

Summary: NC Medicaid Draft 1115 Waiver Application released March 1, 2016

In the NC DHHS draft 1115 waiver application released to the public on March 1, 2016, the North Carolina Department of Health and Human Services (DHHS) outlined the rationale for the request of an 1115 waiver as well as four demonstration initiatives they plan to implement under the 1115 waiver.

Rationale:

The Department lists two main reasons the state must apply for an 1115 waiver. First, they say “transitioning to next-generation Pre-Paid Health Plans (PHP) under a state plan or section 1915(b) waiver alone would not authorize the comprehensive reforms that North Carolina must implement in order for managed care and system transformation to be a success.” Second, they also state “This overhaul includes a transition of approximately \$2 billion in payments, predominantly to hospitals, that must stay in our safety net system, yet have no clear regulatory path for doing so under any authority other than 1115 demonstration authority.”

They also list their goal of building “advanced patient centered medical homes through person-centered health communities” as a reason the Centers for Medicare and Medicaid Services (CMS) should approve an 1115 waiver.

Overview:

The Department lists the following as a summary of their waiver proposal: improving access to, quality of, and cost effectiveness of health care for Medicaid and CHIP beneficiaries by restructuring care delivery using accountable, “next-generation PHPs”, redesigning payment to reward value over volume, and planning toward true person-centered care grounded in patient-centered medical homes and wrap-around community support and informatics.

The stated goal is achieving the “quadruple aim,” which the department defines as improving the patient experience of care, improving health of populations and containing the per capita costs of health care, while improving provider engagement and support.

Demonstration initiatives:

- 1) Building a system of accountability for outcomes
- 2) Creating North Carolina “person-centered health communities” (PCHCs)
- 3) Supporting providers through engagement and innovations
- 4) Care transformation through payment alignment

Building a system of accountability for outcomes

The department lists the following approaches for achieving this initiative’s goal:

- *Next Generation Prepaid Health Plans (PHPs) in a hybrid model*- Each region of the state will have a choice of Provider-Led Entities (PLE) or Commercial Managed Care companies (CPs)
- *Transformation of PCMH to Person-Centered Health Communities (PCHCs)* - PHPs will support and be held accountable for quality outcomes of PCHCs. PCHCs will be responsible for

community-based comprehensive care management to impact social determinants of health and ensure all beneficiaries are reaching and maintaining the highest level of health possible. DHHS plans to standardize the approach used to provide practice supports while supporting innovation and excellence through the PCHCs.

- *Progress toward integrated behavioral and physical health*- This integration is a DHHS priority. They aim to build off of the strengths of the current LME/MCO system.
- *Long-term services and supports (LTSS) for Medicaid-only individuals*- DHHS proposes to operate this demonstration concurrently with NC's already approved Community Alternatives Program for Children and Disabled Adults, currently a section 1915© waiver to enable PHPs to provide LTSS for Medicaid-only individuals.

Creating North Carolina "person-centered health communities" (PCHCs)

The department lists the following approaches for achieving this initiative's goal:

- *NC PCHCs to participate in PHP provider networks*- Person-Centered Health Communities (PCHC) will be North Carolina's next generation of medical home. It will build on the current infrastructure, well-documented population management and care management and transitional care performance to extend care management activities beyond the current PCMH and Pregnancy Medical Home. PCHCs will provide comprehensive and coordinated care with the goal of maximizing health outcomes, preventing higher levels of care and reducing needs for institutional care and containing per member costs. The draft waiver lists PCHC features that will be considered for inclusion in PHP contracts, such as requiring each beneficiary to receive a comprehensive health assessment (see pages 20-22 of the draft waiver).
- *Improve rural health access, outcomes and equity*- DHHS will use the demonstration as an opportunity to enhance rural health programs underway currently through collaborative partnerships between the DHHS, PHPs and PCHC models of health care delivery. They will use tools such as value-based payment structures, telemedicine and data analytics to expand on the existing primary and specialty care rural infrastructure.
- *Enhance outcomes for children and families in the child welfare system*- The Department proposes the designation of a statewide PHP that will specialize in providing care for children in foster care, as well as expanding the "Fostering Health NC" program (a current pilot under the Children's Health Care Quality Measurement and Improvement Activities or CHIPRA), and extending Medicaid coverage to parents of children in foster care.

Supporting providers through engagement and innovations

The Department lists the following approaches for achieving this initiative's goal: DHHS will design, develop and implement a pioneering-level of PCHC to once again lead the nation in the area of ongoing programmatic improvement.

- *Practice supports for quality improvement*- "practice supports will help support implementation of a next generation medical home PCHC model of care." The Department points to N3CN's practice supports to PCMH as well as AHEC support to practices. DHHS aims to standardize the approach used to provide practice supports while supporting innovation at the provider and PHP level. PCHCs will engage in ongoing QI moving practices through CMS' five stages of practice transformation. The PCHC model will include a common set of quality measures aligned with

Meaningful Use, HEDIS, and Physician Quality Reporting System (PQRS), but chosen based on North Carolina's priorities. PCHCs will report on measures encompassing acute care, chronic disease care, specialty care and preventive care.

- *Developing an Innovations Center at the state-* The Innovations Center will support providers with the use of technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices.
- *Mandating use of an HIE-* All Medicaid providers must be connected to the HIE by February 2018. The HIE Authority will have an Advisory Board that will work with public and private stakeholders to enhance the capacity of the HIE. Future plans include the development of chronic and specialized disease registries and analytics along with connections to behavioral health providers, nursing homes and pharmacies.
- *Creating a "statewide informatics layer"-* The state will develop data analytics capacities to enable transition to total person care. This will combine clinical and administrative claims data and focus on population health data. It will accelerate a statewide "learning health system" through the NC Innovations Center.
- *Developing community residency and health workforce training programs-* This aim is to strengthen the health care safety net (FQHCs, RHCs, local health departments, and free and charitable clinics through "essential provider" designations for these entities to preserve their current wrap-around payments. DHHS plans to expand current programs designed to ameliorate NC's rural health workforce shortages and underserved communities such as loan repayments, community grants, recruitment efforts, AHEC residencies and new community-based graduate medical education. DHHS is requesting federal match for the state-only funds that are directed to support community based residency programs.
- *Creating provider administrative ease in PHP contracts-* The Department proposes all PHPs will be required to use the State's preferred drug list, apply DHHS' prompt pay requirements for PHPs, develop a uniform credentialing process including a standardized application and centralized verification process, create a common set of performance measures for providers to be held accountable for, and DHHS lastly plans to standardize the approach used to provide practice supports as well as approaches to care management while also supporting innovation.

Care transformation through payment alignment

The Department lists the following approaches for achieving this initiative's goal:

- DHHS aims to carefully transition supplemental payment financing to a new model centered on value-based capitation to PHPs. A portion of the current supplemental payment funds will be available through incentive payments like the Delivery System Reform Incentive Payment (DSRIP) as well as direct safety net hospital payments. "These funds, both today and in the future, are essential support to safety net providers who partner with DHHS to ensure access for Medicaid enrollees." The Department proposes the creation of the DSRIP program and direct or directed value-based payments to providers to keep this funding stream.

Other issues to note as discussed in the Legislative Report, "Transformation and Reorganization of North Carolina's Medicaid and NC Health Choice Programs":

Regions

Although not included in the draft waiver document, the NC DHHS also is proposing six regions to be created throughout the state for the purposes of health care operations by PLEs and MCs. The six regions currently proposed by DHHS can be viewed [here](#) (see pages 17-18 of the Report). When issuing PHP contract solicitations, DHHS plans to specify the maximum number of PHPs it intends to contract with in each region, determined in part by the number of eligible Medicaid beneficiaries in the region. DHHS is proposing a minimum of 50,000 eligible beneficiaries per regional PLE and 33,000 to 40,000 beneficiaries per region for each statewide CP.

Beneficiary enrollment and assignment to PHPs

DHHS proposes to use an enrollment broker and auto-assignment process to support beneficiary selection and enrollment in PHPs. Enrollment brokers will assist with “choice counseling” to help patients select a plan that corresponds with their current primary care provider/practice. Those who do not select a plan will be assigned to one through an auto-assignment process. DHHS proposes the auto-assignment process will first consider preserving existing primary care provider relationships. After considering this relationship, DHHS will consider adding quality considerations to the auto-assignment process (after year one of the program).

Access standards

DHHS does not make any specific proposals or recommendations on access standards. DHHS instead states they will take into consideration potential competition between PLEs and CPs to ensure all players are properly incented to build viable networks aligned with the state’s transformational goals. DHHS also will designate certain providers as “essential providers” for PHP networks (see description of this above). An essential provider designation is intended to assist these providers in maintaining sufficient volume of insured patients to sustain service availability. Section 5(13) of SL 2015-245 specifies that at a minimum, federally qualified health centers (FQHCs), rural health centers (RHCs), free clinics and local health departments be designated as essential. DHHS also will consider adopting an essential provider policy requiring PHPs to make at least a good faith effort to contract with all essential providers in their region, however an essential provider will not be required to participate with all, or any, PHPs in its region. Lastly, DHHS states they plan to prohibit a PHP from having an exclusivity clause in a contract with an essential provider.

Performance Measures

DHHS does not make any specific proposals or recommendations on performance measures to be used in the new program. Instead, they list the process they will undertake to select measures for assessing the system, PHPs and providers which includes:

- Application of guiding principles
- Identification of performance standards and benchmarks
- Ensuring a transparent process
- Being relevant to Medicaid and NC Health Choice programs
- Involving stakeholders

DHHS states that the performance measures will be used at the system level for monitoring and evaluation, to monitor and evaluate PHPs, to reward those who exceed benchmarks and to sanction PHPs that fail to meet minimum thresholds, and for provider performance evaluation to support value-

based payments. DHHS proposes that providers be held accountable for “meeting a common, simple set of measures.”

Department of Insurance (DOI) requirements

DHHS and DOI staff jointly recommend the following in the Legislative Report:

- PHP solvency requirements be similar to the solvency requirements in the Health Maintenance Organization (HMO) Act (N.C.G.S. §58-67). This includes the existing formula for capital/solvency requirements.
- PHPs, including PLEs and CPs, licensure and DOI regulatory oversight will focus on solvency and liquidity requirements; DHHS will regulate the non-financial aspects of the PHP (covered services, provider network, etc.) through regulations and the PHP contracts. DHHS will also conduct financial monitoring, with DOI as the primary regulator of PHP finances.
- Chapter 58 amendments to specify the licensure requirements for PHPs, the applicable financial requirements, and the regulatory authority of DOI and DHHS with respect to PHPs.
- PHP licensing process will build on existing processes and be efficient for both DOI and organizations seeking PHP licensure.

Application of Chapter 58 requirements

DHHS and DOI recommend in the Legislative Report that, except for the financial requirements specified for PHP licensure, PHPs be exempt from Chapter 58 of the General Statutes (insurance protections). DHHS will instead incorporate key protections in its PHP regulations and/or the PHP contracts. Administrative efficiency and compliance with the federal Medicaid requirements are cited as the main reasons for this recommendation.

Later in the Legislative Report DHHS states they intend to limit the use of rate floors for circumstances where they are critical to achieve transformation goals. DHHS expects to establish primary care and specialist physician rate floors that are expressed as a percentage of the effective Medicaid fee schedule, and at rates that are no higher than that required to ensure smaller providers with less negotiating leverage can be reasonably competitive.

They also discuss a proposal to require, through regulation or PHP contracts, to process 100 percent of clean claims within 30 calendar days of the day of receipt (prompt pay requirement). Lastly, the Legislative Report discusses using a uniform credentialing process to ease administrative burden on providers to avoid having to complete multiple applications.

Plan for transition of certain N3CN contract features

DHHS states they plan to build upon the successful medical home model in place today to develop PCHCs. These PCHCs will use the current medical infrastructure and population management performance as a foundation. DHHS is in the process of defining how to supply this infrastructure and will make determinations about transition activities at a later date. DHHS states in the Legislative Report that they will require PHPs to support community-based care management and related activities consistent with those provided by N3CN, including engagement with local health departments and other programs similar to Care Coordination for Children and Pregnancy Care Management. DHHS also notes the importance of continuing system integration and information exchange including exploring options

to develop a state interface similar to the current NC3N Case Management Information System (CMIS) either through the Innovations Center or a contractual relationship to provide a uniform care management record.

Timeline for issuing RFPs

DHHS must submit the 1115 waiver to CMS no later than June 1, 2016. DHHS expects to issue PHP RFPs in March 2018 and to award PHP contracts in September 2018. Under this scenario, they expect a go-live date of July 1, 2019. This predicted timeline could be significantly altered based on the time necessary for CMS to approve the state's 1115 waiver, which is unknown at this time.

Opportunities for comment:

A public comment period is currently open and will end on April 18th. Comments can be submitted online at: www.ncdhhs.gov/nc-Medicaid-reform. Additionally, a series of 12 stakeholder listening sessions will be held across the state during the comment period. Locations include Asheville, Boone, Charlotte, Elizabeth City, Greensboro, Greenville, Lumberton, Raleigh, Sylva, Wilmington, and Winston-Salem. For more information on dates, times and locations of these events visit:

<http://www.ncdhhs.gov/nc-medicaid-reform/public-hearings>.

The NCMS wants to hear your feedback. Your input is valuable and will assist us in advocating for changes to the draft waiver to improve the final product which will ultimately be submitted to the CMS for approval. Please share your comments at ncmsgovtaffairs@ncmedsoc.org.