MEDICAID TRANSFORMATION
Supporting Provider Transition to Medicaid Managed Care

Department of Health and Human Services
June 2018

NC Medicaid Transformation website:
www.ncdhhs.gov/medicaid-transformation
What we’ll cover today

• Medicaid managed care overview

• Provider enrollment and credentialing

• Provider contracting with Prepaid Health Plans (PHPs)

• Meeting Advanced Medical Home (AMH) requirements
SUPPORTING PROVIDER TRANSITION TO MEDICAID MANAGED CARE | JUNE 2018

By implementing managed care, and advancing integrated and high-value care, North Carolina Medicaid will
improve population health, engage and support providers, and establish a sustainable program with more predictable costs.

NORTH CAROLINA’S VISION FOR MEDICAID MANAGED CARE
North Carolina’s Goals for Medicaid Managed Care

1. Measurably improve health
2. Maximize value to ensure program sustainability
3. Increase access to care
Medicaid transformation status

- Proposed Plan Design: Aug. 2017
- Amended 1115 Waiver: Nov. 2017
- Enrollment Broker RFP: March 2018 opened April 13, 2018
- Policy Papers: Nov. 2017 to Summer 2018
Medicaid managed care rumor #1

Some PHPs have already been selected to participate in NC Medicaid Managed Care

You may have heard...
Medicaid managed care rumor #1

FALSE

Some PHPs have already been selected to participate in NC Medicaid Managed Care

TRUE

• NO PHPs have been selected
• NO PHP contract has been drafted
Key milestones in progress

- **PHP RFP**
- **PHP Licensure & DOI Chapter 58 Provider Protections**
- **Behavioral Health Integration**
- **1115 Waiver Approval by CMS**

ONGOING: Listening to and talking with stakeholders

Recent and upcoming releases

- June 6: Beneficiary ombudsman program request for information
- Provider data management (PDM)/CVO request for proposal
Transition to Medicaid managed care

- Enrollment
- Credentialing
- Contracting
- Payments
- AMH Requirements

Changing how Medicaid benefits are delivered

From predominantly fee-for-service program to Medicaid managed care model
Provider enrollment and credentialing

• Enrollment process similar to today

• Centralized credentialing and recredentialing policies uniformly applied

• Nationally recognized, third-party credentials verification organization (CVO)

Provider Participation

Providers must be enrolled as a Medicaid or NC Health Choice provider to be paid for services to a Medicaid beneficiary

Credentialing is a central part of the federally regulated screening and enrollment process

2016 Medicaid Managed Care Final Rule
21st Century Cures Act

NC Medicaid Transformation website: www.ncdhhs.gov/medicaid-transformation
Centralized credentialing—full implementation

**APPLICATION & VERIFICATION**

- **Department Process**
  - Provider applies
    - Application is single point-of-entry for all providers
    - Required to participate in Medicaid Fee-for-Service or Medicaid Managed Care
    - Follows Medicaid rules
  - PDM/CVO verifies credentials
    - Managed by accredited PDM/CVO
    - Required to contract in Medicaid Managed Care
    - Follows national accreditation standards (e.g., NCQA)

- **PHP Process**
  - PHP PNPC reviews & approves/denies
    - Established and maintained by PHP
    - Reviews & makes “objective quality” determinations
    - PHP Provider Network Participation Committee
    - Cannot request more information for quality determinations
    - Monitored by the Department
  - PHP and provider negotiate contract
    - PHP network development staff secures contracts with providers credentialed & enrolled in Medicaid
Medicaid managed care rumor #2

You may have heard...

There will be only ONE plan offering Medicaid managed care
Medicaid managed care rumor #2

FALSE

There will be only ONE plan offering Medicaid managed care.

TRUE

• DHHS may select up to 15 PHPs using established, thorough state procurement processes

• 3 statewide PHPs and up to 12 regional provider-led entities
Network adequacy

• PHPs must maintain sufficient provider networks for adequate access to covered services

• The Department will develop network adequacy standards; e.g., time/distance, “realized access”

• Law requires PHPs to contract with all “essential providers”

• Building provider networks is a standard business operation for health plans
Medicaid managed care rumor #3

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future.

You may have heard...
Medicaid managed care rumor #3

**FALSE**

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future.

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**TRUE**

- PHPs must contract with DHHS
- PHPs must be licensed by the state
- PHPs must have their provider manuals, contracts and contracting policies and procedures approved by DHHS
- Medicaid Fee-for-Service program will remain operational to serve excluded populations – although a smaller program.
Before PHP contracts are awarded

Pre-Award Period

Build relationships with health plans

Understand contract terms, conditions, payment and reimbursement methodologies

Contracting Guidance

• **Letters of intent**
  Non-binding indication of health plan and provider’s intent to enter into contract negotiations

• **“Any willing provider”**
  PHPs must contract with providers willing to accept reimbursement unless “objective quality” concerns

• **Department-approved contracts**
  Mandated clauses and specific provisions
Conflict resolution for enrollment & credentialing

Appeals process will be the same across all PHP contracts

Providers can appeal determinations, including enrollment and contracting

Submitting Appeals

Appeal to Department
Enrollment, including credentialing, as a provider in Medicaid only

Appeal to PHP
“Objective quality” contracting determinations
Provider payments

• Rate floors/ceilings
  – PHPs will comply with Department-established rate floors for certain in-network providers
  – PHPs and providers can mutually agree to different rates through PHP/provider contract
  – Department will monitor PHP/provider contracts to determine if rate ceilings need to be established

• Department will hold PHPs to prompt pay requirements

• Out-of-network services will be covered if PHP provider network is unable to provide necessary services covered under the contract, subject to prior authorization

• Out-of-network provider of emergency or post-stabilization services will be paid no more than Medicaid fee-for-service rates
Contract monitoring & compliance oversight

Department Goal
Ensure PHP operations consistently provide reliable health care to Medicaid managed care members

External Quality Review Organization
• Federally required
• Performs external quality review of mandatory and optional activities (to be defined in upcoming EQRO RFP)

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EQRO requirements are listed in 42 CFR Part 438, subpart E
PHPs will be responsible for care management of enrollees

Under AMH, PHPs delegate primary responsibility to practices, when practices certify into higher AMH tiers
Advanced Medical Home overview

AMH program will:

- Build on strengths of current primary care infrastructure
- Offer range of participation options for providers
- Emphasize local delivery of care management
- Offer opportunity for providers to be rewarded for high-quality care by aligning payment to value

Care management will be a shared responsibility of practices and PHPs, with division of responsibility varying by AMH tier

AMH program will launch concurrently with managed care, with a DHHS certification process for practices launching later this year
Transition plan for Carolina ACCESS practices

<table>
<thead>
<tr>
<th>CAROLINA ACCESS STATUS</th>
<th>ELIGIBILITY FOR AMH PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOT PARTICIPATING IN CA</td>
<td>NOT AMH ELIGIBLE</td>
</tr>
<tr>
<td></td>
<td>AMH TIER 1 CERTIFIED (will phase out after 2 years)</td>
</tr>
<tr>
<td></td>
<td>AMH TIER 2* CERTIFIED</td>
</tr>
<tr>
<td></td>
<td>AMH TIER 3 CERTIFIED</td>
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<tr>
<td>CA I</td>
<td>Default placement</td>
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<tr>
<td></td>
<td>Not permitted</td>
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<tr>
<td></td>
<td>If successfully attests to Tier 2 requirements</td>
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<tr>
<td></td>
<td>If successfully attests to Tier 3 requirements</td>
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<tr>
<td>CA II</td>
<td>Choose:</td>
</tr>
<tr>
<td></td>
<td>• Not to contract as an AMH, OR</td>
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<td></td>
<td>• Notify DHHS to be removed from master list</td>
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<tr>
<td></td>
<td>Default placement</td>
</tr>
<tr>
<td></td>
<td>Notify DHHS to be placed into Tier 2</td>
</tr>
<tr>
<td></td>
<td>Default placement</td>
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*Tier 2 requirements are same as Carolina ACCESS requirements  **CAI providers are already meet Carolina ACCESS requirements
Tier 3 AMH oversight roles/responsibilities

- Place CM requirements in contract
- Conduct oversight/monitoring of PHPs
- Develop attestation; require PHPs to have selected terms/conditions in PHP/AMH contract
- Certify AMH practices

Establish specific terms/conditions in PHP/AMH contract

- Attest to requirements
- Contract with PHPs and, if applicable, CIN

- Support Tier 3 AMHs in meeting requirements
- Contract with AMHs

The Department does not place direct requirements on CINs or have an attestation/certification process for CINs
Next steps

• Policy paper comments (Monday, June 11)
• MCAC Provider Engagement Subcommittee (meetings begin summer 2018)
• Provider engagement and support training
  – Strategy, planning and rollout
  – AMH certification training (Q3 2018)
• Future Medicaid program announcements
  – PHPs
  – PDM/CVO
  – Enrollment broker
  – Beneficiary Ombudsman
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Next Webcasts:
Monday, June 11 – 1-2 p.m. Eastern time
Thursday, June 14 – 3-4 p.m. Eastern time

To Register:
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