NC Provider Community Medicaid Reform Proposal

Summary: Provider-led entities (PLEs) would take from the state the financial risk of Medicaid enrollees' utilization of services through capitation. These entities would then have a vested financial interest in delivering efficient care for Medicaid enrollees. Unlike insurance companies rooted in a financial model of managing care, provider-led entities would put higher quality care first, which not only lowers costs but produces better health outcomes. PLEs would build on the existing foundation of the patient-centered medical home model and on successes such as primary care and pediatric care case management, coordinated preventative care, non-medical care options that avoid higher cost medical care, increased data sharing, and other initiatives already begun by North Carolina and its Medicaid providers. PLEs would work immediately to integrate care with other provider groups including physical health, mental and behavioral health, and long-term services and supports. Capitation would expand over time to encompass all Medicaid spending.

Overarching Goal: To pursue the Triple Aim:

- Reducing the per capita cost of health care;
- Improving the health of populations; and
- Improving the patient experience of care (including quality and satisfaction).

Responsible Entities: Groups of providers would come together to provide patient-centered care and would agree to be jointly accountable for the cost and quality of health care for the Medicaid enrollees they serve. The legal entities formed by the providers would have to be both provider-owned and provider-controlled. Local management entities/managed care organizations (LME/MCOs) may be members of PLEs and will serve as an important partner in achieving integrated patient care and managing quality and costs for special populations. In order to enroll Medicaid recipients, each PLE should be required to demonstrate it meets network and financial adequacy standards and can administer the delivery of services.

Shared Governance, Leadership and Management: Subject to provider ownership, conflict of interest, and provider control requirements, governance should be flexible, allowing partnerships among hospitals, physicians, and other Medicaid providers. A majority of each PLE governing board shall be comprised of physicians providing clinical services to Medicaid patients.

Health Care Delivery Redesign and Payment Reform

- Focus on integration, coordination, and team-based care with aligned incentives, including payment reform both during the transition period and as part of reform
- In order to ensure transparency, commit to standardized public reporting of cost, quality, and patient satisfaction performance metrics

- Work toward "whole person" care:
    - Begin capitated payments for physical health (including hospice and palliative care) no later than three years after approval of waiver by CMS
    - Integrate the following no later than five years after the approval of waiver by CMS:
        - Mental health, behavioral health, substance abuse, intellectual/developmental disabilities (IDD)
        - Long-term services and supports (LTSS)
        - Dental
        - All other providers
- Throughout at least the transition period, continuation and appropriate expansion of programs that contain costs and improve outcomes, including the primary care case management system, the current Medicaid informatics infrastructure, patient-centered medical homes, and pregnancy medical homes.

Behavioral and Mental Health: Behavioral health, mental health, and intellectual/developmental disability benefits in NC are currently capitated under the LME/MCO system. To avoid service disruption in patient care and destabilization of providers, the capitated behavioral health and intellectual/developmental disability waivers should remain operational while the physical health system is fully capitated and while efforts are under way to develop a system that ensures statewide integrated care for patients.

Pharmacy Benefits: PLEs should coordinate with the State so as to manage costs and provide appropriate care through pharmacy benefits, but, due to the intricate payment systems involved and the cost savings initiatives currently underway, pharmacy benefits should remain with the State during the first five years of the 1115 waiver.

Rate Setting for Capitated Payments: Actuarially sound rates for PLE capitated payments shall be established through an open process that includes meaningful participation by PLEs and Medicaid providers. Capitated rates should be appropriately risk-adjusted for covered populations.

Administrative Functions: The transfer to a PLE of any administrative functions, such as billing, enrollment, credentialing, or other functions, should be carefully designed to minimize the disruption to providers and beneficiaries while also improving the quality of those administrative functions.

Attribution/assignment: Beneficiaries shall prospectively choose a PLE plan for a plan year. If an enrollee does not choose a plan, then the beneficiary should be assigned to a plan on the basis of the plan in which the beneficiary's providers participate or other appropriate factors. Beneficiaries should be allowed to change plans for certain life events, such as a move to an area not served by the beneficiary's existing PLE.

Benefit Design: Each PLE should provide, at a minimum, the same benefits package currently provided by NC's Medicaid program. Benefit design should incentivize enrollees' personal responsibility for their health.

Quality Measurement: A statewide quality assurance (QA) committee with a physician majority shall, in collaboration with PLEs, Medicaid providers, and the Division of Medical Assistance,set quality and performance measures for the PLEs. Each PLE shall have its own QA committee with a physician majority to determine quality and performance measures for the providers within the PLE.

Medical Loss Ratio: Each PLE receiving a capitated payment should be expected to meet a minimum medical loss ratio of 90/10; the ratio should take into account certain benefit enhancements that promote health that are not traditionally considered medical.

Data Sharing and Access: Timely and accurate access to clinical, claims, and program performance data is essential to achieve triple aim objectives. To ensure real time access to clinical data, PLEs must ensure connectivity and health information exchange between Medicaid providers. Prior to beginning capitation, the State shall provide to the PLEs past claims, utilization, encounter, and cost data.

Corporate Partners for Risk: PLEs may partner with whomever they need to in order to make capitation work as long as Medicaid providers maintain majority ownership and control of the PLEs.

Regions and Competition: If CMS requires regions, then regions should be defined by the PLEs and should cover all areas of the State. Any CMS-required regions should be based on existing referral patterns and ensure adequate competition within each region.

Provider Participation: In order to maintain provider independence and encourage competition among PLEs for providers, providers should be free to participate in more than one PLE.

1115 Waiver: Capitation should be accomplished through an 1115 waiver.

Preserve Supplemental Income Streams: The 1115 waiver should be designed to maintain non-General Fund revenue coming into the Medicaid program and its providers. Examples of such income streams include the additional federal funds obtained through provider assessment programs, special federal payments available for certain types of facilities, rebates from drug manufacturers, supplemental physician payments available under the State Plan, and primary care incentive payments. Existing assessment programs should be carefully modified so as to continue comparable funding to Medicaid providers. All Medicaid-related revenue should be transparently reported to the PLE governing body and taken into account by the PLE when making payments.

Sequencing: Any significant modification to the Medicaid program should be sequenced such that the 1115 waiver delivers optimal federal financial participation.