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Roanoke Chowan Community Health Center (RCCHC) is pleased to provide comments on the North Carolina Medicaid and NC Health Choice Section 1115 Demonstration Waiver Application that was submitted by the North Carolina Department of Health and Human Services (NC DHHS) to the Centers for Medicare and Medicaid Services (CMS) on June 1, 2016.

RCCHC is a federally qualified health center (FQHC) organization that provides comprehensive primary care services to the medically underserved across five sites in Bertie, Hertford, Gates, Northampton and Washington counties. As a community health center, we serve all patients regardless of ability to pay, and in 2014 we served 14,287, including 1,842 Medicaid patients and 2,254 uninsured patients. Along with North Carolina's 37 other community health centers, we form the backbone of North Carolina's safety net and its Medicaid primary care providers. We are by statute and by mission required to serve Medicaid and NC Health Choice patients, and we therefore have a vested interest in ensuring that the Medicaid program maintains accessibility for patients and providers alike, sustainability, and integrity throughout the transformation process. However, we have several significant concerns regarding the waiver application as submitted by the State, and we urge CMS to consider the following comments.

#### **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 1115 Demonstration Waiver submitted by NC DHHS lacks the most important health policy change needed to improve access and quality of care for North Carolinians and strengthen the provider community — Medicaid expansion as called for under the Affordable Care Act. Medicaid coverage should be extended to all adults ages 18-64 with incomes at or below 138% of the Federal Poverty Level (FPL). In North Carolina, expanded Medicaid would cover more than 400,000 people; at least 244,000 of those in the Coverage Gap would be uninsured as a result.<sup>i</sup>

In 2014, 43% of all FQHC patients in North Carolina were uninsured and more than 70% of patients lived at or below 100% FPL. FQHC providers see firsthand the significant health challenges and barriers to needed services that these uninsured and low-income 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



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with depression are not getting the treatment they need.<sup>ii</sup> In fact, providers often have to modify treatment plans for uninsured patients because of their inability to afford a specialist visit or pay for needed medications.

North Carolina community health centers estimate statewide health center revenues would increase by up to \$35 million if the state increased access to affordable insurance for low-income populations. If Medicaid were expanded, we estimate that RCCHC would receive an estimated \$360,547.46 in annual revenue through reimbursement from the Medicaid program, a vast increase over the revenue we collect from our uninsured patients now. This additional funding would allow us to enhance and expand our existing operations and explore innovations to better deliver care to our communities. *In particular, RCCHC recently opened a new facility, Creswell Primary Care, which serves the entirety of Washington County with only one full time provider. With additional funding from Medicaid Expansion, we would be able to expand our facility by bringing on more staff, not only improving the reach of our services, but providing valuable jobs in a county with an unemployment rate of 7%.*<sup>iii</sup>

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.<sup>iv</sup> The report highlights research showing health centers experience decreases in uninsured visit rates drop 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.<sup>v</sup> 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.<sup>vi</sup> 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.

Many of RCCHC's uninsured patients fall within the eligibility criteria for Medicaid expansion as proposed under the ACA. The revenue which would be generated by patient visits covered by an expanded Medicaid program would be used to provide better health outcomes for all RCCHC patients, whether insured or uninsured. For our currently uninsured patients who meet the eligibility requirements of an expanded Medicaid program, their health outcomes would improve dramatically simply by having affordable access to the type of preventive care their PCP is intended to provide.<sup>vii</sup> This would lead to earlier diagnoses of serious health conditions, and a reduction in unintentional non-compliance with treatment that requires medication or specialty care which cannot be covered by an in house program within RCCHC.<sup>viii</sup> This could not only prevent the painful, and costly, advancement of illness, but in some cases, the death of the patient.<sup>ix</sup> To provide an example, RCCHC is currently serving a patient who has a known family history of breast cancer, but has not been able to afford a mammogram for 2 years. If caught in the early stages, breast cancer has a 5 year survival rate of nearly 100% - compared to as low as 22% in later stages.<sup>x</sup> While the most important outcome is that of a healthy patient, in purely financial terms, the cost of treating a patient in the late stages of breast cancer is significantly higher than those in early stages.<sup>xi</sup>



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It is true that charity care for specialty care or medications are an option for some, but those that are able to access it still face barriers of timeliness: For an uninsured patient, they may have to complete 2 charity applications for 2 separate medical offices: e.g., hospital charity care application for hospital fees accrued and a physician/specialty group charity care application for physician fees. While we try to ease their burden by assisting with the application process, the patient often feels stressed and overwhelmed when it comes to completing the process, all the while going without needed treatment.

### **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 State claims that it plans to build upon the successes of North Carolina's nationally acclaimed enhanced primary care case management program, Community Care of North Carolina (CCNC). However, the Waiver eliminates this program entirely from the new system without any articulated model to replace the services it provides. The CCNC program provides FQHCs and other primary care providers with vital financial support to integrate case management services that address Medicaid beneficiary needs. Federally qualified health centers served more than 144,000 Medicaid beneficiaries in 2015 and stand to lose at least \$5.6 million in PMPM payments for case management services under the current Waiver proposal. RCCHC received \$103,399.50 in 2015 to support case management functions. Without this financial support, *RCCHC will lose a source of revenue which goes directly back into funding the basic cost of operations, including providing care for uninsured patients that would otherwise be uncompensated.*

We are concerned that the Waiver does not provide an explanation of how the newly-developed Person-Center Health Communities (PCHCs) or Prepaid Health Plans (PHPs) will continue current levels of financial support for case management services. We question whether the PHPs replacing CCNC will 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. We worry that our patients insured through Medicaid will lose a valuable tool to support their ability to manage their health, while at the same time removing financial resources which RCCHC needs to help address the additional demand for services this would cause. It has been found that Medicaid recipients have the lowest levels of health literacy<sup>xii</sup>, which makes them unable to navigate the complex healthcare system, or understand the need to follow treatment guidelines as described by their physician. These patients benefit greatly from the extra guidance they receive through CCNC's case management, which helps them stay on track with their treatment plan, again avoiding potentially costly complications.

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 participating in the Medicaid program. FQHCs will continue to serve Medicaid patients, but losing \$5.6 million across our health centers will make it very difficult for us to provide the same quality of care. The increased



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administrative burdens, lost case managers and high uninsured patient rates will significantly increase the financial strain on our organizations.

We ask the Centers for Medicare and Medicaid Services to demand North Carolina Department of Health and Human Services make a commitment and present a clearly articulated plan for how the State plans to ensure current levels of financial support so that case management services among primary care providers are retained in the transitioned Medicaid program.

### **Increased administrative burden on providers**

*Moving North Carolina Medicaid away from single payer system toward one in which up to 15 plans may operate throughout the state will dramatically increase the administrative burden and cost to providers of participating in the Medicaid program.*

It is possible RCCHC will need to employ additional billing personnel in order to maintain timeliness in our accounts receivable, while at the same time we are potentially facing a loss of revenue from our participation in CCNC. Additionally, having so many potential payers would likely increase the amount of time it would take to receive all owed payments.

### **Beneficiary eligibility and enrollment systems**

Medicaid reform should streamline beneficiary eligibility and enrollment processes. However, under the State's proposal, beneficiaries will be subject to a two-step eligibility and enrollment process in which they must select a plan through an enrollment broker after having had their eligibility for Medicaid determined by the county Department of Social Services. The existing North Carolina Medicaid eligibility systems in place for beneficiaries regularly fails to meet timeliness standards, delaying access to Medicaid and access to needed health care services as a result.

Currently RCCHC does not have the ability to assist our patients with Medicaid enrollment. We must refer them to their county's Department of Social Services (DSS), which unfortunately presents increased barriers some, such as lack of transportation, lack of interpretation services for low English proficiency (LEP) patients, and simply time added to the process for eligible patients who are in need of health services. Wait times for applications are often unreasonably long, and in some cases an individual is inappropriately denied. To provide two of our patients as examples: an LEP pregnant mother with deferred action status, eligible under CHIPRA, who was denied for not having a social security number although it was not required; a gentleman who was unable to work after suffering an injury on the job that caused chronic lower back and neck issues, leading to his accrual of nearly \$20,000 in unpaid medical bills in the five years before he was considered eligible for Medicaid, after having his claim denied seven times.

Given these situations we have encountered, we are very concerned that adding the additional step of choosing a PHP through an enrollment broker will make the process even more time-consuming and complicated for the beneficiary. We again request that DHHS unify Medicaid eligibility and PHP enrollment so as not to cause patients



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an increase in the already substantial burden they face during the application process, and that this service is available in a location where they may already receive services, such as their local DSS office or FQHC.

In addition to the preceding, we would like to echo the comments of the North Carolina Community Health Center Association, which is the state primary care association of which we are a member. Please see their comments for additional details.

Thank you for considering our comments. Any questions about the preceding should be directed to:

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<sup>i</sup> 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>

<sup>ii</sup> 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-medicaid-expansion-the-health-and-financial-impacts/>.

<sup>iii</sup> "North Carolina's May County and Area Employment Figures Released." (2016): Available Online At: <http://www.nccommerce.com/LinkClick.aspx?fileticket=OEtu2Fe9F7c%3d&tabid=1849&mid=4733>

<sup>iv</sup> 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](http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf)

<sup>v</sup> Ibid.

<sup>vi</sup> R. Garfield and K. Young, 2015. "How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults." Kaiser Family Foundation. Available Online At: <http://kff.org/health-reform/issue-brief/how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insured-adults/>

<sup>vii</sup> Ibid.

<sup>viii</sup> 2015. "Key Facts about the Uninsured Population" Kaiser Family Foundation. Available online at: <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

<sup>ix</sup> S. Tejada et al., 2013. "Patient Barriers to Follow-Up Care for Breast and Cervical Cancer Abnormalities." *Journal of Women's Health* 22(6):507-517. Available Online At: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3678568/>

<sup>x</sup> Breast cancer survival rates, by stage. Available Online At: <http://www.cancer.org/cancer/breastcancer/detailedguide/breast-cancer-survival-by-stage>

<sup>xi</sup> Blumen, H., Fitch, K., Polkus, V. "Comparison of Treatment Costs for Breast Cancer, by Tumor Stage and Type of Service." *American Health & Drug Benefits* (2016) Available Online At: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822976/>

<sup>xii</sup> America's Health Literacy: Why We Need Accessible Health Information. An Issue Brief from the U.S. Department of Health and Human Services. 2008. Retrieved from: <http://health.gov/communication/literacy/issuebrief/>