North Carolina Medical Society

Leadership in Medicine

To: The Honorable Mandy K. Cohen, MD, MPH

Secretary, North Carolina Department of Health and Human Services

From: Paul Cunningham, MD, President

Robert W. Seligson, CEO/EVP

Date: September 8, 2017

RE: North Carolina's Proposed Plan Design for Medicaid Managed Care – August 2017

On behalf of the more than 12,000 physician and physician assistant members of the North Carolina Medical Society (NCMS), we respectfully submit these comments on the Proposed Plan Design for NC Medicaid. We appreciate the ongoing conversation with NC Department of Health and Human Services (DHHS) and appreciate the opportunity to comment on these and future proposals regarding the transition to managed care in NC.

The NCMS has been engaged in helping to make NC Medicaid successful for decades. Our members participate in all aspects of the program and our organization has been an integral voice in helping to shape the future of Medicaid. To that end, we remain steadfast on the basic principles we reaffirm today. Those include a commitment to:

- Move Medicaid to a value-driven system, consistent with the rest of health care;
- Quality and efficiency goals that are thoroughly vetted, accepted and consistent with current practice;
- Providing physicians with the needed data and tools to identify and address problems;
- Utilizing physician-led teams, in Accountable Care Organizations (ACOs) or similar entities; and
- Transparency and accountability for all partners.

Today, we would like to focus our remarks on the necessity of successfully transitioning to a value-driven system of care, truly integrating physical and mental health for every recipient, collecting and sharing robust data and providing for the protection of patients and providers in the new system. While the vast majority of our comments are limited to these four important areas, our comments are not meant to limit

the need for a continued discussion we believe is necessary for a successful and timely transition to Medicaid managed care.

Move Medicaid to a Value-Driven System

We appreciate the focus in the proposed plan around moving to value. We believe this is essential to a successful Medicaid system transition. For years we have promoted innovation in the delivery of care to Medicaid recipients. We have already moved well beyond traditional fee-for-service in NC to include per-member/per-month (PM/PM) payments for medical homes and improvements in care delivery. We believe that those earlier innovations should be included as foundational contract elements of all Prepaid Health Plans (PHPs).

This transition to managed care is an opportunity to truly transform the healthcare payment and delivery system for Medicaid. We support the continuation of the current Medicaid rates as a floor, together with the PMPM to preserve the robust primary care network. Additionally, we have to be thoughtful to include more specialty care partnerships to ensure that Medicaid patients are receiving the right care, at the right time and by the right provider. **Above all, we ask that DHHS make every effort to preserve existing physician patient relationships.** NC physicians and physician assistants have developed these long standing relationships through a commitment to always putting the patient first.

We agree that quality and efficiency should be a primary focus for transformation. **To that end, we request Medicaid standards and measures be consistent to every extent possible with the CMS Quality Payment Program (QPP).** In particular, Tier 4 AMH should meet the criteria established in 42 CFR 414.1420 for Other Payer Advanced APMs. Doing so will help physicians treating vulnerable Medicaid patients avoid the risk of payment reductions under the QPP**.** Where appropriate, these programs should run in parallel to ensure the success of both. Our members are committed to improving quality, but excessive and changing administrative burdens will tax our practices. Additional details about quality measurement and reporting would be especially helpful in making comments and preparing for launch.

We applaud the program design's focus on robust system testing before go-live to avoid the problems experienced in previous transitions in network and payment management systems. We also request DHHS include support measures like bridge loans and other administrative supports in their transition plan as many small providers cannot bear these burdens without help during a protracted transition period.

Integrate Physical and Mental Health

NCMS is committed to whole-person care for everyone. For too long, NC has divided care based on diagnosis, physical or mental health. This has led to mass confusion among providers and patients, loss

of coordination of care and services and ultimately worse outcomes for our patients. We agree with DHHS that this should change. For more than a decade, our patients who endure mild to severe mental health issues have been subjected to a myriad of well-intentioned changes. These transitions have been hard on patients and providers alike. While we support transitioning the care model, we are cautious about how and when to make the transition in order to minimize further impacts on patients' continuity of care and providers learning new systems of care delivery. We believe more discussion is needed to understand who would be eligible to offer a Tailored Plan and how the care provided through the Tailored Plan would be integrated.

Full integration was contemplated to occur in the original Medicaid reform legislation four years after go-live. This would theoretically have PHPs responsible for all care delivery, no matter the diagnosis, by the fifth year of the move to managed care. NCMS supports the effort to integrate more fully as early as reasonably possible with a minimum of impact on this already vulnerable population. **We encourage DHHS to fully integrate mental and physical health through the PHPs.** We are concerned that multiple plans could lead to a continuation of the current silo of services.

Robust Data Sharing

We agree that robust data sharing will be vital to transformation. Data will be important for DHHS to measure and qualify successful outcomes reported by the plans. Likewise, data is indispensable to providers in order to recommend the appropriate changes in treatment plans for their patients to achieve optimal health. **This is an area where DHHS can be especially helpful in making sure every provider is receiving patient level data.**

Additionally, this transition comes at a time when many quality measures have already been determined through other avenues. **We recommend at every possible opportunity, DHHS utilize existing data collection and quality measures to ensure additional administrative burden on practices is minimized.** This will also provide a basis for evaluating success. As much as possible, Medicaid quality metrics should parallel Medicare initiatives already in place. This helps to ensure the measures are manageable as well as quantifiable. Additional measures can be evaluated and added at later dates if necessary.

This will be especially important to the proposed Advanced Medical Homes. The proposed tier structure differs in many ways from the existing APM Medical Home Model under the QPP. We would like to work with you to align these programs. We would also like to see additional flexibility in the early years of transformation allowing practices and ACOs ready to go beyond fee-for-service to move into more advanced risk-based arrangements as suggested in Tiers 3 and 4 of the proposed plan.

NCMS supports the efforts by DHHS to address the Opioid Crisis in NC. Data is one essential element to achieving the change that recent legislation seeks, and mirrors DHHS strategic plan initiatives. We recommend DHHS support patients and their health care providers by implementing policies driven by best prescribing practices and broadly accepted guidelines such as those used by the NC Medical Board (NCMB) and Centers for Disease Control and Prevention (CDC). In addition, PHPs and others should be incentivized to try innovative approaches to addressing this crisis.

Patient and Provider Protections

Chapter 58 Provisions

PHPs selected to manage North Carolina Medicaid beneficiaries and create networks composed of North Carolina providers should follow the requirements already in place in North Carolina's commercial market, absent a more comprehensive, patient-focused federal standard. Among these crucial Chapter 58 provisions are requirements for prompt and accurate claim payments, overpayment recovery processes, parameters for utilization review, fair provider contracting practices, prohibitions on most favored nation clauses, and more.

Incorporating these provisions into the transformed Medicaid program will reduce administrative burden for providers by ensuring their commercial health plan partners must follow a uniform set of rules. We believe support from DHHS for these rules beyond contract language is essential to ensuring patient and provider protections as well as robust provider participation in the new Medicaid system.

Network Adequacy

NCMS supports DHHS's proposal of concrete, uniform network adequacy standards for PHPs and the stated goal to maintain NC Medicaid's high rates of physician participation in a transformed system. Strong, measurable, enforceable standards for PHPs are central to achieving these goals and ensuring appropriate levels of access to health services for Medicaid patients. It is also important for the State to monitor PHP compliance with these standards throughout the contract term.

We also note the initial proposal differentiates simply on a rural-versus-urban basis. Because of our state's geographical diversity, and the fact that many of our communities may not fall neatly into either category, we recommend DHHS consider a more graduated approach to network adequacy. For example, CMS measures network adequacy in the Medicare Advantage program with a sliding scale based on five different designations that take into account population size and density at the county level.[1] More exacting standards could have the added benefit of PHPs seeking fewer exceptions from DHHS.

Credentialing

NCMS supports DHHS's approach to credentialing and the effort to streamline the administrative requirements that accompany physician participation in Medicaid FFS, the PHPs, and the LME-MCOs. A centralized approach has significant potential and we have seen this model work effectively in other states. We look forward to additional conversations about this effort.

Provider Appeals

DHHS's *Proposed Program Design* discusses a direct appeal to the PHP by a provider that has experienced an adverse action. DHHS goes on to state, "[p]roviders will not have the ability to request a hearing before DHHS or through the state fair hearing process before [OAH] if dissatisfied with the results of the PHP's appeals process, unless the appeal relates to program integrity issues and DHHS takes separate action based on PHP action."

[1] *See* Centers for Medicare & Medicaid Services, "Medicare Advantage Network Adequacy Criteria Guidance," Jan. 2017, accessed via: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

NCMS requests DHHS reconsider its proposal to empower PHPs with final authority on matters such as claims denials, inaccurate claims adjudication, prompt claim payments, and other administrative matters. As we've experienced with NC's Medicaid FFS program, claim processing and technological problems can bring payer operations and patient care to a halt, all at the expense of the provider community.

Providers should have access to a neutral arbiter who is authorized to resolve disputes and order appropriate remedies. This should be available once all internal PHP appeals are exhausted or on emergency grounds. Providers have such ability already in North Carolina's commercial insurance markets. In that context, providers who believe an insurer is operating in a manner that is harmful to patient care or in violation of state law may request assistance from and file complaints with the NC Department of Insurance. The scope is much broader than matters relating to program integrity.

Such a mechanism will also benefit DHHS in its role of monitoring PHP business operations and ensuring compliance with contract terms and, applicable state and federal requirements, while also affording the opportunity to order corrective action.

Rate Floor

DHHS proposes to establish a rate floor for physician services and physician extenders at 100 percent of the current fee-for-service rate. This will require PHPs contracting on a *FFS or enhanced FFS basis* to offer physician practices a rate no lower than 100 percent Medicaid.

The *Proposed Program Design* then states that "PHPs and providers will be able to mutually agree to a different rate or alternative payment arrangement." This accords with other sections of the proposal and our position that PHPs and providers be given maximum flexibility and encouragement to form value-based arrangements. However, we are unclear how the FFS-based physician rate floor will apply in the context of, for example, new bundled payments or shared savings arrangements featuring upside and downside risk. **Therefore, we request that DHHS consider developing guidance on how the rate floor will apply as physicians and PHPs transition into value-based arrangements.**

We must also note that for some services, the current Medicaid reimbursement rate is dangerously low. For example, NCMS has worked with DHHS consistently to improve reimbursement rates in the Physician Drug Program (PDP). Considerable progress has been made, but many drugs and devices in the PDP remain "underwater." The below-cost reimbursement from Medicaid forces physicians to incur a financial loss on every unit. This inevitably means the physician will have to direct patients needing that drug or device to other (often more expensive) care settings, undermining both access and cost effectiveness. **Prior to the initiation of capitated payments to the PHPs, DHHS should work to increase historically underpaid physician services to ensure adequacy of the rate floor.**

Out of Network Rate

Finally, we ask that the current out-of-network proposal be reconsidered. The implications of reduced payment for Medicaid services are significant because the rates are already well below Medicare. While the rate floor provides some protection to the contracting providers, there can be many legitimate factors that can lead to non-participation in a PHP network. Based on experience, whatever the out of

network rate is, PHPs should be required to make those payments directly to the provider, rather than to the patient.

All of the preceding recommendations are predicated on success, and as a result incorporates principles and elements that are embedded in what has been called the "quadruple aim". We have adapted them for the specific benefit of the citizens of North Carolina. We expect the strategies we have defined above will create a system of care that will "enhance patient experience, improve population health, reduce costs, and improve the work life of health care providers, including clinicians and staff"[2]**.**

In conclusion, we would again like to take this opportunity to thank DHHS for your collaborative efforts to collect stakeholder feedback. We look forward to working with you to make sure the transition to Medicaid managed care is thoughtful, timely and successful.

[2] Reference access at: http://www.annfammed.org/content/12/6/573.full. and at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

1. **Thomas Bodenheimer, MD**1⇑ **and**
2. **Christine Sinsky, MD**2,3