



July 18, 2016

Victoria Wachino
Director
Center for Medicaid and CHIP Services
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Dear Ms. Wachino:

The NC Community Health Center Association (NCCHCA) is pleased to provide public comments on North Carolina's Medicaid and NC Health Choice Section 1115 Demonstration Waiver Application, which proposes to transform North Carolina's Medicaid Program. While NCCHCA is grateful to the NC Department of Health and Human Services (DHHS) for its commitment to engaging the provider community throughout the development of this application, the existing Section 1115 Waiver does not demonstrate sufficient innovation to meet the Centers for Medicare and Medicaid Services' objective criteria for Medicaid/CHIP. Most concerning is that the Waiver is missing the health policy action our state most desperately needs — accepting federal funding under the Affordable Care Act to expand the Medicaid program to cover adults with incomes up to 138% of the federal poverty level. As an association representing safety net providers who offer continuity of care for patients regardless of insurance status, our concerns reflect aspects of this waiver that could have far-reaching impacts for both beneficiaries and providers. We ask that you strongly consider the concerns outlined in the following pages, and we encourage you ask our state leaders when and how they intend to address them.

Sincerely,

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About the NC Community Health Center Association (NCCHCA)

NCCHCA is a Section 501(c)(3) tax-exempt organization, designated by HRSA as the state's primary care association, representing North Carolina federally qualified health centers and look-alikes ("FQHCs" or "community health centers"). North Carolina's 38 FQHCs are a vital part of the health care delivery system, providing comprehensive primary medical, dental, behavioral health, pharmacy, and enabling services to all patients regardless of ability to pay at approximately 200 sites across 72 counties.

In 2014, North Carolina community health centers served 119,000 Medicaid patients, accounting for 26% of all patients served at health centers. Another 43% of health center patients are uninsured. Community health centers provide continuity of care for many families who cycle on and off the Medicaid program.

NCCHCA Concerns Regarding North Carolina’s Section 1115 Demonstration Waiver Application

At the core of North Carolina’s Section 1115 Waiver application, there are five demonstration initiatives: building a system of accountability for outcomes; creating person-centered health communities; supporting providers through engagement and innovations; connecting children and families in the child welfare system to better health; and implementing capitation and care transformation through payment alignment. NCCHCA and its members support the intentions behind these initiatives, but they do not go far enough to improve access to and quality of care. In fact, the implementation of the some of the demonstration proposals would have negative impacts on Medicaid providers and beneficiaries in North Carolina.

In reviewing the criteria by which the Centers for Medicare and Medicaid Services evaluates Section 1115 Demonstration waivers, NCCHCA is concerned that our state fails to meet the criteria in a number of ways:

CMS Demonstration Criteria #1	How the Waiver Fails to Meet Each Criterion
Increase and strengthen overall coverage of low-income individuals in the state	<ul style="list-style-type: none"> - The waiver includes almost no coverage expansion, only providing a very small expansion to cover parents who lose custody of their children to the foster care system. - The waiver does not include any plan to expand services covered.
<p>CMS Demonstration Criteria #2</p> <p>Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state</p>	<ul style="list-style-type: none"> - Currently, approximately 90% of primary care providers participate in the Medicaid program. The increasing administrative burdens associated with billing to, credentialing with, and resolving payment errors with multiple statewide and regional Medicaid network plans is expected to reduce Medicaid participation among private providers. Safety net providers are concerned the added administrative burdens are likely to raise administrative costs and squeeze resources from patient services. - The State’s Waiver offers no information about how it plans to replace the services provided by the highly effective Community Care of North Carolina (CCNC) Medicaid case management program. As it is currently written, FQHCs expect to lose financial support for Medicaid case managers which they will not be able to retain.
<p>CMS Demonstration Criteria #3</p> <p>Improve health outcomes for Medicaid and other low-income populations in the state</p>	<ul style="list-style-type: none"> - The Waiver proposes to build and improve upon the CCNC program, which has improved health outcomes. However, there are no details regarding how the program will be replaced and what resources will be available to providers to improve health outcomes.

CMS Demonstration Criteria #4	- It is at best unclear whether the state’s plan to transition away from CCNC and toward Pre-Paid Health Plan (PHP) networks will be successful in increasing efficiency and quality of care.
Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks	- The Delivery System Reform Incentive Payment (DSRIP) program proposed in the Waiver leaves out key primary care providers, such as FQHCs.

NCCHCA appreciates the NC Department of Health and Human Services’ (DHHS) efforts to incorporate provider and public feedback in development of the state’s Section 1115 Demonstration Wavier application. However, DHHS did not sufficiently address our major objections to provisions of the draft waiver identified in our previous public comments. The transition to multiple, capitated networks will increase the administrative burden on providers and affect beneficiary access to services and providers. While the DHHS Section 1115 waiver indicates the State will seek to mitigate some of these issues, the structure and plan outlined in the Waiver are too vague to sufficiently address these concerns.

NCCHCA supports the NC DHHS effort to move the Medicaid program toward a value-based system, yet they must recognize that the transition to value requires a greater upfront investment into primary care and prevention, including social services supports to address social determinants of health, in order to reduce and prevent higher costs down the line. These investments have yet to be made in North Carolina and the Waiver does not indicate further effort to provide those necessary investments.

NCCHCA’s comments fall into five categories which CMS should incorporate into its consideration of North Carolina’s Section 1115 Waiver Application:

1. Expand Medicaid to Improve Access and Health Outcomes
CMS should encourage the State of North Carolina to Expand Medicaid by extending insurance coverage options to all adults ages 18-64 with incomes at or below 138% of the Federal Poverty Level.
2. Develop a Plan to Replace Eliminated Resources and Services
CMS must require the North Carolina Department of Health and Human Services to articulate how they will maintain current levels of investment to primary care providers for integrating on-the-ground, Medicaid case management services in their practices.
3. Make New Investments in the Safety Net
CMS should require North Carolina Department of Health and Human Services to outline new primary care safety net investments which will be the available to Federally Qualified Health Centers. These should include participation in the DSRIP program, support for new primary-care residency programs at FQHCs, level case management funding, and Medicaid expansion.
4. Address Existing Problems with Medicaid Eligibility and Enrollment
CMS must require the North Carolina Department of Health and Human Services to develop a more streamlined Medicaid eligibility and enrollment process for beneficiaries and ensure sufficient funding for outstationed eligibility workers at Federally Qualified Health Centers.
5. Ensure Greater Provider and Beneficiary Protections
CMS must require the North Carolina Department of Health and Human Services to add greater detail on provider and consumer protections to ensure the state will have a neutral

- ombudsman to resolve provider and beneficiary disputes and a mechanism for monitoring Prepaid Health Plans for compliance with all applicable laws and regulations.*
6. Protect Against Conflict of Interests within Networks
CMS must work proactively with the North Carolina Department of Health and Human Services to protect against anti-competitive environments that could disadvantage safety net and private primary care provider practices.

1. Expand Medicaid to Improve Access and Health Outcomes

CMS should encourage the State of North Carolina to Expand Medicaid by extending insurance coverage options to all adults ages 18-64 with incomes at or below 138% of the Federal Poverty Level.

The Section 1115 Demonstration Waiver submitted by the North Carolina Department of Health and Human Services lacks the most important health policy change needed to improve access and quality of care for North Carolinians — Medicaid expansion as called for under the Affordable Care Act. Many of the issues in this proposal cannot be successfully addressed until the uninsured in our state have access to health coverage.

Medicaid coverage should be extended to all adults ages 18-64 with incomes at or below 138% of the Federal Poverty Level (FPL), as many other states have already done. Estimates indicate 244,000 uninsured North Carolinians fall in the Medicaid Coverage Gap and as many as 400,000 would benefit from extending Medicaid coverage.ⁱ Additionally, there are 144,000 uninsured children in North Carolina, and closing the Coverage Gap could greatly reduce that number since children are more likely to get covered and stay covered if their parents gain access to insurance coverage.ⁱⁱ

In 2014, 43% of all FQHC patients in North Carolina were uninsured, and more than 70% of patients lived at or below 100% FPL. Community health centers served 179,447 uninsured adults in 2014, and the majority of those fall in the Medicaid Coverage Gap. Our providers see firsthand the significant health challenges and barriers to needed services that these patients face. In North Carolina, nearly 40,000 women are not receiving recommended preventive screenings, 27,044 diabetics cannot get much needed medications, and 45,500 individuals with depression are not getting the treatment they need.ⁱⁱⁱ In fact, community health center providers often have to modify treatment plans for uninsured patients because of their inability to afford a specialist visit or pay for needed medications.

Safety net providers do their best to address the health care needs of the uninsured, but the safety net is incomplete. The health care needs and costs of patients in the Coverage Gap could be much more effectively managed if they were provided access to the full range of needed health care services through affordable insurance coverage. Under Medicaid expansion, outpatient providers could address many of the currently untreated issues that often result in patients seeking inefficient, costly, and inappropriate care in the emergency department. Within the first year of closing Michigan's Coverage Gap, more than half of expansion enrollees saw a primary care doctor and 17 percent received preventive services.^{iv} In Kentucky, 46,000 people were screened for diabetes and 13,000

people were treated for substance use disorders within the first year of expansion.^v A recent study in Oregon showed that Medicaid expansion improved the ability of Medicaid beneficiaries to receive appointments and care, reduced the number of enrollees visiting the emergency room, and reduced the number of hospital readmissions within 30 days of discharge for Medicaid beneficiaries.^{vi}

The North Carolina Waiver proposes to reduce hospital readmissions and unnecessary emergency department visits through a Delivery System Reform Incentive Payment (DSRIP) program. However, we believe extending Medicaid coverage may be more successful in achieving those goals systematically across all regions of our state, not just for those living in areas engaged in the DSRIP program.

Research shows that state Medicaid spending grew more slowly in states that expanded Medicaid than in those that did not. In fact, Medicaid spending in non-expansion states grew twice as much as spending in expansion states between FY 2014 and FY 2015 (6.9% compared to 3.4%).^{vii} Thus, our state would be more successful in achieving cost neutrality through a transformation that includes Medicaid expansion.

Impacts on Community Health Centers

A policy brief from the Georgetown Center for Children and Families finds that federally qualified health centers and safety net hospitals in states that expanded Medicaid see fewer uninsured patients, provide less uncompensated care, and experience more budget savings compared to their peers in states that have not expanded the program.^{viii} The report highlights research showing health centers experience uninsured visit rates dropping by as much as 40% following Medicaid expansion. These budget savings have provided the safety net with more flexibility to expand their sites and services, hire new staff, update clinical and medical equipment, and integrate and improve the care they provide.^{ix} For example, health centers in expansion states were significantly more likely than those in non-expansion states to report having expanded their capacity for dental and mental health services since the start of 2014.^x Health centers in our state remain hampered from expanding their efforts to innovate and improve their practices due to a lack of funding streams to support them. Under Medicaid reform as proposed by this Waiver application, our state will not achieve such levels of integrated care without expanding access to coverage for the remaining uninsured population in our state.

NCCHCA estimates statewide health center revenues would increase by up to \$35 million if the state expanded Medicaid to low-income populations. One community health center member estimated potential annual revenue of \$1.4 million from uninsured medical patients who would qualify for expanded Medicaid. Right now, this health center is only collecting \$300,000 from these same uninsured patients, suggesting that the lack of Medicaid expansion is costing that particular health center \$1.1 million in annual revenue.

Between 2013 and 2014, the number of health center patients nationwide covered by Medicaid rose by 1.85 million, or 22%.^{xi} During that time, the portion of patients NC FQHCs served increased from only 24% to 26%. For North Carolina community health centers, we see rates of uninsured and Medicaid covered patients that are the inverse of the rates seen nationally (see Table 1).

Table 1: Community Health Center Medicaid and Uninsured Rates Nationally and in North Carolina

Community Health Center Patients	% Medicaid	% Uninsured
U.S.	46	28
North Carolina	26	43

2. Develop a Plan to Replace Eliminated Resources and Services

CMS must require the North Carolina Department of Health and Human Services to articulate how they will maintain current levels of investment to primary care providers for integrating on-the-ground, Medicaid case management services in their practices.

The NC 1115 waiver proposes to “build upon the successes of North Carolina’s nationally acclaimed enhanced primary care case management program, Community Care of North Carolina (CCNC)” while eliminating it entirely from the new system. The CCNC program has provided FQHCs and other primary care providers with vital financial support to integrate case management services that address Medicaid beneficiary needs. For North Carolina FQHCs who served more than 144,000 Medicaid beneficiaries in 2015, eliminating the CCNC networks’ case management program will result in at least \$5.6 million in PMPM payments lost across our health centers. Existing case managers will lose their positions unless other resources can be found. This could have economic impacts in addition to beneficiary services impacts, and those may be most acute in rural areas.

The Waiver includes no articulated plan for how the newly-developed Person-Centered Health Communities (PCHCs) or PHPs will continue that level of financial support and replace those services. Will the PHPs replacing CCNC be willing to provide primary care providers with resources to continue critical on-the-ground case management services so our providers can offer the same quality of care and achieve comparable savings?

NC DHHS states its commitment to retaining North Carolina’s strong participation in the Medicaid program. Currently 90% of all North Carolina primary care providers serve Medicaid patients, but lost case management resources and increased administrative burdens for providers will likely push many private physicians away from Medicaid. FQHCs will continue to serve Medicaid patients, but losing \$5.6 million across our health centers will make it very difficult for our health centers to provide the same volume of care. The increased administrative burdens, lost case managers, and high uninsured patient rates will significantly increase the financial strain on FQHCs.

3. Make New Investments in the Primary Care Safety Net

CMS should require North Carolina Department of Health and Human Services to outline new primary care safety net investments which will be available to Federally Qualified Health Centers. These should include participation in the DSRIP program, support for new primary-care residency programs at FQHCs, level case management funding, and Medicaid expansion.

As the Medicaid program changes in North Carolina, some private providers may exit the program due to greater administrative burdens and lower levels of financial support. The program will thus increasingly rely on primary care safety net providers. While FQHCs and other primary care safety net providers are preparing for possible increases in Medicaid patient panels, they are also preparing to deal with the administrative and financial challenges that will discourage Medicaid participation by private practices. The North Carolina Waiver recognizes the importance of supporting and strengthening the health care safety net as part of the new Medicaid program (2.3.3.6, p32), but it offers minimal support for primary care safety net providers, eliminates case management financial supports, and includes no new financial support for federally qualified health centers.

NCCHCA and its members appreciate the State’s decision to include FQHCs as “essential providers” with which all prepaid health plans (PHPs) must make a good faith effort to contract. However, this important protection may be limited in practice. FQHC experiences in the Federally Facilitated Marketplace include being excluded from narrow network Qualified Health Plans despite requirements for including essential community providers in the plans—in some instances, Marketplace issuers simply did not comply with these requirements.

Additionally, even if FQHCs are contracted with all possible PHPs, there is no requirement the PHP assign patients to an FQHC’s patient panel. Finally, Appendix A of Session Law 2015-245 includes a caveat that PHPs can exclude essential providers from their network if “DHHS approves an alternative arrangement for securing the types of services offered by the essential providers” (Appendix A of Session Law 2015-245, Waiver p. 104-105). Thus, while this protection is important, we do not believe it will play a significant role in strengthening the primary care safety net. The other Waiver initiative focused on strengthening the safety net — extending wrap-around payments to safety net providers — would not apply to, or directly benefit, federally qualified health centers.

NCCHCA is pleased the Waiver indicates the state will follow federal guidance and pay FQHCs the difference between their full prospective payment system (PPS) and alternative payment methodology (APM) rates and their PHP reimbursement rates through a direct wrap-around payment from the state. However, to date, FQHC and rural health center (RHC) Medicaid PPS rates have been inappropriately suppressed due to North Carolina’s failure to comply with federal law and guidance with respect to FQHC/RHC PPS rates. There are three mistakes in the state’s implementation of the FQHC/RHC Medicaid PPS rate that have stifled FQHC/RHC rates since the FQHC/RHC PPS methodology was first implemented in 2000:

- 1) The state implemented PPS rates based on Medicare PPS rates with cost caps and productivity screens. Federal guidance to states indicates such limits should not apply unless they conducted an analysis demonstrating doing so does not limit payment of reasonable and related costs. Two federal court cases have overturned this practice in other states.

Following about 18 months of discussion, NC DHHS recently acknowledged this error and, as of July 1, 2016, eliminated the caps and productivity screens from the rates of those FQHCs/RHCs affected by that misinterpretation. However, no retroactive payments will be made to those FQHCs/RHCs, and NCCHCA is monitoring implementation to ensure that all rates are being corrected appropriately.

- 2) Health centers that have gained FQHC/RHC status since 2005 were given an interim rate based on another FQHC/RHC, and those health centers have never received unique rates based on their own services and costs. It is believed that, in most cases, interim rates are lower than unique rates would be for those health centers. NCCHCA is in discussions with North Carolina DHHS related to this issue and hopes it will be resolved before the end of 2016.
- 3) North Carolina DHHS never developed a process as required by federal law whereby FQHCs/RHCs that experience a change in scope of service can request a PPS/APM rate adjustment based on an updated set of services. This has significantly suppressed rates for FQHCs, many of which have experienced substantial growth in services and sites since the implementation of the Affordable Care Act. NCCHA has been working to address this issue with NC DHHS since December 2014, and we continue to wait for a resolution.

Finally, the NC Waiver proposes developing a Delivery System Reform Incentive Program (DSRIP) to reduce hospital readmissions and unnecessary use of the emergency department (6. Payments, pgs 60-64). However, the only primary care providers included in the DSRIP program are local health departments. In other states with DSRIP initiatives, FQHCs and other primary care providers are integral participants in the programs. If the Waiver intends to strengthen the primary care safety net and to achieve stated cost and quality outcomes, more primary care safety net providers should be included in this initiative.

Lastly, as mentioned previously, the loss of the per-member, per-month case management payments through the CCNC networks will account for at least \$5.6 million lost to FQHCs across the state. The Waiver includes a single line stating, “DHHS will ensure that similar payment levels for care management will be available to providers” (2.3.2.1., p23). However, the Waiver provides no details regarding how those payment levels will be maintained. Thus, nothing in the Waiver indicates how support for FQHCs, as key primary care safety net providers, will be strengthened in this new Medicaid program.

4. Address Existing Problems With Medicaid Eligibility and Enrollment

CMS must require the North Carolina Department of Health and Human Services to develop a more streamlined Medicaid eligibility and enrollment process for beneficiaries and ensure sufficient funding for outstationed eligibility workers at Federally Qualified Health Centers.

The existing North Carolina Medicaid eligibility systems in place for beneficiaries regularly fail to meet timeliness standards and eligibility workforce demands. The results are delays in access to Medicaid and needed health care services. Currently, when a consumer applies for Medicaid—either through the federally facilitated Marketplace, a paper application at a county Department of Social

Services (DSS) office, or the state's consumer-facing online application (ePASS)—their application must be processed by caseworkers at the DSS office in the county in which the applicant resides. North Carolina is one of only eight states to have county workers determine beneficiary eligibility for Medicaid. Our state has 100 counties and 100 County DSS offices implementing eligibility slightly differently.

Given North Carolina's strict and complicated categorical eligibility requirements for Medicaid, this process can be time-consuming. DSS caseworkers must often conduct follow-up to ask additional questions of applicants prior to issuing a final eligibility determination. What's more, by delegating eligibility determinations to the county level, the arrangement exposes the process to vulnerabilities—such as county DSS offices being consistently understaffed and under-resourced—that prevent the timeliness standard from being met. A recent North Carolina Program Evaluation Division report to the NC General Assembly's Joint Oversight Committee on Medicaid and NC Health Choice indicated that in both fiscal years 2013-2014 and 2014-2015, North Carolina County DSS offices failed to meet the timeliness standard that requires applications be processed within 45 days.^{xii} In fact, the percentage of applications processed in a timely manner dropped from 2013-2014 to 2014-2015, and not a single DSS office among the state's 100 counties met its individual timeliness standard. While the report attributed the challenges to implementation of the Affordable Care Act, we expect the transition of the Medicaid program to cause similar staffing and resource challenges that will further tax an already struggling DSS eligibility system.

Additionally, FQHCs are one of the entities that should be eligible for out-stationed Medicaid eligibility staff to be located onsite. However, many of our FQHCs report a lack of county resources available to meet this federal requirement (42 CFR 435-904) to process applications for low-income groups.

The 1115 waiver assumes this challenged system will be sufficient to support an additional, separate step for beneficiaries that requires them to select a Medicaid Prepaid Health Plan (PHP) (Section 7.2(a)). This two-step process would require beneficiaries to apply for Medicaid, have their eligibility processed by their local DSS office, and then complete PHP selection/enrollment with an enrollment broker. Both CMS and the State ought to pursue processes that encourage active plan selection/enrollment by beneficiaries so that they select a plan that best meets their needs. However, the two-step process as proposed is not conducive to beneficiaries making active plan selections. Anecdotally, DSS caseworkers report denying many Medicaid applications because of missed deadlines resulting from DSS workers' inability to make contact with the applicant for follow-up questions within a specified timeframe. Currently Medicaid beneficiaries may apply and not receive a response about their eligibility determination within 45 days. Given the many social and economic barriers that the Medicaid-eligible population faces in North Carolina, subjecting them to a multi-step eligibility/enrollment process that may take weeks or months is unwise.

In our April 18, 2016 comments to DHHS on the draft of the Section 1115 Waiver Application, NCCHCA encouraged DHHS to streamline and simplify the Medicaid beneficiary eligibility and enrollment processes. Our member FQHCs' experiences as Certified Application Counselors (CACs) helping consumers apply and enroll in health coverage through the Health Insurance Marketplace has taught us that consumers experience higher rates of success when they can apply, select a plan, and

pay their first premium—in other words, complete all the required steps to effectuate coverage—in *one sitting* with assistance from an expert. Subjecting Medicaid beneficiaries to a long, multi-step process flies in the face of these lessons learned.

In an appendix to the Section 1115 Waiver Application, DHHS responded to this comment: “DHHS recognizes the potential benefits of having a unified Medicaid eligibility and PHP enrollment process. However, since capitated managed care will be new to North Carolina beneficiaries and other stakeholders, DHHS plans to keep these processes separate for at least the first year or two of the new program” (Appendix B.11. Eligibility and Enrollment (6)). NCCHCA respectfully disagrees with DHHS on this matter. While the application proposes to make many disruptive changes to the Medicaid program for providers, beneficiaries, the State, and other actors, streamlining the eligibility process is likely to mitigate some of these disruptions and challenges for beneficiaries. The first service a Medicaid beneficiary receives from the state is the eligibility determination to be included in the program. Thus, NCCHCA encourages CMS to work with NC DHHS to improve and streamline the beneficiary eligibility and enrollment processes and expand access to eligibility and enrollment services through fulfilling the federal requirement to provide outstationed workers at all qualifying FQHCs.

5. Ensure Greater Provider and Beneficiary Protections

CMS must require the North Carolina Department of Health and Human Services to add greater detail on provider and consumer protections to ensure the state will have a neutral ombudsman to resolve provider and beneficiary disputes and a mechanism for monitoring Prepaid Health Plans for compliance with all applicable laws and regulations.

The NC 1115 Waiver needs to be modified to include greater detail on provider and consumer protections before it is approved. Failing to have sufficient provider protections contrasts with Section 1115 Demonstration criteria #2 of stabilizing and strengthening providers and provider networks. It would also fail to meet criteria #4 of improving the quality of care for Medicaid populations.

In response to public recommendations that the State outline provider and beneficiary protections in the Waiver, the State indicates many details regarding provider and beneficiary protections will be included in the PHP request for proposals (RFP) rather than in the Waiver. However, without such details, it is unclear how the Waiver will meet the CMS Section 1115 criteria. For example, despite NCCHCA’s request in comments to the State, the Waiver includes no neutral, state structure for resolving disputes between providers and PHPs. Based on our members’ experiences with commercial plans in the Federal Marketplace and from peers’ experiences in other Medicaid managed care states, providers and PHPs will experience disputes, including but not limited to rejections of claims, requests for prior authorizations, and claims processing delays. The State must provide more detail to CMS outlining a structure for how the NC Department of Health and Human Services will enforce PHP program provisions.

In our comments on the Draft 1115 Waiver, NCCHCA proposed establishing a neutral ombudsman to resolve disputes regarding PHPs. In addition, we suggested the State create a mechanism through

which PHPs are proactively monitored for compliance with applicable law and regulations, including the provisions set forth in S.L. 2015-245 and in the final 1115 Waiver approved by CMS. As the State undergoes the significant transition from fee-for-service Medicaid to a capitated system in which up to 15 new PHPs may be actively administering Medicaid benefits, proactive oversight will ensure parity of benefits, access, quality, and program integrity for beneficiaries and providers alike under the new model.

6. Protect Against Conflict of Interest for Networks

CMS must work proactively with the North Carolina Department of Health and Human Services to protect against anti-competitive environments that could disadvantage safety net and private primary care provider practices.

The North Carolina Waiver, designed based on State Law 2015-245, will divide the state into six regions and within each region, capitated provider-led entities (PLEs) will be able to compete with statewide PHPs. NCCHCA recognizes the intent of this mixed model was to give providers more control over the future of capitated managed care contracts in North Carolina. Thus far the only provider groups that have stated intentions to serve in this capacity are large regional health systems. FQHCs value our partnerships with these systems, many of whom provide in-kind and financial resources to assist FQHCs to improve access and quality of health care services for community members. Nonetheless, NCCHCA is concerned about the implications of PLEs as both insurers and providers in a reformed, capitated Medicaid program. Many of the health systems expressing interest as PLEs have also established ACOs with narrow provider networks. We are concerned this could lead to a conflict of interest for networks and set the stage for unfair competition within the provider community.

As an example, in June 2016, the U.S. Department of Justice announced a civil antitrust lawsuit against Carolinas HealthCare System (CHCS) based on concerns that CHCS was requiring health insurers to steer patients to particular providers. The suit contends those providers may not have been either of higher quality or more cost-effective. What would limit PLEs in the newly transformed NC Medicaid program outlined in the Waiver from acting similarly and steering patients to providers within their own networks? When Medicaid patients are hospitalized or visit an emergency department, they could be instructed to go to hospital-owned providers for their follow-up, outpatient care. This would allow those network providers to develop a closed network loop that would hurt competition. Limiting DSRIP to hospitals and health departments could create incentives to limit participation to in-network providers exclusively.

FQHCs have experienced similar challenges with qualified health plans on the Federal Marketplace. Coventry Health Care of the Carolinas offered health plans named after a regional health system. They included the health system's logo on a cobranded member ID card that was provided to each enrollee. As a result, FQHCs reported that patients had the impression their new Marketplace plans only included the health system's primary care providers. An FQHC in that region reported losing many patients as a result.

Patients also may be at risk if PHPs are both insurers and providers. A 2015 article in the Charlotte Observer outlined a practice among Carolinas HealthCare System of billing uninsured patients for care, despite laws intended to reduce aggressive billing practices against low-income, uninsured patients.^{xiii} While we hope this practice is not widespread among health systems, we wonder if there won't be more financial pressure within a capitated Medicaid program, such that these insurer-providers would have an even greater incentive to bill low-income uninsured patients for uncompensated care to make up for losses within their Medicaid networks.

Furthermore, a group of 11 of North Carolina's largest hospital systems have announced intention to apply for one of the three statewide PHP contracts. Many of the healthcare systems within that group may also apply to be regional PLEs. How will North Carolina avoid anti-trust and conflict of interest that may arise from health systems serving as providers, regional PLE and statewide PHP members? North Carolina's Section 1115 Waiver is particularly void of any information related to network contracting and any protections and requirements related to those contracts. The state response to comments asking such questions was that all those issues will be addressed in the PHP request for proposals. How can the Centers for Medicare and Medicaid be assured contractual issues will meet the appropriate level of scrutiny if none of that information is included in the Section 1115 Waiver which it has the opportunity to review and approve? NCCHCA asks that CMS work proactively with the NC Department of Health and Human Services to protect against an anti-competitive environment that could disadvantage safety net and private primary care provider practices.

Thank You

The North Carolina Community Health Center Association thanks the Centers for Medicare and Medicaid Services for the opportunity to comment on North Carolina's Section 1115 Waiver. We hope the information provided above is instructive in offering suggestions for changes to the submitted Waiver such that North Carolina can develop a stronger Medicaid program that provides significantly greater access to uninsured North Carolinians and improves support for primary care safety net providers like Federally Qualified Health Centers.

ⁱ Dorn, S., McGrath, M., Holahan, J. (August 2014). *What is the Result of States Not Expanding Medicaid?* Robert Wood Johnson Foundation & Urban Institute. Retrieved from: <http://www.urban.org/UploadedPDF/413192-What-is-the-Resultof-States-Not-Expanding-Medicaid.pdf>

ⁱⁱ Georgetown University Health Policy Institute, Center for Children and Families. (July 2015). *Many Working Parents and Families in North Carolina Would Benefit from Medicaid Coverage*. Retrieved from: <http://ccf.georgetown.edu/wp-content/uploads/2015/07/NC-Medicaid-Parent-Paper.pdf>

ⁱⁱⁱ Dickman, S., Himmelstein, D. McCormick, D., and Woolhandler, S. *Opting Out of Medicaid Expansion: The Health and Financial Impacts*. (January 30, 2014). Health Affairs Blog. Available online at: <http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicare-expansion-the-health-and-financial-impacts/>.

^{iv} Udow-Phillips, M. et al. *The Medicaid Expansion Experience in Michigan*. (August 28, 2015). Health Affairs Blog. Available at: <http://healthaffairs.org/blog/2015/08/28/michigan-the-path-to-medicare-expansion-in-a-republican-led-state/>.

^v Richardson, K. and Sebastian, T. *Ky's Medicaid Expansion: 40,000 Jobs, \$30B Economic Impact*. (February 12, 2015). Available at: <http://kentucky.gov/Pages/Activity-Stream.aspx?viewMode=ViewDetailInNewPage&eventID=%7B97DA58DC-A167-4B3B-9B18-7C1E2CA79C88%7D&activityType=PressRelease>.

^{vi} Oregon Health Authority. (June 2016). *Oregon's Health System Transformation: CCO Metrics 2015 Final Report*. Retrieved from: http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf

^{vii} Kaiser Family Foundation. *Medicaid Enrollment & Spending Growth: FY 2015 & 2016*. (October 2015). Available online at: <http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/>.

^{viii} Georgetown University Health Policy Institute Center for Children and Families. (June 2016). *Beyond the Reduction in Uncompensated Care: Medicaid Expansion Is Having a Positive Impact on Safety Net Hospitals and Clinics*. Retrieved from: http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf

^{ix} Ibid.

^x Ibid.

^{xi} Shin, P., Sharac, J., Zur, J., Rosenbaum, S., Paradise, J. (December 2015). *Health Center Patient Trends, Enrollment Activities, and Service Capacity: Recent Experience in Medicaid Expansion and Non-Expansion States*. The Kaiser Commission on Medicaid and the Uninsured.

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