

**North Carolina Medical Society  
Response to RFI–DMA 100-13**

The North Carolina Medical Society (NCMS) is pleased to submit this response to the Request for Information (RFI) issued by the Department of Health and Human Services (DHHS).

It would be difficult to overstate the importance of Medicaid as it finances health services for over 1 million of our state’s most vulnerable citizens. We understand that the necessity of medical assistance for eligible individuals and the cost of medical care combine to create major challenges for public officials who are responsible for state spending. The NCMS response to this RFI outlines an approach that would ensure the program fulfills the promise of access to needed medical care, emphasizes clinical quality, and contains per-patient costs through efficient use of state resources.

We are recommending an approach that would build strong networks of providers who understand the goals of the Medicaid program, are committed to making systemic improvement in health care delivery, and can be counted on to respond to new demands being placed on the program. This approach would enable us to make change happen as quickly and cost-effectively as possible to ultimately improve the quality of and access to health care for North Carolina’s Medicaid enrollees.

**What reform would have the biggest impact? Move to a comprehensive value-driven system that includes and holds accountable all North Carolina Medicaid providers.**

Almost every economic market in America, with the exception of health care, rewards the delivery of value—that is, delivery of the highest quality at the lowest cost. Movement to a comprehensive value-driven system for North Carolina Medicaid is the most promising market-based reform the state can pursue. We need to move from “pay for volume” under the fee-for-service system, to “pay for value;” from “pay for quantity” to “pay for quality.” If we had the luxury of time, innovations, savings, efficiencies and use of technology would naturally occur over time. But we do not have that luxury, and payment reform alone is not enough. Medicaid must move to a comprehensive value-driven system.

**How could we organize a comprehensive value-driven system for all North Carolina Medicaid providers? Fortunately, the key elements for a prompt and successful transition to such a system are available in North Carolina.**

**1. Teams**

In a comprehensive value-driven system, physician-directed teams work together to coordinate each patient’s care, anchored by a primary care “medical home” network. The teams, or networks, must be physician-directed to find the best care by the best person at the best time.

Physician-led teams work. This is why there are now more physician-sponsored accountable care networks than any other in the Medicare Shared Savings Program.

Also, North Carolina Medicaid is the envy of the country because of its successful relationship with the statewide collaborative care network of over 5,000 primary care providers – Community Care of North Carolina (“CCNC”). Primary care providers must be at the heart of any value-based system because of their abilities to improve patient health and create savings through prevention, wellness, patient contact, and helping a patient navigate through the health care system. CCNC has undergone multiple audits that have confirmed its track record of saving the state over \$1 billion dollars in its first 10 years of service.

But a value-driven system includes more than just primary care; our state needs physician specialists (specialists), hospitals and other providers on board, too. Specialists throughout the state would be able to participate in the new Medicaid value-driven system through one of the following types of value-driven networks:

- a physician-directed accountable care organization that contracts with Medicare and/or commercial payers; or
- a CCNC accountable care network, which is a proposed expansion of the existing primary care CCNC networks to include any physician specialists and other providers that collectively work toward value-driven improvements.

For medical specialists who are not affiliated with another accountable care organization, direct enrollment in a CCNC accountable care network would be attractive because CCNC is a trusted organization with a sound reputation in the physician community for developing and implementing clinically relevant quality and efficiency measures that save money. In fact, the AMA has said, “Their commitment to vetting clinical issues with physicians and relentlessly pursuing quality and efficiency in North Carolina’s health system sets them apart from other models.”

Fortunately, in anticipation of the need for these reforms, the North Carolina medical community, through over 30 North Carolina-based medical societies and associations, formed the Toward Accountable Care Consortium, under the auspices of the North Carolina Medical Society. Its goal is to prepare every specialty, regardless of location, to create value—highest quality at the lowest cost—for patients they treat, and to accomplish for all payers the goals identified above for CCNC-enrolled specialists. This effort includes the development of clinically valid metrics and benchmarks for measuring and reporting the quality and efficiency of the care they give to Medicaid patients.

The Medicaid program, its providers, and their patients would benefit from this approach. A broad value-driven network that includes specialists and other providers would advance the goal of achieving savings through delivery of higher quality, more efficient care. This is more effective and more palatable than painful and controversial benefits and payment rate reductions.

Parallel efforts should be initiated to address other non-physician providers such as podiatry, optometry, dentistry, and a variety of mental health providers. All could quickly be folded into

the system through a value-driven network. We understand that hospitals and other facilities are also thinking along these lines on how to help the Medicaid program squeeze out waste while not compromising care.

We also should consider expanding pilot programs that have already proven successful. One such pilot was the ICARE project in Buncombe County. That program co-located mental health providers with primary care providers in the Buncombe County Health Department. The program improved patient outcomes and reduced the utilization of emergency mental health services in the area. Further adoption of the program was hindered by the inability to implement a new payment model for such treatment delivery in private physician settings. With this transformative time comes an opportunity to reinvigorate this and other patient-focused program that should lead to long-term cost controls if incentivized for broad adoption.

## **2. Technology Tools**

Providers need technology tools to identify and address problems related to their patient populations, the status of individual patients, how best to treat them, how best to engage them in their own management, and what innovations are working elsewhere. Again, we are fortunate that the Medicaid program has worked with CCNC to create a rich database and care coordination tools. We must build upon that foundation. CCNC is developing even better capabilities in population management through a closer relationship with the North Carolina Health Information Exchange (NC HIE).

Data are critical to a value-driven health care delivery system. Without appropriate access to clinical data (combined with claims and other financial data) efforts to control costs and improve quality would be severely handicapped. The NC HIE has been established for the purpose of sharing clinical information but is lacking the level of participation needed to move the health care delivery system forward. Physicians and other providers should be offered incentives to drive participation in the NC HIE. Hospitals should be required to connect to the NC HIE, as well, because managing Medicaid program costs without broad access to hospital data is not possible, no matter how the delivery system is organized.

While efforts are underway to cover the annual subscription fees for physicians through third party payers (and the state should not be the only payer to assume this burden), the initial connectivity costs have proven to be out of reach for many physician groups. A tax credit or similar incentive for the initial connection fees for practices below a certain income threshold that agree to participate in the NC HIE and in a Medicaid value-driven network should be considered. A robust exchange of clinical data, and appropriate access to claims and other financial data, coupled with sophisticated integration and analytic capabilities are key to the success of a value-driven, cost-effective, health care delivery system. This cannot be accomplished with mere regional informational exchanges that are separate and do not share information with the NC HIE. Statewide participation in the NC HIE by all providers and hospitals treating Medicaid patients would go beyond parochial boundaries and empower the Medicaid program to better understand and resolve problems that frustrate attainment of program goals.

The NC HIE has made tremendous strides in preparing for widespread participation by physicians, hospitals and other providers in North Carolina and to ultimately connect to the national eHealth Exchange. Medicaid should take advantage of that work and considerable expenditure to help achieve efficiency and quality targets sooner.

### **3. Physician-directed Patient Engagement**

Movement to a value-driven system obviously prioritizes a provider's commitment to patient engagement; it directly affects quality and cost of care. Providers would be able to devote more time to patients and deploy care coordinators to follow up with patients, often in their homes. This more intensive provider-directed patient engagement would lead to significant cost savings as has already been proven through CCNC's efforts in asthma, diabetes and heart disease. This engagement must grow beyond these disease states in order to gain new savings and achieve lower overall per-patient costs.

Patient incentives, such as copays, coinsurance, deductibles and other cost sharing arrangements are distinct from provider-directed patient engagement. Cost sharing should be aligned with patient engagement to further promote patient compliance and health. Reasonable cost sharing requirements can provide meaningful incentives to Medicaid patients. Cost sharing should be implemented carefully for this program but should not be overlooked as a means to reduce emergency department visits and other services where there is an obvious lack of patient activation. DMA should consider reducing cost sharing for any Medicaid client who enrolls in the value-driven system. Cost sharing could be further reduced for meeting certain health metrics or participating in health and wellness activities aimed at those metrics; for example, smoking cessation, weight loss, medication adherence and nutrition.

As noted above, patient engagement strategies would be formulated within the various accountable care organizations and CCNC accountable care networks to drive attainment of efficiency and quality goals. New research to identify patient motivations, beliefs and health literacy would be an important resource as Medicaid program officials seek the support and involvement of patients in program efficiency and ensuring the quality of medical care provided.

### **4. Best Practices**

North Carolina physicians would assist in building upon existing CCNC and Medicaid program protocols and best practices to ensure everyone across the state is in position to provide care that works best for all patients with the same illness.

While it is tempting to seek immediate implementation of payment models that shift the incentives as described above, it is important to note that the program goals that relate to medical practice (addressing quality and efficiency) be thoroughly vetted and accepted by the provider networks or by trusted organizations. Attempting to implement care management protocols that are not properly vetted, and ultimately accepted, by the network providers has proved to be impractical. CCNC has learned how to vet quality measures with the physician community and

has an approach that can be expanded and used to address many aspects of specialty care. Metrics would be identified from reliable peer-reviewed sources or formulated by the physician community to quantify success or failure against quality and efficiency goals established by the Medicaid program. As noted above, an effort is already underway to do this in North Carolina through the Toward Accountable Care Consortium.

An important first step in the evolution of best practices in the mental health arena has been forming over the past year with the Artemis Project. This partnership, which brings Critical Access Behavioral Health Agencies (CABHAs) into CCNC, enables medical directors from the CABHAs to better coordinate with the patient's primary care medical home to achieve savings in that patient's mental health costs. Best practices are the foundation for this program, where physician leadership provides the basis for the rest of the program interventions.

## **5. Shared Savings**

The RFI calls for new approaches that would compensate only those who make meaningful contributions to efficiency. We propose an approach that would deliver savings to the state beginning in the first year. As mentioned above, there are a growing number of physician-directed organizations approved as accountable care organizations by CMS to participate in the Medicare Shared Savings Program. A similar shared savings approach could be developed for Medicaid. Much of the work done for Medicare could be used with adaptations to accommodate unique characteristics of the Medicaid population. Under this approach, there is nothing to share if there are no savings. Accordingly, a shared savings approach would readily accomplish another goal expressed in the RFI to ensure that providers have a meaningful stake in the success of programs aimed at efficiency and quality beyond the traditional, ethical mandate of the medical profession to pursue the patient's interest first and foremost.

The existing fee-for-service payment system would remain, although the volume of certain services would decline as unnecessary utilization is eliminated, lowering overall expenditures. Primary care providers would continue to receive a per member, per month (PMPM) stipend for their additional patient management responsibilities, but at least a portion of those payments should be tied to adherence to agreed-upon care coordination responsibilities and clinical outcomes. It is essential that every participating provider and facility be incentivized to generate as much value as possible. To achieve this, Medicaid should authorize a shared savings approach with each of the value-driven networks.

Value-driven networks would enter into a 3-year contract with CCNC; fee-for-service rates would be restored to 95% of Medicare; savings would be apportioned 60/40 (accountable care entity/state) with no downside risk in the event of overspending. In addition, individual providers would be eligible for income tax incentives. As soon as practical, the value-driven network would move to a shared savings arrangement that would include limited downside risk (in the event of overspending), but savings would be apportioned 70/30 (accountable care entity/state). Each value-driven network and its providers would be responsible for the appropriate and equitable distribution of any savings.

## **6. Transparency**

The collection of meaningful data based on metrics adopted and implemented across the value-driven system would provide the Medicaid program with a transparent and accountable system to ensure integrity of the program. Program integrity and accountability is a high priority of the NC General Assembly. Implementation of a value-driven system would permit Medicaid program officials to internally verify data together with CCNC rather than depending on outside vendors who are not as accountable to the public officials responsible for program outcomes.

### **Physicians should be incentivized to participate in Medicaid and contribute to its value-driven programs.**

#### Shared Savings Incentive

Shared savings would provide a good short-term incentive for physicians to work toward Medicaid program goals and develop more sophisticated organizations that may eventually be in a position to assume risk. There is tremendous work occurring now to identify pathways to efficiency and value for the private and public sector payers. Implementing these changes takes local attention and competency embedded in the medical practices. Given the degree and pace of change in this area, it only makes sense for Medicaid to establish incentives for doctors to use these new approaches to conserve state resources.

#### Restoring Medicaid Rates

At the onset of the great recession, as Medicaid rolls were increasing and state revenues were decreasing, Medicaid payment rates for specialists were cut, creating disparities in payment rates between primary care and other specialties. These disparities became a disincentive for specialists to participate in Medicaid. Some specialties do not have an opportunity to manage their patient mix directly and for them the 2009 rate cuts were especially onerous. Research by the NCMS and The Physicians Foundation demonstrate that payment rate reductions are highly relevant to decisions that may limit access to care. For those specialists who participate in value-driven networks within Medicaid, the rates should be restored to 95% of Medicare. This follows the rationale used in 2009 for keeping primary care services at 95% of Medicare, plus the PMPM compensation, with one important difference, shared savings would only be paid if earned.

#### Income Tax Incentive

While much of the institutional care provided to Medicaid clients occurs in nonprofit hospitals, which are exempt from income tax and a variety of other taxes, physician care is provided largely by for-profit medical practices. Serious consideration should be given to providing a tax incentive in the form of either a tax credit or tax deduction for physicians enrolling in a value-driven network that is open to Medicaid patients.

#### Address Administrative Burdens

More physicians would be inclined to participate in Medicaid if the state were to reevaluate its network management approach with an eye toward reducing the administrative burdens imposed on providers by Medicaid and Health Choice. A prime example is the state's provider

enrollment/credentialing processes, which require intensive staff and clinician resources for tasks that should be straightforward, such as providing notice that a medical practice has added an additional physician partner-owner. Another example is the current inability to quickly identify and resolve claims processing issues that are highly disruptive for medical practices, which are highly automated in their dealings with Medicare and other payers. These Medicaid-specific burdens add avoidable costs, impede efforts to grow the network, and divert the provider's time away from patient care. Accordingly, we encourage DHHS to actively seek out ways to streamline the administrative processes that it has created for Medicaid providers and to improve its communications strategy for educating Medicaid providers about the various requirements. We stand ready to assist in these efforts, which we believe would benefit patients, providers, the State of North Carolina and its citizens.

#### Avoidance of Commercial Managed Care

Physicians in North Carolina value the investment made by taxpayers in the Medicaid program. The introduction of commercial managed care into Medicaid would supplant CCNC and put at risk \$450 million in annual savings of state taxpayer money that CCNC programs are already delivering. Taking steps to expand on CCNC successes by creating a value-driven system would be a major incentive for physicians to participate in Medicaid.

Managed care companies have been an active part of America's health care system since the 1970s. The wasted resources and constant unproductive distractions from hands-on patient care that have resulted directly from the efforts of the managed care industry would be hard to overstate. Implementation of a clinically-oriented care management approach, which reduces cost and improves quality, would be received far better by physicians than the kind of classic managed care approach seen in other states' Medicaid programs. There is a strong preference in the medical community for a cooperative approach with the Medicaid program. That has been the environment fostered by CCNC among primary care physicians and would serve as a powerful incentive for other specialties to engage and work toward Medicaid's quality and cost containment objectives.

Retaining a state-based partnership, like that already in place with CCNC, also provides DHHS and the state more control, more direct engagement with the provider community and greater oversight of the ongoing cost savings initiatives than could be accomplished with a commercial managed care vendor. These benefits far outweigh the short-term cost savings promises that usually come along with commercial managed care contracts. The partnership we propose, to implement a value-driven system for Medicaid, expands the state's ability to bring provider groups together while holding everyone accountable for quality and per-patient cost reductions within the system.

We appreciate the opportunity to respond to this RFI and look forward to working with DHHS to strengthen Medicaid by moving toward a comprehensive value-driven system.