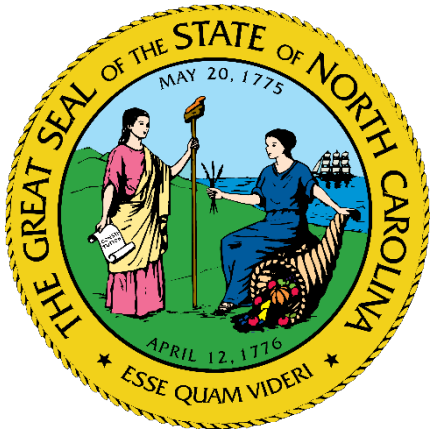

North Carolina's Transition to Managed Care

Virtual Office Hours

June 11, 2019

Agenda

- Introduction
- Fee for Service Fee Schedules/Rate Floors
- Provider Contracting, Network Adequacy, Appeals and Grievances (Provider and Member)
- Resources

Questions?

PLEASE ENTER ALL QUESTIONS INTO THE CHATBOX AND SEND ONLY TO:

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Fee for Service Fee Schedules/Rate Floors

Important Links

PHP shall maintain its own services web page available to providers, members and the Department.

Fee Schedules are published on the Department's website at:
https://medicaid.ncdhhs.gov/providers/fee-schedule-index

Medicaid State plan:

https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

Payment Standards/In-Network

Provider Type/Service	Policy
In-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants)	No less than one hundred percent (100%) their respective Medicaid Fee-for-Service Fee Schedule rate or bundle, as set by the Department, unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.
Hospitals **(Excluding Behavioral Health Claims)**	
In-network hospital inpatient	One hundred percent (100%) of the hospital specific Medicaid Fee-for-Service reimbursement rate using the Medicaid Fee-for- Service case weights and outlier methodology.

Payment Standards/In-Network

Provider Type/Service	Policy
Hospitals (Excluding Behavioral Health Claims)	
In-network Hospital Outpatient	The applicable rate floor and methodology for outpatient hospital services, including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.

Hospital Rate Floors

The hospital rate floors shall apply for the following defined time periods, after which the PHP will have flexibility to negotiate reimbursement arrangements with the hospitals:

- The first five (5) contract years for critical access hospitals and hospitals in economically depressed counties as defined by the Department.
- The first three (3) contract years for all other hospitals.

Payment Standards/In-Network

Provider Type/Service	Policy
Nursing Facilities (excluding those owned and operated by the State)	For a period of time to be defined by the Department, the PHP shall reimburse in-network nursing facilities (excluding those owned and operated by the State): A rate that is no less than the Medicaid Fee-for- Service rate in effect six (6) months prior to the start of the capitation rating year (e.g., January 1 prior to a July 1 rating year), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

Payment Standards:

Provider Type/Service	Policy
Federally qualified health centers (FQHCs) and Rural health centers (RHCs)	The rate floor for each FQHC/RHC rate will be their respective Medicaid FFS Fee Schedule rate, and rates for all ancillary services (i.e. radiology, etc.) will be the based on the Medicaid Physician fee schedule

Payment Standards:

Provider Type/Service	Policy
Public ambulance providers	The PHP shall negotiate base reimbursement amounts to in-network public ambulance providers no lower than rates paid to non-public providers for similar services. In addition to base reimbursements, the PHP shall make additional utilization-based payments to in-network public ambulance providers for Medicaid Members, only, (not NC Health Choice Members) as defined by the Department The PHP shall pay the negotiated base reimbursement to in-network public ambulance providers, which will serve as payment in full, for NC Health Choice.

Payment Standards:

Provider Type/Service	Policy
Local Health Department (LHD)	The PHP shall negotiate base reimbursement amounts to in-network LHDs that are no less than one hundred percent (100%) of their respective **Medicaid** Fee-for-Service Fee Schedule rate, as set by the Department. The rate floor for Lab fee reimbursement shall be based on the **Medicare** fee schedule. The PHP shall reimburse in-network local health departments' enhanced role registered nurses providing EPSDT well child exams, STD exams, low-risk family planning, and obstetrical services according to the enhanced local health department Medicaid fee schedule (as allowed under 42 C.F.R. § 438.6(c)).

Questions?

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Provider Contracting, Network Adequacy, Appeals and Grievances (Provider and Member)

PHP – Provider Contracting

- PHPs may not exclude qualified providers from their network except for failure to meet the PHP's objective quality standards or refusal to accept network rates.
  - A qualified provider is a provider who is an enrolled Medicaid provider.
- PHPs must establish a documented process for making quality determinations using objective quality standards; PHPs must make their policies public This review is the PHP's credentialing review.
- 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
- Providers who receive an adverse quality determination are permitted to appeal the decision to the PHP

SOURCE: 42 C.F.R. § 438, subpart F and Section V.B.6 of Revised and Restated RFP 30-190029-DHB

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
    - PHP/Provider contract templates must be reviewed and approved by DHHS to ensure the standard contracting provisions are included and the contract templates meet all requirements of the contract between DHHS and the PHPs.

SOURCE: 42 C.F.R. § 438, subpart F and Section V.B.6 of Revised and Restated RFP 30-190029-DHB

Timing of Contracting

- PHPs are permitted to use draft PHP/Provider contract templates in contracting as long as the provider is informed the contract is under review by DHHS and therefore is subject to change based upon that approval.

- There is no State requirement or deadline for a provider to sign a contract with a PHP. Providers may sign PHP contracts that have not been officially approved as long as they understand that the PHP may come back with contract amendments following State approval.

- PHPs are permitted to require a provider give verbal or written acceptance of a written offer to contract within 30 calendar days of receipt of the offer, or the PHP can consider the provider to be out-of-network and subject the provider to the out-of-network payment requirements.
  - The Department interprets a "written offer" to only have been made when the offer includes a copy of the approved provider contract and all related addendums and appendices.
  - Providers who fail to respond within 30 calendar days to the written offer may be considered an out-of-network provider by the PHP. However, should a provider decide to contract after the 30 calendar days are finished, the PHP is required to issue a new offer, in writing, to the provider.

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

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	

Network Adequacy Oversight

- DHHS will monitor PHP's networks for adequacy on an ongoing basis.
- Monitoring will include review and analysis of PHPs networks, review of consumer and provider complaints, and analysis of accessibility data.
- PHPs will be required to submit evidence of the adequacy of their network several times in preparation for Medicaid managed care launch.
- After Medicaid managed care launch, in addition to quarterly submission of the current content of the network, PHPs will submit an annual demonstration of network adequacy. That submission will be reviewed against the standards and if there are deficiencies, PHPs may be subject to corrective action plans, fiscal penalties or other action permitted DHHS under the PHP Contract.

Provider Grievances and 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.
Appeals are when providers challenge certain PHP decisions.

Examples	
Grievances	**Appeals**
• Provider information is inaccurate in PHP directory • Provider is dissatisfied with the resolution of payment dispute	• 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

Overview of Provider Appeals

- DHHS has outlined requirements, including timeframes, for how PHPs must handle provider appeals; DHHS will review PHPs' provider appeals policies
- Like grievances, PHPs must handle appeals promptly, consistently, fairly, and in compliance with state and federal law and DHHS requirements
- PHP will establish a committee to review and make decisions about appeals
- 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
- Providers will be able to submit appeals through the provider portal

Provider Ombudsman

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

Member Appeals and Grievances

- The PHPs are required to do the following:
  - Maintain a grievance and appeals system for Members which must include a grievance process, a plan level appeal process, and access to a State Fair Hearing (also referred to as a Contested Case Hearing in NC).
  - Educate the Member on their rights and provide reasonable assistance with understanding and navigating the appeals and grievances processes.
  - Use DHHS-developed standardized templates for all written appeals and grievance notices.
  - Ensure that the individuals making decisions on appeals and grievances: (1) have the appropriate clinical expertise in treating the Member's condition or disease and (2) were not involved in any previous level of review or decision-making nor a subordinate of any such individual.
  - Allow an authorized representative (including providers), with written consent, to request an appeal or file a grievance on behalf of a Member. PHPs are prohibited from taking punitive action against a provider for supporting a Member's appeal or grievance request.
  - Provide the Member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the PHP (or at the direction of the PHP).
- Members must exhaust the PHP appeal process before requesting a State Fair Hearing at the Office of Administrative Hearings (OAH), unless the PHP fails to adhere to the notice and timing requirements.

SOURCE: 42 C.F.R. § 438, subpart F and Section V.B.6 of Revised and Restated RFP 30-190029-DHB

Member Appeals

- Adverse Benefit Determination: (1) the denial or limited authorization of a requested service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner; (5) the failure to act within the timeframes regarding the standard resolution of grievances and appeals; (6) for a resident of a rural area with only one PHP, the denial of an enrollee's request to exercise his or her right, under to obtain services outside the network; or (7) the denial of a Member's request to dispute a financial liability.
- The Member (or an authorized representative, including a provider) has 60 days from the date on the Notice of Adverse Benefit Determination to file an oral or written appeal with the PHP. Unless orally requesting an expedited appeal, the oral request must be followed up in writing.
- The PHP must acknowledge, in writing, each appeal request within 5 days of receipt (within 24 hours for expedited requests).
- For standard appeal requests, the PHP must provide written notice of resolution to the Member within 30 days of receipt of the request. The PHP may extend the timeframes for resolution by up to 14 days, under certain circumstances.
- When the standard appeal resolution timeframe could jeopardize the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function the Member (or an authorized representative) may request an expedited appeal. The PHP determines if the expedited appeal is necessary, however, the PHP shall presume an expedited appeal is necessary when the request is made by a provider.
- For expedited appeal requests, the PHP must provide written notice of resolution as expeditiously as the Member’s health condition requires but no later than 72 hours of receipt of the request. The PHP may extend the timeframes for resolution by up to 14 days, under certain circumstances.

SOURCE: 42 C.F.R. § 438, subpart F and Section V.B.6 of Revised and Restated RFP 30-190029-DHB

Member Appeals

- If the PHP upholds the original adverse benefit determination, in whole or in part, the PHP must allow Members (or an authorized representative) 120 days from the date on the Notice of Resolution to request a State Fair Hearing at the Office of Administrative Hearings (OAH).
- Upon requesting a State Fair Hearing, the Member will be offered, through the Mediation Network of North Carolina, a voluntary opportunity to participate in mediation with the PHP. If the appeal is not resolved during the mediation, the appeal will proceed to a hearing at OAH.
- After the hearing, the Administrative Law Judge (ALJ) will issue a Final Decision. If the ALJ reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP is required to authorize or provide the services promptly and as expeditiously as the Member's health condition requires and no later than 72 hours from the date it receives the Final Decision.
- Continuation of Benefits (COB) during the pendency of an appeal:
  - a Medicaid Member may request COB if all the following occur: (1) the Member files a timely appeal; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) services were ordered by an authorized provider; (4) the period covered by the original authorization has not expired; (5) the Member files for COB within 10 days of the date on the Notice of adverse benefit determination, or on the intended effective date of the PHP's proposed adverse benefit determination, whichever comes later.
  - Although a provider may request an appeal on behalf of a Member, a provider may not request COB on behalf of a Member.
  - NC Health Choice Members are not entitled to COB.

SOURCE: 42 C.F.R. § 438, subpart F and Section V.B.6 of Revised and Restated RFP 30-190029-DHB

Member Grievances

- Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination including, but not limited to, the quality of care or services provided, rudeness of a provider or employee, or failure to respect the enrollee's rights.
- A Member (or authorized representative), may file a grievance with the PHP, orally or in writing, at any time.
- The PHP must acknowledge, in writing, each grievance within 5 days of receipt.
- The PHP must resolve the grievance and provide written notice of resolution to the Member within 30 days from the date the PHP receives the grievance. The PHP may extend the timeframes for resolution by up to 14 days, under certain circumstances.

SOURCE: 42 C.F.R. § 438, subpart F and Section V.B.6 of Revised and Restated RFP 30-190029-DHB

Disenrollment Appeals

- Member Requests for Disenrollment
  - The Member (or an authorized representative) may make an oral or written request to the Enrollment Broker (EB) to disenroll from a PHP "without cause" during specified periods each year and may make a "with cause" request to disenroll at any time.
  - There are eight "with cause" reasons for a Member to request disenrollment (e.g., Member moves out of the PHP service area, a newly eligible family member is enrolled in a different PHP).
  - If the request is denied, the Member will receive a written notice from the EB and will have 30 days to request a State Fair Hearing at the Office of Administrative Hearings (OAH).
  - Upon requesting a State Fair Hearing, the Member will be offered, through the Mediation Network of North Carolina, a voluntary opportunity to participate in mediation with DHHS. If the appeal is not resolved during the mediation, the appeal will proceed to a hearing at OAH.
  - After the hearing, the Administrative Law Judge will issue a Final Decision.
- PHP Requests for Disenrollment
  - The PHP may only submit requests to the EB for Member disenrollment if the Member's behavior seriously hinders the PHP's ability to care for the Member, or other Members of the PHP, and the PHP has documented efforts to resolve the Member's issues that form the basis of the request for disenrollment.
  - The PHP is prohibited from requesting disenrollment because of an adverse change in the Member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs.
  - A Member (or authorized representative) may request a State Fair Hearing to contest a PHP's approved request from a PH for a Member to be disenrolled.

SOURCE: 42 C.F.R. § 438.56 and Section VII., Attachment M.1. of Revised and Restated RFP 30-190029-DHB

Questions?

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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
- Provider Resources: https://Medicaid.ncdhhs.gov/providers

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

PLEASE CONTINUE TO SEND ALL QUESTIONS IN THE CHATBOX TO: AADMIN_FOR_QUESTIONS --

THANK YOU FOR JOINING THE VIRTUAL OFFICE HOURS DISCUSSION!