



September 8, 2017

The Honorable Mandy K. Cohen, MD, MPH  
Secretary, Department of Health and Human Services  
2001 Mail Service Center  
Raleigh, NC 27699-2001

*Delivered via email: [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov)*

Dear Secretary Cohen:

Thank you for the opportunity to comment on North Carolina's Proposed Program Design for Medicaid Managed Care (August 2017). We believe the overall direction of the proposed program design is positive. We understand, as noted in the program design paper, that there are several areas where continued thought, guidance and stakeholder input are still needed and that there are a number of details to still be resolved with CMS and the legislature. We will be prepared to comment on any areas that require additional clarity or development. We look forward to continuing to work with you, the Governor and the legislature in developing the framework to provide the best care for Medicaid beneficiaries throughout the State through the managed care delivery system.

As we continue to work together on these issues, we wanted to highlight a few areas where we have specific comments for consideration.

First, thank you for working with us on the supplemental payment issues and acknowledging that collaboration within the program design document. The ongoing discussions on that issue between the Department and NCHA's MRI/GAP Technical Advisory Committee have been very productive, and the NCHA Board of Trustees has recommended the following approach to preserving these critical safety net payments:

### **SAFETY NET PAYMENTS**

Preserving the safety net in North Carolina is paramount to the long-term success of Medicaid managed care. DHHS' reimbursement methodology for hospitals needs to preserve one of the country's strongest Medicaid safety nets, which has equitably distributed Medicaid and uninsured volumes among all hospitals across the state. To ensure a successful transition to Medicaid managed care, NCHA recommends the following reimbursement methods for both managed care and fee-for-service Medicaid services effective Oct. 1, 2018.

### Inpatient reimbursement

- The cost of full graduate medical education (GME) should be excluded from the per discharge rate and paid directly to teaching hospitals by DHHS.
- Gross cumulative (base rate and supplemental) Medicaid payments funded by both the state and providers should be consolidated into a hospital-specific per discharge rate, which would exclude the cost of graduate medical education. The hospital-specific per discharge rate would be based on the historical and CMS- approved Medicare Upper-Payment Limit.
- The hospital-specific per discharge rate would be the floor for which Prepaid Health Plans (including Managed Care Organizations and Provider-Led Entities) would be required to reimburse hospitals for inpatient services for all patients including in-network and out-of-network and those still in fee for service.
- The cost of full medical education will be calculated using Medicare cost finding principles and data available in the Medicare Healthcare Cost Report Information System.
- Current Medicaid Disproportionate Share Hospital (DSH) payments and funding will be utilized to address any inequity in Medicaid payments for smaller/rural hospitals.

### Outpatient reimbursement

- Hospital-specific payment rates would be established based on the outpatient ratio of payments to gross charges. For Medicaid services, this rate would be reflective of each hospital's unique outpatient ratio of cost to charges.
- The hospital-specific payment rate would serve as a floor for which Prepaid Health Plans would be required to reimburse hospitals for outpatient services for all patients including in-network and out-of-network and those still in fee for service.
- The hospital-specific payment rate would be neutralized for increases in hospital gross charges, but would be adjusted using an annual inflation rate in years after the payment floor is established.
- The State should commence a task force of payers, providers and state representatives to study other states' reimbursement models for future waiver periods with the goal of determining if a more equitable method can be implemented.

## **MEDICAID EXPANSION**

NCHA supports coverage expansion, such as that envisioned in Carolina Cares. We will work with the Department and the legislature in a bipartisan effort to achieve this. Today, hospitals provide the state share through assessments, intergovernmental transfers and certified public expenditures to provide payments above the state supported payments primarily to mitigate the significant losses from providing services to Medicaid patients that occur from the state supported base payments. Relying totally on assessments of hospitals to fund the State share of the expansion would not be an equitable assessment process since hospitals are less than one third of the services provided and many systems are struggling to generate adequate margins to reinvest and maintain the infrastructure of the safety net. We look forward to continuing bipartisan discussions with both DHHS and the legislature on the funding of expansion coverage.

## BEHAVIORAL HEALTH INTEGRATION

NCHA concurs with DHHS' efforts to achieve whole person healthcare by integrating behavioral and physical health now. The consequences of the current bifurcated system radiate throughout the care delivery spectrum, causing missed opportunities for early diagnosis and treatment, slow and ineffective crisis response, and poor transition from inpatient to community-based care. Most urgently, North Carolina's lack of integrated care has fed a current crisis in NC's emergency departments, where upwards of 50% of the state's ED beds are filled with patients in need of behavioral health treatment. As acknowledged by the Department, this will require legislative changes to expedite the integration. However, we believe the Tailored Plan concept and phase-in of those populations as proposed by DHHS needs further review. At present, the Department has not clarified the role of Prepaid Health Plans (PHPs), the necessity of the inclusion of non-Medicaid funded services, the role of LMEs in the delivery of these Tailored Plans and the scope of the populations to be carved in or out. With such fundamental questions outstanding, reasoned feedback is not yet possible.

To the extent that DHHS proceeds with a Tailored Plan for the special needs population, we believe the plan must assume responsibility for integrating the physical and behavioral needs of the patient. The Department should structure any Tailored Plans so that all PHPs can be eligible to deliver these integrated benefit packages. Additionally, if LME/MCOs bid on PHP or a specialty needs contracts, they should be held to the same standards as all other PHPs and be prohibited from using governmental funds to meet capital requirements.

## CONTRACTING PROVISIONS AND PROVIDER SUPPORT

We appreciate DHHS's efforts to address some of the administrative burdens that providers face and to provide support to healthcare providers. These are critical in ensuring providers can seamlessly integrate into Medicaid managed care. We do need to ensure that the reform proposal acknowledges delegated credentialing, as many health systems are delegated that function in commercial managed care.

DHHS' position paper notes that it will prohibit exclusivity provisions in contracts between PHPs and providers; will require providers that partially own or control a PHP to negotiate with rival PHPs in good faith; and will have authority to review contracts between PHPs and providers to require modifications if any term is deemed anti-competitive. While we support good faith in all negotiations, it should be expected of all parties. DHHS should explicitly recognize that all parties, including PHPs, must negotiate in good faith.

We are opposed to the proposed blanket authority for DHHS to deem any term of the contract "anti-competitive" and require modifications. It is unclear how DHHS would establish that a contractual term is anti-competitive (absent a court finding), and it potentially puts the State in the middle of rewriting a contract between private parties. A better approach is to identify specific areas of concern regarding contracts between PHPs and providers and allow the stakeholders to review and comment on how to address those areas. For example, the legislature has enacted laws for commercial health insurance relating to contract amendments between plans and providers (GS 58-50-280) and the use of most favored nations clauses (58-50-295) in contracts. Additionally, the Department of Insurance has adopted nearly two dozen specific provisions that are required in contracts between commercial plans and providers (11 NCAC .0200 *et seq.*). This targeted approach would provide more clarity on the contractual relationship between PHPs and

providers in Medicaid managed care, while leaving DHHS oversight intact. We would need to see examples of what types of issues or contract terms the Department considers to be potentially anti-competitive.

We are also opposed to the 90% rate for out of network services, *as Medicaid already reimburses providers below their costs*. It should be anticipated that all providers will not be contracted with all Medicaid plans. At the same time, it should also be anticipated that some Medicaid beneficiaries will seek services from non-contracted providers either out of need or because there will be a learning curve in understanding how managed care plans work. If the state reduces payment to non-contracted providers, there will be an adverse impact on the providers' ability to provide services to Medicaid beneficiaries of non-contracted plans at such rates that are below the cost. In addition, a singular, uniform cap on out-of-network payments will create a disincentive for the PHPs to negotiate mutually agreeable terms, thereby keeping more providers out of network. All of this will reduce the beneficiaries' access to care, and potentially affect their quality of care. For hospitals, we recommend using the same payment floors for in-network, out of network, and fee for service (as noted above in the supplemental payment discussion).

NCHA also notes that insurers must comply with the provisions of Chapter 58 of the insurance laws, as required by the legislature in S.L. 2015-245. The prompt pay requirement proposed by DHHS is helpful; there are related provisions in Chapter 58 that must also be applied. In addition, NCHA opposes any changes to Chapter 108C that would impair or dilute providers' rights thereunder. There are statements in the proposal that appear to be inconsistent with Chapter 108C. We believe that the proposal attempts to give too much decision-making authority to the PHPs with regard to a number of issues that may be appealed. There must continue to be a robust, independent appeals process for providers.

### **MEDICAL LOSS RATIO**

NCHA concurs with the Department's plan to hold PHPs accountable on the obligation to maximize the funds delivered to beneficiary care through the Medical Loss Ratio (MLR). While the Department is federally mandated to implement and monitor an MLR, the Department should insist upon rebates from those PHPs failing to satisfy the MLR. Any funds recovered should remain within the Medicaid program to address beneficiaries' health needs. The legislatively established baseline MLR of 88% for care was deemed acceptable by all parties, but will need to be increased with the Department's plan to raise MLR levels if PHP rates include providers' (hospitals, nursing facilities, ICF/I-DD) supplemental payments. It should be noted that there has been great interest of PHPs to participate at the 88% level and supplemental payments not being included in the premium per the legislation and waiver filed. To the extent that the PHP rates include supplemental payments, the MLR must be adjusted upward to restore supplemental payments to the providers such that the supplemental payments are not funding the MLR. NCHA recommends a transparent calculation of any increased MLR arising from inclusion of providers' supplemental payment in PHP rates. The Department's monitoring of the increased MLR should focus upon ensuring that these supplemental payments, key to maintaining Safety Net health services across North Carolina are utilized to support these Safety Net health services delivered by North Carolina' hospitals.

## **CARE MANAGEMENT**

In our comments on the RFI in May 2017, NCHA noted that any requirements for case management and population health should recognize the significant investments made by North Carolina's hospitals, health systems and other providers in helping to establish our state as a national leader in the primary care medical home model. NCHA commends the Department's plan to support and compensate providers for their transition to AMH capabilities. The Department should work with all stakeholders to determine what specific attributes will be required to achieve each tier of AMH status.

## **VALUE BASED PAYMENTS**

Hospitals and health systems believe that the primary care medical home, along with pre-established quality metrics, is the most effective means of achieving the quality results desired by the State. However, establishing the PCMH model requires providers to change their operations to achieve desired results, including heavy investment in the necessary infrastructure. Providers are at different stages in their journey to achieve the PCMH model and assuming risk for patient outcomes. Some providers may never be large enough or have large enough populations to assume pay for performance models, and requiring such models may discourage contracting with PHPs. DHHS and PHPs should advance providers toward pay for performance arrangements, but DHHS should allow flexibility and encourage innovation in the development of such arrangements. Allowing the PHPs and providers to negotiate will allow providers, with their PHP partners, to identify the current state of their journey from volume to value and contract accordingly, while being accountable to quality metrics established by DHHS. This is especially true during the first few transitional years of Medicaid managed care, where mandating ACO-like payment structures could disrupt or weaken the safety net. As has been proposed by DHHS for telemedicine, specific value-based arrangements can be piloted between PHPs and providers.

## **TELEHEALTH**

DHHS' proposal to ensure rural enrollees have access to quality services through additional telehealth investments and piloting telemedicine through the PHPs is encouraging. The proposal notes that DHHS "plans to work with PHPs, providers and other stakeholders to develop a comprehensive strategy related to telemedicine during the coming months." We support the development of a comprehensive strategy, including eliminating any unnecessary restrictions or barriers that impede the use of telemedicine for Medicaid beneficiaries. We look forward to working with the Department on development of a strategy.

## **DATA**

DHHS indicates that it has begun the development of the basic data system components to support data processing and payment functions at the launch of Medicaid managed care, and is developing a longer-term roadmap for the additional functionality to support broader quality and value goals. NCHA supports a robust data system that gives providers the access they need to data in order to care for Medicaid patients. We are unclear how the legislative mandate for hospitals, physicians and certain others to provide clinical data on Medicaid patients by June 2018 ties into the infrastructure envisioned by DHHS. We look forward to working with DHHS, the NCHIE and others on these data issues. Additionally, as you are aware, NCHA has

partnered with both DHHS in providing real-time ADT data for syndromic surveillance and with CCNC in providing real-time data to enhance care management for Medicaid beneficiaries. We strongly recommend leveraging existing data infrastructure, technology and platforms developed by NCHA and its partners, including the Department, to assist Medicaid patients and providers.

While not expressly mentioned by DHHS, an all-payer claims database has recently come up for discussion in North Carolina. NCHA has concerns with some of the proposals it has reviewed, as the State already collects a substantial amount of claims data (including the Medicaid clinical data beginning 2018), and the dataset is typically incomplete, as ERISA plans do not report their data. Nevertheless, NCHA welcomes the opportunity to discuss with DHHS and others the best methods and means of data collection and reporting in providing quality and value to Medicaid beneficiaries.

Thank you again for the opportunity to comment. The proposed reform plan is a positive step forward. There are a number of areas where we have not commented yet, pending further development of and clarification of the concepts outlined in the paper. As those concepts are developed, we intend to comment further and provide additional input. We look forward to continuing to work with the Department and the legislature on all of these issues. Please do not hesitate to contact us if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "S. J. Lawler".

Stephen J. Lawler  
President  
North Carolina Hospital Association