September 8, 2017

Mandy K. Cohen, MD, MPH
Secretary, NC Department of Health and Human Services
101 Blair Drive, Adams Building
2001 Mail Service Center, Raleigh, NC 27699

Subject: North Carolina's Proposed Program Design for Medicaid Managed Care

Dear Dr. Cohen,

It is with pleasure that I present to you the following response from Community Health Centers (CHC) to the Request for Comments on North Carolina's Proposed Program Design for Medicaid Managed Care, August 2017. We support many components incorporated into this design and we are grateful for the opportunity to offer feedback on these greater details of the new Medicaid program.

Our comments are outlined to respond to specific sections of the program design as they were included in the document issued in August 2017 and are not ranked based on priority. The comments are a collaboration of perspectives collected by Community Health Center leaders, providers, and staff, as well as those of NCCHCA staff who assist with training and technical assistance for the CHC members.

We thank you for the ongoing dialog and incorporation of many of our previous suggestions into this Program Design. We are encouraged by the direction Medicaid Reform is taking under your leadership.

Sincerely,

E. Benjamin Money, MPH
President & CEO
NC Community Health Center Association
4917 Waters Edge Drive, Suite 165
Raleigh, NC 27606
919-469-5701
moneyb@ncchca.org

I.   Overview of Managed Care

I. A. Key Goals and Objectives for Transformation Efforts

The North Carolina Community Health Center Association is encouraged by the NC Department of Health and Human Services' commitment to the key objectives outlined at the forefront of the program design proposal. In particular, the focus on whole-person, coordinated, equitable care is consistent with the Community Health Center program vision and goals. We are also supportive of NC DHHS efforts to maintain access to care and minimize administrative burdens for providers.

I. C. Continued Stakeholder Engagement

NCCHCA is appreciative of NC DHHS' efforts to gather feedback from the public and we are thankful for the outlined set of opportunities that remain to provide feedback over the next six months. As the transformation process evolves, there are new components of the program that will impact providers and patients in ways we haven't considered and it is helpful to have an opportunity to respond to updated design plans.

A few suggestions with respect to public feedback include:

- Make the Medical Care Advisory Council (MCAC) meetings more accessible to the general public by broadcasting them via webinar in addition to the conference call.
- Establish a consumer advisory group for Medicaid transformation that would include beneficiaries receiving a variety of Medicaid services such that different components of the Medicaid program are represented, as well as including consumer advocate groups.
- Launch a FAQ document on the DMA website that is updated on a weekly basis.

II.   Types of Managed Care Plans

II. B. Implementation of PHPs

NCCHCA supports the DHHS recommended approach to implementation of Prepaid Health Plans (PHP). We are pleased to see the protections against anticompetitive behavior for commercial plans and provider-led entities. This is particularly a concern with respect to hospitals systems and large specialty groups. Some Community Health Centers have experienced being excluded from private insurance networks because they were seen as a competition to hospital-owned primary care practices. In a Medicaid environment, that would be detrimental both to Community Health Centers and to the Medicaid beneficiaries themselves. To further strengthen protections against anticompetitive behavior, NCCHCA would like to see added prohibitions against limiting essential community providers' access to health system owned/controlled specialists and hospitals participating in health system-owned PLEs.

II. C. Standard Plans and Tailored Plans

NCCHCA supports DHHS' intention to develop tailored plans for special populations with unique health care needs. However, NCCHCA encourages DHHS to consider (and look to other states for examples) of how this can be implemented in a way that does not stigmatize beneficiaries that can be identified as members of these tailored plans.

III.   Populations in North Carolina Managed Care

III. B. Delayed Mandatory Enrollment

NCCHCA supports the DHHS recommended approach to delaying enrollment for certain populations with some minor suggestions. First, the Program of All-Inclusive Care for the Elderly (PACE) is a very effective model for managing the costs of nursing-home eligible

North Carolinians while also providing them with the opportunity to continue living independently by surrounding them with the medical and social resources they need. Two Community Health Centers have very successful PACE sites and we recommend you follow the Governor's Advisory Council on Aging's recommendation to expand the PACE program.[1] Doing so would allow new programs to be established before they are transitioned to the new Medicaid system under the delayed mandatory enrollment.

Secondly, we recommend providers participating in PACE and the Medicare Shared Savings Program (MSSP) be given access to Medicaid claims data on their assigned beneficiaries now, in advance of the enrollment of duals. This will allow them to evaluate the data and learn to better manage this costly population at the provider level before entering the managed care environment.

IV.   Integration of Physical and Behavioral Health
IV. A. Integration of Physical Health, Behavioral Health, and Intellectual and Developmental Disability Services

NCCHCA strongly agrees with the approach DHHS intends to use to incorporate behavioral health, intellectual and developmental disabilities services and physical health services. That is the basic model of Community Health Centers. CHC leaders recognized the populations they serve – those with health care access barriers or targeted unmet needs – have more than just physical health needs. Addressing their behavioral health needs in an integrated setting has allowed CHCs to minimize the transportation and access barriers for individuals needing services beyond physical health care services. Additionally, it has made the physical services more effective by also meeting patients' other behavioral and social needs. CHCs welcome the opportunity to expand and enhance their integrated services and appreciate state policies that will support those efforts.

V.   Medicaid Opioid Strategy

DHHS' focus on combatting the opioid crisis is both commendable and necessary. Community Health Centers often end up being the primary care providers for this population because many of them are uninsured and have significant unmet health needs. We strongly agree with your assessment that the Carolina Cares program would strengthen your efforts to address this issue statewide by directly serving 150,000 North Carolinians with substance use disorders, as well as improve detection and greater prevention. We are also pleased to see the plan includes the addition of low intensity residential substance use disorder services.

Upon release from correctional institutions, individuals with substance abuse history are highly vulnerable to relapse, overdose, and death. We suggest expanding initiatives such as the Formerly Incarcerated Transitions (FIT) Program to connect these individuals to community-based treatment services.

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[1] Letter to Governor Roy Cooper from Governor's Advisory Council on Aging with 2017 Legislative Recommendations. Available at:
http://ncpace.org/images/uploads/GAC%20Letter%20to%20Governor%202017.pdf

VI. High-Functioning Managed Care System
VI. A. Quality, Value, and Care Improvement
VI. A. 1. Quality Strategy

NCCHCA supports the DHHS commitment to identify a single set of statewide quality priorities tied to a streamlined set of measures and metrics. This will be particularly important at the provider level so that individual providers and practices do not have to manage data collection and reporting that is different for each Prepaid Health Plan (PHP). Some Community Health Centers operate sites in multiple regions and, thus, could be reporting to as many as 7 PHPs.

- NCCHCA requests that NC DHHS incorporate into the RFP, a requirement that each selected PHP collect the same set of measures and metrics from providers.
  As the August 2017 program design is currently written, it is not clear that this section is referring to a single set of measures and metrics at the provider level. Instead, it may be inferred that the single set of measures and metrics will be set at the state level and PHPs will have some variability in how they collect those measures and metrics. NCCHCA recommends clarification that the "concise set of metrics" (p.31) will be collected by the PHPs at the provider level, as required in the successful RFPs.
- Secondly, we recommend developing uniform submission process that will minimize the administrative burden of reporting this data to multiple PHPs. We suggest NC DHHS ensure a streamline process for reporting from the provider-to-PHP level.
- Finally, NCCHCA recommends fully engaging the assets of NC Health Connex (NC-HIE) to support data exchange and analytics.

VI. A. 2. Value-Based Payment

NCCHCA strongly supports accelerating the adoption of Value-Based Payment (VBP) arrangements to increase providers' attention to population health, appropriateness of care, and overall value. Community Health Centers have been early adopters and leaders in VBP initiatives. For example, eight NC Community Health Centers are members of a CHC-only Medicare Shared Savings Program ACO. Together, they are evaluating their performance metrics and determining how they can improve patient quality of care and concurrently reduce costs. A number of other Community Health Centers are in other heterogeneous Medicare ACOs across the state.

Another example is the Program of All-Inclusive Care for the Elderly (PACE) program at Piedmont Health Services. PACE is a Category 4 VBP program according to the Health Care Payment Learning and Action Network (HCP-LAN) because the program's payments are capitated and they must manage quality outcomes within a designated total cost of care.

Many Community Health Centers are anxious for new VBP opportunities within the managed care environment because they believe moving away from fee-for-service care will allow them the capacity to develop new, innovative care models to better serve their patients. Nonetheless, we also advise NC DHHS to take a careful approach to the encouragement of VBP initiatives and the outcomes of those efforts. A recent study in Health Affairs that evaluated the impact of Community Health Center participation in the Center for Medicare and Medicaid Services' Advanced Primary Care Practice Demonstration from 2013-2014 found clinicians and staff in the health centers reported statistically significant declines in multiple measures of satisfaction, work environment and practice culture. Possible stressors included the adoption of health information technology, practice

transformation and increased demand for services.[2] Thus, we recommend monitoring the impact the numerous changes to Medicaid managed care will have on Medicaid providers and staff and prioritizing the satisfaction and participation of providers to ensure a robust clinician network remains accessible to and happy to serve Medicaid beneficiaries in North Carolina.

Finally, Community Health Center experiences with VBP initiatives have already taught us a lot about challenges that arise within these programs. First and foremost, risk adjustment is integral. If the acuity of the patient conditions and their circumstances are not taken into account, savings can be unattainable. Furthermore, inaccurate provider coding, data collection inconsistencies, and data cleaning challenges also can result in less than optimal results. It may take time for providers and the VBP processes to coalesce to where they are both successfully achieving the value goals and reflecting that in their data outcomes.

VI. A. 4. Data Collection, Exchange and Analysis
Data is crucial to effective care and prevention. NCCHCA supports the NC DHHS program design outline for data collection, exchange and analysis. It is not clear in the Program Design whether or not MCOs will be responsible for standardizing data collection for providers. NCCHCA strongly recommends clarification that PHPs will collect standardized data from providers such providers are reporting the same set of data to all PHPs.

Two key components of information that will help primary care providers improve care to their patients include the immediate reporting of patients who are hospitalized and discharged from the hospital. NCCHCA recommends NC DHHS include in the RFP a requirement that PHPs provide primary care providers (PCP) with real-time data on assigned beneficiaries who fall into these categories. Having this information will enable the PCP to follow up with his/her patient to ensure he/she receives needed follow up and preventive care.

NCCHCA is encouraged by NC DHHS explorations of a standardized social needs screening instrument. We believe this would be very valuable for primary care providers to help them assess social needs of which they may otherwise be unaware. Community Health Centers are well positioned to implement this type of screening instrument because they have extensive experience with other screening tools, such as collecting SDOH data for the Uniform Data System report, piloting their own tools to assess and assist with patient social needs, piloting PRAPARE, and utilizing the Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments. Beyond identifying a social needs screening instrument, NCCHCA believes it is important to determine how the tool can be actionable. Clinicians and staff often feel compelled, once they collect such information, to act upon it in a way that can benefit the patient. Without adequate resources and actionable guidelines, it may be demoralizing for providers to collect such information. Investment should be made in systems that can monitor in real-time the availability of resources at social service agencies to avoid referring patients to agencies that have been depleted.

VI. A. 5. Care Management and Advanced Medical Homes
The NC DHHS overall care management strategy and vision for Advanced Medical Homes are well envisioned and we strongly support their implementation. NCCHCA believes the

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[2] Friedberg M et al. *Federally Qualified Health Center Clinicians And Staff Increasingly Dissatisfied With Workplace Conditions.* Health Aff:August 2017,vol. 36 no. 8 1469-1475.

third key principle – that of ensuring care management and care coordination are delivered at the local level to the fullest extent possible – is the most crucial component. We are pleased that care management and care coordination requirements for all PHPs will include preserving current provider-led care coordination functions. Additionally, it should be required that Advanced Medical Homes maintain the option of directly hiring care coordinators, case managers, and community health workers.

Community Health Centers are well positioned to serve as Advanced Medical Homes (AMH). They already have a patient-centered, team-based care model and, in many cases, have integrated behavioral health and connect patients to needed social services. Furthermore, most Community Health Centers have already been identified as Patient-Centered Medical Homes. We believe CHCs with these qualifications should be recognized as AMHs.

NCCHCA is grateful to NC DHHS for maintaining minimum Medical Home Payments for Advanced Medical Homes at all Tiers so that existing levels of care coordination for Medicaid beneficiaries remain. Without that access, many Community Health Center providers would no longer be able to support their on-site care coordinator positions. Furthermore, NCCHCA believes AMHs should receive Medical Home Payments starting above the current Carolina Access payment rates if they are functioning beyond the current Carolina Access standard for Medical Home because the work is more costly and intense than current Carolina Access participation requires. NCCHCA is encouraged by the opportunity to take on additional functions that will both improve their performance and make them eligible for performance-based payments which will enable them to enhance services or implement new innovative models of care.

NCCHCA recognizes the work that still needs to be done to develop the AMH model, including the functional requirements and performance expectations. We request an opportunity to identify a CHC representative to assist NC DHHS in the development process.

VI. A. 6. Provider Supports
NCCHCA supports the DHHS recommended approach to managing provider support through the Medicaid managed care transition. Carolina Medical Home Network (CMHN), a HRSA-supported Health Center Controlled Network (HCCN), receives federal funding to assist federally qualified health centers (FQHCs) with achievement of PCMH, data analytics, and practice transformation towards value-based care. CMHN is specifically designed to serve the unique model of Community Health Centers. CMHN should be allowed to serve, and be funded, as a Regional Provider Support Center (in a statewide manner) for all FQHCs. This approach would leverage the federal investment and enhance services to transition these essential safety net providers to managed care.

The transition to managed care and the implementation of new technologies and services may lead to unintended payment disruptions. We urge the department to make available preliminary payments, bridge loans, and other supports to keep the doors of care open.

VI. A. 7. Social Determinants of Health
NCCHCA commends NC DHHS for incorporating social determinants of health into the Medicaid transformation initiative. We agree that North Carolina currently lacks a comprehensive strategy to address social determinants of health (SDOH) and that transformation is a unique opportunity to identify and address social needs. We support the three primary areas of focus – food insecurity, housing instability and transportation.

Community Health Centers often identify these three areas as concerns for their patients. NCCHCA recommends the broadest definition of transportation barriers, including those impacting access to employment and other social needs, rather than just barriers to healthcare services.

NCCHCA is excited to learn more details about how NC DHHS intends to approach these issues through Medicaid reform. First and foremost, it will be helpful for providers to have specific guidance on collecting SDOH data in a standardized way so that it can be comparable across the state and over time. NCCHCA recommends developing an advisory group to assist NC DHHS with this process and outlining participant roles and anticipated outcomes from the group. Of course, Community Health Centers would like to be represented on any such committee and would actively contribute ideas and offer feedback.

With respect to resource mapping and resource databases, NCCHCA suggests allowing the social resource management databases to be edited by all users so that resource changes can be reflected in real-time and people accessing services can comment on accessibility (e.g., Yelp, GasBuddy, Waze).

As NC DHHS gets further along in developing the SDOH assessment protocol, NCCHCA encourages you to ensure the assessment is focused on the entire family, rather than solely the Medicaid beneficiary. In many cases, the Medicaid beneficiary is the child. However, his/her parent/guardian and the circumstances of his/her family environment must be accounted for to identify the full range of needs for the family and, thus child. There are a few policy options that are good examples of this:

- NC DHHS should ensure that state policy guidelines reimburse providers for maternal depression screening, even when the mother is not a Medicaid beneficiary.
- North Carolina should explore how the state and counties can use available data and application and enrollment encounters with Medicaid beneficiaries to conduct outreach, education, and enrollment into other programs and benefits to address social needs. For example, NC DHHS should implement a streamlined process to automatically assess Medicaid recipients for SNAP eligibility. As a result, beneficiaries could be assisted even before social needs are identified through a social needs assessment.

Many community health centers are already collecting and acting on SDOH data, both formally and informally. This work requires additional time and planning on the part of practices, especially for providers who attempt to act on identified needs and for providers serving a large number of uninsured patients. There should be incentives for providers to collect and act on SDOH data, especially for those who have committed workforce to not just identify patient needs but follow up on identified needs. Implementation will not be easy and it will require resources to support staff who can manage patients' needs and connect them to services. Even Community Health Centers will be limited in what they are able to accomplish without financial support.

NCCHCA supports the intent to identify, scale, and strengthen existing innovative initiatives that aim to more closely link the health care and social services systems. More information is needed on what initiatives will be supported, what entities can pursue funding for this work, and how SDOH indicators will be integrated into the proposed program design. While we understand and agree with the importance of evidence-based initiatives, we note that many existing interventions have not had the opportunity to undergo rigorous outcomes

testing. We suggest that NC DHHS outline criteria, but also give flexibility to programs who are testing innovative solutions. We also believe that the innovation projects should not be limited to those that address the three domains to be incorporated into the screening (transportation, housing, food security).

VI. A. 8. Workforce Initiatives
NCCHCA is very encouraged NC DHHS included workforce initiatives in the expanded Medicaid transformation program design. Provider recruitment and retention is a major challenge for Community Health Centers because it is (a) difficult to compete financially with offers from private offices, (b) many students and residents remain unaware of the opportunities and rewards of working in underserved areas and (c) there are limited incentives to offer providers in these challenging work environments.

NCCHCA strongly supports DHHS' proposal to expand community-based residency programs with a primary care focus. We recommend extending the residency and loan repayment opportunities to low-income and/or medically underserved urban areas where provider recruitment is also challenging for safety net primary care providers. This expansion proposal comes at a key time because of threats to existing federal residency and loan repayment programs. This month, the National Health Services Corps (NHSC) loan repayment program and the Teaching Health Centers Graduate Medical Education programs (TMCGME), funded through the Health Resources and Services Administration of the US Department of Health and Human Services, are set to expire. If no extension or reauthorization of the programs are developed, they will lose all of their funding as of October 1st. This means, no renewals of existing NHSC repayments will be made and no new loan repayments will be available. Additionally, Teaching Health Center programs will have no funding after this year. Developing a state program to the primary care workforce will provide an important safety net to ensure a foundational investment in provider recruitment and retention that will benefit the Medicaid program.

Workforce initiatives should also consider attention to recruiting paraprofessionals with a particular focus on developing the cadre of community health workers from the beneficiary population to serve in critical peer-to-peer social determinant of health interventions. Workforce programs for this population must be augmented with reimbursement policies to help Medicaid providers incorporate these staff as part of the care team.

NCCHCA supports the expansion of the Med Serv program[3] to expose aspiring clinicians to service in rural, low-income and under-resourced communities. Med Serve fellows often work as scribes to seasoned physicians. This exposes them to community needs, provides mentoring, and eases the burden of navigating the Electronic Health Record (EHR) for overworked providers.

VI. A. 9. Telehealth
NCCHCA is encouraged by the inclusion of telehealth as a focus of the program design proposal. However, we feel the current outline fails to address the changes most important to the successful use of telehealth and telemedicine opportunities. Instead, the section suggests allowing PHPs to use telemedicine to replace providers and meet network adequacy requirements.

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[3] http://www.med-serve.org/

- NCCHCA strongly advises NC DHHS against allowing PHPs to leverage telemedicine to meet network adequacy standards when an essential community provider – or other face-to-face provider – could be contracted to meet that service area's needs.
- NCCHCA believes a more effective use of telemedicine will be to develop new policies that allow providers to utilize new telemedicine technologies to serve patients where they are (to reduce transportation barriers, for example). Current telemedicine policy requires patients be at a designated site of care. Instead, consider developing new policies that will allow a care manager to be with a patient who can receive care from a distant provider utilizing telehealth technologies. NC DHHS should also consider new licensing opportunities for telehealth such that Medicaid beneficiaries could benefit from the services of specialists – particularly in workforce shortages specialties such as psychiatry – who are licensed in other states. There are very effective models of this in other states and NCCHCA encourages NC DHHS to reach out to Kathy Wibberly with the Mid-Atlantic Telehealth Resource Center for models. That organization is funded by HRSA to provide telehealth technical assistance in our region.

VI. B. Beneficiary Protections
VI. B. 1. Eligibility and Enrollment
NCCHCA is strongly supportive of NC DHHS efforts to re-evaluate the current eligibility determination process to improve the timeliness of eligibility determinations and annual redeterminations. A number of Community Health Centers have run into problems with primary care provider (PCP) assignments changing during the redetermination process and, thus, we recommend reviewing all aspects of the renewal process be evaluated, including the technologies used to identify and maintain existing PCP assignments. As mentioned earlier, NCCHCA suggests coordinating these changes with automatic review of family qualifications for other benefits, such as SNAP.

It is excellent that the state is developing a single-step eligibility and enrollment process. A modernized, simplified process for Medicaid enrollments and renewals will reduce burden on applicants, enrollment brokers and county DSS staff. It is also likely to increase the number of beneficiaries who select a primary care provider. Ensuring an eligibility determination and PCP selection system that is available in the four outlined ways (online, by telephone, in-person or by mail) will expand the accessibility of this process for all beneficiaries and is in line with Affordable Care Act (ACA) requirements. We strongly encourage building and testing the NC FAST system early and often to ensure it works at program launch. We also strongly encourage making improvements to the current ePASS interface to make it more consumer-friendly. We strongly recommend that DHHS rigorously test these systems well before the go-live date.

NCCHCA has serious concerns with the plan to continue using County Department of Social Services (DSS) offices as the only resource for processing and determining eligibility applications and renewals. A 2016 Program Evaluation Division report to the NC General Assembly's Join Oversight Committee on Medicaid and NC Health Choice indicated that NC County DSS offices failed to meet NC timeliness standards to process applications within 45 days during 2013-14 and 2014-15. The report attributed the challenges to implementation of the Affordable Care Act, but problems still remain. Thousands of applications are currently behind the processing time permitted under federal law and ongoing problems with the NCFAST system has resulted in recertification delays across the state. The current 1115 proposal does not indicate that the State plans to allocate additional staff to county

DSS offices to respond to the increase in applicant and enrollee needs during and following managed care implementation. Furthermore, federal requirements call for Medicaid eligibility and enrollment staff to be available at all Federally Qualified Health Centers that request the assistance. However, DSS staffing limitations often prevent them from meeting these requests.

NCCHCA therefore recommends that DHHS consider allowing Community Health Centers' federally certified enrollment assisters and other navigator organizations to become trained to provide additional enrollment and choice counseling services. CHCs have historically assisted their patients and their broader communities in applying for public benefits, and 35 CHC organizations throughout the state maintain existing outreach and enrollment programs with staff who are trained and experienced at helping consumers apply for and compare private health plans. As consumers churn on and off of coverage through the Marketplace and Medicaid/Health Choice, CHCs can be a one-stop shop for application, enrollment, and choice counseling assistance. The online systems could then be used to verify application receipt, approval, and enrollment.

If NC DHHS will not allow CHC's federally certified enrollment assisters and other navigator organizations to provide enrollment and choice counseling services, DHHS should engage them to provide support to Medicaid applicants and enrollees in other ways. Through their outreach and enrollment work, these professionals have already, and will continue to, assist NC residents applying for or enrolling in Medicaid. NC DHHS can further equip these professionals to offer education and services related to Medicaid managed care by providing training on Medicaid eligibility and enrollment, requiring PHPs to provide training on their plans and networks, providing them access to accurate provider directories, and providing avenues for direct communication, such as a phone line, with the state or counties to find out information about a consumers' application status, eligibility status, current PHP and PCP enrollment, and other information (with the consumers' approval). Additionally, NC DHHS should provide a streamlined phone number for community assisters to call to reach an enrollment broker so beneficiaries don't need to go into DSS to switch their PCP or PHP. DHHS should also continually seek feedback from the existing enrollment community, consumer advocates, and other community-based organizations as to how applicants and enrollees can be better supported.

NCCHCA is concerned about the intention to phase out the enrollment broker after the first year without adding additional capacity to assist DSS. We strongly believe the enrollment broker should be a permanent, fully funded component of the plan. The plan should also include more detailed requirements for the broker such as: strong protections for persons with limited English proficiency (LEP) and disabilities; cultural competency; and community outreach. We encourage DHHS to contract with existing community based non-profit organizations already experienced with this work and population. We also believe enrollment brokers should be an access point for complaints and concerns about enrollment, access to covered services and assistance in navigating the grievance and appeal process.

With respect to PHP and PCP selection, NCCHCA supports the State's goal to "maintain lasting care relationships with crucial providers." Community Health Centers, also known as Federally Qualified Health Centers (FQHCs) are often the historical providers from a Medicaid perspective but sometimes beneficiaries think of their individual providers and do not realize their care is being provided by an FQHC and may not realize the specific site

where they are served is part of a larger multi-site FQHC entity.

- Therefore, it is imperative that all provider directories list (a) the individual FQHC providers, (b) all specific FQHC sites, and (c) the larger FQHC entity by name. These multiple levels of names should also be included in the online and telephone provider search tools.
- Additionally, there should be an explanation in the directory of what an FQHC is and the full range of services they provide. Doing so will promote meaningful access by informing beneficiaries of their right to receive their services from an FQHC. The enrollment broker should be made aware of this as well. NCCHCA welcomes the opportunity to assist with development of this description.
- In cases where the individual FQHC provider is no longer a Medicaid provider, we request that patients of that individual provider be assigned to another individual provider within the same FQHC at the same FQHC site.

Special Considerations for Current Beneficiaries Transitioning to Medicaid Managed Care at Program Launch
NCCHCA disagrees with NC DHHS' intention to stagger Medicaid managed care launch dates by region. Several Community Health Centers have sites in more than one of the proposed managed care regions. A staggered launch would mean they would be operating in two models simultaneously. This would create an operational strain on systems, particularly if their split sites are remote and rural. Furthermore, this could create difficulties for beneficiaries that live on regional boundaries and may access care in the neighboring region.

Switching PHP Enrollment
NCCHCA supports the DHHS recommended approach to switching PHP enrollment. However, we also request restrictions that prevent PHP-affiliated practices from coercing or enabling beneficiaries to switch to their practices. For example, this could occur when a CHC patient served by a PHP-affiliated hospital is then sent by the hospital for follow-up to a PHP hospital-affiliated primary care practice rather than back to the non-PHP affiliated CHC. (We have examples of this practice occurring with CHC patients in Marketplace plans.)

Auto-Assignment to PCP
NCCHCA supports the recommended approach to auto-assignment of PCP. However, it is imperative that NC DHHS ensure patient auto-assignment incorporate nurse practitioners and physician assistants into the assignment methodology. In 2016, NPs and PAs provided 46% of all primary care clinic visits at Community Health Centers in the state. In some instances, an NP or PA may be the principal provider in a rural community. Assigning away from that provider would significantly increase beneficiary travel time and access barriers.

VI. B. 2. Member Services and Education
NCCHCA supports the NC DHHS approach to member services and education. We also recommend PHPs are incentivized to hire current and/or former Medicaid recipients to provide education on member services and education.

Beneficiary Education Related to Health Promotion, Wellness, and Disease Prevention
NCCHCA agrees with this beneficiary education approach and encourages NC DHHS to require PHPs to communicate the same messages to PCPs so the providers understand what resources and services their beneficiary patients are receiving from the PHP to assure continuity of care and messages.

VI. B. 3. Grievances and Appeals
We strongly support the development of an ombudsman program to address beneficiary grievances and appeals. We recommend NC DHHS designate sufficient funding to ensure meaningful assistance is available. NCCHCA would like to see more details on the role, duties, and powers of the ombudsman, which should be an independent nonprofit agency.

Furthermore, NCCHCA is disappointed that the ombudsman program is not concurrently being made available for provider grievances and appeals. In the 1115 waiver application to the Centers for Medicare and Medicaid Services (CMS), NC DHHS references provider satisfaction as the 4th Aim. To achieve this aim, DHHS will need to have a third-party provider grievance and appeal process that extends beyond the PHP appeal process.

- Medicaid providers should have access to the ombudsman program to appeal decisions made by PHPs. The option offered by most PHP contracts (binding arbitration) is not a cost effective or workable solution for providers – particularly small safety net providers.

VI. C. Managed Care Plan Accountability
VI.C.1. Access to and Oversight of Network Services
Network Access and Out-of-Network Protections
NCCHCA greatly appreciates and supports the recognition that FQHCs are designated as mandatory essential providers (consistent with N.C.S.L. 2016-121) and that PHPs not exclude them from their networks.

- We would like assurance that NC DHHS will not allow telemedicine to replace face-to-face delivery of services by essential community providers in the "alternative arrangement for service delivery" referred to in this section.

We wish to point out a provision of federal law that we believe will apply to the provision of beneficiary services on an out-of-network basis: "in the case of medically necessary services which were provided [on an out-of-network basis] . . . because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity [the PHP] or the State provides for reimbursement with respect to those services."[4]

- Under this provision, NC DHHS must designate whether it or the PHP will provide reimbursement for such medically necessary services that were immediately required due to an unforeseen illness, injury or condition when provided by an FQHC on an out-of-network basis. As currently outlined in the program design, it appears the PHP will be responsible for the payment (page 58), but only at 90% of the Medicaid fee-for-service rate. Federal guidelines require that FQHCs receive at least their full prospective payment system (PPS rate) or cost-based rate. Therefore, we request that NC DHHS clarify whether or not it will wrap the PHP out-of-network payment to the PPS/cost-based FQHC rate or if it is expecting the PHP to pay the full PPS/cost-based FQHC rate in such instances.

Network Adequacy Standards
Due to the unique breadth of services and populations targeted by essential community providers, we recommend NC DHHS add Essential Community Providers as a "Provider Type" in *Table 2: North Carolina Draft Network Adequacy Standards – Time and Distance Standards* and develop specific network adequacy standards for essential community

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[4] Social Security Act § 1903(m)(2)(A)(vii).

providers to ensure adequate access for vulnerable Medicaid populations.
- NCCHCA believes it is integral that NC DHHS collect and monitor enrollee access to essential providers as a unique provider type in each region and network.

Network Data reporting/Provider Directory Tool
As mentioned previously, it is imperative that network data reporting and the provider directory tool include listings of FQHC individual provider names, FQHC individual site names, and the FQHC organization name so that beneficiaries can recognize their provider from each of the possible perspectives.
- We also recommend that essential community providers be clearly identified in the listings and that each essential community provider type is listed and the full range of services provided is described somewhere in the provider directory.

We encourage DHHS to keep the provider directory tool up-to-date and to make ongoing network data reporting publicly available.

Provider Relations and Appeals
NCCHCA appreciates that NC DHHS will review and approve the PHPs' provider appeals process. We would like clarification as to which appeals cannot proceed to a hearing before NC DHHS or through the state fair hearing process. We oppose the elimination of Office of Administrative Hearing (OAH) appeals for providers. To ensure due process, both providers and beneficiaries must have meaningful access to state fair hearings when they are negatively impacted by a PHP action. As mentioned earlier, we believe a third-party ombudsman should be available to providers to resolve grievances with PHPs.

Monitoring and Oversight
NCCHCA supports the PHP requirement to submit reports showing their compliance with network adequacy standards. NCCHCA requests that these reports include a requirement to outline all the essential community providers within the PHP-covered area and report on the PHP's contracting status with each of these essential community providers. This will assist NC DHHS with identifying PHP achievement of meeting the state requirement to network with all ECPs.

VI. C. 2. Provider Credentialing
NCCHCA is pleased to see NC DHHS responding to our previous request to provide streamlined, centralized provider credentialing. We believe this will simplify processes for providers and prevent inappropriate PHP denials due to provider credentialing delays.
- In addition to the centralized process, NCCHCA recommends that clinically and financially integrated providers networks that perform credentialing for their providers should have the option of batch submissions of applications and documents for credentialing.
- NCCHCA requests a seat at the table of the NC DHHS-led work group of plans and providers developing the uniform credentialing policies.

As with other centralized systems, we recommend build and rigorously test NC TRACKS system early and often to ensure it works at program launch.

VI. C. 3. Clinical Coverage Policies and Utilization Management (p56)
NCCHCA supports the DHHS recommended approach to clinical coverage policies and utilization management. In particular, we are pleased to see the development of a common prior authorization request from for use by all PHPs.

VI.C.4. Pharmacy
Many FQHCs participate in the Federal 340B Program that allows them to purchase medications at greatly reduced prices. FQHCs provide these medications to FQHC uninsured, low-income patients at greatly reduced prices and any savings generated by the 340B Program can be reinvested in providing access to medications for more patients or other services for the uninsured. This is the intent of 340b. Savings should go to patient care and access, not private managed care company profits. With limitations on the federal 330 health center grant, savings from 340b make the difference in many health centers in keeping sites with high uninsured populations open and making medications available to the uninsured. Medicaid recipients and their families churn in and out of insurance. Having health center sites open is critical to their medical stability.

FQHCs with in-house pharmacies are usually reimbursed by Medicaid for actual 340B Program cost plus a dispensing fee. The cost of FQHC Medicaid prescriptions billed to DMA are approximately $60.00 less than most community pharmacies billing costs to Medicaid. Under Managed Care Medicaid, it would require an enhanced dispensing fee (probably $15-$20) to continue this as a feasible scenario for FQHC pharmacies. Under Medicaid managed care, many states have opted to go with a Usual and Customary Charge for FQHC pharmacies. This would be satisfactory for FQHC pharmacies.
- It is critical under Medicaid managed care to include the requirement for "adequate dispensing fees" for FQHC pharmacies.
- Initiating a Usual and Customary fee structure would also be feasible for FQHC pharmacies.

VI. C. 5. Plan and Provider Payments
Rate Floor Protections
NCCHCA wishes to point out that FQHCs have their own specific sort of rate floor protection under federal law located in 42 U.S.C. § 1396b(m)(2)(A)(ix). This protection requires that the managed care entity must make payment to FQHCs in an amount "*that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center . . ."* This federal payment protection accomplishes two things:
(1) Ensures that FQHCs are viewed by PHPs similarly to other providers and are not some sort of "special case" that would deter PHPs from contracting with FQHCs and
(2) Protects the State from situations in which PHPs underpay FQHCs with the expectation that the supplemental/wraparound payment of 42 U.S.C. § 1396a(bb)(5) will make up the difference.
We appreciate that the State's plans to establish rate floor protections for other types of providers will, in turn, support the FQHCs' level of payment.

Cost Settled Providers
We strongly support the State's recognition that FQHCs are entitled to their PPS-level rates which will be comprised of two components: (1) the rate negotiated with the PHP which must be "at least the same amount they would pay if those services were furnished by providers other than FQHCs and RHCs and (2) the wraparound payment to cover the difference between the negotiated PHP rate and the state-determined PPS or cost-based rate. We believe this approach is consistent with both federal law and policy (as explicated by CMS in guidance).

We would like to note that FQHCs have historically had their state-determined PPS or cost based-rates unduly constrained by limitations including (a) the inappropriate application of Medicare urban and rural caps and productivity screens, (b) the failure to establish unique rates for newly established FQHCs in a timely manner, and (c) the lack of a change in scope process that accounts for changes in type, intensity, duration and amount of services provided by FQHCs. While the NC Division of Medical Assistance (DMA) has addressed the first issue (a) and continues to finalize the second issue (b), NCCHCA has been working with state on the final issue (c) for two years and feels DMA is unwilling to make the required changes to address appropriately account for changes in Medicaid costs of services at FQHCs since implementation of the FQHC rate.

- We strongly urge NC DHHS to finally settle the FQHC change in scope process in a way that is agreeable with Community Health Centers and apply it before Medicaid managed care payment rates and wrap-arounds are set.

Furthermore, the current system for cost-settling providers at the end of the year results in major cash-flow issues for many FQHCs. We are pleased that under Medicaid managed care, quarterly reconciliation will occur. However, we believe there is an even more efficient process that should be implemented by NC DHHS:

- NCCHCA strongly recommends DHHS implement an automated Medicaid reconciliation process for FQHC PPS/APM reimbursement similar to that used in Kentucky. Kentucky is saving significant staff resources, reducing errors, saving costs and paying the FQHC wrap-around payments weekly using its automated system.[5] NCCHCA welcomes the opportunity to work directly with NC DHHS staff to develop this process.

VII.   Increased Access to Medicaid

NCCHCA strongly supports the Carolina Cares program and any other state effort to increase access to insurance coverage and healthcare services for uninsured adults and children in North Carolina. With respect to the Carolina Cares program, we hope that if it is able to get approval from the NC General Assembly, NC DHHS will be allowed to set the standards and thresholds for work requirements.

NCCHCA recommends that the NC DHHS encourage PHPs to participate in the Health Insurance Marketplace in addition to the Medicaid program. Beneficiaries in plans that participate in both markets would benefit if they had changes in eligibility for Medicaid and were then able to access coverage under a Marketplace plan under the same insurer. NCCHCA recommends PHPs be encouraged to design plans that create options for low-wage employers and small employers that include employee/employer contributions to a Medicaid buy-in model utilizing direct primary care coupled with a Health Savings Account (HSA) - a "Tripartite" approach.

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[5] Yalowich, Rachel. *The Kentucky 'Wrap': Decreasing Administrative Costs for Medicaid and FQHCs in MCO Payment Reconciliation*. National Association for State Health Plans, January 12, 2016. Available at: http://www.nashp.org/15032/. Accessed September 8, 2017.