North Carolina Medicaid Transformation

Provider Payment and Contracting

April 11, 2019

Contents

Part I: North Carolina Medicaid Transformation

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

Prepaid Health Plans (PHPs) for NC Medicaid Managed Care

Medicaid managed care will "go-live" in November 2019 with four statewide PHP contracts and one regional provider-led entity (PLE).

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.

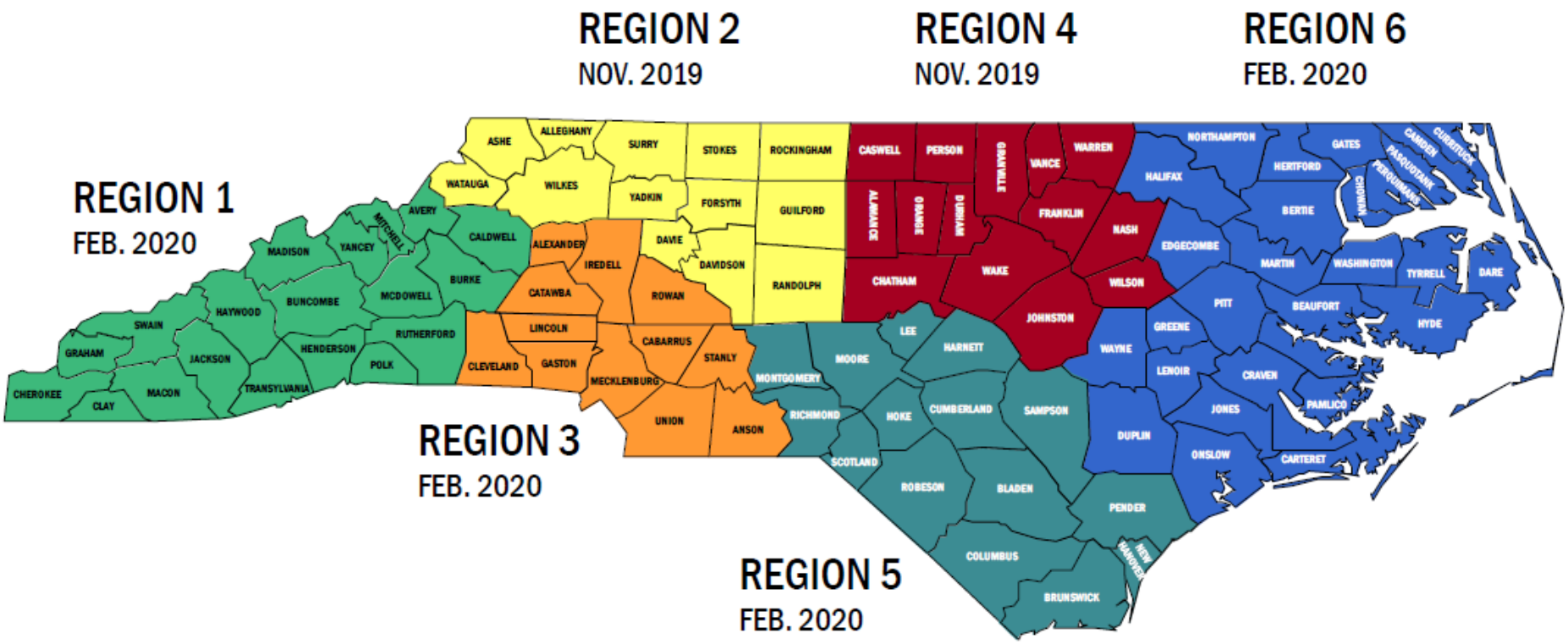
One Regional PLE

- Carolina Complete Health, Inc.

Note: Regions 3 and 5

Learn more: https://www.ncdhhs.gov/news/press-releases/dhhs-announces-prepaid-health-plan-contracts-medicaid-managed-care

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

Learn more: https://www.ncdhhs.gov/news/press-releases/dhhs-announces-prepaid-health-plan-contracts-medicaid-managed-care

Medicaid Transformation Timeline

Timeline	Milestone
February 2019	PHPs begin contracting with providers through managed care "go-live"*
June - July 2019	Enrollment broker sends Phase 1 enrollment packages to beneficiaries; open enrollment begins
Summer 2019	PHPs must meet network adequacy requirements
October 2019	Phase 2 open enrollment
November 2019	Managed care SPs launch in selected regions
February 2020	Managed care SPs launch in remaining regions

Key Takeaways:

- The time for PHP contracting is **now.**
- If a PHP has not reached out to you, please reach out to them as soon as possible.
- There will be "meet and greet" events with PHPs to discuss policies and procedures *(timing TBD)*.

** Contracting can occur at any point in time and is not subject to the timeline of PHP-State contracting years.*

Part II:
General Payment Provisions

Provider Payment: In Network

PHPs will be required to contract with "any willing qualified provider."
PHPs must offer these provider types contracts with these payment terms.

In-Network Payment

- PHPs are required to contract with "any willing qualified provider"
- Payment to in-network hospitals[1], physicians, and physician extenders must be **no less than 100% of the Medicaid fee-for-service (FFS) rate**, unless the PHP and provider mutually agree to an alternative reimbursement arrangement.[2]
- PHPs must offer these provider types contracts with these payment terms.
- Providers can negotiate higher rates or alternative payment arrangements, but are not required to do so.
- Special payment provisions apply to certain provider types.[3]
- Provider types that do not have a rate floor must negotiate rates with PHPs

Key Takeaway:

If you meet quality standards and accept a PHP's rate, the PHP must contract with you.

However, you **do not need to contract with every PHP.**

[1] Hospital FFS rates are currently being updated; [2] Certain rate floors are permanent and others are temporary. Specifics will be discussed in subsequent slides; [3] See Part III of this presentation.

Provider Payment: Out of Network

PHP payment levels to out-of-network (OON) providers depends on why the provider is OON and the type of service provided.

Situations in which PHPs must pay no more than 90% of FFS to OON providers

- PHP has made a "good faith" effort[1] to contract with a provider but the provider has refused that contract
- The provider was excluded from the PHP's network for failure to meet objective quality standards

Situations in which PHPs must pay 100% of FFS to OON providers[2]

- The provider has not been offered a contract or is still engaged in good faith negotiations
- All family planning providers
- Out of state providers that deliver emergency and post-stabilization services
- In state providers that deliver emergency and post-stabilization services

Out of Network services are generally subject to prior approval by the PHP.[3]

[1] PHPs must develop a policy that defines (1) a "good faith" contracting effort and (2) objective quality standards used in contracting decisions. PHPs must also provide a process for providers to "cure" identified quality issues;
[2] OON benefits almost always require prior approval from the Plan.
[3] PHPs are prohibited from paying more than 100% of FFS to OON providers

Network Adequacy

Network adequacy standards help ensure PHPs build robust provider networks and beneficiaries have access to care.

NC Medicaid's network adequacy standards vary by geographic area and include time and distance standards* and appointment wait-time standards.

Provider Type	Urban County Standard	Rural County 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 Behavioral Health	≥ 1 provider of each inpatient behavioral health service within each PHP region	

Key Takeaway: PHPs need to meet network adequacy standards by Summer 2019 and are actively building provider networks. **The time for contracting is now.**

Part III:
Payments by Provider Type

Overview of Payments by Provider Type

- Physicians and Physician Extenders
- Advanced Medical Homes (AMHs)
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Local Health Departments (LHDs)
- Hospital
- Pharmacy
- Public Ambulance
- Indian Health Care Providers
- Nursing
- State-Owned and Operated Facilities
- Hospice

Physicians and Physician Extenders

PHPs must reimburse physicians and physician extenders no less than 100% of Medicaid FFS rates unless they have mutually agreed to an alternative arrangement. The Department plans to increase FFS rates to Medicare levels for a subset of primary care services, contingent on CMS approval.[1]

Provider	Description

Primary Care	• PHPs must reimburse primary care providers according to the following parameters for all E&M codes[2]:
	  • *For primary care physicians and OB/GYNs,* PHPs must pay 100% of Medicaid physician rates.[3]
	  • *For physician nurse practitioner and physician assistants,* PHPs must pay 100% of Medicaid nurse practitioner and physician assistants rates.
	• PHPs and providers can mutually agree to alternative payment arrangements
	• Medicaid FFS codes serve as rate floor for all remaining services

Specialty Care	• PHPs will reimburse all in-network specialty care physicians and physician extenders at least 100% of the Medicaid FFS rate for the service or bundle and can mutually agree to alternative arrangement[4]

[1]Medicaid FFS rates are based Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule (PFS) in effect as of January 01, 2018.
[2] E&M codes range from 99201 to 99499, as defined in Section §1202 of the Affordable Care Act.
[3] Medicaid Physician Non-Facility Rate: Set at 100% of Medicare Physician Non-Facility rates; Medicaid Physician Facility Rate: When facility and non-facility rates differ, set at 100% of Medicare Physician Facility rate. When rates are the same, set at 90% of non-facility rate.

AMHs

AMH practices will continue to receive Medical Home Fees for assigned members and may earn additional care management fees and performance incentive payments depending on their "Tier" status.

Tier	AMH Payment Component			
	Clinical Services Payments	PMPM Medical Home Fee	Care Management Fee	PHP Performance Incentive to Practices
1	Will continue—PHPs must comply with minimum rate floors set at Medicaid FFS levels	$1.00	None	None required
2		$2.50 (most enrollees) or $5.00 (members of the aged, blind and disabled [ABD] eligibility group)	None	
3		$2.50 (most enrollees) or $5.00 (members of the ABD eligibility group)	Negotiated between practices, or CINs on behalf of practices, and PHPs	PHP must offer performance incentive programs to practices. If practices participate and meet performance thresholds on standard AMH measures, they will receive payments

Medical Home Fees
- Serve as payment floors

Care Management Fees
- Fees will be negotiated between PHPs & AMHs
- Tier 3 AMHs should consider assigned care management responsibilities, regional cost variation, and other factors when negotiating

Performance Incentives
- There are opportunities for primary care practices to receive additional payments in managed care

**For more information, please see the AMH training webpage.*

FQHCs and RHCs

Federally qualified health clinics (FQHCs) and rural health centers (RHCs) will receive two separate payment streams under managed care: service payments from PHPs and wrap-around payments from DHHS.

Payment Component	Description
Service Payments	• PHPs must reimburse FQHCs and RHCs at least 100% of the FFS rate for covered services • Medicaid FFS unique FQHC/RHC encounter codes serve as rate floor for all "core" services
Wrap-Around Payments	• Federal rules permit DHHS to continue making additional wrap-around payments to FQHCs and RHCs, over and above PHP payments for services, after the transition to managed care ○ ***Note***: FQHC/RHC will receive wrap-around payments to PPS rate or to costs based on current status prior to managed care transition • In many cases, PHP per-unit payments may be less than under the current payment methodology, which pays FQHC/RHCs based on either the PPS rate or allowable costs, depending on the FQHC/RHC • DHHS will make quarterly wrap payments to FQHC/RHCs to ensure FQHC/RHCs receive aggregate payments equal to the PPS per-visit rate, as required by federal law* • Annually, for FQHCs/RHCs that are cost settled, DHHS will make additional wrap-around payments representing the difference between Medicaid costs and payments

**Section §1902(bb)(5) of the Social Security Act*

LHDs

LHDs will receive three separate payment streams from PHPs under managed care: service payments, care management payments, and a replacement for cost settlement payments, known as "additional utilization-based payments."

Payment Component	Description
Service Payments	• 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.

Care Management Payments	• PHPs will pay LHDs no less than PMPM payments they receive today for the provision of Care Management for High-Risk Pregnancy (CMHRP) and Care Management for At-Risk Children (CMARC) during managed care contract years 1-3. These amounts are:
	  • CMHRP: $4.96 PMPM*
	  • CMARC: $4.56 PMPM**
	• PHPs will compensate LHDs/other providers of CM services at net mutually agreed upon rates beginning in Year 4

Additional Utilization-Based Payment (AUBPs)	• DHHS is committed to ensuring LHDs receive similar per unit payments under managed care compared to the current state under FFS • Under federal rules governing managed care, DHHS cannot pay cost settlements to LHDs directly, but can direct PHPs to make additional payments to LHDs that promote quality, access and/or delivery system reform*** • To ensure continued access to LHD services for Medicaid beneficiaries, DHHS will make, through PHPs, additional payments to cover the difference between each LHD's PHP reimbursement rate and a set rate per LHD that approximates 100% of costs (calculated using a cost-to-charge ratio) • To finance the AUBPs, LHDs will make IGTs to DHHS in an amount equal to the non-federal share of the AUBP received

For all PHP member women ages 14 – 44 on Medicaid residing in the LHD county/service area; **For all PHP member children ages 0 – 5 on Medicaid residing in the LHD county/service area; * 42 CFR § 438.6.*

Hospital

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

Payment Component	Description
Base Payments	• Most supplemental payments—excluding DSH and GME—folded into base rates • Inpatient payment rates set to ensure each hospital within a class receives the same percentage of Medicaid and uninsured costs covered (on a per unit basis) • Outpatient payments set to approximately 100% of costs • Enhanced inpatient and outpatient rates set in Medicaid FFS and serves as a rate floor in managed care (see below)
Rate Floors	• PHPs required to pay mandated rates for five contract years to all critical access hospitals and all hospitals located in economically distressed counties (designated as “tier 1” or “tier 2” by North Carolina’s Department of Commerce) • PHPs required to pay mandated rates for three contract years to all other hospitals
“Glide path” Payments	• DHHS would direct PHPs to make directed or pass-through payments (depending on when the managed care proposed rule is finalized) to hospitals to address approximately 40% of estimated hospital revenue declines net of provider assessments and IGTs • DHHS is seeking general fund appropriations to finance the non-federal share of glide path payments
GME	• State to make GME payments directly to hospitals (outside of managed care) • Direct GME payments will be calculated based on statewide per-resident average; indirect medical education will be calculated based on Medicare formula • Hospitals to finance 100% of non-federal share of GME payments, including assuming responsibility for State’s current annual contribution of $30 M • DHHS to propose parallel reduction of $30 M to State retention from provider assessment to account for additional hospital contribution to non-federal share of GME

Hospital, Continued

Hospitals will continue to finance a similar proportion of Medicaid payments under managed care.

Intergovernmental Transfers

- Hospitals that currently make intergovernmental transfers (IGTs) will continue to do so under the new methodology based on 2018 IGT amounts, with annual adjustments based on the year-over-year change in Medicaid payments to public hospitals

Assessments

- DHHS will establish two separate hospital assessments:
  - **Base assessment (replaces UPL assessment)**, set based on 2018 UPL assessment amount and adjusted to finance higher hospital payments related to crossovers, NC Health Choice, and GME. Assessment will be adjusted in subsequent years based on the change in Medicaid payments to all hospitals subject to the base assessment
  - **Supplemental assessment (replaces equity assessment)**, set based on 2018 equity assessment amount and adjusted based on the change in Medicaid payments to all hospitals subject to the supplemental assessment

**In the event Medicaid eligibility is expanded to childless adults up to 138% FPL currently in the coverage gap, hospitals will finance the non-federal share of Medicaid payments for these individuals, minus PHP premium tax revenue generated from these individuals, through an additional assessment.*

Pharmacy

PHPs will implement a pharmacy benefit which ensures members have access to therapeutically needed medications at the best overall value.

PHP Requirements

- Cover all outpatient drugs for which the manufacturer has a Centers for Medicare and Medicaid Services (CMS) rebate agreement and for which DHHS provides coverage
- Adhere to DHHS' defined preferred drug list (PDL); and
- Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid FFS program

Rate Floors

- **Dispensing Fees:** Same rate as Medicaid and NC Health Choice FFS dispensing fee as determined by the methodology defined in the Attachment 4.19-B of the North Carolina State Plan
- **Ingredient Costs:** Same rate at the Medicaid and NC Health Choice Fee-for-Service rate*
- **Drug Rebates:** PHPs are not permitted to negotiate rebates for any covered drugs in the Medicaid and NC Health Choice program

**In contract Year Two, the PHP may develop its own pharmacy contracting for ingredient reimbursement if the PHP can demonstrate that the reimbursement results in overall savings and does not impact access to care. PHP must also submit a pharmacy network access monitoring plan.*

Public Ambulance

Public Ambulance Providers (PAPs) will receive two separate payment streams from PHPs under managed care: service payments and AUBPs, which serve as a replacement for cost settlement payments.

Payment Component	Description
Service Payments	• PHPs will reimburse PAPs for services after the managed care transition based on negotiated rates between the parties, no less than the amount private ambulance providers receive for similar services
AUBPs	• DHHS is committed to ensuring PAPs receive similar per trip leg payments under managed care compared to the current state under FFS • Under federal rules governing managed care, DHHS cannot pay cost settlements to PAPs directly, but can direct PHPs to make additional payments to PAPs that promote quality, access and/or delivery system reform* • To ensure continued access to PAP services for Medicaid beneficiaries, DHHS will pay, through PHPs, additional payments to cover the difference between their PHP reimbursement rate and a "fully loaded" per trip leg rate, which includes Medicaid FFS base payments and gross cost settlement payments divided by trip legs • To finance the AUBPs, PAPs will make IGTs to DHHS equal to the non-federal share of the AUBP amount received

** 42 CFR § 438.6*

Indian Health Care Providers

PHPs will reimburse Indian Health Care Providers (IHCPs) as follows[1]:

- Those that are **not** enrolled as an FQHC, regardless of whether they participate in the PHP's network:
    1. The applicable encounter rate (also known as the OMB rate) published annually in the Federal Register by the Indian Health Service; or
    2. The Medicaid FFS rate for services that do not have an applicable encounter rate
- Those that are enrolled as FQHCs, but do not participate in the PHP's network, an amount equal to what the PHP would pay a network FQHC that is not an Indian Health Care Provider
- PHPs will permit Tribal members to obtain services from out-of-network IHCPs
- PHPs will permit IHCPs to refer a Tribal member to any provider within the IHCP purchase referred care (PRC) network, even if the provider is not a contracted provider, without having to obtain prior authorization or referral from a contracted provider
- The PHP may not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care Indian Health Care Provider through cost sharing or other similar charges levied on the Tribal member

* as defined by 42 C.F.R. § 438.14

Additional Providers

Provider	Payment Components
Nursing Facility	• For a period of time to be defined by DHHS, PHPs will reimburse in-network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid FFS rate in effect six 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
State-Owned and Operated Facilities	• PHPs will reimburse facilities that are state-owned and operated by the Division of State Operated Healthcare Facilities (DSOHF) according to the rates established by DHHS • PHPs will also reimburse Veterans Homes according to the rates established by DHHS in collaboration with DMVA*

Hospice	• The PHP will reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:
	• Rates will be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year)
	• For hospice services provided to Members residing in nursing facilities, the PHP shall reimburse the hospice provider:
	  ○ Hospice rate, and
	  ○ 95% of the Medicaid nursing home FFS room and board rate in effect at the time of service

**As allowed under 42 C.F.R. § 438.6(c)*

Part IV:
Operationalizing Provider Payments

Prompt Payment Standards

PHPs must reimburse medical and pharmacy providers in a timely and accurate manner.

Medical Claims

- Within 18 days of receiving a claim, PHPs will notify the provider whether a claim is clean or hold ("pend") the claim and request additional information
- Within 30 days of receiving a clean claim, PHPs will pay or deny the claim
- Within 30 days of receipt of requested additional information, PHPs will pay or deny a pended claim

Pharmacy Claims

- Within 14 days of receiving a pharmacy claim, PHPs will pay or deny a clean claim or pend the claim and request additional information
- Within 14 days of receiving the requested additional information, PHPs will pay or deny a pended claim
- If PHPs do not receive requested information within 90 days, the PHP shall process the claim based on what information is available, and then may pay or deny the claim accordingly*

PHPs may require that claims be submitted within 180 calendar days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 calendar days after the date of the patient's discharge from the facility*

**In accordance with N.C. Gen. Stat. § 58-3-225(d); ** In accordance with N.C. Gen. Stat. § 58-3-225(f).*

Interest and Penalties

PHPs will be held responsible for delayed payments to providers.

- The PHP will pay interest on late payments to providers at an annual rate of 18% beginning on the first day following the date that the claim should have been paid
- PHPs will also pay the provider a penalty equal to 1% of the claim for each calendar day following the date that the claim should have been paid as specified in the PHP Contract
- PHPs will maintain written or electronic records of its activities*

**As specified in N.C. Gen. Stat. § 58-3-225(i).*

Part V:
Q & A

Part VI:
Next Steps

Additional Information

Questions?

- **Email:** Medicaid.Transformation@dhhs.nc.gov
- **U.S. Mail:** Dept. of Health and Human Services, Division of Health Benefits
  1950 Mail Service Center
  Raleigh NC 27699-1950

DHHS Webpage

- https://www.ncdhhs.gov/assistance/medicaid-transformation

White Papers, Manuals, and FAQs

- *Concept Paper, Prepaid Health Plan Network Adequacy and Accessibility Standards, February 2018*
- *Concept Paper, Addressing Hospital Supplemental Payments in the Transition to Managed Care, November 2017*