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Supporting Wellness, Equity, and Medicaid Transformation in North Carolina's Healthcare System

NC Medicaid Section 1115 Demonstration Waiver

Comments Regarding Objective 1 Initiative 1a

> ***"Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans. "***

In our experience, the ability to offer integrated, well-coordinated whole-person care for Medicaid beneficiaries relies upon the strength, stability, and resilience of Medicaid providers. This means that it is essential that Medicaid providers are systemically supported while undertaking this care delivery transformation envisioned and adjusting to the operational challenges inherent to the transition to managed care.

Comment 1:

What support or oversight does the Department envision for fair, effective, and responsive contracting between providers and PHPs?

The relationship between Medicaid providers and Pre-Paid Health Plans (PHPs) is governed, first and foremost, by contract. The Advanced Medical Home model and Medicaid Transformation are predicated on the flexibility of good faith contract negotiations between providers and PHPs. The Department has a critical and indispensable role in ensuring (1) fair and good faith contract negotiations between providers and PHPs that are consistent with the objectives and framework outlined by the State and (2) oversight of PHP adherence to contract protections of both providers and Medicaid beneficiaries.

North Carolina is fortunate to have a high number of independent provider practices compared to other states.[1] While this presents important advantages as it relates to the "health" of the State's health system – it is important to recognize the power disparity between providers (specifically independent providers) and PHPs. It is, unfortunately, too common for PHPs to be unwilling or operationally unable[2] to negotiate contract terms with smaller, independent providers. This includes everything from Care Management rates to other contract terms. During the implementation of Medicaid Managed Care, the Department had to intervene on multiple occasions, issuing guidance on its expectations on contract negotiations – and eventually establishing minimum care management rates.

The Department has recently communicated that it will not publish a minimum care management rate for AMH contracts between Standard Plans and providers going into the new procurement period. In our direct experience negotiating contracts with PHPs on behalf of providers absent this protection from the state, the PHPs intended to pay insufficient care management fees, between 2 and 4 times less than what NC DHHS ultimately identified as the likely cost of providing the required level of care management. Can the Department outline its rationale for this approach? Are there other supports or resources the Department anticipates having in place or utilizing to ensure the integrity and efficiency of provider contracting under the Standard Plans going forward?

Comment 2:

What support or oversight does the Department envision deploying to ensure timely adherence to contract terms by PHPs as may arise related to (1) claims administration, (2) appeals, and (3) systemic operational challenges?

The transition to managed care represented a huge operational transformation for many practices. The Department and all stakeholders are to be commended for the rapid troubleshooting associated with systemic operational issues that arose during implementation (particularly during the Public Health Emergency). We particularly wish to applaud the Department for the institution and maintenance of the AMH Technical Advisory Group and hope this workgroup continues. This monthly forum allows the Department to collect "real-time" stakeholder feedback and troubleshoot issues.

In addition to the AMH Technical Advisory Group, we encourage the Department to consider additional avenues and resources that the Department may use or have available to oversee PHP administration – particularly on operational issues impacting providers, particularly providers operating outside of a large health system. Again, we commend the Department for its efforts to track and resolve issues at a systemic and aggregate level. **However, we suggest that additional resources and infrastructure may be needed to collect direct feedback from smaller, independent providers as the aggregate level monitoring may not be**

sufficient to capture the day-to-day administrative and operational challenges experienced by many providers as it relates to issues such as (1) PHP responsiveness; (2) claims administration; and (3) appeals and claims disputes. In our experience, many providers feel "caught" navigating the various byzantine PHP operations and procedures. When issues fall through the cracks, it feels like there is no effective recourse.

We raise this question and concern because of our own experience related to the NC Medicaid Ombudsman. In one experience, a pressing issue regarding a PHP's failure to follow its procedures related to claims disputes and appeal procedures remained outstanding with the Ombudsman for nearly five months without any discernable action by the assigned representative, despite routine follow-ups and our updates to the Ombudsman of our independent efforts at resolution. While eventual, important progress was made, the experience was very frustrating and required the provider to expend considerable resources on external support and internal staffing to obtain any resolution.

We identify additional resources for the administration of the Ombudsman office as a necessary measure in the ongoing operation of Medicaid managed care. **There is a strong public interest in preserving the viability of smaller, independent healthcare providers across the State – particularly in rural areas**. **An important step in accomplishing this is to ensure that those providers are supported when seeking to address operational issues or otherwise enforce negotiated contract terms with PHPs.**

Comments Regarding Objective 2 – The Expansion of Healthy Opportunities Pilot Services

We are thrilled that the State has decided to expand the Healthy Opportunities Pilot (HOP) services and infrastructure to beneficiaries across the State. North Carolina is leading the nation in the design, deployment, and evaluation of the effective delivery and integration of health-related social needs through Medicaid, and we are very proud of the State's vision and the progress made by all contributing stakeholders.

Comment 3:

We suggest reframing and rephrasing Objective 2 to acknowledge the need to establish the necessary infrastructure and capacity development in non-pilot regions before being able to expand access to integrated services.

Our first comment relates to the phrasing and framing of the second objective, which is currently framed as "expanding access to a person-centered and well-coordinated system of care integrating both medical and non-medical drivers of health." We suggest that this should be reframed to more accurately reflect the diversity of preparedness or implementation of this desired future state of a person-centered and well-coordinated system of care that systematically addresses both medical and non-medical drivers of health.

We suggest the following revision of the objective so that it reads:

> *Establish or expand and sustain a person-centered and well-coordinated system of care that addresses both medical and non-medical drivers of health across the State.*

As currently phrased – where the focus is on expanding access – it sets an unrealistic expectation that the desired final state (namely a person-centered and well-coordinated system of care that addresses both medical and non-medical drivers of health) exists – and that it is primarily a matter of expanding access to this network and system to more people. While extraordinary and laudable progress has been made in this aspiration - this is not the case even in existing Pilot counties where HRSN services are already available. Acknowledging the evolving need for continued refinement, capacity development, and system transformation in no way undermines the significant and critical investments made by the State to date – or the stellar work of all stakeholders in launching this initiative. Instead, it simply illustrates the magnitude of the task – and the iterative nature of any transformation.

North Carolina's vision for integrating health and health-related social needs is revolutionary and transformative. Establishing the foundations for this level of complex system transformation will take more time and resources than a single waiver period. Developing the model and processes for implementing

that vision is iterative and evolving. There remains a great deal of network and capacity development work to be done – in addition to refining the administration of services in a way that is (1) sustainable, (2) equitable, (3) representative of community needs, and (4) imposes the least unnecessary burden on network Health Service Organizations. This includes requiring continued investment in and resources for current pilot regions.

We believe that it is a disservice to the Department's vision of care transformation to not fully and frankly recognize that even in a renewal of the waiver application, we are necessarily still developing, testing, and refining the model, which we hope will help us realize this objective of integrated, person-centered care, delivered in a manner that is well-coordinated, repeatable, and equitable.

We also offer the following additional comments and questions related to HOP Expansion for your consideration:

Comment 4:

We are pleased to see the allocation of capacity development funds for counties yet to be served by the Pilot. Does the Department anticipate allocating resources or support for HSOs in Pilot counties going forward? As explained above, the existing Pilot sites need ongoing investment to develop further the community's capacity to meet the community needs.

Comment 5:

In our experience and observation, there is a great diversity in the nature and scope of support needed by Health Service Organizations. Has the Department considered developing a plan to address HSO needs or maturity development at a state level? Frequently, the smaller organizations – the ones with the most immediate relationships within the community – and, therefore, with potentially the most significant impact, need the most assistance. We strongly recommend the Department, potentially in coordination with other State Agencies, consider creating an initiative to provide additional resources, capital funds, and technical assistance and support to smaller nonprofit organizations. This support for HSOs should include investments covering information technology, contract negotiation

and understanding, and continued compliance and billing support. Our experience working directly with a Network Lead and its HSO network has conclusively identified these needs, with many critical HSOs not participating in the pilot because of these needs and lack of capacity internally.

Comment 6:

While recognizing the need for flexibility, we encourage the State to provide greater guidance regarding the planned deployment of HRSN services across the state. For example, which domains (and services within those domains) are expected to be launched statewide? Information on the projected direction and format of expanded services will assist stakeholders seeking to support the expanded launch in capacity development planning and coordination with potential HSO partners. In addition to helping stakeholders in the State prepare for this next phase of Medicaid Transformation, we believe the Centers for Medicare and Medicaid Services will likely expect additional controlling criteria or navigational direction.

Comment 7:

One recurring concern identified through the State's stakeholder engagement and evaluation of the Pilot centered on questions around the sustainability of Pilot services and the administration of the HSO network going forward. Lack of clarity around the long-term sustainability of pilot service delivery was identified as a barrier to various HSOs in the pilot through stakeholder engagement and program evaluation. While this remains a "moving target," we firmly believe that planning for and communicating the Department's long-term strategy to sustain the infrastructure and networks developed through these waivers is critical. We strongly encourage the State to provide guidance on its expectations or aspirations regarding the sustainability of (1) Network Lead administration and support and (2) HRSN service delivery by HSOs. **Without this guidance, Network Leads and HSOs may feel they cannot take steps to implement sustainability efforts, which will significantly impede efforts later.**

Comment 8:

The Department highlighted the importance of the close communication and collaboration of Network Leads, PHPs, and the Department throughout the design and deployment of the Pilot. We commend the Department for the success of this complex implementation and rapid evaluation and

iteration. We agree that the structured collaboration and troubleshooting across stakeholders was critical to the pilot's effective implementation. **How does the Department anticipate maintaining this effective communication and collaboration level while expanding pilot services statewide?**

We strongly encourage the Department to plan for the same level of communication and collaboration in the next phase of the pilot – including the availability of the Network Lead's access to Department expertise and resources. We also recommend that the Department formally leverage existing Pilot Network Leads to support new lead entities as they enter the coalition.

Comment 9:

A big takeaway from the published evaluation of the pilot to date has been the depth of need across communities related to health-related social needs and, in some instances, the degree to which existing resources and networks struggle to meet those needs: housing being the pre-eminent example. Has the Department considered any statewide or regional plans to expand access to affordable housing to complement or dovetail with pilot services? While the Department is likely already well aware of other state's efforts in this area – we would like to highlight Washington State's inter-agency housing initiative (Apple Health and Homes), which provides capital development and other capacity development and support funding for organizations to assist in the recruitment and retention of participation in the state's Foundational Community Support Service program. While this pilot anticipates significant capacity development funds available to HSOs, **planning for additional funding and coordination from other state departments is likely to be (1) needed to meet needs and (2) advantageous to North Carolina's application to CMS, which has identified coordination across Department and demonstrating that the state has maintained or expanded state funding for HRSN programs external to Medicaid funding as a controlling criterion in its evaluation of new applications**.

Comment 10:

Finally, we wish to applaud the State on its HOP network design and the creation of Network Leads as a critical player in the pilot. Network Leads are responsible for essential administrative and operational tasks and represent

the needs and interests of diverse network HSO participants. Their depth of understanding of community needs and potential "levers" of influence is invaluable. **We strongly encourage the Department to draw upon the expertise and experience of the existing Network Leads in planning for and deploying HOP services and networks across the state. Similarly, we hope the infrastructure developed throughout this first phase of Medicaid Transformation is sustained and expanded**. Network Leads, as community-based organizations, serve as an essential bridge between health systems and human service organizations and constitute a critical "public forum" and center of innovation and transformation going forward.

[1] Provider consolidation has been associated with increased costs and, in some measures, stagnation or reduced quality by some metrics and reduced access in more rural communities. *See e.g.,* Karyn Schwartz, Eric Lopez et al, "What We Know About Provider Consolidation," Kaiser Family Foundation, September 2, 2020.

[2] A specific example of this is the use of PHP provider representatives who do not have the authority to negotiate any changes to the model contract.