North Carolina Department of Health and Human Services
Draft Section 1115 Medicaid Reform Waiver (Demonstration) Application
Public Comment Period: March 7-April 18, 2016

Response to Public Comments

Introduction

As part of waiver development, DHHS collected public comments from Monday, March 7, 2016, through 11:59 p.m. Eastern time, Monday, April 18, 2016. DHHS solicited and received comments through various means, including the website, postal mail, email, voice mail, 12 public hearings (written and verbal) and two Medical Care Advisory (MCAC) meetings. Overall DHHS received feedback from more than 750 commenters during the public comment period. The approximate break down by mode is:

- 41% of commenters commented through the website,
- 41% spoke at a hearing,
- 8% by email,
- 5% through written comments at a hearing,
- 2% by postal mail,
- 2% at MCAC, and
- Less than 1% by phone.

Commenters reflected a wide range of stakeholders including beneficiaries and their families, trade associations and advocates, providers, health plans, and other interested North Carolina residents. Approximately 90% of the comments were about the demonstration application.

The attached summarizes comments received by DHHS during the public comment period and DHHS' responses. Comments are organized into two sections: those specific to the draft 1115 demonstration application, and those not specific to the draft demonstration. Comments on the draft demonstration addressed key sections and also can be found within the application submitted to CMS June 1, 2015. Comments not on the demonstration application address issues related to implementation and operations (e.g., regions, application of insurance provisions, rate floors, program regulations and enrollment broker contract). Comments within each section are organized by theme and summarize either a single comment or group of similar comments.

DHHS will continue seeking stakeholder input throughout the development and implementation of Medicaid reform.

Comments – Specific to the Waiver

A. Rationale for the 1115 and the Quadruple Aim		
	Summary of Comments	**Response**
1. Reason for system change	Several commenters asked why DHHS is changing the current system.	DHHS revised the demonstration application to better describe the rationale for the demonstration.
2. Support for the current system	Many commenters expressed support for the current system and concern about changing it.	DHHS recognizes the strengths of the current system, and plans to build on these strengths in the new system while also addressing some of the limitations of the current system.
3. Concern about capitated managed care	Many commenters expressed concern about capitated managed care, including the possibility of reduced access and lower quality of care.	DHHS acknowledges these concerns and will consider ways to prevent these outcomes in the development, implementation and operation of the program.
4. Quadruple Aim	A few commenters expressed general support of the Quadruple Aim. A couple of commenters raised skepticism about the ability to maintain, much less improve, provider engagement and support.	DHHS acknowledges these comments and appreciates support for the Quadruple Aim. DHHS will focus on provider engagement and support in the development, implementation and operation of the program.

B. Prepaid Health Plans (PHPs)		
	Summary of Comments	**Response**
1. Network adequacy standards	Several commenters requested more detail on network adequacy standards.	DHHS revised the demonstration application to include more detail on network adequacy standards, including reference to the final Medicaid managed care rule. DHHS will include additional detail on network adequacy standards in the PHP contract, and will monitor compliance with those standards on an ongoing basis.
2. Regions and access to specialists	Many commenters expressed concern about how specialist referrals will work within the regional structure.	PHPs will be required to develop networks that meet the needs of their enrollees, which, for regional PHPs, is likely to include contracting with providers outside of the applicable region. DHHS will include detailed network adequacy standards, including those required by the final Medicaid managed care rule, in the PHP contract, and will monitor compliance with those standards on an ongoing basis.
3. Out-of-network providers	Many commenters expressed concern about access to out-of-network providers.	Per federal Medicaid regulations, if a PHP is not able to provide necessary services to a particular enrollee, the PHP must adequately and timely cover these services out of network for the enrollee, for as long as the PHP is unable to provide them. DHHS intends to include requirements regarding out-of-area and out-of-network providers in the PHP contract.
4. Intent to contract with three statewide PHPs	One commenter asked DHHS to confirm that it intends to contract with three statewide PHPs.	DHHS revised the demonstration application to clarify its intent to contract with three statewide PHPs.
5. Support for provider-led entities (PLEs)	Several commenters expressed support for including PLEs, though one commenter expressed concern about PLEs.	DHHS acknowledges these comments and appreciates the support for PLEs.
6. PLE governing body	A couple of commenters requested that DHHS retain the requirement that a majority of a PLE's governing body be composed of physicians. One commenter suggested changes to this requirement.	This requirement is in Section 4(2)(b) of SL 2015-245, and DHHS does not anticipate requesting a change to this requirement.

B. Prepaid Health Plans (PHPs)		
	Summary of Comments	**Response**
7. One statewide PLE	A couple of commenters requested that there be at least one statewide PLE. Another commenter requested that DHHS confirm that it will only award statewide contracts to commercial plans (CPs).	DHHS does not interpret Section 4(6)(b) of SL 2015-245 as prohibiting DHHS from contracting with a PLE as a statewide plan. Therefore, DHHS could award a statewide contract to a PLE.
8. Number of PHPs	Many commenters expressed concern about the number of PHPs, and one commenter suggested that DHHS limit the number of PHPs in a region to three.	DHHS recognizes these concerns and will consider ways to address these concerns in the development, implementation and operation of the program. Section 4(6) of SL 2015-245 requires DHHS to have three statewide contracts and up to 10 regional contracts, and DHHS supports having a choice of models in each region.
9. Speciality pediatric PHP	A couple of commenters recommended DHHS establish a statewide, pediatric-specific PHP so that the unique needs of pediatric patients can be accommodated efficiently.	DHHS acknowledges this comment. However, given the number of beneficiaries who are children, all PHPs must be qualified to serve this population. Also, if a large percentage of children enrolled in a specialty PHP, the other PHPs would not be financially viable. DHHS did modify the demonstration application to clarify that DHHS will focus on pediatric requirements for PHPs, including pediatric network adequacy requirements and quality measures.
10. Provider education prior to implementation	A couple of commenters recommended that DHHS learn from the experience from other states and provide appropriate education to providers before the implementation of PHPs.	DHHS agrees and intends to provide appropriate education to all stakeholders, including providers and beneficiaries, prior to the implementation of PHPs.
11. PLEs as Managed Care Organizations (MCOs)	One commenter asked whether PLEs would be MCOs, as defined in 42 CFR 438.2.	The application has been revised to more clearly state that PHPs, whether PLEs or CPs, will be MCOs, as defined in 42 CFR 438.2.
12. Same requirements for PLEs and CPs	A couple of commenters asked whether the requirements for PLEs will be the same as for CPs.	DHHS intends to have one standard contract for PHPs, with the same requirements for both PLEs and CPs.
13. Medicaid requirements	One commenter expressed concern that the draft demonstration application did not reference applicable federal Medicaid requirements.	Unless DHHS has requested authority to not comply with a Medicaid requirement (see Section 9 of the demonstration application), all Medicaid requirements will apply to this program.

B. Prepaid Health Plans (PHPs)		
	Summary of Comments	**Response**
14. Grievances and Appeals	A couple of commenters expressed concern that the draft demonstration application did not discuss grievance and appeals.	While the demonstration application does not describe the grievance and appeals process, it includes an assurance that PHP contracts will comply with all requirements in 42 CFR Part 438, which includes requirements for grievance and appeals.
15. Consumer protections	A few commenters recommended that the demonstration application include language about consumer protections.	DHHS acknowldeges this comment and notes that while the demonstration application does not include language about consumer protections, DHHS intends to incorporate consumer protections, including all federal and state requirements, into regulation and/or the PHP contract, and will monitor the PHPs for compliance with those requirements.
16. Profit motive	Several commenters expressed concern about the profit motive of PHPs, particularly the financial incentive for PHPs to limit access to care.	DHHS acknowledges this concern and will have safeguards, including a medical loss ratio (MLR), robust contract requirements, and monitoring mechanisms, to protect against excessive profit and inappproriate limitations on care. DHHS also believes that PHPs will have an incentive to develop innnovative ways to provide services to enrollees in a more cost-effective manner while ensuring access and quality.

C. Person-Centered Health Communities (PCHCs)		
	Summary of Comments	**Response**
1. Building on medical homes	Several commenters expressed support for building on what is currently working with medical homes.	DHHS appreciates the support and revised the demonstration application to clarify that ePCCM and PCMH models are the foundation of PCHCs.
2. Pregnancy medical home	Several commenters expressed support for preserving and strengthening the pregnancy medical home program as part of Medicaid reform.	DHHS appreciates the support and intends to preserve and strengthen the pregnancy medical home program, specifically through the advanced pregnancy programs in PCHCs.
3. PCHC details	Several commenters requested additional detail about PCHCs, including functions and activities, how they will be organized and structured, and how they will meet the needs of various communities and populations. Individual commenters also recommended that PCHCs include certain features and services.	It is not DHHS' intent to have a "one size fits all" approach to PCHCs. However, DHHS revised the demonstration application to include additional detail regarding PCHCs. As part of program development, DHHS will continue to work with stakeholders to further define PCHCs.
4. Role of PHPs	A couple of commenters asked about the role of PHPs with respect to PCHCs, and a couple of other commenters expressed concern about requiring PHPs to delegate functions such as care coordination to a PCHC.	Details regarding the role of the PHP and what functions will be provided by the PHP versus the PCHC will be addressed during development of the program.
5. Comprehensive Primary Care Plus Initiative	One commenter requested that DHHS implement a Comprehensive Primary Care Plus (CPC+) initiative in North Carolina.	DHHS appreciates this comment and intends to evaluate the possibility of implementing CPC+ in North Carolina. The PCHC model may be aligned with CPC+, but it will be a North Carolina-specific model.

D. Integrating Behavioral and Physical Health		
	Summary of Comments	**Response**
1. State law and integration	Two commenters noted that language in the draft demonstration application incorrectly stated that SL 2015-245 requires integration of behavioral health services within a single capitated system after the four year carve out of LME-MCO services.	DHHS revised the demonstration application to remove the incorrect statement.
2. Coordination between PHPs and LME-MCOs	Several commenters noted the importance of clarifying the responsibilities of PHPs and LME-MCOs, and ensuring coordination between PHPs and LME-MCOs.	DHHS agrees that clarifying responsibility and ensuring coordination between the PHPs and LME-MCOs is critical. DHHS will work with stakeholders to develop the contract requirements for PHPs and LME-MCOs and establish a process to monitor compliance with those requirements.
3. Fee-for-Service (FFS) payments for integrated services by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	Two commenters recommended the demonstration application clarify that integrated behavioral health/primary health services provided by FQHCs/RHCs will continue to be paid by the State outside of the PHP and LME-MCO contracts.	Integrated behavioral health/primary care services by FQHCs/RHCs will continue to be reimbursed by Medicaid, but the specific payment mechanism will be determined as part of program development. Therefore, DHHS did not revise the demonstration application.
4. Intellectual/ Developmental Disability (I/DD) health home	Two commenters asked for additional detail about the proposed I/DD health home.	DHHS revised the application to remove the term I/DD health home. However, DHHS intends to support I/DD providers to enhance their ability to provide primary care for individuals with I/DD and to increase the capacity of primary care providers to provide care to individuals with I/DD. DHHS will work with stakeholders to develop the requirements for these conceptual I/DD health homes as part of program development.

D. Integrating Behavioral and Physical Health		
	Summary of Comments	**Response**
5. Behavioral health supports and models of care	Several commenters suggested including specific behavioral health supports or models of care in the demonstration, including: • Co-location of behavioral health and primary care • Collaborative care models • Case management expertise • Tools such as telemedicine and tele psychiatry • Medical homes, intense case management, and clinical pharmacy care • Social supports and safety nets for individuals with SPMI • Incorporating principles of recovery-based care	DHHS appreciates these suggestions. Some of these are part of the current LME-MCO system, some are included in the demonstration application, and DHHS will consider including the others as part of program development.
6. Long-term plan for physical and behavioral integration	Several commenters asked what happens after the four years during which the LME-MCOs continue to manage behavioral health services. Some suggested that behavioral health services be carved in; some recommended that the PHP carve-out continue; and a couple of commenters recommended the development of a specialty plan to provide integrated services to individuals with behavioral health needs.	SL 2015-245 does not specify whether or how physical and behavioral health will be integrated after the four years that LME-MCOs continue to manage behavioral health services. The decision on whether or how physicial health and behavioral health services will be integrated after the fours years will be determined by the North Carolina General Assembly and the Governor with input from key stakeholders.

E. Long-Term Services and Supports (LTSS)		
	Summary of Comments	**Response**
1. Inclusion of LTSS in the new system	A couple commenters expressed confusion about which LTSS will be included in the demonstration, and how these services will be administered.	All LTSS, other than PACE and services provided by LME-MCOs, will be provided by PHPs to their enrollees. Dually eligible beneficiaries – beneficiaries who also are eligible for Medicare – will not be included. LTSS provided by PHPs will include both state plan services (such as nursing facility services, personal care, private duty nursing, and home health) and services included in the CAP/C and CAP/DA 1915(c) waivers. Unlike some other states with managed LTSS, DHHS will operate 1915(c) waivers concurrently with the 1115 demonstration, so coverage for these services will continue to be authorized through the 1915(c) waiver, not the demonstration. The demonstration will provide authority for the 1915(c) services to be delivered through the PHPs. DHHS revised the application to clarify that the demonstration changes the delivery system for state plan and 1915(c) LTSS, not the coverage of those services.
2. Additional LTSS services	A couple of commenters suggested adding a specific home and community-based service (structured family caregiving) to the demonstration.	DHHS appreciates the suggestion and may consider covering this service in the future.
3. LTSS network development	One commenter suggested that DHHS provide data on providers currently serving the potential LTSS member population so that prospective PHPs can identify care patterns and target providers for contracting.	DHHS thanks the commenter and will consider providing this information as part of the PHP procurement.

E. Long-Term Services and Supports (LTSS)		
	Summary of Comments	**Response**
4. Outcomes	A couple commenters noted that a stakeholder group reached consensus about five outcomes that are important to individuals and families from all disability groups for a managed care system: (1) more independent; (2) no waiting lists; (3) jobs in integrated employment settings; (4) individuals live inclusively in their communities, where people with disabilities have the ability to develop assets; and (5) system is accountable for meaningful outcomes.	DHHS appreciates the comments and supports these outcomes for individuals with all types of disabilities.
5. Financial management services (FMS)	A commenter encouraged DHHS to procure a single FMS administrator with which each PHP must contract.	DHHS will consider this suggestion in the development of the PHP requirements.

F. Rural Health and Community-Based Residency and Health Workforce Training		
	Summary of Comments	**Response**
1. Rural access	A few commenters expressed the need to increase access and expand services to beneficiaries residing in rural areas.	DHHS agrees and reiterates that one of the key goals of the demonstration is to expand the availabilty and accesibility of services to beneficiaries residing in rural areas. Specifically, this will be facilitated by value-based payments, PCHCs, expanded telemedicince/telepsychiatry, community-based residency and health workforce training, and DSRIP projects.
2. Telemedicine	Several commenters recommended expanding telemedicine, though a couple of commenters cautioned that telehealth should not be a substitute for the doctor/patient relationship.	DHHS supports the appropriate use of telemedicine and anticipates that the demonstration, particularly through value-based payments, will allow and encourage expanded use of telemedicine.
3. Community-based residency and health workforce training	A few commenters expressed support for the initiatives around community-based residency and workforce training included in the draft demonstration application. A couple of other commenters suggested additional ways to increase the workforce.	DHHS thanks the commenters for their support and input and will consider the suggestions as part of program development.

G. Provider Administrative Ease		
	Summary of Comments	**Response**
1. Multiple PHPs	A large number of commenters expressed concern about the administrative burden of moving from a single payer to multiple PHPs and the potential impact on providers and beneficiaries.	DHHS understands these concerns and will work with stakeholders to minimize the administrative burden. This will include working with stakeholders to maximize standardization, centralize functions where feasible, and reduce unnecessary requirements (also see responses to comments below).
2. Standardization	A number of commenters recommended standardization of policies and procedures, forms, coverage requirements, prior authorization, billing, credentialing, quality measures, reimbusement, provider contracts, reporting, and/or monitoring.	DHHS understands the potential burden on providers of having to comply with multiple different sets of requirements. DHHS proposes to organize a collaborative effort among providers and PHPs to create and embed standardization to the greatest extent possible.
3. Centralization	Several commenters suggested that certain functions, such as credentialing, billing, prior authorization, quality, care management, shared savings, and informatics, be centralized.	DHHS has proposed that certain credentialing functions be conducted by DHHS. DHHS will work with stakeholders to determine the feasibility of centralizing other functions.
4. Ombudsman for PHP/provider disputes	Several commenters requested that DHHS establish a state-operated ombudsman to settle disputes between providers and PHPs.	DHHS will consider this request as part of program development.

H. Provider Practice Supports, HIE, and Statewide Informatics Layer		
	Summary of Comments	**Response**
1. Preserve and enhance current provider supports	Several commenters requested that DHHS preserve and enhance current provider supports, both direct (per member per month payments) and indirect (care management, quality initiatives, and informatics).	DHHS agrees with the commenters and intends to preserve and enhance provider supports as part of the demonstration.
2. Additional detail on how supports will be provided	A few commenters requested additional detail about how provider supports will be provided, including who will be providing them (e.g., PHP, State, or other entity) and who will be paying for them (e.g., PHP, State, or provider).	DHHS plans to identify additional detail on how provider supports will be delivered as part of program development, which will reflect additional input from stakeholders.
3. Health Information Exchange (HIE)	Many commenters expressed support for the State's health information exchange (HIE). However, several of these same commenters expressed concern about participation rates, cost, data blocking, timeliness, and privacy.	DHHS appreciates the support and input and will work to address these concerns as part of program development.
4. Statewide informatics layer	Several commenters expressed general support for collecting quality measures and having centralized, robust, real-time informatics, at low or no cost to providers.	DHHS appreciates the support and is committed to working with stakeholders to develop the specifications for the statewide informatics layer.
5. Quality of care information for beneficiaries	One commenter asked if beneficiaries will have access to quality of care information for PHPs and providers and, if so, how the information will be made available.	DHHS intends to provide the public with information on the performance of PHPs. This will include, at a minimum, adopting a managed care quality rating system as required by the final Medicaid managed care rule. At this time, DHHS does not anticipate providing beneficiaries or the public with quality of care information for individual providers. However, PHPs may provide this information as part of their provider directory.
6. Role of Community Care of North Carolina (CCNC)	Many commenters asked about the role of CCNC in the new system.	As required by Section 7 of SL 2015-245, DHHS is working with CCNC to develop a transition plan.

I. Child Welfare Initiatives		
	Summary of Comments	**Response**
1. Three child welfare care initiatives	A few commenters expressed support for all three of the child welfare initiatives.	DHHS appreciates the commenters' support of these initiatives.
2. Single statewide PHP for foster care children	A couple of commenters asked for additional detail about the proposal to designate a single statewide PHP for children in foster care, including whether the procurement for this plan would be conducted as part of the PHP procurement. One commenter suggested that all statewide PHPs serve foster care children, and other commenters suggested that LME-MCOs manage specialized care for foster care children.	DHHS is not proposing any changes to its proposal to designate a single statewide PHP for foster care children while not restricting choice of other PHPs. Additional details will be defined as part of program development. DHHS intends to procure this plan as part of the PHP procurement (not a separate procurement).
3. Coverage of parents of kids in foster care	Several commenters expressed support of extending coverage to parents whose children are placed in foster care. One commenter was not supportive.	DHHS appreciates this input.

J. Payments and Budget Neutrality		
	Summary of Comments	**Response**
1. Capitation rates	Several commenters asked for additional detail or made suggestions about the capitation rates, including risk adjustment, blended LTSS rates, inclusion of provider incentives, individual stop loss, and risk sharing.	Additional detail regarding capitation rates will be defined during program development, and DHHS will consider commenters' suggestions and additional stakeholder input as part of rate development.
2. PHP performance-based payment	One commenter supported and applauded DHHS' plan to vary payments to PHPs according to the PHP's performance on quality measures.	DHHS appreciates the support and believes that this will be an important tool for incentivizing PHP performance.
3. Support for value based payment (VBP)	Several commenters expressed support for VBP and incentive payments, while a couple of commenters expressed concern about being accountable for outcomes that were outside the provider's control.	DHHS appreciates this input and will consider these concerns as DHHS works with stakeholders to develop VBP and incentive payment methodologies.
4. VBP design	Several commenters requested additional detail and/or provided suggestions regarding the design of VBP. For example, the commenters offered the following suggestions: VBP should be specialty-specific; VBP should not apply to certain providers; VBP should "meet providers where they are;" VBP should include a limited number of measures; VBP should be the same across PHPs; PHPs should have flexibility to design their own VBP approaches; VBPs should include social determinants of health; and VBPs should be piloted or phased in.	Additional detail regarding VBP will be defined during program development. DHHS will consider commenters' suggestions and additional stakeholder input during development of the VBP requirements. DHHS will include requirements regarding VBP in the PHP contract.
5. Flexible funding	A few commenters recommended that DHHS ensure that payments to practices include funding flexibility to enable practices to provide services that are not otherwise Medicaid reimbursable such as phone nurse consults and Reach Out and Read.	DHHS supports reimbursement methodologies that allow for the flexibility to provide these types of supports, and expects that VBP will provide this type of flexibility. In addition, DHHS will encourage PHPs to provide cost-effective alternative services that may decrease costs and improve outcomes.

J. Payments and Budget Neutrality		
	Summary of Comments	**Response**
6. Clarifying FQHC/RHC "wrap around" payment language	One commenter noted that the draft demonstration application states that DHHS will continue the current FQHC/RHC wraparound payments; however, under the current FFS system FQHCs and RHCs do not receive a wraparound payment. Rather, they receive the prospective payment system (PPS) rate or alternate payment methodology (APM).	DHHS revised the demonstration application to clarify that "wrap around" payments will be part of the future capitated PHP system, when DHHS will pay an FQHC/RHC the difference between the FQHC/RHC contracted rate with the PHP and the FQHC/RHC PPS/APM rate.
7. Automated payment of FQHC/RHC "wrap around" payment	Two commenters recommended that DHHS familiarize itself with Kentucky's automated Medicaid reconciliation process for FQHC/RHC PPS/APM reimbursement.	DHHS will consider this option as part of program development.
8. Out-of-network FQHCs/RHCs	Two commenters requested the following: if DHHS establishes rate ceilings that apply when non-participating essential providers deliver services to PHP enrollees after declining a good faith offer, DHHS should exempt FQHCs/RHCs with established PPS/APM rates from the rate ceiling and ensure they are reimbursed directly by the State at their PPS/APM rate.	DHHS will consider this comment as it works with stakeholders to further develop the requirements for contracting with essential providers. DHHS intends to include requirements regarding out-of-network providers in the PHP contract.
9. Cost settlement for EMS agencies	Many commenters requested that DHHS continue to provide cost settlement payments to municipal EMS agencies for the provision of ambulance services to Medicaid beneficiaries.	DHHS has revised the demonstration application to request authority for DHHS to provide "wrap around" payments to EMS agencies to preserve cost-settlements.
10. Cost settlement for free and charitable clinics	One commenter requested that free and charitable clinics that serve Medicaid receive a "wrap around" payment to cost.	DHHS is considering this request but did not amend the demonstration application to include these clinics as receiving "wrap around" payments.
11. Cost-based reimbursement for other providers	A couple of commenters requested that reimbursement for all or certain providers (e.g., personal care) be based on cost.	PHPs will determine the reimbursement rates for covered services, and DHHS will only provide "wrap around" payments to cost for FQHCs/RHCs (as required by federal law) and a limited number of other safety net providers.
12. Preserving supplemental payments	A few commenters supported the preservation of supplemental payment funding.	DHHS thanks the commenters for their feedback.

J. Payments and Budget Neutrality		
	Summary of Comments	**Response**
13. Supplemental payments	A couple of commenters requested more information on how supplemental payments would be made under the demonstration.	DHHS revised the demonstration application to include more information on its Care Transformation through Payment Alignment proposal, and additional detail will be developed, with stakeholder input, as part of DHHS' negotiations with CMS.
14. DSRIP	A few commenters offered suggestions on DSRIP, specifically that DHHS should: include stakeholders in the design; include a broad spectrum of providers; invest DSRIP funding in infrastructure; align measures with the program's defined quality goals; and develop a reasonable implementation schedule.	DHHS revised the demonstration application to include a sample list of DSRIP projects, but additional details will be developed with stakeholder input as part of DHHS' negotiations with CMS.
15. Impact on other funding streams	A couple of commenters asked whether all Medicaid funding would be included in the PHP capitation rates and how that would impact other programs that address social determinants of health, such as public health. The same commenters recommended that the demonstration application identify programs that will lose funding and the potential impact on services for North Carolina children and others. Another commenter recommended that DHHS explore innovative and flexible options to pay for non-medical services outside of PHPs' capitated rates, in order to ensure that appropriate and adequate revenue streams are available to support the Medicaid population's needs.	DHHS appreciates this input and reiterates that one of the key goals of the Care Transformation through Payment Alignment proposal is to ensure that funding continues to be available for programs that support Medicaid beneficiaries.
16. Missing graphic	Two commenters noted that the draft demonstration application (p. 34) referenced a graphic that is not included.	DHHS revised the demonstration application to delete this reference.
17. Physician rate floor	Many commenters expressed support for establishing Medicare reimbursement rates as the rate floor for primary care and specialty physicians.	Section 5(5)(b) of SL 2015-245 requires DHHS to establish "appropriate rate floors" for network primary care physicians and specialist physicians. As noted in its March 1 report to the JLOC on Medicaid and NC Health Choice, DHHS expects to establish these rate floors as a percentage of the effective Medicaid fee schedule.

J. Payments and Budget Neutrality		
	Summary of Comments	**Response**
18. Hospice rate floor	One commenter recommended that DHHS establish a rate floor for hospice services consistent with rates set by CMS.	At this time, DHHS does not anticipate establishing rate floors for providers other than those currently itemized in SL 2015-245.
19. Reimbursement of Clinical Laboratory Improvement Amendments (CLIA) certified labs	One commenter requested that DHHS require PHPs to negotiate fair and acceptable reimbursements for CLIA certified labs.	DHHS understands the concern, but PHPs will be responsible for establishing reimbursement rates for covered services.
20. Reimbursement rates	Many commenters expressed concern about the current Medicaid provider reimbursement rates and requested that these rates be increased.	DHHS understands this concern but notes that current provider rates are outside the scope of the demonstration application. The PHP capitation rates will be based on current expenditures, but PHPs will have some flexibility to adjust provider rates and will be expected to develop VBP methodologies within their capitation payments.
21. PHP rates 2% below national spending growth	Two commenters asked about the requirement in Section 5(6) of SL 2015-245 that the PHP contract include that risk-adjusted cost growth for "enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non - expansion states." One commenter recommended that DHHS clearly outline the actual formula to achieve this savings in the demonstration application. The commenter also suggested that national Medicaid spending growth be based on the increase in spending on a per beneficiary basis and that the measurement occur retrospectively using actual, not projected, growth in spending. Further, the commenter requested that statute be modified as required to reflect the demonstration. Another commenter noted that this provision, as written, could cause significant problems for the long-term viability of the Medicaid program.	DHHS appreciates the input. The respective components of the calculation will be defined with additional input with stakeholders.

J. Payments and Budget Neutrality		
	Summary of Comments	**Response**
22. Budget neutrality	Two commenters asked about the enrollment and expenditures chart on page 58 of the draft demonstration application. The commenters calculated the cost per member for the historical five year total and the five year total for the demonstration period and noted that the five year total cost per member for the demonstration period was higher than the historical five year total cost per member.	The five year total cost per member for the demonstration period was higher than the historical five year total cost per member due to projected enrollment growth and expenditure cost trend. Note that the final demonstration application includes the completed budget neutrality forms, and DHHS projects savings as a result of the demonstration.

K. Eligibility and Enrollment		
	Summary of Comments	**Response**
1. Medicaid expansion	Many commenters requested that the State expand Medicaid under the Affordable Care Act.	DHHS appreciates these comments. The decision to expand Medicaid in North Carolina is outside of the demonstration proposal. SL 2013-5 does not give DHHS authority to expand Medicaid.
2. North Carolina Health Insurance Premium Payment program (NC HIPP)	Many commenters expressed concern that DHHS is proposing to discontinue the NC HIPP.	DHHS apologizes for the misunderstanding and has revised the demonstration application to clarify that NC HIPP will continue as it is currently administered under FFS and that beneficiaries enrolled in NC HIPP will be excluded from PHP enrollment.
3. Individuals dually eligible for Medicaid and Medicare ("dual eligibles")	A couple of commenters requested clarification on whether dual eligibles will be part of the demonstration. A couple of other commenters stated that carving out dual eligibles was a mistake and encouraged DHHS to accelerate the inclusion of this population in the demonstration.	As specified in SL 2015-245, dual eligibles will not be part of the demonstration at this time. DHHS defers to the Dual Eligibles Advisory Committee, which will develop a strategy to cover dual eligibles through capitated PHP contracts.
4. Children	Several commenters proposed that children be left out of the demonstration and remain in FFS Medicaid.	SL 2015-245 requires inclusion of children other than dual eligibles.
5. Retroactive coverage	One commenter asked how providers will be paid for retroactive eligibility situations, when a beneficiary has received services and later it is determined he/she qualified for Medicaid.	DHHS intends to pay claims incurred during a retroactive coverage period on a FFS basis.
6. Unify enrollment in Medicaid and PHPs	Several commenters recommended that DHHS unify Medicaid eligibility and PHP enrollment, and some of these commenters suggested that this could be done by local departments of social services (DSS) or FQHCs.	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. DHHS notes that given the "independence" requirement for enrollment brokers, providers, such as FQHCs, could not perform choice counseling or enrollment activities.

K. Eligibility and Enrollment		
	Summary of Comments	**Response**
7. Information for beneficiaries	One commenter noted that beneficiaries must have the information they need to make an informed decision about enrollment, including information about formularies, providers, and plan performance.	DHHS agrees and intends, through the enrollment broker, to provide information and support to beneficiaries to help them make an informed choice of PHP.
8. Enrollment broker	One commenter expressed concerns with the plan to use an enrollment broker, particularly the potential for poor matches between beneficiaries and PCPs/PHPs.	DHHS appreciates the commenter's concerns but has determined that the advantages of having an enrollment broker outweigh the potential disadvantages. DHHS will seek to address the commenter's concerns through requirements in the enrollment broker contract.
9. Enrollment broker activities	One commenter stated that it is ineffective to use enrollment brokers to assist in the selection of a PCP because many PCPs will be participating in a number of PHPs.	While DHHS understands the comment, given the importance of the PCP-patient relationship, DHHS intends to use every opportunity to help beneficiaries select an appropriate PCP.
10. Enrollment broker and the Program of All-Inclusive Care for the Elderly (PACE)	One commenter recommended that DHHS ensure that the enrollment broker is fully informed about PACE and actively refer potentially eligible beneficiaries to PACE.	DHHS will consider including requirements regarding PACE information and referral in the enrollment broker contract.
11. Current PCP as factor in the auto-assignment algorithm	Several commenters noted that consideration of a patient's current PCP is crucial in any auto-assignment.	DHHS agrees and, as noted in the demonstration application, will consider continuity of care in the auto-assignment process.
12. PCPs should include nurse practitioners and physician assistants	A few commenters requested that DHHS broaden primary care assignment to include nurse practitioners and physician assistants.	DHHS intends to continue the current practice, which allows beneficiaries to be assigned to nurse practitioners or physician assistants.
13. Assignment to FQHCs	One commenter requested that beneficiaries be assigned to the FQHC organization, rather than to a specific provider.	DHHS understands and intends to continue the current practice of assigning beneficiaries to the FQHC organization, rather than to a specific provider within the FQHC.
14. Protecting providers against adverse risk	Two commenters encouraged DHHS to present mechanisms to protect network providers from having a disproportionate number of high-risk patients attributed to them by a PHP.	DHHS understands the concern and will address this as part of program development, which will include input from stakeholders.

K. Eligibility and Enrollment		
	Summary of Comments	**Response**
15. Assignment of LTSS members	One commenter suggested that DHHS design an LTSS auto-assignment algorithm to ensure that each of the selected PHPs will serve a balanced mix of LTSS members in both institutional and community settings.	DHHS understands the need to balance enrollment of LTSS members and will consider including this in the the auto-assignment algorithm.
16. Assignment of new beneficiaries	A couple of commenters asked how new beneficiaries will be assigned to a PHP if DHHS does not have claims data.	DHHS will develop details on beneficiary assignment as part of program development, but the general approach is as follows: 1) If a new Medicaid beneficiary selects a PCP but not a PHP, he/she will be assigned to a PHP that includes the PCP and serves the beneficiary's region consistent with DHHS's program goals (e.g., balanced enrollment among PHPs the first year) or PHP performance (if implemented). If a beneficiary is new to Medicaid and does not select a PCP or PHP, he/she will be assigned to a PHP in his/her region consistent with DHHS's program goals (e.g., balanced enrollment the first year) or PHP performance (if implemented); or 2) If DHHS does not have a program goal and has not incorporated PHP performance into the auto-assignment algorithm, new beneficiaries who did not select a PCP would be assigned to a PHP serving their region on a random basis.
17. Assignment based on PHP performance	A couple of commenters encourage DHHS to develop an auto-assignment process that rewards quality performance.	DHHS agrees that high-quality PHPs should be rewarded for high performance, and, as noted in the demonstration application, intends to review the assignment process after the first year to determine whether the assignment process should consider PHP quality performance.
18. Choice period before auto-assignment	One commenter recommended that beneficiaries have 90 days to enroll in a PHP before being auto-assigned.	DHHS appreciates the comment and will determine the choice period as part of program development, which will include additional stakeholder input.

K. Eligibility and Enrollment		
	Summary of Comments	**Response**
19. Enrollment lock-in	A couple of commenters asked whether DHHS will limit disenrollment/require enrollment lock-in.	DHHS intends to limit disenrollment/require lock-in for all mandatory enrollees in order to maximize continuous enrollment, consistent with federal Medicaid managed care regulations. The details will be identified as part of program development, which will reflect additional stakeholder input.

L. Pharmacy		
	Summary of Comments	**Response**
1. Pharmacy carve-in	One commenter asked whether pharmacy will be separate from medical benefits or carved into the PHPs.	The pharmacy benefit will be provided by the PHPs, but a PHP may subcontract with a pharmacy benefit manager (PBM) to manage the pharmacy benefit.
2. Responsibility for behavioral health drugs	One commenter requested that DHHS require PHPs to accept full risk for all pharmacy costs and administer the pharmacy benefit for both physical and behavioral health drugs.	In accordance with DHHS' interpretation of SL 2015-245, PHPs will be responsible for both physical and behavioral health drugs.
3. Prompt pay	One commenter noted that extending the time to receive payment will create cash flow issues for some pharmacies, since pharmacies generally must pay wholesalers within 14 days.	DHHS will consider specifying a shorter timeframe for payment of pharmacy claims in the PHP contract and/or program regulations.
4. Standard formulary/ Preferred Drug List (PDL)	One commenter asked whether PHPs will be able have their own formulary or if it will be mandated by DHHS. Another commenter stated that DHHS should maintain its FFS formulary and designate it as the required, uniform formulary for all PHPs. Two other commenters urged DHHS to allow PHPs to develop their own PDLs.	As specified in Section 5(6)(b) of SL 2015-245, PHPs will be required to use the same drug formulary, which shall be established by DHHS.
5. Development of a standard PDL	One commenter recommended that DHHS include PHPs with multi-region or statewide coverage and practicing providers in the committee developing a statewide formulary. The commenter also requested that DHHS limit committee participation of entities whose incentives are misaligned with containing the rate of growth in prescription drug spending. Another commenter raised concern with the required use of the State's PDL and requested clarification and transparency on who determines what drugs are included.	DHHS acknowledges these comments and will consider including PHP and provider representatives in the committee that provides clinical recommendations for the State PDL. DHHS intends to require conflict of interest forms for each member of the committee. DHHS makes the final determination on what drugs are included on the State's PDL. Currently, there are three committees that provide clinical review and recommendations on the drug determinations for the PDL. Meetings of the final committee review will continue to be held in a public venue in order to receive comments from the general public.

L. Pharmacy		
	Summary of Comments	**Response**
6. PHP utilization management	A few commenters recommended that the PHP contract specify that PHP prior authorization criteria be no more restrictive than the State's prior authorization criteria. One commenter recommended that DHHS specify that PHP utilization management requirements be no more restrictive than the State's. A couple of other commenters raised concern with the use of utilization management tools, and one commenter requested a "medically necessary" exception process.	DHHS intends to specify in the PHP contract that the PHP's utilization management requirements can be no more restrictive than the State's requirements unless the State has provided prior approval of the PHP's UM requirements.
7. Dispensing fee rate floor amount	One commenter noted that given DHHS' new reimbursement methodology, the dispensing fee rate floor (required by Section 5(5) of SL 2015-255) should be no less than a weighted average of $10.24. Another commenter recommended that DHHS allow PHPs to negotiate appropriate pricing methodologies and dispensing fees for the pharmacy benefit.	DHHS intends to determine the dispensing fee rate floor based on a cost of dispensing survey.
8. Protecting the 340B program	A couple of commenters requested that DHHS protect the 340B program by restricting PHPs from the following: • Prohibiting 340B providers from using 340B drugs for their patients; • Requiring providers to agree to not use 340B drugs for their patients as a condition of network participation; • Paying lower rates for drugs purchased by 340B covered entities than for the same drugs when purchased by other PHP network providers; • Requiring 340B providers to use a method for identifying 340B claims that makes it difficult or impossible for providers and their contract pharmacies to use 340B for PHP members; and • Using billing information from 340B claims to reduce reimbursements for 340B commercial claims.	DHHS will consider including these provisions in the PHP contract. DHHS intends to require PHPs to use the State's methodology for identifying 340B claims.

L. Pharmacy		
	Summary of Comments	**Response**
9. Lock-in program	One commenter requested that DHHS require PHP participation in the Medicaid pharmacy/prescriber lock-in program for high-risk beneficiaries.	DHHS will consider requiring PHPs to have a pharmacy/prescriber lock-in program for high-risk beneficiaries.
10. Medication review	One commenter recommended that every enrollee who meets certain criteria (e.g., number of medications, disease state, age, surgical procedure) have access to a licensed pharmacist for a full medication review.	DHHS thanks the commenter for the suggestion and will consider including medication therapy management (MTM) in the PHP contract.
11. Enhanced pharmacy services	One commenter expressed support for the inclusion of Community Pharmacy Enhanced Services Network (CPESN) in the demonstration and encouraged DHHS to consider recognizing enhanced services provided by pharmacists. Another commenter was pleased to see DHHS' commitment to continue to develop a network of pharmacies that provide enhanced services.	DHHS appreciates the commenters' support and will determine how to include enhanced pharmacy services in the PHP contract.
12. Role of PBMs	Two commenters asked whether PBMs would be bidding on the demonstration.	Pharmacy will be part of the benefit package provided by the PHPs, so DHHS will be contracting with the PHPs for the pharmacy benefit. However, a PHP could contract with a PBM to manage the pharmacy benefit.
13. Access to local pharmacists	One commenter requested that DHHS apply the "pharmacy of choice" provisions in Chapter 58 to Medicaid.	DHHS appreciates the commenter's input and will consider applying the "pharmacy of choice" provisions in Chapter 58 to Medicaid, consistent with the requirements in Section 5(6)(d) of SL 2015-245 regarding objective quality standards.
14. Mail order pharmacy	One commenter requested that PHPs be allowed to utilize mail order pharmacy programs without restriction.	DHHS appreciates the comment and will consider allowing mail order pharmacy programs consistent with pharmacy of choice requirements.

M. Other Benefits		
	Summary of Comments	**Response**
1. Local education agencies (LEA) services	Two commenters asked that DHHS allow LEAs to continue billing for the following school-based services: speech, occupational and physician therapy, and audiology.	As noted in the demonstration application, LEAs are carved out of the PHP benefit package. DHHS will continue to pay LEAs on a FFS basis.
2. Dental carve-out and fluoride varnish treatment	A few commenters raised concerns that the current oral health program, which includes coverage of fluoride varnish treatments by medical providers, will not be covered since it was not addressed in the draft demonstration application.	While this program is not described in the demonstration application, DHHS intends to require PHPs to reimburse medical providers for the application of fluoride varnish for children.
3. School-based health center services	A couple of commenters either assumed or requested that school-based health centers be carved out of PHPs.	DHHS considered the request but will not carve out school-based health centers. As part of the PHP contract DHHS will encourage PHPs to contract with these centers. DHHS also notes that in order to meet network adequacy standards PHPs may need to contract with school-based health centers.
4. Non-emergency medical transportation (NEMT)	One commenter asked how DHHS is handling NEMT in the demonstration.	PHPs will be required to cover NEMT as a service.
5. Preventive services	A couple of commenters requested that DHHS include U.S. Preventive Services Task Force (USPSTF) recommended preventive services as covered benefits. The commenters also noted that if DHHS provides these services without cost-sharing, the State is eligible for a 1% increase in the Federal Medical Assistance Percentage (FMAP) on preventive services.	DHHS thanks the commenters for the recommendations. DHHS is conducting a policy assessment to evaluate its options regarding coverage of the preventive services recommended by the USPSTF.
6. Chiropractic care	One commenter requested that DHHS consider that chiropractors are an underutilized part of treating the Medicaid population.	DHHS thanks the commenter for the suggestion.
7. Services for persons with HIV/AIDS	A few commenters requested that DHHS support services for persons with HIV/AIDS.	DHHS supports services for persons with HIV/AIDS and plans to include requirements specific to persons with HIV/AIDS in the PHP contract.

M. Other Benefits		
	Summary of Comments	**Response**
8. Paramedic services	A few commenters requested that DHHS cover community paramedic programs.	DHHS revised the demonstration application to note that DHHS supports the use of cost-effective alternative services by PHPs and includes community paramedic services as an example. DHHS will consider covering this service under the State plan based on the results of the current pilots.
9. Coverage of other services	A couple of commenters requested that DHHS include services in the demonstration that are not currently covered by NC Medicaid (e.g., home visitation services, alternative therapies).	DHHS appreciates these suggestions. DHHS is not proposing to cover any "new" services as part of the demonstration except those that PHPs may provide as "in lieu of" or "value-added services."
10. Additional carve-outs	A couple of commenters requested that certain services (e.g., personal care, pediatric therapies) be excluded from the PHPs.	DHHS acknowledges the requests but does not intend to request exceptions to SL 2015-245 (which requires PHPs to cover all Medicaid services except LME-MCO and dental services) other than those specified in the 3/1 draft of the demonstration application.
11. Waitlists	Two commenters raised concerns that individuals will be put on a waitlist for physical health services and asked whether PHPs will have the ability to "close" certain services as they do for HCBS waiver services.	PHPs will not be able to "close" any state plan services. However, PHPs will be able to limit or close the CAP 1915(c) waiver services (covered by the PHPs for Medicaid only beneficiaries) since the enrollment limit/registration lists for those waivers will remain intact.

Additional Comments

a. Innovations Center (renamed the North Carolina Health Transformation Center)
b. Demonstration Hypotheses and Evaluation Plan
c. Implementation Timeline
d. Procurement
e. Proposed Waivers and Expenditure Authorities
f. Essential Providers
g. Stakeholder Engagement
h. Other

N. Additional Comments		
	Summary of Comments	**Response**
a. Innovations Center (renamed the North Carolina Health Transformation Center)	One commenter endorsed the creation of the center as a means for providers and PHPs to achieve the Quadruple Aim and recommended the center as the vehicle through which PHPs collaborate to ease provider administrative burdens through process standardization. A couple of commenters asked which stakeholders (e.g., physicians, beneficiaries, family members advocacy groups) would be engaged in the process and how, and two commenters asked how I/DD will be integrated into the program. Another commenter recommended that the center create common set of pregnancy medical home 2.0 measures and work on connecting physicians and practices with social supports already in place in the community such as faith-based groups, YMCAs, etc.	DHHS appreciates the input. DHHS' legislative report on the North Carolina Health Transformation Center (dated May 1, 2016) provides additional information on the center, including capabilities related to performance measurement and analysis, stakeholder engagement, liaison center, and center of excellence. DHHS will develop additional details regarding the center over the next couple of years.

N. Additional Comments		
	Summary of Comments	**Response**
b. Demonstration Hypotheses, Evaluation, and Related Data Sources	One commenter encouraged DHHS to measure and reduce health disparities. Another commenter noted that more detail was needed about how outcomes will be measured and monitored.	DHHS appreciates the input and notes that the final Medicaid managed care rule requires a State's quality strategy to include the State's plan to identify, evaluate, and reduce health disparities. DHHS will develop measures and data sources as part of program development, which will include stakeholder input. DHHS will submit to CMS a more comprehensive evaluation design as required by CMS after approval of the demonstration.
c. Implementation Timeline		
1. Allow 90 days from JLOC consultation to PHP RFP release	A couple of commenters requested that the 30-day timeframe from JLOC consultation to the release of the PHP RFP be extended to 90 days.	DHHS did not revise the timeline but intends to include stakeholders throughout the development of the program, including PHP contract requirements.
2. Start RFP development based on draft demonstration application	Two commenters suggested that DHHS begin development of the RFP based on the draft demonstration application.	DHHS thanks the commenters for the suggestion. DHHS has included RFP development in its workplan.
3. Program implementation 18 months from demonstration approval	One commenter expressed strong support for the full 18-months from the demonstration approval to the contract effective date to provide adequate time to successfully launch program.	DHHS agrees and appreciates the support.
d. Procurement		
1. Request for application (RFA) instead of an RFP	One commenter suggested procuring PHPs bids through a competitive RFA, which is data-driven and uses yes/no questions and attestations to gather historical actual performance, instead of an RFP.	DHHS thanks the commenter for the suggestion and will discuss this approach with DHHS procurement staff.
2. Lowest cost bidder	One commenter requested that DHHS not choose the PHPs with the lowest bid.	DHHS agrees with the commenter and intends to select the PHPs that provide the best value to the State, considering all factors, not just price.

N. Additional Comments		
	Summary of Comments	**Response**
3. Suggested language for PHP contracts	A few commenters suggested topics and language to include in the PHP contracts (e.g., provider directories, third party liability, program integrity network adequacy standards, readability standards, grievance and appeals).	DHHS thanks the commenters for their input and will consider these suggestions for inclusion in the PHP contract.
e. Proposed Waivers and Expenditure Authorities	A couple of commenters requested that DHHS clarify that there is an error on pg. 59 of the draft application, which states that DHHS will "restrict choice," as this conflicts with what is proposed throughout the rest of the application.	While DHHS will encourage and support beneficiary choice of PHPs and providers, this language is requesting authority from CMS for DHHS to require beneficairies to enroll in PHPs. Thus, DHHS did not change this language.
f. Essential Providers		
1. Ryan White providers as essential providers	A few commenters encouraged DHHS to include Ryan White providers as essential providers.	While DHHS values these providers, Section 5(3) of SL 2015-245 prohibits DHHS from classifying physicians and other practitioners as essential providers. However, DHHS intends to include requirements specific to enrollees with HIV/AIDS in the PHP contract, including network requirements that encourage PHPs to contract with Ryan White providers.
2. School-based health centers (SBHCs) as essential providers	One commenter requested that SBHCs be designated as essential providers.	As noted above, Section 5(3) of SL 2015-245 prohibits DHHS from classifying physicians and other practitioners as essential providers. Thus, a SBHC run by an essential provider (e.g., FQHC or local health department) will be designated as an essential provider, but a SBHC run by a physician or other practitioner will not. However, DHHS intends to include requirements in the PHP contract that encourage PHPs to contract with SBHCs, regardless of whether they are designated as an essential provider.
3. Critical access hospitals (CAHS) as essential providers	One commenter recommended that CAHs should be designated as essential providers.	DHHS considered this suggestion but has decided not to designate any hospitals, including CAHs, as essential providers. However, DHHS expects that PHPs will likely need to contract with CAHs in order to meet network adequacy requirements.

N. Additional Comments		
	Summary of Comments	**Response**
4. Psychiatrists as essential providers	A few commenters recommended designating psychiatrists as essential providers.	DHHS considered this recommendation but, as noted above, section 5(13) of SL 2015-245 prohibits DHHS from classifying physicians as essential providers.
5. Good faith negotiations	One commenter recommended that the demonstration application include the requirement from the JLOC report that PHPs make at least a "good faith effort" to contract with essential providers. Another commenter encouraged DHHS to formulate a plan to monitor these negotiations to ensure that essential providers are able to negotiate fair and reasonable contracts with PHPs.	DHHS revised the demonstration application to include the referenced language from the JLOC report. DHHS will consider developing a plan for ensuring that essential providers are able to participate in the PHP networks on fair and reasonable terms.
6. Additional protections for essential providers	A couple of commenters requested that DHHS provide additional protections to essential providers, such as requiring PHPs to give essential providers priority for inclusion in the network and ensuring that essential providers are given preferential assignment for beneficiaries who do not choose a primary care provider (PCP).	DHHS acknowledges these comments and will consider including the suggestions as part of program development.
g. Stakeholder Engagement		
1. Stakeholder involvement in development of the demonstration application	A few commenters expressed concern about not being involved in the development of the demonstration application.	As noted in Section 10 of the application, since the passage of SL 2015-245, DHHS has proactively sought input from stakeholders across the State, including physicians, beneficiaries, beneficiary advocates, hospitals, potential PHPs, etc. DHHS looks forward to ongoing stakeholder engagement on the development, implementation and operation of the program.
2. Public notice and comment period	A couple of commenters thanked DHHS for allowing stakeholders the opportunity to provide feedback on the proposed program. A few other commenters expressed concern that more beneficiaries and self-advocates were not at the public hearings.	DHHS thanks the commenters for their participation in the process. DHHS received comments from almost 100 commenters who identified themselves as beneficiaires, family members, and caregivers. DHHS will continue to engage stakeholders, including beneficiaries and self-advocates, as part of program development, implementation and operations.

N. Additional Comments		
	Summary of Comments	**Response**
3. Stakeholder engagement in later phases of the demonstration	Several commenters offered to work with DHHS on developing, implementing, and monitoring the new program and suggested various structures for ongoing stakeholder engagement (e.g., a formal advisory committee, focus groups, or a body like the physician advisory group).	DHHS appreciates the input and will consider these suggestions as DHHS creates a robust stakeholder engagement process for providing ongoing input into the development, implementation, operation, and oversight of the new program.
4. Limited English proficiency	One commenter asked whether the presentation from the public hearing will be available in other languages.	Translation of the public hearing slides into Spanish is available upon request.
5. Public record	A couple of commenters requested that DHHS make the record of comments public, along with how these comments were addressed.	A summary of the comments and DHHS' responses are included in this section of the demonstration application. In addition, DHHS will post to its website this summary as well as a summary of comments collected on other Medicaid reform topics (e.g., regions) that are not included in this document.
h. Other		
1. Social determinants	A couple of commenters expressed support for addressing social determinants including food insecurity and housing.	DHHS appreciates the comment and agrees that addressing social determinants is key to improving health.
2. Children and Youth with Special Health Care Needs (CYSHCN)	One commenter expressed concern that the definition of CYSHCN was under-inclusive.	DHHS appreciates the comment. DHHS does not intend to limit CYSHCN to the populations listed in the referenced language and has removed that language from the final demonstration application.
3. Veterans	A few commenters expressed concerns about the treatment of veterans, particularly access to mental health services. One commenter noted that veterans were not addressed in the demonstration application. Another commenter encouraged all reforms to consider the mental health needs of our veterans.	DHHS values and supports our veterans, and DHHS will continue to work to improve services to veterans. DHHS notes that while there are not initiatives in the application specific to veterans, DHHS has designated veterans' homes as essential providers. DHHS anticipates that veterans will benefit from the reformed system, particularly from PCHCs and initiatives to integrate physical and behavioral health.

N. Additional Comments		
	Summary of Comments	**Response**
4. Public health	Many commenters raised the valuable role of public health in North Carolina's Medicaid system. Several commenters noted that public health has a strong network of services in all 100 counties and provides quality, low-cost care, with a population health focus.	DHHS appreciates the input and agrees that public health departments have and will continue to have a critical and valuable role in North Carolina's Medicaid system. As written in the demonstration application, DHHS has designated all local health departments as essential providers and has requested authority to provide "wrap around" payments to local health departments.
5. Definition of safety net provider	A couple of commenters expressed concern about the definition of "safety net provider" and asked that it be expanded. The commenter noted that the safety net providers listed in the draft demonstration application do not provide services 24 hours a day, seven days a week.	DHHS thanks the commenter for the input. While the safety net providers listed in the demonstration application may not be available 24 hours a day, seven day a week, they do provide after hours coverage.
6. Quality metrics	Several commenters provided suggestions regarding quality measures, including the process for selecting measures, the importance of including selecting measures relevant to the provider type/population, sources of measures, particular measures, and the need to standardize measures across PHPs.	DHHS appreciates the input and will consider theses suggestions and part of program development.
7. Frequency of PCP assignment	A couple of commenters suggested that DHHS limit the frequency of PCP assignments and changes. One commenter who is a physician shared personal experience from another state where PCP assignment occurs monthly, which made it impossible to plan and manage care.	DHHS appreciates the comment and will consider this during the development of the program. DHHS intends to establish a PCP assignment methodology that honors current relationships and fosters the development of long-term PCP-patient relationships.
8. Medical loss ratio (MLR)	A few commenters expressed support for the 88% MLR in SL 2015-245 or a higher standard. A couple of these commenters requested that DHHS adopt applicable CMS guidelines. Another commenter requested that DHHS consider directing funds from MLR rebates to DSRIP or a provider quality incentive program.	DHHS appreciates this input and is reviewing the language in SL 2015-245 in light of the final Medicaid managed care rule and will consider these suggestions as it develops the MLR requirements.

N. Additional Comments		
	Summary of Comments	**Response**
9. Chapter 58 protections	Several commenters requested that DHHS ensure that the provider and patient protections in Chapter 58 (NC's insurance statute) are maintained in the demonstration.	When not superceded by federal Medicaid managed care requirements, DHHS intends to incoporate the provider and patient protections in Chapter 58 in the PHP contract, program regulations, and/or NC Medicaid statute.
10. Conditioning provider participation in commercial network	A few commenters requested that DHHS prohibit PHPs from requiring that providers participate in the PHP's Medicaid network as a condition of participating in the PHP's commercial network.	DHHS acknowledges the concern and will consider whether to include this requirement in the PHP contracts.
11. Preventing double dipping	A couple of commenters requested that in order to maximize choice and competition, DHHS prohibit "double dipping." This would mean that an entity that is awarded one of the three statewide contracts would not be eligible to also participate in the regional awards either as a PLE or as a significant partner to a PLE. Both commenters strongly recommended that DHHS consider requirements similar to those in the most recent Florida Medicaid managed care procurement. Florida required bidding entities to disclose any business relationships with any other responding health plans and prohibited the Medicaid agency from selecting health plans within the same region if a business relationship existed. One of the commenters also referenced language in Arizona's MCO contract.	DHHS acknowledges the comments and will consider requirements that address this concern.

Comments Not Specific to Waiver

A. Regions		
	Summary of Comments	**Response**
1. Interaction with LME-MCO regions	Several commenters had questions about the interaction between the provider regions and the LME-MCO regions.	DHHS understands and will work with stakeholders to address these concerns in the development, implementation and operation of the program.
2. Support for regions	A commenter suggested that regions will most likely result in improved compliance and reducing travel times.	DHHS acknowledges this comment and appreciates the support for regions.
3. Regions and access to specialists	Many commenters expressed concern about inability to access specialty care or a particular hospital outside of their region. Many of these patients have very complex needs that can only be handled by a few specialists, or have high-level care that must be handled at UNC or Duke. One commenter asked that Medicaid beneficiaries be allowed to go outside of the state to receive specialty care when necessary.	PHPs will be required to develop networks that meet the needs of their enrollees, which, for regional PLEs, is likely to include contracting with providers outside of the applicable region. DHHS will include detailed network adequacy standards, including those required by the final Medicaid managed care rule, in the PHP contract, and will monitor compliance with those standards on an ongoing basis.

A. Regions		
	Summary of Comments	**Response**
4. Referral pattern disruption	Several providers commented that they receive referrals from practices that would be considered out-of-region under this reform. They expressed concern about disruption to referrals and continuity of care for these patients. One practice has offices located in two counties, with the same patients being seen at both locations.	Per federal Medicaid regulations, if a PHP is not able to provide necessary services to a particular enrollee, the PHP must adequately and timely cover these services out of network for the enrollee, for as long as the PHP is unable to provide them. DHHS intends to include requirements regarding out-of-area and out-of-network providers in the PHP contract.
5. Complexity of plan	Several commenters expressed concern about the complexity of the plan being overwhelming for providers and patients, resulting in poor care and over utilization of emergency departments. One commenter observed that these regional plans could lead to increased siloes of care. Another practice commented that they serve patients from four to six regions for same-day walk in service, and restricting by region will result in less access and greater emergency department use.	DHHS recognizes these concerns and will consider ways to address these concerns in the development, implementation and operation of the program.
6. Regional plan discriminatory	Three commenters described the regional plan as “discriminatory” because it gives those who have private insurance in addition to Medicaid the ability to receive care outside of their region, thus creating different classes of Medicaid recipients.	Per federal Medicaid regulations, if a PHP is not able to provide necessary services to a particular enrollee, the PHP must adequately and timely cover these services out of network for the enrollee, for as long as the PHP is unable to provide them. DHHS intends to include requirements regarding out-of-area and out-of-network providers in the PHP contract.

A. Regions		
	Summary of Comments	**Response**
7. Adequacy of plan size	Three commenters expressed concern that too many PHPs in a region would result in too few patients per PHP.	Section 4(6) of SL 2015-245 requires DHHS to have three statewide contracts and up to 10 regional contracts, and DHHS supports having a choice of models in each region.
8. Cultural considerations of regions	A commenter pointed out that cultural issues should be considered when dividing regions.	DHHS thanks the commenter for the suggestion.
9. Specific region feedback: Nash and Edgecombe Counties	A commenter explained that Nash and Edgecombe counties are often linked as a region ("Twin County Region") and residents travel between the counties for many things—including health care. Rocky Mount is in both of these counties.	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.
10. Specific region feedback Onslow County	Many commenters expressed concern about Onslow county not being in their region, as this will disrupt care. Other commenters requested that the region remain intact to allow a big enough population and adequacy for asthma management in children.	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.
11. Specific region feedback: Watauga and Avery Counties	Four commenters spoke about Appalachian Regional Healthcare System, which resides in both Watauga and Avery counties. The proposed rule divides these two counties into separate regions, potentially disrupting patient care. They would like to meet with DHHS to discuss this concern.	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.
12. Specific regional feedback: Alexander and Iredell Counties	A commenter urged the state to place Alexander and Iredell counties in Region 2.	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.

A. Regions		
	Summary of Comments	**Response**
13. Specific region feedback: Alexander and Catawba Counties	A commenter said that the proposed regions incorrectly assign Alexander and Catawba counties in Region 3. The majority of patients in these counties receive tertiary services in Forsyth county.	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.
14. Specific region feedback: Alexander, Iredell, and Catawba Counties	A commenter urged these counties to be placed in Region 2, to allow for ease of access to tertiary care and reduced travel times.	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.
15. Specific region feedback: Unifour area (Catawba, Burke, Caldwell and Alexander).	A commenter expressed concern about breaking up the Unifour area (Catawba, Burke, Caldwell and Alexander Counties).	DHHS understands the concerns about the regions, and will work with stakeholders to finalize the design of the regions as part of the development, implementation and operation of the program.

B. Payments and Rates		
	Summary of Comments	**Response**
1. Specialist payments	A commenter asked how reimbursements to specialists will work, since specialists do not see chronic conditions.	DHHS plans to provide additional detail on provider payments as part of program development and will work with stakeholders to develop those details.
2. Prompt payment	A commenter pointed out that there is no enforceable time frame for Medicaid to resolve issues on their end, but they can penalize providers for not returning money owed within 30 days.	DHHS will consider specifying a timeframe for payments claims in the PHP contract and/or program regulations.
3. Dual eligible payments	A commenter pointed out that when seeing dual-eligible patients, providers must accept the lower Medicaid rate reimbursement, which is inadequate. Another commenter supported the establishment of a rate floor for dual-eligibles, and urged the state to include a decision on dual-eligible payments in the waiver.	As specified in SL 2015-245, dual eligibles will not be part of the demonstration at this time. DHHS is convening a Dual Eligibles Advisory Committee, which will develop a strategy to cover dual eligibles through capitated PHP contracts.
4. County of origin payment	A commenter urged that the state remove outdated payment requirements that link payment to the patient's county of origin.	DHHS will consider this request as part of program development.

C. Provider Concerns		
	Summary of Comments	**Response**
1. Any willing provider: physicians	A commenter encouraged the state to prevent the exclusion of providers except for failure to meet objective quality standards or refusal to accept network rates.	This provision is currently included in SL 2015-245.
2. Any willing provider: specialty Pharmacies	Three commenters asked if specialty pharmacies will be included under any willing provider protections, and asked if specialty pharmacies will be able to participate in PHPs as long as they meet pricing and criteria requirements.	DHHS plans to provide additional detail on specialty pharmacies as part of program development and will work with stakeholders to develop these details.
3. Physician recruitment and retention	Three commenters noted that with several medical schools in North Carolina, we want to encourage new physicians to stay in-state instead of forcing them to move to a more supportive state. The commenters want to attract new physicians to North Carolina.	DHHS agrees with the commenters and intends to preserve and enhance provider supports and expand workforce initiatives as part of the demonstration.
4. Psychiatry	A commenter urged the need to reduce the marginalization of psychiatry in Medicaid. Another commenter had recently heard that Medicaid would no longer cover self-administered psychological medications. A third commenter questioned the sunset clause that disallows nurse practitioners (NPs) without psychiatric certification from working in the mental health field, as there is already an NP shortage in this field.	DHHS appreciates these suggestion and will consider them as part of program development.
5. Locum Tenens payments	A commenter expressed the need for the state to not exempt PHPs from the requirement to provide payment within locum tenens arrangements.	DHHS appreciates the suggestion and may consider covering this service in the future.

D. Prepaid Health Plans (PHPs)		
	Summary of Comments	**Response**
1. Overhead costs	A commenter expressed concern about overhead costs doubling and the increase going to for-profit MCOs.	DHHS acknowledges this concern and will have safeguards, including a medical loss ratio, robust contract requirements and monitoring mechanisms, to protect against excessive profit and inappropriate limitations on care.
2. Human rights protections	A commenter expressed concern that budgetary cuts would result in cuts to human rights protections. This commenter also urged the creation of rules to specify who should be members of human rights committees.	DHHS thanks the commenter for this suggestion and notes that while the demonstration application does not include language about human rights protections, DHHS intends to incorporate consumer protections, including all federal and state requirements, into regulation and/or the PHP contract, and will monitor the PHPs for compliance with those requirements.
3. Solvency requirements	A commenter urged that the state ensure all PHPs (PLEs and CPs) have the same solvency and capital requirements. They also requested that the state clarify the approach to establishing appropriate start-up reserve requirements.	The licensing process will require all PHPs to meet the same solvency and capital requirements, and will clarify the reserve requirements needed. DHHS is working with the Department of Insurance and other interested stakeholders to develop a PHP licensing process.
4. PLE supports	A provider group commented that it would like to form a PLE, and requests supports be established to help the PLE compete against commercial plans.	DHHS appreciates the suggestion and may consider including this in the future.
5. Continuity of care	Several commenters expressed concerns about interruptions to the patient-provider relationship.	When possible, DHHS intends to honor current relationships and foster the development of long-term provider-patient relationships.

D. Prepaid Health Plans (PHPs)		
	Summary of Comments	**Response**
6. Contracting requirements to ensure network adequacy	A commenter expressed the need for commercial plans to contract with competitor PLEs to ensure choice of providers and network adequacy. Another commenter supported the state's proposal to prohibit PHPs from having exclusivity clauses in contracts with essential providers. A third commenter expounded on this, saying that PHPs must be able to contract with a large hospital if it is a sole source provider to reach network adequacy in a region. The commenter suggested looking at the Georgia Families program policy, which requires a "good faith contracting" effort in contracts between PHPs and providers. Several commenters also support prohibition on provider exclusivity.	PHPs will be required to develop networks that meet the needs of their enrollees, which, for regional PLEs, is likely to include contracting with providers outside of the applicable region. DHHS will include detailed network adequacy standards, including those required by the final Medicaid managed care rule, in the PHP contract, and will monitor compliance with those standards on an ongoing basis.
7. DHHS engagement with PHPs	A commenter expressed that it is critical that the Department has open and collaborative discussions with PHPs throughout the implementation and operation of the program.	Since the passage of SL 2015-245, DHHS has proactively sought input from stakeholders across the state, including physicians, beneficiaries, beneficiary advocates, hospitals and potential PHPs. DHHS looks forward to ongoing stakeholder engagement on the development, implementation and operation of the program.
8. Oversight	Several commenters urged the state to ensure oversight of the PHPs and providers to ensure accountability and high quality care.	DHHS intends to provide the public with information on the performance of PHPs. This will include, at a minimum, adopting a managed care quality rating system as required by the final Medicaid managed care rule.

D. Prepaid Health Plans (PHPs)		
	Summary of Comments	**Response**
9. Feedback process	Several commenters requested processes for feedback or reporting of quality concerns, or for reporting Medicaid abuse violations. One commenter mentioned current Medicaid beneficiaries who have programmatic problems with Medicaid (such as being assigned to the wrong clinic) do not know whom to contact to fix this problem.	DHHS will consider this request as part of program development.
10. Independent appeals	Two commenters requested that there be an independent mechanism for adjudicating appeals and the creation of an expedited appeals process.	DHHS will consider this request as part of program development.

E. Medicaid Eligibility and Benefits		
	Summary of Comments	**Response**
1. CAP-Choice	A commenter wanted to ensure CAP/Choice continues.	DHHS does not intend to discontinue CAP/Choice as part of Medicaid reform.
2. Modification budgets	A commenter stressed that the vehicle/home modification budgets should be increased and allowed to be combined.	Vehicle/home modification budgets are part of the CAP/Choice programs. Changes to CAP programs fall outside the scope of this waiver.
3. Transportation services	A commenter suggested that transportation services be streamlined to make the service easier for patients to access.	DHHS will consider this request as part of program development.
4. Lack of Medicaid coverage due to program eligibility criteria	Several commenters described people who should be covered by Medicaid are not covered due to the strict age, financial or disability requirements. One commenter was concerned about the need for spenddown before being able to access behavioral health services, and another was upset that parents who make too much money are unable to have coverage for their disabled child. Another commenter expressed concern about a perception that some families who have Medicaid live in expensive homes, while others who are just over the income threshold must go without. Another commenter expressed frustration that once their disabled child turned 22, he was no longer eligible for glasses or hearing aids. Commenters also pointed out that delaying care due to lack of access can lead to serious injury and inability to work.	DHHS appreciates these comments. A decision to make changes to Medicaid eligibility falls outside the scope of the current reform efforts.
5. Lack of access to covered services	Some commenters were concerned that, although eligible for a program, they were unable to access it because of physical barriers or the services not being offered due to too much demand and a shortage of providers.	DHHS understands these concerns and will include detailed network adequacy provider access standards, including those required by the final Medicaid managed care rule, in the PHP contract, and will monitor compliance with those standards on an ongoing basis.

E. Medicaid Eligibility and Benefits		
	Summary of Comments	**Response**
6. Frustration with Medicaid services	Several commenters expressed frustration with their Medicaid services and concern that providers did not having adequate training to deal with complex patient needs. One commenter was concerned that too few number of specialist visits were allotted for the level of care required.	DHHS will consider this request as part of program development.
7. Waiting lists	A commenter detailed the current problems with waiver waiting lists.	DHHS thanks the commenter for the suggestion. Changes to waiting lists are outside the scope of current reform efforts.
8. Inadequate case management	A beneficiary commented that case management has been inadequate.	DHHS thanks the commenter for the suggestion.
9. High Medicaid deductibles	A commenter expressed concern about the high deductible for Medicaid. Another commenter described the bills had to be paid while on Medicaid.	DHHS thanks the commenter for the suggestion.
10. Beneficiary education Prior to implementation	A commenter recommended that DHHS provide appropriate education to beneficiaries before the implementation of any reform measure.	DHHS agrees and intends to provide appropriate education to all stakeholders, including providers and beneficiaries, prior to the implementation of PHPs.

F. Additional Comments		
	Summary of Comments	**Response**
1. Veterans	A commenter stressed the responsibility of the entire state (across agencies) to support the needs of veterans. Another commenter pointed out that many inmates who need mental health services are veterans who had untreated trauma; their mental health issues should be addressed before they commit crime.	DHHS understands and will work with stakeholders to address these concerns in the development, implementation and operation of the program.
2. Additional LME-MCO regulations	A commenter requested that the state revise NCGS Chapter 108C and the NC Admin Code to align with 42 CFR Part 438 and permit PHPs and LME-MCOs to effectively manage their provider networks. This commenter also requested that the state work with LME-MCOs to develop and implement VBP options for network providers – even if this requires modifications to NCTracks. The commenter also requested that the state establish a workgroup that includes DHHS, NCDOJ, LME-MCO, county and CFAC representatives to develop recommendations for significant revisions to NC General Statute Chapter 122C that will bring the LME-MCO system in line with Medicaid reform, eliminate unfunded, outdated or contradictory requirements, allow for greater human resources flexibility necessary to succeed in the managed care environment, and improve person-centered language.	DHHS agrees that clarifying responsibility and ensuring coordination between the PHPs and LME-MCOs is crucial. DHHS will work with stakeholders to develop the contract requirements for PHPs and LME-MCOs and establish a process to monitor compliance with those requirements.
3. Medicaid/Medicare regulatory alignment	A commenter suggested that the regulations and quality measures for skilled nursing facilities be aligned for participation in the Medicaid and Medicare programs.	DHHS will consider this request as part of program development.
4. Critical Incident Reports	A commenter requested that death reports/critical incident reports include the reasons for unknown deaths.	DHHS appreciates the suggestion; however, this is outside the scope of current reform efforts.

F. Additional Comments		
	Summary of Comments	**Response**
5. FQHC Collaboration	A commenter suggested the state expand capacity to allow Federally Qualified Health Centers to work together.	DHHS will consider this request as part of program development.
6. Skilled service definition	A commenter expressed concern at the definition of "skilled service." Even though this commenter provided services that would fit the definition, she was unfamiliar with the term as used and found it confusing.	DHHS thanks the commenter for the suggestion.
7. Expanded services	A commenter requested that North Carolina expand the scope of LME-MCO responsibilities under the 1915(b)/(c) waiver to include children from birth to age 3 and services funded through NC Health Choice.	DHHS thanks the commenter for the suggestion, but believes that this request is inconsistent with SL 2015-245.
8. Services for Autistic children	A commenter requested there be more services offered in Onslow County for autistic children. Specifically, they would like respite care, ABA therapy and day camps.	DHHS appreciates these suggestions. DHHS is not proposing to cover any "new" services as part of the demonstration except those that PHPs may provide as "in lieu of" or "value-added services."
9. CNA training	The shortage of CNAs could be addressed by a statewide program that encourages people to get CNA licensure.	DHHS thanks the commenter for the suggestion.
10. Education and job creation	A commenter expressed concern at the loss of jobs in the Appalachian region and suggested creating a learning community to help provide jobs. Another commenter pointed out that the poor economy and underemployment have led to more people on Medicaid.	DHHS thanks the commenter for the suggestion and reiterates that one of the key goals of the reform and the demonstration is to expand the availability and accessibility of services to beneficiaries residing in rural areas. Specifically, this will be facilitated by value-based payments, PCHCs, expanded telemedicince / telepsychiatry, community-based residency and health workforce training, and DSRIP projects.