Comments on the North Carolina Section 1115 Waiver Proposal

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Introduction

North Carolina's Section 1115 Waiver application intends to modernize and streamline the State's Medicaid program. Among other provisions of the proposal, the NC Department of Health and Human Services (DHHS) aims to establish long-term contracts with Medicaid managed care organizations (MCOs) and/or health care providers organized into systems of care on a regional or statewide basis (Provider-Led entities, or PLEs). DHHS will use value-based purchasing principles to encourage these entities to achieve and in turn reward their affiliated providers for favorable health and cost outcomes.

DHHS also contemplates a number of care and benefit coordination efforts, notably clinically integrating behavioral and physical health as well as long-term services and supports (LTSS).

This brief document is intended to be supportive of the overall principles and key directions of the proposed Medicaid reform agenda, as well as provide some specific comments on the above key provisions. We also recognize that waiver negotiations with the Centers for Medicare and Medicaid Services (CMS) will likely result in opportunities to reconsider North Carolina's past decision to not expand Medicaid eligibility. For purposes of this document, however, we are focused on the payment and delivery reform aspects of the waiver while noting that the waiver process itself offers an opportunity to consider the coupling of changes in Medicaid eligibility with new efforts to control cost growth as is contemplated under this waiver proposal.

We are available for more detailed discussion about the specifics of these or other provisions of the waiver application.

Toward a more patient-centered, value-based health-care system

The waiver proposal includes numerous provisions that move toward integrating the Medicaid population into the broader health care system and the ongoing process of health care payment and delivery reform. Of particular note, the waiver foresees the movement toward value-based purchasing, supporting a continuing shift from traditional "fee-for-service" (FFS) payments, which promote volume and intensity of services, toward supporting providers and patients in establishing stronger accountability for coordinated care and health outcomes at a population level. The waiver requires that prepaid health plans reward the providers in their networks based on these concepts (e.g., quality enhanced FFS, capitation, shared savings, etc.). In general, we support the development and testing of these initiatives aimed at coupling more efficient care delivery with efforts to enhance the quality of care.

The waiver proposal notes the many innovative programs created by the Affordable Care Act (ACA), such as the Medicare Shared Savings Program (MSSP) and various practice transformation initiatives that are already underway in North Carolina, along with the movement toward quality-based payments at the national level due to implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). This waiver application, we think, rightly notes that Medicaid can be joined to these efforts to encourage coordinated, statewide health-care reform.

In addition to clearly aligning these programs, we would add that a range of other commercially-driven initiatives are also underway in the State, including the efforts of the North Carolina State Employee and Retiree Health Plan, which also operates under a strategic plan that incorporates a shift toward value-based payment and delivery models. We believe it is essential that the waiver process identify specific ways to explicitly harmonize important aspects of these and other public and private efforts in order to ensure that reform truly produces better care at a lower overall costs, with significantly reduced administrative for complexity than a payer-by-payer approach.

Specifically, we believe North Carolina also has a key opportunity to be a national leader in this rapidly emerging area of health care payment and delivery reform, if the State will commit to implementation and timely and effective evaluation of the payment models themselves along with resulting care delivery and coordination innovations that emerge from new payment models. Key steps include:

- **Supporting capitation and other forms of performance risk**. In general, we support efforts to shift the payment system from fee-for-service to risk-based approaches, to one that more strongly supports more coordinated and efficient approaches to care. We appreciate that the goal of the waiver is to emphasize organized, well-coordinated systems of care, and we encourage clarity that value-based payments should move beyond traditional payer-sponsored "pay-for-performance" (P4P) programs toward those that foster actual accountability for the total cost and quality of care by organizations capable of taking on and effectively managing financial risk.
- **Harmonizing quality and other performance measures** across Medicaid PHPs and, where possible, the measures that North Carolina providers are already required to measure and report on for other value-based purchasing efforts from the Center for Medicare and Medicaid Innovation (CMMI), the Centers for Medicare and Medicaid Services (CMS) more broadly, the NC State Employee and Retiree Health Plan, and commercially-sponsored initiatives. Today, providers are inundated with an "alphabet soup" of different measure sets and reporting requirements for different payers and programs, which can produce suboptimal outcomes, impose a heavy administrative burden on clinicians that distracts them from patient care, and engender significant frustration along the way. In building on the measures and reporting requirements with which North Carolina providers are already familiar in the context of participating in various CMS and other programs, North Carolina's Medicaid reform can take a leadership role in distilling the most important measures, specifying them consistently across multiple programs, and harmonizing reporting requirements. We think this would produce better outcomes overall, it would allow clinicians to be more attentive to serving patients in clinical care, and it will result in less administrative complexity and costs.
- **Utilize technology** to coordinate care as Medicaid recipients navigate across different provider silos and settings of care (including evolving MCO or PLE affiliations) and come in and out of eligibility for services over time. Data-sharing efforts and requirements can be used to facilitate "rapid-cycle" evaluations of changes in care delivery, new technology-enabled approaches to

care coordination and patient monitoring, and overall health-system performance. As noted above, where possible, data-sharing requirements should also be aligned with the federal health-care landscape to reduce provider burden and ensure comparability with reporting requirements on the national scale. Of note, the North Carolina state health information exchange can be positioned to help support the goals of health-care reform under this waiver to meet the demands of payment reform, care coordination, quality reporting, and to supply much of the clinical outcome data need to evaluate and report on reforms.

Engaging physicians and other clinicians in the evolution of health care delivery reform

The waiver application admirably calls out the importance of "Provider Engagement and Support". This aspect of the waiver is intended to support the longstanding tradition in this State of collaboration with the medical profession, other providers, beneficiaries and other stakeholders, innovating to meet North Carolina's health care needs. Community Care of North Carolina (CCNC), a nationally recognized initiative of North Carolina Medicaid, has long exemplified this spirit in the context of engaging physician practices and other providers at the local and regional levels around quality improvement, care redesign, and population health. In particular, the waiver includes Enhanced Primary Care Case Management (ePCCM), through which NCDHHS proposes to build on and expand the work of CCNC toward more patient-centered care, and eventually toward a population-based perspective. As Medicaid reform evolves to incorporate a more prominent role for large MCOs in the state, it will be important for these organizations and for policy officials implementing reform to be particularly attentive to the needs and perspectives of North Carolina's medical community, as ongoing provider engagement and participation are critical to the success of the proposed reforms in the context of a health system that is already undergoing rapid organizational and technological change. To be sure, shifting from "volume to value" and implementing new risk-based payment models have great potential but are also very complex and challenging to administer. We have noted elsewhere in this document the need to consolidate and streamline performance measurement and reporting requirements across payer entities and with the Federal government to ease provider reporting burdens and ensure comparability and usability of resulting data. More generally, given the already rapidly changing, multi-factorial, and highly complex health-care environment in which health-care providers practice medicine today, the proposed reform effort needs to be flexible, highly attuned to the market experience of providers and the beneficiaries they serve, and also include clear mechanisms to allow for adjustments to be made based on experience.

More coordinated services and support

The waiver outlines a plan to move toward better integration of mental health care services with other types of care, which has long been an important if unfulfilled goal in North Carolina. The current Medicaid approach to mental and behavioral health is regionally oriented, and could dovetail nicely with the PLE approach of regional PHPs. However, it is less clear how well this will work with statewide plans. There is some risk of the goal of competition leading to an unintended consequence of upending regional networks of mental health care services that may be improving.

The waiver also discusses better integration of Long Term Services and Support (LTSS) care for Medicaid beneficiaries who are not dually eligible for Medicare. We understand the rationale for excluding the dual-eligible population because of the difficulty of integrating this population into a fully at-risk MCO bidding process, but this also means that the most predictably expensive group of Medicaid beneficiaries, who likely could benefit substantially from more coordinated medical care and non-

medical services and support, are excluded from any reform. We suggest that more work should be done to address costs in the most expensive group of Medicaid beneficiaries since the waiver does not directly address this important and often vulnerable portion of the population.

Toward greater access to care

Medicaid 1115 waivers are typically used to expand insurance coverage to new groups of people, while implementing complementary changes like designing benefits or narrowing provider networks as a means of financing these expansions. However, the present waiver application does not include a provision to expand Medicaid coverage. We understand the historical political and budgetary arguments for and against Medicaid expansion. In general terms, we envision a high-quality, efficient health-care system that every North Carolinian can access in one form or another, and we anticipate that the negotiation of this waiver itself will present new opportunities to re-open discussions about the feasibility of expanding Medicaid eligibility in the context of new opportunities to control health care spending as contemplated under this waiver.