Contracting with Health Plans

NC Medicaid

It is important to contract with Prepaid Health Plans (PHPs) in advance of NC Medicaid Managed Care launch on Feb. 1, 2020

North Carolina is transitioning its Medicaid program to managed care. Most beneficiaries will choose one of five health plans and a primary care provider (PCP). Those who do not make a choice will be auto-enrolled in a plan. Health plans will then assign beneficiaries to a primary care provider in their network. ***For inclusion in auto-enrollment, provider PHP contracts must be signed and mailed to the health plan by Nov. 15, 2019.***

The November 15 deadline allows health plans to process provider contracts and ensure that providers can be paid. This typically takes **at least** two to three weeks, but it may take longer. Additional time is then needed to transmit information to the Department for inclusion in the auto-enrollment process. PCPs need to contract with health plans in a timely fashion to avoid losing patients as health plans will assign beneficiaries to in-network providers.

Providers who do not contract with health plans in a timely fashion may also miss out on the ability to earn per member per month (PMPM) payments through the Advanced Medical Home (AMH) program.

ARE PROVIDERS REQUIRED TO CONTRACT WITH ALL HEALTH PLANS?

No. While we encourage providers to contract with each health plan, providers can contract with as many or as few as they desire. However, providers who contract with fewer health plans risk losing patients and Advanced Medical Home (AMH) payments as health plans will only work with providers in their network.

WHAT ARE THE HEALTH PLANS' CONTRACTING RESPONSIBILITIES WITH PROVIDERS?

DHHS expects health plans to negotiate with any willing provider in good faith regardless of provider or health plan affiliation.1 Health plans may only exclude eligible providers from their networks under the following circumstances2:

- Provider fails to meet Objective Quality Standards; [3] or
- Provider refuses to accept network rates.

[1] PHP Contract, Section V.D.2.a

[2] PHP Contract, Section V.D.2.c.v

[3] Means, as defined in Section 5. (6) d. of Session Law 2015-245, the objective standard that PHP can apply when determining if to refuse a contract to a provider during the credentialing process. PHP Contract, Section III.A.87

- Providers can contact health plans to check on the status of a contract. Contracting contacts for health plans can be found at https://medicaid.ncdhhs.gov/health-plans/health-plan-contacts-and-resources.

WHAT ARE THE HEALTH PLANS RESPONSIBILITIES WITH MEDICAID TIER 3 ADVANCED MEDICAL HOMES (AMH)?

Health plans are required to contract with all AMH Tier 3 practices located in each health plan's region.[4]

WHAT PAYMENTS ARE REQUIRED FOR PROVIDERS AND AMHs?

- Health plans must reimburse physicians and physician extenders no less than 100 percent of Medicaid fee-for-service rates unless they have mutually agreed to an alternative arrangement.[5]
- In addition to fee-for-service payments, health plans must make directed payments to AMHs[6]:
- All AMHs will receive per member per month (PMPM) Medical Home Fees with amounts varying by Tier and category of beneficiary.
- Tier 3 AMHs receive an additional, negotiated Care Management Fee from health plans in exchange for taking on additional care management responsibilities.
- Many AMH practices will also be eligible to earn negotiated Performance Incentive Payments. These payments are optional for Tier 1 and 2 AMHs. Health plans are required to offer opportunities for such payments to Tier 3 AMHs.

HOW WILL PATIENTS CHOOSE OR BE ASSIGNED TO A HEALTH PLAN?

- Beneficiaries will have the option to choose a health plan during the open enrollment period.
- Open enrollment has launched in all 100 counties and ends statewide on December 13, 2019.
- **Beneficiaries may choose a health plan based on whether their preferred provider(s) are in-network.** Beneficiaries who do not actively choose a health plan will be automatically assigned to one based on an algorithm developed by DHHS. DHHS expects most beneficiaries to be auto-assigned into health plans. **Auto-assignment is scheduled to begin the week of December 16,2019.**
    - The health plan auto-assignment algorithm takes into account geographic location, whether a beneficiary is a member of a special population, historic provider relationships, plan assignment for other family members, previous health plan enrollment, and equitable plan distribution.[7]
    - For a provider to be considered in the algorithm for health plan assignment, the provider needs to have an executed contracted that has been fully processed by the health plan and transmitted to DHHS prior to the start of auto assignment on December 16, 2019.

HOW WILL PATIENTS CHOOSE OR BE ASSIGNED TO A PRIMARY CARE PROVIDER (PCP)?

- It is the health plan's responsibility to ensure that each beneficiary has a PCP. Beneficiaries will have the opportunity to select their PCP or will be assigned one by the health plan. Beneficiaries who actively enroll with a health plan during open enrollment will have the opportunity to select a PCP from a list of contracted providers.
- **PCP auto-assignment will occur shortly after health plan auto-enrollment (i.e., mid-December 2019).** The health plan must consider prior PCP assignment, beneficiary claims history, family member PCP assignment, family member claims history, geography, special medical needs, and language/cultural preference.[8]
- Auto-assignment is based on 1) where the beneficiary lives, 2) whether he or she is a member of a special population, 3) *historical provider-beneficiary relationship*, 4) health plan assignments of other family members, and 5)

[4] PHP Contract, Section V.C.6.b.iii.a
[5] PHP Contract, Section V.D.4.d.i.
[6] PHP Contract, Section V.D.4.p
[7] PHP Contract, Attachment M., Section 1.e.vi.3
[8] PHP Contract, Section V.C.6.c.iii

previous health plan enrollment within the past 12 months.

WHAT IS THE SIGNIFICANCE OF PCP ASSIGNMENT?

- PCP assignment determines the flow of PMPM AMH payments (including Medical Home Fees, Care Management Fees, and Performance Incentive Payments) from PHPs to AMHs.
- Providers are still eligible for regular fee-for-service payments from PHPs for patient visits even if the patient is not assigned to them.

WHAT DEADLINES DO PROVIDERS NEED TO KNOW?

- Providers may contract with one or more Medicaid health plans at any time; there are no deadlines for participation as a Medicaid provider with the following exceptions:
    - Providers need to have signed contracts with health plans by November 15, 2019 to be included in auto-enrollment.
    - It takes health plans approximately 2 to 3 weeks to process provider contracts and ensure that providers can be paid.
    - Additional time is then needed to transmit information to DHHS for inclusion in the auto-enrollment process.

WHAT HAPPENS IF I CONTRACT WITH A HEALTH PLAN AFTER MID-NOVEMBER?

- Providers may execute contracts with one or more health plans at any time.
- Providers who do not execute contracts with one or all health plans in time for auto-enrollment (i.e., no later than mid-November) will not receive any auto-assigned patients from those health plans.
- Beneficiaries can change PCP assignment following auto-assignment (described above), but the beneficiary must request such a change from the health plan directly.