



The NC Public Health System and Medicaid Transformation Comments from the NC Association of Local Health Directors

Executive Summary:

Thank you for the opportunity to respond to North Carolina's Proposed Program Design for Medicaid Managed Care. We share and value North Carolina's vision outlined in the August 8th Proposed Program Design to *"implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. DHHS' goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health."*

Local public health departments in NC currently provide both medical and non-medical health related services, programs, referral, and education in every one of North Carolina's 100 counties with a mission to protect and promote health. The public health system working so well across state and local partnership is strong here not only because we have a 100-year tradition of mission-focused and locally-supported work, but it is strong because it is needed. Public health is for everyone in all communities – and at the same time, is depended upon by our state's most vulnerable populations. Public health services fill gaps identified in community health needs assessments and provide the kind of care, upstream planning, and response the rest of the health care system is not always available for or trained to provide, including:

- 1. Communicable Disease surveillance, investigation, and treatment**
- 2. Health screenings and provision of primary care/early life care or referral to primary care***
- 3. Community public health nurses and community health workers**
- 4. Family Planning including long-active reversible contraception, and prenatal care**
- 5. Tobacco cessation, education and control***
- 6. School-based work: Whole Child-Whole Community approach to child health***
- 7. Nutrition counseling and treatment including diabetes management and pre-diabetes support, Women, Infant and Children Supplemental Nutrition Program (WIC) and breastfeeding support**
- 8. Healthy homes and home visiting nurses / environmental health specialists working already on social determinants of health**
- 9. Care management –for pregnant women (OBCM) and children (CC4C), but also for those patients in our communities with TB, Hepatitis C, HIV/AIDS, and chronic diseases**
- 10. Immunizations – often the immunizing provider for local family practice***

The vision you offer will be much more easily realized with local public health as an essential partner in a new Medicaid managed care approach. (**Services above noted with an asterisk are related to the CDC 6/18 Project described in more detail on page 7).*

Introductory points:

- Local health departments currently play a major role in Medicaid, both as primary care providers and also in providing care management services. Local Health Departments across NC serve a large number of **Medicaid patients** (~50% of those served in our agencies) and **Uninsured patients** (~40% of those served in our agencies). Public health has been inextricably linked with the Medicaid program in order to better serve these populations, and now, with a health equity lens for our growing population, it's critical we find a way to continue a synergistic link between local public health and Medicaid.
- The **rural - urban continuum** in our state has many infrastructure, capacity, and referral service differences that should be taken into consideration. As you propose different types of managed care plans and funding flows that may be tiered, one thought from our perspective is that different levels could be based on services offered. Or, perhaps having just one tier with a baseline of expected services for all patients whether provided by a local health department, other safety net provider, private office, or a regional group would be more **equitable and quality-oriented for patients**.
- **Care management works best when it's as close to the provider as possible**, and again, we must remember patients in smaller Medicaid practices in rural communities. It is helpful to consider what local health departments (LHDs) and Community Care of NC (CCNC) have learned in Obstetrics Care Management (OBCM) and Coordinated Care for Children (CC4C) care management programs. A regional model may be considered now, but for care management to have the best outcomes, **connectivity to the community served is ESSENTIAL – local health departments do this community connection well**.
- Across North Carolina, local health departments have served as consistent service access points for generations; particularly for rural and disenfranchised populations. **The current public health infrastructure can help improve the quality of care, relieve the strain on primary care providers in the community, and help save money.**
- **Addressing Social Determinants of Health is what we are trained and staffed to do.** Local health departments have enhanced role nurses, social workers, and health educators who have longed for a mechanism to better connect individuals to community resources. It's nice to see that care providers and payers across the system now better understand the connection between place and health and a greater need for the data collected by local health departments that identify resources and gaps in those resources like we do through Community Health Needs Assessments. NC Medicaid should provide a reimbursement mechanism for programs that support housing, transportation, child care programs for the working poor, and environmental supports needed in well-connected, well-audited, community-based agencies. Local health departments are ready to pilot such reimbursable services.

“Evidence indicates public health programs improve health, extend longevity and can reduce healthcare expenditures.”

Health Cost Containment and Efficiencies: Public Health and Cost Savings.

National Conference of State Legislators. Briefs for State Legislators. Number 14. February 2011.

Response:

As the NC Department of Health and Human Services (DHHS) refines the proposed program design for Medicaid managed care, please continue to work closely with Division of Public Health (DPH) and Local Health Department (LHD) leaders to communicate the details and work through the potential hurdles. Public health in NC is a well-established decentralized system and depends not only on federal and state funding sources to carry out our work, but also cobbles together a highly variable contribution of local funds from county to county – this makes a statewide or regional approach to contracts with Prepaid Health Plans (PHP) an interesting challenge we have not yet sorted all the way through.

LHDs in NC work from a shared mission and a common language in providing the three core functions and ten essential services of public health, and LHDs are proudly, all accredited agencies providing a standardized approach to capacity and quality of care. Operating budgets for local health departments across NC are entirely another thing. In our view, the patchwork quilt of local health department budgets and control of those budgets will be the hardest piece to navigate with the proposed plans, regions, and outlines for the transition to Medicaid managed care. We are all willing to think and act differently within the realm of a newly managed Medicaid and health care system, but we must admit, there are some limits to the control we possess to navigate and negotiate wholly on our own with corporate managed care. We appreciate your partnership.

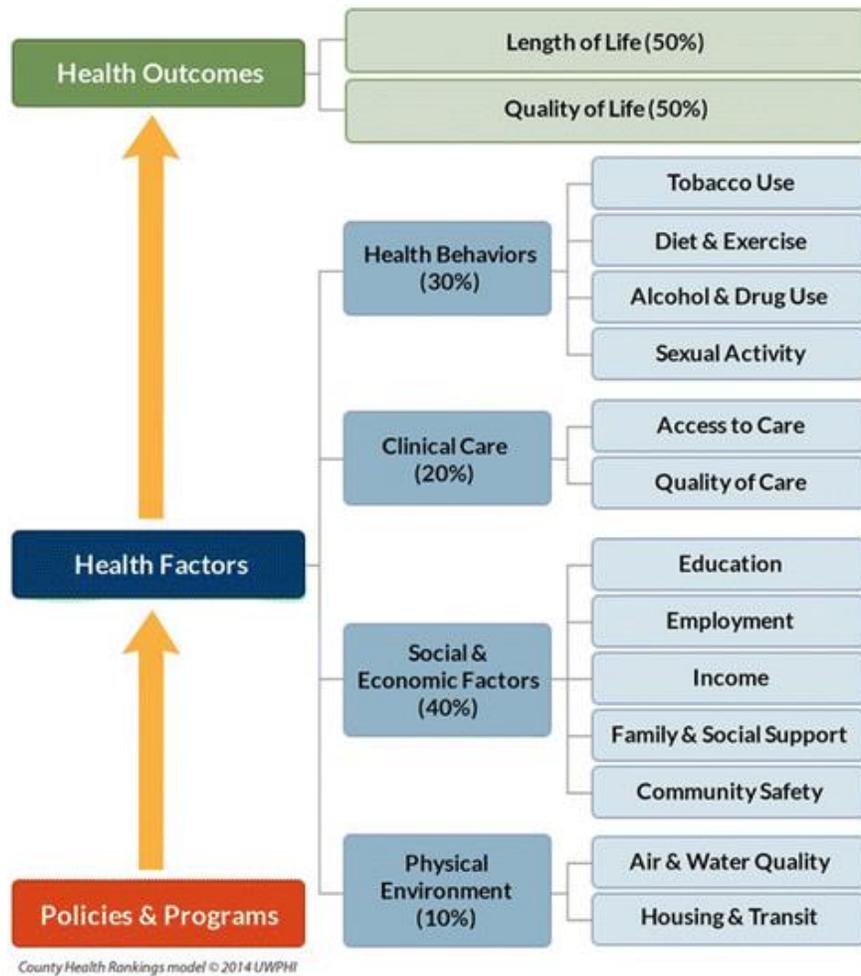
The NC Association of Local Health Directors has had many discussions on the topic of Medicaid transformation. Included below are initial thoughts and reactions about how public health can work with DHHS / Medicaid to deliver on the aspects outlined most recently in the August 8th 2017 proposed program design for Medicaid managed care.

1. Creating an innovative, integrated, and well-coordinated system of care

This section of the proposed plan outlines a common connection between public health and managed care: We absolutely support and value addressing unmet social needs as part of overall health. It is our desire as the local public health workforce to do all in our power to realize the strengthening and support of care management as part and parcel of addressing those unmet needs community by community. As the NC Division of Public Health mentions in their response to you, LHDs have been providing and improving care managements services since 1986 for pregnant women and for at-risk children birth to age five. The models of care management LHDs are required to provide have been evidence-based, outcomes-focused and data-driven for decades. High standards of care and a continuous quality improvement model to this established framework for care management puts local health departments at a high level of readiness for providing care management across our state.

We plan for DHHS and PHPs to recognize that care management does not begin and end with primary care alone. Though essential to usher and assist people through a care plan, primary care is only one piece of how we address health outcomes for individuals and populations. The County Health Rankings from the University of Wisconsin, outline a framework that includes both health outcomes and health factors. “Health factors are divided among four components thought to be modifiable determinants of the future health of a county. They include **health**

behaviors (30%), clinical care (20%), social and economic factors (40%), and the physical environment (10%) (Remington, P. "The County Health Rankings, Rationale and Methods" Population Health Metrics, December 2015, 13:11 Accessed online September 7, 2017: <https://link.springer.com/article/10.1186/s12963-015-004>)."



Further, the integration of physical health, behavioral health, substance use disorders, and intellectual and developmental disability (I/DD) services will be stronger with a community convener (LHDs) working with primary care to connect the system together as depicted visually by the University of Wisconsin’s County Health Rankings “Framework for Taking Action” on the following page. **The integration of different parts of the health care system will need a collective impact approach and will only be successful if there are aligned motivators, facilitators, and incentives for providers to communicate, and a ‘no-wrong-door’ approach for the provision of integrated services to those accessing care.** Although these frameworks are helpful and familiar to us, what LHDs are able to do well is apply these frameworks to communities in ways that bring about lasting change. That’s the “je ne sais quoi” LHDs bring to a Medicaid managed care model. Risa Wilkerson, executive director of Active Living by Design

stated in an article about community leadership, “While using a model to guide your approach is important, lasting change also requires an understanding of community context; strategies that improve policies, systems, and the built environment; and the ability to ground every aspect of the work in essential practices. (Wilkerson, R. “Check Your Leadership Lens Before Embarking on Collective Impact. June 21, 2016. Accessed online September 7, 2017: <https://www.linkedin.com/pulse/check-your-leadership-lens-before-embarking-impact-risa-wilkerson>).



Along with collective impact, the framework for action provides an approach LHDs would apply to work on integrating physical health, behavioral health, substance use disorders, and intellectual and developmental disability (I/DD) services in our communities. “Each step on the action cycle is a critical piece of making communities healthier. You can start at ‘Assess’ [like public health departments do] or enter the cycle at any step. ‘Work Together’ and ‘Communicate’ sit outside because they are needed throughout the Cycle. At the core of the action cycle are people from all walks of life because we know we can make our communities healthier if we all get involved. (Accessed online September 7, 2017: <http://www.countyhealthrankings.org/roadmaps/action-center>).

In addition to integrating health the system components, addressing unmet social needs of the population is another area LHDs have experience navigating, but need more resources to do well. The Center for Health Progress in Colorado published an article (August 24, 2017 by Joe Sammen), about social determinants of health (SDOH), explaining how clear the data are that “SDOH are the greatest predictors of a person’s health – more than genetics, individual behavior choices, and access to health care.” The article goes on to state that SDOH are also

significant drivers of preventable health disparities... In general, SDOH fall into one of four domains:

- **Environmental:** pollution, housing, crime, access to transportation and healthy food, and other aspects of the spaces we inhabit
- **Economic:** income, employment, personal education, and opportunities for upward mobility
- **Interpersonal:** discrimination, violence, social bonds, and other interactions between individuals
- **Institutional:** the education system, criminal justice system, government, and the structures of major institutions that advantage some and disadvantage others

(Sammen, J. "Intervening on Interpersonal and Institutional Social Determinants of Health." Center for Health Progress. August 24, 2017. Accessed online September 7, 2017: <https://centerforhealthprogress.org/blog/intervening-institutional-interpersonal-sdoh/>.)"

Through LHD staff, community health assessment processes, and care management that links providers and patients well, NC can do a much better job addressing SDOH at all of these levels. It is nice to see that Medicaid transformation plans include this important connection to health outcomes and supports **innovative approaches** to getting this right community by community – because, after all, zip code matters a great deal.

2. Supporting providers and beneficiaries during the transition

We are happy to see provider supports through regional provider support centers, provider credentialing in a 'one-stop-shop' fashion, as well as a streamlined approach to beneficiary eligibility and enrollment. The intentions here are marvelous. We did see a few barriers to the roll out of NC Tracks a few years ago that still paint a picture of what implementation barriers can emerge, so perhaps LHDs can assist DSS in the process to enroll individuals into their plans.

To reiterate our collective notion about how local public health fits in a new system of Medicaid managed care in NC, in sum: **The public health system in NC is ready and willing to lead change, to collect data in new ways, to shift resources, and to work closely with DHHS and Medicaid Managed Care to find ways that promote and protect health the best way possible for North Carolinians.** In purely honest fashion and with quick follow-up to that sincere statement, we must also admit that our system has not been built for private business negotiations, for profitable service line competition, or for competition in general. It's PUBLIC health after all. Our system was simply born of an entirely different structure, purpose, mission, communication approach, and outcome than the one we are moving toward. In reading through the DHHS proposed plan for the future, there are so many things we are already doing well in our more traditional public system that will only need slight twists and tweaks to fit in the new world order of how Medicaid will work. **We know we can provide quality services, we know we can transition easily to value-based payment, and we know we can help Medicaid**

save money. We will need DHHS, DPH, DSS and DMA as partners to help us navigate this transition.

It is also nice to see efforts to commit to a streamlined beneficiary eligibility and enrollment processes: Please think about local health departments as additional **provider choices** for beneficiaries to seek care – especially in rural areas where provider choices may be limited. A strong focus on client services and education is a mainstay of public health work. We can provide member services and education about plans available to them. It is validating to see that you mention member services and education as part of the plan.

A specific way DHHS could build on the strength of LHDs during the transition, and support the existing trained workforce well, is to borrow what appears to be a good start to population health efforts in other states with the CDC 6|18 Project. Other states beginning this journey across payers, providers, and public health, includes a direct Medicaid connection to the Centers for Disease Control and Prevention’s (CDC) 6|18 project. With the triple aim in mind, an aim to improve the quality of health care, reduce costs, and improve population health), **CDC is partnering with “purchasers, payers, and providers” to improve health for Americans in six of the more common and costly health conditions: tobacco use, high blood pressure, healthcare -associated infections, asthma, unintended pregnancies, and diabetes. Along with those conditions, there are 18 proven or evidence-based interventions that address the six conditions.**

So far, there are a reported nine states already including the 6|18 initiative as part of their Medicaid reform plans, these are interventions public health departments are well poised to provide and already working on in large part. From the CDC web site overview of the 6|18 Project: “CDC is partnering with 9 State Medicaid Agencies...that have the potential to reach up to 17 million Medicaid enrollees with prevention interventions that work. The initial focus for this collaboration is on 3 of the 6 health conditions – asthma, tobacco, and unintended pregnancies - because these conditions are particularly prevalent among Medicaid beneficiaries.

The 9 states had the following factors critical for success:

- They had active efforts in place to control one or more of the 3 priority health conditions.
- They were working to implement the specific interventions highlighted within the set of 18.
- The state supported the Medicaid Agency and the Department of Public Health working on this initiative in partnership.

(Accessed online via CDC September 7, 2017 <https://www.cdc.gov/sixteen/>)”

3. Promoting access to care

Thank you for recognizing that North Carolinians have been building health care and public health workforce capacity for a long time, but still have shortfalls in rural and underserved areas of our state that persist. Public Health also supports community-based residency programs, rural health incentives, and specialized behavioral health training for the existing workforce. The community health worker model is an opportunity whose time is not yet realized fully – we must recognize that initial concepts of this approach are complex in that they unintentionally dismantle some of the professional establishment of the hard-working health education workforce. There is room for both community health worker models and more traditional health educators as qualified by the NC Office of Human Resources. But we must balance the responsibilities and the cost/benefit of when and how to most appropriately deploy such resources at the right time, for the right and fair payment, for the individual and the population.

The public health workforce in NC includes approximately 10,000 individuals working across the state with so many levels of training, expertise, skill sets, and passion about community health. A number of rural LHDs are already applying telehealth and new approaches to care for children, adults, and even, in cases where we are trying to address the jail population, we are adding telehealth in local jail systems to connect with psychological and medical services alike.

Local Health Departments are on the front lines of the Opioid epidemic across NC

LHDs are involved in Opioid leadership forums taking place in each county. The NC Association of County Commissioners (NCACC) has involved local public health directors as a facilitator in many cases for these NCCA planned forums intended to bring awareness and action to the opioid crisis. From the well-known Project Lazarus community model born in Wilkes County, NC, to federal grant funding and local coalition work with the NC Harm Reduction Coalition, local health departments are convening community members and providers in most every county to review data, reduce death and harm, and address both the prescriber training needs as well as the community education and prevention needs.

One example of local communities working together to address social determinants complexities and address the opioid epidemic is the ***Stepping Up Initiative***. The National Association of County Officials (NACO) has compiled evidence-based resources to help communities pull together law enforcement, mental health providers, social workers, county management, and public health leadership to address the fact that the majority of local jail populations nation-wide suffer from mental illness and/or substance use disorder.

Medicaid could acknowledge the role of the backbone (convener) of collective impact projects like the Stepping Up Initiative, and for Medicaid patients, ensure a continuity of care across a community of providers whether jail is the point of contact and diagnosis or not. Persons in jail

who are booked for minor offenses such as trespassing and loitering who end up unable to afford an attorney and are assigned a public defender, can languish in jail for days and months and have Medicaid suspended. If a mental illness has been diagnosed and medication is needed, if housing is not available when the person is released, and transportation is not available in the community, it's easy to understand how communities are challenged with caring properly for individuals in these situations. Working together across the systems of mental health, public health, law enforcement, and county government, there is a significant opportunity to promote lasting treatment and recovery through jail diversion for minor offenses and for opioid and other substance dependency... as long as we acknowledge also the need for more substance use treatment and recovery services.

There is much work left to do to adequately address the public health crisis related to opioid use disorder and its ripple effects. LHDs are continuously leading, learning, and connecting resources to find solutions. We look forward to working with Medicaid in the future on this issue that will not disappear soon enough.

4. Promoting quality and value

The balance of standardization and flexibility is a challenge most certainly, but again, our public health system has worked hard in this decentralized world to make the connections effective and efficient over time. There are MANY programs, services, and systems that touch LHDs that require accountability and standard work, but that also require the public health workforce to create new and streamlined strategies for patient care. For example, it can be a test to get patients through required evidence-based program data collection instruments while also being patient-centered and education-focused. It takes translation, good communication, and persistence. In asking a nursing supervisor this week what she thought about promoting quality and value, she answered very matter-of-factly, "We have been held to very high quality standards for a long time in each of our programs and this part of Medicaid transformation should be easy for us – we conduct business every day in a way that is patient-focused, data-focused, and we work as if we don't get everything right, every t crossed and every i dotted, and every patient happy and healthy, we'll get money taken away. Private practice has not had to work under the same pressures we have of constant data collection, multiple chart reviews, program audits, customer service satisfaction surveys, and multiple electronic systems to enter data within quite the same way we have. I'm ready for standardization and value based payment!"

As much as negotiating with corporate managed care gives us pause, working toward a standardized value-based payment strategy does not make us blink. Your inclusion of a desire to enhance data collection and sharing capabilities is positive to see, even though we have lived through decades of state systems not being able to move quickly in that realm. We will remain optimistic.

Public health is very used to investments and program plans that include evidence-based health outcomes and strategies while at the same time, aim to address health-related social needs and reduce health inequities. Yes, Yes, and Yes to all of that! We have the tools, the will and the workforce to promote quality and value across Public Health 3.0 and beyond.

5. Setting up relationships for success

Thank you for working prospectively with PHPs to ensure success. We have more questions in this area than confidence we know how all of this will work out over time.

Unlike other partners in the safety net service arena, LHDs do not receive direct federal funding to provide services for the uninsured, yet are still held accountable to federally-imposed safety net standards. In the past, Medicaid payments for clinical services have been a tremendous stabilizing force for local health departments and transforming Medicaid in North Carolina should continue to include Medicaid payments to health departments – that funding not only assists with the ability to serve those in need, but provides essential support for the infrastructure that remains tremendously fragile from a funding perspective.

The new PHPs should be encouraged to work with LHDs on innovative payment models that reflect not only quality of care, but the ability to have an integrated care team that is focused on patient-centered care with measurable outcomes. In this context however, our ability to continue cost settlement is critical and would need to be carefully considered if the payment models are changed. Regardless, we are eager to showcase our programs, services and people in ways that will highlight the role LHDs play as an essential community provider across NC in the health system. We commit to being equally transparent as you work on payments, data, and methodology.

Finally, the questions we have center on getting the information we need to allow LHDs to make an informed and accurate assessment concerning our future in providing clinical services to both Medicaid and our most vulnerable clients.

1. In the current system LHDs receive fee-for-service payments and a year-end cost settlement.
 - a. Will cost settlement be continued or not?
 - b. If not, what rate structure will be in place?
2. Approximately 50 % of our LHD's do not have primary care clinics. They provide preventive health screening, vaccines, STD diagnosis and treatment, family planning services and maternity care.
 - a. Is there any information you can provide that clarifies when, how or if these patients would be able to access non-PCP LHD's for preventive health screenings, vaccines, or STD diagnosis and treatment.

- b. The same applies to school based health centers who have never needed a PCP authorization to provide care and are not themselves PCP's?
- 3. For the 50% of our LHDs that do have primary care practices.
 - a. What are the specific requirements to be a PCP at level 1 and 2.
 - b. What new requirements will be added for each tier and who is responsible for financing any of the necessary changes to meet these requirements? e.g.. New certifications? new IT functions, new data and reporting requirements?
 - c. What are the specific financial incentives that will be provided?
- 4. For the 80%+ of our LHDs who have maternity clinics, all participate as the OB medical home through CCNC.
 - a. How will this model be changed under transformation?
- 5. When will we have a detailed understanding of the *added* administrative requirements for providers participating in new Medicaid plan versus those that are the responsibility of either the State or the MCO's? A side-by-side showing current vs. planned changes would be helpful.

Note: There is a need to plan for and attempt to secure funding for additional costs that will be incurred to meet new requirements.
- 6. Case Management (OBCM) & (CC4C). What changes are planned for these case management programs? Will LHDs be able to receive direct Per Member Per Month payment for these services in the future or will these services be negotiated by region / by PHP?

Conclusion

Thank you for your work on this complex transition plan. We want you to know that LHDs are unique in NC in that we have three separate roles with responsibility, obligation and potential cost savings to DHHS and to Medicaid. Many LHDs provide Direct Clinical Services including Primary Care: LHDs are one of different types of Essential Community Providers, but LHDs are the only Essential Community Provider listed directly in the same organizational chart together with DHHS. With our experience offering wrap-around services, in addition to focusing on our natural role as an Advanced Medical Home, LHDs remain interested in providing continued Medicaid Cost Reporting and Cost Settlement for the future. This is important because of our frequent role as "provider of last resort," serving patients who have been discharged or even blocked from private Medicaid providers for various reasons. Additional services we have mentioned in this response are the Care Management services of OBCM and CC4C and the Community or Population Health initiatives. These initiatives include the impact of social determinants of health and the impact of policy and environmental changes we lead. **LHDs aim to be thoughtful and cohesive in making the connection for DHHS regarding our impact on population health. We look forward to working together to navigate what the future holds in NC for Medicaid patients, local communities, and the public health infrastructure.**