

North Carolina Medicaid Managed Care

Prepaid Health Plan Request for Proposal Fact Sheet

Today, the North Carolina Department of Health and Human Services (DHHS) released a Request for Proposal (RFP) for Prepaid Health Plans (PHPs). The PHP RFP is the largest procurement in DHHS history and solicits proposals to provide managed care services to most Medicaid and NC Health Choice beneficiaries. The RFP clearly communicates DHHS' requirements and defines the standards that PHPs must adhere to in contracting with DHHS. All plans will be subject to rigorous oversight by DHHS to ensure strong provider networks, a full range of benefits, accountability for quality and outcomes, a positive beneficiary experience and timely payments to providers, among the aspects of a successful managed care program.

Context: In 2015, the NC General Assembly enacted Session Law 2015-245,¹ directing the transition of Medicaid from a predominantly fee-for-service structure to managed care. In managed care, 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 PHPs, which will contract with care providers to deliver services to their members.

Background: Since 2015, DHHS has collaborated with and solicited extensive feedback on its transition to managed care from clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates and other stakeholders. Throughout this process—from hosting listening sessions across the state, reviewing more than one thousand written public comments, and holding hundreds of meetings with various stakeholders—feedback has shaped the program design. As a result, DHHS has developed a detailed program for Medicaid Managed Care that is innovative, consistent with North Carolina and federal laws, and responsive to the needs of the beneficiaries, as well as clinicians, hospitals and health plans. DHHS continues to negotiate the final details of its 1115 waiver application with the federal Centers for Medicare & Medicaid Services. If those final negotiations result in a policy change that impacts this RFP, DHHS will amend the RFP and notify potential respondents, consistent with the procurement process.

Overview: DHHS is committed to improving the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health. This fact sheet summarizes five broad goals of this RFP and how the structure of the managed care program will advance each goal for Medicaid beneficiaries:

1. Create an innovative, integrated and well-coordinated system of care
2. Support clinicians and beneficiaries during and after the transition
3. Promote access to care
4. Promote quality and value
5. Ensure a successful managed care program

This fact sheet provides a high-level summary of key content within the PHP RFP, but it is not a part of the RFP and should not be construed as superseding any information contained in the RFP.

This is an official procurement. Send all procurement related inquiries to Medicaid.Procurement@dhhs.nc.gov. For more information about Medicaid Managed Care, visit the Medicaid Transformation website at www.ncdhhs.gov/medicaid-transformation.

¹ Session Law 2015-245 has been amended by S.L. 2016-121; Section 11H.17.(a) of S.L. 2017-57, Part IV of S.L. 2017-186; Section 11H.10.(c) of S.L. 2018-5; Sections 4 - 6 of S.L. 2018-49; and S.L. 2018-48.

1. CREATE AN INNOVATIVE, INTEGRATED AND WELL-COORDINATED SYSTEM OF CARE

Integrate physical health, behavioral health and intellectual/developmental disability (I/DD) services. This RFP procures Standard Benefit Plans, which will provide integrated physical health, behavioral health and pharmacy services to the majority of Medicaid and NC Health Choice beneficiaries with lower intensity behavioral health needs. Beginning in 2021, most individuals with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability or a traumatic brain injury will receive integrated physical health, behavioral health, pharmacy services and I/DD services through Behavioral Health Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans), an integrated specialized managed care product. BH I/DD Tailored Plans will be procured later through a separate process, and this population will continue receiving benefits through a combination of Medicaid Fee-for-Service and LME-MCOs as they do today until BH I/DD Tailored Plans begin.²

Implement a groundbreaking Advanced Medical Home (AMH) program. 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. DHHS understands that payment reform takes time and that it is essential to preserve the strengths of today's system in the transition to managed care, and the AMH program introduces changes to payment models with sufficient time for clinicians to prepare. DHHS will support clinicians in the transition.

Make smart investments in "Opportunities for Health." Research shows that overall health is driven by many things outside the four walls of a hospital or clinic. To ensure the most efficient managed care program and to build on work already being done by pediatricians, family physicians, community-based organizations and others, DHHS has identified five priority domains for making smart investments

in Opportunities for Health: housing, food, transportation, employment and interpersonal safety. PHPs will offer screening and navigation support within these domains through their care management programs, quality standards, value-based payment strategies and the provision of *in lieu of services*. PHPs also are encouraged to voluntarily contribute to health-related resources targeted toward high-impact initiatives that improve health outcomes and cost-effective delivery of care in the regions and communities they serve. Additionally, PHPs will play a key role in DHHS' enhanced case management pilot with the goal of improving health and reducing health care costs. Subject to final negotiations of North Carolina's 1115 waiver application, the pilot will enroll a subset of high-need Medicaid beneficiaries that can most benefit from evidenced-based healthy opportunity interventions.

2. SUPPORT CLINICIANS AND BENEFICIARIES DURING AND AFTER THE TRANSITION

Mitigate clinician administrative burden whenever possible. DHHS is dedicated to maintaining broad clinician participation in Medicaid by reducing or mitigating clinician administrative burden whenever feasible. PHPs will be required to comply with DHHS efforts to ease clinician administrative burden, which include:

- Standardizing and simplifying processes and standards across PHPs wherever appropriate
- Incorporating a centralized, streamlined enrollment and credentialing process
- Ensuring transparent payments for PHPs and fair contracting and payments for clinicians
- Establishing a single statewide preferred drug list that all PHPs will be required to utilize
- Requiring PHPs to cover the same services as Medicaid Fee-For-Service (with exception of services carved out of Medicaid managed care)
- Requiring all PHPs to use DHHS' definition of "medical necessity" when making coverage decisions
- Standardizing quality measures across PHPs

Preserve strong clinician participation and fair payments to providers of care. Under Section 5.(6)d. of Session Law 2015-245, PHPs must include all willing providers in their networks (except when the provider fails to meet objective quality standards or refuses to accept network rates) and must contract with all essential providers in their region, unless an alternative arrangement for members to access those services is approved by DHHS. PHPs must pay all in-network

² While BH I/DD Tailored Plans will be considered PHPs, they will be subject to different contractual requirements than Standard Benefit Plans. References to PHPs in this document generally refer to requirements for Standard Benefit Plans.

primary and specialty care physicians and physician extenders no less than 100 percent of the current Medicaid Fee-For-Service rate. This rate floor will apply to in-network hospitals and nursing facilities for the first few years of the new managed care system (see later in this document for additional details on the hospital reimbursement methodology). To encourage innovation related to value-based payments, PHPs and clinicians may mutually agree to alternative reimbursement arrangements. Generally, PHPs must pay, deny or pend a claim within 30 calendar days of receipt (14 days for a pharmacy claim), or pay interest and a late payment penalty to the provider.

Support continuity of doctor-patient relationships. DHHS is contracting with an independent, third-party enrollment broker to ensure that Medicaid beneficiaries understand their plan choices in Medicaid Managed Care. The enrollment broker will provide choice counseling to help beneficiaries select the PHP and the AMH/PCP that is most appropriate to meet their needs while, to the extent possible, maintaining existing doctor-patient relationships. PHPs will be required to provide the enrollment broker with network provider directory information that will be consolidated and used by the enrollment broker in choice counseling.

Build an accessible and convenient beneficiary experience. PHPs must maintain a robust member services department, including a member call center and a dedicated member services webpage; easy to understand member materials such as a Welcome Packet; and other community engagement strategies, all with the goal of ensuring an orderly transition to Medicaid Managed Care or from one PHP to another. PHPs must maintain a member service line providing access information about benefit and services, a nurse line providing around-the-clock access to medical information and advice, and a 24/7/365 behavioral health crisis line.

Protect the rights of beneficiaries: DHHS is committed to ensuring that beneficiaries understand and can freely exercise their rights to resolve issues efficiently with minimal burden. PHPs will educate beneficiaries on their rights and provide assistance with understanding and navigating the appeals and grievances processes. DHHS is establishing a new Ombudsman program to provide education, advocacy and issue resolution for Medicaid beneficiaries whether they are in the Medicaid managed care program or the fee-for-service program.

3. PROMOTE ACCESS TO CARE

Ensure PHPs maintain strong networks. The RFP contains specific standards around network adequacy, including time and distance and appointment wait time standards. In addition, Medicaid beneficiaries will receive adequate and timely coverage of out-of-network services (that have been pre-approved) if the PHP is unable to provide coverage within network on a timely basis. DHHS will closely monitor PHP Network Access Plans, which must demonstrate that the PHP has a network with the capacity to serve the expected enrollment. The Access Plan will be submitted annually and whenever there are substantial changes. To assist members in obtaining covered services from network care providers, PHPs will produce, monitor, and maintain consumer facing network care provider directories that are compliant with content requirements outlined in the RFP.

Ensure beneficiaries maintain medical and pharmacy benefits. At minimum, PHPs must cover the same physical health, behavioral health and pharmacy services as Medicaid Fee-For-Service State plan services, except for a small number of services excluded from Medicaid Managed care by law (which will continue to be covered through Medicaid Fee-for-Service) and a subset of behavioral health services that will only be available through LME-MCOs, and subsequently BH I/DD Tailored Plans. Additionally, PHPs must comply with all federal requirements related to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and not set benefit limits that are more stringent than the existing Medicaid Fee-for-Service program; PHPs also are encouraged to provide in lieu of services. The RFP provides a summary of State Plan covered services, services excluded from Medicaid Managed Care and NC Health Choice non-covered services. For each covered service, the RFP provides a description, key federal and state statutory and regulatory citations, clinical coverage policy references, and indication if the service is covered by Medicaid or NC Health Choice. All services will be delivered within the defined standards of care and meet DHHS quality standards.

As directed by Section 5.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, the pharmacy benefits includes all covered outpatient drugs for which the manufacturer has a CMS rebate agreement and for which DHHS provides coverage, and requires PHPs to adhere to DHHS' defined preferred drug list (PDL). As with medical benefits, PHPs will furnish these benefits in an amount, duration and scope no less than what members currently receive in Medicaid Fee-For-Service.

Ensure access to non-emergency medical transportation (NEMT).

To ensure members have coordinated, timely, safe, clean, reliable and medically necessary transportation to and from care providers, PHPs will provide NEMT services for all members through the least expensive mode possible and to the nearest appropriate care provider. Members must be informed of their rights to access this service if they are unable to arrange or pay for transportation or arrive at a care provider in time for a scheduled appointment. PHPs will develop an NEMT provider network that will be monitored by DHHS.

Encourage innovative use of telemedicine. To promote innovation, PHPs will be encouraged to provide telemedicine services as an alternative service delivery model and to support clinicians in optimizing the use of telemedicine in their practices, but will be prohibited from restricting services to telemedicine-only, as outlined in the RFP. Telemedicine will be used to enhance the member experience and improve access to care. PHPs must include payment parity in their payment of these services. For purposes of any programs that pilot new approaches to telemedicine and value based payment, the PHP may propose, for DHHS' review and approval, a waiver of telemedicine payment parity requirements.

4. PROMOTE QUALITY AND VALUE

Hold PHPs 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 clinicians 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.

Require high-quality, local care management. PHPs will be accountable for ensuring that appropriate, community-based 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 his or her needs and must coordinate care between physical and behavioral health clinicians, specialists, and

community resources. PHPs must develop a local care management model in coordination with Advanced Medical Homes (AMHs) and Local Health Departments (LHDs) to support rising and high-risk members, including At-Risk Children (0-5) and Women with High-Risk Pregnancies. PHPs and their local partners will conduct a care needs screening for members. PHPs and their local partners will be required to use risk scoring and stratification to identify members who should receive a Comprehensive Assessment. Using the findings of this assessment, the PHPs or their local partners will develop an individualized, person-centered care plan for each member who has been determined to require care management. PHPs must ensure that the majority of high-need members in each region requiring care management services receive it locally, in the community, including care management provided by AMHs and Local Health Departments.

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 manner, DHHS is requiring PHPs to establish value-based payment (VBP) arrangements. PHPs must complete a standard assessment developed by Health Care Payment-Learning and Action Network (HCP-LAN) and develop a Value Based Purchasing Strategy over an initial 3-year period that aligns to DHHS' short- and long-term goals to shift from FFS to VBP. The VBP Strategy must detail required incentive programs for 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% of total medical expenditures.

Require PHPs to implement Opioid Misuse Prevention Programs.

Consistent with DHHS' commitment to combating the opioid epidemic, PHPs will implement comprehensive opioid misuse prevention programs and a member lock-in program, coupled with quantity limits, mandatory electronic prescribing, and requirements to utilize the Controlled Substances Reporting System. PHPs will also be required to work upstream and build prevention programs that focus on appropriate prescribing and alternative pain management approaches and to build adequate networks of chronic pain clinicians. These programs and requirements will promote appropriate utilization of health care resources and support and promote safer prescribing of opioids.

Figure 1: Overview of rate setting process



5. ENSURE A SUCCESSFUL MANAGED CARE PROGRAM

Provide fair capitation rates for plans. Capitation rates are set using actuarial principles and are meant to provide a reimbursement structure that will match payment to the expected financial risk of the managed care program assumed by the PHPs. This includes projecting clinical expenditures, administrative costs, profit/underwriting gain, and premium taxes imposed on the PHPs. The PHP RFP includes a Draft Rate Book that provides draft capitation rates and describes the methodology and considerations by which DHHS will set final capitation rates. Final capitation rates for the first year of the PHP contract will be set prior to program launch and will reflect more recent program data, provider reimbursement levels, and legislative and other PHP requirements not reflected in draft rates. PHPs must accept the capitation rates and risk adjustment methodology developed by the Department and its actuary.

As required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49, the minimum aggregate Medical Loss Ratio (the percent of premium an insurer spends on claims and expenses that improve health care quality) threshold will be 88%. If the PHP's MLR is less than the minimum threshold, the PHP must rebate the difference to DHHS or make contributions to health-related, high-impact initiatives that improve health outcomes.

Transition hospital reimbursement 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 currently no supplemental payments for behavioral health services covered by LME-MCOs.) Federal rules for Medicaid managed care do not allow for 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 and Disproportionate Share Hospital 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.

Require PHP accountability for compliance and program integrity.

In accordance with 42 C.F.R. § 438.608, PHPs will have a Compliance Plan in effect to ensure a successful Compliance Program and establish criteria for preventing, detecting, and referring any cases of fraud, waste, or abuse. The annual Compliance Plan and Program will also contain any monitoring and auditing work plans. PHPs will be required to ensure the PHP does not pay federal or State funds to excluded persons or entities. PHPs must also submit ownership and control disclosures to DHHS annually and perform criminal history record checks on their owners, directors, and managing employees.

Enforce rigorous contract performance standards: DHHS has created a contract enforcement and oversight system to provide transparency to PHPs and stakeholders on DHHS' expectations for contract performance and compliance, while preserving flexibility for DHHS to appropriately address violations based on the nature of the harm incurred. As allowed under federal law, DHHS will retain broad authority to impose sanctions and take other appropriate action against PHPs for contract noncompliance. DHHS will utilize a wide array of enforcement mechanisms to ensure compliance and maintain a high performing managed care system, including imposing remedial actions, intermediate sanctions, liquidated damages, and, if necessary, contract termination. DHHS intends to publicize actions taken against PHPs for noncompliance and, when applicable, notify external state and federal agencies. Additionally, DHHS will contract with an External Quality Review Organization (EQRO), which will review each PHP's performance and quality outcomes on an annual basis against DHHS' contractual expectations and will administer annual satisfaction surveys to members and clinicians.

Conduct thorough readiness reviews of PHPs. To ensure that all PHPs are prepared to support the managed care program, DHHS will complete a thorough review of PHP administration, customer service, clinical technology, financing, and reporting functions starting immediately following contract award through the first few months after managed care launch. The readiness review will also include activities to verify that the PHP, its staff, providers, subcontractors, and other individuals and organizations are prepared to support, administer, and provide services on behalf of DHHS. This may include onsite reviews, desktop reviews, system demonstrations, staff interviews, and self-audit evaluations.

Encourage financial stability for PLEs. DHHS defined six PHP regions covering North Carolina. A PLE must cover any region in its entirety in which the PLE is contracted. Actuarial analysis has indicated that to best ensure the financial and administrative viability of all contracted PHPs, DHHS should establish an aggregated minimum of 45,000 to 50,000 lives for a given entity across all regions it is awarded. Given the increase in the number of statewide contracts that will now be awarded and the projected distribution of Medicaid Managed Care enrollment across the six regions, a PLE that bids on only one region may find reaching the minimum enrollment challenging and would be at an increased risk for financial instability. Therefore, the Department strongly encourages PLEs to bid on more than one region (per Session Law 2015-245, the proposed regions must be contiguous). DHHS will cap the number of regional contracts awarded at one for each of Regions 1 and 6, and two for each of Regions 2, 3, 4 and 5.

Ensure PHPs are appropriately licensed. DHHS is committed to ensuring that Prepaid Health Plans (PHPs) are appropriately licensed by the NC Department of Insurance (NC DOI) and meet solvency and other financial requirements to participate and remain in North Carolina Medicaid managed care. While licensure is required for entities operating as a PHP, it is not a pre-requisite for bidding on the PHP RFP; however, potential PHPs must provide proof of application as part of the proposal.

NEXT STEPS

RFP evaluation and award: DHHS will accept proposals from potential PHPs until October 12, 2018, at 2 p.m. ET. DHHS will first review offers to determine that they are in the proper form and include all required documents. The Evaluation Committee will then screen the offers to determine if the minimum qualifications have been met. The Evaluation Committee will evaluate proposals meeting the minimum qualifications and develop consensus ratings, ultimately developing an award selection that is aligned with state law, and will provide supporting documentation for their selection. DHHS will submit the contracts to the federal Centers for Medicare & Medicaid Services for its approval. PHP contract awards are anticipated to be announced in February 2019.

ANTICIPATED TIMELINE

- **Now and ongoing.** Care providers may be contacted by potential PHPs who wish to initiate contract discussions.
- **February 2019.** NC will award contracts to the selected health plans to be PHPs in managed care.
- **Summer 2019.** PHPs must have contracted with enough care providers for their network to meet DHHS standards.
- **July 2019.** PHPs must have all call centers operational and all relevant staff located in North Carolina.
- **July-September 2019.** Managed care will start in two phases. For regions of the state in Phase 1, this will be the window in which beneficiaries select a PHP.
- **November 2019.** The Medicaid managed care program will launch in regions in Phase 1.
- **October-December 2019.** For regions of the state in Phase 2, this will be the window in which beneficiaries select a PHP.
- **February 2020.** The Medicaid managed care program will launch in regions in Phase 2.

