

TALKING POINTS FOR COMMENTS TO CMS ON 1115 WAIVER

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ACCESS

Complexity may reduce access. With a basic model of 15 different Medicaid insurance companies (PHP – Prepaid Health Plans), complexity is inherent in the design. Complexity would likely reduce access to care not just for children insured through Medicaid and Health Choice, but all children, especially in rural areas. (For example, if practices close rather than make all the changes needed to participate with PHPs; if providers spend more time on paperwork and less time on patient care; if pediatricians chose to retire rather than deal with all the new and multiple requirements, etc.)

Payment structure may reduce access and quality of care. Higher percentages of payment going to PHP means less money for health care for children. A survey of NC pediatricians by NCPeds in March 2015 found that recent cuts (relating to loss of the ACA bump plus state changes) led practices to limit the number of Medicaid patients and that additional cuts would likely lead to limits on seeing Medicaid patients (46%), staff lay-offs (31%), practice closures (8%), and retiring earlier than planned (17%). If there are fewer practitioners or practices, all children in the area will lose access to care, not just those with public health insurance.

Networks may not have adequate access to pediatric providers, especially specialists. There are only a handful of pediatric specialists, such as urologists, in the state. It is unclear how access to needed specialists for children will be assured. Adult specialists who also see children (such as ENTs) may not want to deal with increased hassle of multiple different Medicaid plans for low payment on a handful of children.

LOSS OF CCNC

CCNC provides important benefits for child health. The law directing DHHS to submit the 1115 waiver calls for eliminating CCNC. This is not good for children or taxpayers since CCNC is a proven effective strategy to improve care while reducing cost. While DHHS clearly intends to keep many of the elements of CCNC, CCNC itself will go away. Instead of one care manager and one set of metrics, practices may have to deal with five (or more depending on their region). The state will lose the focus, improved quality and reduced cost that CCNC has been able to achieve. Practices could become frustrated and scattered as a different PHP comes in with a different area of focus, different QI initiatives, etc. Professionals are urged to give personal examples of benefits of CCNC in their comments to CMS.

Brief Waiver Background:

In 2015, the NC General Assembly passed a Medicaid Reform law. One key provision is that the State will pay a capitated rate to Prepaid Health Plans who will then contract with providers for health services. Payments to providers are not required to be capitated but could be. The law requires multiple Prepaid Health Plans (PHPs) – both commercial and provider-led, abolishes CCNC as an entity once the first PHP contract is signed, keeps CCNC in the interim, preserves many CCNC functions after PHPs begin operation, allows statewide MCOs or provider-led entities, allows regional provider-led entities, and allows 18 months for implementation once the waiver is approved.

To meet the law's requirement, DHHS submitted an 1115 waiver request to the federal CMS (Center for Medicare and Medicaid Services) in June 2016. An 1115 waiver is a very "high bar" type of waiver and requires a state to show substantial system change. Before submitting the waiver, DHHS held about a dozen hearings around the state and received input for well over 1000 North Carolinians, including many pediatricians and practice managers. DHHS notes in the revised waiver submission that children are approximately 71% of the affected population.

The comment period to CMS is open until July 20th. Link to waiver and CMS submission info: <http://www.ncdhhs.gov/nc-medicaid-reform>