

## **Medicaid Reform Recommendations**

### **January 15, 2014**

The North Carolina Providers Council is pleased to present our recommendations for transforming our state's Medicaid health care delivery system. Our organization represents a blend of the best providers of mental health, intellectual/developmental disabilities, substance use (mh/dd/sa), case management, and other Medicaid services within the state. Together, we envision a model that achieves health care reform, without sacrificing the specialized needs of the populations we support, including habilitative and rehabilitative supports, and also seeks to: 1) improve the health of persons supported; 2) enhance the experience of care, including quality, access, and reliability; and 3) control/ stabilize and improve the predictability of Medicaid spending.

#### **I. Health care delivery system model vision statement:**

We support a regional approach to services and supports with a strong emphasis on an integrated, person-centered model that embraces four MCO (Managed Care Organization) regions, as well as the six medical region introduced by Mr. Bob Atlas (See Draft Attachment A map that illustrates proposed overlapping medical and MCO regions). Our vision includes a health home approach for I/DD that expands the current health home State Plan Amendment (SPA) that CMS has approved for NC; and expands an integrated approach to care for persons with mental illness and addictive disorders, with specific attention given to prevention. We also envision a stronger focus on the health and crisis management of persons with co-occurring disorders (their care must be more effectively managed to affect real system's change).

#### **A. Regional models - Moving from our current model to a four MCO region and six medical region model may be a step in the right direction. Regional models offer an opportunity to improve efficiency and communication throughout the health care spectrum. Other opportunities exist to:**

1. Manage care more effectively through a better understanding of local community needs.
2. Minimize costs through more deliberate utilization of available local resources (enhance what exists rather than re- build/ start over). "The existing reservoir of disability-specific expertise within each region should be fully engaged in designing service delivery, financing strategies, and in performing key roles within the restructured system."<sup>1</sup>
3. Prioritize the use of scarce dollars based on goals for the state, but allow regions to provide incentives to address the unique needs of the local population and communities.
4. Increase efficiencies to move from a fragmented system to one of uniformity. Fewer administrative entities should bring streamlined, standardized processes that include: IT/ billing systems that communicate with each other; contract terms and requirements; quality and appropriateness of care coordination; monitoring methods and scoring interpretations; objective criteria used in determining qualified providers, and alignment of payment with outcome measures.

#### **B. Regional approaches also create some challenges that providers and MCOs are working together to address. (A regional model that builds on what has been cultivated over a decade may hold less risk than the unknown risks of a private managed care system, if certain challenges are addressed). We must:**

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<sup>1</sup> National Council on Disabilities (NCD), "Guiding Principles of Managed Care," March, 2013.

1. ***Minimize further erosion of an already fragile provider system and limit disruption of services for Medicaid recipients.*** We strongly urge that collapsing the regions to fewer entities should not become another de-stabilizing force for providers and families. We must work to stabilize our provider base by limiting the requirements for movement to the new system and set reasonable, but firm timeframes for completion so as not to increase provider costs, overly burden a workforce that is already suffering from *reform fatigue*, and cause families and consumers to experience more angst and dissatisfaction with the system.
2. ***Remove barriers to access to services as consumers move freely within the state and between MCO/ medical regions through the use of reciprocal agreements between managed care entities.*** Recipients should experience seamless transition and access to services from one region to the next - and when possible, “should be able to retain existing physicians, other health practitioners, personal care workers, and provider support agencies that are willing to adhere to plan rules and payment schedules.”<sup>2</sup>
3. ***Address communication and care coordination challenges that will continue to exist due to disparate medical/ MCO models that both manage crucial health care partners and systems.*** To achieve integration/ population health management strategies, enhanced care coordination and communication between MCOs, CCNC, hospitals, primary care physicians, specialists, and specialty providers is the linchpin to success. We believe that one entity must serve as the “quarterback” to ensure adequate access, coordination between health care providers, and compliance with all treatment modalities. We encourage NC to consider a model adopted by Arkansas that requires “certified providers” to serve as Principal Accountable Providers (PAPs) and *who are given financial incentives to support the cost and appropriateness/ intensity of care coordination.*<sup>3</sup>
4. ***Develop a mechanism that ensures increased meaningful stakeholder involvement which will become more complicated with the creation of larger MCO regions and with the adoption of multiple medical models.*** Significant progress has been made through the MCO/Provider Stakeholder Workgroup initiative and such partnerships should be continued. Providers and other critical stakeholders must be included in all decision-making roundtables. Managed care rules set out at 42 CFR 438 stress the importance of stakeholder involvement and require states to demonstrate all efforts used to engage stakeholders. We would like to see stakeholder involvement become sought after, with meaningful dialogue, and incorporation of relevant ideas.
5. ***Hold MCO’s and providers accountable.*** NC needs to invest more fully in: 1) coordinated IT systems throughout the spectrum of care; 2) training to improve business acumen within MCO regions; and 3) skill development related to the interpretation and use of evidenced-based population management data analytics that include both behavioral and physical health indicators. We also respectfully request that MCOs be required to be transparent in all financial practices: 1) Authorizations and payments must be processed timely. 2) The Affordable Care Act specifies that managed care entities are to submit data on the proportion of dollars spent on clinical services and quality improvement (medical loss ratio). CMS specifies that expenditures of at least 80% or 85% of Medicaid dollars be spent on services.<sup>4</sup> This should be increased to 90% of Medicaid dollars to be spent on services. 3) MCOs should be expected to use reserves during times of economic growth for services. “It is important to keep in mind that use of budget stabilization reserves is not in and of itself a credit weakness. The reserves are clearly in place to be used [prudently].”<sup>5</sup> 4) The MCO service array should be monitored to ensure that there is not an over-

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<sup>2</sup> NCD’s, “**Guiding Principles of Management Care.**”

<sup>3</sup> **Arkansas Health System, State Innovation Plan** (submitted to CMS 9/21/12), p3.

<sup>4</sup> Medical Loss Ratio, CMS.gov

<sup>5</sup> “**A Balanced Approach to Closing State Deficits,**” by Iris J Lav and Dylan Grundman, Center on Budget and Policy Priorities, 2011.

reliance on the least expensive services, to the detriment of high needs consumers who may need treatment and/or habilitation services. 5) Waiting lists should be made public along with plans to address the immediate needs of people waiting for services. 6) Continuation of benefits provisions, pursuant to the managed care rules of 42 CFR 438, “should be rigorously enforced in health and long-term service reform waivers and mandate that any savings achieved through reduced reliance on institutional care be reinvested in home and community-based service expansion and improvements.”<sup>6</sup> 7) *Finally, contracts between MCOs and providers should represent bi-lateral agreements that are fairly negotiated with providers, entered into with promises made by both parties, adequate consideration, a detailed scope of agreed upon work, and specific performance that leads to satisfaction of services by the MCO and the person/family supported.*

**C. Integrated, person-centered care/ population management: CMS gave state Medicaid director’s detailed analysis of its expectations for “integrated care models (ICM),” which include accountable care organizations, accountable-like models, and medical homes.<sup>7</sup> The Affordable Care Act provides a “health home option” for enrollees with chronic conditions which are also considered an ICM.<sup>8</sup>**

**Integrated Care Models (ICMs) must include:**

1. **Person-centered planning** that promotes choice and desired outcomes of the person’s served and focuses on the identification and improvement of a person’s deficiencies and strengths throughout the planning process. “All managed care delivery systems must be capable of addressing the diverse needs of plan enrollees on an individualized basis.”<sup>9</sup>
2. **Delivery system reform: structural, technological, and programmatic reforms and new financial incentives can form the basis for high performing Medicaid systems.** Much work needs to be done in NC to accomplish integrated care for Medicaid recipients who are aged, blind, or disabled and who have chronic illness, as well as for those considered dual eligible. The NC Providers Council believes that this work needs to remain within the purview of the Division of DD/MH/SA providing oversight to MCOs who work with specialty providers in each region. The health home model is an essential part of various reform efforts as evidenced by the work in Arkansas, Connecticut, Delaware, Indiana, and Maine, and is also a successful and nationally recognized model in Missouri for the mental health community.<sup>10</sup>
3. **Collaboration:** Broad system transformation is only achievable by partnership between the state, consumers, providers, MCOs, and other stakeholders.<sup>11</sup>
4. **Enhanced access:** Consumers must have the ability to choose a provider within the health home paradigm and have access to appropriate routine/urgent care and clinical advice/ information at all times, whether in-person, by phone, or via tele-health technologies. Use of social media, coaching, and mobile applications will also increase a person’s/ family’s engagement in health management.
5. **Risk stratified, tailored care delivery:** Providers must have readily available data analytic information, both behavioral and medical, including health risks, clinical diagnoses and severity, as well as information regarding functional status and family or other support structures, ensuring

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<sup>6</sup> NCD’s, “Guiding Principles for Managed Care.”

<sup>7</sup> SMDL# 12-001, ICM# 1, “Integrated Care Models,” letter to State Medicaid Directors, July 10, 2012.

<sup>8</sup> SMDL# 10-024, ACA# 12, “Health Homes for Enrollees with Chronic Conditions,” letter to State Medicaid Directors, November 16, 2010.

<sup>9</sup> NCD’s, “Guiding Principles of Managed Care.”

<sup>10</sup> **Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014**, by Vernon K Smith, PhD, Kathleen Gifford and Eileen Ellis, Robin Rudowitz and Laura Snyder, Kaiser Commission on Medicaid and the Uninsured.

<sup>11</sup> SMDL# 12-001 ICM #1 Re: Integrated Care Models letter from CMS to State Medicaid Directors, July 10, 2012.

the type and intensity of care is tailored to each individual and to similar populations. The availability of administrative (claims) data and data analytic tools is a critical start for providers in better understanding and utilizing data to inform care and lower costs. (Note: A pilot project is currently underway between a member agency and CMT, a data analytics company and several MCOs.)

6. **Evidence-informed, shared decision making:** Providers consult with Medicaid recipients about person-centered treatment options, making decisions on clinical care that reflect both (a) an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness, and (b) patient needs and preferences. This collaboration is not possible without: (1) evidenced based information readily in the hands of providers; (2) data transparency with providers and consumers/ family caregivers; and (3) the development of payment models that adequately cover the cost.
7. **Team-based care coordination:** Multi-disciplinary teams, including primary care providers, care coordinators, and other support providers must collaborate to improve care planning, diagnosis, treatment, patient coaching to ensure treatment adherence, and management through transitions of care. Teams extend their reach beyond the walls of the hospital or physician's office to include CABHA's and/ or certified health home providers (depending on disability), pharmacists, CAP-C case managers, CAP-DA case managers, care coordinators and others. Comprehensive care coordination cannot occur without a technological infrastructure that allows for data exchange.
8. **Enhanced practice metrics:** Providers understand the cost, quality, and health outcomes of care for people supported.<sup>12</sup> Identifying and implementing practice measures that track true clinical outcomes and properly incentivize providers to move in the direction that NC DHHS desires is a central component to Medicaid reform.

**II. Innovative funding models that are less burdensome and provide incentives for quality care have been suggested by the state, including: 1) pay for performance; 2) shared savings; 3) episode bundled payments; 4) partial capitation; 5) total capitation.**

The NC Providers Council respectfully requests that providers be intimately involved in the planning and implementation of any or all payment models and encourages the development of innovative pilot models. Each model must be carefully crafted by experienced health care and financial analysts who understand how to determine actuarial soundness, and fair and reasonable cost finding and rate structure; and with the assistance of providers who understand the difficulties in operationalizing services that are financially unsustainable and/ or result in inadequate care. We urge NC to start with an innovative payment pilot that might ferret out unintended consequences as well as shine a light on the technical merits that should be replicated. The episodes of care payment option for behavioral health might be a good pilot option because it is designed to align payment with performance. According to Arkansas, episode bundled payments that properly incentivize providers have the potential to deliver person-centered, coordinated, evidence-based care, that is outcome-driven<sup>13</sup> In a discussion with Arkansas' Medicaid Director, however, this funding model has not been implemented and plans are to move forward in July of 2014. (Also note: We recently learned that Connecticut and New Jersey are returning to 'fee for service' models after a pilot).

Providers are eager to continue to work with the Department and MCOs to reduce administrative burdens that create unnecessary costs. However, reductions in rates (including those used in shared savings plans) will result in provider closures and create gaps in service delivery and impact timely access to care. A rate that is actuarially sound must first establish the cost of

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<sup>12</sup> **Arkansas Health System Transformation, State Innovation Plan** (submitted to CMS September 21, 2012) pp 17, 18.

<sup>13</sup> Developmental Disabilities Workgroup Agenda, Arkansas, p. 1, 2012.

service before any savings can possibly be attained. CMS provided guidance regarding financial models to support state efforts to integrate care for Medicare-Medicaid enrollees on July 8<sup>th</sup>, 2011. The document specifically mentions two financial alignment models. The first model is a capitated approach to integration for Medicare-Medicaid enrollees; the second is a managed fee-for-service approach to integration. *Under the capitated model, CMS states that the model would target aggregate savings through “actuarially” developed blended rates.*<sup>14</sup> *“States electing to compensate managed care contractors through a capitated payment system should adopt a fair, equitable, and transparent methodology for calculating and adjusting payment rates.”*<sup>15</sup>

### **III. Health care workforce development**

Addressing the health care workforce is critical to transforming the care delivery system. Not only is there a general provider workforce shortage, but particularly in primary care, mh/dd/sa services, and dentistry; and also in physicians geographically concentrated in larger cities which creates health care delivery shortages and care coordination challenges, especially in rural and poorer counties. The direct support workforce (personal care and habilitation assistants) is also a critical component of an efficient, low- cost system that poses current challenges. The University of Minnesota, and other academic centers that have researched this class of workers, predicts a critical shortage of direct support professionals in the next five years. A competitive wage is necessary to prevent costly turn-over, instability in service delivery, health and safety issues, and dissatisfaction of services by beneficiaries.

### **IV. Use of Technology**

Aside from informatics technology, we believe that use of other kinds of technology could reduce costs and improve quality. Technology might include remote monitoring, use of the internet in developing employment opportunities/ small business ventures, mobile applications that help to improve a person’s own accountability in health care management, social media, software applications used to enhance habilitative and rehabilitative efforts, etc. However, use of these technologies must take into account: capital costs for hardware and software, privacy and ethical issues, HIPAA concerns, an analysis of whether remote monitoring might hamper efforts to assist in integration into the community, and an examination of controls needed to prevent exploitation of persons supported by disgruntled employees and/ or families.

### **V. Affordable Care Act (ACA)**

Finally, while Medicaid expansion may not be in NC’s near future, we believe that there are some benefits in the ACA, particularly those relating to prevention that should be explored for purposes of cost reduction and improved quality care for NC’s low-income citizens. These preventative measures would be particularly beneficial for people who present with mental illness and substance use disorders in staving off more expensive services needed due to a lack of early detection. Some successful approaches adopted by some Republican administrations to leverage federal dollars for low-income residents through insurance exchanges, include efforts in Pennsylvania, Arkansas, and Iowa. In Pennsylvania, Republican Governor Tom Corbett posted a draft Medicaid waiver that would allow the state to collect federal Medicaid funds to help low-income residents buy coverage in the health insurance exchange established under the ACA. In addition to following Arkansas’ lead in steering Medicaid beneficiaries into private insurance plans, it calls for those who make more than 50% of FPL to pay monthly premiums, and it requires working-age recipients to prove employment or demonstrate efforts to find a job. The plan would extend coverage to as many as 500,000 of the state’s poorest residents beginning

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<sup>14</sup> SMDL@ 11-008, “**Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees,**” a letter to State Medicaid Directors, July 8, 2011.

<sup>15</sup> NCD’s, “**Guiding Principles for Managed Care.**”

January 1, 2015. <sup>16</sup> Iowa has also used the federally-facilitated insurance exchange to assess eligibility and then to transfer low-income adults to the federal exchange, utilizing federal dollars, beginning January 1, 2014. <sup>17</sup>

**The North Carolina Providers Council appreciates the opportunity to submit these recommendations. For questions or additional information, please contact Bob Hedrick, MA ED, Executive Director, NC Providers Council, [bob.hedrick@ncproviderscouncil.org](mailto:bob.hedrick@ncproviderscouncil.org) , 919-784-0230.**

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<sup>16</sup> “Briefs”, **Modern Healthcare**, p. 2, December 9, 2013 edition.

<sup>17</sup> “Iowa Medicaid Moving Forward in 2014”, [www.Medicaid.gov](http://www.Medicaid.gov)