NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS

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September 5, 2017

The Honorable Mandy Cohen, MD
Secretary
NC Department of Health and Human Services
1950 Mail Service Center
Raleigh, NC 27699-1950

RE: Medicaid Transformation: Comments on NC Proposed Program Design for Medicaid Managed Care

Dear Secretary Cohen:

On behalf of the NC Academy of Family Physicians (NCAFP), thank you for the opportunity to submit comments on North Carolina's Proposed Program Design for Medicaid Managed Care released on August 8, 2017. The NCAFP is the largest medical specialty society in North Carolina, representing more than 4,000 family physicians, residents in training, and medical students throughout the state. As you know, we have been integrally involved in the Medicaid reform process throughout the legislative and administrative phases.

With one in five North Carolinians covered by Medicaid, and a much higher percentage of our state's children covered, it is crucial that we take care to implement this reform in the most effective manner possible. We appreciate your willingness to continually seek stakeholder engagement, and the NCAFP and our members want to remain at the table helping you design a system that works for all: patients, providers, our taxpayers and the state. In fact, we would encourage representatives of the Department to meet with a family physician stakeholder panel at the NCAFP Annual Meeting in Asheville this December.

First and foremost, primary care must be the foundation of reform. If this plan does not work for family physicians and pediatricians, it likely will not work for anyone involved: patients, providers, or the state. It is clear that our state needs to continue to invest more in primary care. Recent results in Rhode Island have further confirmed that as primary care spending as a portion of overall healthcare spending has increased, quality has gone up and costs have at a minimum plateaued.

We look forward to continuing to work with the Department. Given the length and complexity of the Proposed Program Design document, our comments will follow each section of said document (utilizing your document's section numbers). As a result, there may be some duplication given that certain themes arise throughout the document. However, we believe this is the best way to provide feedback on your plan.

OVERALL COMMENTS ON EXECUTIVE SUMMARY

1. **Innovative, Integrated and Well-Coordinated System of Care**

We applaud efforts to better integrate behavioral health and primary care. In fact, most behavioral healthcare can occur in a primary care practice. We are also generally supportive of tailored plans for special needs populations with some caveats. We will address this further in subsequent comments. Finally, we believe care coordination should be consistent across plans. Not having a consistent care coordination infrastructure will particularly harm small and independent practices, a portion of our primary care infrastructure that is crucial to maintain. Otherwise, practices will be left with no choice but to join larger systems leaving less local competition, even when smaller practices have been shown to provide high quality, low-cost care.

2. **Support Providers and Beneficiaries During Transition**

While many of these areas will be addressed later in our comments, it still bears noting the concerns in conjunction with the Executive Summary. We applaud efforts to have one-stop provider credentialing. We also applaud preserving existing provider relationships and keeping a family together when auto-assigning plans and medical homes. And we support a beneficiary having access to eligibility determination, plan enrollment, and medical home selection all at the same time in one setting. We do have some concerns about how Advanced Medical Home Certification will occur and how provider supports will be implemented. These will be addressed more below.

3. **Promoting Access to Care**

We strongly support the Department's efforts to maintain current loan repayment programs, community grants and residency programs. We also agree with the need to increase community-based residency slots to attract physicians to rural and underserved areas. In addition, we believe that utilizing telehealth is one answer to increasing access to specialty care, as long as it is integrated with the individual's medical home. And we unequivocally support expanding coverage as outlined in the Carolina Cares Program. Finally, we applaud efforts to strengthen pain management treatment capacity and encourage increasing access to both alternative means of pain management and access to substance use disorder and addiction treatment. We are concerned that primary care physicians may ultimately quit providing pain management services given the state's opioid problems, particularly in rural and underserved areas that could lead to a significant lack of access to care.

4. **Promoting Quality and Value**

We strongly believe that there should be a limited set of quality metrics that coincide with measure sets utilized by other payers. We also believe care should be taken to make sure these measures are meaningful and actionable. We do believe that – at times – quality measures can be more burdensome for primary care than any other specialty in healthcare, and this should be considered in implementation of quality tracking. We will discuss this further elsewhere in our comments. We do support innovative payment strategies and would encourage the Department to examine payment strategies unique to primary care, such as the federal Comprehensive Primary Care Plus initiative.

5. **Setting up Relationships for Success**

We believe – to ensure robust access to primary care – the rate floor for primary care should be set at Medicare fee-for-service rates as opposed to the current Medicaid fee-for-service rate structure. We have seen an erosion of primary care physicians accepting Medicaid since the sunset of the Affordable Care Act's Medicaid to Medicare parity program. Primary care is foundational, and a higher rate floor would help re-establish the strong primary care infrastructure our state has enjoyed. With additional administrative burdens, which are unavoidable in a Managed Care environment, current Medicaid rates will simply not be enough to keep that strong infrastructure in place. Having a higher rate floor will ensure access to preventive care, which is critical to the success of these

changes. Steps must also be taken to ensure that all physicians – whether in private practice or employed – benefit from the value-based payment contracts that will likely occur in this new environment. We have significant concerns about the loss of supplemental payments once managed care is enacted, and we strongly encourage the Department to identify or develop alternative funding mechanisms to avoid the loss of this funding. We applaud the use of a single pharmaceutical formulary, as well as the planned oversight of the Pre-Paid Health Plans. However, it is crucial that practices have access to strong grievance processes, prompt payment regulations, and ultimately an ombudsman for providers as well as beneficiaries.

I. OVERVIEW OF MANAGED CARE

While we are pleased that you are utilizing the Medical Care Advisory Committee (MCAC) as one way to seek ongoing stakeholder engagement, we believe the Department must cast a wider net than the MCAC. While this is an important group, we believe additional feedback from primary care physicians on the front line of care is crucial. We also remain concerned about the timeline of this process and believe that July 1, 2019, remains a very aggressive target.

II. TYPES OF MANAGED CARE PLANS, REGIONS

We believe 12 regional plans are simply too many. There are many primary care practices that could ultimately serve multiple regions, making the combination of three statewide plans and several regional plans simply unwieldy. We also believe that there is likely a limited number of organizations that could meet the definition of a PLE - Provider Led Plan - that are equipped to manage risk. These are likely hospital systems. We do not believe that a regional plan should also be able to engage in a coalition as a state plan due to anti-competitive reasons. We do encourage the Department of Insurance and the Department of Health and Human Services to work to make sure that all plans are meeting financial and other regulatory requirements on an ongoing basis. Finally, we generally like the concept of tailored plans but urge caution to ensure that all recipients have access to high quality care.

III. POPULATIONS IN NORTH CAROLINA MANAGED CARE

While we understand the Department's rationale, we are concerned about recipients with "presumptive eligibility" remaining in "Fee for Service" Medicaid. Our primary concern is how a provider will know who to bill: a prepaid health plan or Medicaid directly. We are also concerned about the administrative burden this may cause. We are not sure of a definitive solution to this issue but wanted to make sure we brought it to your attention.

We believe the phase-in timeframe for special populations make sense. We are also pleased that the Department is paying special attention to children in foster care. However, we are concerned that the number of additional plans (tailored plans for SPMI, plans for children in foster care, etc.) will bring about more administrative complexities and maybe even provide an obstacle to some physicians enrolling in Medicaid at all. Even the section about the CAP waivers in the report indicates that "the Department will develop a Medicaid managed care product to meet the specialized needs and services of these populations." While we totally agree this population has special needs, we are concerned this too will add to administrative burdens that will inhibit network adequacy and ultimately access to care.

IV. INTEGRATION OF PHYSICAL HEALTH, BEHAVIORAL HEALTH, AND INTELLECTUAL AND DEVELOPMENTAL DISABIILITY SERVICES

Family physicians and other primary care physicians are already treating many behavioral health issues as a routine part of their practices. We believe that - for most patients - this could have been done much more effectively and efficiently if Medicaid had not carved out behavioral health into our current LME/MCO System. In fact, the NCAFP, the NC Pediatric Society, the NC Psychiatric Association and other provider groups have worked together for years to better integrate behavioral health into primary care. However, our efforts became much more difficult with the implementation of the LME/MCO System. We do concur that the Severe and Persistently Mentally Ill Population (SPMI Quadrant 4 individuals) and the most severe portion of the Intellectually and Developmentally Disabled (IDD) populations are best served in another setting. However, many other patients with mild to moderate behavioral health or substance abuse issues are most appropriately managed in primary care. For example, a newly diagnosed diabetic is a likely candidate for depression, that when coordinated, can be cared for much more effectively in primary care. But our current system simply makes that too difficult. We strongly believe that behavioral health professionals should be embedded in primary care and the "Collaborative Care" model where a master's level professional is embedded with support from a psychiatrist should be encouraged.

We do have some concerns about how the population for the tailored plans will be defined. For example, many individuals with IDD will likely need to be managed under a tailored plan. However, some individuals with IDD, such as a high functioning autistic adult, would likely receive more appropriate care in a primary care setting with integrated behavioral health. These individuals may not need the intensive services, but it is unclear where the dividing lines may be, causing some concern. As a result, will some individuals move in and out of special needs plans for instance if their enhanced behavioral health service ends? We also believe it is important to phase in the tailored behavioral health plans as outlined in this document. Our state's behavioral health system is already very fragile and without careful forethought, could be further damaged.

V. MEDICAID OPIOID STRATEGY

While much work remains, much has already been done to begin to combat opioid abuse in North Carolina, and it's crucial that we build on the successes we have had including our existing care management infrastructure and programs like the Chronic Pain Initiative. We also believe it is crucial that other pain management treatments and services are fully covered by the Medicaid plans, and that the state should make a greater investment in treatment and recovery. Better integration of behavioral health in primary care will also help in this area. For example, primary care practices already use the SBIRT model in other areas, and additional early intervention and prevention investments are needed.

We also support implementing the Carolina Cares Program so more individuals can ultimately have insurance and receive the treatment they need for addiction and substance use disorders. These investments will ultimately save the state money in both the healthcare system and the state's judicial system. Finally, we agree with eliminating prior authorizations for suboxone.

While we do believe ongoing physician education for pain management and opioid use is needed, the requirement that Pre-Paid Health Plans deliver this education may not be needed. For example, the Chronic Pain Initiative, education by the state Medical Board and education by various medical specialty societies like ours, is already ongoing. For example, the NCAFP has been delivering chronic pain education at our meetings for over five years.

VI. HIGH FUNCTIONING MANAGED CARE SYSTEM

A. QUALITY, VALUE, AND CARE IMPROVEMENT

We support the Department's plan to try to provide a balance of standardization toward common goals with flexibility for innovation. Given the importance of this entire section to the primary care community, we will address these areas in more detail.

1. Quality Strategy

It is crucial that the number of quality measures are limited, and that they can be utilized in a meaningful way to improve patient care. While these measures are finalized and implemented, program managers should carefully consider the specialty, setting, and accountability of recipients. Too many times measures for primary care are impacted by actions beyond the physician's control, including patient accountability and social determinants of health. For example, an emergency room physician can implement procedures to control how quickly an aspirin is given to someone who enters the ER with chest pain. However, it is not that simple to impact a patient's HbA1C or hypertension. Remember, primary care physicians treat people not diseases, and there are so many complex variables with most individuals, including the prevalence of multiple chronic conditions. At times, trying to improve one chronic condition can have a negative impact on the patient's overall health or even cause death. As a result, disease specific measures must not be used in a vacuum. We strongly encourage use of existing measures and alignment with other payers in our state. We must also ensure that measures are up-to-date. For example, in the proposed measures developed by the NC Institute of Medicine Task Force, the HPV vaccine measure includes a three-dose series, where now in most cases two doses are recommended. Finally, quality measurement must not place an undue administrative burden on the medical home that ultimately takes time away from caring for the patient. As a result, data extraction should be as seamless as possible.

2. Value-Based Payment

We would encourage the state to examine blended payment models for primary care such as the federal Comprehensive Primary Care Plus initiative. We also encourage the state to engage in multi-payer initiatives outside of Medicaid. It is difficult for practices to truly transform when they are being paid using entirely different models, and this is especially important for independent practices. It is crucial to keep the infrastructure of independent practices intact in North Carolina, and this will only be made more difficult with competing payment models. We believe primary care physicians are ready to engage in value-based payment models, and some can even undertake risk, but are only willing to undertake risk that they can control. For example, some practices would be willing to undertake a bundled payment for a defined basket of primary care services.

We do have some concerns over condition-specific payment models and plan, because many patients have more than one chronic condition. If these models are truly for oncology and high need mental health patients, that may be fine. However, if it is for a diabetic patient, that is a very different thing. We also hope the state will ensure that value-based payment models are passed on to the medical homes. Nationally, even when managed care is capitated, only a small percentage of managed care payment to practices is truly value based. And even in larger healthcare systems, the individual primary care practices may be incentivized in a fee-for-service model even though the state is pushing for value-based care. These must be aligned for this plan to be effective.

3. Accreditation

We support some level of accreditation for managed care plans.

4. Data Collection, Exchange and Analysis

We believe physicians must have a trusted source for data to improve patient care, and it cannot be from someone who may have a financial stake in how the data is presented – it must be neutral and transparent. Primary care physicians have had a strong trust level with Community Care of North Carolina and their data analytics, and the value of that trust cannot be underestimated. We would encourage the state to have a uniform and transparent source of data not aligned with individual health plans. In addition, primary care cannot be responsible for producing all data. Data extraction must be seamless, and we believe that a highly effective state Health Information Exchange, NC HealthConnex, will be key. Data exchange simply cannot create new layers of paper work for primary care when the medical home needs to be spending greater time and resources on direct care for the patient. Finally, we do like the concept of a social needs screening tool and would ask to be involved in that development process.

5. Care Management – Advanced Medical Homes

This is likely the most important area for our membership. As a result, we believe it is crucial to maintain our trusted care management infrastructure: primary care physicians are familiar with it, utilize it, trust it, and this infrastructure helps improve patient care. The patients also trust these crucial local "boots on the ground" care managers. This infrastructure is even more important to our independent practices. We simply cannot afford to have a different care manager or care management infrastructure for each plan. This would be duplicative, expensive, and administratively impractical for smaller practices.

Next, practices must be paid appropriately by the PHPs or the state if they are an Advanced Medical Home or providing these services. For smaller practices, these changes may become difficult to manage, so adequate resources must be available. We urge the state to carefully consider any recognition process. While the NCQA PCMH recognition is most well-known, there are numerous other options utilized in our state, including JCAHO, URAC and others. In addition, some states have developed their own recognition process. We must make this process meaningful and not overly onerous in paperwork requirements that simply do not improve care.

We believe that many of our members' practices are undertaking numerous – if not all – of the functions outlined in the Advanced Medical Home model in your proposal. To make these processes as effective as possible, we encourage the state to have a strong group of frontline practicing pediatricians and family physicians on your stakeholder group defining the criteria for each tier of advanced medical home. We would be glad to put together a group of frontline practicing physicians to provide input for you on behalf of family medicine.

We appreciate the inclusion of additional performance based payments and payments for the medical home. However, we encourage you to increase the care management fees substantially as greater responsibilities are placed on the medical home and to work to make sure these fees are spent on the front line of care in the primary care office. Finally, we appreciate some level of standardization of the medical home process.

6. Provider Supports

We truly appreciate the Department's emphasis on provider supports. While we agree that ongoing localized support by the regional provider support centers is needed closer to the location of practices, we also encourage you to engage primary care specialty societies to help those who are going to be advanced medical homes with the managed care education and training and practice transformation education. For example, the NCAFP Annual meeting draws close to 800 educational attendees each year, and we are already trying to integrate education in these areas into our meeting. In past years, we have had education on medical homes, accountable care organizations and other value-based payment mechanisms; and this year we are planning a workshop on the move to managed care.

7. Social Determinants of Health

We also appreciate the emphasis on social determinants of health. We encourage you to engage with primary care physicians about what they experience on the frontlines of health care regarding the greatest needs around housing, education, and food insecurities. While all these cannot be met through primary care, local primary care practices and local care management are certainly crucial in screening for and identifying needs of their patients, and more broadly, their communities. Education, affordable housing, and access to healthy food are key to improving overall health, and acknowledging these is crucially important.

8. Workforce Initiatives

We strongly support the Department's desire to expand community-based residencies, as well as the need for greater transparency and accountability in the Medicaid GME funding the state provides. We also believe this provides a great opportunity to look at other incentives for healthcare professionals to locate and practice in rural and underserved areas. We encourage the Department to look at best practices in other states, including upfront payment of medical education, tax incentives to practice in rural areas, etc. We also encourage the state to make sure that workforce efforts build upon the medical home infrastructure. Team-based care is essential, and an increase in numerous types of providers is needed. However, this must be coordinated in the medical home to ensure effective and coordinated care.

9. Telehealth

We believe telehealth is a complement to, not a supplement for, direct hands-on care. However, it is an important supplement. We believe the key is to use telemedicine in conjunction with the medical home to avoid fragmented care. Making sure advanced medical homes are wired and have tele-contact with needed subspecialists should be a key goal of this portion of the plan.

B. BENEFICIARY PROTECTIONS

The bottom line is simple: if beneficiaries cannot get the care they need in a timely manner, we will have failed. But we must all acknowledge that it will ultimately be more difficult for beneficiaries to navigate this new system. We applaud the Department's effort to streamline the process for enrollment, particularly the concept of a one-stop enrollment, plan selection, and primary care choice process. This is simply crucial. Local social services agencies will likely need extra resources to make this happen, and it makes sense to supplement these local resources with an enrollment broker. We also applaud the Department's decision to prioritize the existing primary care relationships as part of the auto enrollment algorithm, and we would like to re-emphasize the importance of that key step. Unfortunately, enrollment processes in other states have been cumbersome and led to multiple members of the same family having different medical homes or different plans, making it very difficult to navigate.

We remain concerned about many of the beneficiaries' understanding of all of this process and this change, even with safeguards the Department plans to put into palace. We are concerned this may be confusing to everyone involved. The processes for enrolling in a plan or changing plans must be as simple as possible. We are also concerned about the medical home knowing who has chosen them or has been assigned to them in a timely manner. Accurate and timely information is critical to providing good care. Finally, we encourage some standardization across PHPs in terms of health education and prevention and wellness programs. If these programs are all different, it will be difficult for the medical home to help reinforce these messages.

Grievances and Appeals

A streamlined grievance and appeals process is going to be crucial. We recommend an ombudsman service for both beneficiaries who may be appealing a plan's decision and for practices that are participating in the PHPs who may have grievances with the plans. We urge the Department to take adequate time to ensure that all these safeguards and protections are firmly in place before rolling out managed care.

C. MANAGED CARE PLAN ACCOUNTABILITY

It is simply crucial that the health plans be held accountable. And it's further crucial that primacy care practices desire to remain involved in Medicaid. We believe that network adequacy must reflect a combination of distance and timeliness of appointments. If there's a practice or subspecialist within a certain number of miles or minutes but the patient cannot get an appointment, then access is not adequate. And in some instances, the 30-day access standard may not be sufficient for some areas of care. We also urge you to consider the following areas:

- With children, do some of the specialties need to specialize in children? For example, it simply may not be enough to have a cardiologist within a certain distance if they do not have skill sets to take care of early childhood cardiology needs.
- We believe care needs to be taken with the definition of urban and rural and how that impacts access.
- We even question whether there is a hospital within 30 minutes or 30 miles of every place in North Carolina. This may not be the case today.
- Finally, we encourage you to have a statewide ombudsman for providers beyond the requirements you outline for provider relations by the PHPs. We have significant concern about the inability of providers to appeal to the state as is noted under provider relations and appeals. Participating providers should be able to appeal to someone beyond the PHP. To not be able to do so is simply unacceptable. In addition, provider satisfaction should be used as a measurement of the PHPs.

Provider Credentialing

We applaud the Department's efforts to streamline credentialing, particularly one-stop credentialing for all plans and a uniform electronic application.

Clinical Coverage Policies and Utilization Management

We applaud the decisions that benefit limits cannot be more stringent than the Department's current FFS program, as well as the use of a common Prior Authorization Request form. We also recommend requiring PHPs to offer a way for providers to opt out of prior authorizations if they have shown consistently evidence-based decision making in ordering tests, pharmaceuticals, etc. This is particularly beneficial to primary care physicians, who many times must complete the prior authorization process but do not provide the service themselves. As a result, they do not receive compensation for a service even though they face the burdensome paperwork requirements. We also ask that Medicaid continue the use of the current Physician Advisory Group (PAG) for feedback on both clinical policies and the preferred drug list.

Pharmacy

We applaud the concept of one statewide formulary. However, the idea of plan specific Preferred Drug List (PDL) or (Prior Authorization) PA policies after 13 months is troubling at best and would have an undue burden on practices, particularly primary care. Given that legislation requires one PDL, this appears to be contrary to the intent of the General Assembly. Finally, the single state Medicaid PDL should still come under the guidance and direction of the Physician Advisory Group. We also encourage the state to require that the Opioid Misuse Prevention program be across plans so practices are not examining different criteria or barriers that are plan dependent. We are also concerned about the possibility of the use of multiple Pharmacy Benefit Managers across the state. This also seems contrary to the intent of the General Assembly to have one uniform Preferred Drug List.

Plan and Provider Payments

As previously stated, we encourage the Department to establish Medicare rates as the rate floor for primary care to keep access to care high. We are also very concerned about the loss of supplemental payments and the lack of details around this area.

Next, the Department must ensure timely payment, and there should be an appeals process to the state if a PHP is not complying. We also believe that payment to primary care should have the same time requirements that are placed on payment to pharmacy – a minimum of 90% of claims cleared and paid within 14 calendar days even though the plans may not have to pay interest for unpaid claims until the 30th day.

Further, we encourage the state to enforce a cap on administrative costs and profits for plans to ensure the majority of state dollars is going to provide care for the citizens of North Carolina, not developing additional administrative bureaucracy. We agree that the Medical Loss Ratio (MLR) should be set by the state at a minimum but preferably higher than what is in federal regulations. With uncertainty in what the federal government may do around healthcare, we do not believe the state should leave this important decision up to the whims of the federal government.

Finally, given there is going to be risk adjustment to the plans, we believe there should be consideration given for risk adjustments for advanced medical homes that serve high need populations.

Oversight, Compliance and Program Integrity

We encourage the Department to consider standardizing fraud waste and abuse prevention programs, so that practices are not dealing with multiple sets of standards or potential audits from multiple different managed care plans.

VII. INCREASED ACCESS TO MEDICAID

We applaud the Department's support of the Carolina Cares Program and welcome the opportunity to work closely with you to help close the coverage gap in our state.

APPENDIX: MEASURES SELECTED BY TASK FORCE ON HEALTHCARE ANALYTICS

We remain concerned about the data collection burden on primary care practices. In reviewing the list of measures, most of these impact primary care, and many of those have items impacting the measure that the practice may not be able to completely control – patient decisions, social determinants of health, etc. In contrast, the inpatient measures are more easily achieved in a controlled environment without as many outside influences. For primary care for example, the portion of asthma medication measure "that the patient remained on" is sometimes outside the control of the physician, as is the measure for HbA1C control. In addition, as stated earlier, some measures are not universally recommended anymore, such as the three-shot HPV series.

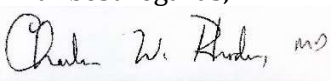
We also wonder if there will be measures around oral health services, such as dental varnish provided in primary care offices, or if the oral health measures only involve true dental codes.

Finally, we hope the patient experience measures truly are limited to availability and access to care. Other patient satisfaction measures have in some instances been correlated with higher costs and provision of services that are not evidence-based (unnecessary antibiotic prescribing, unnecessary utilization of MRIs for lower back pain & over utilization of opioids, as examples).

We truly appreciate the effort to minimize the number of measures & align the Medicaid measure set with other payers. We also appreciate a focus on population health and the social determinants of health. We hope that the state will develop tools to measure social determinants in various communities and take this into consideration when measuring both quality and cost of care, without individual practices having to report social determinants.

Once again, thank you for the opportunity to provide feedback. If you have any questions about our comments, please do not hesitate to contact us.

With best regards,



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cc: Dave Richard, Deputy Secretary for Medical Assistance

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