North Carolina **Medical Society**
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Leadership in Medicine

May 25, 2017

Mandy K. Cohen, M.D., M.P.H.
Secretary
Department of Health and Human Services
Division of Health Benefits
1950 Mail Service Center
Raleigh NC 27699-1950

Dear Secretary Cohen:

On behalf of the North Carolina Medical Society, thank you for inviting public comment concerning NC Medicaid and Health Choice Transformation. We strongly support efforts to transform the health care delivery and payment system and to ensure that Medicaid is a driver of that change. Below please find our thoughts on the seven areas outlined in the Request for Public Input.

1. **Physical and Behavioral Health Service Delivery**: The NCMS supports whole person care and encourages changes to the program to promote coordination and alignment between mental, behavioral and physical health. The Triple Aim of better health, better care and lower costs will not be achieved as long as there is continued fragmentation.

   1.1 We believe integrating mental and behavioral health services with physical health services will result in better care, better health, less cost and less stress on patients and caregivers who bounce back and forth between providers. NCMS supports medical homes and believes that integrating mental and behavioral health services within the medical home results in better continuity, efficiency and efficacy of care and reduces the stigma associated with providing treatment to individuals with mental and behavioral health issues by having a separate system as is currently the case in NC. NCMS supports changing the Medicaid Transformation legislation to (1) expedite inclusion of mental and behavioral health with physical health, and (2) simultaneously transition both mental/behavioral health patients and dually-eligible patients. If the current carve-out schedule is not changed, there may be ways to move toward integration while the current schedule is in place. Many of the LME/MCOs are already reaching out to potential Prepaid Health Plans (PHPs) to discuss how to integrate during the carve-out period. DHHS could include in its PHP Request for Proposal (RFP) a requirement that the PHP describe its plan for integrating mental and behavioral care services during the carve-out and give preferential treatment to those PHPs who have a viable plan.

   1.2 Individuals with lower-moderate intensity, lower-moderate frequency behavioral health needs should be in a PHP. The case for including these individuals earlier may be more palatable to policy makers than including those with more complex and expensive issues. This might ease the reunification of services through one system.

1.3 Special Needs Plans (SNP) – Individuals with serious mental illness (SMI) and Intellectual/Developmental Disabilities (I/DD) are high-need, complex and expensive to care for appropriately. All require treatment and ongoing engagement to maintain progress. They also have social determinants that have a direct impact on their health – housing, poverty, lack of family support, etc. – that fall outside the normal scope of health care delivery. The services needed to treat and support this population require a deep and broad continuum of care. In many communities, these services are lacking. Statewide or multi-region SNPs would encourage the expansion of the continuum of care. We recommend that DHHS consider including the SMI and I/DD populations in the SNP into a capitated, integrated health program in order to: (1) spread the administrative costs across the entire population that will benefit, (2) minimize the administrative burden on providers who would have to follow one set of rules for the SNP population and another set for their other Medicaid patients, and (3) facilitate the capture and reporting on a broad spectrum of quality indicators. DHHS may consider ensuring that the managed care structure enables PHPs to provide services within the capitated rate and are not limited by waiver restrictions. Additionally, DHHS may consider another term for these plans so as not to result in confusion with Medicare SNPs.

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a. Rather than subdivide the Medicaid population through numerous contracts, DHHS should promote integrated care by consolidating the number of contracts and requiring PHPs to offer a broader array of services. This would streamline administration, stimulate rapid expansion of community-based services, and rely on the PHPs, under state oversight, to design appropriate utilization and case management based on the intensity of the needs.
b. Any managed care approach for people with I/DD should incorporate long-term services and supports (LTSS), physical, mental and behavioral health, and pharmacy benefits. Carve-outs of any kind fracture the PHP and undermine the State's goal to deliver truly efficient, whole-person care.
c. Any program should include I/DD or SMI patients in the State's Developmental Centers to ensure coordination of services across the system and enable seamless transitions into the community.
d. I/DD and SMI providers should have the opportunity for value-based arrangements with PHPs to support physical, mental, behavioral and social determinant outcomes.
e. Ensure crisis services are available for individuals and guardians/caregivers 24/7 telephonically or by other means, as well as in-person, along with coordinated follow-up post-crisis to ensure stabilization.

2. **Supporting Provider Transformation:** The NCMS has been a leader in promoting provider and practice transformation across payers and facilitating successful participation in value-driven arrangements. We are continuously looking for ways to assist providers in developing appropriate infrastructure and embracing necessary culture change to ensure that everyone is practicing at the top of their license and are not hampered or distracted by administrative burdens. The Medicaid program, in its move to managed care, must encourage alignment with the move to value in a deliberate and measured manner. The Division of Health Benefits, PHPs, contracting providers and patients all need to be working to achieve these common goals.

2.1 The transformation of North Carolina Medicaid presents a clear opportunity to reduce the program's substantial administrative burdens on the provider community. NCMS encourages DHHS to develop and incorporate detailed strategies into its amended 1115 waiver application.

a. One area of considerable concern for providers in Medicaid transformation is provider enrollment, verification, and credentialing (or "EVC"). And there is good reason for concern – Medicaid's current EVC system is easily the most lengthy and demanding of all North Carolina payers. The idea of additional fragmentation and administration is difficult to endure. Our recommendations are twofold. First, DHHS should further simplify and shorten current EVC processes. Improvements in this area could include (1) requiring faster processing of complete applications; (2) retaining the five year re-credentialing cycle and requiring PHPs to follow it; (3) dropping the $100 application fee; (4) revamping the provider training requirement; and (5) limiting when state approval is required for changes to provider records (i.e., MCRs). Second, the State should establish a centralized credentialing verification system to allow the PHPs to obtain all verified provider data from the State and without supplementation by the provider. Such an approach may be designed to accord with NCQA accreditation programs, while also relieving providers of engaging in the EVC processes of 3-15 (or more if SNPs are contemplated) new organizations within Medicaid. As an example, the State of Georgia has implemented a "centralized CVO" that handles all Medicaid provider credentialing for the State and the "care management organizations" operating in the jurisdiction (with the exception of certain delegated credentialing arrangements).[1]

b. We also seek assurances that claims processing and provider payment functions handled by the PHPs will be stable, consistent, and offer a sense of finality. Since the launch of NCTracks in 2013, Medicaid providers have been subjected to countless system design changes, claims reprocessing efforts, and payment recoupments/modifications. NCMS understands this will continue to be the case until PHPs go live. North Carolina's Medicaid program, including provider participation, has been harmed as a result. In the transformed Medicaid program, DHHS will be in a position to benefit from recent years' experience and will be well-positioned to monitor and ensure that PHPs process claims and payments accurately, make systems updates in a manner that minimizes disruption to providers and beneficiaries, and that all related problems are corrected promptly.

2.2 Currently, CMS has efforts underway through its Transforming Clinical Practice Initiative to fund practice transformation assistance and education. NCMS is currently encouraging practices to enroll in the National Rural Accountable Care Consortium (NRACC) Practice Transformation Network and utilizing existing grant dollars to help more vulnerable and under-resourced practices with in-office practice transformation consulting in partnership with AHEC. Any incentives that Medicaid might offer before go-live for medical practices to

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[1] For more details, see https://dch.georgia.gov/centralized-cvo.

enroll in programs like this one would be helpful, although objective measures of success would need to be developed. Ensuring consistency where feasible between the Medicare Quality Payment Program (QPP) program and Medicaid will help all practices with the transition.

2.3 Under the current legislation, providers could have patients in up to 15 statewide and regional PLEs plus however many LME/MCOs remain. The proliferation of PLEs will add administrative burden, which will lead to frustration and disenfranchisement of Medicaid providers.

3. **Care Management and Population Health:** Any changes should encourage more proactive interventions that promote health, such as care management that is high-touch when needed. PHP contracts should include incentives to help providers migrate into value-driven arrangements. But this should be done only in a responsible and measured manner, with the focus on population health management. PHPs should be motivated to develop and deploy programs to assist providers as they develop competency in population health management. Data sharing between the State, PHPs, and providers is fundamental.

   3.1 & 3.2 Standardized statewide criteria and a certification process for advanced medical homes consistent with CMS requirements under the Quality Payment Program (QPP) should be considered for consistency.[2]

   3.3 NCMS believes that care coordination and case management and similar services are essential to successful population health management. That said, PHPs should have maximum flexibility to encourage innovation in the provision of care coordination, care management and similar services. Currently, the PMPM payments that Medicaid allocates for care management are paid without regard to performance, and this is inconsistent with the move to value. We are aware that some primary care doctors are prepared to work under a sub-capitation arrangement rather than a PMPM supplement. We urge DHHS to closely evaluate RFP responses for how each PHPs plans to approach care coordination, case management and related services.

   3.4 For small providers in rural and underserved communities, DHHS should require PHPs to demonstrate how they plan to support these providers and their patients with population health management. Also, when setting rates, it is important to take into account that most providers in rural and underserved areas have a patient population that is disproportionately comprised of Medicaid and uninsured patients, and that these practices have difficulty absorbing the steeply discounted Medicaid rates currently provided. DHHS may even consider whether rates may be risk-adjusted based on complexity and by the percentage of their patients who are enrolled in Medicaid and/or uninsured.

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[2] *See* 42 CFR 414.1420.

3.5 Capitated payments to PHPs must be risk-adjusted and adequate to provided needed services to all enrollees. The current enhanced fee that is paid through CCNC should be included in the risk-adjusted rates of those complex patients that need case management and other services.

3.6 Most services are best when provided at the local level; however, we understand that many providers currently do not have the ability to provide population health management services. Generally, the more sophisticated practice arrangements should be able to take on more services. For example, there are many Medicare ACOs that provide their own care coordination, case management, and similar services and should be able to extend those services to their Medicaid patients. PHPs should be encouraged to give these sophisticated providers the latitude to maximize their investments in these services. On the other hand, there will be other providers who do not have this capability, and PHPs should be able to support these practices by providing these services when needed. DHHS also should give preference to PHPs that have a credible plan to help move their participating providers into value-based arrangements/alternate payment models.

4. **Addressing Social Determinants of Health:** The vast majority of health care costs are driven by social, economic and environmental factors that are outside the direct control of the health care system. Addressing social determinants of health in order to promote patient health therefore requires collaboration between providers, PHPs, local social service agencies, and community partners. Strategies to formalize these relationships at the PHP and provider levels should be a durable component of North Carolina's cost control strategy for Medicaid. Barriers that discourage health care providers from helping their patients receive needed services outside the traditional health care system need to be minimized or eliminated.

4.1 DHHS, through the RFP and selection process, could give preference to PHPs that integrate community health partners—both public and private—into their networks. PHP contracts also should provide flexibility to the PHPs and their networks in addressing social, economic and environmental factors that impact health and the total cost of care. North Carolina has the opportunity to learn from other states experiences integrating social determinants of health within the PHP framework.[3]

4.2 While we believe investments in addressing social, economic and environmental factors are critical to promoting health and decreasing total cost of care, we defer to others such as public health and social services who have more expertise in this area. Based on our own experience, however, integration of social determinants data within patients' medical records is critical. Leadership by DHHS in capturing this data will be indispensable in breaking silos

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[3] Dr. Laura Gottlieb, an Associate Professor of Family and Community Medicine at the University of California, San Francisco and Robert Wood Johnson Health & Society Scholar, recently completed an evaluation of how social health interventions have been adopted within Medicaid Managed Care Organizations ("MMCO"). This evaluation concluded that, despite recognition of the role social determinants play in health outcomes, relatively low investment has been made to date in addressing these factors at the MMCO level, and identifies the primary barriers to expansion of systemic expansion of social needs screening at the provider level. Clinical Interventions Addressing Nonmedical Health Determinants in Medicaid Managed Care, Gottlieb, et al., Am J Manag Care. 2016;22(5):370-376

between social service providers and health systems.[4] As a starting point, DHHS may choose to integrate some limited social determinants of health indicators into the NC Health Information Exchange (NC HIE) platform. This could be accomplished by cross-referencing or integrating existing state and county level social service databases (*e.g.*, WIC, Adult and Child Protective Services, Housing and Urban Development) to identify Medicaid patients at risk of food or housing insecurity or other social risk factors impacting health.

We also expect that prioritization of community-level needs will vary along with the targeted strategies to address these needs. It is for this reason that formal, sustained community partnerships at the PHP and provider levels are so important, justifying the preference that may be accorded them in the RFP.

4.3 While investments to address social determinants of health need to be made at the State level, we hope that DHHS will enable and encourage PHPs and their network providers to address the social needs of their patients. Some record keeping of identified needs and activities undertaken to address those needs, if any, outside of traditional medical (mental, behavioral and physical) should be regularly reported and measured.

4.4 Barriers to addressing social determinants of health include real or perceived legal prohibitions on providers delivering these types of services. Where possible, the State should seek opportunities to allow and encourage PHP-provider contractual arrangements to foster actions that will help their patients.

5. **Improving Quality Care:** A focus on improving the quality of care in the transformed Medicaid program is key. Quality measurement programs (1) need to be done in a way that does not add unnecessary administrative complexity, and (2) include measures of the extent to which social determinants of health are being addressed.

   5.1 Uniformity in measures across PHPs and alignment with other payer and program measures (such as those recognized by the Core Quality Measure Collaborative[5]) will help manage the administrative burden borne by providers. Measures must be meaningful, relevant to the Triple Aim, and be developed by and have significant buy-in from health care professional organizations.

   5.2 To the extent possible, quality programs should be consistent with the QPP. PHPs should be rewarded financially provided they successfully meet or exceed goals for population health, patient experience of care (including quality and satisfaction) and total cost of care. Also, provider satisfaction and engagement should be measured and factored into any bonus structure.

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[4] Robert Woods Johnson Foundation. (2016) Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report. July 2016. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2016/rwjf428872.

[5] https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/core-measures.html

5.3 Full participation in, enabled by low cost connections to, the NC HIE and EMR interoperability are critical to our quality improvement efforts. If possible, having the NC HIE assimilate data needed to evaluate performance could relieve providers of the burden of submitting reports.

5.4 PHPs should be required to provide regular updates to providers on their performance on the current measures. Actionable data should be shared with network providers on a timely basis.

5.5 Achievement of quality goals established for providers should be an important part of the evaluation of PHPs; this will ensure PHPs are supportive of providers as they work to achieve quality goals.

5.6 Reduction of administrative burdens and ensuring adequate payment for performance will have a positive impact on patient experience and engagement. Patient experience is sometimes adversely affected by provider pursuit of established clinical guidelines such as the prescription of antibiotics, opioids, and lifestyle drugs, and related performance measures should account for this phenomenon.

6. **Paying for Value**: The NCMS strongly supports the move to value and a graduated approach to moving away from fee for service as the predominant payment methodology. PHPs should be incentivized to help move providers into value-based arrangements, based on the Triple Aim as defined by the Institute for Healthcare Improvement, in a deliberate and measured manner that minimizes disruption. NCMS welcomes an opportunity to work together with the Department and others to promote this goal.

6.5 PHPs should be able to demonstrate in their RFP response how they intend to work with providers to move them into value-based purchasing arrangements in a reasonable time frame. This should include what programs they will put in place to do this and how the PHP will support the providers in this journey.

6.6 Many providers still need education and training on value-based arrangements. In addition, developing the infrastructure to participate in most value-based arrangements is outside the financial and human resources of most smaller providers. PHPs could be asked in their RFP response to detail how they plan to assist providers through this transition.

7. **Increasing Access to Care and Treating Substance Use Disorder (SUD)**

7.1 In general, providing health coverage to the working poor will reduce the uncompensated care burden now carried by medical care providers and reduce cost shifting to employers who purchase health coverage for their employees. The options to extend coverage to this group include establishing categorical eligibility within Medicaid or identifying funds to subsidize coverage on the federally administered exchange. The State should amend its waiver application to include coverage for the working poor, financed to the greatest extent possible by federal funds.

With respect to SUD, increasing access to services for the SUD population can significantly reduce the rising costs of health care among the Medicaid population. As noted above, those with SUD and mental health diagnoses are best served through integrated health treatment in which primary care, mental and behavioral health, and SUD are integrated. This provides the opportunity for lower costs and better outcomes.

7.2 We believe the current Medicaid benefits structure and the essential benefits structure established for coverage offered in the federally administered exchange are appropriate.

To improve population health and reduce Medicaid costs, those with SUD need access to adequate behavioral health care using an integrated health care model providing physical, mental and behavioral health benefits.

7.3 DHHS should continue efforts to ensure mental and behavioral health parity and elevate the same medical and ethical standards of treatment for those with SUD as exist for patients with other chronic diseases. This population needs a simple, single path to accessing care to help with prevention, treatment, and ongoing recovery efforts.

It is imperative the Medicaid program is adequately resourced to ensure access to SUD care for enrollees. Prevention is needed to address the alarming trend in opioid related deaths and addiction. We encourage DHHS to encourage the use of CDC guidelines for prescribing opioids for chronic pain, and other tools available to them (e.g., Controlled Substances Reporting System, CME programs).

Coverage of Medication Assisted Treatment (MAT) and the counseling and behavioral therapies used for the treatment of SUD is an additional step to meet the needs of this population. Treatment needs to provide for evidence-based strategies for preventing opioid misuse and overdose. MAT programs need to be available throughout the state. Maintaining or expanding the MAT programs in the adult correction and juvenile justice division can be beneficial in treatment and ongoing recovery efforts.

We appreciate the opportunity to comment on these important issues identified by the Department. At the appropriate time, we would like to meet with you to discuss these comments in greater detail. Please let us know how we can support DHHS further in this effort.

Sincerely,

Stephen W. Keene
General Counsel