

Role and Structure of the North Carolina Physician Advisory Group:

A Collaborative Effort Between Providers and Medicaid

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Bringing practitioners into the process of implementing a program like CCNC is an important element in its success. Since Community Care of North Carolina (CCNC) is part of the Medicaid program in the state it falls under legislative guidance provided by Congress. The Deficit Reduction Act of 2005 required states to restructure their Medicaid programs and many were criticized for not including appropriate input from health care providers or the public.^{1a} North Carolina had already developed a strong process to bring physician input into the CCNC planning and implementation process and was able to make use of existing structures to help achieve federal as well as state goals. Still, CCNC physicians wanted to provide input regarding the clinical content of Medicaid policies in order to benefit the Department of Medical Assistance (DMA), the public, and the physician community. The North Carolina Physician Advisory Group (NCPAG) was formed to address this need.

The NCPAG is a not-for-profit organization of health care professionals that makes recommendations to the North Carolina Department of Health and Human Services (DHHS) regarding Medicaid clinical coverage policies. This collaborative advisory role allows the NCPAG to suggest clinically appropriate policy decisions early in the administrative process, offering a potential model for other states to follow.

NCPAG Background and Statutory Authority

Federal regulations (Title 42, section 431.12) mandates each state to support a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services. While this entity is mandatory for every state that operates a Medicaid program, the roles and

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structures of such committees vary significantly from state to state. Roles of such committees may include setting budget priorities, lobbying for funds or legislation to support medical assistance objectives, involvement in policymaking, or recommending priorities and actions for the Medicaid agency. In addition, each state agency is directed to consult with the MCAC in the review of marketing materials from managed care entities.

Each state defines its own set of responsibilities for the MCAC. Only a select group of states relies on their committees to play an active role in determining the actual clinical context for

a In response, the American Medical Association is developing model state legislation to encourage a standard public comment process for proposed Medicaid changes. See Resolution 701, AMA House of Delegates, 2006 Interim Meeting, November 10, 2006. Available at: <http://www.ama-assn.org/ama1/pub/upload/mm/475/comjannotatedi06.doc>. Accessed on January 5, 2007.

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policies. For example, Alaska has five standing subcommittees that focus on strategic planning, legislative matters, and consumer relations, in addition to bylaws and executive matters. Pennsylvania has a highly structured group that focuses primarily on consumer issues, with subcommittees for consumers, fee-for-service, managed care, and long-term care. Several states involve their MCAC membership in the review of new technologies.

North Carolina has successfully taken the advisory concept to a more expert level. The North Carolina Physician Advisory Group was formed in December 1997 when the North Carolina Medical Society incorporated a 501(c)(3) not-for-profit organization to work with the state's Division of Medical Assistance to implement medical management policies for Medicaid patients. In 2003, the North Carolina General Assembly further expanded the role of NCPAG by requiring DHHS to consult with NCPAG during the development of new Medicaid medical coverage policies or amendments to existing medical coverage policies.²

On March 27, 2006, NCPAG entered into a contract with DHHS to make recommendations regarding clinical coverage policies and to provide funding for NCPAG to develop a representative panel of medical expertise and an organizational infrastructure.³ Later in 2006, the General Assembly modified a provision outlining the process for changing medical coverage policies that reiterated the role of NCPAG by requiring that:

During development of new medical coverage policy or amendment to existing medical coverage policy, [the Department shall] consult with and seek the advice of the Physician Advisory Group of the North Carolina Medical Society and other organizations the Secretary deems appropriate.^{4,b}

NCPAG Structure

The NCPAG is structured in three basic membership levels: 1) Board of Directors, 2) Committees, and 3) Consulting Council. The Board of Directors is comprised of 12 members. The NCPAG bylaws require all of the Board members to be physicians or dentists licensed in North Carolina. At least three board members must represent CCNC. Currently the following specialties are represented on the Board: family medicine, pediatrics, internal medicine, psychiatry, dental, hospitals, plastic surgery, neurosurgery, and obstetrics/gynecology.⁵ The standing committees review several policies, while members of the clinically diverse consulting council provide advice on policies related to their specialty by joining existing or ad hoc committees as needed.

In addition to these permanent members, supplementary review groups are formed when the subject of the referred Medicaid policy is outside the scope of an existing committee. These review groups are comprised of a mixture of consulting

council members, board members, and clinicians referred by state medical societies, associations, and the community. Over 100 professionals representing all medical specialties actively participate with the NCPAG as either direct members or ad hoc reviewers.

NCPAG Medical Policy Review Process

The medical policy review process begins at a monthly meeting between the NCPAG executive director, NCPAG board chair, DMA medical director, DMA assistant director for clinical policy and programs, and chief of policy development and special projects. This initial meeting facilitates open discussion between DMA and NCPAG leadership about the monthly NCPAG agenda, potential controversies, and other Medicaid issues such as service expansion, improvement, and access.

After the agenda is determined, the NCPAG holds its monthly meeting, generally via conference call due to the geographic dispersion of its members. The attendance at these meetings includes the Board of Directors, NCPAG committee chairs, the NCPAG executive director, and DMA staff. The executive directors of the state medical societies are also invited to participate in each meeting. When face-to-face meetings are scheduled, all members of the NCPAG inclusive of the consulting council and invited guests are asked to attend.

During the monthly NCPAG meeting, each new policy is introduced by DMA staff and assigned to a lead reviewer. The lead reviewer, who may be a committee chair, will oversee the review team's examination of the policy, which is typically reviewed via email and completed in one month, depending on the complexity of the issue. DMA staff members are often invited to participate in the policy review team's discussions.

Once the review team completes its deliberations, the lead reviewer and the NCPAG executive director present the policy recommendations to the Board for discussion and vote at the next NCPAG meeting. After the recommendations are approved by a quorum of the Board, the board chair sends an official communication to the DMA medical director citing the suggested revisions to the policy. However, because the NCPAG acts in an advisory capacity only, DMA has the ultimate authority to choose which recommendations to incorporate into policy.

NCPAG 2008 Policy Reviews

During the 2008 state fiscal year, DMA introduced 28 new Medicaid policies to NCPAG for review. The NCPAG completed reviews and provided clinical recommendations for 29 Medicaid policies. The number of policies reviewed by the NCPAG is greater than the number of policies received from DMA during SFY 2008 because some of these were introduced to the NCPAG at the end of SFY 2007, but not presented for

b This process is now codified in NC General Statutes Chapter 108A.

approval to the Board until the beginning of SFY 2008. These 29 policies covered a wide range of clinical services and resulted in 102 recommendations; 91 (89%) of the recommendations were incorporated into policy by DMA.⁶

NCPAG considered most policies within a relatively short period. The panel reviewed and approved all of the policies within three months of the initial presentation from DMA. Within two months, DMA posted the majority of these policies on their website for public comment. While input is often received from the public during the required 45-day period of notice, it is rare for those policies that include the full recommendations of the NCPAG to generate negative commentary that is substantial enough to delay implementation. If comments received during the standard 45-day posting period result in significant policy changes, DMA will grant an additional 15-day posting and comment period.

NCPAG reviewed an additional 92 policies during state fiscal years 2004 and 2005, before the role of NCPAG was codified by the North Carolina General Assembly.⁷

Advantages of the NCPAG Advisory Model

First, the advisory nature of NCPAG allows it to control the collaborative process used by its physician board members to provide recommendations to DHHS. Members are asked to "leave specialty advocacy at the door," and the DHHS contract limits input only to "questions referred by the Department," specifying that NCPAG "shall not advocate for any unrefereed issue."⁸ If the General Assembly were to grant NCPAG formal decision-making authority, then its Board meetings would be subject to open meetings and public records laws.

Second, this structure ensures that any DHHS decisions requiring clinical input consider current clinical practice standards and reliable evidence. By having experienced providers and academic leaders share their knowledge during policy development, DHHS is able to reinforce its assessment of current information through additional reliable sources. In fact, when DHHS has been challenged through fair hearings processes about specific policy decisions, administrative hearing officers have acknowledged the value and high standards that the NCPAG process brings to North Carolina Medicaid policy.

Third, this advisory role encourages the resolution of potential conflicts before they occur. The deliberations of technical advisory groups like the NCPAG are regulated through disclosure laws like the Freedom of Information Act, sunshine laws, or other statutes.⁹ In the Medicaid program, conflicts over the applicability of these laws often lead to costly litigation over questions of payment adequacy, coverage of denied services, or other issues.¹⁰ Public policy conflict resolution models like the NCPAG encourage up-front negotiation between parties, greater buy-in from participants, and a more efficient use of taxpayer dollars.

Fourth, since the law requires that NCPAG be involved early in the process of a proposed policy change, NCPAG members have the necessary time to consider thoroughly any relevant clinical concerns before giving an opinion. While many policies are discussed quickly, NCPAG also has adequate time to discuss recommendations that are more complex. In contrast, once DHHS publishes such policies, outside parties, including Medicaid providers, have only 45 days to comment on the proposed changes.¹¹ NCPAG's deliberations provide an opportunity for timely provider input while preserving the typical forum for relevant public comment. In contrast, the comment period for the standard administrative rule-making procedure allows for 60 days of public comment.

Finally, the consultative role of NCPAG has streamlined the process for adopting medical coverage policies. The North Carolina General Assembly has exempted the adoption of new or amended medical coverage policies from the regular rulemaking process under the North Carolina Administrative Procedure Act.¹² As a result, DHHS medical coverage policy decisions are implemented much more quickly than most other state agency policy changes. When clinicians give input in the early stages of policy development, the public benefits through the creation of timely, well-informed policies.

Disadvantages

While the NCPAG model has many advantages, its advisory nature also presents a potential weakness. Because the panel's recommendations are nonbinding, similar bodies could be at risk of becoming irrelevant to or ignored by policymakers. In North Carolina, the caliber of medical participation, the quality of its prior recommendations, and its constructive relationship with DHHS and DMA officials have contributed to the group's reputation as a trusted advisory panel. However, should other states or agencies consider this type of arrangement, it should be noted that structure alone would not guarantee success.

Additionally, the streamlined review process leaves room for criticism that patients and the public do not have early input into Medicaid coverage policy. While these policies are implemented more quickly than many state regulations, North Carolina assures the protection of patient interests by preserving the 45-day public comment period after clinicians work with DMA to revise the initial policy draft.

The nonbinding advisory nature of the clinical recommendations of the North Carolina Physician Advisory Group is the key to its nimbleness in the administrative process. Through an early integration of input from North Carolina physician experts, the NCPAG model secures informed decision-making by policymakers while streamlining the process itself. Although the final policy may occasionally differ from the advisory group's recommendations, the collaboration between North Carolina policymakers, CCNC, and specialists offers a promising model as other states continue to redesign Medicaid's federal-state partnership. **NCMJ**

REFERENCES

- 1 Center on Budget and Policy Priorities' Medicaid Waiver Workgroup. Letter to HHS Secretary Michael Leavitt. November 21, 2006. National Council for Community Behavioral Healthcare website. <http://www.nccbh.org/POLICY/SC-Letter.pdf>. Accessed January 12, 2007.
- 2 Session Law 2003, Section 285 10.19 (bb)
- 3 Contract between the North Carolina Physicians Advisory Group, Inc. and the North Carolina Department of Health and Human Services. #DHHS1045-06. March 27, 2006.
- 4 Session Law 2006, Section 66 10.4.
- 5 North Carolina Physician Advisory Group Bylaws. Contract between the North Carolina Physicians Advisory Group, Inc. and the North Carolina Department of Health and Human Services. #DHHS1045-06, Attachment K. March 27, 2006.
- 6 North Carolina Physician Advisory Group. *Summary of NCPAG Activities, July 1, 2007-June 30, 2008*. North Carolina Physicians Advisory Group website. <http://www.ncpag.org/PDFDocs/2008SummaryNCPAGActivity.pdf>. Accessed November 17, 2008.
- 7 North Carolina Physician Advisory Group. *Summary of NCPAG Activities, October 2003-September 2004*. North Carolina Physicians Advisory Group website. http://www.ncpag.org/PDFDocs/NCPAGACTIVITIES10_03-9_04.pdf. Accessed January 4, 2007.
- 8 Contract between the North Carolina Physicians Advisory Group, Inc. and the North Carolina Department of Health and Human Services, #DHHS1045-06, Attachment B, Sec. 11a. March 27, 2006.
- 9 Reporters Committee for Freedom of the Press. *Open Governments Guide, 2006*. Reporters Committee for Freedom of the Press website. <http://www.rcfp.org/ogg>. Accessed January 12, 2007.
- 10 Sorrel AL. *Connecticut groups sue to find out Medicaid HMO physician pay rates*. *American Medical News*. September 18, 2006. <http://amednews.com> website. <http://www.ama-assn.org/amednews/2006/09/18/gvsb0918.htm>. Accessed January 16, 2007.
- 11 Session Law 2005-276, Section 10.11.(w)
- 12 NC General Statute §150B-1(d)(9).

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