NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS

2018 Government Affairs and Legislative Report

Legislative Priorities

During the 2018 Short Session of the NC General Assembly, the NCAFP lobbying team's priorities included the following:

- Monitor/Track progress around Medicaid Transformation.
- Monitor budget process and work to secure additional loan repayment and residency funding.
- Monitor/track legislation related to Opioid abuse/misuse.
- Monitor recommendations from the Committee on Access to Healthcare in Rural North Carolina (LRC).
- Monitor recommendations from the Select Committee on School Safety.

Medicaid Transformation – In 2015, the General Assembly passed legislation to move North Carolina's Medicaid Program from a Fee For Service structure to a capitated Managed Care program. Since that time, the NCAFP has worked to minimize disruptions to primary care as this move takes place. The state's 1115 waiver application is pending with the federal government with expected approval in the coming weeks.

This year, two key pieces of legislation were needed to move forward with the 'Medicaid Transformation' process: House Bill 403: Medicaid and Behavioral Health Modifications, and House Bill 156: Medicaid PHP Licensure and Transformation Modifications.

House Bill 403 modified the state's Medicaid Transformation law to allow the state's seven mental health managed care organizations to operate comprehensive plans that include both behavioral health and physical health services (aka "Tailored Plans"). The bill also allows for "Standard" Managed Care Plans to cover behavioral health services for most Medicaid recipients (mild to moderate mental health issues, substance abuse issues, etc.). For most Medicaid recipients, this will allow better integration of behavioral health into primary care. Those individuals who have Severe and Persistent Mental Illness or Intellectual or Developmental Disabilities will receive all their care in tailored plans. The NCAFP worked to minimize administrative burden for both providers and recipients as part of this process. There will still be confusion around who qualifies for what plans and on what services, particularly for young children who have or are at risk to have developmental delays.

House Bill 156 creates a Prepaid Health Plan (PHP) Licensure Act governing the Department of Insurance's licensure of Medicaid PHPs as part of Medicaid transformation. Prior to enactment of this bill, there was no way to license Medicaid Managed Care Plans, like commercial plans are licensed in the state. There were several specific battles around this bill. First, the medical community wanted to ensure that certain provider protections were included, just as they are in our commercial health insurance laws. These include items such as prompt payment requirements. Second, at the last minute, the Medicaid Managed Care plans tried to seek a lower Medical Loss Ratio and less oversight by the state.

An early draft of the bill, sought to cap the required Medical Loss Ratio (the MLR) managed care plans would have to meet at 85 percent, as opposed to a minimum of 88 percent proposed by the Department of Health and Human Services. The MLR is the portion of every dollar that the plans must spend on health care. But the NCAFP and others in the healthcare community fought back, keeping over **$400 million** in state and federal dollars to provide healthcare as opposed to additional administrative fees and profits for the managed care companies. A senator also proposed stripping out all funding for medical homes, which would have meant the loss of any care management or medical home fees that practices would receive in the new system. The NCAFP, NC Pediatric Society, NC Medical Society and others fought back against the changes and prevailed on the first two points. A proposal to prohibit certain accountability

measures for managed care plans using withholds by the Department did move forward but with a shortened timeframe (an 18-month prohibition on withholds).

Outside of the Legislature, the NC Academy of Family Physicians continued to respond to a series of "White Papers" outlining how the Department of Health and Human Services (DHHS) will implement Medicaid Managed Care. Some of the proposals NCAFP commented on included concept papers on Pre-Paid Health Plans in Managed Care; Benefits and Clinical Coverage Policies; Supporting Provider Transition to Managed Care; Centralized Credentialing in Medicaid Managed Care; Managed Care Quality Strategy; Care Management and the Advanced Medical Home; and Network Adequacy and Accessibility Standards.

Representatives of the NCAFP and the NC Pediatric Society continue to meet jointly with the Department's Deputy Secretary and Director of the Division of Medical Assistance, and the Assistant Secretary for Medicaid Transformation monthly.

Residency and Loan Repayment Funding – The ratified budget provides an additional $4.8 million in nonrecurring state funds to the Southern Regional Area Health Education Center for surgery and family medicine residencies and for facility and structural improvements associated with current residency programs. Despite a committee recommendation to increase funding for loan repayment efforts to attract healthcare providers to rural areas, the legislature did not appropriate additional funds for this purpose.

Opioid Abuse/Misuse Legislation – Senate Bill 616 – Heroin & Opioid Prevention and Enforcement (HOPE) Act -- was signed into law on June 22. The HOPE Act, as it is referred, is touted as an additional tool for law enforcement to help control the movement of opioids into the illegal drug market. The key provision impacting healthcare allows for expanded access to the Controlled Substance Reporting System (CSRS) for certain law enforcement officials.

The NCAFP expressed early concerns about some provisions of the act, particularly around how law enforcement would garner access to information in the CSRS. Based on input from the NCAFP and others in the healthcare community, the bill ultimately contained these provisions:

- Individuals requesting information around controlled substance prescriptions must be a "certified diversion investigator" and must be conducting a "bona fide active investigation." In addition, they must be supervised by a "certified diversion supervisor."
- There will be an audit trail for all information released from the CSRS.
- To become a certified diversion investigator, a law enforcement official will have to undergo specific training including HIPAA training, training on proper investigative techniques in drug diversion cases, training on proper handling of confidential data and records, and best practices for working with pharmacies in a manner that minimizes disruption of customer service and operations.
- Investigators will have to be recertified every three years.

As an additional safeguard, any individual (including law enforcement) who knowingly and intentionally accesses prescription information in the CSRS for a purpose not specifically authorized or discloses or disseminates information from the system for a purpose not authorized is guilty of a Class I felony. If the person disseminates the information for commercial advantage or personal gain or to maliciously harm any person, then the felony is increased to a Class H felony.

Beyond the provisions regarding access to the CSRS, the Act also increases penalties for anyone who sells, manufactures, delivers transports or possesses certain controlled substances, such as opioids, heroin, fentanyl, etc. The Act also implements criminal penalties for anyone who diverts controlled substances by means of dilution or substation, including healthcare professionals who would dilute or substitute a controlled substance to divert said substance.

Recommendations from the Committee on Access to Healthcare in Rural North Carolina (LRC)

- **Improving NC Rural Health –** House Bill 998 Improving NC Rural Health was signed into law in late June. The Act directs DHHS to study incentives for medical education in rural areas and assist rural hospitals in becoming designated as teaching hospitals. In addition, the bill also directs the Office of Rural Health to ensure the loan repayment program is targeted to benefit health care providers in rural areas. Part V of the bill directs DHHS to conduct a study to propose two new Medicaid coordinated quality outcomes programs designed to reduce unnecessary and inappropriate service utilization and generate sustainable savings to the Medicaid program. One recommendation from the Committee on Access to Healthcare in Rural NC did not make the final legislation. Among other things, that recommendation would have provided for pilot studies of implementing "Direct Primary Care-like" payment mechanisms into the State Health Plan and Medicaid.

- **Telemedicine Policy** – The state looked to update policies around Telemedicine. With some concerns about language, a study bill emerged from the House but did not pass the Senate.

- **Medical Education & Residency Study** – House Bill 1002 Medical Education & Residency Study was unanimously passed out of the House this session; however, the Senate did not consider the legislation. The bill would have continued the work of a separate Study Committee examining ways to make medical education and residency expenditures more transparent and accountable, with efforts to ensure that North Carolina ultimately produced the right specialty and geographic mix of physicians.

Recommendations from the Select Committee on School Safety – This year's budget provides funds to expand the School Resource Officer grant program for elementary and middle schools, to expand the anonymous tip-line to all schools statewide, and to create new grants to support students in crisis, school safety training, safety equipment, and school mental health personnel.

Budget Overview

Key healthcare funding items included:

- **Western Campus of the UNC School of Medicine, Asheville** – An additional $4,802,500 in one-time funding for the UNC School of Medicine's Asheville Campus, a joint program between the UNC School of Medicine, other UNC System universities, and the Mountain Area Health Education Center. The revised net appropriation is $15.4 million in FY 2018-19.
- **UNC Rockingham Health Care** – One-time funding of $500,000 to UNC Rockingham Health Care for matching grant funds for a primary care rural advancement program in the region.
- **Smoking Cessation Programs** – Provides $250,000 nonrecurring funding for QuitlineNC and You Quit Two Quit smoking cessation programs.
- **Youth Tobacco Prevention** – Provides $250,000 nonrecurring funding to develop strategies to prevent the use of new and emerging tobacco products, including electronic cigarettes, by youth and people of childbearing age.
- **Newborn Screening** – Budgets increased fee receipts to support the full cost of the State's Newborn Screening Program. Receipts will be used to support direct and indirect costs (including supplies, equipment maintenance, staff, etc.) and to add 3 new tests to the State's newborn screening panel to conform to the federal Recommended Uniform Screening Panel.
- **Physician Supplemental Payment Plan** – Provides $3,200,000 recurring to expand allowable slots for the physician upper payment limit plan by 60 slots to be allocated between East Carolina University (ECU) Brody School of Medicine and University of North Carolina (UNC) Health Care. The total Upper Payment Limit slots allowed after this addition will be 1,761 slots. These slots are designed to offset the cost of clinical operations in an academic health center.

- **Medicaid Funding** – Full funding for physician and other provider payments (no additional rate cuts). In addition, the budget sets aside $60 million for a Medicaid Transformation Reserve.
- **Other Departments --** Outside of healthcare, the budget provides an average 6.5 percent pay raise for public school teachers; allocates nearly $12 million to provide a permanent salary increase to veteran teachers with more than 25 years of experience; offers a 2 percent permanent salary increase for most state employees and a one-time cost-of-living supplement for retirees; implemented a minimum "living wage" of $15 per hour for all state employees; increases funding for public education by nearly $700 million; lowered the maximum personal income tax from 5.499 to 5.25 percent in 2019; and lowered the maximum corporate income tax rate from 3 to 2.5 percent in 2019.

The Shortest of Short Sessions

We were told by trusted sources that the 2018 Short Session would live up to the name and that we should be ready for a quick pace. To say that our sources' statements lived up to the hype is an understatement! The General Assembly kicked off the session with an unconventional parliamentary maneuver by placing its agreed upon budget into an existing conference report and releasing the document to both chambers simultaneously to be voted on without allowing for amendments. This is the first time anyone can remember this procedure being utilized in the budgetary process. To say this quickened approach caught a lot of observers off guard is another understatement. In roughly four weeks, the General Assembly passed a budget, moved most of their intended legislation to the Governor for his consideration, and then waited for any vetoes to come their way.

As the General Assembly awaited gubernatorial action on a host of bills, this last week of session focused on veto overrides, local bills, and six proposed constitutional amendments. Several of the proposed constitutional amendments, including a Voter ID requirement and a lowered income tax cap, appeared to be designed to increase voter turnout, especially in rural areas, during this year's election. It will be interesting to see how the proposed constitutional amendments play out as the November elections draw near.

In another surprising move, the General Assembly did not adjourn *sine die*, as is typical at the end of the second year of the biennium. Instead the adjournment resolution calls the legislature back to Raleigh at noon on Tuesday, Nov. 27. The agenda is expected to include the passage of necessary legislation to accompany any of the six proposed constitutional amendments that pass in the November election.

Other Government Affairs/Advocacy Activities

<u>Successful Legal Action Against the State's Medicaid Program</u>

The NCAFP, along with the NC Pediatric Society and some large pediatric practices, successfully sued the state's Medicaid Program regarding underpaid vaccine administrative fees during the Medicaid to Medicare parity period under the Affordable Care Act. After over a year of negotiation with the state Division of Medical Assistance, the groups came to an impasse and took legal action. Legal arguments were heard in superior court in September of 2017 with Superior Court Judge Beecher Gray ordering Medicaid to pay an additional $6.74 on certain vaccine administrations that were given during 2013 and 2014. The state ultimately decided not to appeal in November of last year. The decision not to appeal occurred after the plaintiffs, including the NCAFP, agreed to provide DHHS 365 days to fix the underpayment versus an original 120 days ordered by Judge Gray. The lawsuit sought to rectify a significant underpayment of approximately half of vaccine administration payments paid by Medicaid to attested providers under the Affordable Care Act during 2013 and 2014. Under the ACA, states were required to provide enhanced payments for both E&M codes and for administration of vaccines under the Vaccines for Children program. However, due to technical issues and disagreements in interpretation of the law, the state only paid the enhanced administration fee for about half the vaccines provided during those two years. We estimate that the corrected payments will total between $10 and $15 million for our state's family physicians and pediatricians. The NCAFP believes about half of the total will be due to

family physicians. After working to identify which vaccines administrative fees were underpaid, Medicaid is finally set to reprocess the claims and will make the additional payments in August and September of this year.

State Health Plan Budget Issues

In May, North Carolina State Treasurer Dale Folwell directed Blue Cross and Blue Shield of North Carolina, the third-party administrator for the State Health Plan, to begin seeking significant rate reductions in "major" provider contracts on behalf of the State Health Plan. In July, Treasurer Folwell brought together representatives of various healthcare organizations, including the NCAFP, to discuss ways to lower costs in the plan, representing 700,000 state and local government employees as well as retirees. The Treasurer has a goal of saving $300 million in the next plan year and maintaining that savings over the next five years on what he characterized as unsustainable spending growth by the State Health Plan. Currently, the plan spends about $3 billion each year on healthcare costs.

The NCAFP has ramped up advocacy efforts on behalf of its members touting the value of primary care and the role family physicians play in coordinating care, improving health and lowering costs. These points appear to be well received and the Treasurer reiterated the importance of family physicians and primary care. Healthcare organizations are discussing a myriad of issues with the Treasurer and the Administrator of the State Health Plan including: healthcare transparency; the need for claim and referral outcome data at the point of care; the need for a greater emphasis on value-based care; and a better examination of the key cost drivers in the plan. The Treasurer has indicated he appreciates the initial dialogue but wants immediate changes that will provide long-term cost relief. This will likely continue to be a significant issue for the NCAFP in the coming months.