



## INTRODUCTION

Late last Wednesday night, the Senate released their proposed budget online. On Thursday morning at 8:30 am, the budget was heard in the Senate Appropriations Committee, then the Finance Committee at 1:00 pm, and finally in the Pensions and Retirement Committee at 3:00 pm. Then on Friday it was debated on the Senate floor and approved on the first vote. The Senate then adjourned and went back into session at 12:05 am (yes - just after midnight since the budget requires two votes on two separate days) on Saturday. The whole process took a little over 48 hours! No member of the public was allowed to speak on any of the proposals, and many legislators struggled to read the budget in any real sense before the actual votes. It is the fastest and most "behind closed doors" budget process that we have ever seen.

This week was a bit strange after the craziness of last week. The Senate took a few extra days and didn't come back into session until Wednesday. They had very few committee meetings, but did start talking about the Governor's Coal Ash Plan and also discussed the Repeal of Common Core educational standards. The House kicked into high gear to finalize their version of the budget and had hoped to release it this week, but then they had to find an additional \$60 million once it was determined that a plan to bring in more revenue that was in both the Governor's budget and the Senate version could not legally be done. The plan now is to release their budget next week and then go into Conference Committee with the Senate to work out their differences.

Although we provided a short overview of the Senate budget proposal in the last legislative report, we wanted to provide more detail about the proposal before the House version is released. We expect the House version to be vastly different from the Senate proposal and will summarize the differences.



## NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS



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The Senate budget contains a number of major provisions: significant raises for teachers (over 11% on average) tied to a surrender of their tenure rights, major cuts to spending in Health and Human Services; reductions to Medicaid reimbursements for providers and hospitals; a transfer of the State Bureau of Investigation from the Department of Justice to the Department of Public Safety; the establishment of a 3-judge panel to review challenges to the constitutionality of state statutes; and steps to move the Division of Medical Assistance out from the Department of Health and Human Services. By any standard it is an extreme document, a statement of values and priorities that immediately drew strong reactions from all sectors. In many ways, the document differs from the recommended budget released by Governor McCrory, and leaders in the House have already made comments indicating the distance between the chambers in terms of spending and policy provisions may be difficult to bridge. How difficult it will be remains to be seen, but the House's budget will provide some evidence, after which the chambers will go to work and try to find a middle ground. In the meantime, members, advocates, and citizens will continue to convene on the General Assembly, working furiously to try to influence the final product.

Key provisions of the Senate's proposed budget are summarized below. If you have questions or need more information about these or other provisions, don't hesitate to contact us.

### Teacher Raises (with Caveats)

The budget includes roughly \$468 million for teacher raises, which would raise starting teacher pay to \$33,000 and the average educator salary to over \$51,000, an average increase of 11%. Additional funding for administrators and staff, as well for the masters-level supplement eliminated last year, are also included. The budget also contains, however, a \$233 million reduction in teacher assistants, eliminating them in 2<sup>nd</sup> and 3<sup>rd</sup> grade (roughly 7,400 positions). Also, to qualify for the proposed raises, teachers would be required to voluntarily give up their "career status" (tenure), as a judge ruled that last year's budget provision eliminating tenure was unconstitutional and blocked enforcement of the tenure elimination provisions. Given these provisions the teacher raises, while a popular idea generally, have become a flashpoint of debate inside and outside the General Assembly.

### Medicaid Changes

The budget proposed dramatic reductions and changes to the state's Medicaid service delivery and funding structures. Among other changes, these provisions would:

- appropriate \$143.8 million to cover Medicaid shortfall and an unpaid claims backlog and \$206 million to cover the Medicaid Rebase for Fiscal Year 14-15, including 5.3% growth in enrollment and utilization.
- eliminate automatic Medicaid eligibility for Aged, Blind and Disabled/State County Special Assistance recipients, effective January 1, 2015. This eligibility standard is not mandated by the federal government. There are currently 11,886 individuals that have Medicaid eligibility as a result of this policy who will lose Medicaid coverage, and estimated savings total \$28.75 million. Coverage for the medically needy would also be eliminated, except those categories that the State is prohibited from eliminating by the maintenance of effort requirement of the Patient Protection and Affordable Care Act.

Effective October 1, 2019, coverage for all medically needy categories would be eliminated.

- detail the intent of the General Assembly to transfer the Medicaid and NC Health Choice programs to a new state entity that will “define a new, more successful direction for the programs and that will be able to focus more clearly on the operation of the programs. Specifically, the Medicaid program will move away from unmanaged fee-for-service towards a system that manages care. To that end, Medicaid will include all dimensions of care for a recipient through full-risk, provider-led and non-provider-led, capitated health plans. Such full-risk capitated health plans will include all aspects of care, without exceptions, so that the State will bear only the risk of enrollment numbers and enrollment mix.” The governance structure and short-term expectations of the new State entity are detailed, and \$5 million would be appropriated for consultants, contractors and initial staffing of this entity.
- **direct DHHS to “cease any activities related to implementing Medicaid reform based on its proposed accountable care organization (ACO) model.”**
- eliminate the “shared savings plan” established for Medicaid providers in last year’s budget, and convert the plan’s 3% withholding to a 3% reduction, with optical, podiatry, chiropractic and hearing aid services removed from the list of services subject to the 3% reduction.
- reduce Medicaid provider rates by an additional 2%, effective January 1, 2015. This reduction would apply to all fee-for-service providers with the exception of drugs, nursing homes, all cost based providers, and services where rates are set by the federal government, negotiated through a managed care contract, or as specified in special provisions.
- modify the supplemental payments that increase reimbursement to the average commercial rate for certain eligible medical providers, by limiting the number of eligible providers. This provision also details the information UNC and ECU would be required to report to the Joint Legislative Oversight Committee on Health and Human Services regarding the activities of providers for whom the supplemental payment is received.
- require the Division of Medical Assistance to publish on its website and update annually “comprehensive information on Medicaid payments made to providers.”
- preclude the state from entering into or renewing any contracts with Community Care of North Carolina after December 1, 2015.
- direct DHHS, in consultation with the North Carolina Medical Society **and any other appropriate groups**, to study the imposition of an assessment on physicians as part of the federally authorized Medicaid assessment program. The study would consider “the opportunities to increase funding to the Medicaid program and to providers by collecting additional State funds to leverage additional federal funding. DHHS would be directed to report its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2014.
- implement a Medicaid assessment program for LME/MCOs at a rate of 3.5% (totaling nearly \$60 million in FY 14-15) Note: this is the program that mentioned earlier that would not be legal creating the \$60 million budget hole.
- require preauthorization for mental health drugs within Medicaid.
- create a statewide hospital base rate, effective January 1, 2015. The individualized base rates for hospital inpatient services under the Medicaid and NC Health Choice programs would be replaced with a single statewide base rate for hospital inpatient services. This would not apply to the UNC Health Care System or Vidant Medical Center (previously known as Pitt County Memorial Hospital).  
increase the state’s annual Medicaid assessment on hospitals from 25.9% to 28.85%.

reduce the settlement for the UNC-CH and ECU hospitals for outpatient services to 70% of Medicaid costs effective July 1, 2014. Historically, the State has funded the State share of payment to UNC-CH and ECU at 100% of costs, unlike other hospitals, which are paid 70% of cost through the claims and settlement processes.

### DHHS Studies

The budget would direct DHHS to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2014, which would include:

- a strategy for improving communication and coordination among all divisions within the Department that administer funds or programs related to the delivery of behavioral health services, especially regarding the most appropriate and efficient uses of public and private inpatient behavioral health services, including a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan.
- **a plan developed in collaboration with local management entities that have been approved to operate as managed care organizations (LME/MCOs) to increase access to, and availability of, community-based outpatient crisis and emergency services for the stabilization and treatment of individuals experiencing mental health, developmental disability, or substance abuse crises in settings other than local hospital emergency departments and State-operated psychiatric hospitals.**
- a plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO catchment area, and to ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area.
- findings and recommendations for increasing the inventory of inpatient psychiatric and substance abuse services within the State, examining the advantages and disadvantages of increasing this inventory of services through (i) additional State-operated facilities, (ii) community hospital beds, (iii) United States Department of Veterans Affairs beds, and (iv) community-based services that decrease the need for inpatient treatment.
- a plan for offering hospitals and other entities incentives to apply for licenses to begin offering new inpatient behavioral health services, or to begin operating existing licensed beds that are currently unstaffed, or both.
- recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. In developing its findings and recommendations, DHHS would conduct a study that includes an inventory and assessment of the condition of every building located on the existing Cherry Hospital campus, including an examination of the feasibility of using the existing Cherry Hospital facility to provide community-based and facility-based behavioral health services, including additional child and adolescent inpatient beds.
- a method by which the Division of Health Service Regulation can begin tracking and separately reporting no later than January 1, 2015, on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.
- a status update on the implementation of each component of the 2008 Mental Health Commission Workforce Development Plan.

The budget would direct DHHS to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by March 1, 2015, which would include:

- a comprehensive strategy, developed in collaboration with stakeholders deemed relevant by DHHS, to address the dearth of licensed child and adolescent inpatient psychiatric beds throughout the State, which would (i) ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area, and (ii) include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed inpatient facility in the State.
- recommendations for meaningful outcome measures to be implemented by State-operated alcohol and drug abuse treatment centers to assess the impact of inpatient treatment on an individual's substance use following discharge from a State-operated alcohol and drug abuse treatment center, including a proposed timeline for implementation of these outcome measures.

The budget would direct DHHS to study and submit a written report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than December 1, 2014, summarizing its recommendations for extending North Carolina's Health Care Cost Reduction and Transparency Act of 2013 (the Act) to additional health care providers. The report would identify:

- recommended categories of additional health care providers that should be subject to the requirements of the Act.
- recommended data to be collected for the purpose of transparency from each category of identified health care providers.
- recommended exemptions, if any, from certain requirements of the Act for each category of identified health care providers.
- recommended effective dates for the applicability of the Act to each category of identified health care providers.

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