

North Carolina Medicaid Transformation: *Key Policies for Providers in Managed Care*

May 9, 2019

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Medicaid Transformation Vision

“ To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health. ”

Context for Medicaid Transformation

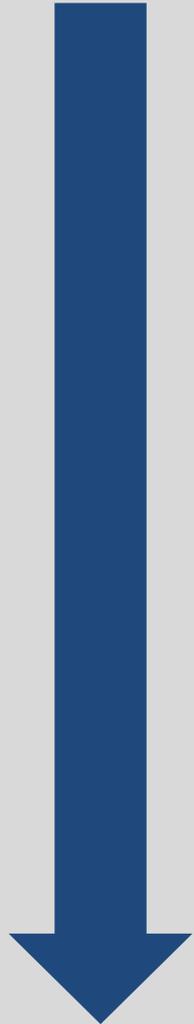
In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service (FFS) to managed care.

Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:

- Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden

Webinar
Focus Area

Medicaid Transformation Timeline



Timeline	Milestone
October 2018	1115 waiver approved
February 2019	PHP contracts awarded
June - July 2019	Enrollment Broker (EB) sends Phase 1 enrollment packages; open enrollment begins
Summer 2019	PHPs contract with providers and meet network adequacy
November 2019	Managed care Standard Plans launch in selected regions; Phase 2 open enrollment
February 2020	Managed care Standard Plans launch in remaining regions

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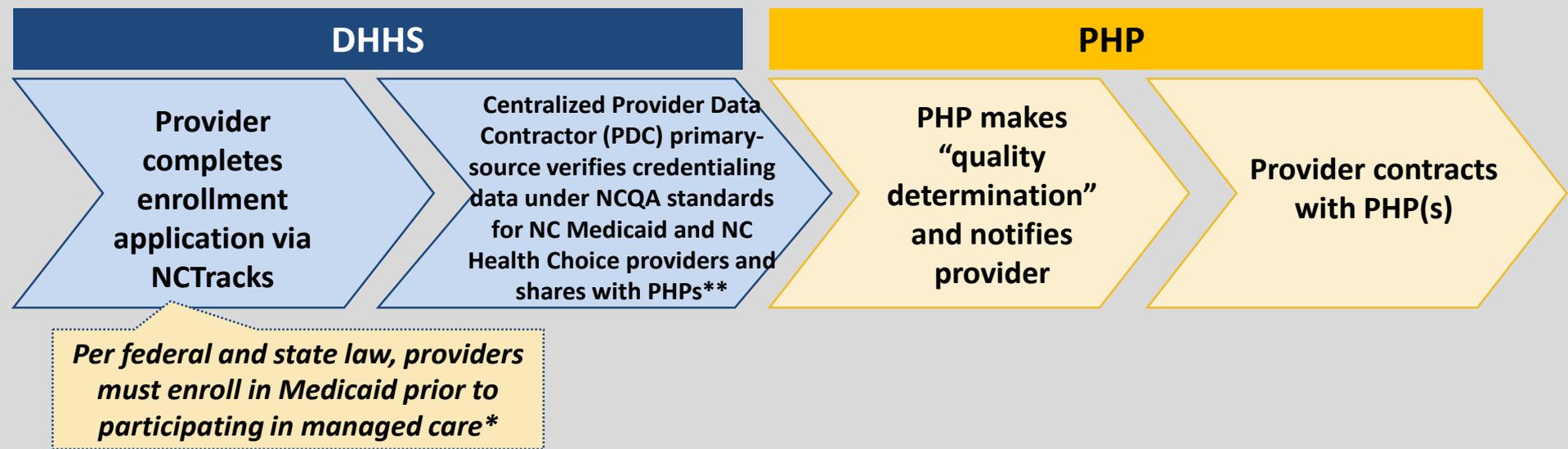
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Provider Enrollment & Centralized Credentialing

Overview of Provider Enrollment & Credentialing Process

To ease administrative burden, North Carolina has developed a centralized credentialing process that supplements the State's existing provider credentialing data and provides a single source of all credentialing information to all PHPs

Provider Credentialing Process



*Federal Rule 42 CFR 438.602 states that Medicaid managed care providers who order, refer, or render covered services must fully enroll as a "billing" provider with the state Medicaid agency by January 1, 2018, to receive payments from managed care plans

**See appendix for additional information

Provider Credentialing Information

NC Medicaid Provider Credentialed File

NC Medicaid Enrollment & Demographic Data

- NPI / Atypical Number
- Service Location
- Correspondence / Contact
- Taxonomy Code(s)
- Medicaid / Health Choice Enrollment Status
- Indicators (AMH Tier, Essential)

Additional Credentialing Data (Individual Providers)

- Work History
- Education
- Malpractice History
- Board Certification
- DEA/ CDS Certification
- Medical Board Sanctions

PHP Quality Determinations

- PHPs must establish a documented process for making quality determinations using objective quality standards; PHPs must make their policies public
- Objective quality standards must:
 - Assess a provider's ability to deliver care;
 - Include specific defined thresholds for adverse quality determinations;
 - Meet standards established by the NCQA; and
 - Not be discriminatory
- PHPs review provider information received from the PDC and the NCTracks enrollment process and make quality determinations based on the objective standards
- PHPs are required to accept verified information from the PDC and may not ask providers for additional credentialing information to make quality determinations
- Providers who receive an adverse quality determination are permitted to appeal to the PHP or re-submit missing and/or incomplete data to the PDC

Quality Determination Timeframe



Timeframe	Milestone
Within 30 – 45 calendar days	PHP to complete quality determination after receiving complete credentialing and verified information
Within 5 business days	Within five business days of PHP's quality determination decision, PHP is to provide written notice to provider
No more than 75 business days	The entire enrollment, credentialing and quality review process should take no more than 75 business days

Support for Provider Credentialing Concerns

- Providers may contact the PDC Help Desk by email or phone to inquire about data provided to the PHPs
- The Help Desk will assist providers with the following:
 - A dispute on the information that was provided
 - Assistance on correction of data that was provided
 - Assistance on providing data for missing information
 - Verifying that the key identifiers used to obtain information were correct
 - Guiding the provider on how to provide additional or updated information

Providers are encouraged to keep their credentialing information up to date in NCTracks

Reminders: Contracting with PHPs

- Once enrolled/credentialed, providers must sign a contract with PHPs to be officially “in network”
 - PHPs are required to contract with “any willing qualified provider” but providers do not need to contract with every PHP
 - DHHS is developing a set of standard contracting provisions that will be included in all contracts between providers and PHPs
 - Contract provisions are still undergoing review with DHHS
 - State has set policies for most payments to providers and for the timeliness of payments
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Provider Networks and Directories

Network Adequacy Standards

Network adequacy standards are an important tool for ensuring that beneficiaries have access to providers

- PHP networks must include “any willing provider” and all “essential providers” in the geographic area*
- North Carolina’s network adequacy standards vary by geographic area and include time and distance standards and appointment wait-time standards
- DHHS will maintain a monitoring and oversight system to ensure PHPs have adequate capacity to provide care to all beneficiaries in their respective service areas

Select PHP Time and Distance Standards		
Provider Type	Urban Standard	Rural Standard
Hospitals	≥ 1 hospital within 30 min. or 15 miles for ≥ 95% of members	≥ 1 hospital within 30 min. or 30 miles for ≥ 95% of members
Primary Care	≥ 2 providers within 30 min. or 10 miles for ≥ 95% of members	≥ 2 providers within 30 min. or 30 miles for ≥ 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 min. or 15 miles for ≥ 95% of members	≥ 2 providers (per specialty type) within 60 min. or 60 miles for ≥ 95% of members
All State Plan LTSS (excludes nursing facilities)	≥ 2 LTSS provider types with distinct NPIs accepting new patients available to deliver each State Plan LTSS service in every county	≥ 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers not required to live in same county in which they provide services
Inpatient Behavioral Health	≥ 1 provider of each inpatient behavioral health service within each PHP region	

*Essential provider include: FQHCs, rural health centers, free/charitable clinics, State veterans homes, and local health departments.

Other Network Standards

- Out-of-network services generally require PHP prior approval
 - PHPs must provide coverage of out-of-network services for a beneficiary if their network is unable to provide the needed, covered service on a timely basis
 - PHPs must provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provider women's routine and preventive health care service
 - PHPs must provide direct access to family planning providers regardless of network status without prior approval
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PHP Provider Directories

- PHPs must maintain a consumer-facing provider directory of all network providers both online and in written formats
 - Though PHPs cannot ask providers for additional credentialing data, they may ask providers for certain information for use in the provider directory, for example:
 - Address of service location
 - Provider linguistic capabilities
 - Whether the provider is accepting new beneficiaries
 - Providers are responsible for updating demographic information with **each contracted PHP**
 - PHPs must update the online directory within 10 business days of receiving a provider's updated information
 - PHPs must share provider directory information with the Enrollment Broker on a daily basis for its Consolidated Provider Directory to support PHP choice counseling and selection
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PHP Provider Relations and Engagement

PHP On-Boarding Resources for Providers

- Each PHP will operate a provider relations division to provide training and education on PHP-specific clinical and administrative practices, as well as to answer provider questions
 - Within 5 days of contracting, providers will receive an enrollment notice and “Welcome Packet” with orientation information and instructions to access the PHP’s Provider Manual
 - The PHP’s Provider Manual will provide information and education about the PHP and Medicaid managed care on numerous topics, including:
 - Clinical practice standards and utilization management program;
 - Member rights and responsibilities; and
 - Provider appeals and grievance processes
 - Within 30 days of contracting, providers will receive training on PHP prevention and population health management programs, among other topics
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PHP Resources for On-Going Provider Support

- PHPs will provide the following resources to providers:



Provider Service Line: Assists with issues including: enrollment, service authorization and reimbursement.

- Service line staff will be trained on PHP requirements/policies and be able to respond to all areas within the Provider Manual including resolving claims payment inquires in “one-touch”



Web-Based Portal: Provides access to program and provider-specific information, including the Provider Manual

- DHHS will roll out **provider surveys** to ensure provider satisfaction and compliance with applicable performance standard metrics as outlined in the provider/PHP contract
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Provider Grievances & Ombudsman

Provider Grievances vs. Provider Appeals

PHPs are required to have both formal grievance and appeals processes

Grievances are issues that providers bring to the PHP for which remedial action is not requested, whereas **appeals** are when providers challenge certain PHP decisions

Examples	
Grievances <ul style="list-style-type: none">• Provider information is inaccurate in PHP directory• Provider is dissatisfied with the resolution of payment dispute	Appeals <ul style="list-style-type: none">• PHP denies a pre-authorization request for a service• PHP does not permit a provider to join their network due to quality issues

Overview: Provider Grievances

- PHPs must handle provider grievances promptly, consistently, fairly, and in compliance with state and federal law and DHHS requirements
 - Providers will be able to submit grievances through the PHP provider portal; PHPs must also accept grievances referred from DHHS
 - Provider grievances must be resolved in a timely manner
 - There is no formal appeals process to the State for grievances but PHPs must share information about the types and frequency of provider grievances with DHHS
 - DHHS will monitor provider grievances for broad and recurring issues but will not review individual provider grievances
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Overview: Provider Appeals

- DHHS has outlined requirements, including timeframes, for how PHPs must handle provider appeals; DHHS will review PHPs' provider appeals policies
 - Providers have the right to appeal certain actions taken by the PHP, including:
 - Program integrity related findings or activities
 - Finding of fraud, waste, or abuse by the PHP
 - Finding of or recovery of an overpayment by the PHP*
 - PHP will establish a committee to review and make decisions about appeals
 - Providers will be able to submit appeals through the provider portal
 - Providers must exhaust the PHP internal appeals process before seeking recourse under any other process permitted by contract or law
 - Providers have the right to be represented by an attorney during appeals process
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Provider Appeals Timeline

- Providers have **30 calendar days** to appeal a PHP decision (based on when provider receives written decision notice or when PHP should have taken a required action)
- Within **5 calendar days** of PHPs receiving appeal request, providers will receive acknowledgement from PHP of request
- PHPs must provide written notice of Committee's appeal decision within **30 calendar days** of receiving complete appeal request
 - Committee must include external peer reviewer when appeal involves whether provider met objective quality standards
 - Notice must include information about future appeals rights, if any

PHP may extend timeframe by 30 days for "good cause reasons" including voluminous nature of required evidence/supporting documentation and appeal of an adverse quality decision

Appeals of Suspension or Withhold of Provider Payment

- PHPs will limit issue on these appeals to whether PHP had good cause to withhold or suspend provider payment and will not address whether provider has/has not committed fraud or abuse
- PHP will notify DHHS within **10 business days** of suspension or withhold of provider payment
- PHPs must offer providers an in-person or telephone hearing when provider is appealing whether PHP has good cause to withhold or suspend payment
- Within **15 business days** of receiving provider's appeal, PHP must schedule hearing and issue written decision about whether PHP had good cause to suspend/withhold payment
- If no good cause is found, PHP will reinstate any suspended or withheld payments within **5 business days** and pay interest and penalties
- Within **5 business days**, PHPs must notify DHHS of any provider appeal regarding payment suspension/withhold, finding/recovery of an overpayment, or action related to fraud, waste, or abuse or if a provider has sued the PHP

Provider Ombudsman

- DHHS will make a provider Ombudsman service available where a provider may submit a complaint about a PHP
- Provider manual must notify providers of the Ombudsman service and include instructions on how providers can submit complaints

Additional information will be provided at a later date

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More Opportunities for Engagement

DHHS values input and feedback and is making sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website:
<https://www.ncdhhs.gov/assistance/medicaid-transformation>
- Comments, questions, and feedback are all very welcome at
Medicaid.Transformation@dhhs.nc.gov

Providers will receive education and support during and after the transition to managed care.



Upcoming Events

Upcoming Managed Care Webinar Topics

- **Beneficiary Policies (5/16)**
- **Behavioral Health Services: Standard Plans and Transition Period (5/23)**
- **AMH Contracting with PHPs (5/30)**
- **Clinical Policies (6/13)**
- **Healthy Opportunities in Medicaid Managed Care (6/27)**

Other Upcoming Events

- **Virtual Office Hours (VOH):** Running bi-weekly, as of April 26th
- **Provider/PHP Meet and Greets:** Regularly hosted around the State

Schedule for VOH and Meet & Greets available on the [Provider Transition to Managed Care Website](#)

Look out for more information on upcoming events and webinars distributed regularly through special provider bulletins

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Q&A

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PDC Credentialing Data for Individual Providers

- **For Individual Providers**, the PDC may provide the following:
 - Education and Training (highest level)
 - Board Certification (current board status)
 - Malpractice History/Liability Insurance (past 5 years)
 - Work History (past 5 years)
 - DEA or CDS Certification
 - Licensure
 - State Licensing Board Sanctions (past 5 years)
 - Medicare/Medicaid Sanctions (past 5 years)
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PDC Credentialing Data for Facility Providers

- **For Facility Providers**, the PDC may provide the following:
 - Liability Insurance (verification of effective and expiration dates and coverage amounts)
 - Evidence of accreditation from the Joint Commission or other appropriate accrediting body
 - **For Facility Providers without Accrediting bodies**, the PDC may provide the following:
 - Information on Quality Management Program
 - Reports on Disciplinary Action from the last 5 years
 - Letters of Recommendation attesting to quality or cost effectiveness of care
 - Documented Policies for coverage arrangements or onsite quality assessment on Quality Management Program
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Criteria for Provider Appeals

Reference Number	Appeal Criteria
For Network Providers	
1	A network provider has the right to appeal certain actions taken by the PHP. Appeals to the PHP shall be available to a network provider for the following reasons:
a)	Program Integrity related findings or activities;
b)	Finding of fraud, waste, or abuse by the PHP;
c)	Finding of or recovery of an overpayment by the PHP;
d)	Withhold or suspension of a payment related to fraud, waste, or abuse concerns;
e)	Termination of, or determination not to renew, an existing contract based solely on objective quality reasons outlined in the PHP's Objective Quality Standards as described in <i>Section V.D. Providers</i> of the RFP, as provided under Section 5.(6)d. of Session Law 2015-245, as amended;
f)	Termination of, or determination not to renew, an existing contract for LHD care/case management services;
g)	Determination to lower an AMH provider's Tier Status; and
h)	Violation of terms between the PHP and provider.
For Out-of-network Providers	
2	An out-of-network provider may appeal certain actions taken by the PHP. Appeals to the PHP shall be available to an out-of-network provider for the following reasons:
a)	A determination to not initially credential and contract with a provider based on objective quality reasons outlined in the PHP's Objective Quality Standards as described in <i>Section V.D. Provider</i> , and as provided under Section 5.(6)d. of Session Law 2015-245, as amended;
b)	An out-of-network payment arrangement;
c)	Finding of waste or abuse by the PHP; and
d)	Finding of or recovery of an overpayment by the PHP.