

## Public Input Summary

*This document summarizes themes from more than 200 comments the North Carolina Department of Health and Human Services (the Department) received from Aug. 8 through Sept. 8, 2017, on “North Carolina’s Proposed Program Design for Medicaid Managed Care.” The Department sincerely appreciates the thoughtful comments received, and looks forward to continuing this collaborative process to build a strong Medicaid managed care program.*

### Introduction

In September 2015, the North Carolina General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice programs from a primarily fee-for-service structure to a primarily managed care structure. As the Department prepares to launch managed care in 2019, it will work with stakeholders to refine program details.

As described in [“North Carolina’s Proposed Program Design for Medicaid Managed Care,”](#) the Department seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. The Department’s goal is to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses medical and non-medical drivers of health.

In managed care, the Department will remain responsible for all aspects of the Medicaid and NC Health Choice programs. As directed by the North Carolina General Assembly, the Department will delegate the direct management of health services and financial risks to Prepaid Health Plans (PHPs). PHPs will receive a capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by the Department across many metrics to ensure strong provider networks, high program quality and other aspects of a successful Medicaid program.

### About This Summary

Each comment received during the input period was reviewed by the Medicaid transformation team and used to identify recurring themes. In addition to the comments on specific topics that are summarized in this document, the Department received many general comments (e.g., commenters expressed approval or disapproval for the transition to managed care, or commenters requested more detail on parts of program design), and several specific or technical comments that may not be mentioned in this document but have been read and reviewed by subject matter experts.

No names of individuals or organizations are identified in this summary.

To provide transparency through the transition to managed care, and as the Department continues to refine and finalize program design, additional information will be provided to beneficiaries, providers and other stakeholders. In coming months, the Department will release white papers or requests for information (RFIs) on specific program design topics that will address many of the questions raised by commenters.

Please send questions or comments to [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov).

For more information, visit [ncdhhs.gov/nc-medicaid-transformation](http://ncdhhs.gov/nc-medicaid-transformation) on the Medicaid website.

## 1. Creating an innovative, integrated and well-coordinated system of care

### 1.1 Integrate physical health, behavioral health, substance use disorders, and intellectual and developmental disability (I/DD) services

Many commenters supported the Department's proposal to integrate physical health, behavioral health and I/DD services, and its proposed move toward a model that embraces whole person care. A few commenters stressed the importance of considering the unique needs of specific populations (such as the I/DD population or children with complex needs) as the Department plans for integration.

Several commenters supported the proposal to create "standard plans" that would integrate physical and behavioral health services for most beneficiaries, and "tailored plans" that would provide integrated services to individuals with serious mental illness (SMI), serious emotional disturbance (SED), moderate to severe substance use disorder (SUD), or intellectual and developmental disabilities (I/DD). A few commenters indicated that standard plans could adequately serve the tailored plan population.

Several commenters requested additional detail on tailored plans, including clarity regarding the population that would be included, the anticipated role of current LME/MCOs, and how the transition from fee-for-service to managed care would be handled for this population. Other commenters wanted more information about the number of tailored plans, their regions and governance structures, the launch date, or how tailored plans would be monitored and evaluated.

**Department Response:** *To maximize the clinical and financial benefits of whole person care, the Department seeks to integrate physical and behavioral health care delivery and care management. This area of the proposed program design will require legislative authority from the General Assembly to implement.*

*The Department envisions that standard plans will provide integrated physical and behavioral health services (including substance use disorder services) to those with lower intensity behavioral health and I/DD needs. During a transition period, beneficiaries with more serious needs will continue to receive care as they do today (through fee-for-service and LME-MCOs). At the end of that transition period, the Department envisions rolling out tailored plans providing integrated care to those with serious behavioral health and I/DD needs.*

*The Department acknowledges the concerns and additional detail desired regarding this aspect of the proposed program design, particularly regarding the covered population of and proposed transition to tailored plans. The Department looks forward to further refining its proposal and will continue to adapt its strategy based on stakeholder feedback to create the strongest possible program. The Department intends to provide additional detail for public feedback in the near future.*

### 1.2 Address unmet social needs as a part of overall health

Several commenters supported the Department's proposal to address social determinants of health, the unmet social needs like healthy food and safe housing that drive up to 70 percent of health outcomes. A few commenters specifically endorsed the Department's proposals to implement a standard screening tool, and to map resources for addressing social needs in communities.

A few commenters recommended that specific social needs receive emphasis or additional focus, such as transportation, education and cultural/language barriers to accessing care. Some commenters also recommended that the Department partner with community organizations (such as homeless shelters) to best address these needs.

A couple commenters sought more detail on how the Department's strategy to address social determinants would interact with other areas of the proposed program design, particularly with value-based purchasing (VBP) and the advanced medical home (AMH) model.

**Department Response:** *In designing its Medicaid transformation, the Department is committed to optimizing health and well-being for all beneficiaries by effectively stewarding our collective resources to unite communities and the health care system. Given the compelling body of evidence linking social determinants to health and well-being, the Department views addressing unmet social needs as central to this vision. The Department agrees that implementing a standard screening for unmet social needs and mapping available resources in communities are important, and seeks to leverage and build upon existing investments and efforts. The Department is seeking federal funding to support this effort.*

### **1.3 Strengthen and support care management**

Several commenters agreed with the proposal to strengthen and support North Carolina's care management infrastructure and were supportive of the proposed AMH model. Some commenters also noted the importance of maintaining or replicating North Carolina's existing care management infrastructure.

Several commenters also requested additional detail or clarity on the Department's vision for care management in general and AMH in particular. Some commenters wanted to know whether there would be specialized AMH models for specific populations (such as a pregnancy health home) or wanted to better understand how AMHs would interact with other entities, particularly tailored plans.

A few commenters stressed the importance of care management in the community or at the site of care. A few also stressed the importance of flexibility in the AMH model (e.g., flexibility for plans and providers to design their own financial arrangements; and flexibility for practices that are ready to move more quickly toward higher tiers of the AMH model).

**Department Response:** *North Carolina Medicaid has long been known for its successful primary care case management (PCCM) program, including a strong care management infrastructure for beneficiaries, transitional care populations, high-risk/high-cost patients, and supports for pregnancy care and other programs. The Department is considering how to maintain and strengthen the best elements of today's programs while establishing appropriate flexibility to allow for PHPs innovation. The Department also wants to maintain strong provider participation in Medicaid through medical homes. Additional work is underway on the development of the care management infrastructure, and stakeholders will continue to be engaged throughout the development process. The Department intends to provide additional detail for public feedback in the near future.*

## **2. Supporting providers and beneficiaries during the transition**

### **2.1 Support providers through the transition**

Several commenters supported the proposed creation of Regional Provider Support Centers (RSPCs), although some requested more detail about their role and scope of activities. A few commenters noted that providers would need significant training and education with the transition to managed care. Some noted that small, independent or rural providers, and Medicaid providers without experience in commercial insurance (e.g., local health departments) might particularly need this support.

Several commenters also stressed reducing administrative burden as an important central focus for provider support. Commenters suggested several ways to accomplish this, with most recommendations focusing on

standardizing or centralizing processes to avoid duplication, and refraining from changing existing systems (such as NCTracks) unless necessary.

Many commenters supported the Department's proposal to adopt a centralized credentialing process with a single electronic application. Several commenters asked for additional detail on the credentialing process, including clarity on how long credentialing would take, and what the process would look like for certain types of providers (e.g., I/DD specialists or out-of-state providers).

**Department Response:** *Providers are crucial partners in ensuring a long-term, successful Medicaid managed care program. The Department will continue to partner with providers to work toward easing administrative burdens during and after the transition. To ensure providers are prepared to adapt their practices and support their patients throughout the transition, the Department will establish a provider support infrastructure through the RSPCs, which will include managed care education and training, practice transformation and education, and advanced medical home certification. The Department intends to provide additional detail for public feedback in the near future.*

## **2.2 Streamline beneficiary eligibility and enrollment processes**

Several commenters commended the Department's goal of moving toward a "one-stop shop" eligibility and enrollment process in which beneficiaries could apply for Medicaid, receive a determination, and select a PHP and primary care provider in one visit. Other aspects of the proposal in this area also received generally positive feedback from several commenters, including the emphasis on preserving existing beneficiary-provider relationships in auto-assignment algorithms and the proposal to use an enrollment broker.

A few commenters expressed concerns about the Department's vision for eligibility and enrollment, including concerns about the burden on county Department of Social Services (DSS) case workers.

A few commenters emphasized the need for education and choice counseling to ensure that beneficiaries make informed decisions in plan selection, with one commenter cautioning that county DSS staff may not be well positioned to provide such counseling.

**Department Response:** *The Department wants Medicaid applicants to experience a simple, timely, and user-friendly eligibility and enrollment process, which will be available online, by telephone, by mail or in-person. Over time, the Department seeks an eligibility and enrollment process that can be completed in a single visit. The Department is also committed to providing beneficiaries with the tools and supports necessary to successfully select the PHP best-suited to their needs.*

*At Medicaid managed care launch, the Department will contract with an enrollment broker. With the future upgraded eligibility and enrollment system, applicants will move seamlessly from the application process to the PHP/primary care provider selection process. The Department will ensure that county DSS caseworkers, the enrollment broker and PHPs receive extensive training and education to enable them to seamlessly support beneficiaries through the eligibility and enrollment process. The Department intends to provide additional detail for public feedback in the near future.*

## **2.3 Focus on member services, education and choice**

A few commenters noted the importance of giving beneficiaries a choice of plans or a choice of primary care providers. Some of these commenters recommended allowing beneficiaries to switch between plans for cause

but otherwise suggested limiting the ability to switch. One commenter noted that beneficiaries who would be in behavioral health and I/DD tailored plans should also have a choice of plans.

A few commenters commended the Department's emphasis on member services, education and the ombudsman program with one commenter recommending that the Department establish PHP requirements to ensure adequate beneficiary education (e.g., on selecting a primary care provider).

**Department Response:** *At Medicaid managed care launch, applicants and beneficiaries will receive support and educational materials to make a well-informed PHP selection. This includes explanation of the Medicaid managed care program, services covered through Medicaid managed care, a list of PHPs available to that individual, and instructions on how and by what deadline to select a plan.*

*The Department envisions that the enrollment broker, PHP member services, and the ombudsman program will jointly serve as the beneficiary support system. Further details around the functions of the ombudsman program and the enrollment process (including primary care provider selection) will be released in the future. The Department intends to provide additional detail for public feedback in the near future.*

## **2.4 Stakeholder Engagement**

Several commenters addressed the Department's engagement of the standing Medical Care Advisory Committee (MCAC) as the formal stakeholder engagement body charged with providing feedback and input on a wide range of transformation efforts. One commenter expressed concern that using the MCAC quarterly meetings to receive public input was inadequate. Others suggested that the MCAC needed behavioral health representation, including family and youth advocates and a consumer advocate. One commenter suggested use of a webinar format for MCAC. A few commenters noted a need for clear communication, more public hearings about payment strategies, and collaboration with associations to develop provider communications. A few commenters recommended the creation of a behavioral health workgroup.

One commenter requested that the Department allow for public comment on its final quality strategy. A few suggested that the Department hold regular ongoing meetings with diverse consumer advocates and consider establishing a consumer advisory group for Medicaid transformation.

**Department Response:** *The Department agrees that ongoing stakeholder engagement is crucial for a successful Medicaid transformation. Stakeholders, such as individuals and family members with personal experiences, advocates, diverse provider organizations/associations, and social service agencies including faith based groups, are essential to the successful implementation of managed care. The Department will continue to engage with beneficiaries, providers, plans, elected officials, local agencies, communities and other stakeholders throughout the health care and social services systems to refine Medicaid managed care program details, and implement and monitor program changes. The Department will seek public comments on its quality strategy, support MCAC in filling committee vacancies and development of subcommittees, and supplement invitations for further written comments on white papers with targeted outreach to specific stakeholders and groups.*

## **3. Promoting Access to Care**

### **3.1 Support provider workforce initiatives**

Several commenters supported provider workforce initiatives such as loan repayment and residency programs as an important component of promoting access to care, noting that these initiatives are crucial to increasing

the number of clinicians in rural and underserved areas. Workforce initiatives allow for North Carolina to target gaps in its state health care delivery system, and better align and develop practitioners to fill those gaps. In particular, commenters praised or advocated using loan repayment programs, Area Health Education Centers' (AHEC) residency programs, and the Community Health Worker (CHW) model.

A few commenters recommended several improvement opportunities, such as making modifications to Graduate Medical Education (GME) payments, doing more to attract subspecialists to rural or underserved areas, increasing the number of residency slots and offering loan repayment to social workers.

**Department Response:** *North Carolina has long been focused on building health care capacity in rural and underserved areas. The Department proposes to expand, and is seeking federal funding to support, community-based residency programs that promote essential workforce training with a primary focus on ambulatory and preventive care.*

*Recruitment and retention of a well-trained, multi-disciplinary workforce will be crucial to ensuring adequate access to services in rural and underserved communities. This effort will include continuation of existing loan repayment, community grant and AHEC residency programs, and may also include new community-based graduate medical education and fellowship programs.*

*The Department will also examine the feasibility of introducing a community health worker model to assist in addressing social determinants of health.*

### **3.2 Support telehealth initiatives**

Several commenters supported the Department's plan to leverage telehealth and telemedicine initiatives to ensure that rural enrollees have access to quality health services. A few commenters also recommended specific actions that the Department could take toward achieving this end, such as removing originating site requirements, helping to bring high-speed internet access to rural areas or expanding the availability of telehealth for the I/DD population.

One commenter expressed concern that telehealth would be used as more than just supplemental care in rural areas or as a replacement for in-person care.

**Department Response:** *PHPs will be encouraged to support the use of telemedicine as a tool for ensuring access to needed services. When a PHP enrollee requires a medically necessary service that is not available within the PHP network, the PHP would be permitted to provide access to the service through telemedicine. Accordingly, PHPs will be permitted to leverage telemedicine in their Request for Exception to the Department's network adequacy standards. The Department will also encourage PHPs to implement pilots that test additional telemedicine strategies and will invite PHPs to propose innovative pilots related to telemedicine in their responses to the Department's Medicaid managed care procurement.*

*The Department is also working with CMS to explore strategies to increase provider awareness, education and training on telemedicine opportunities and best practices. These strategies involve telehealth alliances and innovation funds that support provider-PHP collaborations that test evidence-based telemedicine initiatives aligned with the Department's quality strategy goals, such as chronic disease management, wellness promotion and high-value care.*

### **3.3 Increase access to Medicaid**

Many commenters supported increasing access to Medicaid, including several commenters who praised “Carolina Cares,” the proposed legislation in the NC General Assembly that would allow low-income individuals to enroll in Medicaid if they meet work and personal responsibility requirements, and paid a required premium. Commenters noted that such legislation would be beneficial to many individuals with behavioral health and substance use disorder needs and would particularly help combat North Carolina’s opioid epidemic.

A few commenters suggested potential changes to the proposed legislation. A few commenters expressed concerns about mandatory employment activities included in the legislation, including one commenter who recommended removing these requirements. Another commenter recommended that hospital assessments fund only a portion of the non-federal share for this program.

**Department Response:** *Proposed legislation in the North Carolina General Assembly (NCGA) aims to increase access to affordable health care under Medicaid by requiring the Department to design the Carolina Cares program. If passed, this program will begin at the same time as the launch of the Medicaid managed care program. This aspect of the proposed program design will only be implemented with additional legislative authority from the NCGA.*

### **3.4 Combat the opioid epidemic**

Many commenters agreed that combatting the opioid crisis is a crucial public health priority in North Carolina and offered several recommendations for the Department as it continues these efforts. Several commenters would like increased access to Medication Assisted Treatment (MAT) for opioid use disorder, including elimination of prior authorization for the use of MAT and increased resources dedicated to MAT. A few commenters also supported expanding access to low-intensity residential SUD services. A few commenters also noted the importance of provider education on opioids (e.g., training on safe prescribing).

One commenter expressed concern that Suboxone® was too often prescribed without concurrent treatment services. One commenter also recommended that provider-led entity governance should be required to have a substance use specialist on staff. A commenter also stressed that tailored plans would need additional resources to adequately serve the SUD service needs of many of their enrollees.

**Department Response:** *Independent of the Medicaid managed care transformation, doing everything possible to combat the opioid epidemic is among the Department’s highest priorities. As part of a comprehensive Department-wide effort to combat the opioid epidemic, the Department developed a multi-pronged Medicaid strategy to reduce the number of North Carolinians who develop SUDs and better treat those who have those disorders. Implementation of numerous initiatives is underway, including reducing the permitted maximum daily dosage of opioids, requiring prior approval for certain prescriptions or supply sizes, and working toward Medicaid matching funds for SUD treatment in institutions of mental disease.*

*The Medicaid managed care program will be another tool that the Department can use to deliver needed services. The Department is exploring additional strategies to prevent new cases of SUDs (e.g., training physicians and pharmacists on best practices in prescribing) and treat existing SUDs (e.g., adding low intensity residential services as covered benefits). The Department is always interested in receiving feedback and comments as it continues to address this crisis.*

## 4. Promoting Quality and Value

### 4.1 Implement a statewide quality strategy

Many commenters made recommendations regarding the use of quality measures, with several recommending using a standard set of measures across all PHPs that leverages existing quality programs or measures used by other payers, and focuses on a narrow set of measures selected with significant stakeholder feedback and engagement. A few commenters recommended quality measures for specific populations (e.g., children, behavioral health or I/DD population), and several commenters recommended specific measures (e.g., HIV viral load suppression or contraceptive care/counseling).

A few commenters commended the Department's proposal to implement a statewide quality strategy generally, with two commenters recommending leveraging CMS's Quality Payment Program. A few commenters also supported having PHPs accreditation done by a single accrediting body to maintain consistency across multiple health plans. A few commenters also requested that the Department publish its quality strategy.

**Department Response:** *If North Carolina is to realize its transformation goals, it is crucial that a cross-cutting quality strategy for Medicaid aligns efforts by PHPs, providers and the Department to measure and achieve value with a set of clear priorities for quality improvement and innovation. North Carolina's quality strategy must identify a single set of statewide quality priorities, tie those priorities to a streamlined set of measures and metrics, and use those measures and metrics to assess performance and drive progress on Department transformation efforts. The Department will publish a quality strategy document and will solicit public comment on this document.*

*Key quality priorities and initiatives will be derived from existing performance on quality measures and outcomes in North Carolina and build on the work of the North Carolina Institute of Medicine (NCIOM). The Department will also leverage existing quality efforts underway today to develop these metrics.*

### 4.2 Encourage value-based payment

Several commenters agreed with the Department's proposal to move toward VBP arrangements between PHPs and providers. Some commenters advocated for specific payment frameworks or strategies (e.g., HCP-LAN framework or CPC+ program). A few commenters noted that providers are at varying levels of readiness to adopt VBP arrangements and cautioned that the Department's approach must recognize and account for these variations.

A few commenters noted potential barriers to the adoption of VBP, such as the need to change culture and behaviors, and the need for timely and transparent data. Some commenters also recommended giving PHPs and providers flexibility in designing their VBP arrangements, as well as continuing to engage stakeholders through the process (e.g., for determining pay-for-performance measures).

**Department Response:** *VBP offers an opportunity to move away from volume-based reimbursement and, instead, more closely align the quality of services delivered with payment. For that reason, the Department plans to encourage accelerated adoption of VBP arrangements between PHPs and providers in Medicaid that tie to quality strategy priorities. The goal of pursuing VBP is to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures of value, rather than on a fee-for-service basis.*



PHPs will be encouraged to develop and lead innovative strategies to increase the use of VBP arrangements over time, and to submit their VBP strategies to the Department and report on their use of VBP contracting arrangements each year. Over time, PHPs will be rewarded for having a strong VBP baseline and making measurable improvements against their baseline from year to year. The Department will create a VBP roadmap to engage stakeholders on this topic and will develop clear goals for moving toward VBP.

#### **4.3 Enhance data collection and sharing capabilities**

Multiple commenters noted the importance of continuing North Carolina's investment in data collection, analysis, and sharing among plans and providers as an integral component of promoting quality and value. Several commenters stressed the need to minimize the administrative burden of data collection and analysis on providers. A few commenters highlighted the need for data to be timely and actionable, and others noted the importance of building on or leveraging existing data systems and capabilities.

A few commenters sought more detail or clarity on how the Health Information Exchange ties into the data infrastructure envisioned by the Department.

**Department Response:** *Data will play a crucial role in North Carolina's Medicaid transformation. The Department will facilitate the development of the infrastructure and processes to support timely data collection, and to produce and disseminate data and information. Such data are needed to ensure appropriate program oversight and operations, and to support its quality, VBP, care management and population health strategies.*

## **5. Setting up Relationships for Success**

### **5.1 Ensure transparent and fair payments for PHPs**

A few commenters addressed the need for transparent and fair payments to PHPs. One commenter stressed that rates must be actuarially sound, and another noted the need for sufficiently sized risk pools for each plan. One commenter felt that risk adjustment was not necessary for capitated payments for all Medicaid populations. Another commenter asked that the Department's data book be released at least 90 days prior to procurement.

**Department Response:** *The Department will ensure that capitation rates are set according to actuarially sound principles and will reflect specific program design considerations, covered populations and benefits, and PHP provider payment requirements including rate floors and payments to special provider types (e.g., FQHCs/RHCs). The payments to the PHPs under Medicaid managed care are in the form of prospective per member per month (PMPM) capitation rates. The Department, in consultation with its actuary, will develop the capitation rate methodology through a transparent process that solicits information from potential PHPs and other stakeholders. Through the medical loss ratio, the Department will monitor the expenditure of the capitation payments to ensure that funds are spent primarily on medical services.*

### **5.2 Ensure transparent and fair payments for providers**

Many commenters stressed the need for fair payments for providers. Many commenters recommended increasing Medicaid provider payments, including general recommendations of payment increases and specific recommendations to set payments at particular levels (such as matching Medicare rates). Several commenters also noted the need for timely payments to providers in managed care.

A few commenters commended the Department’s proposal to set a rate floor at 100 percent of the current fee-for-service rate, with one commenter also suggesting a rate ceiling. One commenter asked that the Department state that all parties, not just providers, must negotiate in good faith.

A small number of commenters also mentioned the Department’s proposal to migrate the current supplemental payment structure to an alternative arrangement, either offering general advocacy of the proposed approach or making technical recommendations for the new payment structure.

**Department Response:** *The Department wants to maintain beneficiary access to care and strong provider participation in Medicaid managed care. As a part of those objectives, the Department seeks to balance flexibility and prescriptiveness in its proposed approach to provider reimbursement by requiring PHPs maintain a certain level of payment, including a rate floor of 100 percent fee-for-service for physicians and physician extenders. The Department looks forward to continued work with hospitals and other stakeholders in developing an approach for supplemental payments. The Department intends to provide additional detail for public feedback in the near future.*

### **5.3 Ensure provider access**

Several commenters noted the importance of maintaining an adequate provider network in managed care and supported networks that would ensure timely access to care. Many commenters supported the “any willing provider” rules in North Carolina statute, but some expressed concerns. A few commenters noted that if the Department requires the plans to demonstrate network adequacy within their RFP responses, that this requirement should be in the form of Letters of Intent rather than signed contracts.

A few commenters opposed the proposed 90 percent of fee-for-service rate for out-of-network providers who have declined a PHP contract. A few commenters also recommended specific changes or additions to the network adequacy standards enumerated in the proposed program design (e.g., more stringent standards for prenatal care).

**Department Response:** *North Carolina’s Medicaid program enjoys strong participation from a range of providers. Moving to Medicaid managed care, it is crucial to ensure continued participation and to monitor access, while balancing the PHPs’ ability to manage their networks and patient care. States with Medicaid managed care are required to ensure that PHPs maintain a network of appropriate providers that is “sufficient to provide adequate access” to all services covered under the contract for all enrollees. North Carolina’s Medicaid managed care legislation also requires PHPs to “not exclude providers from their networks” except for the inability to negotiate rates or quality concerns. The Department intends to provide additional detail for public feedback in the near future.*

### **5.4 Take a thoughtful approach to pharmacy policies**

Several commenters responded to the Department’s proposal for pharmacy policies. Some commenters supported the legislation mandating a single statewide formulary, while others recommending instead that PHPs be given more flexibility to adopt their own preferred drug list (PDL). Other comments included consulting plans as a part of the formulary design process and making the PDL available with the data book as part of the managed care procurement process.

A few commenters also expressed concerns about the potential administrative burden on providers if PHPs were to have unique clinical coverage policies or suggested that current policies be maintained.

**Department Response:** North Carolina’s Medicaid pharmacy program has a history of effective program management, using drug rebates and careful selection of drugs on a PDL to acquire the correct mix of drugs at the most advantageous cost. The Department wants to continue providing the best overall value to beneficiaries, providers and North Carolina. The proposed approach will assist the Department in meeting the statutory requirement that PHP spending for prescribed drugs, net of rebates, ensures that the Department realizes a net savings on spending for prescribed drugs. This approach will also help the Department meet statutory requirements mandating a single statewide formulary and rate floors for dispensing fees. The Department will provide additional detail for public feedback in the near future.

### **5.5 Ensure compliance and program integrity**

A few commenters made recommendations regarding actions the Department could take to ensure compliance and program integrity after the launch of managed care. A few commenters recommended that the Department conduct audits of commercial plans and provider-led entities. Others suggested that the PHPs use their special investigation units to combat fraud, waste and abuse. Multiple commenters highlighted the need for clear guidelines and expectations, and frequent communication among plans, providers and the Department as important components of maintaining program integrity.

**Department Response:** While some of the Department’s operations will change with the transition to Medicaid managed care, the Department remains responsible for all aspects of North Carolina’s Medicaid program. To ensure that PHPs comply with Medicaid managed care requirements and align with Department-defined program goals, the Department is designing rigorous requirements and oversight protocols for the Medicaid managed care program.

### **5.6 Build a fair grievance and appeals process**

A few commenters made recommendations or expressed concerns about the proposed provider grievance and appeals process. For example, one commenter felt that providers needed access to a state hearing that was not run by a PHP and another advocated for the implementation of an ombudsman program for providers.

**Department Response:** The Department will ensure that Medicaid beneficiaries and providers will have a transparent and predictable mechanism to complain, grieve or appeal issues involving PHPs. The Department is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their Medicaid managed care plan or, upon exhaustion of the Medicaid managed care plan appeal process, through timely access to a North Carolina fair hearing. PHPs will be required to establish a provider appeals process through which providers can appeal PHP actions related to termination or non-renewal of contract for quality reasons or violation of terms between the PHP and provider (e.g., prompt pay or denial of claims). In designing these processes, the Department seeks to strike a balance between the protection of provider rights and respecting the contractual relationship between providers and PHPs.