GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H **1**

HOUSE BILL 313

Short Title: GPAC-Medicaid. (Public)

Sponsors: (by request) Representatives Nesbitt, Blue, Barnes, Diamont, Hackney, Hensley, H. Hunter, G. Miller, and Robinson.

Referred to: Appropriations.

February 25, 1993

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT THE RECOMMENDATIONS OF THE GOVERNMENT PERFORMANCE AUDIT COMMITTEE REGARDING MEDICAID.

The General Assembly of North Carolina enacts:

—-MEDICAID COST CONTROL POLICY.

Section 1. (a) The General Assembly finds that certain drastic measures could be taken to reduce the level of Medicaid expenditures, such as by eliminating eligibles and services, and imposing restrictive service limits. The General Assembly finds, however, that these measures are effective only in the short term. In the long term, they do not decrease demand for services. The cost of care provided to newly ineligible clients may be shifted to other payors as hospitals and other providers attempt to recover the costs of uncompensated care. Eliminating services that allow individuals to remain at home will eventually increase the use and costs of more expensive facility-based care. Eliminating coverage of primary care services will result in many individuals postponing care. Eventually, more expensive institutional services are needed. Thus, these drastic measures may result in the ultimate increase of expenditures for health care. Also, by shifting costs to other payors, State expenditures for health care will increase because federal matching funds will be forfeited.

It is the intent of the General Assembly that State Medicaid policy should incorporate more creative strategies for controlling Medicaid costs, such as by the development of a managed care program. This policy shall also make clear that drastic

measures such as the elimination of eligible groups and optional services or the imposition of restrictive service limits shall be employed only as options of last resort.

(b) The Division of Medical Assistance, Department of Human Resources, shall conform its State Medicaid policy to the requirements of subsection (a) of this section.

(c) This act is effective upon ratification.

—-MEDICAID BUDGET CONSENSUS.

Sec. 2. (a) The General Assembly finds that it is in the best interests of the State to develop a formal communications process among State staff to develop and monitor Medicaid budget projections.

(b) The Secretary of the Department of Human Resources, the Director of the Office of State Budget and Management, and the Cochair of the Legislative Services Commission shall ensure that the finding made by Section 1 of this act is effected to serve the best interests of the State.

(c) This section is effective upon ratification.

—-MEDICAID SERVICES COPAYMENTS.

Sec. 3. (a) Effective January 1, 1993, the Division of Medical Assistance, Department of Human Resources, shall impose copayments for the following services: home health, hospital inpatient, ambulatory surgical center, personal care, and durable medical equipment. The copayments shall be established by rule and shall not exceed the limits allowed by federal law and regulation.

(b) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by five million seven hundred thousand dollars ($5,700,000) for the 1993-94 fiscal year and by six million one hundred thousand dollars ($6,100,000) for the 1994-95 fiscal year due to the imposition of copayments mandated by subsection (a) of this section.

(c) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to this act's imposition of copayments, according to the following schedule:

Fiscal Year	Amount
1995-96	$6,500,000
1996-97	$7,000,000
1997-98	$7,600,000
1998-99	$8,100,000
1999-00	$8,700,000
2000-01	$9,300,000
2001-02	$9,800,000.

(d) This section becomes effective July 1, 1993.

—-DRG-BASED PAYMENT.

Sec. 4. (a) Effective July 1, 1994, the Division of Medical Assistance, Department of Human Resources, shall implement a Diagnosis-Related Groups (DRG)-Based Medicaid reimbursement system that uses peer groups to establish base payment amounts for hospitals.

(b) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of three hundred sixty-two thousand five hundred dollars ($362,500) for the 1993-94 fiscal year for administrative costs incurred in implementing this section.

(c) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by six million eight hundred thousand dollars ($6,800,000) for the 1994-95 fiscal year due to the savings incurred by implementing subsection (a) of this section.

(d) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to the savings incurred by implementing subsection (a) of this section, according to the following schedule:

Fiscal Year	Amount
1995-96	$7,000,000
1996-97	$7,300,000
1997-98	$7,500,000
1998-99	$7,800,000
1999-00	$8,100,000
2000-01	$8,300,000
2001-02	$8,600,000.

(e) This section becomes effective July 1, 1993.

—-MEDICAID CONTRACTING.

Sec. 5. (a) Effective July 1, 1994, in order to encourage facilities to operate efficiently and reduce Medicaid expenditures for inpatient hospital services, the Division of Medical Assistance, Department of Human Resources, shall implement selective contracting programs for Medicaid in geographically feasible regions of the State. The Division may consider these programs for areas where competition among hospitals exists, such as in Durham, Charlotte, and Raleigh. If the Division does implement selective contracting programs in these areas, the Division shall negotiate with facilities to obtain better rates. The Division shall also develop mechanisms that encourage physicians to send Medicaid recipients to these low-cost facilities whenever possible.

(b) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of one hundred thirty-five thousand dollars ($135,000) for the 1993-94 fiscal year, as administrative costs incurred in implementing subsection (a) of this section.

(c) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by six million nine hundred thousand dollars ($6,900,000) for the 1994-95 fiscal year due to savings incurred by the implementation of subsection (a) of this section.

(d) This section becomes effective July 1, 1993.

—-MEDICAID "BUNDLED" PAYMENT.

Sec. 6. (a) The General Assembly finds that prospective reimbursement of outpatient hospital services encourages hospitals to control costs and efficiently use

resources. "Bundled" prospective payment relies on a fee schedule for specific service "bundles", which are groups of services that are provided on the same day or as part of the same incident of care.

(b) Effective July 1, 1994, the Division of Medical Assistance shall implement a "bundled" prospective payment approach for Medicaid outpatient hospital services. The development of this approach shall include consideration of the following:

(1) Use of peer grouping to address the problem that facilities that serve more seriously ill patients may be underpaid;

(2) Consideration of prospective fee-for-service payment versus current cost-settled arrangements;

(3) Payment of nonemergency care at comparable clinic or office visit rates;

(4) Flat rate payment for all facilities versus current facility-specific percentage of costs;

(5) Rates set based on relative cost of "bundled" services versus current service-specific costs;

(6) Payment for outpatient surgeries at rates based on Medicare's Ambulatory Surgery Center (ASC) Groups; and

(7) Rebasing on a multiyear cycle, with annual updates based on an inflator.

(c) The Division shall report on its progress towards implementing a "bundled" prospective payment approach for Medicaid hospital outpatient services to the appropriate subcommittees of the House and Senate Appropriations Committees of the 1993 General Assembly, Regular Session 1994.

(d) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of one hundred fifty thousand dollars ($150,000) for the 1993-94 fiscal year, as administrative costs incurred in developing the "bundled" prospective payment approach mandated by this section.

(e) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by eight hundred thousand dollars ($800,000) for the 1994-95 fiscal year due to implementation of the "bundled" prospective payment approach mandated by this section.

(f) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to implementation of the "bundled" prospective payment approach mandated by this section, according to the following schedule:

Fiscal Year	Amount
1995-96	$900,000
1996-97	$1,000,000
1997-98	$1,200,000
1998-99	$1,400,000
1999-00	$1,600,000
2000-01	$1,800,000

2001-02 $2,000,000.

(g) This act becomes effective July 1, 1993.

—-MEDICAID NURSING HOME PAYMENT.

Sec. 7. (a) The General Assembly finds that peer grouping identifies facilities that can be expected to incur similar costs based on certain statistically valid variables such as geographic location, bed size, and occupancy levels. A peer group ceiling rate, generally based on a percentile of costs or on the median cost, establishes the standard for efficient and economic facilities. The General Assembly finds that peer grouping will achieve savings for North Carolina because facilities with costs above the ceiling will have payments capped at the ceiling level. To encourage facilities with costs below the ceiling to maintain these costs, an efficiency incentive can be paid.

The General Assembly further finds that separate peer group ceilings should be established for each cost component. North Carolina's current policy to allow more generous reimbursement of direct patient care costs to ensure quality of care should continue, but costs such as housekeeping and laundry and linen, which do not reflect the costs of hands-on patient care, should be moved into another component with more stringent ceilings.

(b) Effective July 1, 1994, the Division of Medical Assistance, Department of Human Resources, shall implement a prospective peer-grouped, case mix-based Medicaid reimbursement methodology for nursing homes, not only to achieve savings but also to promote access for patients requiring a higher level of care, because this reimbursement is more closely tied to patient needs than the one currently employed. This methodology shall address the findings made in subsection (a) of this section and, in addition, shall:

(1) Update rates each year by an appropriate inflation factor, in order to allow greater predictability in estimating nursing facility expenditures;

(2) Adjust payments by the case mix, to reflect the varying levels of resources required to treat patients; and

(3) Incorporate the input of nursing facilities in the development of the methodology, to promote greater understanding of its goals and objectives.

(c) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of one hundred eighty thousand dollars ($180,000) for the 1993-94 fiscal year in administrative costs incurred in implementing this section.

(d) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by nine million six hundred thousand dollars ($9,600,000) for the 1994-95 fiscal year due to the implementation of this section.

(e) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to the implementation of this section, according to the following schedule:

Fiscal Year	Amount
1995-96	$10,200,000
1996-97	$10,800,000

1997-98 $11,400,000
1998-99 $12,100,000
1999-00 $12,800,000
2000-01 $13,600,000
2001-02 $14,400,000.

(f) This section becomes effective July 1, 1993.

—-CON REIMBURSEMENT.

Sec. 8. (a) The General Assembly finds that the Certificate of Need process remains justified for long-term care beds but that the Medicaid reimbursement system for these beds should be adjusted to promote savings.

(b) Effective July 1, 1993, the Division of Medical Assistance, Department of Human Resources shall make those changes in the Medicaid reimbursement system for long-term care facilities that will promote savings.

(c) This act becomes effective July 1, 1993.

—-MEDICAID INDIRECT CARE CAP.

Sec. 9. (a) The General Assembly finds that, under the current Medicaid reimbursement policy, nursing facilities retain the entire difference between actual indirect costs and the flat indirect rate. Differences between indirect costs and the flat indirect rate are substantial for some facilities. The General Assembly finds that establishing a ceiling amount on these payments does not impair the State's ability to encourage facilities to operate efficiently.

(b) Effective January 1, 1993, the Division of Medical Assistance, Department of Human Resources, shall establish a cap of two dollars ($2.00) on Medicaid indirect care efficiency payments for nursing facilities, to eliminate excessive nursing facility "profits" and to reduce Medicaid expenditures with little impact on incentives to control indirect care costs.

(c) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by one million two hundred thousand dollars ($1,200,000) for the 1993-94 fiscal year and by two million four hundred thousand dollars ($2,400,000) for the 1994-95 fiscal year due to the implementation of this section.

(d) This section becomes effective July 1, 1993.

—-ELIM. RETURN-ON-EQUITY PAY.

Sec. 10. (a) The General Assembly finds that many states have eliminated Medicaid return-on-equity payments to private nursing facilities because current reimbursement policy permits facilities to retain the difference between the facilities' indirect costs and the statewide flat rates. The General Assembly finds that, for this reason, nursing facilities already receive a "profit" and that eliminating the extra return-on-equity payments in North Carolina would reduce Medicaid expenditures and be consistent with other states' policies.

(b) Effective July 1, 1993, G.S. 108A-55 is amended by adding a new subsection to read:

"(e) No payment shall be made as 'return-on-equity' reimbursement to nursing homes and no such payment shall be included in the State Health Plan."

(c) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by one million three hundred thousand dollars ($1,300,000) for the 1994-95 fiscal year due to the implementation of this section.

(d) This section becomes effective July 1, 1993.

—-FREEZE DRUG DISPENSING FEE.

Sec. 11. (a) The General Assembly finds that North Carolina's Medicaid prescription drug dispensing fee is the highest in the country and that it has increased by fifty percent (50%) since 1985, from three dollars and sixty-seven cents ($3.67) in 1986 to five dollars and sixty cents ($5.60) in 1992. The General Assembly further finds that North Carolina Medicaid spent more than thirty-five million dollars ($35,000,000) in the 1992-93 fiscal year for dispensing fees alone. The most recent increase approved by the General Assembly resulted in additional Medicaid expenditures of four million five hundred thousand dollars ($4,500,000).

(b) Effective July 1, 1993, through June 30, 1995, the Division of Medical Assistance, Department of Human Resources, shall freeze the Medicaid prescription drug dispensing fee at its July 1992 amount of five dollars sixty cents ($5.60) and shall not pay a higher amount.

(c) It is the intent of the General Assembly to continue the freeze mandated by subsection (b) of this section through fiscal year 2002.

(d) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by the sum of five million dollars ($5,000,000) for the 1993-94 fiscal year and the sum of five million seven hundred thousand dollars ($5,700,000) for the 1994-95 fiscal year due to savings incurred by the implementation of this section.

(e) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to the implementation of this section, according to the following schedule:

Fiscal Year	Amount
1995-96	$6,500,000
1996-97	$7,400,000
1997-98	$8,400,000
1998-99	$9,500,000
1999-00	$10,900,000
2000-01	$12,400,000
2001-02	$14,100,000.

(f) This section becomes effective July 1, 1993.

—-MEDICAID DRUG-PURCHASING.

Sec. 12. (a) The General Assembly finds that North Carolina Medicaid expenditures per prescription are among the highest in the country, that, in 1990, they were nearly three dollars ($3.00) higher than the national average, and that the growth in expenditure is due to increases in the number of prescriptions as well as increases in the cost per prescription. The General Assembly further finds that North Carolina has implemented other prescription drug cost containment strategies, including a six

prescription limit per month and a copayment amount of one dollar ($1.00) per prescription.

(b) Effective July 1, 1994, the Division of Medical Assistance, Department of Human Resources, shall implement alternative purchasing approaches for Medicaid prescription drugs. In developing these approaches, the Division shall consider:

(1) Purchasing maintenance-level medications through mail order pharmacies or community pharmacies and involving local pharmacists in managing this program, as the core of this managed drug plan is a trial therapy period that limits the supply of the drug during its initial period of use in order to ensure that the drug is tolerated and effective before a maintenance supply is dispensed;

(2) Developing a State network to supply the maintenance drug or contracting with existing networks currently providing services in the State;

(3) Acquiring the necessary freedom-of-choice waiver, because recipients would not be able to obtain services from all pharmacists, but only from those who agree to supply the maintenance-level drugs at an agreed upon, discounted price;

(4) Working closely with the Health Care Financing Administration;

(5) Making sure that certain portions of the State are not excluded from the program because of the lack of presence of competing community pharmacies;

(6) Making sure that recipients are not excluded because they do not have regular mailing addresses; and

(7) Continuing current dispensing procedures with local pharmacists to assure availability of nonmaintenance prescription drugs.

(c) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of one hundred twenty-five thousand dollars ($125,000) for the 1993-94 fiscal year, for administrative costs incurred in implementing this section.

(d) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by one million five hundred thousand dollars ($1,500,000) for the 1994-95 fiscal year due to the implementation of this section.

(e) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to the implementation of this act, according to the following schedule:

Fiscal Year	Amount
1995-96	$1,600,000
1996-97	$1,700,000
1997-98	$1,800,000
1998-99	$2,000,000
1999-00	$2,100,000
2000-01	$2,200,000

2001-02	$2,400,000.

(f) This section becomes effective July 1, 1993.

—-CAROLINA ACCESS/RISK-SHARING.

Sec. 13. (a) The General Assembly finds that its recently implemented Carolina Access program, modeled after successful primary care case management programs of other states and currently serving 12 counties, effectively improves access to primary care services, encourages development of physician/patient relationships, and encourages appropriate utilization of all health care services. The General Assembly finds that it is important to move quickly to phase in statewide implementation of the program so that it is available by July 1, 1994. The General Assembly further finds that the additional administrative costs incurred in early statewide implementation will be more than offset by savings and that improved quality of care will also contribute to long-term savings, that access for Medicaid patients will be significantly enhanced, and that physicians and patients statewide will be introduced to coordinated care concepts. The General Assembly further finds that the State should introduce risk-sharing into its Medicaid reimbursement system.

(b) Effective July 1, 1994, the Division of Medical Assistance, Department of Human Resources, shall introduce elements of risk-sharing into its Medicaid reimbursement system. These elements shall include at least one of the following:

(1) A savings-sharing policy, in which primary care providers share in the savings that result from appropriate and cost-effective utilization of other health services, including physician specialty services, prescription drugs, and outpatient hospital services;

(2) The capitation of payments for physician services to guarantee certain savings levels and for outpatient hospital services and prescription drugs to guarantee even greater savings.

(c) Effective July 1, 1994, the Division of Medical Assistance, Department of Human Resources, shall have phased in Medicaid Carolina Access statewide.

(d) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of twenty-five thousand dollars ($25,000) for the 1993-94 fiscal year and the sum of one million seven hundred ten thousand dollars ($1,710,000) for the 1994-95 fiscal year, to implement this section.

(e) It is the intent of the General Assembly to appropriate additional funds to the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years, to implement this act, according to the following schedule:

Fiscal Year	Amount
1995-96	$1,900,000
1996-97	$2,000,000
1997-98	$2,000,000
1998-99	$2,100,000
1999-00	$2,200,000
2000-01	$2,300,000
2001-02	$2,400,000.

(f) This section becomes effective July 1, 1993.

—-STATEWIDE MANAGED CARE.

Sec. 14. (a) The General Assembly finds that managed care programs offer several advantages over traditional fee-for-service arrangements.

(b) Effective July 1, 1993, the Division of Medical Assistance, Department of Human Resources, shall develop a statewide managed care system to contract with existing provider networks. This system shall address the following objectives:

(1) Promote early diagnosis and treatment for preventive health care;
(2) Shift care from hospitals to physicians' offices and clinics;
(3) Stabilize and contain the escalation of Medicaid costs;
(4) Enable clients to form primary care contact with physicians;
(5) Ensure patient access to care; and
(6) Improve the quality of care.

Facilities that serve as contractors for the system shall provide all health care services and shall receive a capitated payment per Medicaid patient per month. In developing the system, the Division shall consider whether to limit the financial risk of the contractors by implementing a stop-loss provision in which each contractor's losses are limited to a fixed amount of aggregate capitation payments. The Division shall encourage Carolina Access providers to participate through their inclusion in provider networks.

(c) The Division of Medical Assistance, Department of Human Resources, shall evaluate the feasibility of statewide managed care programs for certain populations and certain regions of the State. The Division shall report the results of its feasibility study to the General Assembly by May 1, 1994. This study shall include:

(1) How best to ensure physician and hospital acceptance and involvement;
(2) Consideration of the theory that the greater the financial risk borne by the managed care program and providers the greater the success in controlling utilization and cost;
(3) Consideration of long-term care; and
(4) How to ensure that the State and counties will make investments in establishing the appropriate administrative systems for internal operations and external oversight.

(d) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of four hundred thousand dollars ($400,000) for the 1993-94 fiscal year and the sum of six hundred thousand dollars ($600,000) for the 1994-95 fiscal year, as administrative costs incurred in implementing subsection (b) of this section.

(e) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of one hundred thousand dollars ($100,000) for the 1993-94 fiscal year to implement subsection (c) of this section.

(f) This section becomes effective July 1, 1993.

—-MEDICAID MANAGED CARE.

Sec. 15. (a) The General Assembly finds that the use of managed care encourages physicians to coordinate and monitor utilization of services and provides physicians with incentives to use low-cost facilities and make referrals to cost-effective hospitals.

(b) Effective July 1, 1994, the Division of Medical Assistance, Department of Human Resources, shall expand its use of Medicaid managed care options to include implementation of a savings sharing program or capitation of all primary care services. In developing its expanded options the Division shall:

(1) Continue to work with physicians to educate them regarding the importance of managed care programs, as these programs can improve quality of care as well as achieve cost savings and can provide physicians with greater incentives to monitor and control utilization;

(2) In order to develop savings-sharing options, collect extensive data regarding utilization of services in order to determine savings payment amounts and to ensure that the Medicaid Management Information System (MMIS) tracks utilization of groups of services used by specific recipients assigned to primary care physicians;

(3) Work with rural hospitals and health care clinics;

(4) Develop enhanced utilization review to ensure that quality of care and access to services are not compromised;

(5) Consider ways to limit a physician's risk, such as limiting it to ten percent (10%) above the total amount of capitated payments;

(6) Consider exempting patients requiring large amounts of health care from the capitation plan; and

(7) Implement other mechanisms that encourage appropriate care, including a disenrollment process and patient control process.

(c) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of twenty-five thousand dollars ($25,000) for the 1993-94 fiscal year and the sum of twenty-five thousand dollars ($25,000) for the 1994-95 fiscal year, to implement this section.

(d) The base budget of the Division of Medical Assistance, Department of Human Resources, is reduced by one million six hundred eighty-five thousand dollars ($1,685,000) for the 1994-95 fiscal year due to the savings incurred in implementing this section.

(e) It is the intent of the General Assembly to reduce the base budget of the Division of Medical Assistance, Department of Human Resources, in subsequent fiscal years due to implementation of this section, according to the following schedule:

Fiscal Year	Amount
1995-96	$1,900,000
1996-97	$2,000,000
1997-98	$2,000,000
1998-99	$2,100,000
1999-00	$2,200,000
2000-01	$2,300,000

2001-02 $2,400,000.

(f) This section becomes effective July 1, 1993.

—-MMIS REPLACEMENT PLAN.

Sec. 16. (a) The General Assembly finds that, when the current base contract with the Medicaid fiscal agent ends on June 30, 1993, the State should begin to develop a plan to replace the existing Medicaid Management Information System. The General Assembly finds that, under the current system, useful data on health care services and expenditures are limited.

(b) The Division of Medical Assistance, Department of Human Resources, shall develop a plan for the replacement of the current Medicaid Management Information System. Development of the plan shall:

(1) Focus on Medicaid future directions, such as expanded managed care;

(2) Have as the highest priority the design of a system capable of supporting many, if not all, of North Carolina's publicly administered health care programs;

(3) Be in concert with, but in advance of, federal health care reform planning, to provide North Carolina with the full opportunity to define and promote a strategy consistent with State political and social objectives; and

(4) Include representation from each agency involved in health care claims processing.

The Division shall report the plan, implementation schedule, and detailed fiscal analysis to the 1993 General Assembly by January 1, 1995.

(c) There is appropriated from the General Fund to the Division of Medical Assistance, Department of Human Resources, the sum of two hundred twenty-seven thousand five hundred dollars ($227,500) for the 1993-94 fiscal year to implement this section.

(d) This section becomes effective July 1, 1993.