments are based on criteria initially proposed by the Department in November 2017; the Department is in the process of finalizing the criteria based on

legislation passed last session and final Medicaid Managed Care operational approach. Changes are not expected to significantly impact the aggregate requirements presented in this report; however, they could impact the split of total enrollment and per member per month for Standard Plan PHPs, Medicaid Fee for Service, Local Management Entity-Managed Care Organizations (LME-MCOs: entities currently under contract to manage Medicaid behavioral health care for the state) and, ultimately, Behavioral Health I/DD Tailored Plans.

- Legislative changes will be enacted to align with the Department's proposed approach, including:
    - Application of North Carolina's 1.9% insurance premium tax and associated regulatory charge on PHPs, including Behavioral Health I/DD Tailored Plans and managed care for delayed populations expected to begin in 2023
    - Hospital assessment changes as outlined in a separate report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice
    - UNC/ECU Faculty Physician Upper Payment Limit changes to comply with Medicaid managed care federal regulations
- CMS approval of the following:
    - The Department's Standard Plan PHP contract, capitation rates and associated "pre-prints" related to provider reimbursement arrangements under managed care
    - BH Health Home State Plan Amendment and request for enhanced funding
    - Various State Plan Amendments

Enrollment

(1) Forecasted enrollment by program aid category (PAC) and the assumptions used in each forecast.

In previous years, NC Medicaid forecasted enrollment using a point-in-time count, organized by Program Aid Category (PAC). Under Medicaid Managed Care, managed care cohorts (e.g., Standard Plan mandatory, exempt, delayed and excluded population groupings), and capitation rate cells for each eligibility group become the more relevant measures of enrollment for forecast purposes. To adjust to this new context, NC Medicaid (in conjunction with OSBM) organized the NC Medicaid new budget model around the cohorts and eligibility group capitation rate cells of Medicaid Managed Care.

NC Medicaid and OSBM independently generated enrollment forecasts for each Medicaid Managed Care cohort and eligibility group rate cell using statistical models, and compared those estimates to figures produced by a third-party vendor (using a proprietary method). NC Medicaid and OSBM then used information regarding the history of each NC Medicaid service line and other extenuating circumstances to evaluate the rate cell predictions and reach a consensus enrollment forecast. Results are provided in Exhibit 3 on page 6.

EXHIBIT 3. Forecasted Medicaid Enrollment Based on Current Eligibility Rules, SFY 2019-20 to SFY 2024-25

ELIGIBILITY GROUPS	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Non-Dual Aged, Blind, Disabled (ABD)	174,330	177,095	179,966	182,861	185,779	188,717	191,674
TANF & Other Adults	219,342	211,363	209,091	208,643	208,770	209,071	209,421
TANF & Other Child (includes NC Health Choice)	1,136,862	1,146,710	1,158,957	1,171,619	1,184,371	1,197,133	1,209,890
TANF & Other Infant	77,119	77,413	77,414	77,414	77,414	77,414	77,414
CAP/C	2,648	2,648	2,648	2,648	2,648	2,648	2,648
CAP/DA	10,677	10,677	10,677	10,677	10,677	10,677	10,677
Full Medicaid/ Medicare Dual-Eligible	239,944	233,115	228,144	223,604	219,199	214,838	210,489
Foster Care/ Adoptive[4]	21,158	22,103	23,271	24,438	25,606	26,773	27,941
MC Subtotal	***1,882,080***	***1,881,125***	***1,890,168***	***1,901,905***	***1,914,463***	***1,927,273***	***1,940,154***
% growth	***-2.1%***	***0.5%***	***0.6%***	***0.7%***	***0.7%***	***0.7%***	***0.5%***
Groups excluded from managed care[5]	417,643	481,925	545,146	608,343	671,552	734,771	797,998
Medicaid Total	**2,299,723**	**2,363,050**	**2,435,314**	**2,510,247**	**2,586,015**	**2,662,043**	**2,738,152**

[4] Includes foster care, former foster care and adoptive placement populations.

[5] Growth in this cohort is primarily in the Family Planning eligibility group because the income threshold and age restrictions were removed in 2014. Family Planning-eligible receive a limited benefit package with a historical cost of under $5 PMPM. indicating low service utilization and limited financial impact of enrollment growth.

Assumptions Used in Enrollment Forecast

Managed Care Cohorts

The enrollment forecast assumes no change in the current Medicaid eligibility rules. Enrollment modeling begins with a mapping of beneficiaries in each Medicaid eligibility group to the following managed care population cohorts:

- Standard Plan PHP *mandatory*
- Standard Plan *exempt*, including populations who meet eligibility for Behavioral Health I/DD Tailored Plans. These beneficiaries will generally continue in the current FFS/LME-MCO system until July 2021 when Tailored Plans are scheduled to launch. They have a choice of opting into a Standard Plan PHP.[6]
- Foster Care/Adoptive populations, including children currently or formerly in foster care or adoptive placements. These beneficiaries are assumed to be enrolled in managed care on July 1, 2021.
- Delayed managed care populations, including individuals eligible for both Medicare and full Medicaid benefits, beneficiaries in nursing facilities for longer than 90 days and beneficiaries in the CAP/C and CAP/DA waivers.[7] These beneficiaries are assumed to be enrolled in managed care on July 1, 2023.
- Medicaid Managed Care Excluded populations, as defined in legislation (and listed on page 8). These beneficiaries will remain in Medicaid Fee for Service.

The capitation rate cells for **Standard Plan** PHP enrollees are as follows:

- Aged, Blind and Disabled (ABD); all ages
- Temporary Assistance to Needy Families (TANF) and Other Related Children (ages <1)
- TANF and Other Related Children (ages 1-20)
- TANF and Other Related Adults (ages 21+)
- Maternity Event, all ages[8]

The Behavioral Health I/DD Tailored Plan population includes those meeting specified criteria related to Behavioral Health conditions, Traumatic Brain Injury (TBI) and Intellectual/Developmental Disability (I/DD).

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[6] While members of federally recognized tribes are exempt from Medicaid Managed Care enrollment, they were not separately identified for purposes of this Forecast.

[7] Beneficiaries in the CAP/C and CAP/DA waivers are excluded from Medicaid Managed Care per legislation; however, NC Medicaid has proposed and assumes they will be enrolled in Medicaid Managed Care in 2022-23 concurrent with the dual-eligible population.

[8] While "maternity event" is not a population grouping, it is a measure that will need to be tracked for forecasting purposes.

Managed Care **Excluded** populations include the following:

- Family Planning only (approximately 75% of the Excluded cohort)
- Eligible for Medicare, but not full Medicaid benefits, including Medicaid cost-sharing
- Program of All-Inclusive Care for the Elderly (PACE)
- NC Health Insurance Premium Program (HIPP)
- Medical Emergency Services only
- Medically Needy
- Prison Inmates

Refugees receiving coverage through the Refugee Medical Assistance program are also Excluded.

Factors Influencing Enrollment

In Exhibit 3 on page 6, the "Groups excluded from managed care" category (the Excluded cohort) is the most significant driver of overall Medicaid enrollment growth; however, since this category contains mostly beneficiaries receiving only Family Planning benefits (low utilization, low cost), the enrollment growth in this cohort produces negligible effects on the NC Medicaid budget. Therefore, for purposes of modeling future expenditures, NC Medicaid does not count population growth in the Excluded category. Excluding this population, we project annual overall Medicaid enrollment growth between 0.5% and 0.7% across the Forecast period.

The forecasted Medicaid enrollment growth is primarily a function of three factors:

1. **Historic trends.** Growth rates are consistent with observed growth since SFY 2013-14. Declines are concentrated in the Adult cohort.

2. **Labor market softness.** Researchers consistently find that Medicaid enrollment increases as unemployment (UE) levels increase. National forecasters believe the baseline UE rate will increase from the current 3.8% to 4.5% through 2025 (assuming no major recession event, which would increase the rate further). The NC Department of Commerce (NC Commerce) projects the rate of job creation will decline from an average of 2-3% per year over the last few years to less than 1% annually over the next decade. If UE were to rise from the current 3.8% to 4.8%, the Department would expect to see a 3-4% increase in NC Medicaid enrollment. This scenario is consistent with our projections.

3. **Population growth.** North Carolina is growing faster than the United States as a whole. NC Commerce projects that the state's population will grow by 7% between 2019 and 2025. North Carolina will add 360,000 individuals over age 65, an increase of 20%, during this period.

Claims Runout and Other Associated Beneficiary Transition Costs

(2) Forecasted claims run-out, and associated costs, for populations transitioning from a fee-for-service (FFS) system to a managed care (MC) system and the assumptions used in developing this forecast.

Approximately 75% of NC Medicaid beneficiaries will move from Medicaid Fee for Service into Medicaid Managed Care in SFY 2019-20 (approximately one-third effective Nov. 1, 2019, and two-thirds beginning Feb. 1, 2020). While fee-for-service claims are typically paid after the service is provided (providers generally have 12 months to submit claims after the date of service), under a managed care model, the Department will be making advance payments to PHPs for beneficiaries enrolled in Medicaid Managed Care. This cash flow change results in increased program payments each time a new population is transitioned into Medicaid Managed Care, as the Department must pay for claims incurred prior to a beneficiary's Medicaid Managed Care enrollment and the prospective payments to PHPs for those same beneficiaries. The incurred Medicaid Fee for Service claims paid after the beneficiaries are enrolled in PHPs are known as "claims runout" (runout) and are non-recurring expenditures.

The estimated annual cost of claims runout in each state fiscal year is summarized in Exhibit 4 below. All claims are assumed to be paid within 12 months of the service. The projected runout increases in SFY 2021-22 when the Behavioral Health I/DD Tailored Plans are scheduled to launch, and then again in SFY 2023-2024 when dual-eligible and other populations requiring long-term care services transition to Medicaid Managed Care.

The NCGA established a Medicaid Transformation Reserve to provide funding for the non-recurring costs associated with the transition to managed care. Runout is expected to be paid from this Reserve.

EXHIBIT 4. Financing of Claims Runout (in millions)[9]

	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25	TOTAL
Total Requirements	473	36	134	7	199	4	853
Less Federal Receipts	322	25	91	5	135	3	581
State Appropriation	**$150**	**$11**	**$43**	**$2**	**$64**	**$1**	**$272**

Medicaid Managed Care Capitation Rates and Medicaid Fee for Service Per Member Per Month Costs

(3) Assumed capitation rates and fee-for-service (FFS) per member per month (PMPM) costs, including at least all of the following components of those assumed rates and costs:

a. Changes in utilization by service type for each program aid category compared to fiscal year 2017-2018, including what assumptions were used to forecast those changes.

[9] Numbers as pictured here may not sum precisely in some columns due to rounding.

b. New programs or changes to existing programs.

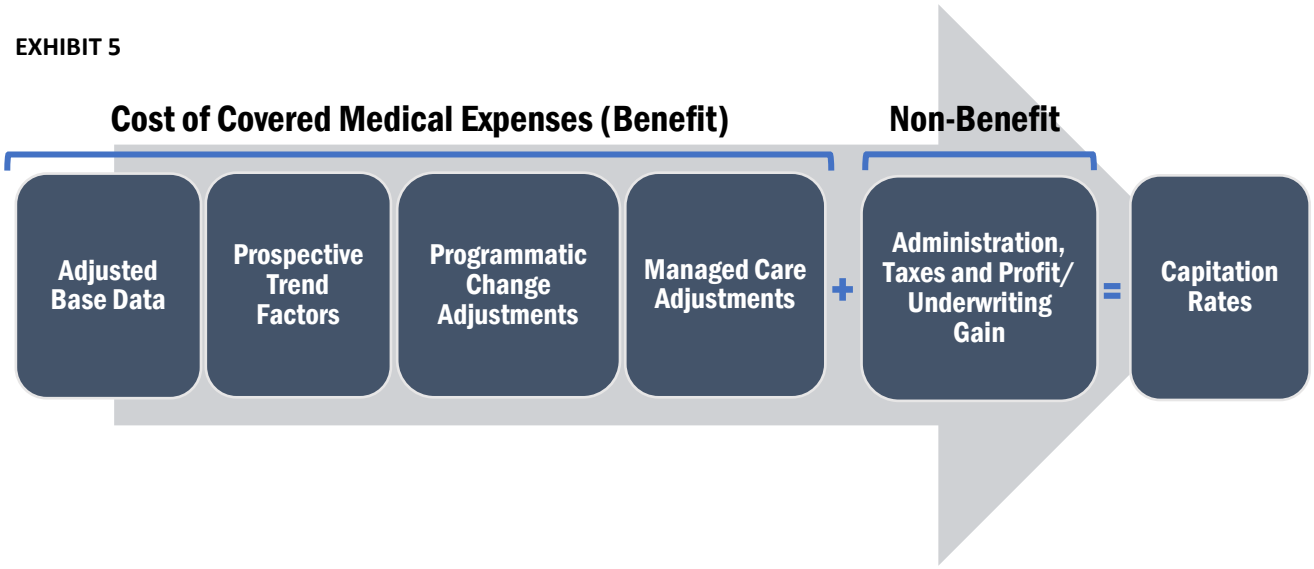
c. Any new reimbursement rates or methodologies proposed as part of Medicaid Transformation.

The Department modeled Medicaid Managed Care and LME-MCO capitation payments and Medicaid Fee for Service costs using data and assumptions developed by the Department's actuarial consultant, Mercer Government Human Services Consulting (part of Mercer Health & Benefits, LLC).

The capitation rate is an actuarially sound cost projection for the average beneficiary (per rate cell) enrolled in the PHP; the rate is comprised of both the projected cost of covered medical services (benefit cost) and estimated non-benefit (administrative/overhead, including profit) expenses.

Mercer develops capitation rates using historical expenditures on Medicaid Fee for Service claims and LME-MCO encounter data for the covered populations, projected forward based on expected unit cost (per type of service) and utilization trends (in the absence of program or delivery system changes). The actuaries then adjust for any program changes (e.g., changes in covered benefits) and the expected impact of Medicaid Managed Care on expenditures. Finally, the actuaries add estimated non-benefit expenses, including plan administration, taxes and profit or underwriting gain.

EXHIBIT 5



Mercer estimates that it will take approximately three years following the launch of Standard Plans to realize the full potential for expected savings resulting from that transition. With the shorter first contract year, full savings for the Standard Plan populations are not realized until sometime in Contract Year 4 (SFY 2022-23). The full expected savings for other populations will also take time to materialize.

Exhibit 6 on page 11 illustrates the expected reductions in the benefit costs relative to Medicaid Fee for Service (assuming all else equal) by category of service for each of the first four Standard Plan PHP contract years. The reductions are primarily driven by reduced utilization of services and shifts from high cost to lower cost services. PHPs are limited in their ability to reduce provider reimbursement below current fee-for-service levels due to rate floor requirements for physicians, hospitals and other provider types. In addition to service-specific savings anticipated through Medicaid Managed Care, Exhibit 6 also provides the expected savings resulting from the integration of physical and behavioral health services for the Standard Plan populations. This integration savings is an aggregate savings figure applicable to all service costs, rather than a service-specific estimate.

EXHIBIT 6. Expected Cumulative Reduction in Services-Related Costs for Standard Plan Populations[10]

SERVICE CATEGORY	STANDARD PLAN CONTRACT YEAR			
	YEAR 1 SFY 2019-20	YEAR 2 SFY 2020-21	YEAR 3 SFY 2021-22	YEAR 4 + SFY 2022-23 +
Inpatient Hospital	-10.1%	-13.9%	-15.7%	-15.8%
Outpatient Hospital	-14.9%	-20.5%	-23.1%	-23.3%
Emergency Room	-9.7%	-13.3%	-15.0%	-15.1%
Physician	-5.9%	-8.2%	-9.2%	-9.3%
Pharmacy	-1.6%	-2.1%	-2.4%	-2.4%
LTSS Services	-3.0%	-4.1%	-4.6%	-4.6%
Durable Medical Equipment	-10.0%	-13.7%	-15.5%	-15.6%
Behavioral / Physical Health Integration Savings	-0.5%	-0.6%	-0.7%	-0.7%
Total Savings Percentage	**-7.1%**	**-9.8%**	**-11.0%**	**-11.1%**
Percent of Ultimate Expected Savings Achieved (Savings Phase-In)	**64%**	**88%**	**99%**	**100%**

The assumptions in Exhibit 6 were developed based on a review of current program experience coupled with other data sources, which includes specific data analyses such as clinical efficiency analyses specific to inpatient and emergency room services, and analysis and application of pharmacy clinical edits.

The overarching intent of these analyses and expected savings are based on the concept that in general, PHPs are expected to impact the current levels of medical cost and utilization through care management and other initiatives. The overall Medicaid Managed Care savings may be achieved through a reduction to utilization of high-cost and high-intensity services as a result of activities such as, but not limited to the following:

1. Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the emergency department or hospitalization.

2. Reducing non-emergent use of the emergency department through member education and viable alternatives (e.g., extended doctor office hours, after-hours urgent care clinics or nurse advice lines).

3. Hospital discharge planning designed to minimize readmissions by ensuring a smooth transition from facility-based care to community resources.

4. Adherence to appropriate prescribing and/or dispensing patterns in line with pharmacy utilization management observed in other state Medicaid programs.

Estimated capitation rates are provided in Exhibit 7 on page 12 and Exhibit 8 on page 133, broken out by the Medicaid Managed Care cohorts and rate cells described in Section 1, above. The estimated rates leverage

[10] Savings computed here do not take into account the non-benefit portion of the capitation rate (see section 9 for discussion of non-benefit costs) or the Healthy Opportunities Pilots (described in section 3b). Also, savings in Year One are a blend of savings in Phase 1 regions and Phase 2 regions, and must be pro-rated to account for partial first year.

assumptions used by Mercer to develop draft capitation rates in fall 2018 (that were incorporated in the Standard Plan PHP Request for Proposal). Estimated Medicaid Fee for Service PMPMs (incurred basis) are also provided by Medicaid Managed Care cohort and rate cell; these estimates represent expenditures that will remain covered through Medicaid Fee for Service once Medicaid Managed Care begins for each population cohort. These PMPMs include services "carved-out" of managed care (i.e., not managed by PHPs, therefore not provided for in capitation payments) such as dental, eyeglasses and services provided by local education agencies and Children's Developmental Services Agencies. The full estimated PMPM for each population cohort is therefore the sum of Medicaid Fee for Service and capitation PMPMs for each applicable year. Runout expenditures described in Section 2 are not included in the PMPMs.

The projected Medicaid Fee for Service and PHP Capitation PMPM rates used in the Forecast are as follows:

EXHIBIT 7. Estimated Medicaid Fee for Service PMPM

STANDARD PLAN COHORT	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Non-Dual Aged, Blind Disabled (ABD)	$1,127	$696	$109	$113	$117	$122	$126
TANF & Other Infants	423	320	5	5	5	5	5
TANF & Other Child (includes NC Health Choice)	134	83	26	27	28	29	29
TANF & Other Adults	314	183	22	23	23	24	25
Maternity Event	5,292	3,825	25	25	25	26	26

TAILORED PLAN COHORT	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Non-Dual Aged, Blind Disabled (ABD)	$1,169	$1,382	$1,474	$64	$65	$67	$68
TANF & Other Infants	2,383	4,451	5,204	62	63	64	65
TANF & Other Child (includes NC Health Choice)	503	576	611	51	53	54	56
TANF & Other Adults	741	891	959	38	39	40	42
Full Medicare/Medicare Dual-Eligible	386	398	405	33	33	34	34

OTHER COHORTS	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Foster Care/ Adoptive	$321	$361	$381	$42	$43	$45	$46
Full Medicare/Medicare Dual-Eligible	370	388	399	412	420	34	34
LTSS Composite CAP & Full Dual	3,479	3,691	3,813	3,906	3,984	152	155
Excluded from Medicaid Managed Care	216	201	181	181	164	150	138

EXHIBIT 8. PHP Capitation PMPM[11]

STANDARD PLAN COHORT	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Non-Dual Aged, Blind, Disabled (ABD)	$0	$1,388	$1,386	$1,411	$1,460	$1,513	$1,568
TANF & Other Infants	0	711	691	687	697	709	721
TANF & Other Child (includes NC Health Choice)	0	147	148	151	155	160	164
TANF & Other Adults	0	412	413	421	435	450	465
Maternity Event	0	9,494	9,554	9,655	9,790	9,929	10,071

TAILORED PLAN COHORT	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Non-Dual Aged, Blind, Disabled (ABD)	$0	$0	$0	$3,069	$3,124	$3,192	$3,262
TANF & Other Infants	0	0	0	3,849	3,906	3,966	4,028
TANF & Other Child (includes NC Health Choice)	0	0	0	1,209	1,240	1,272	1,305
TANF & Other Adults	0	0	0	1,469	1,506	1,546	1,588
Full Medicare/ Medicare Dual-Eligible	0	0	0	2,219	2,229	2,248	2,268

[11] The Department is working with Mercer to develop final Standard Plan PHP and LME-MCO capitation rates for SFY 2019-20. Final capitation rates will be available in the spring and will reflect updated historical claims and encounter data through SFY 2017-18; and updated trends and adjustments for program changes, including provider reimbursement changes, as needed.

OTHER COHORTS	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Foster Care/Adoptive	$0	$0	$0	$907	$932	$957	$983
Full Medicare/Medicare Dual-Eligible	0	0	0	0	0	284	288
LTSS Composite CAP & Full Dual	0	0	0	0	0	4,989	5,045
Excluded from Medicaid Managed Care	0	0	0	0	0	0	0

b. New programs or changes to existing programs.

The Forecast includes projected costs for initiatives proposed to address the opioid crisis and non-medical drivers of health, and to build a robust care management system for beneficiaries with significant mental health and/or substance abuse disorders, traumatic brain injury and/or intellectual and developmental disabilities who are enrolled in the Behavioral Health I/DD Tailored Plans.

Addressing the Opioid Crisis

To support broader state efforts to combat the opioid crisis, the Department received federal authority through its Section 1115 demonstration waiver to increase access to inpatient and residential substance use disorder treatment through reimbursement for services in institutions of mental disease (IMD).

Consistent with the waiver, the Department plans to expand the continuum of services for individuals with substance use disorders (SUD). Additional services may include substance abuse halfway house services and high-intensity residential services for individuals no longer needing inpatient care but not yet ready to return to their homes. This expansion is part of the State's comprehensive strategy to address opioid use disorders.

Addressing Non-Medical Drivers of Health

As part of North Carolina's 1115 waiver, the Department received CMS approval to spend up to $650 million to implement within Medicaid Managed Care an innovative Healthy Opportunities Pilot program in two to four areas of North Carolina. These Pilots will test the impact of providing selected evidence-based interventions to Medicaid Managed Care enrollees. Over the next five years, the Pilots will provide funding to PHPs to cover the cost of Pilot services related to housing, food, transportation and interpersonal safety, and directly impact the health outcomes and health care costs of enrollees. More information is available at https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots.

Care Management Program in Behavioral Health I/DD Tailored Plans

The Department is developing a robust model of integrated, whole-person care management for enrollees in Behavioral Health I/DD Tailored Plans. Under this model, care managers will be required to coordinate physical health, behavioral health, I/DD, TBI waiver, Innovations waiver, pharmacy and social services. The Department plans to submit a State Plan Amendment to seek a 90% federal match under the federal Health Home program for the first eight quarters of the program, which is scheduled to begin July 1, 2021, concurrent with the launch of the Behavioral Health I/DD Tailored Plans.

c. Any new reimbursement rates or methodologies proposed as part of Medicaid Transformation.

Medicaid Fee for Service includes reimbursement arrangements for several provider types that cannot continue under Medicaid Managed Care because they are not allowed under the federal Medicaid managed care rules. As a result, the Department has developed new reimbursement methodologies for the following provider types to preserve similar reimbursement levels as those currently provided through Medicaid Fee for Service:

- Local Health Departments
- Public ambulance providers (Medicaid only)
- State-owned and -operated facilities
- Hospitals, for both inpatient and outpatient services
- Certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school

Other providers generally will be reimbursed based on negotiated rates between the PHP and provider, in compliance with any applicable rate floor (e.g., the rate floor for physicians and pharmacy dispensing fees as defined in S.L. 2015-245).

Following are descriptions of current and future reimbursement methodologies for the provider types above. The Department will seek federal approval for these reimbursement methodologies through a State Plan Amendment and "42 CFR 438.6(c) pre-prints," which are part of CMS' Medicaid managed care contract review process.

Reimbursement for Local Health Departments

Current State: Medicaid Fee for Service reimburses Local Health Departments (LHDs) through two mechanisms: (1) claims-based payments according to the Medicaid fee schedule; and (2) cost settlements, representing the difference between LHDs' Medicaid costs and claims payments. The State funds the non-federal share of claims payments, while LHDs finance the non-federal share of cost settlements through certified public expenditures (CPEs).

Future State: Reimbursement to LHDs under Medicaid Fee for Service will continue as it does today. LHDs will be reimbursed by PHPs in a new way that will result in similar net reimbursement levels. PHPs will reimburse LHDs for services based on negotiated rates between the parties, and in compliance with any physician or applicable rate floor. In many cases, PHP claims payments will not fully cover LHDs' Medicaid costs. To ensure continued access to care for beneficiaries, the Department is requiring that LHDs receive similar per-unit payments compared to the current state.[12] Because payments for LHD-provided services are factored into PHP capitation rates, the Department is not permitted to make additional payments directly to LHDs.[13] However, the Department can direct PHPs to make additional payments to LHDs that promote quality, access or delivery system reform[14] (referred to as "directed payments" in regulation and "additional

[12] LHDs' overall Medicaid reimbursement may differ from current levels based on changes in utilization.
[13] 42 CFR 438.60
[14] 42 CFR 438.6(c)

utilization-based payments" in the PHP contract). Unlike cost settlements, these additional payments must be based on utilization. LHDs will cover the non-federal share of these payments in the form of an intergovernmental transfer (IGT). No state appropriations are anticipated to support this reimbursement methodology change.

Reimbursement for Public Ambulance Providers

Current State: Medicaid Fee for Service reimburses public ambulance providers through two mechanisms: (1) interim payments based on the fee schedule for ambulance services; and (2) cost settlements, representing the difference between public ambulance providers' Medicaid costs and interim payments. Cost settlements apply only to services provided to Medicaid enrollees (not NC Health Choice). The State funds the non-federal share of interim payments, while public ambulance providers finance the non-federal share of cost settlements through CPEs.

Future State: Reimbursement to public ambulance providers under Medicaid Fee for Service will continue as it does today. PHPs will reimburse public ambulance providers for services after the transition to Medicaid Managed Care based on negotiated rates between the parties, which cannot be less than the amount paid to private ambulance providers for similar services. In many cases, PHP claims payments will not fully cover public ambulance providers' Medicaid costs. To ensure continued access to care for beneficiaries, the Department is requiring that public ambulance providers receive similar per-trip leg payments compared to the current state.[15] Because base payments for public ambulance provider services are factored into PHP capitation rates, the Department is not permitted to make additional payments to public ambulance providers.[16] However, the Department can direct PHPs to make additional payments to public ambulance providers that promote quality, access or delivery system reform[17] (referred to as "directed payments" in regulation and "additional utilization-based payments" in the PHP contract). Unlike cost settlements, these additional payments must be based on utilization. Public ambulance providers will cover the non-federal share of these payments in the form of an intergovernmental transfer (IGT). No state appropriations are anticipated to support this reimbursement methodology change.

The Department and North Carolina hospitals, working through the North Carolina Healthcare Association (NCHA), participated in a collaborative process to develop an approach to non-behavioral health-related hospital payments as part of the State's transition to Medicaid Managed Care.[18] The sections below outline the approach agreed to by all parties, which will be incorporated in the final PHP rate-setting methodology.[19]

Reimbursement for State-Owned and -Operated Facilities

Current State: State-owned and -operated facilities include those operated by the Division of State Operated Healthcare Facilities (DSOHF) and Veterans Homes operated by the Department of Military and Veterans

[15] Public ambulance providers' overall Medicaid reimbursement may differ from current levels based on changes in utilization.

[16] 42 CFR 438.6

[17] 42 CFR 438.6(c)

[18] Hospitals currently negotiate behavioral health reimbursement with LME-MCOs and will continue to negotiate behavioral health reimbursement with PHPs after transition to Medicaid Managed Care. Additionally, the Medicaid Fee for Service reimbursement methodology for behavioral health claims will remain unchanged.

[19] Note that many categories include special treatment for hospitals owned by UNC Health Care and for Vidant Medical Center to maintain current net payment levels, and reflect that these hospitals have historically been treated differently under Medicaid Fee for Service.

Affairs (DMVA). Medicaid Fee for Service reimburses state-owned and -operated facilities through two mechanisms: (1) claims-based payments according to the Medicaid fee schedule; and (2) cost settlements, representing the difference between the facility's Medicaid costs and claims payments. The State funds the non-federal share of claims payments and settlements.

Future State: Reimbursement to state-owned and -operated facilities under Medicaid Fee for Service will continue as it does today. PHPs will be required to reimburse state-owned and -operated facilities for services using rates determined by the Department that are inclusive of expected cost settlements. The Department does not anticipate any impact on state appropriations as a result of this change.

Reimbursement for Hospitals

Current State: North Carolina currently makes the following base payments and supplemental payments to hospitals for services provided under Medicaid Fee for Service.[20]

- **Inpatient Base Payments.** To calculate inpatient base reimbursement, the Department uses a diagnosis related group (DRG) methodology.
    - Most hospitals have a base payment of $2,704 that is multiplied by the applicable DRG weight.
    - Hospitals also receive outlier payments to offset a portion of costs above a specified threshold.
    - Teaching hospitals have a graduate medical education (GME) component added to their base rate to offset a portion of Medicaid GME costs.
    - Critical access hospitals receive an interim payment based on DRG methodology and receive a year-end cost settlement to get them to 100% of their inpatient and outpatient Medicaid costs.
- **Outpatient Base Payments.** Today, hospitals receive an initial reimbursement based off 100% of the hospital's cost for critical access hospitals and Vidant Medical Center, or 70% of the hospital's costs (for other hospitals), based on a ratio of cost to charges.
- There are two state teaching hospitals, UNC-Chapel Hill and Vidant Medical Center, that are also settled to their inpatient and outpatient costs.
- **Supplemental Payments.** North Carolina also makes several categories of supplemental payments to hospitals.[21] The three major categories are:
    - **Disproportionate Share Hospital (DSH) payments.** North Carolina makes several categories of DSH payments to various provider types. Public hospitals and critical access hospitals receive "basic DSH" payments, and public and private hospitals receive "HMO DSH" payments. UNC

[20] This report provides an overview of the generally applicable payment methodologies. Some specific hospitals, including Vidant Medical Center and hospitals in the UNC Health System, are paid using different methodologies.
[21] Supplemental payments apply to inpatient and outpatient services, except that teaching DSH payments apply only to inpatient care.

and institutions for mental disease each also receive DSH payments, and public hospitals receive "teaching DSH" payments.[22]

- **Deficit payments.** Public hospitals receive deficit payments to cover the difference between Medicaid DRG payments and Medicaid costs. Public hospitals finance the non-federal share of these payments through intergovernmental transfers. Private hospitals receive a deficit payment and an equity payment to cover the difference between the Medicaid DRG payments and Medicaid costs. Private hospitals fund the equity payment through a provider assessment. For hospitals with GME programs, the deficit payments cover any GME costs not covered by the base rate add-on described earlier.

- **Upper Payment Limit (UPL) payments.** Hospitals receive a UPL payment to cover the difference between Medicaid costs and what Medicare would have paid. Both private and public hospitals fund the non-federal share of these payments through a provider assessment.

- State appropriations fund the non-federal share of base payments, but the sources of the non-federal share for supplemental payments are predominantly provider assessments, intergovernmental transfers and certified public expenditures.

- Hospital payments made for behavioral health claims covered by LME-MCOs are negotiated in contracts between those entities and are generally not prescribed by the Department.

Future State: Under Medicaid Fee for Service and Medicaid Managed Care, most hospital reimbursements will be made through base payments, which are being increased from the current statewide base rate of $2,704 to new hospital-specific base rates that will incorporate the deficit and UPL payments described above. Additional utilization-based payments will be leveraged to accommodate different payment arrangements for UNC and Vidant hospitals under the current state, and to support other hospitals through the transition to Medicaid Managed Care to compensate for anticipated revenue loss due to utilization declines.

The following outlines the hospital reimbursement approach under Medicaid Transformation.

KEY ISSUE	APPROACH
Hospital payment rate floors under managed care	PHPs will be required to reimburse hospitals no less than the applicable Medicaid Fee for Service rate, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology, for the following durations: • Five PHP contract years to all critical access hospitals and all hospitals located in counties designated as "tier 1" or "tier 2" by NC Commerce. The Department ranks each county based on its unemployment rate, household income, population growth and property tax base. Counties are categorized in three tiers, with tier 1 representing the 40 most economically distressed counties.[23] • Three PHP contract years to all other hospitals.

[22] Most DSH payments are financed through intergovernmental transfers and certified public expenditures. Distributions made to public and private hospitals are based on hospital class and degree of Medicaid and uninsured care delivered.
[23] North Carolina 2018 County Tier Designations.

KEY ISSUE	APPROACH

Inpatient payment methodology	• Each hospital assigned unique DRG base rate that applies in Medicaid Fee for Service and serves as the basis for rate floor under Medicaid Managed Care.[24]
	  ○ Base rate calculated to ensure all hospitals in a class of providers receive the same portion of total inpatient Medicaid and uninsured costs covered
	  ○ Base rate for hospitals owned by UNC Health Care and for Vidant Medical Center set according to same methodology as other hospitals in same class
	  ○ Inpatient base rates for critical access hospitals calculated to approximate each critical access hospital's current Medicaid Fee for Service per-discharge reimbursement
	• The rate floor for PHPs includes Medicaid case weights and outlier methodologies used in calculating inpatient payments to hospitals under Medicaid Fee for Service.
	• Each hospital's DRG base rate will be increased annually by the Medicare Hospital Inpatient Prospective Payment System (IPPS) market basket update less the productivity adjustment, as published in the Medicare "Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule" (called "Medicare market basket update minus productivity adjustment" throughout remainder of this report)[25]
	• PHPs make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center to maintain current net payment levels (in combination with other payments). The Department will reimburse PHPs for these expenditures outside the PMPM capitation rate.
	• PHPs make additional, utilization-based directed payments to all hospitals up to the first three PHP contract years, to offset expected reductions in hospital revenue resulting from utilization declines.

Outpatient payment methodology	• Each hospital paid defined percentage of charges that approximates 100% of outpatient costs • Applies in Medicaid Fee for Service and serves as the rate floor under managed care[26] • For purposes of the outpatient payment methodology, charges will not be permitted to increase by more than the Medicare market basket update minus productivity adjustment. • PHPs make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center to maintain (in combination with other payments) current net payment levels. The Department will reimburse PHPs for these expenditures outside the PMPM capitation rate. • PHPs make additional, utilization based directed payments to all hospitals up to the first three PHP contract years, to offset expected reductions in hospital revenue resulting from utilization declines. The Department will reimburse PHPs for these expenditures outside the PMPM capitation rate.

[24] Hospital rate floor requirements are prescribed in the PHP contract.

[25] "Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule". CMS also tracks quarterly changes in the market basket update (see quarterly market basket data). The Final Rule incorporates these data in setting the annual market basket update.

[26] Hospital rate floor requirements are prescribed in the PHP contract.

KEY ISSUE	APPROACH

Graduate Medical Education	• The Department will make Medicaid GME payments directly to hospitals; GME payments will be excluded in developing hospital-specific inpatient DRG base rates (see Inpatient Payment Methodology on page 19)
	• *Direct* graduate medical education payments (DGME) calculated using statewide per-resident average of salary/fringe benefit costs, multiplied by each hospital's number of residents (not subject to Medicare resident caps) and adjusted for hospital's share of Medicaid days
	  ○ For UNC hospitals and Vidant Medical Center (as the primary affiliated teaching hospitals for each University of North Carolina medical school), DGME payments will be calculated using hospital-specific fully loaded salary/fringe benefit costs, multiplied by each hospital's number of residents and adjusted for hospital's share of Medicaid days
	• *Indirect* medical education (IME) calculated using Medicare formula (excluding Medicare resident caps), multiplied by each hospital's number of Medicaid discharges and case mix index
	  ○ UNC hospitals and Vidant Medical Center will calculate IME according to the same methodology
	• GME payment amounts to be recalculated annually

Medicaid Fee for Service	• Inpatient and outpatient payment methodologies listed above apply to Medicaid Fee for Service discharges/encounters. • Approach will lead to increased gross payments only for "crossover claims" (claims where Medicaid is secondary to Medicare or third-party coverage), since supplemental payments are not currently made on those claims. • Increase in provider assessment and/or IGTs will fund the non-federal share of any additional Medicaid Fee for Service payments, so this will not result in increased cost to the State.
MCHIP/NC Health Choice	• Inpatient and outpatient payment methodologies listed above apply to MCHIP and NC Health Choice discharges/encounters. • Approach will lead to increased gross payments, as supplemental payments are not currently paid on NC Health Choice population. • Increase in provider assessment/IGTs will fund non-federal share of additional payments, so this will not result in increased cost to the State.
DSH	• The Department will continue to make DSH payments directly to hospitals and is in the process of revising its DSH distribution methodology. Changes are not expected to impact state appropriations.

KEY ISSUE	APPROACH

Financing	**Provider Assessment**[27]
	• Establish two separate assessments:
	  ○ *Base assessment*. Applies to qualified public hospitals (QPH) and non-qualified public hospitals (NPQH)
	  ○ *Supplemental assessment*. Applies to NQPHs only
	Base assessment methodology
	  ○ Identify total amount collected under current UPL assessment
	  ○ Add non-federal share of crossover claims, incremental GME costs and enhanced NC Health Choice payments
	  ○ Divide amount by total hospital costs for all hospitals subject to the base assessment
	Supplemental assessment methodology
	  ○ Identify dollar amount collected under current equity assessment.
	  ○ Divide amount by total hospital costs for all hospitals subject to the supplemental assessment.
	• State retains $110 million annually, trended annually based on the Medicare market basket index minus productivity adjustment, from assessment proceeds. Remainder of proceeds used to fund PHP capitation payments, Medicaid and CHIP FFS inpatient and outpatient hospital payments and GME payments.
	• State to recalculate assessment rates annually to account for changes in Medicaid hospital payments, GME slots, and Medicaid/CHIP federal matching rates, among other factors.
	• Hospitals currently exempt from the provider assessment under NC 108A-122 will remain exempt from the assessment under the new hospital payment plan.
	Intergovernmental Transfers (IGTs)
	• All hospitals that currently make IGTs will continue to make IGTs after the transition to managed care.
	• Aggregate IGT amounts will be calculated to approximate total IGTs made in the 2018 Medicaid Reimbursement Initiative/GAP plan, adjusted to account for increased crossover claims, incremental GME costs, enhanced NC Health Choice payments, and any other payment increases, and will be adjusted annually to account for changes in Medicaid hospital payments.

Reimbursement for Certain Faculty Physicians Affiliated with Teaching Hospitals for each UNC Medical School

Current State: Medicaid Fee for Service reimburses certain faculty physicians affiliated with teaching hospitals for each UNC Medical School through two mechanisms: (1) claims-based payments according to the Medicaid fee schedule; and (2) UPL payments equal to the difference between that base payment and the Average Commercial Rate.

Future State: The Department will leverage the current physician UPL payment methodology memorialized in the State Plan to the extent possible. Minor adjustments will be made to comply with managed care regulations and transition reimbursement to the "directed payment" framework. A legislative change will be

[27] Revisions to assessment methodology require legislative approval.

required to revise the methodology in a manner that is compliant with federal Medicaid managed care regulations.

Federal Financial Participation (FFP)

(4) The assumed Federal Medical Assistance Program (FMAP) percentage.

The Forecast model assumes the following FMAP[28] and Enhanced Federal Medical Assistance Program (EFMAP); used for the Children's Health Insurance Program (CHIP) percentages:

EXHIBIT 9. FMAP and EFMAP for Children's Health Insurance Program Percentages

TIME PERIOD	FMAP	EFMAP
FFY 2019	67.16%	100%
FFY 2020	67.03%	88.42%
FFY 2021 and beyond	67.03%	76.92%

The Forecast models federal receipts monthly, thereby allowing a more precise application of the FMAP than if they were used annually, in which case FMAP from two FFYs would need to be "blended" to align to each state fiscal year.

Department Administrative Staffing Changes & Any Related Savings

(5) Additions, changes, consolidations, and eliminations of administrative staff, Department functions, or contracts that occur as a result of Medicaid Transformation.

The Department has already taken the following actions to remodel the NC Medicaid organization due to Medicaid Transformation:

- Started to realign the NC Medicaid organization to clearly define staff roles in continuing to support Medicaid Fee for Service (for approximately 25% of beneficiaries who will remain in Medicaid Fee for Service) and to implement Medicaid Managed Care.
- Consolidated all NC Medicaid administrative operations, including Medicaid Fee for Service and Medicaid Managed Care business lines, into one budget/fund (captured in the North Carolina Accounting System as 14445 1101). The budget is approximately $203 million, with an additional $55 million in restricted Health Care Information Technology (HIT) grant funds accounted for separately (14445 1103).
- Consolidated the former Division of Medical Assistance staff into DHB, which is now the single NC Medicaid administrative organization; started training staff on new/modified roles/responsibilities within the modified DHB.
- Started hiring time-limited positions allowed in S.L. 2019-5.

[28] Family Planning services receive a 90% FMAP

- Reviewed existing contracts for potential modification and/or phase-down.
- Requested additions to the NC Medicaid administrative operation, as presented in the proposed Governor's Budget for the SFY 2019-21 biennium.

Department Information Technology (IT) Changes and Costs

(6) All anticipated infrastructure funding needed, including IT funding, and the FMAP assumptions and time line for receipt of funds from an enhanced FMAP rate associated with those needs.

NC Medicaid anticipates many IT and other infrastructure projects being required to implement the transition to Medicaid Managed Care. Some projects underway are supported by funding that has been approved, others are being requested in the 2019-21 biennium or will be requested in future biennia. A summary of anticipated IT and other infrastructure projects is shown in Exhibit 10 below.

EXHIBIT 10. Approved IT Project Costs (in millions) Associated with Medicaid Transformation

PROJECT	TOTAL REQUIREMENTS	FMAP	STATE APPROPRIATION (NR)
Managed Care System Modification	$ 76	Some at 90%; Some at 75%	$ 12
IT Staffing and Implementation Consulting	$ 30	75-90%	$ 3
New System Implementation	$ 18	75-90%	$ 2
Approved Total	**$124**	**75-90%**	**$ 17**

In addition, NC Medicaid has requested state appropriation of **$105 million** (drawing $320 million in federal match) in IT and other non-IT infrastructure items (such as a contract enrollment broker) through the 2019-21 biennium budget expansion request (as represented in the proposed Governor's Budget). FMAP for the additional requested IT items is 75% or 90%, while for non-IT administrative items (such as the enrollment broker) it is 50%.

NC Medicaid anticipates requiring additional State Appropriation of approximately **$18 million** (drawing $95 million in federal match) for IT projects for SFY 2021-22 through SFY 2024-25.

Cost Settlements, Program Integrity, Rebates and Supplemental Payments

(7) A forecast of expenditures and receipts from cost settlements, program integrity, rebates, supplemental payments, Disproportionate Share Hospital (DSH) payments, intergovernmental transfers (IGT), assessments, and fees.

Exhibit 11 on page 244 summarizes estimated expenditures and receipts (federal and non-federal) for Medicaid services, including cost settlements, program integrity, rebates and supplemental hospital payments, including DSH payments, and any associated assessments. At the bottom of Exhibit 11, the net required State Appropriation is adjusted for key non-Medicaid Managed Care external budget influences (changing FMAP and EFMAP) and to account for Premium Tax receipts to the State (to be consistent with the Department's assumption that the current Premium Tax applicable to all insurers will apply to PHPs; the tax is also built into the projected PHP capitation payments and is, therefore, in the expenditure figures in Exhibit 11). The result is

a net "baseline" Medicaid services State Appropriations budget that better approximates the effect on total expenditures and receipts related to the transition to Medicaid Managed Care.

EXHIBIT 11. Medicaid Services Budget (in millions; terms are defined on page 25)[29]

TOTAL REQUIREMENTS	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
FFS Claims, LME-MCO, Buy-in, GME, Excluded	$12,823	$12,303	$9,508	$5,696	$5,646	$3,955	$3,822
CCNC Management Fees	210	176	113	89	88	51	48
MC Capitation + Directed Pmts[30]	0	3,403	6,750	10,614	10,992	13,501	13,803
Cost Settlements	328	178	135	118	116	90	87
Third Party Liability/ Program Integrity	-64	-42	-29	-24	-25	-10	-11
Pharmacy Rebates	-1,292	-1,271	-1,324	-1,381	-1,442	-1,505	-1,571
DSH, Other Direct Payments	2,673	1,085	453	434	454	475	497
Requirements Subtotal	**$14,677**	**$15,831**	**$15,605**	**$15,546**	**$15,830**	**$16,557**	**$16,675**

FEDERAL RECEIPTS	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
FFS Claims, LME-MCO, Buy-in, GME, Excluded	$8,431	$8,111	$6,148	$3,548	$3,503	$2,347	$2,245
CCNC Management Fees	146	122	79	62	61	36	33
MC Capitation + Directed Pmts	0	2,313	4,568	7,217	7,475	9,134	9,339
Cost Settlements	220	119	90	78	78	60	58
Third Party Liability/Program Integrity	-50	-31	-22	-18	-19	-8	-8
Pharmacy Rebates	-896	-878	-910	-948	-990	-1,033	-1,078
DSH, Other Direct Payments	1,641	606	209	200	210	220	230
Federal Receipts Subtotal	**$9,492**	**$10,363**	**$10,162**	**$10,140**	**$10,318**	**$10,756**	**$10,819**

[29] Exhibit 11 addresses Medicaid services expenditures only – it does not include the NC Medicaid/DHB Administrative budget, which is addressed in sections 5 and 6 of this report.

[30] Expenditures for Healthy Opportunities Pilots and BH Health Homes are included in this row.

NON-FEDERAL RECEIPTS	SFY 2018-19	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
FFS Claims, LME-MCO, Buy-in, GME, Excluded	$170	$665	$836	$760	$741	$738	$744
MC Capitation + Directed Pmts	0	41	62	71	72	85	86
Cost Settlements	81	75	53	44	44	30	29
Third Party Liability/Program Integrity	1	0	0	0	0	0	0
DSH, Other Direct Payments	1,153	578	319	305	319	334	350
Non-federal Receipts Subtotal	**$1,404**	**$1,359**	**$1,271**	**$1,180**	**$1,176**	**$1,187**	**$1,210**
Net (Requirements – Receipts)	**$3,781**	**$4,110**	**$4,173**	**$4,225**	**$4,336**	**$4,614**	**$4,647**
Plus Premium Tax Receipts	0	-13	-210	-209	-244	-259	-292
Net / Appropriations, Assuming Premium Tax	**$3,781**	**$4,097**	**$3,963**	**$4,017**	**$4,092**	**$4,355**	**$4,355**
Less Runout	0	150	11	43	2	64	1
Less FMAP & EFMAP Changes	0	56	121	132	136	142	146
State Appropriations for Adjusted "Baseline" Medicaid Services	**$3,781**	**$3,891**	**$3,830**	**$3,841**	**$3,954**	**$4,149**	**$4,208**

Buy-in refers to individuals whose Medicare premiums are paid by Medicaid. This population is sometimes referred to as "duals" because they receive both Medicare (primary) and Medicaid (secondary) benefits.

GME (Graduate Medical Education) refers to supplemental funding for teaching hospitals supports their GME programs. This funding will be paid outside the capitation payments rather than part of hospital base rates.

Excluded refers to the populations currently eligible for Medicaid Fee for Service who will not move into Medicaid Managed Care. This group includes the following:

- Family Planning benefits only
- Eligible for Medicare, but not full Medicaid benefits, including Medicaid cost-sharing
- Program of All-Inclusive Care for the Elderly (PACE)

- NC Health Insurance Premium Program (HIPP)
- Medical Emergency Services only
- Medically Needy
- Prison Inmates
- Community Alternatives Program for Children (CAP/C) waiver
- Community Alternatives Program for Disabled Adults (CAP/DA) waiver

Community Care NC (CCNC) Management Fees are payments made to CCNC to support care management activities for the Medicaid Fee for Service population.

Directed Payments made through the PHPs (therefore included on the line with Medicaid Managed Care Capitation) are utilization-based payments that are considered part of PHP premiums, but are in addition to prospective PMPM and maternity event capitation payments. These directed payments include payments for the following:

- Public ambulance
- Local Health Departments (LHD)
- Faculty physicians at UNC and ECU medical schools for payments formerly known as Physician Upper Payment Limit (UPL)
- UNC and Vidant Health Systems
- Hospital payments to support managed care transition

Third Party Liability/Program Integrity and **Pharmacy Rebates** show negative expenditures because both categories end up with net collections (collections exceed payments).

DSH, Other Direct Pmts captures the payments the Department will make directly to providers (and not through PHPs); DSH payments will be made to all participating hospitals (UNC and Vidant will not receive DSH payments after SFY 2019, but UNC will provide funds through IGT to support a non-tax revenue transfer to the State equivalent to the federal share of the current DSH payment), while UNC and Vidant will receive direct payments that are part of negotiated alternative arrangements to the DSH program.

Premium Tax Receipts will be collected (if proposed legislation passes) from PHPs, who will be paid the tax amount as part of capitation payments (the tax is already built in to projected expenditures). These receipts are not currently counted as revenue to NC Medicaid, but will draw down federal match that will be a net gain to the State.

Other Medicaid Transformation Transition Cost

(8) By line item or category, any recurring or nonrecurring Medicaid Transformation transition cost that is not otherwise addressed under this section, including costs associated with the elimination of the Division of Medical Assistance.

The other sections of this report capture the Medicaid Transformation transition costs.

Costs/Savings Associated with Transition to Managed Care

(9) Savings anticipated as a result of the transition from a fee-for-service (FFS) system to a managed care system and the source or reason for the identified savings

As described in Section 3, the Department's actuarial consultant, Mercer, estimates that it will take approximately three years for the population moving from Medicaid Fee for Service to Standard Plan PHPs to realize the full potential for expected savings resulting from the transition. With the shorter first contract year, full savings for the Standard Plan populations are not realized until Contract Year 4 (SFY 2022-23). Exhibit 12 below summarizes the expected reduction in the roughly $6.6 billion of services-related costs for the populations that will transition to Standard Plans starting Nov. 1, 2019.

EXHIBIT 12. Expected Cumulative Reduction in Services-Related Costs for Standard Plan Populations

	STANDARD PLAN CONTRACT YEAR			
	YEAR 1 SFY 2019-20[31]	YEAR 2 SFY 2020-21	YEAR 3 SFY 2021-22	YEAR 4 + SFY 2022-23 +
Total Savings Percentage	-7.1%	-9.8%	-11.0%	-11.1%
Percent of Ultimate Expected Savings Achieved	64%	88%	99%	100%

Assumed reductions in services spend (due primarily to utilization changes) are offset by non-benefit expenses incorporated into PHP capitation rates. The non-benefit expense load includes consideration for general administration (including program management, administrative operations and utilization management personnel), care management personnel, non-personnel costs, profit/underwriting gain and premium taxes imposed on the PHPs. The non-benefit expense considerations (with the exception of profit/underwriting gain and premium taxes) were developed to reflect the PHP contract requirements as defined by the Department.

[31] Savings apply to only the portion of the SFY after managed care is implemented and are a blend of savings in Phase 1 regions and Phase 2 regions.

The estimated overall impact of the non-benefit expense considerations is summarized in Exhibit 13 below:

EXHIBIT 13. Contract Year 1 Non-Benefit Load (Cost) for Standard Plan PHPs (Per Draft Rate Book)[32]

	GENERAL ADMINISTRATION AND UTILIZATION MANAGEMENT	CARE MANAGEMENT	PROFIT/ UNDERWRITING GAIN	TOTAL	PREMIUM TAXES[33]
Per Member Per Month Load (Cost)	$16.37	$10.86	$5.84	$33.07	$6.85
Load (Cost) as a Percentage of Premium	4.9%	3.3%	1.75%	9.95%	2.0%

The net fiscal impact of Standard Plan implementation (comparing projected capitation payments to equivalent Medicaid Fee for Service costs) can be calculated by combining the service cost reduction assumptions in Exhibit 12 on page 2727 with the non-benefit load components in Exhibit 13 above. For purposes of the numbers outlined in Exhibit 14 on page 2929, the spending impact is illustrated with and without the impact of premium tax which overall results in a total non-benefit load of 11.95% and 9.95%, respectively.

The premium tax, as currently proposed, would be a net benefit to the State and therefore the results are illustrated in this manner. The premium tax would be paid out to the PHPs via capitation using a split of state and federal dollars based on Federal Financial Participation percentages, while the receipts would be fully maintained by the State. The tax is net neutral to the PHPs.

Note that the cost impact illustrated in Exhibit 14 on page 2929 also incorporates the cost of the proposed Healthy Opportunities Pilots described in Section 3b.

[32] Draft rate book

[33] Application of premium tax is pending legislation to apply the premium tax to PHP premiums. The application of the premium tax results in a net benefit to the State.

EXHIBIT 14. Expected Net Managed Care Impact (Cost) for Populations and Services Covered Under Standard Plans[34]

	STANDARD PLAN CONTRACT YEAR			
	YEAR 1 SFY 2019-20[35]	**YEAR 2 SFY 2020-21**	**YEAR 3 SFY 2021-22**	**YEAR 4 / 5 SFY 2023-24 / SFY 2024-25**
Net Managed Care Impact Compared to FFS Equivalent, *Including Premium Tax Benefit*[36]	-0.3%	-1.9%	-3.2%	-3.2%
Net Managed Care Impact Compared to FFS Equivalent, *Excluding Premium Tax Benefit*	+3.5%	+1.8%	+0.5%	+0.5%

Exhibit 15 on page 30 summarizes the expected reduction in the State share associated with the roughly $3.3 billion of services-related costs for the populations that will transition to managed care in July 2021. This includes the Foster Care, former Foster Care and Adoptive Placement populations as well as the Behavioral Health I/DD Tailored Plan populations (including dual-eligible who are enrolled in both Medicare and full Medicaid benefits). Because the Medicaid Managed Care design details for these populations are still under development, the cost impact is based on high level assumptions leveraging Mercer's experience working with other states.

[34] The impact illustrated does not account for changes in the cost of care management, prior authorization and other contracts that support Medicaid Fee for Service.

[35] Standard Plans will be implemented in two phases: a limited rollout of two regions on Nov. 1, 2019, and the remainder of the state on Feb. 1, 2020. Savings in Year One is a blend of savings in Phase 1 regions and Phase 2 regions, and must be pro-rated to account for partial first year.

[36] Calculations do not account for initial lag in collection of Premium Tax receipts. The net impact to the State of the premium tax application is approximately 1.2% of gross premiums, or 3.8% of non-federal share, which is the difference between the State share of the 2.0% premium tax and regulatory charge built into premiums (which is jointly funded by the State and federal government) and the 1.9% Premium Tax receipts collected by the Department of Revenue.

EXHIBIT 15. Expected Net Managed Care Impact (Cost) for Populations and Services Transitioning to Managed Care in SFY 2021-22

	CONTRACT YEAR FOR PLANS STARING JULY 1, 2021			
	YEAR 1 SFY 2021-22	YEAR 2 SFY 2022-23	YEAR 3 SFY 2023-24	YEAR 4 SFY 2024-25
Net Managed Care Impact Compared to FFS Equivalent, *Including Premium Tax Benefit*[37]	-2.2%	-2.5%	+0.8%	+0.1%
Net Managed Care Impact Compared to FFS Equivalent, *Excluding Premium Tax Benefit*	+1.4%	+1.1%	+4.4%	+3.8%

Note that the cost impact illustrated above incorporates the cost of the proposed Healthy Opportunities Pilots and BH Health Homes described in Section 3b. The net savings are greater in the initial years due to higher federal match rate for the BH Health Home Initiative (90% match in SFY 2021-22 and 2022-23; regular FMAP of ~67% in 2023-24 and 2024-25). [38]

Exhibit 16 on page 31 summarizes the expected change in the State share associated with the roughly $2.0 billion of services-related costs for the populations assumed to transition to managed care in July 2023. This includes dual eligible beneficiaries who are enrolled in Medicare and eligible for full Medicaid benefits, beneficiaries in nursing facilities for greater than 90 days, and beneficiaries enrolled in the CAP/C are CAP/DA waivers. Because the managed care program design details for these populations are still under development, the cost impact is based on high level assumptions leveraging Mercer's experience working with other states. Based on that experience, Mercer has assumed that service cost savings for these populations take several years to materialize. Because much of the cost related to this population is for long-term care services, ultimate savings are generated by transitioning and/or diverting populations from nursing homes to community-based settings, which could take several years. Exhibit 16 shows the upfront net cost associated with transitioning these populations into managed care. Any future savings are outside the period of this forecast.

[37] Calculations do not account for initial lag in collection of Premium Tax receipts. The net impact to the State of the premium tax application is approximately 1.2% of premiums, which is the difference between the State share of the 2.0% premium tax and regulatory charge built into premiums (which is jointly funded by the State and federal government) and the 1.9% premium tax receipts collected by the Department of Revenue.

[38] Per CMS, "The 90% enhanced FMAP is good for the first eight quarters the program is effective. A state can get more than one period of enhanced FMAP, but can only claim the enhanced FMAP for a total of eight quarters for one enrollee."

EXHIBIT 16. Expected Net Managed Care Impact (Cost) for Populations and Services Transitioning to Managed Care in 2023

	DUAL-ELIGIBLES /LONG-TERM CARE POPULATIONS CONTRACT YEAR	
	YEAR 1 SFY 2023-24	YEAR 2 SFY 2024-25
Net Managed Care Impact Compared to FFS Equivalent, *Including Premium Tax Benefit*[39]	Neutral	-0.8%
Net Managed Care Impact Compared to FFS Equivalent, *Excluding Premium Tax Benefit*	+3.9%	+3.1%

The numbers above do not account for the potential application of the federal Health Insurance Provider Fee (HIPF). The HIPF is a federal fee that applies to certain health insurers. In the context of rate-setting, the HIPF is considered a cost of doing business that is appropriate to recognize in the payments to PHPs. Currently, there is a moratorium on the HIPF (for premiums earned in 2019) and uncertainty with respect to the applicability of the HIPF in the future. As such, no adjustment has been included in the draft capitation rates for the HIPF. Should these fees apply, the Department will need to reimburse PHPs for these fees. The fees vary based on the size and characteristics of each PHP. For 2018, a general estimate for large organizations would suggest HIPF payments would have been approximately 2.6% of total premium (i.e., would have increased the non-benefit load by 2.6% for large organizations). The HIPF does not apply to any portion of premiums that are applicable to long-term services and supports (e.g., nursing homes and home and community-based services). ***Should the moratorium be lifted and HIPF need to be added into future PHP capitation payments, managed care savings would be reduced significantly.***

Limitations of the Forecast

The following limitations should be considered in utilizing the projections in this report:

- Standard Plan capitation estimates were developed based on assumptions outlined in the Mercer draft rate book based on best available data at the time. Subsequent data affecting the capitation rates could update the Forecast.

- While the details of the Standard Plan design are known and documented in the contract with the newly procured PHPs, details of the Behavioral Health I/DD Tailored Plan and the managed care design for dual-eligibles and other Delayed populations are still under development. Estimated costs and capitation rate setting assumptions will be refined over time as design decisions are made.

- Actual managed care expenditures will be based on actual program enrollment and final capitation rates certified by Mercer.

[39] Calculations do not account for initial lag in collection of Premium Tax receipts. The net impact to the State of the premium tax application is approximately 1.2% of gross premiums, which is the difference between the State share of the 2.0% premium tax and regulatory charge built into premiums (which is jointly funded by the State and federal government) and the 1.9% Premium Tax receipts collected by the Department of Revenue.