mhpa Medicaid Health Plans of America

January 5th, 2018

Seema Verma
Administrator
U.S. Center for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

RE: North Carolina Medicaid and NC Health Choice Amended Section 1115 Demonstration Waiver Application

We thank you for the opportunity to comment on the North Carolina Department of Health and Human Services amended Section 1115 Demonstration Waiver. Pending approval of the waiver, North Carolina would launch the largest transition to managed care in recent memory and in the post-managed care era. In 1991, 2.7 million beneficiaries were enrolled in some form of Medicaid managed care.[1] By 2017, almost 55 million beneficiaries were in fully capitated Medicaid managed care plans.[2] Consequently, Medicaid managed care plans have become the primary delivery system for care for the majority of Medicaid beneficiaries.

The Medicaid Health Plans of America (MHPA) is the leading trade organization representing the nation's Medicaid managed care plans. We represent a cross-section of national Medicaid managed care plans, Blue Cross Blue Shield (BCBS) plans, and indigenous State Medicaid managed care plans. Our Local Management Entities (LME) managed care North Carolina members have been responsible for managing publicly funded behavioral health services for many years. All in all, MHPA represents nearly half of all Medicaid managed care lives in the United States.

MHPA applauds the changes that North Carolina intends to make to its Health Choice's program in an effort to advance integrated, fully capitated managed health care under the auspices of a financially sustainable program. Moreover, the changes being sought by North Carolina will help to address some of the complicated, confounding variables present in the broader Medicaid environment. For example, establishment of evidence-based public-private regional pilots to address health-related needs will directly impact the myriad of social determinants of health that affect Medicaid populations.

[1] "Medicaid and Managed Care," Kaiser Family Foundation, November 30th, 2001.

[2] "The Complicated State Of Medicaid In The United States," Price Waterhouse Coopers, October 2017.

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Many of our comments echo previous submissions to CMS, and help to supplement the public comments already submitted to North Carolina under its prior public notice. However, for the purposes of this submission, we will restrict our comments to a few provisions in the amended demonstration waiver application.

Designing Managed Care Products Tailored To The Unique Needs Of A Diverse Medicaid Population

The State of North Carolina has recognized the need for a significant investment in ensuring access to integrated high-value care for targeted populations through the use of Prepaid Health Plans (PHPs). Under the State's plan, PHPs will cover individuals with complex behavioral health needs, those accessing home and community-based waivers, long-term services and supports (LTSS), and youth in foster care.

PHPs will be divided between commercial plans (CPs) and Provider Led Entities (PLEs). Pending additional State legislative authorization, North Carolina intends to permit CPs and PLEs to develop and offer two types of products: standard plans and tailored plans.

Standard plans will serve most Medicaid beneficiaries, including adults and children. They will provide integrated physical health, behavioral health, and pharmacy services. Tailored plans will be specifically designed to serve special populations with unique health care needs such as those with co-existing behavioral health (BH) and Intellectually Disabled/Developmentally Disabled (ID/DD) issues, as well as specialized plans for children in foster care. Finally, North Carolina's demonstration will move those beneficiaries eligible for long-term services and supports (LTSS) into managed care.

MHPA Comments: *The creation of fully capitated, integrated plans for specific groups of beneficiaries represents the continued evolution of managed Medicaid. As such, MHPA supports an integrated delivery platform for the diverse populations cared for by Medicaid.*

Integrated Medicaid managed care plans have been a feature of the Medicaid program for the last twenty years, while specialized Medicaid plans focusing on caring for discrete populations have debuted over the past decade.

Various types of fully integrated Medicaid plans cater to beneficiaries with specific health conditions (i.e. HIV/AIDS), co-existing behavioral health co-morbidities;

children and youth with special health care needs, and dually-eligible Medicare/Medicaid beneficiaries (i.e. Special Needs Plans (SNPs)).[3] [4] Finally, long-term services and supports have increasingly made their way into managed care. Currently, 11 states are using § 1115 waivers to provide capitated MLTSS with most of these waivers first approved in the last five years.[5]

Conditioning The Payment Of Appropriate Rates Under The Demonstration's Financing

Actuarially sound rates are the foundation of a robust Medicaid managed care program. North Carolina proposes to pay PHPs at actuarially sound rates plus any incentive arrangements or risk corridors that the State implements consistent with Federal regulations. In addition, the State has signaled a desire to compel PHPs to reimburse contracted providers at a minimum reimbursement.

MHPA Comments: *Our association is concerned with North Carolina's arrangement regarding supplemental payments being coupled to a minimum fee schedule for reimbursement. Most, if not all, Medicaid health plans will be severely challenged to pay rates that are projected to be 100% of Medicare rates.*

Using Health Home Care Management For BH ID/DD Tailored Plan Enrollees

According to the plan submitted by North Carolina, the BH ID/DD tailored plans will eventually contract with community-based care management entities acting as health homes under a health home State Plan amendment. Health home funds will flow to the BH ID/DD tailored plans, and BH ID/DD tailored plans and care management agencies will deliver health home care management services.

MHPA Comments: *MHPA supports the use of health homes as essential elements of a broader managed care network. In 2017, 54% of health home enrollees were in models where the state contracted with the Medicaid health plan.[6] However, we believe that the clinical adjudication and channeling of beneficiaries to such services should entirely be within the purview of the plan.*

Furthermore, we believe that any services attributed to health home management services be included in the capitation rates paid to managed care entities. Health homes themselves should be sub-capitated as part of the managed care plans network. Finally, the State should not dictate the rate the health home is paid—even if the contracting is through a Medicaid health plan. Managed care plans

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[3] "Medicaid Managed Care for Children and Youth with Special Health Care Needs," National Association Of State Health Policy, February 3rd, 2014.

[4] "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options," James Verdier et al., Center For Health Care Strategies Inc., February 2015.

[5] "Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies," Kaiser Family Foundation, January 31st, 2017.

[6] "The Changing Face Of Medicaid Health Homes—The 2017 Update," Open Minds, December 21st, 2017.

should be able to establish rates for health homes through the use of the same "arms-length" negotiations used with other providers.

Increasing Access To Inpatient And Residential Substance Abuse Disorder And Behavioral Health Treatment Through Reimbursement For Services In Institutions Of Mental Disease (IMD)

To improve access to services, North Carolina seeks expenditure authority to make payments to IMDs for all Medicaid enrollees, either through PHPs or local management entities-managed care organizations (LME/MCOs), or directly to IMDs for fee-for-service enrollees, regardless of whether enrollees are enrolled in managed care or through other delivery systems. In addition, North Carolina seeks to waive certain restrictions on payments to IMD: a waiver of the 15-day managed care final rule limitation related to IMD utilization and the ability to provide full-continuum of substance use disorder treatment including treatment in residential settings that may exceed 16 beds.

MHPA Comments: *Data from the 2015 National Survey of Substance Abuse Treatment Services (NSSATS) published in March 2017, depicts a substance use disorder treatment system that is at capacity. In the census of publicly funded substance use treatment facilities, 105 percent of residential (non-hospital) beds and 109 percent of hospital inpatient beds designated for substance use disorder treatment were occupied.*[7]

As IMDs have become an important access point for beneficiaries in substance abuse crisis, MHPA supports the removal of any barriers that are detrimental to beneficiaries accessing needed addiction services. That being said, reimbursement to such facilities should be predicated upon a reasonable baseline that is accountable to value-based metrics.

Establishing Evidence-Based Public-Private Regional Pilots To Address Health-Related Needs

In recognition of the social and economic issues that can adversely impact health, North Carolina is seeking expenditure authority to establish public-private regional pilots to employ evidence-based interventions addressing health-related needs. The universe of potential interventions encompasses everything from housing transition services, connecting individuals to food supports, transportation to health-related social services, etc.

The public-private regional pilots will focus on some of the most vulnerable populations within Medicaid (e.g. children and adults who are food insecure, those

[7] "Medicaid Coverage For Residential Substance Use Disorder Treatment: Addressing The Institution For Mental Disease Exclusion Policy," Kelsey C. Priest, et.al. Health Affairs, August 31st, 2017.

with behavioral health or substance abuse disorders). If successful, the State's long-term goal is to incorporate the pilots into the Medicaid managed care program.

MHPA Comments: *The effects of social determinants on the Medicaid population are well documented, as is the potential of Medicaid managed care to tackle these issues.*[8] [9] *For plans, truly effectuating the care of Medicaid beneficiaries means examining where and how beneficiaries live their lives.*

To address these factors, Medicaid managed care plans have started to become vertically integrated across provider types (e.g. home health) and have closed gaps across multiple operational silos. By marshaling these resources, plans can begin to crack some of the social determinants of health that affect the daily lives of Medicaid beneficiaries.

In this vein, for the last year, MHPA has been developing a Person Centered Integrated Duals (PCID) model that would not only merge the capitated payments for dual-eligibles from both Medicare and Medicaid, but would also possibly "braid" funding streams appurtenant to social services and supports. We believe that such a model could expand beyond just a dual eligible population and eventually bridge many of the functions served by the current Money Follows the Person (MFP) demonstration.

Increasing Access To Care Through The Carolina Cares Program

There is proposed legislation in North Carolina ("Carolina Cares'") that would require enrollees with incomes >50% of the Federal Poverty Level (FPL) to be required to pay monthly premiums of 2% of income. Enrollees that fail to pay premiums within 60 days of their due date would be disenrolled from Medicaid, unless they can demonstrate an exemption from the premium requirement (i.e. medical or financial hardship).

Carolina Cares enrollees would also be required to be employed or engaged in activities to promote employment unless they have an exemption (e.g. caring for a dependent minor child, receiving active treatment for substance abuse, or are medically frail).

MHPA Comments: *MHPA firmly believes that any eligibility determinations related to a beneficiary's Medicaid status should remain the exclusive domain of the States as per their statutory mandate. Therefore, any adjudications of working status should be administered by the States and not by managed care plans. In addition, MHPA offers caution on any cost sharing imposed upon low income beneficiaries that might encumber access to care.*

[8] "Addressing The Social Determinants Of Health Through Medicaid Managed Care," The Commonwealth Fund, November 29th, 2017

[9] "Medicaid's Role In Improving The Social Determinants Of Health," National Academy of Social Insurance, June 2017.

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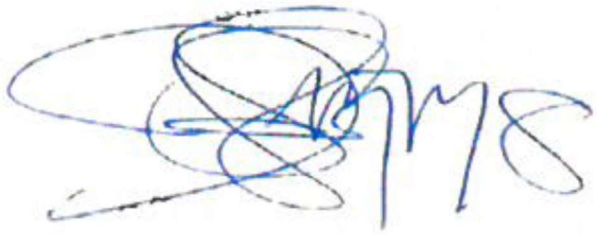
MHPA appreciates the opportunity to provide comments to the agency on this important waiver. As additional waivers get submitted to CMS, we look forward to providing further commentary. Should you have any additional questions, please feel free to contact me at jmyers@mhpa.org or (202) 857-5720.

Sincerely,



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