Background and Evaluation of the NC Medicaid 1115 Waiver and Provider Survey

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Why commission an external evaluation?

- *"The state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses."*[1]
- **Evaluations of Managed Care, Substance Use Disorder and Healthy Opportunities will be conducted according to CMS-approved designs.**[2, 3]
- **The external evaluation will independently assess the degree to which North Carolina Medicaid is achieving the following goals:**

1. **Measurably improve health outcomes via a new delivery system**
2. **Maximize high-value care to ensure sustainability of the Medicaid program**
3. **Reduce Substance Use Disorder (SUD)**

1. Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) for North Carolina Medicaid Reform Demonstration - https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf
2. 1115 Evaluation Design - https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-eval-des-appvl-01152020.pdf
3. Enhanced Case Management and Other Services (Healthy Opportunities) Pilots Evaluation Design - https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-eval-des-appv-ltr-20190815.pdf

Why commission an external evaluation?

The Department is contracting with The Sheps Center for Health Services Research at UNC-Chapel Hill (Sheps) to conduct the independent evaluation of the 1115 waiver.

The Department is obligated to submit to CMS and publicly post the following reports prepared by Sheps:

1. Overall Evaluation
   - Interim Evaluation Report
   - Summative Evaluation Report
2. Healthy Opportunities Evaluation
   - Rapid Cycle Assessment 1
   - Rapid Cycle Assessment 2
   - Rapid Cycle Assessment 3
   - Interim Evaluation Report
   - Summative Evaluation Report

Why commission an external evaluation?

In addition to publicly posted reports, external evaluation findings will inform NC Medicaid's policies and programs through:

- Surveying primary care, obstetrics and behavioral health providers to understand their experience working with NC Medicaid's respective prepaid health plans
- Dynamic, internal dashboards to monitor:
  - Managed Care
  - Substance Use Disorder
  - Healthy Opportunities Pilots
- Narrative and quantitative contributions to quarterly CMS monitoring submissions
- Ad hoc monitoring/evaluation/analytics support

Independent evaluation

1115 Waiver Evaluation requirements

- As Demonstrations, 1115 waivers carry with them the requirement for monitoring and evaluation
- Evaluations are intended to provide generalizable knowledge about what is and isn't working, and why, to encourage evidence-based policy making
- Required components include:
  - Hypotheses on each "large component" of the waiver
  - Research questions
  - Data sources
- Comparison strategies
- CMS guidance indicates: "*The principal focus of the evaluation of a section 1115 demonstration should be **obtaining and analyzing data on the process** (e.g., whether the demonstration is being implemented as intended), **outcomes** (e.g., whether the demonstration is having the intended effects on the target population), and **impacts** of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).*

Independent evaluation

1115 Waiver Evaluation requirements

- CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing
- Waivers that include a substance use disorder (SUD) component, have additional structure
  - Additional goals, milestones and performance metrics

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Evaluation Design in a nutshell

- UNC / Sheps center has been selected as the Independent Evaluators for the 1115 Waiver
- The evaluation will use a mixed-methods approach to testing the evaluation hypotheses.
- The quantitative analyses will use a difference-in-differences approach to the extent possible.
- The quantitative approach will be informed through qualitative analyses by triangulating results from provider interviews and surveys and discussing preliminary results with providers and other stakeholders.

Waiver Evaluation Plans, Goals, Hypotheses

Three Goals of the 1115 Waiver

- Measurably improve health outcomes via a new delivery system
- Maximize high-value care to ensure sustainability of the Medicaid program, and
- Reduce Substance Use Disorder (SUD)

Goal #1: Measurably Improve Health

Goal 1
Hypotheses

- **Hypothesis 1.1**: The implementation of Medicaid managed care will increase access to health care and improve the quality of care and health outcomes.
- **Hypothesis 1.2**: The implementation of Medicaid managed care will increase the rate of use of behavioral health services at the appropriate level of care and improve the quality of behavioral health care received.
- **Hypothesis 1.3**: The implementation of Medicaid managed care will increase the use of medication-assisted treatment (MAT) and other opioid treatment services and decrease the long-term use of opioids.

Goal 1
Hypotheses

Goal #1: Measurably Improve Health

- **Hypothesis 1.4**: Implementation of Advanced Medical Homes (AMHs) and Health Homes (HHs) will increase the delivery of care management services and will improve quality of care and health outcomes.
- **Hypothesis 1.5**: The implementation of Medicaid managed care will reduce disparities (increase equity) in the quality of care received across rurality, age, race/ethnicity and disability status.
- **Hypothesis 1.6**: The greater use of value-based payments by standard plans will increase access to health care and improve the quality of care and health outcomes.

Goal #2: Maximize High-Value Care to Ensure the Sustainability of the Program

Goal 2
Hypotheses

- **Hypothesis 2.1**: The implementation of Medicaid managed care will decrease the use of emergency departments for non-urgent use and hospital admissions for ambulatory sensitive conditions.
- **Hypothesis 2.2:** The implementation of Medicaid managed care will increase the number of enrollees receiving care management, overall and during transitions in care.
- **Hypothesis 2.3**: The implementation of Medicaid managed care will reduce Medicaid program expenditures.

Goal #2: Maximize High-Value Care to Ensure the Sustainability of the Program

Goal 2
Hypotheses

- **Hypothesis 2.4**: The implementation of Medicaid managed care will increase provider satisfaction and participation in the Medicaid program.
- **Hypothesis 2.5**: The implementation of value-based payments will affect the type of services used and reduce Medicaid program expenditures.

Goal 3
Hypotheses

Goal 3: Reduce Substance Use Disorder

- **Hypothesis 3.1**: Expanding coverage of SUD services to include residential services furnished in IMDs as part of a comprehensive strategy for treating SUD will result in improved care quality and outcomes for patients with SUD.
- **Hypothesis 3.2:** Expanding coverage of SUD services to include residential services furnished in institutions for mental diseases (IMDs) as part of a comprehensive strategy for treating SUD will increase the use of MAT and other appropriate opioid treatment services and decrease the long-term use of prescription opioids.

Goal 3
Hypotheses

Goal 3: Reduce Substance Use Disorder

- **Hypothesis 3.3:** Expanding coverage of SUD services will result in no changes in total Medicaid and out-of-pocket costs for people with SUD diagnoses, increases in Medicaid costs on SUD IMD services, increases in SUD pharmacy, outpatient, and rehabilitative costs, and decreases in acute care crisis-oriented, inpatient, ED, long-term care and other SUD costs.

Methods

Qualitative methods

- The qualitative components of the evaluation examine perspectives from:
  - primary care and specialist providers including family medicine, internal medicine, pediatrics, and Ob/Gyn, behavioral health specialists, community-based organizations (CBOs) (e.g., focusing on food and transportation accessibility)
  - as well as state health agency officials, and Prepaid Health Plans (PHPs) impacted by the NC Medicaid transformation.
- Our sample includes approximately 50 practices from across the state, with representation from each of the 6 regions (i.e., approximately 6-8 practices from each region).

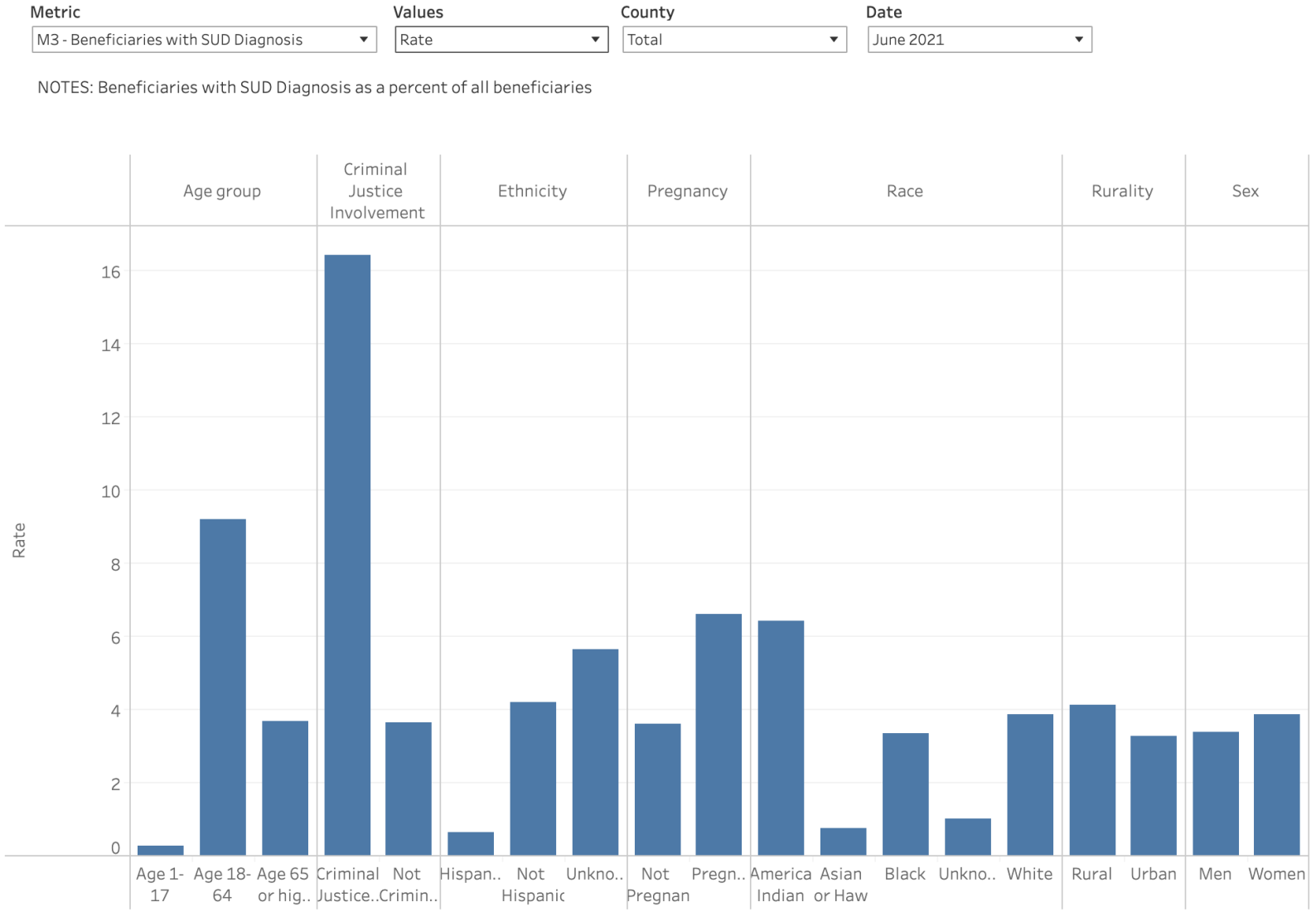
Quantitative Component

- The quantitative evaluation plan focuses on the trends in and analysis of a large number of metrics from each of the hypotheses.
- We will use conduct analyses of metrics that are feasible on a monthly basis and reporting results to NC DHHS through a data dashboard to be developed as part of the Evaluation.
- This approach will allow for the best possible estimates in the shortest possible time, to provide feedback to DHHS and PHPs to allow for short-term quality improvements in plan delivery.

Time Frame

- The evaluation study period runs from October 1, 2015 – October 31, 2024, ~ five years prior to Demonstration Year 1, and through the end of the demonstration.

SUD data dashboard examples



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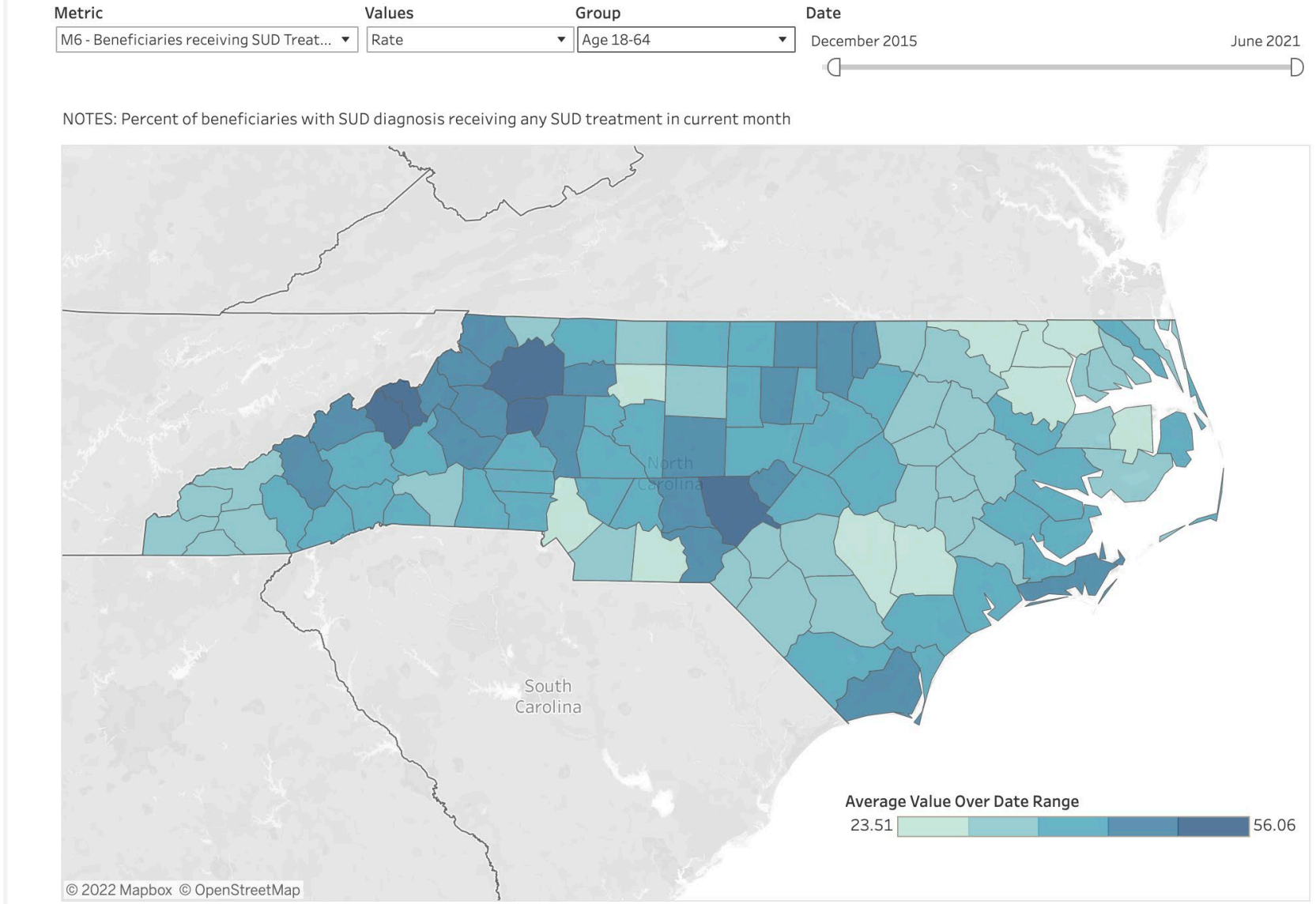
SUD data dashboard examples



Limitations

- Efforts to create a managed care waiver were initiated by North Carolina's General Assembly some time before the baseline time period incorporated here. If provider behavior changed as a result of expectations of upcoming changes, then our baseline period would not capture a true baseline, but rather a baseline under increasing expectation of managed care implementation.
- Any deficits in quality of encounter data would confound the PHP analyses, since they would be contemporaneous to the implementation of capitated care.
- Finally, the evaluation will not be able to assess all aspects of the Demonstration due either to data limitations or statistical limitations.

Conclusion - waiver evaluation

- The mixed methods independent evaluation will provide timely information on how the many moving parts to NC's Medicaid transformation are working, providing feedback to both NC decision makers and the health policy community nationally

Healthy Opportunities Pilots Evaluation

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February 24, 2022

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Healthy Opportunities Pilots

- Goal: provide an “innovative, well-coordinated system of care that addresses both the medical and non-medical drivers of health”
- Process: Enable use of Medicaid funds for services that advance health but fall outside of traditional healthcare spending
- Areas of Focus: Food, Housing, Transportation, Interpersonal Violence, Toxic Stress

Healthy Opportunities Pilots

- 3 Pilot Regions:
  - Access East, Inc.: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
  - Community Care of the Lower Cape Fear: Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
  - Dogwood Health Trust: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Healthy Opportunities Pilots

Eligibility:

- **Physical/Behavioral Health Risk Factors (varies by population):**
  - Adults (such as two or more chronic conditions).
  - Pregnant women (such as multifetal gestation).
  - Children, age 0-3 (such as a baby that was in a neonatal intensive care unit).
  - Children, age 0-21 (such as experiencing three or adverse childhood experiences).
- **Social Risk Factors:**
  - Homeless and/or housing insecure.
  - Food insecure.
  - Lack of transportation.
  - At risk of, witnessing or experiencing interpersonal violence.

Healthy Opportunities Pilots

Organization

- Prepaid Health Plans (PHPs)
  - Identify Eligible Individuals
  - Assess Needs
  - Manage Budget
- Network Lead
  - Develop and oversee network of human services organizations
- Human services organizations (HSOs)
  - Deliver needed services

Healthy Opportunities Pilots

Evaluation

- Rigorous evaluation is a core component of the program
- These are conceived as pilots—we are seeking to learn what works and what doesn't
  - Goal is to inform future practice
  - Not simply evaluate what is being done presently
  - Designed for learning

Healthy Opportunities Pilots

Evaluation Questions

- Evaluation Question 1: Establishing, overseeing, and maintaining a network of human service organizations
- Evaluation Question 2: Screening for social risk factors to identify eligible individuals
- Evaluation Question 3: Improving social risk factors

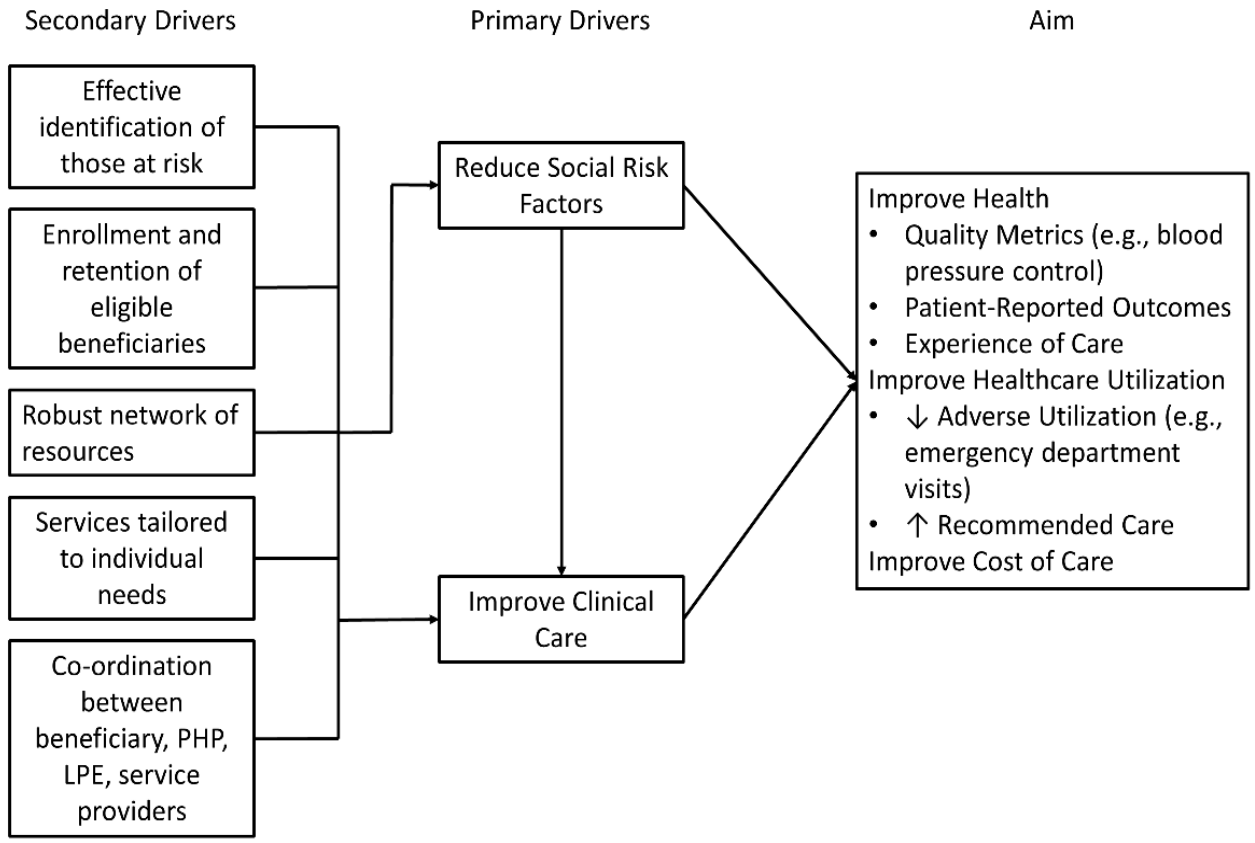
Healthy Opportunities Pilots

Evaluation Questions

- Evaluation Question 4: Improving health outcomes
- Evaluation Question 5: Improving healthcare utilization
- Evaluation Question 6: Improving healthcare expenditures

Healthy Opportunities Pilots

- Driver Diagram



Healthy Opportunities Pilots

Evaluation Phases

- Rapid Cycle/Formative: Learn what is working and what isn’t, modify as needed
- Summative: Apply a rigorous test of the system the LPEs think gives the best chance of improving outcomes

In Summary…

- View this as a ‘best in class’ effort to address social risk factors for poor health
- Goal is learning what works and what doesn’t so we can improve health of Medicaid beneficiaries

Medicaid Transformation Provider Experience Survey Baseline Results

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February 24, 2022

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Survey objectives

Sample

- Organizations providing primary care and Ob/Gyn to Medicaid patients

Objectives

- Experience with NC Medicaid prior to transformation
- Experience with PHPs during the contracting phase

Application

- We will use survey findings as a leading indicator for PHP quality improvement

Sampling & recruitment

Sampling Strategy

- Sampled at the organizational level for large group practices and health systems, and at the practice level for independent practices
- Used IQVIA OneKey data to identify all practices providing primary care and OB/GYN in North Carolina
- Identified 668 organizations

Recruitment

- Multi-pronged approach
- Partitioned out large systems using size data from IQVIA for more customized outreach
- Eligibility rate = 77.6% of our sample
- Final response rate = 58.78%

Descriptive statistics (weighted)

	Total (n = 305)	Any Rural Presence (n = 127)	No Rural Presence (n = 178)
Ownership			
Health Systems	17 (5%)	17 (13%)	0 (0%)
Independent Practices/Medical Groups	288 (95%)	111 (87%)	178 (100%)
Size			
Small (1 – 2 physicians)	126 (41%)	52 (41%)	74 (42%)
Medium (3 – 9 physicians)	124 (41%)	43 (34%)	81 (45%)
Large (10+ physicians)	55 (18%)	32 (25%)	22 (13%)
Services			
Primary care	301 (99%)	126 (99%)	175 (98%)
Prenatal/Postnatal care	36 (12%)	24 (19%)	12 (7%)
Inpatient obstetrics care	30 (10%)	20 (16%)	10 (6%)

Advanced Medical Home

Highest Tier of Medical Home	Health Systems	Independent Practices
Tier 1	2 (9%)	23 (8%)
Tier 2	7 (30%)	36 (12%)
Tier 3	11 (48%)	158 (56%)
Not Applicable	4 (17%)	64 (23%)

Participation in an ACO	Health Systems	Independent Practices
Yes	15 (65%)	117 (42%)

Satisfaction with CCNC/Carolina ACCESS and Current Medicaid program

Highest rated items

Item	% rated Excellent or Good
Timeliness of claims processing	79%
Accuracy of claims processing	77%
Experience with provider relations overall	74%

Lowest rated items

Item	% rated Excellent or Good
Access to behavioral health therapists for Medicaid patients	36%
Access to behavioral health prescribers for Medicaid patients	38%
Process for managing grievances and appeals	53%

Importance of factors when deciding to contract with PHPs

Note: All items had high importance ratings

Most important items

Item	% rated Very Important
Adequacy of reimbursement to provide the care needed for Medicaid patients	86%
Accuracy of claims processing	84%
Access to medical specialists for Medicaid patients	81%
Timeliness of claims processing	80%
Access to behavioral health prescribers for Medicaid patients	79%

Importance of factors when deciding to contract with PHPs

Least important items

Item	% rated Very Important
Support for social determinants of health	59%
Type of data shared for management of quality of care (quality measures, utilization, etc.)	61%
Method by which data is shared	61%
Timeliness of the data that is shared	63%
Information, coaching, or other support which help you improve quality of care for your patients	63%

Considerations for PHP Contracting

Coverage

Covering most of eastern and southern North Carolina, contracting with all the plans was of the utmost importance."

Patient retention, reducing hassles

Our main priority when selecting PHPs to contract is to give our patients options that fit their needs and give our current patients the opportunity to continue to receive care from our practice, so they do not need to change their primary care provider."

"We are participating with all 5 so what ever our patients select we will be in network, hoping to reduce hassles."

Fair terms & rates, willingness to negotiate

"Ease of claim submission and prompt payment thereof"

"Willingness to negotiate" "How quickly they pay us"

"…The templates offered start with the approved definitions/contracts set up by NC Medicaid but then all of the PHPs are adding things into the contract in multiple locations (sometimes sneaking them into either the provider manual or various addendums/appendixes) that essentially drastically reduce access to care, care management and ultimately reimbursement."

"We have not contracted with 2 health plans due to unreasonable time limit on requesting corrections/adjustments to paid claims."

Satisfaction with PHPs thus far: overall experience

	Excellent (%)	Good (%)	Fair (%)	Poor (%)
Overall experience	**14%**	**56%**	**22%**	**8%**
WellCare Health Plans	21%	53%	21%	5%
Carolina Complete Health	18%	53%	21%	8%
BCBSNC Healthy Blue	15%	55%	22%	8%
AmeriHealth Caritas NC	15%	49%	26%	10%
United Health Care	14%	50%	23%	13%

Satisfaction with Individual PHPs

Lower score is better

	Mean (SD) 1= Excellent, 4=Poor
WellCare Health Plans	2.02 (0.76)
Carolina Complete Health	2.21 (0.82)
BCBSNC Healthy Blue	2.21 (0.84)
AmeriHealth Caritas NC	2.31 (0.85)
United Health Care	2.34 (0.91)

*All differences are statistically significant except for no difference between BCBSNC and CCH; no difference between AmeriHealth and United

Wide range of experiences with PHP interactions during the transition

Contract language

All of the PHPs are proposing language that includes proprietary fee schedules (so they can alter reimbursement whenever they like), the ability to unilaterally amend the contract whenever they choose, deny any payment to a provider if a subcontracted provider (ED, RAD, ANES, PATH) is not in network with them, and make you pay them any fines and penalties they incur on your behalf."

Limited patient understanding

As of 6/24/21 6 days to "go live" many of our Medicaid patient families do not understand the change over, what "cards" they must present when arriving to be seen. Leading to inconsistencies with PHPs in IDing patient "membership numbers" to allow otherwise integrating them into the "computer"/EMR system!"

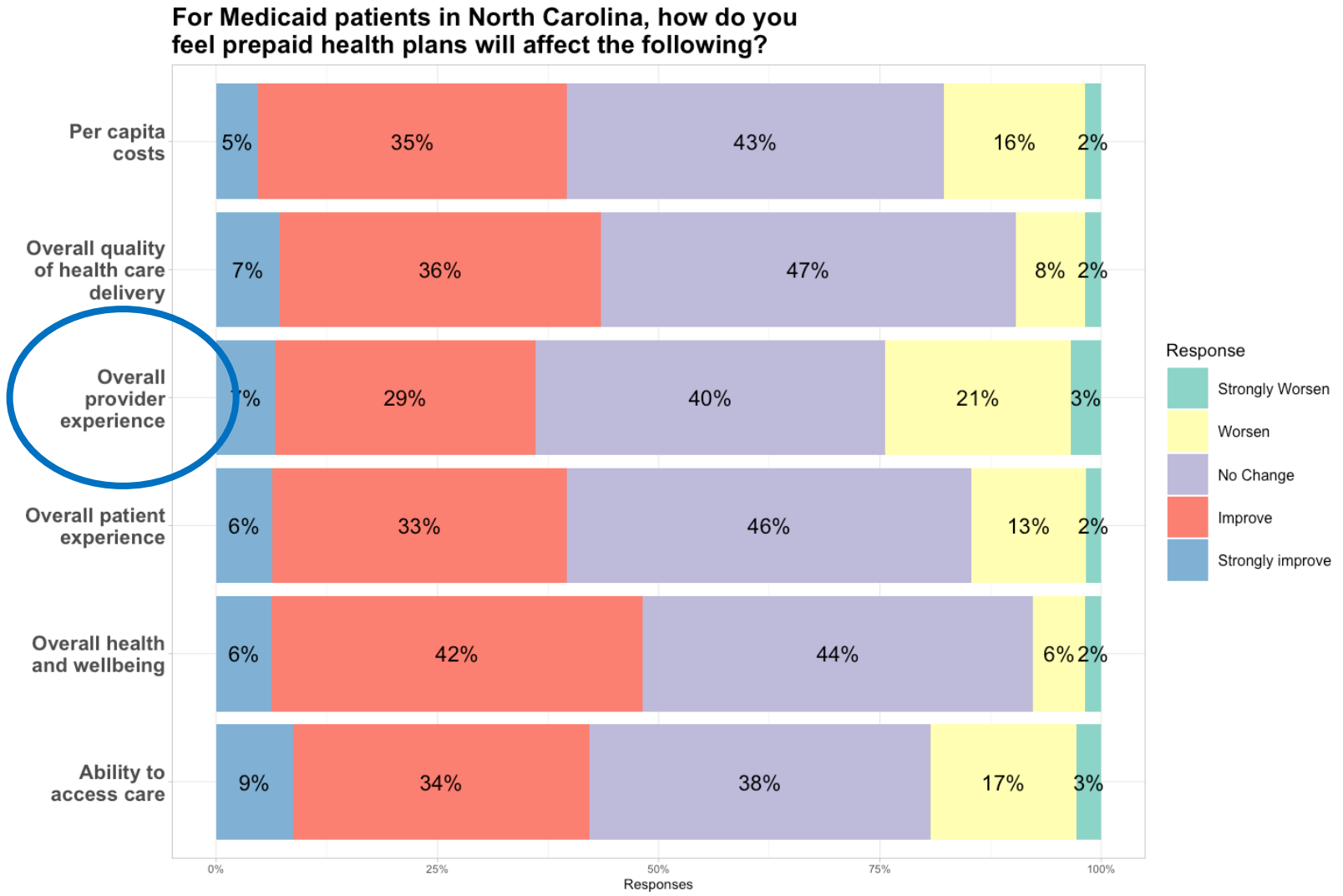
Helpful application, interactions

Contract applications were easy to complete. Training is available for providers and staff with multiple dates to choose from and is on going."

Each of them have been very helpful and answering any questions we may have."

PHPs have been almost unable to help with carve out contracting needs, seem unclear about how all of the various relationships will interact, and leave little hope that the process for providers and beneficiaries will operate smoothly. Finally, PHPs have been highly disappointing in their ability to accurately reflect our primary care locations as participating with their plans."

Anticipations for the PHP transition



Summary take-aways

1. Systems and practices were **generally satisfied** with North Carolina's **pre-existing** Medicaid program.
2. When considering contracting with PHPs, respondents prioritized **claims and reimbursement** as well as **access to specialists and behavioral health for patients.**
3. Services like case management, QI support, and trainings, and data sharing were of **less** importance. Organizations were resoundingly aligned in **wanting timely, accurate claims, and streamlined logistics. (Get out of our way)**
4. Most survey respondents **feel ambivalent to hopeful** about the impact of the PHP transition for North Carolina.