# North Carolina Obstetrical & Gynecological Society

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September 8, 2017

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

*Submitted via Medicaid.Transformation@dhhs.nc.gov*

Dear Dr. Cohen:

On behalf of our members and the women they serve, the North Carolina Obstetrical and Gynecological Society (NCOGS) is pleased to provide the following comments on the Proposed Program Design for Medicaid Managed Care.

Before exploring those parts of the Proposed Program Design that are specific to obstetrical and gynecological care, we want to also convey our support of the priorities and concerns about the Design as outlined by North Carolina Medical Society President, Dr. Paul Cunningham, in his letter dated September 8, 2017.

Concerning Ob/Gyn care specifically, the Design document released for comment is described as "a detailed proposed program design for transforming the state of Medicaid and NC Health Choice programs to managed care."

Indeed, the document does propose a broad vision and strategy for a well-coordinated system of care that addresses both medical and non-medical drivers of health outcomes. It correctly includes many of the elements that are important to providers such as uniform policies, a single electronic application and a single drug formulary. There is reference to "Advanced Medical Homes" and care management, which the NCOGS applauds as this an important part of a much-needed effort to address some of the important social determinants of health in our state. There is also reference to preserving the standardized pregnancy risk screen that has proven to be especially effective in identifying psychosocial needs.

The NCOGS supports these parts of the Design and hopes that those entities that apply to become North Carolina PHPs are required to meet these standards and provide these services as a condition of serving the state's Medicaid patients.

While there is much to support in the Design, there is also much left unexplored or unexplained. The document includes few specifics about the care of the pregnant and postpartum Medicaid population. As I am sure you are aware, Medicaid funds more than 57,000 North Carolina births annually - or about 46% of all births statewide. Because healthy birth outcomes are the foundation of

healthy populations, inclusion of strategies specific to maternity care must be clear before the Department proceeds in the PHP selection process.

The Design document also states "DHHS intends to maintain the effective processes now in place to combine data sets to produce important maternal and child health process and outcome measures." As you may know, the current system includes a linked dataset that provides risk screening, care management, Medicaid claims and birth certificate outcomes. This system produces quarterly metrics for Department, county-based pregnancy care management programs, local Community Care of North Carolina (CCNC) networks and individual practices. These metrics reflect program priorities and provide the compass for quality improvement efforts. Population level and practice level data is available for priority outcome indicators such as low birth weight rates and mode of delivery, as well as care metrics such as timely entry to prenatal care (access), screening for tobacco and substance use, postpartum care and contraception, use of progesterone and frequency of tobacco cessation counseling.

If it is, as stated, the Department's intention to maintain those specific components of the system listed above and which currently "produce important maternal and child health process and outcome measures," these components should be specifically required of PHP applicants and scored in the PHP selection process.

The Design document also includes a description of an "Advanced Medical Home" certification process and "Tiers," but acknowledges that the care management needs for pregnant women, currently run through CCNC in collaboration with local health departments, are not addressed. The current screening strategy utilized for at risk pregnant Medicaid patients allows providers to focus on those patients who will benefit most from care management. By working in collaboration with Pregnancy Medical Home providers, health department care managers are able to achieve face-to-face care delivery integrated with the patient's medical team. The key to developing and sustaining these relationships is local clinical leadership teams who reach out to provider colleagues, promote the benefits of care management and provide local practice support.

I have described the state's current care management system because the NCOGS believes it is imperative that specific plans for pregnancy care management be included in DHHS's reform plans – again, before the PHP selection process begins. These plans should be scored in the PHP selection process and include effective risk screening, locally based care managers who provide face-to-face services in collaboration with the care providers, creation and support of local clinical leadership and local provider support.

In a reformed system, PHPs will be responsible for assisting patients in the selection of their Primary Care Provider/Advanced Medical Home. In reviewing the Design document, it is unclear if Ob/Gyns will be considered primary care providers. Many women look to their Ob/Gyn physician for primary care and should be directly accessible to patients without required referral by another primary care provider. Limiting access to Ob/Gyn care will also result in unnecessary delays in the provision of prenatal care.

On a related issue, Table 4 of the Design document outlines network adequacy standards – including appointment wait time standards. Routine primary care and specialty care are set at 30 days. Timely prenatal care is essential and should be accessible within 14 days to all pregnant women.

The Design document also discusses the Department's intention to include an incentive program to encourage investment in evidence-based strategies. These incentives currently exist within the Pregnancy Medical Home program. Specifically, PMH participating providers agree to perform risk screening, engage with care managers, and other evidence-based strategies to ensure quality care. Incentive for these activities includes enhanced reimbursement for vaginal birth and payments for risk screen

submission and the post-partum visit. The Design document should include the Department's intention to maintain these incentives.

Likewise, the Design document should underscore the need to maintain and strengthen the use of regional networks of obstetrical care providers to support local providers and promote and implement best practices. These teams help guide system improvements that enhance care delivery and help develop care pathways to promote the most current evidence based care. They also bring statewide, regional and practice specific data to local practices to highlight quality priorities and drive continuous quality improvement. Again, the NCOGS believes that this use of clinical leadership, specific to obstetrics, should be included in DHHS's transformation plans and scored in the PHP selection process.

More broadly, the NCOGS believes that there are several components needed in a reformed Medicaid system to keep obstetric care providers engaged in caring for the pregnant Medicaid population and committed to quality improvement. These include:

- Regional clinical leadership teams that support local providers and drive improvements in care
- Adequate reimbursement, including financial incentives
- Patient care management that is embedded in the practice to help address the many complex social determinants of health associated with many Medicaid patients
- Maintenance of a single system for informatics, risk screening and quality metrics across the Medicaid system.

The NCOGS recognizes that the Department faces daunting challenges in reforming the Medicaid system consistent with the requirements and timeline approved by the General Assembly. Our Society's leadership is ready to assist in this effort. However, we are concerned that many of the critical questions concerning reform and its impact on pregnant Medicaid patients and their physicians are unaddressed in the Design document. We believe it is critical that these questions are answered before the PHP selection process begins so that North Carolina's strategy for providing and improving care for this important population is understood by all stakeholders – and PHP applicants can be evaluated for their ability to implement this strategy.

With these concerns in mind, NCOGS requests a meeting with you at your earliest convenience to discuss the issues addressed in this letter and to explore how we might be of assistance in resolving them.

Sincerely,

M. Kathryn Menard, MD, MPH
President
North Carolina Obstetric and Gynecologic Society