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Dear Ms. Wachino:

Blue Ridge Community Health Services (BRCHS) 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.

BRCHS is a federally qualified health center (FQHC) organization that provides comprehensive primary care services to the medically underserved across 14 sites in Henderson, Buncombe, Rutherford, Polk, Transylvania, and Haywood Counties. As a community health center, we serve all patients regardless of ability to pay. In 2015, we served 27,262 patients, including 6,270 Medicaid patients and 14,994 uninsured patients across the region. 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 therefore we therefore 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 are uninsured as a result.ⁱ

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 with depression are not getting the treatment they need.ⁱⁱ 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 BRCHS would receive \$2,950,000 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.

A policy brief from the Georgetown Center for Children and Families finds that FQHCs 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.ⁱⁱⁱ 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.^{iv} 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.^v 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.

If Medicaid were to be expanded in the state of North Carolina, BRCHS could expand access to help address the tremendous unmet need in areas currently experiencing severe shortages of providers and/or other obstacles preventing patients from getting the care they need. In the BRCHS service area, areas like Rutherford, Haywood, and Transylvania Counties in particular, have pockets of populations hemmed in by the formidable geography of the region. The ability to open new sites and offer more services affords greater access to those local residents currently

struggling to access the only options available. Increased revenue will allow BRCHS to open more clinics. More clinic locations will naturally increase access to care and result in healthier outcomes in Western North Carolina.

The increased revenue could also be invested in innovative ways to utilize the data that is currently available, but yet to be tapped. While BRCHS has a lot of data in its database, it's typically very expensive to put dashboards in place to use that data to drive patient care. In other words, simply having electronic medical records doesn't mean a provider has immediate access to all of the improvements that come along with them. Further (and ongoing) investment is required to maximize the impact of EMR implementation. Increased revenue brought about through expanded Medicaid would allow BRCHS to continually make the investments necessary to provide the highest level of quality to the greatest number of people in need.

Without question, expanding Medicaid in NC would increase revenue for BRCHS. With increased revenue BRCHS will have more opportunities to pursue its mission *to provide quality healthcare that is accessible and affordable for all.*

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. FQHCs served more than 144,000 Medicaid beneficiaries in 2015 and stand to lose at least \$5.6 million in Per-member per-month payments for case management services under the current Waiver proposal. BRCHS received \$148,789 in 2015 to support case management functions. Without this financial support, we expect to lose approximately twelve case managers working in various capacities and the high quality case management services will suffer.

CCNC has been the conduit for regional innovation and collaboration for nearly two decades. Not only do they have the expertise in care management for the population we serve, but they have developed an infrastructure to assist us on many facets of our operation. For example, we partner with them on initiatives concerning the quality of care we provide. In addition to their robust data systems (e.g. CareAim), which help us manage our individual quality measures, they also provide support for actual practice transformation with their Quality Improvement Specialists. Furthermore, we work with them on a number of patient population health initiatives such as Impact, a depression protocol for the elderly patient, and a pharmacy initiative to provide

intensive pharmacy review on patients identified as high risk for adverse outcomes or hospitalizations. It should also be noted that the spirit of community building through collaborative efforts has essentially fallen apart since the “reform” discussion began. The nature of the reform has been to build mini monopolies that work only with their exclusive partners. This has been a detriment to forward progress for our health care system.

The Waiver fails to explain 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.

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 close to \$150,000 across our health centers will make it very difficult for us to provide the same quality of care. The increased administrative burdens, lost case managers and high uninsured patient rates will significantly increase the financial strain on our organizations.

The impact will be immediate and cannot be replicated by the “reform” as written. Immediately, we would lose experienced care managers in a system that has saved billions of dollars during CCNC’s existence. No regional managed care entity or statewide MCO will accomplish this without reduction of the services provided by CCNC. We would lose all of the other services provided by CCNC as highlighted above. Finally, we have already lost the collaborative spirit that brought this community together but could be recaptured if proper reform were instituted reaffirming the work of CCNC.

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 to case management services among primary care providers are retained in the transitioned Medicaid program.

Commit to following federal guidelines for PPS Rates

FQHC and rural health center (RHC) Medicaid Prospective Payment System (PPS)/Alternative Payment Methodology (APM) rates are inappropriately suppressed because of North Carolina’s failure to follow all federal guidelines with respect to FQHC/RHC PPS Rates.

While BRCHS has a unique PPS rate, rather than the rate of a “like provider”, the ability to adjust the rate with a functional change-in-scope of services rate adjustment would alleviate some of the challenges we have faced as we have grown these past several years.

BRCHS has experienced tremendous growth in the last 5-10 years. In that time period, the organization has grown from five sites in one county (four of which were small school-based health centers) to 14 sites across six counties – from 30,000 encounters to over 100,000 – while caring for over twice the amount of patients and significantly expanding the capacity of comprehensive primary care and wrap-around services.

While BRCHS costs per visit are below the national and state averages, as the organization has grown, the costs have climbed. If it was possible to request a PPS rate adjustment in response to a change in scope, BRCHS could be more confident that the rate was in line with the cost of care. While the current rate is unique, it doesn't take into account the inefficiencies experienced by newly opened clinics – such as BRCHS New Access Point sites in Rutherford, Transylvania and Polk Counties. An adjustable rate would take those temporary, mostly-unavoidable, increases in the cost per visit into account, leaving BRCHS confident in its ability to take on new sites and new services, as needed. Without the adjustable rate, BRCHS must carefully consider whether or not the organization is taking on too much and must be cognizant of the concern that costs could climb too steeply, harming the long-term outlook for the organization and consequently the care for BRCHS patients.

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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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 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/>.

ⁱⁱⁱ 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://cf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf

^{iv} Ibid.

^v Ibid.