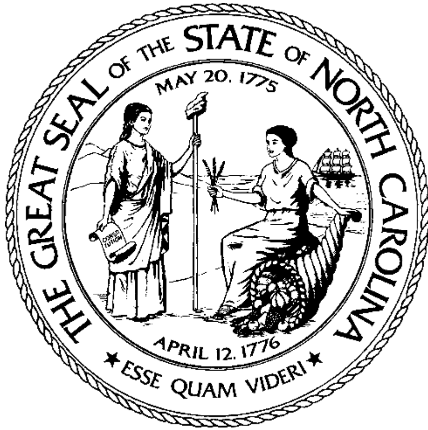


Provider Transition to Medicaid Managed Care 101

March 28, 2019

Contents

- **Medicaid Transformation Vision and Context**
- **Overview of Key Initiatives**
- **Deep Dive: Managed Care**
- **More Opportunities for Engagement**
- **Q&A**

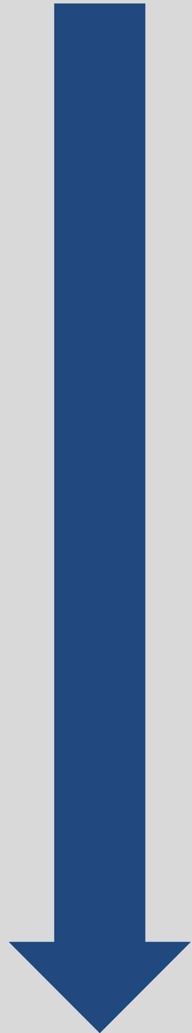
Medicaid Transformation Vision

"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 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

Medicaid Transformation Timeline



Timeline	Milestone
October 2018	1115 waiver approved
February 2019	PHP contracts awarded
June - July 2019	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

Contents

- **Medicaid Transformation Vision and Context**
- **Overview of Key Initiatives**
  - Managed Care
  - Advanced Medical Homes
  - Quality and Value
  - Behavioral Health Integration
  - Opioid Strategy
  - Healthy Opportunities
- **Deep Dive: Managed Care**
- **More Opportunities for Engagement**
- **Q&A**

Overview of Managed Care

The majority of Medicaid and NC Health Choice beneficiaries will receive Medicaid through Prepaid Health Plans (PHPs).

- NC Medicaid providers will contract with and be reimbursed by PHPs rather than the State directly
- Two types of PHPs:
  - Commercial plans
  - Provider-led entities
- Two types of products:
  - Standard Plans for most beneficiaries; scheduled to launch in 2019–2020
  - Tailored Plans for high-need populations; will be developed in later years
- Continued focus on high-quality, local care management

Note: Certain populations will **continue to receive fee-for-service (FFS) coverage** on an ongoing basis.

Beneficiary Eligibility for Managed Care

The majority of Medicaid beneficiaries will transition to standard plans beginning in November 2019. Other populations will have delayed enrollment or will be exempt or excluded from managed care (remaining in FFS coverage):

Excluded from Medicaid Managed Care:

- Partial dual eligibles
- Qualified aliens subject to the five-year bar
- Undocumented aliens
- Medically needy
- Presumptively eligible, during the period of presumptive eligibility
- Health Insurance Premium Payment (NC HIPP) program
- Family planning
- Inmates of prisons
- Community Alternatives Program for Children (CAP/C)**
- Community Alternatives Program for Disabled Adults (CAP/DA)**
- Program of All-Inclusive Care for the Elderly (PACE)

Delayed until Behavioral Health Intellectual/Developmental Disability (BH I/DD) Tailored Plan launch:

- Qualifying beneficiaries with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or a traumatic brain injury*

Temporarily excluded for up to 5 years:

- Beneficiaries with long-term nursing facility stays
- Dual eligibles

Exempt from Medicaid Managed Care:

- Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI)

*DHHS is in the process of finalizing eligibility criteria for the BH I/DD TPs; **Will require legislative change

PHPs for NC Medicaid Managed Care

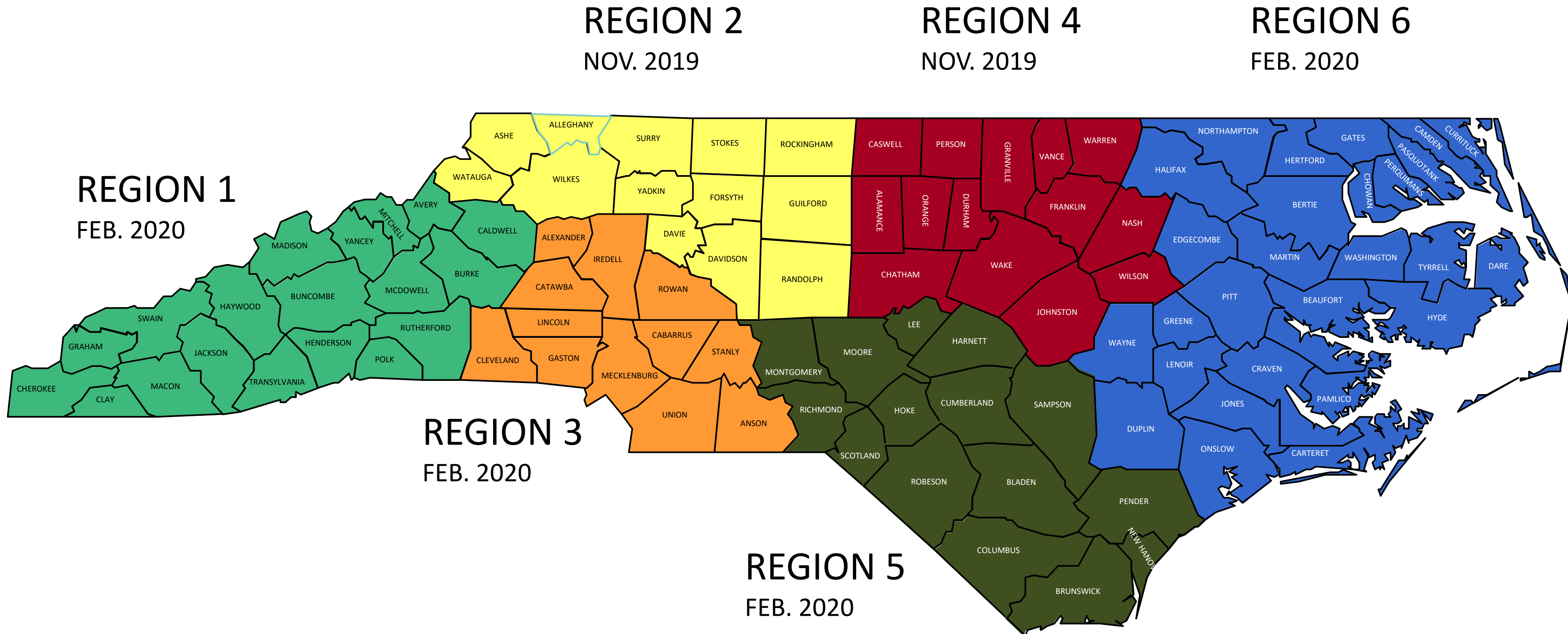
Four Statewide PHP Contracts

- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina, Inc.
- UnitedHealthcare of North Carolina, Inc.
- WellCare of North Carolina, Inc.

One Regional Provider-Led Entity

- Carolina Complete Health, Inc. (Regions 3 and 5)

NC Medicaid Managed Care Regions and Rollout Dates



Rollout Phase 1: Nov. 2019 – Regions 2 and 4

Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6

Contract Year 1 runs through June 30, 2020 for all regions

Advanced Medical Homes

The AMH program provides a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations.

Goals of AMH Program

- Preserve broad access to primary care services for Medicaid enrollees
- Strengthen the role of primary care in care management, care coordination, and quality improvement
- Allow practices to implement a unified approach to serving Medicaid beneficiaries, minimizing administrative burden
- Provide clear financial incentives for practices to become more focused on cost and quality outcomes for populations, increasing accountability over time

Overview of the AMH Program

The AMH Program will serve as the primary vehicle for delivery of local care management under Medicaid managed care.

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Practices will need to interface with multiple PHPs**, which may employ different approaches to care management

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors

Tier 3

- PHP delegates primary responsibility for care management to the AMH
- Practice must meet all Tier 1 and 2 requirements, plus additional Tier 3 care management responsibilities
- Practices will have the option to **provide care management in-house** or **through a single CIN/other partner** across all Tier 3 PHP contracts

*PHPs should **attempt to contract with all certified Tier 3 AMHs** and must **demonstrate a contract with at least 80% of certified Tier 3 AMHs** in each of the PHP's regions.*

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors
- **PMPM Care Management Fees**
  - Negotiated between PHP and practice
- **Performance Incentive Payments**
  - Negotiated between PHP and practice
  - Based on AMH measure set

Note: Tier 4 will launch on a later date and will allow practices to enter more innovative, advanced payment arrangements.

Working with CINs and Other Partners in the AMH Program

AMHs may choose to work with Clinically Integrated Networks (CINs) or other partners* to assist in the fulfilment of AMH practice requirements.

CINs/Other Partner May:

- Provide **local** care coordination and care management functions and services
- Support **AMH data integration** and **analytics tasks** from multiple PHPs and other sources, and providing **actionable reports** to AMH providers
- Assist in the **contracting process** on behalf of AMHs

Although the majority of AMH Tier 3 practices may elect to contract with CINs/other partners for support, practices are not required to do so.

Contracting with CCNC (or any CIN or other partner) is not a requirement of participation in the AMH program at any tier level.

* Regardless of whether such organizations meet federal standards for clinical integration.

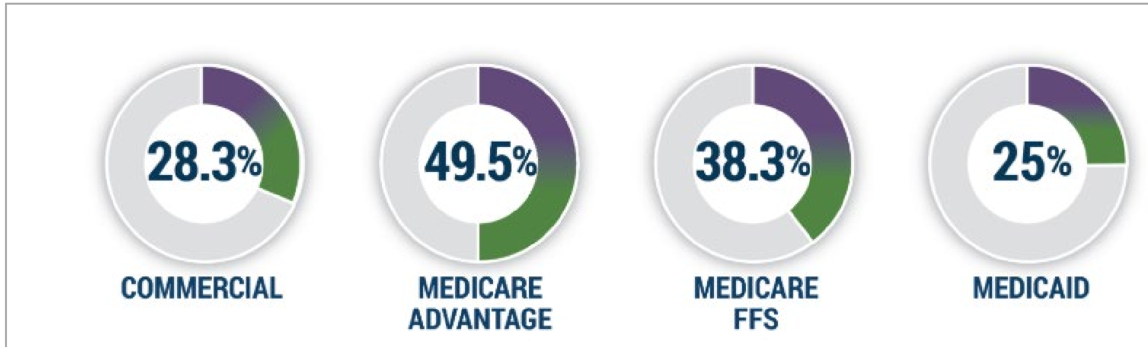
Shift to Value-Based Payment is Well Underway Nationally and in North Carolina

North Carolina Medicaid's increasing focus on value-based payment (VBP) is part of a broader shift in payment models across payers.

National Landscape

- **34%** of U.S. healthcare payments were "value-based" in 2017, up from **23%** in 2015, according to research conducted by the Healthcare Payment Learning and Action Network (HCP-LAN).*
- Value-based arrangements were most common in Medicare but are widespread across payers.

Percentage of Healthcare Payments in Level 3 or 4 Payment Models by Payer (2017)



*Payments categorized as level 3 (alternative payment models built on FFS architecture with upside/downside risk) or 4 (population based payment) under the Healthcare Payment Learning and Action Network (HCP-LAN) alternative payment model framework.

North Carolina

- Major NC health systems are signing value-based arrangements across payers.

"Blue Cross NC and Five Major Health Systems Announce Unprecedented Move to Value-Based Care"
-BCBSNC, 1/2019

"Blue Cross NC, UNC Health Alliance Agreement Lowers Triangle ACA Rates by More Than 21 Percent"
- Business Wire, 8/2018

"Duke Physician-Led Network Exceeds Quality Standards, Saves Medicare Millions"
-Duke Health, 9/2018

Source: "APM Measurement: Progress of Alternative Payment Models", HCP-LAN, 2018. Survey responses were voluntary.

Promoting Value, Quality and Population Health

DHHS is developing a longer-term VBP Roadmap and expects that more advanced providers and systems will take advantage of opportunities to build infrastructure for higher-risk arrangements in the early years of managed care implementation.

Value-Based Payments

- By end of Year 2, PHPs' expenditures governed under VBP arrangements must:
  - Increase by 20 percentage points, OR
  - Represent at least 50% of total medical expenditures
- State's expectations related to VBP and capabilities of AMH practices will increase over time
- The AMH program represents an opportunity for providers—especially larger practices and those affiliated with health systems—to fund population health investments that will be critical in a VBP environment

Ensuring Quality

- Though the Quality Strategy, PHPs will be monitored on 33 priority quality measures against national benchmarks and state targets
- DHHS will require that PHPs implement annual Quality Improvement Projects

Behavioral Health Integration

As part of Medicaid transformation, physical and behavioral health benefits will be administered by one managed care plan, under two types of products: Standard Plans and BH I/DD Tailored Plans.

Behavioral Health Integration in Standard Plans

Standard plans will offer integrated physical and behavioral health services upon managed care launch.

The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower-intensity behavioral health needs, will receive integrated physical health, behavioral health, and pharmacy services through Standard Plans when managed care launches.

Standard Plans will offer a robust set of benefits, but certain higher-intensity behavioral health, I/DD, and TBI benefits will only be offered under Tailored Plans.

Rationale for Integration

Currently, NC Medicaid beneficiaries have their behavioral health benefit administered separately from their physical health benefit through LME-MCOs.

Integrating behavioral and physical health benefits will better enable care managers and providers to deliver **coordinated, whole-person care**.

What is a BH/IDD Tailored Plan (TP)?

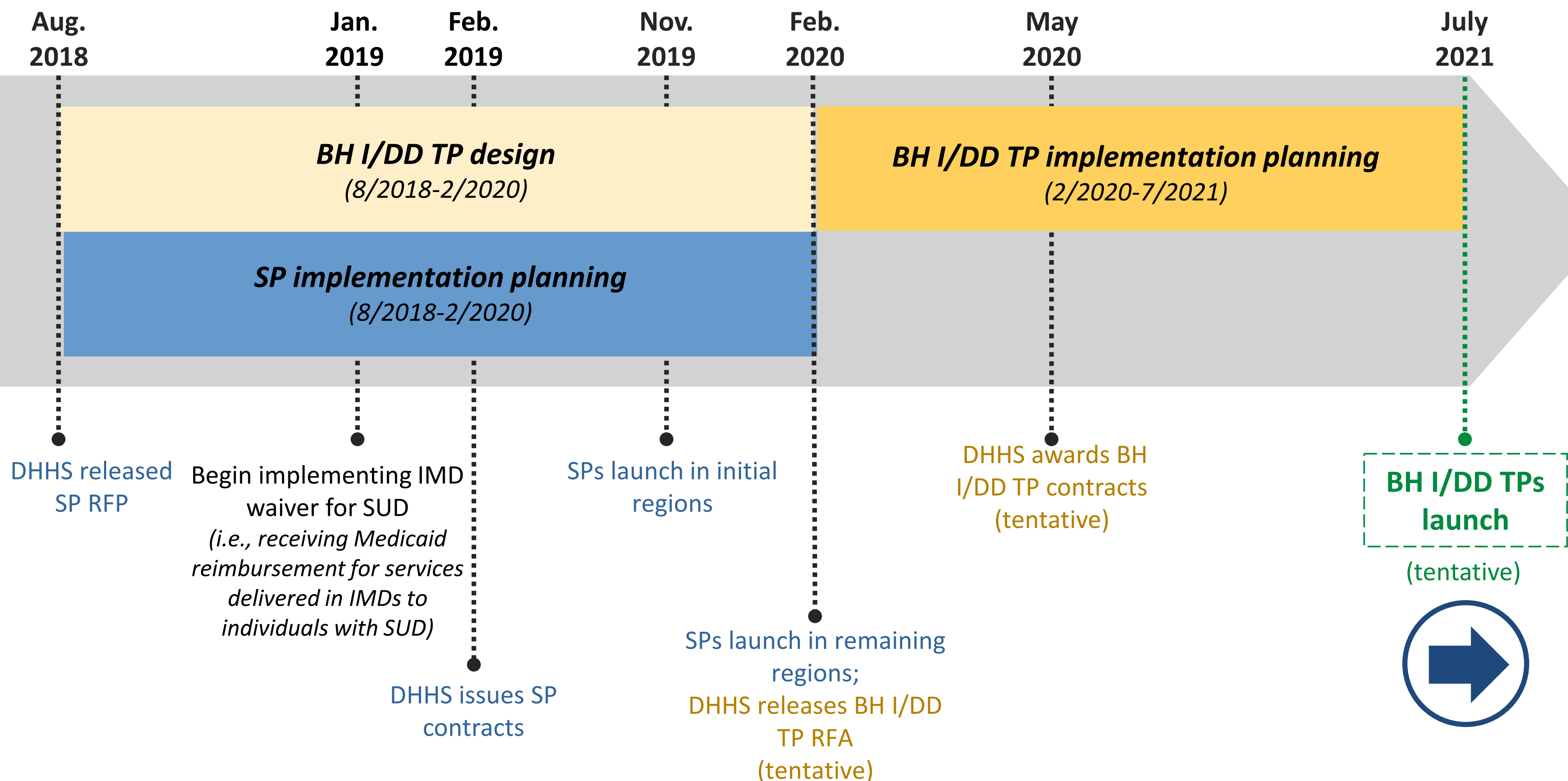
North Carolina will launch specialized managed care plans, called BH/IDD Tailored Plans, starting in 2021; design of these plans is just beginning.

Key Features of BH/IDD Tailored Plans:

- TPs are designed for those with significant behavioral health (BH) needs and/or intellectual/developmental disabilities (I/DDs)
- TPs will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members
- TP contracts will be regional, not statewide
- LME-MCOs are the only entities that may hold a TP contract during the first four years; after the first four years, any non-profit PHP may also bid for and operate a TP
- LME-MCOs operating TPs must contract with an entity that holds a prepaid health plan (PHP) license and that covers the same services that must be covered under a standard benefit plan contract
- TPs will manage State-funded behavioral health, I/DD, and TBI services for the uninsured and underinsured

TP Design and Launch Timeline

DHHS is currently conducting intensive planning for both Standard Plans (SPs) and TPs. After SPs launch, DHHS will continue implementation planning for TPs.



Opioid Strategy

Description

As part of the State's comprehensive strategy to address the opioid crisis, North Carolina will:

(1) Increase access to inpatient and residential substance use disorder treatment by expanding reimbursement for SUD services provided in institutions of mental disease (IMDs), and

(2) Expand the SUD service array to ensure the State provides the full continuum of services.

Impact

Strengthens the State's ability to improve care quality and outcomes for patients with substance use disorders, including by decreasing the long-term use of opioids and increasing the use of medication-assisted treatment (MAT) and other opioid treatment services.

Healthy Opportunities in Medicaid Transformation

North Carolina is committed to improving health outcomes and lowering healthcare costs by delivering "whole person" care and addressing non-medical factors of health.

Embedding Healthy Opportunities in the Managed Care Program:

- All PHPs will have a role in addressing non-medical factors that drive health outcomes and costs, including:
  - Screening for non-medical needs
  - Connecting beneficiaries to community resources using North Carolina's new platform for closed loop referrals, NCCARE360
  - Providing additional support for high-need cases, such as assisting members who are homeless in securing housing

Healthy Opportunities Pilots:

- PHPs in two to four geographic areas of the state will work with their communities to implement the "Healthy Opportunities Pilots," as approved through North Carolina's 1115 waiver.*
- Pilots will test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress for eligible Medicaid beneficiaries.

*For additional detail on North Carolina's Approved 1115 waiver, please visit DHHS informational 1115 wavier website, available at: https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design

Contents

- Medicaid Transformation Vision and Context
- Overview of Key Initiatives
- **Deep Dive: Managed Care**
  - Standardization
  - Plan and PCP Selection
  - Credentialing
  - Network Adequacy
  - Oversight
  - Payment
- More Opportunities for Engagement
- Q&A

Standardization

DHHS has worked to mitigate administrative burden for clinicians.

PHPs will be subject to requirements designed to ease clinician administrative burden, including:

- 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
- Standardizing quality measures across PHPs
- Using standard prior authorization forms
- Establishing a single statewide preferred drug list that all PHPs will be required to use
- Covering the same services as Medicaid Fee-for-Service (except select services carved out of managed care)
- Requiring PHPs to use DHHS' definition of "medical necessity" when making coverage decisions and set FFS benefit limits as a floor in managed care

Plan Selection and Auto-Assignment

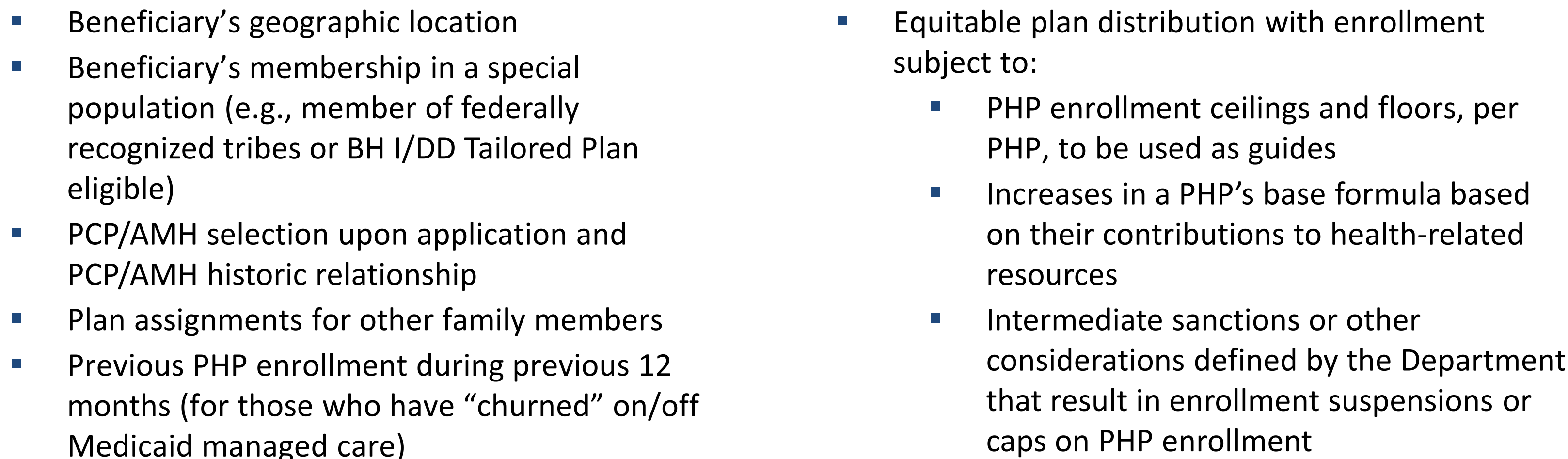
DHHS will conduct extensive outreach to encourage beneficiary plan selection and will auto-assign those that do not choose a plan according to a transparent process.

Plan Selection

DHHS, in partnership with enrollment broker (Maximus), will provide choice counseling, enrollment assistance and education to beneficiaries. Maximus will work with county departments of social services to educate beneficiaries at local level.

Plan Auto-Assignment

The State will auto-assign all beneficiaries who do not select a plan according to the following algorithm:



- Beneficiary's geographic location
- Beneficiary's membership in a special population (e.g., member of federally recognized tribes or BH I/DD Tailored Plan eligible)
- PCP/AMH selection upon application and PCP/AMH historic relationship
- Plan assignments for other family members
- Previous PHP enrollment during previous 12 months (for those who have "churned" on/off Medicaid managed care)
- Equitable plan distribution with enrollment subject to:
  - PHP enrollment ceilings and floors, per PHP, to be used as guides
  - Increases in a PHP's base formula based on their contributions to health-related resources
  - Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment

Beneficiaries have 90 days after PHP enrollment to switch PHPs "without cause." After 90 days, beneficiaries may switch PHPs at annual redetermination.*

Note: *Certain populations may be able to change PHPs more frequently. Additionally, beneficiaries may change PHPs "with cause" at any time. More details available in enrollment broker RFP, available at: https://files.nc.gov/ncdma/documents/Transformation/RFP%2030-180090%20-%20Enrollment%20Broker%20Services%20-%20Final%20%283-2-18%29.pdf

AMH/PCP Selection and Auto-Assignment

Under managed care, enrollees may choose their AMH/primary care provider (PCP) or they will be auto-assigned.

AMH/PCP Selection

- The enrollment broker (Maximus) will provide beneficiaries with information and assistance in selecting their AMH/PCP at the time of PHP enrollment.
- Subsequent changes to AMH/PCP assignment are managed by the beneficiary's PHP. Enrollees can change their AMH/PCP **without cause** within 30 days of notification of assignment, and up to one additional time every 12 months; enrollees may change their AMH/PCP **with cause** at any time.

AMH/PCP Auto-Assignment

- Enrollees that do not select a AMH/PCP during the plan selection period will be assigned a AMH/PCP by the PHP in which they enroll.
- All enrollees will have a 30-day "grace period" after notification of their AMH/PCP assignment to change their AMH/PCP without cause.
- AMH/PCP auto-assignment will consider:
  - Enrollee claims history
  - Family member PCP assignment
  - Geography
  - Special medical needs
  - Language/cultural preference

Provider Enrollment and Credentialing

Credentialing is a critical part of the federally regulated screening and enrollment process. A centralized approach will reduce administrative burden on providers and maximize efficiency among plans.

- Enrollment process similar to today
- Centralized credentialing and recredentialing policies uniformly applied
- Nationally recognized, third-party credentials verification organization (CVO)

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

*Source: 2016 Medicaid Managed Care Final Rule; 21st Century Cures Act

Centralized Credentialing

APPLICATION & VERIFICATION

DHHS Process

Provider applies

- Application is single point-of-entry for all credentialing information
- Medicaid Managed Care and Medicaid Fee-for-Service

PDM/CVO verifies credentials

- PDM/CVO certified by national accrediting organization (e.g., NCQA, URAC)
- Ensures meaningful, rigorous, and fair processes

PROCUREMENT & CONTRACTING

PHP Process

PHP PNPC reviews & approves/denies

- PHP Provider Network Participation Committee (PNPC)
- Established and maintained by PHP
- Reviews and makes objective quality determinations
- Cannot request more information for quality determinations
- Meets nationally recognized accrediting organization standards

PHP and provider negotiate contract

- PHP network development staff secures contracts with providers credentialed and enrolled in Medicaid

Network Adequacy

Network adequacy standards help ensure beneficiaries have access to providers and care.

- North Carolina's network adequacy standards vary by geographic area and include **time and distance standards*** and **appointment wait-time standards**
- PHPs are required to contract with "any willing provider" unless the provider refuses to accept the PHP's rates or does not meet the PHP's quality standards
- The PHP's network must provide adequate access for all beneficiaries, including those with limited English proficiency or physical or mental disabilities

Provider Type	Urban Standard	Rural Standard
Hospitals	≥ 1 hospital within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospital within 30 minutes or 30 miles for at least 95% of members
Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Inpatient BH	≥ 1 provider of each inpatient behavioral health service within each PHP region	

*Partial list of standards listed in table; complete list can be found in PHP RFP, available at: https://www.ncdhhs.gov/request-information

Oversight

The State will perform rigorous oversight of PHPs.

- **PHPs are required to report on compliance** with network access, claims payment, and other programmatic requirements that ensure high quality care delivery.
- DHHS will monitor for compliance, identify trends, and impose corrective actions where needed. PHP contracts will include penalties for noncompliance, from **corrective action plans/training** to **sanctions, liquidated damages, and contract termination.**
- DHHS must **approve each PHP's provider appeals and grievances process**, and PHPs must share information with DHHS on provider appeals and grievances, once implemented.
- A State **provider ombudsman** will be available to assist when a grievance is still unresolved after exhausting the PHP's appeals process.

Oversight, Continued

The State will closely monitor PHP utilization management policies to ensure beneficiaries receive needed services and that providers are paid appropriately.

- PHPs are required to report claims submitted and denied payment as part of encounter data. DHHS will analyze denied payments for patterns suggesting inappropriate denials.
- DHHS will monitor PHP prior authorization on a regular basis (e.g. volume, # of adverse determinations, etc.)
- PHP UM policies must use Medicaid FFS benefit limits as a floor and must leverage nationally recognized clinical practice guidelines and decision support methodologies.
- PHPs will submit UM policies to DHHS for approval and will be subject to NCQA review as part of plan accreditation.

Department seeks ongoing feedback from providers flagging whether certain plans or codes are related to higher denial rates.

Provider Payment

PHPs will be required to contract with "any willing qualified provider."
PHP payment rates to most in-network providers will be subject to rate floors.

In-Network Payment

- PHPs are required to contract with "any willing qualified provider" unless the provider refuses to accept the PHP's rates or does not meet the PHP's objective quality standards.
- Payment to in-network hospitals, physicians, and physician extenders must be no less than 100% of the Medicaid fee-for-service rate, unless the PHP and provider mutually agree to an alternative reimbursement arrangement.
- Special payment provisions apply to certain provider types, such as local health departments, public ambulance providers, and FQHCs; additional details will be provided in future webinars.

Out-of-Network Payment

- PHPs are prohibited from paying out-of-network providers that refused to accept a PHP contract or failed to meet objective quality standards more than 90% of the Medicaid FFS rate.
  This *excludes* emergency and post-stabilization services, which are to be reimbursed at no more than 100% of the Medicaid FFS rate.
- PHPs must reimburse out-of-network providers 100% of the Medicaid FFS rate if the provider was excluded for reasons other than the above.

Gradually Transitioning Hospital Payments to Value

The current system of Medicaid supplemental payments is not permitted in managed care and is not aligned with value. As a first step toward value-based payment, most supplemental payments will be carved into base rates, directly tying most hospital payments to utilization.

- Dollars previously paid through supplemental payments will be reinvested in higher hospital base payment rates to preserve payment levels.*
- Medicaid managed care plans will be required to pay no less than these new, higher base rates for at least the first three contract years (longer for hospitals in economically distressed counties.)**
- Hospitals receive an additional amount in the form of directed or pass-through payments to offset approximately 40% of projected utilization losses due to uncertainty during the transition to managed care. These additional payments phase out over the first three contract years.

North Carolina hospitals have played a leading role in developing the new approach, including the methodology to set higher base rates, the approach to graduate medical education payments, and changes to hospital assessments.

*Note: Does not include DSH or GME payments, which will be paid directly from the State to hospitals.

**Note: The rate floor for in network, out-of-state hospitals will remain at the current Medicaid FFS rate of $2,704.50.

Contents

- Medicaid Transformation Vision and Context
- Overview of Key Initiatives
- Deep Dive: Managed Care
- **More Opportunities for Engagement**
- Q&A

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

- **Provider Payment and Contracting**
- **Overview of Quality and Value Initiatives**
- **Clinical Policies**
- **Provider Policies**
- **Beneficiary Policies**
- **Behavioral Health Services: Standard Plans and Transition Period**

Other Upcoming Events

- **Virtual Office Hours:** Weekly, beginning in Spring, 2019
- **Provider/PHP Meet and Greets:** beginning in Spring, 2019

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

Q&A