NC Medicaid and NC Health Choice 1115

Demonstration Waiver Application

#CloseTheGapNC FACT SHEET

From the NORTH CAROLINA JUSTICE CENTER

INTRODUCTION: *This fact sheet will summarize the content of the NC Medicaid and NC Health Choice 1115 Demonstration Waiver application that was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 1, 2016. This document will also highlight how Medicaid expansion in North Carolina supports and strengthens the aims and initiatives outlined in the Medicaid reform 1115 waiver application.*

▶ Background

On September 23, 2015, the Medicaid Reform Bill (House Bill 372 or Session Law 2015-245) was signed into law by Governor Pat McCrory. With reform, North Carolina will now join 39 other states (including Washington, D.C.) that rely on managed care organizations (MCOs) for delivery of comprehensive Medicaid services. While MCOs and provider led entities (PLEs) will help with Medicaid delivery, North Carolina, and more specifically the NC Department of Health and Human Services (NC DHHS), will be charged with oversight and administration of Medicaid. It is important to note that Medicaid beneficiaries covered by local management entities (LME/MCOs) for behavioral health will continue under the current system for at least four years after managed care companies begin overseeing physical health care and spending. However, the waiver application does state that there will be efforts to enhance collaboration between primary care and specialty behavioral care. The reform bill creates a new Division of Health Benefits (DIB) within NC Department of Health and Human Services (NC DHHS) to oversee the implementation of Medicaid transformation in addition to entering into contracts with the MCOs and PLEs. The General Assembly will continue to determine the criteria for Medicaid eligibility and will monitor Medicaid reform through a Joint Legislative Oversight Committee on Medicaid.

Overall, the bill was passed to help North Carolina's Medicaid program address concerns with growth in spending and enrollment. To address the increased demand and cost, the General Assembly passed a Medicaid reform bill that aims to accomplish four goals:

1. Ensure budget predictability through shared risk and accountability
2. Ensure balanced quality, patient satisfaction, and financial measures
3. Ensure efficient and cost-effective administrative systems and structures
4. Ensure a sustainable delivery system

Following the legislative session, NC DHHS began the challenging task of developing the waiver application. The following are key dates regarding advocates' ability to comment and advocate for Medicaid expansion:

1. January 2016 – Sec. Rick Brajer and NC DHHS began meeting with key stakeholders and interest groups across the state
2. March 7, 2016 – The draft waiver was available for public viewing and comment
3. March 30 – April 18, 2016 – 12 public hearings were conducted
4. April 18, 2016 – Public comment period ended
5. June 20 – July 20, 2016 11:00 p.m. – Federal comment period

The waiver demonstration application's Appendix B reduces the comments supporting Medicaid expansion submitted via email, postal mail, online submission forms, and verbal to one line in a table

that is 50 pages long. Accordingly, the NC Justice Center's health project and our partners believe the federal comment period is a key opportunity to highlight how the waiver application in its current status fails to be innovative and transformative.

▸ Program Description

QUADRUPLE AIM

In an effort to submit an innovative waiver, NC DHHS builds on CMS' Triple Aim[1] by developing a Quadruple Aim:

1. Better experience of care
2. Better health in our community
3. Improved provider engagement and support
4. Per capita cost containment and funding

In order to achieve the Quadruple Aim there are five initiatives with activities:

1. Build a system of accountability for outcomes.
2. Create person-centered health communities.
3. Support providers through engagement and innovations.
4. Connect children and families in the child welfare system to better health.
5. Implement capitation and care transformations through payment alignment.

AIM 1 – Better Experience of Care

In order to improve on Medicaid consumers' health care experience, NC DHHS explains that by transforming North Carolina's Medicaid program from fee-for-service to a shared risk capitation payment model, health service providers will offer more value. The reasoning is that North Carolina Medicaid's current fee-for-service payment model, which pays medical providers per visit and procedure, incentivizes providers to simply provide more services. In contrast, in a capitated system prepaid health plans (PHPs) (includes PLEs and MCOs) receive one risk-adjusted payment per enrollee. In a shared risk system, providers are eligible to share in savings realized in service delivery and may be exposed to penalties for exceeding certain budget targets. Capitated payment models are believed to reward "value over volume" as providers will seek more innovative strategies to develop Person-Centered Health Communities (PCHCs) and move forward to integrate physical and behavioral care.

In order to establish PCHCs, the waiver application states that North Carolina will build on the Patient-Centered Medical Homes (PCMH) model established by Community Care North Carolina (CCNC). Through health communities, Medicaid providers and health systems will also account for the social determinants of health. Further, NC DHHS proposes increased supports to providers such training and coaching, the Health Information Exchange (HIE), and even designating some providers as "essential providers" so that consumers will have enhanced support from safety net providers. The waiver application notes that the transformation of Medicaid will also lead to increased access to underserved rural areas through telemedicine.

How Closing the Coverage Gap Enhances Aim 1

In addition to providing health coverage to up to 500,000 North Carolinians, Medicaid expansion program evaluation reports show that people get the preventive and primary care that they need when

their state closes the Coverage Gap. Within the first year of closing Michigan's Coverage Gap, more than half of expansion enrollees saw a primary care doctor and 17 percent received preventive services.[2] In Kentucky, a state that ranked 33rd for diabetes, 46,000 people were screened for diabetes and 13,000 people were treated for substance use disorders within the first year of expansion.[3] Another report states that while there is still difficulty addressing specialty care, Federally Qualified Health Centers (FQHCs) in states that have closed the Coverage Gap have greater capacity to improve access to specialty care, which could then influence the experience of care.[4] A literature review shows that in Medicaid expansion states, newly insured individuals have fewer unmet medical needs associated with cost, receive more preventive care such as breast exams, and are diagnosed with chronic conditions.[5] One could posit that these newly insured individuals are getting diagnosed sooner for chronic conditions, which may lead to more effective management of the condition instead of relying on urgent care.

In North Carolina, we know that nearly 50,000 women are not receiving recommended preventive screenings, 27,044 diabetics still cannot get much needed medications,[6] and there are 144,000 children who remain uninsured as a result of their parents and/ or caregivers being in the Coverage Gap.[7] What's more, as there are already 16 vulnerable hospitals in the state,[8] NC DHHS will struggle to maintain access for Medicaid patients as the health care infrastructure erodes—especially in vulnerable rural areas—as a result of refusing to close the Coverage Gap. Clinic and hospital closings will only accelerate in the future if we do not access additional federal funds through Medicaid expansion.

AIM 2 – Better Health in Our Community

As in Aim 1, NC DHHS notes that transitioning to a capitated payment system and hybrid model with both commercial insurers (MCOs) and PLEs will help strengthen health in the communities. While there is reason for concern over dismantling CCNC and their established networks and coordinated care, NC DHHS plans to contract with three statewide PHPs and up to 10 regional contracts with PLEs. PHPs in the regions will be responsible for meeting network adequacy standards and ensuring that consumers have access to health care services that meet all of their needs. Through meeting these requirements regions will create networks with enhanced integrated care, addressing the second Quadruple Aim.

The waiver application notes that the development of PCHCs will help address social determinants of health and health equity in rural regions and underserved communities. An effort to build the health workforce is also highlighted in strengthening access to health care services and providers in the long term in rural and underserved areas as well. Section 2.3.2.1 goes into greater detail outlining how programs such as the Advanced Pregnancy Medical Home, improved supports for children and youth with more complex health needs, and enhanced pharmacy services will build on the PCMH model established by CCNC. Data collection and analysis will assist with population health management as all Medicaid providers will be required to participate in the HIE. The HIE will allow providers to view and share the most current patient health information.

Further, NC DHHS proposes to address community health by improving family health and well-being. The waiver application proposes to extend Medicaid coverage to caregivers and parents of children who enter the foster care system so that they can continue receiving the care and services they need to ideally increase their ability to reunite their families.

How Closing the Coverage Gap Enhances Aim 2

The first thing to note is that communities will not experience improved health or fiscal outcomes if children, families, and childless adults remain in the Coverage Gap. If lawmakers and NC DHHS really want to address prevention, health equity, and social determinants of health, North Carolina cannot

continue to block access to health care to one half million people. While extending coverage to caregivers and parents whose children enter foster care is commendable, it only addresses physical and behavioral care needs in times of crisis instead of providing consistent preventive and primary care for all parents, not just to those who meet eligibility requirements. A report by Georgetown's Center for Children and Families shows that closing the Coverage Gap not only increases individual access to health care, but has a huge impact on safety net hospitals and clinics, thus influencing community health.[9] The study reports that as a result of savings from expanding Medicaid, FQHCs – which are "essential providers" in the 1115 waiver application – were able to either open new facilities or expand services that ultimately improve community.

NC DHHS and the General Assembly continue to ignore the economic ripple effect Medicaid expansion will have on the state. The waiver clearly outlines an initiative to develop a community-based residency and health workforce education program, which will address concerns of workforce shortages. If North Carolina lawmakers had accepted 100 percent federal funding by this year to close the Coverage Gap, 43,000 jobs would be created by 2020.[10] Further, between 2016 and 2020, North Carolina could have gained approximately $860 million in state revenue and $161 million in county tax revenue by expanding Medicaid. If the 16 vulnerable hospitals in North Carolina were to close as a result of financial distress associated with uncompensated care, 3,436 jobs in health care would be lost, further adding to the workforce shortages that impact community health. Without Medicaid expansion there could be a negative ripple effect such as the loss of nearly 5,000 jobs and close to 350,000 fewer patient encounters.[11]

AIM 3 – Improved Provider Engagement and Support

One important fact that the waiver highlights is that North Carolina's current Medicaid system already has high provider level engagement, as 90 percent of primary care providers enroll in Medicaid and participate in primary care case management. Like Quadruple Aims 1 and 2, NC DHHS posits that moving towards a capitated payment model will further increase provider engagement as they will have to work towards innovative ways to address cost containment while supporting improved patient health outcomes and community health through PCHCs.

The comments on the draft waiver (Appendix B) bring to light many of the concerns regarding the dismantling of CCNC and the potential administrative burden to providers as North Carolina's Medicaid program moves from primary-cased case management to a managed care hybrid model. NC DHHS' responses to these comments range from offering education to providers prior to implementing reform to working with PHPs and providers to identify ways to reduce administrative burden.

Despite NC DHHS still being in the planning phases and the desire to resist a "one size fits all" model for PHPs, the waiver application does provide an outline of what initiatives are to be included in Quadruple Aim 3. More importantly, the waiver application states that consistent, quality improvement and performance assessments, along with the North Carolina Health Transformation Center, will help NC DHHS achieve the third aim.

One of the waiver's most interesting initiatives to support providers is strengthening the safety net. The 1115 waiver application states that FQHCs, rural health centers, and other free and charitable clinics are critical in providing care to vulnerable populations especially those in rural and other underserved communities. NC DHHS uses statistics like 10 percent of the North Carolina's population receives primary care through safety net providers and of these 32 percent are Medicaid consumers. By naming local health departments, FQHCs, and other safety net providers as "essential providers," they will receive "wrap around" payments and definite placement in PHP networks.

How Closing the Coverage Gap Enhances Aim 3

Instead of proposing vague supports and ideas to increase provider engagement, the waiver application could strengthen its innovation claim by including Medicaid expansion. As stated in the 1115 waiver application, we know that North Carolina providers are invested in serving the Medicaid population, and closing the Coverage Gap would allow health centers to extend their capacity to provide additional services such as dental care or more robust integration with behavioral health.[12] Georgetown's study with FQHCs also noted that as a result of the fiscal benefits associated with Medicaid expansion, FQHCs could hire new staff, update clinical and medical equipment, and even open new clinics. Other health care leaders in expansion states reported that there was a significant increase in communication amongst providers following expansion. Increased communication was linked to improved collaborations which then led to more sustained and improved efforts to integrate primary and behavioral health care.[13]

Closing the Coverage Gap in North Carolina will also enhance the state's planned efforts to strengthen the health care workforce through community-based residency programs and education. Again, if the vulnerable hospitals in rural areas were to close – even as the waiver repeatedly states that NC DHHS wants to improve health equity in the 70 rural counties – there would be jobs lost, creating further strain on providers. It is also possible that even if the federal government provides funding to support the community-based residency program, newly trained health care providers may not want to work in rural and underserved areas with limited health care facilities. Health care executives in non-expansion states noted "brain drain" and that the desire of providers to work elsewhere increases as it becomes more difficult to balance unmet needs and their mission as providers.[14] Based on the provider support we received from Dr. Stephen Luking[15] and Dr. Charles van der Horst,[16] who spoke during the Close the Medicaid Gap Day of Advocacy, and letters to the editor written by providers like Dr. Pradeep Arumugham,[17] we know that there are many health providers that understand Medicaid expansion as an important tool in helping them reach their goals of providing quality and consistent care instead of urgent care.

AIM 4 – Per Capita Cost Containment and Funding

The biggest driver for Medicaid reform in North Carolina over the last few years is cost. Yes, Medicaid is the second largest area of spending in the state budget, but there is also growth in cost for private insurance. Transitioning from fee-for-service to a capitation payment model is the biggest step towards cost containment and rewarding better health outcomes while also increasing accountability. NC DHHS writes in the waiver that payments to the PHPs will be actuarially sound or capitation rates and other revenues will cover all appropriate costs.[18] The waiver additionally states that provider, PHP, and stakeholder feedback will be sought due to the complexity of transitioning to a new payment model. The waiver also requests funding to support initiatives to address workforce shortages and education.

The 1115 waiver application also notes NC DHHS' intent to use delivery system reform incentive payment (DSRIP) programs as a strategy for safety net providers to help transform health care delivery while increasing accountability through measuring performance and outcome metrics. If programs achieve the pre-determined milestones, they will receive performance payments. Many states use DSRIP funding to reduce per capita cost, as well as improve patient outcomes and experience of care.[19] There are three programs for the DSRIP funding: 1) Academic Health System Initiatives, 2) Local Health Department Incentive Payment Program, and 3) Hospital Based Payment Program. Examples of projects range from diabetes prevention to decreasing emergency department visits.

As Medicaid enrollment and costs grow, many states use cost-sharing to promote more cost-effective health service utilization. It is important to note that the federal government has set limits on premiums and cost-sharing as many Medicaid consumers have fewer resources and low incomes.

Section 4 of the waiver application outlines the benefits and cost-sharing for Medicaid reform. NC DHHS states that there will be no change in benefits or cost-sharing. However, a Medicaid budget survey of all 50 states shows that North Carolina increased copayments in 2015 for non-exempt enrollees to the maximum amount.[20] One example of cost-sharing is an $8 copay for non-emergency use of the ER for Medicaid consumers up to 150 percent federal poverty level.[21]

How Closing the Coverage Gap Enhances Aim 4

Table A in the waiver application is the key to understanding funding for Medicaid reform. It provides a description of why NC DHHS is requesting waiver and expenditure authorities. Of the nine authorities requested, six are linked to expenditures and funding. Three of the expenditure authorities are likely unnecessary once you factor in the fiscal benefits associated with Medicaid expansion.

- **Expenditure authority request #4 is for uncompensated care.** A literature review of multiple studies examining the impact of closing the Coverage Gap shows that non-expansion states experience little to no decline in costs associated with uncompensated care, whereas states that have expanded Medicaid report a decrease in uncompensated care costs and fewer uninsured hospital visits.[22]
- **Expenditure authority request #6 describes the need for "wrap around" payments for rural and public health care providers.** A study by professors at UNC Gillings School of Public Health shows that rural hospitals are more likely to experience financial distress as a result of uncompensated care.[23] An infographic by Families USA depicts the link between rural hospital closures and lack of Medicaid expansion.[24] Closing the Coverage Gap will yield a significant boost to rural hospital finances so that additional "wrap around" payments are not needed.
- **Expenditure authority request #9 is linked to funding parents and caregivers once children enter foster care.** Again, this is not real Medicaid expansion as these parents and caregivers already meet income eligibility but have lost coverage due to placement of the child in the foster care system. By only extending Medicaid to income-eligible parents, NC is disregarding families in the Coverage Gap who could have better outcomes with proper physical and behavioral health care.
- **Expenditure authority request #5 highlights the need for DSRIP funding.** There is reason to believe that the federal government will not continue to grant the state DSRIP funding when state-level policymakers refuse to tap into existing federal funds for expansion in order to truly transform NC's health care delivery system. Considering the experience of states like Florida and Texas and that the ACA is written so that low-income pool (LIP) and disproportionate share hospital (DSH) payments will continue to decrease as states are expected to adopt Medicaid Expansion, we strongly recommend closing the Coverage Gap.[25,26]

Expansion is critical for containing costs in Medicaid. Without expansion, individuals and families in the Coverage Gap will continue to receive inconsistent health care. Many people in the Coverage Gap obtain Medicaid for short periods of time and use more services, which is more costly. Additionally, some people with incomes between 100 and 138 percent federal poverty have competing financial priorities and may not be able to afford health coverage on the Marketplace for continuous periods of time. A study by The Commonwealth Fund notes that as people at and below 138 percent federal poverty have limited incomes and savings, Medicaid is more beneficial as there are no premiums and limited copayments.[27]

Conclusion

While the Quadruple Aim and initiatives outlined in the 1115 waiver application are commendable, failing to expand Medicaid will prevent NC DHHS from achieving its goals. North Carolina lawmakers and NC DHHS are ignoring that NC Medicaid reform will not be truly transformative and innovative unless we close the Coverage Gap so that low-wage working adults, children and families, and residents of rural and underserved communities have access to quality health care. Multiple reports provide evidence that Medicaid expansion addresses concerns such as bolstering the health care workforce, strengthening the financial viability of safety net providers, and improving provider engagement. Most importantly, the waiver states the need to improve community health, which is hard to achieve and sustain if 500,000 North Carolinians are left without health coverage.

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