North Carolina Medical Society
Established 1849
Leadership in Medicine

April 18, 2016

North Carolina Department of Health and Human Services
Attention: Secretary Rick Brajer
Re: Comments in response to the draft Medicaid reform waiver proposal

Dear Secretary Brajer,

The North Carolina Medical Society (NCMS) appreciates the opportunity to provide feedback on the NC Department of Health and Human Services (DHHS) Medicaid reform waiver proposal, released to the public for comment on March 1, 2016. The NCMS has advocated for physician-led Medicaid reform since the state began debating how to transition from the current fee-for-service Medicaid program. NCMS supports the broad goals stated in the DHHS waiver proposal that focus on promoting patient-centered care and embracing the "quadruple aim" as the guiding principle in our state's Medicaid reform efforts.

We are committed to working with the Department to make the reformed Medicaid system a success and appreciate the proposal's emphasis on engaging physicians in the practice transformation efforts as part of the state's reforms. However, we have several changes and clarifications we urge DHHS to make to its current proposal to strengthen the state's waiver application.

Initiatives outlined in the waiver proposal

The DHHS waiver proposal outlines four demonstration initiatives: 1) building a system of accountability for outcomes; 2) creating North Carolina "person-centered health communities" (PCHCs); 3) supporting providers through engagement and innovations; and 4) care transformation through payment alignment. The NCMS generally supports these initiatives and is pleased to see DHHS emphasize the use of quality measurement and care transformation through payment reform.

Delivery System Reform Incentive Payment Program (DSRIP)

When designing the Delivery System Reform Incentive Payment (DSRIP) program under the 'care transformation through payment alignment' initiative, we urge DHHS to involve stakeholders in a transparent process to develop program criteria that are fair to all providers and focus on quality and value. Given the large amount of funding tied to this budget category, the state should provide more clarity around how supplemental payments would be continued and/or transferred to other programs as part of this DSRIP program. The NCMS encourages DHHS to make the supplemental payment funding more broadly available to other providers, such as physicians and ambulatory surgical centers, for example, through its DSRIP proposal to CMS. Where direct funds are provided, they should be directed only to those who are serving a higher proportion of underserved patients.

Person-Centered Health Communities (PCHC)

The waiver proposal states DHHS will design, develop and implement a pioneering-level of person-centered health communities (PCHC) to lead the nation in the area of ongoing practice improvement. DHHS notes prepaid health plans (PLEs and Commercial Plans) will participate in PCHCs, however there is little detail describing how health plans and/or providers will be participating in the new PCHCs. In the

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waiver proposal, PCHCs are described as North Carolina's next generation of medical home which will build on the current infrastructure and population management to extend care management activities beyond the current Patient Centered Medical Home (PCMH) and Pregnancy Medical Home. The draft waiver also lists certain PCHC features that will be considered for inclusion in PHP contracts, such as requiring each beneficiary to receive a comprehensive health assessment. We urge DHHS to share additional details regarding how this new PCHC structure will be set up, where it will be housed and who will be required to participate as well as how they will be required to participate. Additionally, DHHS must consider how PCHCs will engage specialists in addition to primary care providers to encourage broad participation in integrated, value-based arrangements that may result from this model. The NCMS looks forward to providing additional input on this PCHC concept as the idea is further developed by DHHS.

The waiver proposal also stresses practice supports will help support the implementation of the PCHC model of care. The department points to N3CN and AHEC support to practices, but also states the DHHS goal of standardizing the approach used to provide practice supports while also supporting innovation at the provider and PHP level. The NCMS urges DHHS to allow for maximum flexibility in providing practice supports to physicians and other practitioners. Physicians and practices should be given the opportunity to develop along the five stages of practice transformation in the way that works best for them. This should not be something dictated by the state. DHHS also must ensure these efforts are aligned with current federal initiatives in this area as a result of the Medicare Access and Chip Reauthorization Act of 2015 (MACRA) legislation. Contradictory requirements or overly prescriptive specifications by DHHS will hinder engagement of physicians in practice transformation efforts. DHHS should continue to consult stakeholders for feedback on ways to align with other similar initiatives currently underway while also allowing for maximum flexibility for physicians.

While the PCHC model may embrace this shift, NCMS requests a greater emphasis on health care delivery redesign and payment reform at the provider level. While bonuses for quality is a start, more needs to be done to encourage movement away from the current fee-for-service system. Care coordination will be a key component and allowances need to be made for the cost of these important services while providers transition away from fee-for-service payments. Incentives should be provided to PHPs to move their contracted providers into value-based arrangements and to progress down the risk continuum.

The state also should place additional focus on disparate facility payment rates for the same procedure or service. Medicaid will be better served if we undertake an effort to understand the true cost of care and pay for such services accordingly, with incentives for quality.

In addition, other services and payment arrangements, such as those for EMS that encourage use of emergency departments by only providing payment for transporting patients to emergency departments, presents an opportunity for innovation. NC has advanced or community paramedic programs that ought to be leveraged and expanded.

NCMS cannot overstate the importance of whole person care and the connection between the mental and physical aspects of health and well-being. We understand mental health services will eventually be "carved back in" to the PHP system being proposed. DHHS should provide additional detail regarding how it expects mental health services will be included in these proposed initiatives, as this inclusion will be critical to the success of the reformed Medicaid program. On this point, DHHS should consider creating incentives for PHPs to work closely with the LMEs/MCOs until the transition is complete and the systems are united.

Issues important to physicians

Insurance protections

DHHS and the Department of Insurance (DOI) recommend in the Legislative Report that, except for the financial requirements specified for PHP licensure, PHPs be exempt from Chapter 58 of the General Statutes (insurance protections). DHHS will instead incorporate key protections in its PHP regulations and/or the PHP contracts. The NCMS urges DHHS to use the regulatory process to define which Chapter 58 insurance protections will be made available under the reformed Medicaid program. Relying on the individual plan contracting processes to accomplish this goal will result in harm to patients, unfair competition, and the inability to compare plans with objective metrics, as plans will not be playing by the same rules. These protections are in place to protect patients and providers, and were put into law because the contracts in use at the time were deficient. DHHS must ensure these protections will be provided in an open, transparent and consistent manner and are applied uniformly to both PLEs and CPs. Having uniform rules for all PHPs better upholds the aim of supporting providers by reducing the variation from plan to plan in how these items are handled.

Definition of a Provider Led Entity (PLE)

NCMS urges DHHS and lawmakers to retain the requirement to have physicians who see Medicaid patients hold a majority of the governing board of PLEs to ensure a focus on patient outcomes and quality in the move to value-driven arrangements for Medicaid as intended by the General Assembly. This should be an innovation highlighted in the waiver proposal. Emphasizing the ability of physicians to drive payment reforms and practice transformation is a critical component of the state's overall waiver proposal.

Metric development process

We are encouraged to see DHHS' commitment to creating one common set of metrics for providers and plans in the new Medicaid system. DHHS must go further, however, to ensure meaningful feedback and buy-in of clinicians throughout the measure development process. This must be clearly stated and the process must be transparent. The NCMS urges DHHS to establish a measure development process on which stakeholders and the public may provide feedback. Moreover, DHHS must ensure practicing physicians are consulted throughout the measure development process. This feedback must be collected early and often. We also urge DHHS to consider measure alignment with other commercial and national measure sets where appropriate. The Department also must more clearly state which measures providers will be subject to, and the process for developing those measures as well as those for which the health plans (both PLEs and Commercial Plans) will be held accountable. We look forward to providing ongoing input in this area.

Health Information Exchange and Physician Access to Data

NCMS applauds the emphasis that the waiver proposal places on successful health information exchange and the statewide informatics layer. In our view, access to timely patient and population data is critical to achieving the quadruple aim.

First, we ask DHHS to expressly prohibit use of data blocking techniques by participants and to take additional steps to ensure high levels of participation within the new Health Information Exchange (HIE). The ability of physicians to access complete, reliable patient data within the HIE will be critical for the move to value-based payments and the reforms envisioned in this waiver proposal. Additionally, DHHS should ensure all practices and physicians can access the HIE data at a minimal cost. For the HIE to be successful, we must find ways to keep participation costs for all providers low. We are especially

concerned about small, rural and independent practices' ability to bear the costs associated with participation, and urge DHHS to consider ways to alleviate these costs where possible.

In a separate area of the waiver proposal, DHHS notes its plans to create a "statewide informatics layer" with data analytics capacities to enable transition to total person care. This will combine clinical and administrative claims data and focus on population health data. It will accelerate a statewide "learning health system" through the NC Innovations Center. We want to underscore the importance of allowing physicians to access real-time clinical and claims data to allow them to better understand the impact of their practices at the patient and population levels. Accordingly, DHHS should provide additional information on what this system would look like, and who would have access to the data as well as the analytic reports that may be generated.

Patient choice in selecting a health plan

DHHS must clarify that there is an error on page 59 of the draft waiver, which states the DHHS plan will "restrict patient choice" as this conflicts with what is proposed throughout the rest of the waiver proposal document. It will be critical to provide patients with a choice of health plan. The NCMS strongly opposes restricting patient choice in any way. We support providing patients with a choice in their health plan, focused around the primary care provider relationship with help of a navigator. In the auto-assignment process for those who do not actively choose a plan, DHHS must ensure a patient's existing primary care provider relationship is preserved.

Innovations Center function and design

The NCMS is encouraged by the state's desire to create an Innovations Center that will help support physicians as they share best practices in progressing along the five stages of practice transformation. It is unclear how this Innovations Center will interact with practices, health plans and the PCHCs. We urge DHHS to involve physicians in further developing this concept, and to best leverage activities already taking place in the state and nationally to support physicians and practices in their practice transformation efforts.

DHHS also should more clearly define its plans to transition the Pregnancy Medical Home program under Medicaid reform. The NCMS urges DHHS to consider using a common set of measures among health plans to achieve similar program goals. The Innovations Center should be tasked with creating a common set of Pregnancy Medical Home 2.0 measures and provide consistent data and feedback with practices throughout the state to achieve this goal. The NCMS believes this program is innovative, and incorporating it more clearly in the state's waiver proposal would enhance the viability of the 1115 waiver application. This should be done in consultation with practicing OBGYN physicians to provide sufficient input on how this could best be scaled.

DHHS also notes the importance of continuing system integration and information exchange including exploring options to develop a state interface similar to the current NC3N Case Management Information System (CMIS) either through the Innovations Center or a contractual relationship to provide a uniform care management record. The NCMS asks DHHS to consider allowing for flexibility among practices to select the case management services that best suit their needs.

NCMS urges DHHS to incorporate language in the waiver proposal that would emphasize the use of social supports and services and the engagement of community health partners as mechanisms to assist physicians and other clinicians in keeping their patients healthy. DHHS would be better served by adding language that would instruct the Innovations Center to work on connecting physicians and practices with social supports already existing in the community such as faith-based groups, the YMCAs and others. Addressing social determinants of health will be critical in transforming the health care system as desired.

Essential Providers

The NCMS supports DHHS goals to strengthen the health care safety net through "essential provider" designations. These providers also must be given additional supports to assist in the transition, as resources are already scarce for these entities and their success is vitally important. We applaud DHHS for its plans to expand current programs designed to ameliorate NC's rural health workforce shortages and underserved communities such as loan repayments, community grants, enhanced recruitment efforts, AHEC residencies and new community-based graduate medical education.

NC also must better understand our future workforce needs and tailor GME funding and other investments in workforce to help meet those needs. The University of North Carolina at Chapel Hill's Sheps Center has developed a tool called FutureDocs to predict workforce needs, which ought to be leveraged.

Contracting issues

The NCMS appreciates the state's commitment to reducing administrative burdens placed on physicians as a result of the transition to a managed care Medicaid program. However, there are several questions remaining regarding how contracting and credentialing will be accomplished under the DHHS waiver proposal. We urge DHHS to continue conversations with stakeholders to collect input to further define this area of the waiver proposal before it is submitted for federal approval.

We recommend that DHHS establish an out-of-network structure that encourages providers to contract with PHPs while maintaining fairness for providers. DHHS also should define reasonable terms, protect against take-it-or-leave-it negotiations and oppose punitive rate structures. We also urge DHHS to expressly prohibit any effort by the plans to force doctors into their Medicaid network as a condition of participating in their commercial network to ensure fair business practices take place in the new Medicaid system.

Conclusion

In conclusion, the NCMS views the DHHS waiver proposal as a positive step forward in developing the state's Medicaid reform strategy for consideration by the Centers for Medicare & Medicaid Services (CMS). Implementation of a new Medicaid system will be challenging work for both the state as well as the physicians of North Carolina and we appreciate the ongoing desire to include stakeholder input throughout this process.

The NCMS and its Foundation have many programs focusing on preparing the medical community for the move to value-based health care such as the NC ACO Collaborative, Rural ACO Initiative, Community Practitioner Program and Kanof Institute for Physician Leadership, which all could be leveraged as part of the state's plan for reforming Medicaid. We are happy to assist in any way that we can and we look forward to continuing to provide physicians' feedback as the waiver application process develops. Should you have any questions, please contact us at 919-833-3836.

Sincerely,

Robert W. Seligson
Executive Vice President, CEO