

Public Input Summary

Introduction

The Department of Health and Human Services is dedicated to improving the health and well-being of all North Carolinians. Medicaid and NC Health Choice programs, which cover more than two million people (about 20 percent of the state's population), hold crucial roles in the Department's efforts to build a healthier North Carolina. These two programs cover over half of births in the state, long-term care for vulnerable seniors and services for those in our communities with disabilities.

The Department is in the process of shifting administration for most Medicaid enrollees to a managed care system. In June 2016, a proposal was submitted to the federal government related to transitioning Medicaid to managed care. Since then, the Department has continued to listen to and talk with North Carolinians about how to make the state healthier.

Through these ongoing conversations, several topics were identified as particularly important to the design of a successful Medicaid managed care program. Recently, the Department asked for comments through a series of public input sessions across the state, and in writing or by phone message.

From April 25 through May 25, 2017, the Department received approximately 700 comments related to improving Medicaid. This Public Input Summary provides the major themes from those comments, organized by the questions covering the seven topics in the [Medicaid and NC Health Choice Request for Public Input](#) document. At the end of the summary, feedback on other subjects is included. Senior leaders in the Department and Medicaid will use the public input as they consider whether modifications are needed to the proposal submitted in June 2016.

The Department sincerely appreciates the valuable, thoughtful comments received and is committed to continuing this open and collaborative process to build a strong, efficient Medicaid program. Thank you for sharing your ideas, thoughts and recommendations.

About This Summary

Each comment received during a public input session, in writing or by phone was reviewed by the Medicaid transformation team and used to identify overall major themes. To ensure the privacy and confidentiality of those who submitted comments, no names are listed in this summary. A list of abbreviations and acronyms used in this summary is included at the end.

Additional feedback is always welcome. Please send written input to:

Email: Medicaid.Transformation@dhhs.nc.gov

U.S. Mail: Department of Health and Human Services, Division of Health Benefits,
1950 Mail Service Center, Raleigh NC 27699-1950

Drop-off: Department of Health and Human Services, Dorothea Dix Campus, Adams Building,
101 Blair Dr., Raleigh NC

Send questions about North Carolina Medicaid transformation to Medicaid.Transformation@dhhs.nc.gov. For more information, visit ncdhhs.gov/nc-medicaid-transformation.

1. Physical and Behavioral Health Service Delivery

1.1 What are the opportunities and risks associated with integrating behavioral health services with physical health services? Should North Carolina pursue an approach of integrating physical and mental health services earlier than four years after the managed care transition?

Many commenters recommended that the Department integrate physical and behavioral health services, with several requesting that this integration occur earlier than four years after the managed care transition and/or as soon as possible. Most commenters who voiced an opinion on integration timing recommended accelerating the currently proposed timeline. Commenters noted that such integration would reduce fragmentation in care and create a single point of accountability for the outcomes of patients with behavioral health needs. A few noted that this integration would benefit from Department support, particularly technical support (e.g., integrating information technology infrastructure), training/education programs, and support to create a collaborative environment among providers (e.g., co-locating behavioral health and primary care services).

Department Response. *The Department seeks to integrate physical and behavioral health services as quickly as possible while minimizing care disruption. The Department appreciates the comments and concerns regarding how such an integration could be accomplished.*

1.2 How can the Department best integrate care delivery for individuals with lower intensity, lower frequency behavioral health needs? Should these individuals be enrolled in a traditional prepaid health plan with the expectation that both physical health and behavioral health services be covered?

Several commenters indicated support for a design where lower intensity or lower frequency behavioral health needs would be covered in an integrated manner within the context of a traditional pre-paid health plan (PHP) that also would cover physical health services. A few commenters recommended integrating additional services into these traditional PHPs for patients with greater needs, including a robust set of substance use disorder services. Many stressed a need for increased funding and improved access to mental health services and resources for these populations, particularly for children and adolescents. A few also recommended that the Department take steps to reduce the administrative burden on health professionals for integrated behavioral health (e.g., streamlined processes).

Department Response. *The Department is committed to ensuring quality care delivery for beneficiaries with lower intensity and/or lower frequency behavioral health needs. The Department appreciates the comments and concerns received on this subject.*

1.3 Should North Carolina use Special Needs Plans (SNPs) to cover the physical and behavioral health services for individuals with serious mental illness, intellectual and developmental disabilities (I/DD) or moderate to severe substance use disorder? If so, how should these plans be structured, and what requirements or protections should be included to ensure access to crucial benefits and specialized care management? Are there any special considerations for the delivery of I/DD services, including the Innovations Waiver, through SNPs?

Many commenters recommended that individuals with serious mental illness, I/DD, or moderate to severe substance use disorder receive integrated behavioral and physical health services through SNPs, particularly if those plans would provide an enriched benefit package that included care management and support services

tailored to the unique needs of their populations. A variety of recommendations regarding potential SNPs were proposed, including rigorous requirements for access and network capacity, quality requirements, physician leadership, need for oversight, and the inclusion of social determinants of health. A few commenters felt that certain populations should have the choice to be in a traditional PHP or SNP, such as patients with low acuity behavioral health needs or those with disabilities. One commenter indicated a preference for a statewide or multi-region SNP. Several advocated for a whole person care approach in addressing behavioral health and I/DD needs.

Department Response. *The Department is committed to ensuring quality care delivery for beneficiaries with serious mental illness, I/DD and moderate to severe substance use disorders. The Department appreciates the comments and concerns received on this subject.*

1.4 How can Medicaid assist LME/MCOs (local management entities/managed care organizations) in transitioning to an integrated managed care system (e.g., helping LME/MCOs prepare to offer SNPs?) How can the Department best design an appropriate governance model for integrated managed care and how can Medicaid facilitate the implementation of that model?

Several commenters recommended ways that Medicaid can assist LME/MCOs with this transition and recommended an appropriate governance model. Recommendations included collaborating with LME/MCOs to develop minimum requirements for LME/MCO participation in SNPs; giving LME/MCOs standard guidelines and quality metrics; allowing PHPs to subcontract with LME/MCOs; ensuring provider and community participation in plan governance; covering enriched benefits for special populations; and outlining care coordination and data-sharing requirements. One commenter recommended that LME/MCOs be given the opportunity to lead whole person care for the SNP population, while another recommended that LME/MCOs not take on this role.

Department Response. *The Department acknowledges that LME/MCOs will require support in transitioning to an integrated managed care system, and looks forward to working with LME/MCOs and other stakeholders throughout any transition to ensure seamless access to care for beneficiaries. The Department also understands the importance of an appropriate governance model for integrated managed care, and is committed to designing and implementing such a model with care and deliberation. The Department appreciates the comments and concerns received on this subject.*

1.5 If not through Special Needs Plans, how should North Carolina ensure delivery of integrated physical and behavioral health for individuals with serious mental illness, I/DD, or moderate to severe substance use disorder?

A few commenters felt that SNPs were not necessary and/or proposed alternative approaches to ensuring integrated care delivery for these populations. One commenter suggested that these populations could be managed by traditional PHPs with a special capitation rate. Another recommended that qualified experienced health plans manage care for these populations within a traditional PHP. A few recommended carving out I/DD populations from managed care and maintaining a fee-for-service structure for this population.

Department Response. *The Department is committed to ensuring quality care delivery for beneficiaries with serious mental illness, I/DD and moderate to severe substance use disorders. The Department appreciates the comments and concerns received on this subject.*

Other themes

Several commenters advocated for maintaining or expanding the Innovations Waiver program for I/DD beneficiaries. A few recommended that the Department require a whole person care approach from practices and clinics and/or screen providers for an ability to provide whole person care. A few recommended expanding the availability of community-based services for mental health and providing a consolidated list of all such services covered by the Medicaid and NC Health Choice programs.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

2. Supporting Provider Transformation

2.1 How can the State minimize administrative burdens on providers as Medicaid transitions to managed care (e.g., standardized provider notifications, standardized data-sharing requirements)?

Many commenters underscored the importance of minimizing administrative burdens on providers as Medicaid transitions to managed care. Recurring suggestions to accomplish this included standard processes and protocols (e.g., standard fee schedules, contract terms, claims requirements, data-sharing requirements and prescription drug list); centralized credentialing; create a single portal for all claims processing; automatic enrollment of newborns; and expanded presumptive eligibility. In addition, some commenters mentioned simplifying or shortening existing processes (e.g., enrollment, verification, credentialing) or increasing automation (e.g., reconciliation for federally qualified health center reimbursement) as ways to reduce administrative burden on providers.

Department Response. *The Department understands it is important to minimize administrative burdens on providers whenever possible and is committed to continuously exploring ways to do so. The Department is investigating centralized credentialing and other administrative simplification techniques, building on best practices in other states, and appreciates the comments and concerns received on this subject.*

2.2 What support will be necessary to assist in the transition to managed care for small providers and providers in rural or underserved communities?

Many commenters highlighted that small and/or rural providers will have unique support needs as Medicaid transitions to managed care, in part due to the disproportionate impact that administrative requirements can have on these providers. Recurring themes included the need for significant implementation support (particularly technology and data), upfront and ongoing provider engagement (including coaching/training for clinical and non-clinical staff, particularly on adhering to claims/billing requirements, performance standards and managing referrals/coordination), and assistance with developing telemedicine and telehealth capabilities. A few recommended modifying certain guidelines (e.g., criteria to qualify as an advanced medical home, ability to engage in community-level care coordination) for small and/or rural providers to encourage participation.

Department Response. *The Department acknowledges that smaller providers and providers in rural or underserved areas may face additional barriers to undergo the transition to managed care. The Department looks forward to working with these providers to support their needs, and appreciates the comments and concerns received on this subject.*

2.3 What are the primary opportunities and barriers for providers interested in establishing provider-led entities (PLEs)? What, if any, support or special accommodations should be made to facilitate the creation of PLEs?

Some commenters noted the importance of maintaining parity between PLEs and traditional PHPs, recommending that the Department take steps such as prohibiting exclusive provider contracts, requiring PLEs to contract with all health plans, and holding PLEs to the same requirements as traditional PHPs (e.g., licensure and solvency standards). Other commenters recommended that the Department encourage the formation of PLEs by, for example, maintaining flexibility for PLE minimum capital requirements or developing processes to equitably distribute members across all PHPs and PLEs. Commenters also highlighted the importance of fostering competition in the managed care market to increase stability and member choice while maintaining rigorous standards for qualifying as a PHP to ensure that that all PHPs meet the needs of enrollees and providers.

Department Response. *The Department acknowledges that there are both opportunities and barriers for providers interested in establishing PLEs. The Department looks forward to continuing to engage our stakeholder community to understand what, if any, support or special accommodations should be made to facilitate the creation of PLEs, and expects to engage in a more formal solicitation of interest later in 2017. The Department appreciates the comments and concerns received on this subject.*

Other themes

Many commenters recommended preserving the Community Care of North Carolina (CCNC) care management infrastructure. Many commenters recommended that the Department increase Medicaid provider reimbursement (e.g., reimbursing at par with Medicare rates), including general increases and targeted increases for specific services or specialties. A few recommended that the Department help expand responsibilities for services provided by non-physician providers (e.g., nurses) as one mechanism to address workforce shortages. A few commenters advocated for a variety of supports, including an ombudsman program, increased continuing medical education support, and maintained PMPM (per member per month) payment and information technology support for medical homes.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

3. Care Management and Population Health

3.1 Should North Carolina consider developing standardized, statewide criteria and a certification process for providers to qualify as advanced medical homes under Medicaid?

Many commenters expressed support for the medical home model and the need for standardized criteria. Most commenters recommended North Carolina institute a certification process in alignment with existing national standards (e.g., the National Committee for Quality Assurance (NCQA) patient centered medical home (PCMH) standards or the Centers for Medicare & Medicaid Services (CMS) standards under the Quality Payment Program). Several commenters suggested national criteria would be sufficient for accreditation, while a few recommended the Department incorporate additional elements, such as standards used by other major payers in the state. A few commenters recommended that the Department not designate specific functions to be included in health plan contracts with medical home providers. Some commenters also highlighted the importance of enhanced financial resources within the medical home model.

Department Response. *The Department believes that supporting the medical home model is an important component in the achievement of North Carolina's health care goals. The Department appreciates the comments and concerns received on this subject.*

3.2 If North Carolina adopts a qualification or certification process for advanced medical homes, please comment on possible guiding principles or factors that should be considered to ensure success (e.g., alignment with other payer programs, specific infrastructure requirements, performance measures).

Several commenters recommended guiding principles for North Carolina's advanced medical home model, with recurring themes including quality/outcomes improvement, patient experience, continuity of care, incentives for innovation, and alignment or collaboration with existing efforts across the state (e.g., PHM efforts). Some commenters recommended specific demonstrated capacities that a qualifying advanced medical home should possess, including the ability to coordinate behavioral health and substance use services, provide comprehensive care management, provide chronic disease management, leverage data analytics, link with community and social supports, and provide high-quality services informed by evidence-based clinical practices. A few commenters also advocated for building on the strong foundations of North Carolina's existing primary care case management (PCCM) and PCMH models.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

3.3 Should the Department contractually mandate that prepaid health plans provide an enhanced care management fee to support delivery of care coordination and care management services to advanced medical homes practices?

Several commenters agreed that the capabilities and infrastructure required for care management and advanced medical home capabilities require investment that should be appropriately compensated. Several recommended that the Department mandate an enhanced care management fee, with recurring themes on payment structure including a flat or acuity-adjusted PMPM add-on payment. A few recommended flexibility and creativity in compensation structures for these payments, such as tying payments to incentive programs or otherwise aligning provider incentives with driving innovation in care delivery.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

3.4 What strategies should the Department consider for providers who may face barriers to meeting the care management criteria, such as small and rural providers?

Several commenters proposed strategies for the Department to take to support small and/or rural providers to implement effective care management. These strategies included ensuring the existence of regional care management organizations that can provide care management services for small providers that lack the scale to provide these services independently (or allowing small providers to develop community-level or multi-provider strategies for care management), requiring PHMs to demonstrate plans to support small/rural providers with care management and population health management during the RFP process, allowing small providers to develop community-level or multi-providers strategies for care management, and providing standard quality data to practices.

Department Response. *The Department acknowledges that smaller providers and providers in rural or underserved areas may face additional barriers to meet care management criteria, and looks forward to*

working with these providers to support their needs. The Department appreciates the comments and concerns received on this subject.

3.5 What types of population health management support should prepaid health plans provide to providers that would assist them in effectively managing care for beneficiaries, particularly those with the most complex needs?

A few commenters made recommendations regarding support that prepaid health plans should offer to providers for population health management. Commenters highlighted the important role that PHPs play in collaborating with providers to coordinate care and (particularly with providers with the most limited capabilities) to identify and implement successful strategies. A few commenters noted that PHPs should provide regular, standardized quality data to providers, and support management of data and service utilization. Two commenters recommended that PHPs be required to demonstrate their population health or care management support plans in their RFP responses. Other recommendations related to PHP population health management support included employing hotspotting techniques to identify high-risk patients, integrating community pharmacies into the medical home infrastructure, and providing monthly patient assignment lists. One commenter noted that services such as medication reconciliation, home visits and transportation intervention are not likely to be supported by MCOs unless required.

Department Response. *The Department is committed to facilitating effective population health management in North Carolina. The Department appreciates the comments and concerns received on this subject.*

3.6 Please comment on the types of services and supports that are best managed at the local provider/practice level and that can best be supported at the prepaid health plan level.

A few commenters noted that, given their scale and experience, PHPs are best-suited to activities such as data and utilization management, population health strategies, technology support, and reporting. Commenters noted that providers/practices are best suited to activities such as care management, care coordination, promoting healthy behaviors, providing follow up care, educating patients and making referrals (including referrals to social supports).

Department Response. *The Department acknowledges that PHPs and providers bring valuable experiences and capabilities that can complement one another in a managed care environment, and is committed to aligning roles and responsibilities with owners who are best-positioned for success. The Department appreciates the comments and concerns received on this subject.*

Other themes

Many commenters emphasized the support providers receive from case managers as important for local care management and population health. Multiple commenters recommended the following actions to improve care management: increase funding/focus on preventive care, embed case managers in practices, create health education programs and improve care coordination throughout the system.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

4. Addressing Social Determinants of Health

4.1 How can the State help providers, community-based organizations and prepaid health plans further integrate and coordinate health care delivery, social support services and targeted interventions regarding social and environmental determinants of health?

Many commenters acknowledged the crucial role of addressing social determinants of health in providing care for North Carolina's Medicaid population, and expressed support for the Department and other stakeholders to do more to integrate health care delivery with social service supports through targeted interventions. Commenters highlighted ways to achieve such integration, including pursue CMS support to establish programs that address social determinants of health within Medicaid; lead development of standardized screening and assessment tools; leverage health technology and data to help identify effective interventions; establish formal referral protocols between PHPs and social services; provide community health worker certification and reimbursement; work with local partners to raise and address unmet resource needs; encourage co-location of health care providers and social services; and allocate flexible funding to pay for emergent unmet resource needs.

Department Response. *The Department understands the importance of addressing social determinants of health in serving North Carolina's Medicaid population, and is committed to supporting our stakeholders to identify and address unmet resource needs, and to identify and encourage the most effective interventions. The Department appreciates the comments and concerns received on this subject.*

4.2 What types of strategic investments in infrastructure to address unmet resource needs (e.g., housing, nutrition, utilities, safety) would have the most significant positive impact on the health of North Carolina communities?

Commenters recommended a wide variety of potential strategic investments to address unmet resource needs. The most commonly cited investments included supportive housing (particularly for beneficiaries with complex chronic conditions), and nutrition and food insecurity interventions (such as identifying and addressing food deserts). Other recommended areas on which to focus included health insurance coverage, utility assistance, transportation, child care, job supports, education support, economic development, legal assistance, safety initiatives and public health initiatives.

Department Response. *The Department acknowledges that there are a wide variety of potential interventions and infrastructure investments that can play an important role in addressing the unmet resource needs of many of our beneficiaries. The Department looks forward to ongoing stakeholder engagement to continuously identify and support the interventions that have the largest positive impact on our communities, and appreciates the comments and concerns received on this subject.*

4.3 Please comment on the types of investments that would be best managed at the local provider/practice level and those that can best be supported at the state level.

Several commenters noted that certain types of investments and activities would best be managed at the Department or plan level, including securing flexible funds; building data-sharing capacity; making benefit package changes; developing certification and training processes; streamlining or expanding eligibility and enrollment entry points; developing financial incentives to address social determinants of health; and compiling a comprehensive social determinants of health resource inventory. Several commenters noted that other types of investments and activities would be best managed at the local/provider level, including

collecting social determinants of health data (e.g., through screening and assessment tools), distributing funds and allocating temporary assistance for crucial unmet resource needs, and performing on-the-ground care management and care coordination activities. Several commenters requested flexibility to use funds at the local level given the diversity and context-dependence of social needs.

Department Response. *The Department acknowledges that prepaid health plans and providers bring valuable experiences and capabilities that can complement one another in a managed care environment, and is committed to aligning roles and responsibilities with owners best-positioned for success. The Department appreciates the comments and concerns received on this subject.*

4.4 What actions can be taken by the State to help providers integrate social and environmental determinants of health into their care for patients and communities? What are the biggest capacity or infrastructure gaps?

Commenters recommended several actions that the Department could take to support providers in their integration of social determinants of health into care delivery. Several stressed the importance of facilitating communication and collaboration among providers, patients, plans and community organizations. A few noted the importance of ensuring adequate financial resources are in place for investment in local infrastructure, data-sharing capabilities and effective interventions. Other commenters highlighted the need for financial incentives to support these efforts (e.g., global capitated payments to providers) and for a clear measure set and assessment process to define and track success. One commenter noted the important role that pilots and demonstration programs could play in addressing social determinants of health.

Department Response. *The Department acknowledges that it holds an important role in helping providers integrate social and environmental determinants of health into standard care processes, and is committed to delivering on that role to the greatest extent possible. The Department appreciates the comments and concerns received on this subject.*

Other themes

One commenter recommended the Department ensure appropriate supports are in place to support small and/or rural providers as they build the capabilities and infrastructure necessary to address social determinants of health. A few recommended creating or strengthening linkages between Medicaid and specific other entities, including Social Security, public schools, behavioral health resources and substance use disorder services. Commenters noted that it is important to create culturally tailored protocols, focus on early childhood and prenatal interventions, and expand the number of entry points into Medicaid as important aspects of a comprehensive social determinants of health strategy.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

5. Improving Quality of Care

5.1 What quality measures should be used? What quality measures will improve outcomes while rewarding value? How can the unique needs of special populations best be considered when creating quality measures?

Many commenters recommended guiding principles for the selection of quality measures, emphasizing a standardized set of quality metrics across PHPs that is consistent with other payers and with common national metrics such as Healthcare Effectiveness Data and Information Set (HEDIS), Physician Quality Reporting System

(PQRS) and NCQA. Commenters recommended using measures from across the continuum of care, with specific quality measures recommended for chronic respiratory conditions (particularly asthma and COPD), diabetes, HIV management, social determinants, inpatient and emergency department utilization, readmission, immunization, and care coordination and management (e.g., medication adherence). A few commenters recommended adopting specific measures for certain special populations (e.g., individuals with I/DD, pregnant mothers, newborns); and measures tailored to unique settings, such as schools or skilled nursing facilities. Recommendations included measures based on process, outcomes, cost and experience.

Department Response. *The Department understands the importance of selecting the right quality measures that will improve outcomes while also rewarding value. The Department appreciates the comments and concerns received on this subject.*

5.2 What types of quality programs should prepaid health plans deploy to advance quality goals? How should prepaid health plans be rewarded to reach quality goals?

A few commenters made recommendations about the types of quality programs that PHPs should deploy to advance quality goals. These recommendations encouraged PHPs to create financial incentives for providers that reward value (particularly for improving outcomes for high-risk populations), and some highlighted a desire for standard measures and processes for quality programs across PHPs. Some commenters recommended that PHPs should be rewarded for achieving quality goals, with reward mechanisms typically focused on either financial incentives or preferred member assignment models.

Department Response. *The Department believes that finding and implementing the right quality programs is key to advancing North Carolina's quality goals, and believes in appropriately rewarding successful achievement of these goals. The Department appreciates the comments and concerns received on this subject.*

5.3 What types of support do providers need to accurately collect and report quality data?

Several commenters recommended forms of support that would be helpful to accurately collect and report quality data. Recurring themes in these recommendations included clarity regarding data metrics and input process (e.g., fields, frequency); financial and technical support; provider-specific dashboards; access to claims data; statewide registries and benchmarks; standardized metrics and processes across PHPs; and specialized support for small or safety net providers.

Department Response. *The Department acknowledges that many providers will require support to accurately collect and report quality data, and is committed to finding ways to make that support available. The Department appreciates the comments and concerns received on this subject.*

5.4 What strategies should the Department consider to ensure prepaid health plans effectively communicate to providers about quality of care provided to their patients?

Commenters recommended several strategies to ensure effective communication between plans and providers. These included recommendations that the Department require plans to regularly provide data, reporting, peer benchmarks and performance assessments to providers. Several commenters recommended that PHPs demonstrate the capacity to effectively communicate such information (e.g., have a dedicated provider liaison or show the ability to share data and reports at required frequency).

Department Response. *The Department acknowledges the crucial role that regular, effective communication holds in maximizing quality of care, and is committed to facilitating such communication. The Department appreciates the comments and concerns received on this subject.*

5.5 How can providers be supported in quality improvement and rewarded for high-quality care?

Several commenters recommended ways for providers to be supported in quality improvement and rewarded for high-quality care, including financially incentivizing quality care, incorporating provider quality performance into PHP evaluations, establishing clear expectations for data-sharing and reporting from PHPs, creating metrics that are well-suited to provider interventions, and sharing regular feedback to providers on their quality performance.

Department Response. *The Department is committed to supporting providers in quality improvement and finding the most effective ways to reward providers for delivering high quality care. The Department appreciates the comments and concerns received on this subject.*

5.6 How can providers be supported in maximizing patient satisfaction and creating a positive patient experience?

Several commenters recommended methods to maximize patient satisfaction, including reduce administrative burdens, ensure adequate payment to support high-quality care, support team-based care approaches, develop provider training programs (including programs based on patient satisfaction) and develop beneficiary training (e.g., benefit design).

Department Response. *The Department believes that creating a positive patient experience is an integral part of quality care delivery, and is committed to maximizing patient satisfaction whenever possible. The Department appreciates the comments and concerns received on this subject.*

Other themes

A few commenters recommended developing quality metrics with a broad base of stakeholders, including beneficiaries, physicians with diverse and representative backgrounds and specialties (e.g., safety net providers), and hospital executives. One commenter recommended that the Department refer to accountable care organizations (ACOs) as the standard for quality metrics. Some recommended that the Department adopt the measures of specific organizations to assess quality for specific specialties or health events, such as NCQA standards for pediatrics and the American Heart Association/American Stroke Association's "Get with the Guidelines" standards for heart failure and stroke.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

6. Paying for Value

6.1 How can Medicaid best support hospitals' delivery of high value care? To what extent can redirecting supplemental payments into significantly enhanced base rates help to achieve this goal?

Many commenters expressed support for the transition to value-based care. Several commenters recommended that the Department create financial incentives that reward high-quality, high-value care, with a focus on alternative payments models such as bundled or episode-based payments, global payments or global budgets, and bonus/enhanced payment structures for meeting specific goals or milestones. One

commenter recommended using the Health Care Payments Learning and Action Network (HCP LAN) framework as a starting point. Some supported redirecting supplemental payments into enhanced base rates, while others recommended against it. A few who recommended maintaining the supplemental payment structure also recommended modifying the current structure.

Department Response. *The Department is committed to transitioning from a fee-for-service model to a model that rewards value, and to ensure that any changes made to supplemental payment structures support the delivery of high-quality care and the overall goals of the Medicaid program. The Department appreciates the comments and concerns received on this subject.*

6.2 How can alignment with transformation goals best be achieved without destabilizing hospitals or disrupting access to care? Should North Carolina use a portion of funds to help transition hospitals to a managed care system? What types of supports would help smooth this transition?

Several commenters offered recommendations to minimize destabilization or disruption during alignment with transformation goals. Many commenters noted that financial supports would be helpful or crucial in transitioning to a value-based environment, particularly funding for safety net providers and sufficient reimbursement levels to support access to care. Several recommended that the Department provide support in getting clear and standard information to providers, including timely data (e.g., discharge information), consistent metrics, standard clinical pathways, clear and achievable value goals, and a reasonable timeline for implementing changes. A few commenters recommended that the Department take a collaborative approach that includes flexibility to providers to acknowledge local circumstances or flexibility to plans to identify mechanisms to minimize disruption and destabilization. Commenters suggested that the Department require that plans provide evidence of, and/or strategies for offering support to providers during the transition.

Department Response. *The Department is committed to ensuring that any changes made to align payments with transformation goals would be accomplished while minimizing destabilization and disruption of access to care. The Department wants to provide necessary supports to smooth such a transition, and looks forward to working with stakeholders to identify the best ways to achieve that. The Department appreciates the comments and concerns received on this subject.*

6.3 What are the opportunities and risks associated with redirecting supplemental payments, including implications on different types of hospitals?

Several commenters supported redirecting supplemental payments into base rates and recommended an incremental approach to minimize disruption, with some requesting additional payments outside of enhanced base rates to lessen payment volatility or incentivize value. A few commenters recommended clear expectations and a transparent process to minimize provider uncertainty in the event of such a transition. Several commenters recommended maintaining a level of reimbursement that supports access to care and creates flexibility to account for local circumstance, particularly for rural providers.

Department Response. *The Department acknowledges that there are opportunities and risks associated with redirecting supplemental payments, and is committed to capitalizing on opportunities while working to minimize risks. The Department appreciates the comments and concerns received on this subject.*

6.4 Are there things the state should consider in this area that are specific to supporting smaller and rural hospital systems?

Several commenters noted that providers have significantly different degrees of capability and readiness to transition to a value-based environment. A few commenters shared that small and/or rural providers would need either additional support from the Department or plans (particularly financial and technical support to make necessary process changes and infrastructure investment) or additional flexibility (e.g., flexible timing to transition to a value-based environment and value-based payment calculations that account for the smaller populations of many rural providers).

Department Response. *The Department agrees that providers across North Carolina have different capabilities and degrees of readiness to make changes, and acknowledges that smaller providers and providers in rural or underserved areas may face additional barriers. The Department looks forward to working with these providers to support their needs, and appreciates the comments and concerns received on this subject.*

6.5 How should North Carolina encourage prepaid health plans to develop value-based purchasing arrangements with their downstream provider networks that align with statewide quality goals and measures?

Several commenters recommended a variety of actions that the Department could take to encourage PHPs to develop value-based purchasing arrangements with providers. A few commenters recommended that the Department create conditions for successful value-based purchasing agreements by establishing clear goals and expectations, including a set of performance metrics consistent with national metrics. A few commenters recommended that the Department require PHPs to demonstrate their experience with value-based purchasing arrangements, and provide flexibility and/or incentives for plans to pursue such arrangements with providers (e.g., incentives tied to graduated numeric targets).

Department Response. *The Department seeks for PHPs to develop value-based purchasing arrangements with provider networks and seeks for these arrangements to align with statewide goals and measures. The Department appreciates the comments and concerns received on this subject.*

6.6 What support would providers need to participate in value-based purchasing agreements?

Several commenters noted that providers would need or desire support to enter value-based payment arrangements, with a focus on financial support to facilitate infrastructure investment or necessary process changes; technical support to ensure availability of timely and actionable data; training and education support on these arrangements; and support to clarify and standardize expectations (e.g., clear standard performance measures).

Department Response. *The Department recognizes that different providers may be at different stages of readiness and is committed to finding ways to provide appropriate support to providers who need it. The Department appreciates the comments and concerns received on this subject.*

Other themes

One commenter recommended that the Department tie growth in rates and payments to provider performance and progress.

Department Responses. *The Department appreciates the comments and concerns received on this subject.*

7. Increasing Access to Care and Treating Substance Use Disorder

7.1 What are the opportunities and risks of increasing care access to North Carolinians under Medicaid? What will be the impact on individuals and families? On providers and communities? State and local government?

More than 200 commenters across provider, payer and patient groups requested that the Department increase access to care through Medicaid, with several commenters specifically mentioning support for North Carolina House Bill 662. The group highlighted positive outcomes of increased access to coverage, including increased access to primary care, preventive care and behavioral health services for many North Carolinians. Commenters noted additional benefits, which included creating 43,000 new jobs and \$5.6 billion in increased economic activity in rural areas, improved health outcomes of hundreds of thousands of North Carolinians, and significant return on investment by using enhanced federal matching funds to treat substance use disorders.

Department Response. *The Department is interested in ways to increase care access to North Carolina individuals and families, and believes in the critical importance of access to affordable health care. The Department appreciates the comments and concerns received on this subject.*

7.2 What health benefits should be covered to meet the health care needs of this population? How should the benefits align or differ from coverage currently available under Medicaid?

Commenters recommended a variety of specific benefits that should be covered to meet the needs of the newly eligible population, including pharmaceutical interventions for opioids (e.g., SUBOXONE®, methadone and VIVITROL®), HIV case management, addiction prevention, medication-assisted treatment, screening and diagnostics, non-opioid treatments for pain, social supports, robust prenatal and infant care, family planning, telemedicine/telehealth services, and behavioral health services.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

7.3 What additional steps can the Department take to ensure that we are doing everything possible to meet the coverage and access needs of North Carolinians addicted to opioids and other substances? How would Medicaid coverage be used for prevention, treatment and ongoing recovery efforts?

Many commenters recommended steps that the Department could take to further meet the needs of North Carolinians with substance use disorders. Recurring themes from these comments include expand the mental health and substance use disorder workforce; cover all types of medication assisted treatment (MAT) and allow non-physician providers to prescribe MAT; cover residential and recovery housing services; offer transition programs for North Carolinians exiting the prison system; increase connectivity between providers and community organizations; increase provider education on substance use disorder prevention and treatment; identify predeterminants of substance use disorder (e.g., genetic predisposition); increase entry points into Medicaid; and ensure continuity of care.

Department Response. *The Department believes that addressing the opioid crisis is one of the most important challenges facing our state, and that access to care is critical. The Department is committed to doing everything possible to meet the coverage and access needs of North Carolinians addicted to opioids and other substances, and to maximize the effectiveness of Medicaid in prevention, treatment and recovery efforts. The Department appreciates the comments and concerns received on this subject.*

7.4 What special programmatic features or strategies should North Carolina consider for the newly eligible population to facilitate enrollment, engage patients in their care and ensure continuity of coverage?

Several commenters recommended specific program features that North Carolina should consider, including a streamlined eligibility and enrollment process; increased Medicaid entry points; in-person enrollment assistance; materials available in multiple languages and for all levels of health literacy; an expanded health care workforce (particularly for primary care and low-paying specialties in rural and underserved areas); expanded Graduate Medical Education payments (particularly for non-physician providers); coverage and access for formerly incarcerated individuals; and reduced barriers to telemedicine and telehealth use (e.g., reimbursement parity, removing the originating site requirement).

Department Response. *The Department acknowledges the importance of facilitating enrollment, engagement and continuous coverage in serving the newly eligible population. The Department appreciates the comments and concerns received on this subject.*

Other themes

A few commenters emphasized the benefit of expanding access to care through Medicaid to specific populations and communities, including rural communities, adolescents and low-income employed individuals. A few commenters requested extending post-partum coverage. Several requested that the Department expand access and pursue an integrated approach to mental health and substance use disorder services.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

8. Other Recurring Themes in Public Comment

Transition to managed care

Many commenters recommended against North Carolina Medicaid transitioning to a managed care model, with several commenters expressing concern about the potential negative impact of managed care on patients. Several commenters recommended that the Department carve out child beneficiaries from managed care, leaving this population in a fee-for-service model.

Department Response. *The Department is committed to design and implement a managed care program that minimizes disruption to care, preserves care access, and ensures that all beneficiaries receive the services they need to live healthy and fulfilling lives. The Department appreciates the comments and concerns received on this subject.*

Dental carve-outs

Several commenters recommended the Department preserve the current carve-out for dental care.

Department Response. *Current state statute exempts dental services from managed care. The Department appreciates the comments and concerns received on this subject.*

Covered benefits

Many commenters recommended that North Carolina Medicaid add specific services to its current benefit package (e.g., eyeglasses and routine eye exams, fundus photography, Spinraza treatment, applied behavioral analysis, denture replacement, and smoking cessation services). Several commenters recommended the Department establish Young Adult Peer Support services for behavioral health as a covered benefit under

Medicaid. Several commenters recommended that the Department ensure that the current benefit package for children is maintained during and after the transition to managed care. Commenters also recommended that the Department ensure children can still access specialty services outside their region.

Department Response. *The Department is committed to ensuring that Medicaid beneficiaries have access to the covered services and supports that they need. The Department appreciates the comments and concerns received on this subject.*

Importance of Medicaid

Several commenters noted the importance of North Carolina's Medicaid program to the health and well-being of more than two million citizens, with multiple commenters offering personal anecdotes of the importance of Medicaid to the lives of their families and loved ones. A few commenters recommended against cuts to funding or coverage for North Carolina's Medicaid program.

Department Response. *The Department agrees that Medicaid is a crucial program to maintain affordable health care access for more than two million North Carolinians, including children, seniors and people with disabilities. The Department strongly agrees that cuts to Medicaid funding or coverage would be harmful to Medicaid's ability to continue providing access to affordable health care. The Department does everything possible to ensure access to quality care for beneficiaries, and appreciates the comments and concerns received on this subject.*

Acronyms and Abbreviations

ACO	Accountable Care Organization
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
DSRIP	Delivery System Reform Incentive Payment
I/DD	Intellectual and Developmental Disabilities
FQHC	Federally Qualified Health Center
HCP-LAN	Health Care Payment Learning and Action Network
HEDIS	Healthcare Effectiveness Data and Information Set
HIV	Human Immunodeficiency Virus
LME/MCO	Local Management Entity/Managed Care Organization
LTSS	Long-term Services and Supports
MAT	Medication Assisted Treatment
NCQA	National Committee for Quality Assurance
PCCM	Primary Care Case Management
PCMH	Patient Centered Medical Home
PHP	Prepaid Health Plan
PLE	Provider-led Entity
PMPM	Per Member Per Month
PQRS	Physician Quality Reporting System
SMI	Serious Mental Illness
SNP	Special Needs Plan