BI-STATE PRIMARY CARE ASSOCIATION
SERVING VERMONT & NEW HAMPSHIRE
Improving Access to Health Care for 32 Years
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July 26, 2018

Jeffrey A. Meyers
Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3852

RE: Comments to the Medicaid Managed Care Draft RFP and MCO Contract

Dear Commissioner Meyers:

Thank you for the opportunity to submit comments to the draft Medicaid care management services request for proposal and model contract. We appreciate the opportunity to provide you with comments that Bi-State and our members believe will improve access to care and reimbursement for providers across the state. A successful Medicaid program is imperative to the success and health of our state, and the financial health and well-being of the health centers and their patients.

Bi-State Primary Care Association is a non-profit organization that advocates for access to primary and preventive care for all New Hampshire residents with a special emphasis on the medically underserved. We also represent New Hampshire's 16 community health centers, which are located in medically underserved areas statewide. Community health centers are non-profit organizations that provide integrated oral health, substance use disorder treatment, behavioral health, and primary care services to more than 113,000 patients, most of whom live below 200% of the federal poverty level or $24,120 for an individual.[1] Medicaid patients comprise more than 30% of health centers patients, and nearly 20% of the state's Medicaid patients receive care at health centers.

Bi-State and our members believe the following principles are essential to the successful delivery services in a managed care environment. Below each principle is a discussion of whether and how the RFP and model contract address our principles.

Invest in the provision of truly integrated primary care, behavioral health, substance use disorder treatment, and oral health care.

Bi-State and our members are grateful for the Department's focus on integrated care, demonstrated by the inclusion of requirements such as the health risk assessment screening, the requirement of a behavioral health strategy plan and report, and the promotion of integrated care.[2] The care coordination provided by MCOs in the first iteration of managed care caused confusion for patients, health centers, and their staff. We hope to avoid any confusion moving forward and ask the Department to allow flexibility to continue programs that work well after July 1, 2019. To that end, we respectfully request that the Department require the MCOs to work

[1] Health Resources and Serv. Admin., Uniform Data System, NH Rollup (2016); BSPCA Survey of Membership (2016).
[2] *See* 4.10.2, 4.10.5, and 4.11.1.2 in the NH Medicaid Care Mgmt. Serv. Model Contract (July 2018).

collaboratively with integrated care providers, including the health centers, to ensure access to care is not impeded or disrupted due to confusion on what entity has the care management role, and that no additional administrative burdens are placed on providers. The draft RFP and model contract appear to allow for a minimum of three organizations providing care management services: the MCOs, local care management entities, and providers. We ask that you clarify the role of the local care management entities, the integrated delivery networks, the MCOs, and the community-based providers.

Health centers are required to provide enabling services, such as care management, and the duplication of these services is unnecessary and an inefficient use of scare resources. We are pleased that the MCOs can contract for care management services, but believe the utilization of codes to capture the work performed by integrated care providers is necessary to understand how patients access care and where improvements can be made to the system. We ask the Department to utilize codes demonstrating the services delivered in an integrated care model (e.g. preventive counseling and case management) and not rely solely on the MCOs and IDNs to do and subcontract for this work. Ideally, care management will be a reimbursable service, possibly as a value-added service.[3]

We understand and sympathize with the financial restrictions placed on the Medicaid program as a consequence of the legislative budget process; however, Bi-State and our members believe that we must treat the "whole person" in order to have a truly integrated care model and for it to be successful. This requires the inclusion of comprehensive oral health services in an integrated care model.

Encourage and incent partnerships with health centers for the provision of dental care to Medicaid enrollees, and create an adult dental benefit that includes preventive and restorative care.

We respectfully request the Department strongly encourage the MCOs to provide oral health services as value-added services.[4] While over 80% of the state's health centers provide oral health services, the health centers recently reported that the greatest unmet needs in their service areas are substance use disorder treatment and oral health.[5] Further, oral health problems are the most prevalent health problems associated with substance use disorder.[6] Overwhelming research correlates the impact of substance misuse, including opiates, on general and periodontal health. In order to adequately address the health of patients, and particularly those with substance use disorder, we need to integrate oral health with physical and behavioral health services.

Health centers are skilled at providing integrated health care services and "putting the mouth back in the body." We hope that the Department will authorize the MCOs to offer preventive and restorative oral health services as value-added services in partnership with the health centers and other community-based oral health providers. Again, any integrated care model should include the provision of and reimbursement for oral health services in order to ensure we are addressing the whole person. Unfortunately, New Hampshire's dental benefit is reimbursed fee-for-service

[3] *See* 4.1.7

[4] *See* 4.1.7.

[5] The information contained in this report resulted from responses submitted by the community health centers to Bi-State's Health Center Growth Plan survey, December 2017. All eleven NH federally qualified health centers participated in the survey.

[6] Shekarchizadeh, H., Khami, M. R., Mohebbi, S. Z., Ekhtiari, H., & Virtanen, J. I. (2013). *Oral Health of Drug Abusers: A Review of Health Effects and Care*. *Iranian Journal of Public Health, 42*(9), 929. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4453891/

and is limited to the treatment of infection through extraction and prescription medicine. This model does not meet the oral health needs of low-income Granite Staters, nor does it foster employment opportunities for low-income individuals. We respectfully request the Department continue to advocate for the creation of a comprehensive adult dental benefit in order to meet the needs of our low-income residents.

Administer behavioral health and substance services in-house rather than contracting out these services.

Many of the issues the health centers encountered when providing and billing for behavioral health and substance use disorder treatment services were related to behavioral health subcontractors. The issues ranged from billing, credentialing, reimbursement, and delayed responses to prior authorizations, all of which created barriers to care and financial issues for the health centers due to unpaid claims. We respectfully request the Department to prohibit the subcontracting of behavioral health and substance use disorder services by the managed care organizations. If the Department chooses to allow MCOs to subcontract their behavioral health and substance use disorder benefits, we ask that you require the subcontractor to accept the credentialing determination of clinicians by Medicaid.[7]

Ensure that Medicaid beneficiaries have access to health centers and the services they provide. This includes following federal and state statutory reimbursement and service requirements.

Community health centers provide high-quality integrated primary care, oral health services, behavioral health services, and substance use disorder treatment regardless of insurance status or ability to pay. Health centers play an indispensable role in the New Hampshire's health care delivery system: health centers serve as the health home to 1 in 12 Granite Staters, and nearly 20% of *all* Medicaid enrollees and uninsured individuals receive care at a community health center.[8] Studies show that each patient seen by community health centers saves the health care system approximately 24% annually.[9] Health centers treat the "whole person" and do so with cultural competency.

We are pleased to see the model contract requires health centers be paid a minimum of their encounter rate, as required by federal and state law.[10] As a condition of their federal grant funding, federally qualified health centers, a subset of community health centers, are required to provide a broad and more comprehensive range of services than is typically performed by many private health clinics or primary care practices, and certainly more comprehensive than required under Medicaid.[11] Evidence shows that relative to other Medicaid providers, FQHCs provide greater access to care for underserved populations overall and for Medicaid beneficiaries specifically.[12] For example, FQHCs are required to provide enabling services, such as

[7] *See* 3.14.1; 4.11.1.1.

[8] Health Resources and Services Administration, Uniform Data System, NH Rollup (2016); BSPCA Survey of Membership (2016).

[9] Richard et al. "Cost Savings Associated with the Use of Community Health Centers," Journal of Ambulatory Care Management, Vol. 35, No. 1, 50–59 (Jan./March 2012).

[10] *See* 4.15.3.

[11] *See* 42 U.S.C. 254b, §330.

[12] *See* Saloner, B., Kenny, D.P., *et al*. "The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings from an Audit Study," The Urban Institute (2014).

interpretation services, which allow patients to better access direct medical care.[13] Access to interpretive services is critical to patients with limited English proficiency, and enabling services alone are not eligible for reimbursement.

In 1999, Congress created the prospective payment system (PPS), which determines the FQHCs' Medicaid reimbursement rate. The PPS is the minimum per visit rate that an FQHC can receive for providing care to Medicaid enrollees.[14] As envisioned by Congress, this enhanced Medicaid rate prevents FQHCs from having to use their federal grant dollars to subsidize the Medicaid program.[15] Inadequate Medicaid payments have a direct impact on the appropriate use of federal grant dollars and access to care because Medicaid is frequently an FQHC's largest third party payer. Any reductions in the FQHCs' Medicaid reimbursement rate will negatively affect their ability to serve patients. Bi-State believes that the continued protection of this payment methodology is essential to low income patients' access to comprehensive health care services. New Hampshire's health centers have large amounts of accounts receivable due to unpaid claims for many reasons, and this practice is unsustainable. Bi-State and our members hope that many of these issues will be resolved with the movement of the Medicaid expansion population to managed care.

Reduce administrative burdens, e.g. aligning reporting requirements, using one preferred drug list, requiring the use of one standard prior authorization form, and using centralized credentialing that follows the same standards required for fee-for-service credentialing, including retroactivity to the date of Medicaid/Medicare credentialing.

Health centers and other providers experienced a dramatic increase in the administrative burden associated with providing services to Medicaid enrollees as a result of the move to the managed care model. While some of this work was arguably related to using a new model, the issues associated with the credentialing of providers, prior authorization denials related to behavioral health prescriptions, and use of multiple preferred drugs lists should and need to be remedied.

Bi-State and our members are grateful that the Department addresses concerns raised by providers by standardizing procedures and forms. We appreciate that the Department requires the use of one PDL in the model contract.[16] We read the draft RFP with Section 4.8.1.4 to require the use of a single "NH MCM standard Prior Authorization form," meaning each MCO will use the same prior authorization form. We ask that the Department clarify this if it was not the intention of the model contract. As Bi-State and our members have mentioned many times and in many forums, the credentialing of clinicians by the MCOs and the subcontractors of the MCOs needs to be improved by implementing centralized provider credentialing. A centralized credentialing entity that dates credentialing back to the approval of Medicaid will address a number of issues.

[13] Enabling services are non-clinical services such as language interpretation and transportation. They are critical to helping the medically underserved because they lessen or eliminate the multiple barriers the medically underserved face when accessing health care. Health centers must provide enabling services and the reimbursement rate that does not cover all costs.

[14] Congress found that many FQHCs were forced to reduce care for uninsured/underinsured patients, thereby undermining the Congressional intent. Before the establishment of the PPS, states were not required by federal law to provide a minimum Medicaid reimbursement to FQHCs. *See* Understanding the Medicaid Prospective payment System for Federally Qualified Health Centers (FQHCs), found at http://www.nachc.org/wp-content/uploads/2016/02/IB69-PPS-Complete.pdf

[15] Congress found that many FQHCs were forced to reduce care for uninsured/underinsured patients, thereby undermining the Congressional intent. Before the establishment of the PPS, states were not required by federal law to provide a minimum Medicaid reimbursement to FQHCs. *See* Understanding the Medicaid Prospective payment System for Federally Qualified Health Centers (FQHCs), found at http://www.nachc.org/wp-content/uploads/2016/02/IB69-PPS-Complete.pdf

[16] *See* 4.2.2.

Implement enrollment, credentialing, and reimbursement methodologies that do not interrupt cash flow or impede the health center business.

Health centers and other providers cannot continue to carry the burden of unpaid claims due to credentialing issues. We implore the Department to require the MCOs and any subcontractors of the MCOs to either honor the credentialing date recognized by Medicaid or to pay claims retroactive to the date of Medicaid's approval date. Currently, clinicians are required to be credentialed by Medicare, then Medicaid, and then the MCOs, and the MCOs are required to adhere to NCQA standards. It is our understanding that NCQA standards prohibit reimbursement for services provided prior to the insurance carrier's credentialing of a clinician. The FQHCs receive federal grants under §330 of the Public Health Services Act, and the Medicaid Act stipulates that FQHCs are to be reimbursed to ensure that §330 grants are not used to subsidize the cost of treating Medicaid patients.[17] The Medicaid Act guarantees FQHCs will be paid the full PPS rate for services provided to Medicaid recipients, even if the FQHC has not been credentialed by an MCO, is considered out-of-network by the MCO, or has been denied payment based on non-Medicaid eligibility reasons.[18]

While the current and model managed care contracts require adherence to NCQA standards, these contractual requirements are not dispositive because delegation of credentialing does not absolve the Department of its responsibility to ensure that FQHCs receive the full payment under the Medicaid Act.[19] The State's reimbursement obligation to FQHCs under the Medicaid Act extends to all Medicaid eligible encounters; therefore, the Department is responsible for ensuring FQHCs receive the full and timely PPS reimbursement regardless of whether the FQHC is credentialed by the MCO.[20] In order to avoid these issues, we ask that the Department require MCOs to use Medicaid's credentialing determination beginning on July 1, 2019 and reimburse health centers and all providers for services provided to Medicaid enrollees. The refusal of MCOs to pay claims due to credentialing issues leaves the health centers and the state open to unnecessary risk.

Require community-based, culturally competent care, including requiring that all communications sent to a beneficiary from DHHS and managed care organizations be written in the beneficiary's native language.

Bi-State and our members appreciate the Department's effort to increase access to culturally competent care as described in the draft RFP and model contract. New Hampshire's urban health centers serve patients who speak over 60 languages, and nearly 10% of health center patients are best served in a language other than English. For example, 30% of Manchester Community Health Center's patients are best served in a language other than English, making access to the translation of written materials from the Department and the MCOs key to enrollment in Medicaid, access to care, and responding to requests from the Department and the MCOs in a

[17] *Three Lower Counties Community Health Services, Inc. v. The State of Maryland* 498 F.3d 294, 303 (4th Cir. 2007); *Community Health Assoc. v. Shah*, 770 F.3d 129, 150 (2nd Cir. 2014); *New Jersey Primary Care Ass'n Inc. v. New Jersey Dep't of Human Servs.,* 722 F.3d 527, 529, 540-541 (3d Cir. 2013).
[18] Medicaid State Plan, TN No. 16-0001; 42 U.S.C. §1396a(bb)(2); 42 U.S.C. §1396b(m)(2)(A)(vii); *Legacy Community Health Services, Inc. v. Janek*, Civil Action No. 4:15-CV-25 (Sept. 9, 2016); *Community Healthcare Assoc.*, 770 F.3d at 157.
[19] §20.7 and §21.3 of NH MCM Contract SFY 2017, Amendment #11; *Community Healthcare Assoc.*, 770 F.3d at 157; *Legacy,* Civil Action No. 4:15-CV-25 (Finding that contractual delegation of the Medicaid benefit does not absolve the state's ultimate responsibility to ensure FQHCs are paid as required under the Medicaid Act.)
[20] 42 U.S.C. §1396a(bb); *N.J. PCA* 722 F.3d at 539; *Legacy,* Civil Action No. 4:15-CV-25.

timely and accurate manner. We ask that all materials sent to Medicaid enrollees best served in a language other than English include the a statement offering translation services in the recipient's native language.[21] We also request that the MCOs work closely with the health centers to ensure patients have access to written materials in their native language.

Uphold the program's guarantee of coverage and at a minimum, maintain current eligibility standards, ensure that the work community engagement requirements do not impose a barrier to care, and guarantee that providers have access to timely Medicaid enrollment data and reimbursement for services provided.

Any amendment to the waiver and our Medicaid program should "increase and strengthen overall coverage of low-income individuals," and the work and community engagement requirement added to our Medicaid program must be no different.[22] The future RFP and MCO contracts should increase and strengthen the coverage of our low-income Granite Staters. We look forward to working with the Department's staff on drafting administrative rules that ensure the successful implementation of the work and community engagement in hopes that the requirements do not affect access to care. Integral to the success of this program is access to timely eligibility and compliance data. The work and community engagement requirement cannot affect the provider's ability to receive reimbursement for services provided to Medicaid enrollees in good faith. We hope that Section 4.3.1.1 includes more details as the administrative rule process moves forward because the burden of program coordination relies heavily on MCOs, organizations that do not traditionally specialize in the compliance of work and community engagement requirements.

Create and require reimbursement for care management services and health care navigators.

As discussed above, Bi-State and our members believe the MCO contracts and any subcontracts need to allow for the billing and reimbursement for care management and patient navigation services. Health centers and other community-based providers currently provide care and case management services to their patients and communities, and the provision of these services would be enhanced by a billing and tracking mechanism.

Guarantee that enrollees will receive, at a minimum, all mandatory care and services in order to meet their unique needs and ensure quality care, and that patient attribution reflects the patient's choice of provider.

We are pleased to see the requirement of care coordination and care management, as we believe this will improve access to mandatory care and services required by patients.[23] As mentioned above, we ask that the Department require collaboration of the MCOs, IDNs (if applicable), and organizations legally required to provide care coordination, such as the community health centers.

The correct attribution of members is the foundation for any alternative payment model. While we are glad the model contract and RFP include language requiring the MCOs to provide

[21] *See* 4.4.2
[22] *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Sept. 26, 2017).
[23] *See 4.10 generally*.

transparency with regard to member attribution methodology and reporting, attribution has been, and will likely remain, an issue for providers in APMs.[24] As a result, we believe it is important to include a mechanism to manually correct attribution errors as part of the contract. The method for attribution correction should be simple and not place an undue burden on providers to track down members that are mistakenly attributed to them by the MCO as part of an APM.

Advance population health through innovations that influence health outcomes, encourage value-based payment programs, and directly address the social determinants of health.

Bi-State is pleased the draft RFP and model contract incorporated many of the recommendations put forth by the New Hampshire APM Stakeholder Work Group. Specifically, Bi-State and its members are pleased the RFP and model contract recognize the importance of: 1) building upon existing APM efforts and infrastructure; 2) starting with upside only models and providing a glide path towards downside risk over time; 3) minimizing the administrative burden placed upon providers; 4) incorporating the social determinants of health; 5) providing meaningful and actionable data and reporting to providers; and 6) emphasizing quality of care and health outcomes as part of any APM methodology.

Sections 4.14.3.3 and 4.14.4.1 of the contract focus on data sharing and reporting requirements are critically important to providers. Without timely and actionable data, providers are unlikely to succeed in a value-based health care environment. While we appreciate the requirements for MCOs to establish feedback systems/reporting for cost and quality data to be shared with providers, the contract should specify how often data are shared and how current those data should be. In addition, there should be specific penalties if data/reporting is not shared with providers in accordance with the requirements.

Section 4.14.6.1 identifies decreasing unnecessary service utilization, as related to ED usage, as a priority for the MCO's APM Implementation Plan. While we agree ED usage should be a priority, it should also include unnecessary utilization of specialty services and inpatient care as a focus for cost reduction and quality improvement activities within the MCO's Implementation Plans. The Department's focus on addressing social determinants of health is woven throughout both the draft RFP and model contract. We appreciate and support these efforts.

Consider investment in health care workforce initiatives, new technologies and infrastructure that payment and delivery system innovations require, and provide appropriate federal investment to reduce inefficiencies.

Like many health care providers in New Hampshire, our health centers face a health care workforce shortage. Bi-State, through our Recruitment Center, works with state, federal, and other non-profit partners to address challenges to our health care system. We continue to advocate for: 1) increasing the state's investment in the State Loan Repayment Program; 2) the restoration the funding to the community health centers' primary care contracts with the Department; 3) the reduction the administrative burdens to train our workforce; and 4) increasing the number of family medicine residents in New Hampshire. Bi-State and our members have discussed these efforts with the insurance carriers that have expressed interest in responding to the draft RFP and we ask the Department to support these efforts and encourage the

[24] *See* 4.14.4.1.

collaboration of partner organizations in order to address New Hampshire's the health care workforce shortage.

In addition, we ask the Department to work with the legislature and stakeholders to add reimbursement for primary care services delivered via telehealth as eligible for reimbursement by Medicaid. Telehealth is an evolving technology and one that our health centers and their patients want to utilize in order to address transportation issues that face patients. We are pleased the Department included telehealth in the model contract and look forward to working on legislation to add additional disciplines to Medicaid's list of eligible providers.[25]

We appreciate all of the time and effort the Department put into creating a comprehensive managed care RFP and model contract. We are also grateful for the opportunity to provide feedback on these documents. Please feel free to contact me if you have any questions on our responses to your request for comment.

Sincerely,

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[25] *See* 4.1.3; RSA §167:4(d).