



Medicaid Managed Care
Proposed Policy Paper

Supporting Provider Transition to Medicaid Managed Care

North Carolina Department of
Health and Human Services

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This document is part of a series of policy papers that the Department of Health and Human Services scheduled for release from late 2017 through mid-2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other policy papers in the series. For more information on the Department’s proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released policy papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

This paper is an overview of what Medicaid providers should expect as the North Carolina Medicaid and NC Health Choice programs transition from a predominantly fee-for-service delivery system to managed care. It offers information and supportive guidance to providers on:

- Overall Medicaid managed care design;
- Provider enrollment and credentialing;
- Contracting with prepaid health plans (PHPs); and,
- Meeting Advanced Medical Home (AMH) requirements with and without clinical integrated network (CIN) support.

For more information on Medicaid managed care design, provider enrollment and credentialing, refer to earlier policy papers and other information on the Medicaid Transformation website.¹

II. Overview of North Carolina Medicaid Managed Care

In 2015, the North Carolina General Assembly (General Assembly) enacted Session Law 2015-245, directing the transition of North Carolina Medicaid and NC Health Choice programs from a predominately fee-for-service model to a managed care model. Since that time, the Department worked with the General Assembly and stakeholders to plan for the implementation of this directive. At the core of these efforts is the goal to improve the health of all North Carolinians in Medicaid through an innovative, whole-person centered, well-coordinated system of care, which addresses medical and non-medical drivers of health.

In Medicaid managed care, the Department will delegate the direct administration and management of certain health services and financial risks to PHPs, which will receive a monthly capitated payment and will be expected to contract with providers to deliver health services to the PHP's members. PHPs will be subject to rigorous monitoring and oversight by the Department across many metrics to ensure adequate provider networks, high program quality and other important aspects of a successful Medicaid managed care program.

Provider participation is essential for delivering high-quality care to Medicaid beneficiaries. In Medicaid managed care, providers will contract directly with PHPs to continue the physician/patient relationship and receive reimbursement from PHPs for treatment and services provided to those enrolled in Medicaid managed care.

Most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs. There will be limited exceptions for certain populations who may be better served outside of Medicaid managed care at this time. These populations may be either exempt, meaning they may choose to enroll in either fee-for-service or Medicaid managed care; or excluded, meaning they must remain enrolled in Medicaid fee-for-service. The Department is proposing to stagger the managed care launch.

All excluded populations will continue to receive health benefits as fee-for-service or through their existing delivery system.

¹ <https://www.ncdhhs.gov/medicaid-transformation>

Exempt populations include members of federally recognized tribes. North Carolina consulted with its only federally recognized tribe, the Eastern Band of Cherokee Indians (EBCI), and concluded that tribal members will benefit from having the choice between Medicaid fee-for-service or enrollment in a PHP. The Department is in discussions with EBCI on pathways to becoming the first Native American managed care entity in the country. The Department will work with the General Assembly, if necessary, on any changes needed to allow EBCI to offer a tribal option.

As previously covered in the Department's "North Carolina's Proposed Program Design for Medicaid Managed Care,"² efforts to ease provider administrative burden have been a priority for the Department. Administrative simplification efforts include:

- Standardizing and simplifying administrative processes and standards across PHPs wherever appropriate;
- Incorporating a centralized and streamlined provider enrollment and credentialing process;
- Ensuring transparent and fair payments for PHPs and providers;
- Establishing a single statewide drug formulary 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)
- Using the Department's definition of "medical necessity" when making coverage decisions; and
- Offering providers some contracting "guardrails" (described later).

III. Provider Enrollment and Credentialing

Today, a provider must be enrolled, through the North Carolina provider enrollment process, as a Medicaid or NC Health Choice provider to be paid for treatment and services provided to a Medicaid beneficiary. Similarly, in managed care a provider must be enrolled to deliver services (whether those services are in-network or out-of-network).

Under managed care, providers will enroll in North Carolina Medicaid in a process like the current enrollment process. The provider will access a standard enrollment application online, submit credentialing information and be notified when the enrollment application is approved. To meet accreditation standards for managed care, PHPs will need additional information about providers that is not a part of the existing credentialing process. This additional information is necessary because the existing North Carolina Medicaid provider enrollment process (including credentialing) does not generally meet PHPs' standards for a credentialing / contracting process or the standards necessary for a plan to be accredited by a nationally recognized accrediting organization.

The Department is taking steps to streamline the process of obtaining this additional information, to avoid providers needing to submit the same information to multiple PHPs. On March 20, 2018, the Department released the "Centralized Credentialing and Provider Enrollment" policy paper, available on the Medicaid Transformation website. Next is an overview of that paper.

² Medicaid transformation-related documents and information mentioned in this policy paper are available at <https://www.ncdhhs.gov/medicaid-transformation>.

Provider Credentialing Transition Period

The Department will, over time, establish a new, integrated Provider Data Management solution and Credentials Verification Organization (PDM/CVO). The new PDM/CVO will not be operational when Medicaid managed care launches. During this transition period, the Department will ensure providers still experience a seamless and largely invisible credentialing process in managed care.

During the transition period, providers will continue to enroll and reenroll in Medicaid using the current process under NCTracks. The Department will supplement its existing enrollment data with additional needed data. Specifically, the Department proposes to contract with a national provider data clearinghouse for verified primary-source information that meets an accrediting organization's standards for an accredited credentialing process. Together, this complete provider information (verified provider enrollment data plus managed care credentialing data) will be provided to PHPs. The PHPs will be expected to accept the information collected for Medicaid enrollment and the data from the national clearinghouse, and use that combined data in their contracting process until the PDM/CVO solution is fully implemented. PHPs' internal provider network quality committees will use the information provided through this process. Providers will not be expected to give credentialing information to every PHP with which they intend to enter into a contract. The Department expects to prohibit PHPs, through the PHP contract, from requesting additional information from providers for use in making objective quality contracting decisions. Providers will interact with individual PHPs to establish the contract itself (a process described later in more detail).

If the Department cannot procure a national provider data clearinghouse that can provide all additional provider data, it will explore other options for the transition period with a continued emphasis on minimizing provider administrative burden.

Full PDM/CVO Implementation

When the integrated PDM/CVO solution is available, providers will initiate a single online application for Medicaid enrollment and re-enrollment, and will submit documentation for initial credentialing and recredentialing (e.g., certifications, insurance) through the PDM/CVO provider portal.

The PDM/CVO will verify all provider information against primary sources, as required by national accrediting entities, federal requirements and the Department. Primary sources will include national databases, state and federal sources, information collected by national health plans and proprietary or licensed databases. Once the CVO has collected documentation and verification is completed, the provider will be enrolled in Medicaid fee-for-service and will be able to receive reimbursement for covered services provided to fee-for-service beneficiaries. PHPs will have access to credentialed information through the PDM/CVO about Medicaid-eligible providers to use in building their networks.

IV. Provider Contracting with PHPs

Under Medicaid managed care, PHPs will be responsible for establishing and maintaining an adequate network of providers to meet the health care needs of their beneficiaries by contracting with a diverse range of providers and establishing provider payment rates, subject to certain rules set by the Department.

In preparation for Medicaid transformation, it is anticipated that health plans intending to submit a proposal to be part of Medicaid managed care will be initiating discussions with providers regarding contracting opportunities. Building provider networks is a standard business operation for health insurance companies, and a robust network is a key component of successful Medicaid managed care programs. Before managed

care becomes operational and PHPs begin to serve beneficiaries, health plans will be required to demonstrate that they meet North Carolina’s Medicaid network adequacy standards. During the procurement process, potential PHPs will have flexibility in how they demonstrate their ability to meet those standards in the future.

Health plans intending to submit a proposal to enter the North Carolina Medicaid managed care market should not pressure, coerce or otherwise compel providers to sign contracts.

IMPORTANT: As of May 2018, the Department has not issued the PHP RFP or awarded any PHP contracts. It also has not issued PHP provider contract requirements and standard clauses, or reviewed or approved PHP provider manuals, contracts, or contracting policies and procedures.

An option that providers may consider, at their own discretion, is to execute Letters of Intent (LOI) with health plans before PHP RFP award. An LOI provides a non-binding indication of the intent of the health plan and provider to enter into contract negotiations for provision of services to North Carolina Medicaid beneficiaries. By signing an LOI, a provider has no future obligation to sign a provider contract with the health plan if contract negotiations do not meet their needs. A provider may also choose not to sign LOIs at this time and consider its contracting options after PHPs have been selected.

While providers may consider entering into LOIs with potential health plans, it may be premature to sign contracts with health plans before the Department completes the PHP RFP procurement process and announces which health plans will be awarded the opportunity to become a Medicaid managed care PHP. The Department acknowledges that not all health plans may be awarded a contract to participate in North Carolina’s managed care program.

Further, North Carolina law³ provides that “any willing provider” will have the opportunity to contract with PHPs. To comply with the any willing provider requirement, PHPs must contract with providers willing to accept reimbursement at or above any applicable rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet “objective quality” standards, as described in the law. Objective quality concerns may include a history of malpractice concerns or fraud or waste and abuse enforcement actions.

Contracting Guidance

A reimbursement rate floor will apply to PHP contracts with physicians and physician extenders, as well as other providers defined by the Department. Additional payments will be made to providers meeting advanced medical home requirements. PHPs will also be incentivized to engage in value-based payment arrangements with providers.

During conversations between health plans and providers, both parties are encouraged to discuss such topics as 1) how the health plan envisions working with providers to help improve patient quality care; 2) rates or reimbursement for services and/or opportunities for alternative payment arrangements (e.g., pay-for-performance, value-based payments); 3) reporting requirements; 4) dispute resolution; 5) data tools and other

³ Per section 5. (6) d. of Session Law 2015-245, as amended

resources that will be available to contracted providers (e.g., business intelligence tools); 6) prior authorization and timely filing requirements; and 7) contract renewal and termination timeframes.

In entering into contract negotiations with PHPs, it is recommended that providers use the pre-award period to understand the health plans' contract terms, conditions, payment and reimbursement offerings. And, that providers be aware of and review the contract template requirement information and the forthcoming PHP RFP provider contract requirements to re-open contract discussion with the PHP, if necessary. Presented below is some additional guidance for providers to consider as they enter discussions with health plans.

To comply with the any willing provider requirement, PHPs must contract with providers willing to accept reimbursement at or above the rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet "objective quality" standards. In addition, there are specific requirements for PHPs to include all essential providers (i.e., federally qualified health centers, rural health centers, local health departments, veterans' homes and charitable/free clinics) in their provider networks.

The Department expects to require PHPs to use Department-approved provider contract templates in contracting with providers, which will include specific provisions that address certain key issues and situations, and mandated clauses with required content around certain key topics. The Department plans to produce a checklist of the standard and mandated provisions for PHPs to use in drafting contract templates.

The Department welcomes feedback on the topics where it should mandate language for inclusion in provider contracts; recommended contract provision language is preferred.

Considerations for Providers Who Have Already Contracted with a Health Plan

Providers who have already entered into and completed contract negotiations with health plans that resulted in a contract signing, should be aware that health plans may be required to re-paper, amend or re-issue the contract if their provider manuals, policies and procedures, or contracts are not approved by the Department. Note that, as of May 2018, the Department has not reviewed or approved any of these documents.

Conflict Resolution

Providers will have access to provider appeals processes relating to provider enrollment, credentialing and contracting:

1. At the Department level for appeals regarding enrollment as a provider in Medicaid; and
2. At the PHP level for objective quality contracting determinations.

For appeals under the first level, the Department or its agent will notify providers of appeals rights and manage the appeals process. The Department expects to leverage the current provider notification and appeals process for these appeals.

For appeals under the second level, PHPs will notify providers of appeals rights and manage the appeal process according to the Department's requirements and any applicable state or federal laws. PHPs must permit a provider, regardless of network status to appeal an adverse objective quality contracting determination. The Department's contract with PHPs will also establish requirements related to notifications (timeframes and content), decision timeframes, the makeup of the PHPs internal appeals committee, and other aspects of appeals and grievance procedures. The PHP's provider appeals process will be submitted to the Department

prior to use, and will be included in the PHP's provider manual and provider contracts, and will be available in written format to providers upon request.

Additional dispute resolution terms and conditions will be established in the PHP's contract with providers.

Provider Payment and Reimbursement

The Department establishes provider payment requirements for PHPs. These requirements, listed below, are intended to encourage continued provider participation in the Medicaid program to ensure beneficiary access and support safety net providers to ensure continuation of current reimbursement levels using mechanisms that mitigate the risk of PHP steerage to other providers. These requirements are contingent on approval from CMS. Final capitation rates will reflect required reimbursement levels.

1. Rate floors, set at fee-for-service levels, will apply to in-network physicians, physician extenders, pharmacies (dispensing fees), hospitals and nursing facilities. Rate floors for hospitals and nursing facilities will apply for a limited duration. For more information on payment to hospitals, refer to the "Addressing Hospital Supplemental Payments in the Transition to Managed Care" policy paper located on the Medicaid Transformation website.
2. PHPs will be required to make additional payments, above those built into the per member per month capitated rate, to certain providers, including in-network public ambulance providers, local health departments and hospitals owned by UNC Health Care and Vidant Medical Center. The Department proposes that these additional, utilization-based payments be made quarterly by PHPs to providers, with an annual reconciliation. The Department will make payments to PHPs outside the per member per month capitation rates to cover the cost of these additional payments.
3. The Department will prescribe reimbursement levels for state-owned and -operated facilities.
4. PHPs will be required to reimburse pharmacies for ingredient costs based on fee-for-service rates for at least the first year of the contract, as described in "North Carolina's Proposed Program Design for Medicaid Managed Care."
5. PHPs will be required to pay per member per month primary care medical home payments for providers that meet AMH standards. These payments will be equal to the payments providers receive today in the Carolina ACCESS program (\$1.00, \$2.50 or \$5.00 per beneficiary assigned to the practice). Additional detail appears in "North Carolina's Care Management Strategy under Managed Care" policy paper.
6. Continued payment of per member per month payments to local health departments for Obstetric Care Management and Care Coordination for Children for at least two years as proposed in the "North Carolina's Care Management Strategy under Managed Care" policy paper.

The Department is working with the North Carolina Community Health Center Association (NCCHCA) on reimbursement requirements for federally qualified health centers and rural health clinics, and will provide additional information in the future.

The Department supports and encourages innovative, alternative payment arrangements between PHPs and providers that promote health and increased value (see additional information on value-based purchasing in the "Provider Health Plan Quality Performance and Accountability" policy paper). For provider types with

applicable rate floors or for AMH-related payments, PHPs and providers will have flexibility to mutually agree to alternative payment arrangements. To comply with the any willing provider requirement, PHPs must contract with providers willing to accept reimbursement at or above the rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet objective quality standards.

Out-of-Network Provider Reimbursement

As is required by federal law, PHPs will cover out-of-network services for enrollees if unable to provide necessary covered services within their network and must coordinate with those out-of-network providers for payment. If a PHP has made a good faith effort to contract with a provider that has refused that contract, or if the provider is excluded from contracting for failure to meet objective quality standards, PHPs will be prohibited from reimbursing the provider more than 90 percent of the Medicaid fee-for-service rate for services. PHPs and providers will have flexibility to mutually agree to alternative payment arrangements on a case-specific basis. As required by federal law,⁴ PHPs will also cover family planning services and supplies regardless of a provider's network status, and will cover and pay for emergency services without regard to prior authorization or network status. For out-of-network emergency or post-stabilization services, PHPs will pay no more than the Medicaid fee-for-service rate. For out-of-state, non-bordering hospitals (that are not part of a PHP's network) PHPs will pay the Medicaid fee-for-service rate.

Prompt Payment

Providers should be aware that PHPs will be responsible for claims processing and payments to providers, and must make timely payments to providers if a claim is submitted within 90 days after the date of service. PHPs must send acknowledgement of electronic claims within 48 hours of receipt and, within 18 processing days of receiving the claim, notify the provider whether the claim is clean or if more information is needed. If the claim is clean, the PHP must pay or deny it within 30 days of receipt. Otherwise, notification must be provided requesting more information. Health plans will be required to act on additional information that is sent according to PHP contract requirements. If a PHP does not receive the additional information in the required timeframe, the PHP must decide on the claim based on submitted information.

The Department expects to award contracts to PHPs that can consistently and accurately pay contracted and non-contracted providers in a timely manner. Therefore, if the PHP does not pay a claim within 30 days, it will owe the provider interest and penalty. Consistent with other states, payments that are not made according to prompt pay requirements will bear interest at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid or was underpaid. In addition to interest, a PHP may be subject to a penalty equal to 1 percent of the claim per day. Providers do not have to make separate requests to the health plan for interest or penalty payments, and are not required to submit another claim to collect the interest and penalty.

Pharmacy Prompt Payment

To facilitate prompt reimbursement to pharmacies for high cost drugs, PHPs will be required to pay 90 percent of pharmacy claims within 14 calendar days, 99.5 percent within 21 calendar days and 100 percent of claims within 90 calendar days of receipt. Interest and penalty as stated above will also apply to pharmacy claims that are not promptly paid.

⁴ 42 C.F.R. §438.10(g)(2)(vii).

V. PHP Contract Monitoring and Compliance

Providers can anticipate that the Department will conduct contract compliance monitoring and oversight of PHP operations consistent with federal requirements. These activities will be carried out to ensure that all aspects of a PHP's operations consistently provide reliable health care to North Carolina's Medicaid managed care members. These activities will include, but are not limited to:

- Reviewing and assessing encounter reports for accuracy, and imposing fines and capitation withholds when PHPs are noncompliant.
- Issuing letters of concern and corrective action plans (CAP) when PHP activities are found contractually deficient.
- Reviewing and approving CAPs when PHP activities are found to be substantially noncompliant with any material provision of a contract.
- Approving PHP marketing and outreach materials for Medicaid managed care beneficiaries.
- Approving PHP provider contracts and manuals, and any amendments to those documents.
- Attending community events to ensure PHPs are adhering to marketing materials distribution in compliance with their contract.
- Facilitating PHP encounter file submission and resubmission.
- Conducting PHP provider network adequacy and access to care reviews.
- Conducting onsite and offsite contract compliance audits.
- Facilitating monthly PHP operations meetings.

In addition, the Department will contract with a federally required⁵ External Quality Review Organization (EQRO) to perform external quality review mandatory and optional activities that will be defined in an upcoming EQRO RFP. The mandatory and optional activities include:

1. "Review, within the previous three-year period, to determine PHP compliance with state standards for access to care, structure and operations, and quality measurement and improvement";⁶
2. Validation of performance measures;
3. Validation of performance improvement projects (PIPs);
4. Validation of encounter data reported by an PHP;
5. Administration or validation of consumer or provider surveys of quality of care;
6. Calculation of performance measures in addition to those reported by an PHP and validated by an EQRO;
7. Conduct PIPs in addition to those conducted by an PHP or PIHP and validated by an EQRO; and
8. Conduct studies on quality that focus on an aspect of clinical or nonclinical services as a point in time.

⁵ 42 CFR Part 438, subpart E

⁶ <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>

The EQRO will issue technical reports summarizing its findings and validation results, which will be used by the Department to evaluate overall performance of contracted statewide and regional PHPs.

In addition, feedback and reporting received from the ombudsman and enrollment broker (future vendors that will be procured through competitive RFP process) will also be used by the Department to monitor trends in beneficiary concerns related to PHP performance.

VI. Advanced Medical Homes Contracting with PHPs

The Department is committed to supporting primary care practices by establishing standards for AMHs. Tier 1 and Tier 2 AMHs will provide medical home services similar to the existing Carolina ACCESS program, and will receive per member per month compensation from PHPs for those services. Tier 3 and Tier 4 AMHs will provide medical home services and will also be responsible for care management for their beneficiaries, and they will receive compensation from PHPs for medical home services and care management work.

Under Medicaid managed care, PHPs will be responsible for contracting with a large majority of Department-certified Tier 3 and 4 AMHs in their service areas. For providers to successfully enter AMH Tier 3 or 4, a practice will need to demonstrate immediate capacity to perform care management and meet the data requirements on AMH practices. There will be more than one route for practices to accomplish this, depending on organizational structure:

- **Health system-affiliated practices.** Many practices that are affiliated with a hospital or health system may want to enter AMH Tiers 3 or 4. The Department expects that those practices will receive data sharing/analytics and care management support at a system level from their hospital or health system. AMHs affiliated with a hospital or health system can designate that system as their Clinically Integrated Network (CIN).
- **Independent AMH practices in Tier 3-4.** The Department specifically aims to support independent practices that want to participate in Tier 3 or 4 of the AMH program without needing to be owned by, or formally affiliated with, a hospital or health system. Such practices may opt to form or join a CIN geared to support independent practices to meet program requirements, including by providing data sharing/analytics and care management support. However, affiliation with a CIN is not a formal program requirement if a practice can independently demonstrate the necessary capacities.

In the context of the AMH program, “CIN” refers to an entity with which the AMH voluntarily contracts to share responsibility for certain services on a centralized basis, particularly data sharing/analytics and care management. A CIN could be a hospital or health system; an independent nonprofit organization delivering data sharing/analytic support and local care management to a group of practices; or a third-party population-health company. The Department expects there will be multiple CINs offering services to support Tier 3 and Tier 4 AMHs, and providers may choose any CIN.

“Clinical integration” means a collaborative effort among providers and a central organizing system to implement clinical initiatives that control costs and improve quality, typically by strengthening coordination, standardizing clinical processes and protocols, and investing significantly in a centralized infrastructure.⁷

The Department will certify AMH practices that apply to the program, per the “North Carolina’s Care Management Strategy under Managed Care” policy paper. The Department will not separately certify CINs. The Department intends to allow providers flexibility in how they decide to meet AMH Tier 3 or 4 program requirements. Providers may change their CIN affiliation over time, and, though we expect it to be rare, providers are permitted to affiliate with more than one CIN. However, the Department expects successful entry into Tier 3 or 4 of the AMH program means a practice can provide seamless services for the entire population under Medicaid managed care, regardless of PHP population.

The Department will continue to arrange for care management for populations that remain in the fee-for-service program, and providers will continue to receive Carolina ACCESS payments for those fee-for-service populations.

⁷ The Federal Trade Commission has established criteria for “clinical integration” as a means of testing whether physicians can appropriately negotiate rates and other contract terms with payers as a single unit. However, North Carolina proposes to use the term “CIN” in a wider sense to denote any network with which providers willingly contract to provide and share population health capabilities, regardless of whether that network would meet the FTC criteria.