NC Medicaid

A guide for hospitals accepting North Carolina Medicaid and NC Health Choice:

What you need to know about North Carolina's Medicaid Managed Care

North Carolina Medicaid and NC Health Choice programs are moving from a predominantly fee-for-service structure to a managed care health insurance model. In managed care, the NC Department for Health and Human Services (DHHS) will remain responsible for all aspects of the Medicaid and NC Health Choice programs. DHHS will delegate the direct management of certain health services and financial risks to Prepaid Health Plans (PHPs), which will contract with providers to provide services for their members.

You will still be able to provide, and be paid for providing, health care services to managed care beneficiaries. A major difference is that most supplemental payments currently made under the fee-for-service system will be built into base rates using a methodology developed in collaboration with the NC Healthcare Association.

1. **HOSPITAL REIMBURSEMENT IS TRANSITIONING AWAY FROM SUPPLEMENTAL PAYMENTS.** DHHS has historically reimbursed hospitals using a mix of claims payments and supplemental payments for services provided in the fee-for-service program. (There are no supplemental payments for behavioral health services covered by LME/MCOs.) Federal rules for Medicaid managed care do not allow the continuation of North Carolina's supplemental payments to hospitals in their current form. To ensure similar reimbursement levels to hospitals under managed care, supplemental payments (excluding Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments) will be incorporated into base rates in the fee-for-service program, which will then serve as the basis for a limited-duration rate floor under managed care. These increased base rates will be utilized in developing final capitation rates to PHPs.

   PHPs will be required to make additional utilization-based payments to hospitals owned by UNC Health System or Vidant Medical Center, to reflect their unique role as hospitals affiliated with the state's public medical schools. Hospital contributions to the non-federal share of Medicaid payments through assessments and intergovernmental transfers will approximate what they are today, with some adjustments to align with the new payment methodology.[1] DHHS will set hospital contributions based on a transparent methodology developed with input from the NC Healthcare Association.

2. **DHHS IS COMMITTED TO PRESERVING STRONG PROVIDER PARTICIPATION AND FAIR PAYMENTS TO HOSPITALS.** PHPs must pay all in-network hospitals no less than 100 percent of Medicaid fee for service inpatient and outpatient rates for the first few years of managed care, unless PHPs and hospitals mutually agree to alternative reimbursement arrangements. Additionally, PHPs must pay, deny or pend a claim within 30 calendar days of receipt, or pay interest and a late payment penalty to the provider. DHHS also remains committed to compensating hospitals for their medical education and uncompensated care costs, and will make GME and DSH payments directly to hospitals after the managed care transition.

3. **THERE WILL BE PROTECTIONS AGAINST ANTI-COMPETITIVE BEHAVIOR.** A health plan affiliated with one hospital or system still must contract with other hospitals/systems. To discourage anti-competitive or self-dealing behavior among PHPs and their owned or related care providers, the RFP requires that PHP payments to any provider or subcontractor that are "related to" the PHP in excess of what the PHP pays other providers for similar services will not count toward the PHP Medical Loss Ratio (MLR) calculation.

4. **THERE WILL BE GUARDRAILS ON THE CONTRACTING PROCESS.** PHPs will develop provider contract templates that DHHS will review and approve prior to use. DHHS will require that these templates include certain provisions which the PHP may draft, and certain prescribed provisions for which the PHP must use the language prescribed by DHHS.

5. **DHHS WILL REQUIRE ADOPTION OF VALUE-BASED PAYMENT (VBP) ARRANGEMENTS.** To ensure payments to providers are focused on improving population health and appropriateness of care in the most cost-effective

[1] Adjustments to the methodology require legislative approval.

manner, DHHS is requiring PHPs to establish VBP arrangements with providers. PHPs must complete a standard assessment developed by the Health Care Payment-Learning and Action Network (HCP-LAN) and develop a Value Based Purchasing Strategy over an initial 3-year period that aligns with DHHS' short- and long-term goals to shift from fee-for-service to VBP. The VBP Strategy must detail required incentive programs for Advanced Medical Homes (AMHs); describe how providers will be supported and encouraged to move through higher levels of the LAN framework; and provide annual expenditure targets in VBP arrangements. DHHS requires that by the end of Contract Year 2, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by 20 percentage points, or represent at least 50 percent of total medical expenditures.

6. **PHPS WILL BE HELD ACCOUNTABLE FOR QUALITY AND OUTCOMES.** To ensure that PHPs are held accountable for quality and outcomes, DHHS has developed a data-driven, outcomes-based quality improvement strategy that requires PHPs to meet relevant targets and benchmarks to improve care delivery, support healthy people and communities, and pay for value. PHPs will track and report on specific measures, submit annual improvement plans, implement improvement projects, and support providers in quality improvement efforts. Eighteen months after managed care launch, certain quality measures will be subject to financial penalties if quality standards are not met. All measures will be stratified by demographics to ensure plans are identifying and addressing health disparities.

7. **WE HAVE MINIMIZED ADMINISTRATIVE BURDEN FOR CLINICIANS.** PHPs will be required to comply with DHHS efforts to ease provider administrative burden, which include:
    - Standardizing and simplifying processes and standards across PHPs wherever appropriate
    - Incorporating a centralized, streamlined clinician enrollment and credentialing process
    - Ensuring transparent and fair payments for PHPs and all care providers
    - Standardizing quality measures across PHPs
    - Using standard prior authorization forms
    - Establishing a single statewide preferred drug list that all PHPs will be required to utilize
    - Covering the same services as Medicaid Fee-for-Service (except select services carved out of managed care)
    - Using DHHS definition of "medical necessity" when making coverage decisions
    - Hospital licensing and CON will not change under managed care

8. **THERE WILL BE A CONTINUED FOCUS ON HIGH-QUALITY, LOCAL CARE MANAGEMENT.** PHPs will be accountable for ensuring that appropriate care management is provided to improve outcomes related to care quality, service utilization, reduction of unmet resource needs, and decreased total costs. PHPs must ensure that each member has an ongoing source of care appropriate to their needs. PHPs will be required to contract with at least eighty percent of Tier 3 AMH practices.

9. **THE NEW ADVANCED MEDICAL HOME (AMH) PROGRAM WILL PROMOTE INNOVATION.** Building on the success of NC's current medical home model, the AMH program will preserve broad access to primary care services for Medicaid enrollees while strengthening the role of primary care in local care management, care coordination and quality improvement. The AMH program keeps the current Carolina ACCESS program payments to practices while also introducing new performance incentives for practices to become more focused on cost and quality outcomes over time by aligning payments for practices to specified measures, including total cost of care and health outcomes measures—which in turn links to PHPs' quality incentives set by DHHS.

10. **SOME POPULATIONS WILL CONTINUE IN MEDICAID FEE-FOR-SERVICE.** Most, but not all, beneficiaries will be in Medicaid Managed Care. More than 90 percent of enrollees will ultimately be in managed care, but many will be phased in over the next few years and some will remain in a fee-for-service structure. You do not need to contract with a PHP to receive reimbursement for patients remaining in fee-for-service, you just be enrolled in Medicaid.

ANTICIPATED TIMELINE

- **NOW AND ONGOING:** PHPs may start to reach out to initiate contract discussions with providers.
- **FEBRUARY 2019:** DHHS will announce which health plans will be PHPs in managed care.
- **SUMMER 2019:** PHPs must have contracted with enough providers for network to meet DHHS standards.
- **JULY 2019:** PHPs must have all call centers operational and all relevant staff located in North Carolina.
- **NOVEMBER 2019:** Managed care will start in some regions of North Carolina.
- **FEBRUARY 2020:** Managed care will start in the rest of the state.