

Secretary Mandy Cohen
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: Medicaid and NC Health Choice Request for Public Comment

Dear Secretary Cohen,

Thank you for extending the opportunity to submit comments regarding the North Carolina Department of Health and Human Services (DHHS) plan to transform North Carolina’s Medicaid program using a Section 1115 waiver. Our team, organized and funded jointly through the Duke-Margolis Center for Health Policy and the Duke University Bass Connections Program, is excited to share input synthesized from a year of extensive literature reviews, stakeholder interviews, and data collection. Our core recommendations for modifying the Section 1115 waiver address the following North Carolina DHHS themes:

Theme 2 – Transition to managed care: Develop a reasonable implementation timeline accompanied by incentives to encourage competition and sustain market participation by managed care organizations

Theme 3 – Care management: Integrate care delivery pathways, particularly for dual-eligible populations

Theme 4 – Social determinants: Employ “hotspotting” analysis and care coordination to better address the social and environmental factors that influence health outcomes

Theme 7 – Increase access to care: Invest in telemedicine and reform graduate medical education to improve outreach to high-risk patients in rural areas

Thank you for your consideration and efforts to improve affordable access to high quality care for vulnerable North Carolinians.



About the Team:

The Duke North Carolina Medicaid Reform Advisory Team is an interdisciplinary group of undergraduate, graduate, and professional students and faculty from the Triangle community formed in 2016 to study leading issues in North Carolina state health policy. Our full 2017 report on opportunities for reforming North Carolina Medicaid and the Section 1115 Waiver can be found here:

https://healthpolicy.duke.edu/sites/default/files/atoms/files/bass_connections_nc_medicaid_5-9-17_final.pdf

The team is funded through the Bass Connections program at Duke University, a groundbreaking initiative aimed at leveraging the intersection of disciplines to address complex social problems. Faculty leads are associated with the Duke-Margolis Center for Health Policy, an institute bridging academic medicine with the policy sphere to advance the next generation of healthcare reform. A full list of student and faculty team members can be found at the end of this document.

RECOMMENDATIONS:

Theme 2 – Help healthcare professionals transition to managed care

Medicaid managed care is common across the United States, with 265 managed care organizations (MCOs) operating in 39 states.¹ Although in theory managed care offers opportunities to reduce costs and improve health outcomes, states have reported variable short- and long-term results with managed care in practice.² Additionally, several states that recently transitioned or are currently transitioning to managed care have experienced significant administrative and financial obstacles, which have significant implications for healthcare delivery. We offer the following recommendations based on our review of peer state Medicaid managed care programs:

Reduce administrative burden and ensure timeliness of payment for providers

Transitioning to managed care has significant implications for providers. Provider participation in North Carolina is better than most southern states (76.4%) due to the state's high Medicaid reimbursement rate for primary care.³ However, provider participation is fragile, and could easily be undermined by major policy changes. For example, 10,000 providers exited North Carolina Medicaid in 2017 when simply asked to revalidate their reimbursement status.⁴ Transitioning to managed care may disrupt provider payments and create undue administrative burdens for providers.

¹ Paradise J. *Key Findings on Medicaid Managed Care: Highlights from the Medicaid Managed Care Market Tracker*. Menlo Park, CA: Kaiser Family Foundation; 2014. <http://kff.org/medicaid/report/key-findings-on-medicaid-managed-care-highlights-from-the-medicaid-managed-care-market-tracker/>

² Sparer M. *Medicaid managed care: Costs, access, and quality of care*. Princeton, NJ: Robert Wood Johnson Foundation; 2012. <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106>

³ Decker S. In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. *Health Affairs*. 2012;31(8):1673-1679. <http://content.healthaffairs.org/content/31/8/1673.abstract>

⁴ Dickson V. More than 65,000 providers are cut from Medicaid rolls in 15 states. 2017. Accessed March 19, 2017. <http://www.modernhealthcare.com/article/20170225/MAGAZINE/302259967>



In Kentucky, providers faced administrative and financial burdens from multiple new coding and billing requirements, communication difficulties with MCOs, and late payments from MCOs. In Florida, higher administrative burdens and lower reimbursement negatively impacted provider participation in the Medicaid program. Consequently, we recommend North Carolina DHHS **set appropriate provider reimbursement rates** that maintain North Carolina's robust provider participation. We recommend North Carolina DHHS **create a centralized payment system** or requirements to reduce providers' administrative burden from working with multiple MCO plans. The state should also **implement mechanisms to hold MCOs accountable** for reimbursing providers in a timely manner.

Set a reasonable implementation timeline that allows stakeholders to adjust

We urge North Carolina to **build in sufficient time to engage with stakeholders and develop administrative resources before transitioning to managed care**. Our analysis of Kentucky's experiences with implementing managed care illustrates the importance of incremental change. In 2011, Kentucky used a 1915(b) waiver to implement three statewide MCOs in a span of four months. This short implementation timeline hindered the MCOs in their ability to properly negotiate contracts with hospitals and providers. This, along with many other factors, spurred one of the three MCOs (Kentucky Spirit) to exit the market before the end of the first fiscal year, in which the two other MCOs ended with financial losses.⁵

Currently, North Carolina's Section 1115 waiver states that DHHS does not intend to use a phase-in approach for implementing prepaid health plans (PHPs). The proposed timeline would involve beneficiary enrollment in PHPs approximately 18 months after waiver approval by CMS, and about 10 months after PHP bids are awarded. We believe an immediate shift to managed care across the entire state would fail to address the complexities of care delivery in diverse clinical and cultural settings. Instead, North Carolina could **pilot MCOs in specific regions** to test the feasibility of the approach while also allowing sufficient time for MCOs to negotiate contracts with major hospitals and to develop the necessary workforce and infrastructure necessary to care for high-risk patients. Thus, North Carolina DHHS should **invest in a multi-year implementation timeline** that utilizes input from key stakeholders in the transition process.

Develop organizational capacity for oversight of MCOs

Transitioning from the current system of primary care case management to managed care will inevitably bring new roles and responsibilities for North Carolina DHHS personnel, who will need new skills to oversee MCOs appropriately. We recommend that North Carolina DHHS **invest in the necessary staff training and technical capacity for oversight** prior to rolling out managed care. Moreover, the Department should **develop a clear strategy for how it will use MCO reports** to monitor plan quality. As an example, we looked again to Kentucky, where staff at the state Medicaid agency had little experience in overseeing insurance companies and analyzing reports from plans prior to the transition. Due to the accelerated timeline, the state agency was unable to develop the necessary monitoring capacity, which undermined efforts to regulate MCOs. The lack of regulatory

⁵ Palmer A, Howell E, Costich J, Kenney GM. *Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report*. Urban Institute and the University of Kentucky; 2012. <http://www.urban.org/sites/default/files/publication/26231/412702-Evaluation-of-Statewide-Risk-Based-Managed-Care-in-Kentucky-A-First-Year-Implementation-Report.PDF>



oversight had negative consequences for Kentucky Medicaid patients; specifically, managed care contracts did not include patient protections that were included in other health insurers' contracts.

Foster MCO competition and work to ensure sufficient plan choices

We recommend that North Carolina **ensure a sufficient level of competition and plan options for patients** to reduce the risk of disenrollment and safeguard the long-term sustainability of care delivery. To do so, we recommend that North Carolina DHHS follow through on its current 1115 commitment to **set actuarially sound and fair capitation rates**, and **supplement payment systems with exit penalties for MCOs** to encourage market stability.

Our examination of Alabama, Indiana, and Kentucky's experiences indicate that despite managed care's promises of savings, MCOs often experience financial losses in early years, which increases the risk of MCO exits. Financial pains in states which chose to expand Medicaid can be partially attributed to the adverse selection of sicker Medicaid patients enrolling into managed care, leading to increased utilization of high-expense services by populations which previously did not have access to care.⁶ Although adverse selection is primarily a consequence of Medicaid expansion, the effect is also likely to occur in NC's transition to managed care, as MCOs would have to account for the starkly different costs of children and disabled/elderly beneficiaries. Additionally, reimbursement schemes may be insufficient for MCOs to generate profit. For example, Kentucky's failure to appropriately risk-adjust payments for Kentucky Spirit eliminated the MCO's financial incentive to continue covering services at the given rate, which led the plan to exit the market.

The state of North Carolina may also experience financial growing pains during the transition to managed care. Our research suggests that states in this position may experience a surge in administrative costs (as seen with Kentucky), as operating multiple plans on a regional or statewide level can increase the demands on DHHS officials to regulate care quality and ensure timely payments to providers.

The unpredictability of MCOs' market behavior is exemplified by the risk of MCO exits, which in some states, occurred prior to implementation. Alabama, whose Section 1115 waiver without Medicaid expansion was approved by CMS in 2016, has experienced difficulties attracting regional care organizations (RCOs), which are similar to the PLEs proposed in North Carolina's Section 1115 Waiver.⁷ Major academic health systems, like the University of Alabama-Birmingham, have expressed skepticism about the effectiveness of managed care and have not submitted bids to participate. Insurers have also created difficulties, with Centene (which is also expected to participate in North Carolina's managed care system) withdrawing its proposal to operate an RCO in each of Alabama's five regions.⁸ In other states, instability can extend beyond the transition. For

⁶ Rob Damler, *Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured* (Washington, DC: Milliman, August 2009).

<http://us.milliman.com/uploadedFiles/insight/research/health-rr/experience-under-healthy-indiana.pdf>

⁷ Brown, Melissa. "UAB, other organizations withdraw from state RCO program." *Industry News: Healthcare*. Birmingham Business Journal, 27 Oct. 2016. Web. 19 May 2017.

<http://www.bizjournals.com/birmingham/news/video/2016/10/uab-other-organizations-withdraw-from-state-rco.html>

⁸ Sell, Mary. "Group pulls out of RCOs, some lawmakers skeptical about future." *Montgomery Bureau*. Times Daily, 3 Mar. 2017. Web. 19 May 2017. http://www.timesdaily.com/news/state-capital/group-pulls-out-of-rcos-some-lawmakers-skeptical-about-future/article_2d783223-9289-505e-91cb-a4ae78a585fc.html



example, Kentucky’s capitation rates failed to compete with established fee-for-service payment levels in existing provider networks, leading one MCO (Kentucky spirit) to exit the market place in less than a year.

Consequently, it is imperative that North Carolina take steps to **foster competition in MCO markets, and adjust for risk** to minimize the possibility of gaps in health coverage.

Theme 3 – Manage care to improve overall health, not only to treat injury or illness

Provision of whole-person care requires facilitating access to delivery systems and designing models that address both the causes and effects of illness. Patients can benefit the most from interventions focusing on overall health if North Carolina DHHS is able to target at-risk populations early in disease progression. This leads to twofold challenge. First, the Department should develop the capacity to stratify populations for risk and need. Second, the Department should work to close gaps in service access, which when unattended, lead to reactive rather than proactive approaches to care delivery. As North Carolina works to develop comprehensive care programs, it will be critical to ensure that DHHS has the bandwidth and resources to provide care across the diverse spectrum of patient needs. To achieve these goals, we recommend the following:

Implementing Population-Level Approaches to Patient Stratification

Employ “hotspotting” techniques to identify high-risk, high-needs patients

“Hotspotting” is a term borrowed from law enforcement, originally used to describe the process of using statistical methods to map neighborhoods and identify the areas of highest crime, or hotspots.⁹ The technique was pioneered in healthcare by the Camden Coalition in New Jersey, which improved the effectiveness of care interventions by identifying where at-risk patients lived and what their overall health needs were. Employing a data-driven approach to risk stratification allowed Camden to reduce reactive care (e.g., hospitalizations) by 40% and focus on proactive health service provision (e.g., medication adherence plans for HIV patients) to support patient health over the long-term.¹⁰ Consequently, we recommend North Carolina DHHS **develop the capacity for hotspotting to identify high-needs patients** who would benefit from whole-person care early-on. To do so, we recommend North Carolina leverage the state’s new health information exchange to gather and integrate data on health and social disparities to better identify high-risk, high-needs patients.

Addressing Obstacles to Continuous Care

Implement facilitated enrollment processes to encourage patient transition to managed care

We recommend that North Carolina DHHS **deploy facilitated (or passive) enrollment processes, specifically for the dual eligible population**. This entails automatically enrolling dual eligible (duals) patients covered by both Medicaid and Medicare into MCOs to ensure that the population is

⁹ Gawande A. The Hot Spotters. *The New Yorker* 2011. <http://www.newyorker.com/magazine/2011/01/24/the-hot-spotters>

¹⁰ Brenner S. One Part Data, One Part Heart Revolutionizes Health Care. 2013; <http://communitywealth.com/one-part-data-one-part-heart-revolutionizes-health-care/>. Accessed April 8, 2017.



continuously insured. We believe that ensuring access to care is a prerequisite for patients to benefit from comprehensive care management programs. Duals often suffer from a range of chronic diseases, and would benefit from enrollment reforms that prevent fragmentation of care delivery. Many states, including Virginia and South Carolina, have continuity of care provisions that allow duals to see the same providers for three to six months after transitioning to a new MCO, even if they are not within the network.^{11,12} South Carolina's Healthy Connections Prime has even gone as far to allow out-of-network contracts on a case-by-case basis, if a patient insists on staying with a doctor that refuses to join an MCO's network. Virginia, which has had relatively successful enrollment into dual-specific MCOs, attributes its success to passive enrollment, through which 92% of beneficiaries joined.¹³ If relying on a passive enrollment strategy, it is critical to ensure that dual eligible patients can maintain provider relationships, given that these patients often have complex medical needs.

Harmonize mechanisms of care delivery for dually-eligible patients

Several states, such as Texas and Florida, rely on D-SNPs (Medicare Advantage's Dual Eligible Special Needs Plan), which requires Medicare Advantage MCOs to contract with state Medicaid agencies, to enhance financial alignment and make Medicaid spending more predictable for the dual population. However, only ~6% of the North Carolina dually eligible population is enrolled in D-SNPs, perhaps because these plans are not consistently offered in all counties. North Carolina DHHS could **promote enrollment in D-SNPs** or **create a dual-specific MCO** to encourage financial alignment between Medicare and Medicaid.

Redesigning Care Systems to Better Meet Patient Needs

Shift the locus of care delivery

A significant source of health spending is long-term care, which is often delivered in costly environments (e.g. nursing homes, institutional facilities). Shifting the locus of care delivery offers an opportunity to improve care quality at a lower cost. As North Carolina DHHS considers the services covered under managed care for the dual eligible population, chronically ill, and elderly populations, overall health can be improved by **reimbursing for community-based services that allow home-based care**, which aligns patient preferences with lower costs. For example, South Carolina's Healthy Connections Prime demonstration covered services like home repairs, meal deliveries, and caregiver support. Moreover, the South Carolina demo reimbursed for community-based case management and home visits, which facilitated the facility-to-home transition while providing holistic, preventative care.¹⁴ Florida, which has introduced managed long-term services

¹¹ Healthy Connections Prime Ombudsman. 2015; <https://www.healthyconnectionsprimeadvocate.com/>. Accessed April 20, 2017.

¹² Program Data. 2017; <https://mssp.scdhhs.gov/SCDue2/site-page/program-data>. Accessed April 9, 2017.

¹³ Cuellar A, L'Huillier A. Enrollment and Disenrollment Patterns in the Commonwealth Coordinated Care (CCC) Program for Dual-Eligibles. *Department of Health Administration and Policy* 2016. http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx

¹⁴ South Carolina Financial Alignment Demonstration -Healthy Connections Prime. *Financial Alignment Initiative* 2016; <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/SouthCarolina.html>. Accessed April 9, 2017.



and support (MLTSS), has accomplished a reduction in usage of long-term care facilities by dual-eligible patients, translating to an increase in cost savings.¹⁵

Expand the Priority Patients Program

Fortunately, North Carolina already has successful models of whole-person health, which can provide a foundation for North Carolina DHHS to expand efforts to shift the focus of care delivery from episodes of illness to overall health. Although North Carolina’s contract with the Community Care of North Carolina (CCNC) will be ending, we recommend that North Carolina DHHS work with MCOs to **build upon the success of CCNC’s Priority Patients Program**. The program includes care management, home visits, and coordination with providers and social services. This model of care serves the “super-utilizer population,” which is approximately 5% of CCNC patients. By addressing social determinants of health in addition to traditional care delivery, North Carolina providers achieved an average reduction in per-patient cost of 6%, with savings rising to 10% for the most expensive patients.¹⁶

Theme 4 – Consider how income, housing, lifestyle, etc., affect health and healthcare services

We applaud North Carolina DHHS’s recognition that social determinants of health – income, race, education, and other characteristics – have significant effects on health outcomes. To address these factors, we recommend that North Carolina incentivize commercial plans and provider-led entities to **employ a “hotspotting” approach**, described in the preceding section, to contextualize a patient’s health needs to their social environment. In addition to identification, DHHS should work with MCOs to account for social disparities when designing models of care delivery. Patients would benefit from an increased use of **interdisciplinary teams**, which integrate the delivery of health and social services to meet the wide range of patient needs, and **greater use of health technology**, which can overcome social barriers to care access. To achieve these goals in practice, we recommend the following:

Incentivize care coordination within organizations

Healthcare delivery alone will not guarantee improved health outcomes, but instead must be paired with the provision of social services. However, doing so requires personnel beyond traditional clinical providers. We recommend that North Carolina Medicaid **incentivize care coordination using multidisciplinary teams**. For example, Virginia’s Coordinated Care Clinic redesigned care delivery for its “super-utilizer” population by using an interdisciplinary team of providers to address both the medical and social determinants of health. Personnel included physicians, nurse practitioners, social workers, clinical psychology fellows, and registered nurse case managers. Each team member offered a distinct skillset to address the diverse needs of patients with chronic diseases. Within a single year, the program achieved a 49% reduction in cost, 44% reduction in inpatient

¹⁵ A Snapshot of the Florida Medicaid Long-term Care Program. 2017;

https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf

¹⁶ Mann C. *Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality*. Baltimore, MD: Centers for Medicare and Medicaid Services; July 24, 2013 2013. <https://www.medicare.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf>



hospitalizations, and 38% fall in ED utilization.¹⁷ Although this progress occurred at the organizational level, we recommend the North Carolina DHHS **develop the data-sharing capacity at the system level for organizations to hotspot at the local level**. We also recommend that DHHS **develop financial incentives for MCOs to engage in care coordination**. To support care innovations, we recommend that DHHS establish best practices (e.g. multidisciplinary teams) for addressing both physical and social determinants of health.

Theme 7 – Increase access to care and treatment of substance use disorder

Gaps in care delivery stem in part from shortages in care capacity. Although North Carolina has a high rate of provider participation, the majority of providers remain concentrated in highly populated urban areas, leaving many high-risk low-income patients in rural areas underserved. To close this gap, we recommend that North Carolina DHHS (1) **invest in telemedicine to improve delivery** and (2) **update graduate medical education (GME) programs** to enhance the provider pipeline for North Carolina and Medicaid beneficiaries' ability to access all care, including for substance use disorders.

Telemedicine Recommendations:

Remove originating site requirements to increase patient access to providers

Telemedicine, the remote delivery of healthcare using telecommunication services, affords providers the ability to connect with patients beyond their geographic scope of practice. This approach has been shown to reduce costs and improve health outcomes. However, telemedicine use in North Carolina is still hindered by the existence of “originating site requirements,” an outdated regulation that stipulates a patient must be at a specific site location to receive telemedicine care. In rural areas, a requirement for patients to be physically present at a provider’s office still poses barriers to accessing care via telemedicine. In contrast, Iowa successfully launched a program called Iowa Chronic Care Consortium (ICCC), which leverages telemedicine for Medicaid patients in their homes, using daily contact and care management by phone. ICCC ultimately reduced per-patient spending by \$11,278 (\$3 million in aggregate) for heart failure patients and decreased inpatient visits for diabetes patients by 54% during a year-long trial.¹⁸ Without the burdensome regulation of originating site requirements, ICCC patients could use telemedicine services in their home – a “telehome” approach. To pilot innovative telehome programs, we recommend that North Carolina follow in the footsteps of other 24 other states (most recently, Iowa, Arizona, and Colorado) and **remove the originating site requirement**, allowing patients in rural areas to better access care using telemedicine.¹⁹

¹⁷ Virginia Commonwealth University Health. *VCU Health Initiative: Addressing High Utilizer/Multi-Visit Patient Readmissions*. 2016. <http://www.vhha.com/quality-patient-safety/wp-content/uploads/sites/20/2016/11/VCU-November-15-Readmission-Presentation.pdf>

¹⁸ Lustig T. The role of telehealth in an evolving health care environment: workshop summary. 2012; <http://www.ic4n.org/wp-content/uploads/2014/06/IoM-Telehealth-2012-Workshop-Summary.pdf>.

¹⁹ Elish P. Telehealth's year in review: 5 trends in state policies. *The Growth Channel* <https://www.advisory.com/research/market-innovation-center/the-growth-channel/2017/01/state-telehealth-2017>.



Establish clarity on reimbursements for telemedicine

Limited reimbursement remains a significant barrier to widespread telemedicine use in NC. North Carolina DHHS’s current definition of telemedicine – the “use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise” – renders three types of telemedicine services (store and forward, remote patient monitoring, and eConsult) non-reimbursable.²⁰

These services have been shown to be beneficial for Medicaid patients in other states. For example, store and forward, or the asynchronous electronic communication of health history such as records or scans to a provider, helped New York Medicaid achieve a 55% drop in hospitalizations and a total 42% drop in medical costs.²¹ Remote patient monitoring, or the use of mobile medical devices that collect and transmit patient data directly to a provider in a different location, increased medication adherence to 98.2% in Pennsylvania’s Keystone Hospice program and reduced costs by 38% in the Kansas Frail Elderly waiver program.^{22,23} Furthermore, eConsults, or asynchronous electronic message exchanges of patient information between a primary care physician and a specialist, allowed providers to resolve 69% of cases without an in-person visit in a Connecticut pilot.²⁴

Based on these results, we recommend that North Carolina DHHS **amend the definition of telemedicine to include broader services, and allow them to be reimbursable under Medicaid.**

Graduate Medical Education

Graduate medical education (GME) is the phase of education following the completion of medical school, which aims to impart clinical knowledge and skills on the future U.S. physician workforce. Programs funding GME for medical students in North Carolina can be a powerful tool for reducing provider shortages, given the fact that medical trainees who complete both their undergraduate medical education and residency within the state of North Carolina are more likely to continue practicing in the state. However, the current GME program lacks transparency and resources, reducing its effectiveness at retaining providers for the state’s health system. We recommend the following to use GME to help close provider gaps:

Create a centralized database for GME

At present, the process of allocating GME funding is neither transparent nor precise, largely due to lack of defined data and metrics about the current program. In response, we recommend North

²⁰ Realizing the Promise of Telehealth: Understanding the Legal and Regulatory Challenges. *Trendwatch* 2015.

²¹ Survey of States Providing Coverage for In-Home Telemonitoring Services. *Survey of States Providing Coverage for In-Home Telemonitoring Services* https://www.cga.ct.gov/hs/tfs/20151008_Medicaid_Rates_for_Home_Health_Care_Working_Group/20151109/Survey_of_States_Providing_Coverage_for_Telemonitoring.pdf.

²² Peifer S. The state of technology in aging services in Pennsylvania. *Center for Aging Services Technologie*. 008.

²³ State Medicaid best practice: Remote patient monitoring and home video visits. 2013; <http://dev.americantelemed.org/docs/default-source/policy/state-medicare-best-practices-remote-patient-monitoring-and-home-video-visits.pdf?sfvrsn=4>.

²⁴ Electronic Consult Reimbursement Roadmap. 2016; http://www.blueshieldcafoundation.org/sites/default/files/u19/eConsult_GPS_032916.pdf.



Carolina DHHS **create a centralized GME database that collects data** on various physician behaviors, including: 1) matching into needed specialties for rural areas (including primary care, general surgery and psychiatry), 2) decisions to practice in North Carolina, and 3) acceptance of new Medicare and Medicaid patients. These data points can be used to guide workforce adjustments, as GME stipends could then be assigned to specific residencies in support of community-based primary care practices with a stronger track record of meeting state needs. Additionally, we recommend North Carolina DHHS **shift more Medicaid funding toward primary care-specific residency programs** to improve North Carolina primary care provider retention, with incentives for medical students to transition to rural programs to improve provider allocation between urban and rural care across the state.

Expand GME payments for non-physician providers

Although Medicare GME payments are limited to physicians, dentists, and podiatrists, states retain the flexibility to use Medicaid funds for other members of the health workforce. Twelve states, including Virginia and South Carolina, support the training of other health professionals, including advanced practice nurses, physician assistants, emergency medical technicians, pharmacists, or laboratory personnel.²⁵ We recommend that North Carolina **expand GME payments to encompass these “physician extender” professions**, while holding these positions to similar tracking and accountability standards as physician GME programs. Allocating funds towards physician extenders would bolster the healthcare workforce – a critical benefit as non-physician providers (e.g. nurses) can help close gaps in care delivery in the face of physician shortages.

CONCLUSION

We are grateful to North Carolina DHHS for providing us and other stakeholders across the state to offer feedback regarding the proposed plan to transform North Carolina Medicaid and Health Choice.

These publicly-administered programs are the backbone of healthcare delivery in our state, supporting two million North Carolinians every day. We hope that North Carolina DHHS will consider our recommendations by working to increase access to care, creating a long-term transition timeline, building in financial flexibility and administrative support for providers, and investing in educational and technological interventions to improve healthcare delivery. Please see our comprehensive analysis of the state Medicaid program in our full report with recommendations for [North Carolina Medicaid reform](#).

We look forward to working with North Carolina DHHS to improve healthcare throughout North Carolina. We would welcome the opportunity to discuss our recommendations with North Carolina DHHS staff. For more information, please contact Dr. Barak D. Richman, J.D. Ph.D. at richman@law.duke.edu.

The following Duke students and faculty were involved in the research and writing of the Bass Connections NC Medicaid Reform report:

²⁵ Eden J, Berwick, D., Wilensky, G. Medical Education. *Recommendations for the Reform of GME Financing and Governance*. 2014; <https://www.ncbi.nlm.nih.gov/books/NBK248022/>.

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