

Medicaid Managed Care  
Proposed Policy Paper

## Prepaid Health Plans in North Carolina Medicaid Managed Care

North Carolina Department of  
Health and Human Services

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*This document is part of a series of policy papers that the Department of Health and Human Services scheduled for release from late 2017 through mid-2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other policy papers in the series. For more information on the Department's proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released policy papers available at [ncdhhs.gov/nc-medicaid-transformation](http://ncdhhs.gov/nc-medicaid-transformation).*

*Input is welcome and appreciated. Send comments to [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov).*

## I. Introduction

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The North Carolina Department of Health and Human Services (NC DHHS) is committed to ensuring that Prepaid Health Plans (PHPs) are appropriately licensed by the NC Department of Insurance (NC DOI) and meet solvency and other financial requirements to participate and remain in North Carolina Medicaid managed care. NC DHHS envisions Medicaid managed care where PHPs, selected by NC DHHS through a competitive bidding process based on qualifications, will serve beneficiaries either on a statewide or regional basis, and provide services to beneficiaries consistent with applicable state and federal laws. PHPs will be subject to operational and financial oversight coordinated between NC DHHS and NC DOI. Provider-Led Entities (PLEs) may be subject to particular entity requirements to qualify as a PLE for the purposes of participating in North Carolina Medicaid managed care.

In 2015, the North Carolina General Assembly (General Assembly) enacted legislation (Session Law 2015-245,<sup>1</sup> as amended) directing the transition of Medicaid from predominantly fee-for-service to a managed care structure. In Medicaid managed care, NC DHHS will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice (Medicaid<sup>2</sup>) programs. NC DHHS seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses medical and non-medical drivers of health. NC DHHS is committed to ensuring PHPs reflect the values and priorities of NC DHHS, assist with practice transformation and can innovate and drive value through their relationships with beneficiaries, providers, community partners and other state agencies.

As directed by the General Assembly, NC DHHS will delegate the direct management of certain health services and financial risks to PHPs. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by NC DHHS and NC DOI. NC DHHS will monitor and oversee operations relating to benefits, network adequacy and provider accessibility, member protections, provider relations, expenditures relative to capitation payments, program integrity and adherence to NC DHHS' high quality standards through establishment of quality aims, goals and objectives that use the managed care infrastructure to push improvement in health care. NC DOI will monitor and oversee licensure and solvency, and other important aspects of a successful insurance entity.

## II. Overview of Types of Managed Care Plans

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Per North Carolina Session Law 2015-245 as amended, NC DHHS may enter into capitated contracts with two types of PHPs: Commercial Plans (CPs) and PLEs. Session Law 2015-245 also provides that PHPs will cover all Medicaid services, except for those specifically excluded from managed care by the legislation. Further, the legislation outlines requirements of the managed care program with which all PHPs must comply including, but not limited to, Medicaid managed care payment, network adequacy and program integrity requirements.

NC DHHS expects to select the entities with which it will contract through a competitive procurement process; e.g., a PHP Request for Proposal (RFP), described later in this paper.

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<sup>1</sup> North Carolina General Assembly session laws and general statutes are located at <https://www.ncleg.net/>.

<sup>2</sup> "Medicaid," when used in this paper, refers to Medicaid and NC Health Choice programs, unless NC Health Choice is specifically referred to separately.

## Commercial Plans

Per Section 4.(2) of Session Law 2015-245, a “CP” is any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by NC DOI.

## Provider-Led Entities

Section 4.(2) of Session Law 2015-245, as amended, provides that a “PLE” is an “entity that meets all following criteria:

1. *A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section or Medicaid and NC Health Choice providers <emphasis added>.*
2. *A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program.*
3. *Holds a PHP license issued by the Department of Insurance.”*

NC DHHS has received questions from interested parties seeking its interpretation of the language added in Session Law 2016-121 and the operation of the emphasized “or” in number 1, above. As previously noted, NC DHHS reads this provision to designate two valid options for the structure of a PLE: 1) a PLE may have as its primary business purpose the ownership or operation of one or more capitated contracts, or 2) a PLE may have as its primary business purpose the ownership or operation of one or more Medicaid providers.

## III. Provider Participation in Provider-Led Entities (PLEs)

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### PLE Governance and Operations

Consistent with state law<sup>3</sup>, NC DHHS will require that the majority of voting members on the governing body of each PLE be licensed in North Carolina as physicians, physician assistants, nurse practitioners or psychologists, and have treated beneficiaries of North Carolina Medicaid. Further, to ensure that that PLE governing bodies include individuals with recent experience treating North Carolina Medicaid beneficiaries, NC DHHS will require that a minimum of 25 percent of voting members on each PLE governing body be providers of the identified types who have received reimbursement for the treatment of at least one NC North Carolina Medicaid beneficiary in the previous 24 months (e.g., a provider joining a PLE’s governing body on June 1, 2018, must have received reimbursement in the 24 months leading up to June 1, 2018, which would be May 31, 2016 through May 31, 2018). Entities seeking to become PLEs will be required to submit as a component of their RFP response a list of members of their governing body with an explanation of how a sufficient share of voting members will satisfy these requirements. For purposes of the RFP response, a PLE should use June 1, 2018, as the end date of the 24-month period noted above regardless of when the voting member joined the governing body.

NC DHHS seeks to ensure that physicians, physician assistants, nurse practitioners and psychologists play a meaningful role in strategic decisions and day-to-day operations of PLEs. An expectation of meaningful

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<sup>3</sup> Section 4.(2) of Session Law 2015-245, as amended.

involvement of providers aligns with Medicaid managed care goals of advancing high-value care, improving population health, and engaging and supporting providers.

Toward that goal, entities bidding as PLEs will also be required to submit as a component of their RFP response:

- The bylaws of their governing body.
- Information to explain the operations and authority of the governing body, (e.g., the types of decisions that will and will not be subject to a board vote).
- A written plan outlining the role of physicians and other health team members in the day-to-day operations of the PLE including, but not limited to:
  - List of clinical staff positions and roles.
  - List of individuals in executive or other leadership positions with clinical experience, and a description of roles and responsibilities.
  - List and description of all provider advisory and consultative committees (e.g., quality committee, advanced medical home advisory committee).
  - List and description of provider relations or provider partnership initiatives.
  - Descriptions of how providers will be held accountable for clinical and financial program outcomes.
  - Description of any other ways that physicians and other health team members will be involved in the day-to-day business operations of the PLE.

## PLE Ownership

Session Law 2016-121 also requires that “a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section or Medicaid and NC Health Choice providers.” Entities bidding as PLEs will be required to submit as part of their RFP response a signed attestation affirming that they comply with this state law. Entities bidding as PLEs will also be required, as a component of their RFP response, to disclose ownership and control information to ensure compliance with state law.

## PHPs and Related Providers

The relationship of a PHP and its owned or related providers is complex, particularly for PLEs. The payment strategy of the PHP to its owned or related providers has the potential to introduce behaviors that could be anti-competitive or self-dealing and, therefore, detrimental to both North Carolina’s healthcare delivery system, generally, and the Medicaid managed care program, specifically. For example, a PHP may pay its owned or related provider more than other providers in order to increase its MLR or to drive higher future capitation rates. To address this potential issue, NC DHHS expects to include in the PHP RFP a requirement that a PHP will not pay for similar services rendered by any provider or subcontractor that is related to the PHP more than the PHP pays to providers and subcontractors that are not related to the PHP. In this context, NC DHHS defines “related to” as providers or subcontractors with an indirect ownership interest or ownership or control interest<sup>[1]</sup> in the PHP, an affiliate of the PHP or the PHP’s management company. “Related to” is also

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<sup>[1]</sup> Refer to 42 C.F.R. § Part 455, Subpart B for criteria determining indirect ownership interest, an ownership interest or a control interest.

defined by NC DHHS as including the PHP, an affiliate of the PHP or the PHP's management company with an indirect ownership interest or ownership or control interest in a provider or subcontractor. As a potential penalty for exceeding these limitations, NC DHHS expects that payments will be considered non-allowable payments for covered services and will be excluded from medical expenses reported in the medical loss ratio (MLR) report.

### Network Adequacy

North Carolina's Medicaid program enjoys strong participation from a range of providers, including 1,900 primary care practices, 2,400 pharmacies and 130 acute care hospitals. Moving to Medicaid managed care, it is critical to ensure continued participation of Medicaid providers and to monitor beneficiary access to services. Network adequacy standards, which are described in more detail in a recent policy paper,<sup>4</sup> are an important tool to ensure that beneficiaries have access to providers and care.

Both commercial plans and provider-led entities will be required to meet strict requirements regarding network adequacy and, pursuant to state law, PHPs must include any willing provider in their networks, except when a PHP is unable to negotiate rates or when there are quality concerns. DHHS will prohibit exclusivity provisions in contracts between PHPs and providers and will require providers that partially own or control a PHP to negotiate with rival PHPs in good faith if those rival PHPs seek to contract with them.

*The Department is seeking comment on these approaches to address potential anti-competitive or self-dealing behavior.*

## IV. PHP Procurement

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### Procurement Process

Per Session Law 2015-245,<sup>5</sup> awarded capitated contracts issued by NC DHHS to PHPs will be the result of a competitive bidding process. NC DHHS will set actuarially sound capitation rates that will apply to all PHPs; thus, PHPs will not be submitting price bids as part of their RFP responses. Therefore, NC DHHS envisions the evaluation of proposals to be based primarily on the bidders' qualifications. RFP responses will be measured on the organization's proposal to meet the expectations and requirements of Medicaid managed care as outlined in the RFP and PHP contract with NC DHHS, consistent with the actuarially sound rates established by NC DHHS.

### Regions

NC DHHS defined six PHP regions throughout the state. Table 1 lists the counties included in each region; the regions are geographically illustrated in Figure 1. NC DHHS may use regions in several different ways, including rate setting, quality monitoring, reporting and, in this context, NC DHHS will use regions to define geo-boundaries of the regional contracts and Medicaid beneficiaries served.

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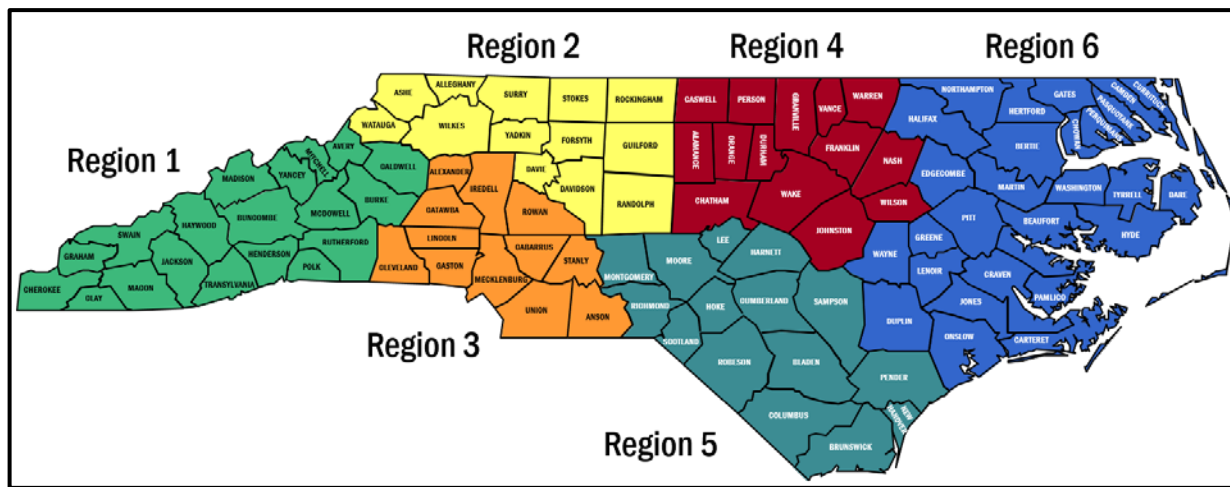
<sup>4</sup>"Prepaid Health Plan Network Adequacy and Accessibility Standards," <https://www.ncdhhs.gov/concept-papers>.

<sup>5</sup> Section 4.(3) of Session Law 2015-245.

**Table 1: List of Counties by PHP Regions**

PHP Regions	Counties
<b>Region 1</b>	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
<b>Region 2</b>	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
<b>Region 3</b>	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
<b>Region 4</b>	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
<b>Region 5</b>	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
<b>Region 6</b>	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

**Figure 1: Map of PHP Regions**



### Minimum Qualifications for PHPs

As part of the PHP RFP, NC DHHS will establish minimum qualifications that each PHP RFP respondent will be evaluated on a pass/fail basis. Failure to meet the minimum qualifications will result in the PHP being excluded from further evaluation. NC DHHS is considering the following minimum requirements for PHPs that seek to participate in Medicaid managed care Standard Plans:

- PHP will accept rate setting and risk adjustment methodologies in the rate book accompanying the PHP.
- PHP is compliant with conflict of interest, performance bond and capital requirements defined in the RFP.
- PHP has made sufficient progress (through obtaining provider letters of intent or contracts) to build an adequate network in each of its proposed regions.

In addition, for PLEs only, the minimum qualifications will also require that PLEs are compliant with PLE governance, operations and ownership requirements as defined in this paper and, if the proposal to participate involves more than one region, that the regions are contiguous and the PLE will operate across the entirety of the regions proposed.



NC DHHS does not intend to make PHP licensure a condition of bidding on the PHP RFP.

### Ownership and Control Interests of PHPs

When NC DHHS evaluates entities bidding to become PHPs to ensure North Carolina is entrusting the care of its Medicaid beneficiaries with the most qualified health plans, one component of that evaluation will be whether the prospective health plan has experience with core competencies of operating a Medicaid managed care plan. These core competencies would include:

- Assuming financial risk through capitated contracts;
- Managing Medicaid beneficiary lives;
- Developing and maintaining a robust provider network that serves the healthcare needs of beneficiaries
- Providing customer service and support for beneficiaries;
- Performing care management functions; and
- Handling administrative functions like processing and paying claims.

As part of their response to the PHP RFP, entities will be evaluated on whether they have experience with these core competencies.

Some entities that bid to become CPs or PLEs may be formed by joint ventures or other partnerships or arrangements between managed care organizations, health care providers or other organizations. As such, a legal entity bidding as a PHP may be a newly formed organization with no direct experience with the core functions of operating a health plan generally, and a Medicaid managed care plan specifically, though one or more of its parent entities or partners may have relevant, separate experience. Alternatively, it may be multiple existing entities partnering together, where the legal entity bidding as a PHP has some experience and other partners have different experience.

In these situations, NC DHHS must determine when the experience of a parent entity or business partner should or should not count as experience for the legal entity bidding as part of the Prepaid Health Plan (PHP) procurement process. NC DHHS will attempt to strike a balance that recognizes the relevant experience of parent entities and business partners that are invested in and committed to the success of the legal entity seeking award of a PHP contract while not inappropriately recognizing the experience of parent entities or business partners with a stake in the success of the PHP that appears limited or nominal.

Each entity proposing to become a PHP must submit as part of its RFP response a list of other entities with experience or history that is to apply toward the proposing entity's experience for all relevant components of RFP evaluation and points allocation. This will include cases where the experience results in points awarded (e.g., performing a core managed care function) and cases where the experience results in points deducted (e.g., a contract termination).

The experience of all entities with an ownership or control interest in the entity proposing to become a PHP will apply toward the experience of the proposing entity. NC DHHS' definition of "ownership or control interest" is in 42 C.F.R. § 455.101:

- “Person with an ownership or control interest” means a person or corporation that -*
- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;*
  - (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;*

*(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;*

*(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;*

*(e) Is an officer or director of a disclosing entity that is organized as a corporation; or*

*(f) Is a partner in a disclosing entity that is organized as a partnership.”*

Entities with an ownership or control interest, as defined above, in the entity proposing to become a PHP will be required to disclose certain information as part of their RFP responses. Consistent with 42 C.F.R. § 455.104, these disclosures will include at a minimum:

- *“Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location and P.O. box address.*
- *Date of birth and Social Security number (in the case of an individual).*
- *Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.*
- *Whether the individual or corporation with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.*
- *The name of any other disclosing entity in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.*
- *The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).”*

### **Requesting NC DHHS Recognition of Parent Entity or Business Partner Experience**

If the entity responding to the RFP would like for NC DHHS to recognize the experience of a parent entity or business partner, but the entity is structured in a way that the definition of “ownership or control interest” as provided in 42 C.F.R. § 455.101 is not met or is not applicable, the entity may still request that NC DHHS recognize the experience of the parent entity or business partner. However, NC DHHS will require the entity making this request to provide additional information or documentation as part of the entity’s response. The purpose of this information or documentation is to confirm that the entity that would like for its experience to “count” as the experience of the entity bidding to become a PHP would have:

1. Meaningful long-term financial incentive in the administrative, clinical, and operational success of the PHP’s Medicaid managed care contract; and
2. Meaningful long-term involvement in the day-to-day operations of the PHP.

NC DHHS may exercise, at its sole discretion, in the PHP RFP evaluation whether or not to consider the experience or to what extent the experience applies.

All entities proposing to become a PHP will also be required to submit a proposed plan that details the participation level of all entities with an ownership or control interest in the day-to-day operations of the entity submitting the proposal. Individuals or entities with an ownership or control interest in the entity submitting a proposal in response to the RFP will also be required to describe their prior experience with performing a set of core competencies of Medicaid managed care, as outlined above and in the PHP RFP.

Demonstrating prior experience with core Medicaid managed care functions during the procurement process will not exempt awarded PHPs from participation in rigorous readiness reviews before managed care launch. A track record of performing those functions in other states or contexts will not exempt awarded PHPs from repercussions, up to and including termination of the PHP contract, for failing to demonstrate readiness to NC DHHS' satisfaction.

If any individuals or entities gain or lose ownership or controlling interest in a PHP or materially alter the extent of their involvement in the day-to-day operations or core functions of the PHP, this could trigger a material change process with NC DOI that may have implications for the PHP's license. Such changes could also trigger a material change process with NC DHHS. As a part of this process, PHPs may be required to submit a signed attestation that they still meet all qualifications included in the RFP and the capitated contract that NC DHHS deems important for the continuance of well-functioning Medicaid managed care.

NC DHHS may require additional documentation to verify some or all aspects of the attestation and reserves the right to take action up to and including termination of the PHP contract if the PHP either declines to submit an attestation or submits a false attestation. NC DHHS also reserves the right to require readiness exercises in the event of material changes. If changes in PHP ownership cause NC DHHS to take on additional administrative cost to support ownership or name changes, NC DHHS will require the PHP to pay those costs in full.

## Qualified Bidders

Per state law,<sup>6</sup> capitated PHP contracts will be limited in number and nature:

- Three capitated PHP contracts between NC DHHS and PHPs will provide coverage to Medicaid NC beneficiaries statewide (statewide contracts).
- Up to 12 capitated PHP contracts between NC DHHS and PLEs will provide coverage for regions as developed by NC DHHS (regional contracts).

NC DHHS defines "statewide" as continuous participation in no less than all six regions; and awarded contracts will be awarded simultaneously where the loss of the ability to participate in any one region results in the loss of the ability to participate in all regions.

PLEs awarded contracts in multiple regions will be counted as having one regional contract per region. Furthermore, NC DHHS intends to use the procurement process to identify the best health plan partners, most qualified proposals and to only issue contracts to those entities. Therefore, based on NC DHHS' evaluation of RFP responses, NC DHHS may decide to issue less than 12 regional PLE contracts and to issue contracts to fewer than 12 unique PLEs.

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<sup>6</sup> Section 4.(6) of Session Law 2015-245, as amended.

NC DHHS’ goal is to ensure viable risk pools, ease provider administrative burden and provide economies of scale while ensuring adequate choice for beneficiaries in each region. To accomplish that goal, NC DHHS is considering:

- Establishing minimum and maximum enrollments for each PHP to apply in the auto-assignment algorithm;
- Setting a maximum number of PLEs per region to ensure all PHPs in a region have sufficient enrollment to operate efficiently; and
- Encouraging PLEs to bid on more than one region.

### Enrollment Minimums and Maximums for Auto-Assignment

Beneficiaries who do not actively select a PHP will be assigned one by NC DHHS. As communicated in prior papers, the auto-assignment algorithm will consider a hierarchy of factors such as:

1. Whether a beneficiary is member of special population;
2. Geographic location;
3. Provider-beneficiary relationship (if available, and only applied at initial rollout);
4. Plan assignment for other family members; and
5. Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors per PHP.

For purposes of step 5 above, but not for beneficiaries who select a health plan, NC DHHS intends to establish plan enrollment ceilings and floors as follows:

- **Enrollment floor:** Set by region as the greater of 10 percent market share or 20,000 lives to ensure economies of scale for efficient PHP operation. The 20,000 lives floor applies only in the Western region (region 1) where there are 140,000 beneficiaries expected to be enrolled in standard plans. Note that the floor is not guaranteed since beneficiary factors will always be looked at first.
- **Enrollment ceiling:** Set by region at 50 percent market share to ensure beneficiaries are distributed across plans in each region.

Following are the proposed initial enrollment floors and ceilings by region based on historical enrollment (see region map on page 5 for reference):

**Table 2. Proposed Enrollment Floors and Ceilings for Auto-Assignment**

Region	Average Lives	Auto-assignment floor (greater of 10% or 20k)	Auto-assignment ceiling (50%)
1	140,000 <sup>7</sup>	20,000	70,000
2	260,000	26,000	130,000
3	370,000	37,000	185,000
4	300,000	30,000	150,000
5	260,000	26,000	130,000
6	210,000	21,000	105,000

<sup>7</sup> Region 1 enrollment is overstated by 4,000 – 5,000 beneficiaries as it includes members of federally recognized tribes who are exempt from managed care.

## Setting a Maximum Number of PLEs per Region

NC DHHS is also considering imposing a cap on the number of regional PLEs awarded contracts for a given region to mitigate the contracting burden on providers while providing a reasonable amount of choice for beneficiaries.

*NC DHHS is seeking comment on this approach.*

## Encouraging PLEs to Bid on More Than One Region

NC DHHS's consulting actuary has indicated that to best ensure the financial and administrative viability of all contracted PHPs, NC DHHS should consider an aggregated minimum of 45,000 to 50,000 lives for a given entity across all regions it is awarded. However, given the dynamics of the number of PHP contracts that may be issued (at least three statewide contracts) and the distribution of Medicaid enrollment across the six regions, a PLE that bids on only one region may find reaching the minimum enrollment challenging. Therefore, NC DHHS will, through the procurement process, encourage PLEs to bid on more than one region. NC DHHS expects to award extra points in the RFP evaluation to PLEs who bid on more than one region.

## Individual Health Insurance Marketplace Participation

In addition to the goal of ensuring the viability of Medicaid managed care as described earlier and awarding capitated contracts to qualified entities only, NC DHHS has a goal to improve the health of all North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses medical and non-medical drivers of health. One way NC DHHS will support that goal is by encouraging PHPs to participate in other North Carolina insurance markets to increase competition and promote seamless access to health care for family units across the coverage continuum or for individuals who churn in and out of various markets. To that end, NC DHHS expects to incentivize PHPs through the procurement process to provide Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM).

The RFP is expected to include an opportunity for PHPs to make a commitment to offer QHPs on the FFM in QHP Plan Year 2021. Commitment to offer QHPs on the FFM will be defined as the timely submission of all necessary NC DOI regulatory submissions (including rates and policy forms) and of a QHP application to the FFM in spring 2020 (or within whatever time frames NC DOI and the FFM establish), and committing to actively seek state and federal approvals to offer QHPs in North Carolina. PHPs will be expected as part of the Technical Response to the RFP to outline current Marketplace participation in North Carolina and other states and to indicate the expected FFM footprint in NC North Carolina in 2021. NC DHHS expects to grant points to RFP respondents for the commitment to participate, for the current participation status, and for the expected footprint in North Carolina in 2021. Should a PHP fail to meet its commitment, as with any commitment made through the PHP response, NC DHHS expects to exercise one of several options to sanction the PHP.

## V. PHP Financial Management and Monitoring

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NC DHHS is developing financial management requirements to monitor and promote program sustainability. NC DHHS expects and will rely on PHPs to be good stewards of Medicaid resources, focusing expenditures on services and benefits that improve beneficiary health. NC DHHS will pay the PHP a monthly risk-adjusted capitation payment that is set in an actuarial sound manner. The PHP is expected to manage its expenditures within the capitation payments and have access to sufficient capital to cover any losses it experiences.

The PHP is expected to closely track and report its expenditures to demonstrate value to NC DHHS and compliance with MLR standards. NC DHHS will monitor PHP expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews and other functions necessary to operate the program.

## Capitation Rate Setting

NC DHHS provided an overview of its proposed capitation rate setting methodology as part of the Actuarial RFI released in November 2017. NC DHHS intends to provide draft capitation rates as part of the PHP RFP, along with detailed documentation to include sufficient information to support organizations' business decisions related to responding to the RFP. Capitation rates will be developed in an actuarially sound manner, reflecting the contractual requirements and expectations of PHPs. The administrative component of the capitation rate is developed based on the costs associated with performing the required functions of a PHP as will be outlined in the contract (rather than a percentage of premium applied).

The capitation rates will include an assumed underwriting gain of 1.75 percent of premium. This is comprised of 1.25 percent for the cost of capital (developed to reflect the recent change in the corporate income tax) and a risk margin of 0.5 percent.

## Medical Loss Ratio

MLR measures the percentage of premiums (less taxes and fees) that are used for health care services and health care quality improvement activities. Session Law 2015-245 includes the following provision related to MLR:

*“Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS, through the Division of Health Benefits.”*

Federal regulations were promulgated in May 2016 (following passage of the state law above), and gave states authority to define an MLR threshold for managed care plans at or above 85 percent with the option to require remittance of any premium falling below the state-required threshold. NC DHHS intends to compare each PHP's aggregate MLR as reported following the end of each rating year against two separate thresholds: one to trigger a required community reinvestment and a lower threshold to trigger premium remittance. These are described in more detail below.

NC DHHS intends to set a minimum MLR threshold based on assumptions used in the development of capitation rates. The threshold will be set to account for the fact that MLR is a one-sided, risk-sharing arrangement in which PHPs must remit premiums when their expenditures for services and health care quality improvement activities are below required levels; however, they do not get additional premiums if those expenditures exceed required levels. Based on this methodology, starting immediately on PHP RFP effective date, NC DHHS expects to set a remittance MLR threshold of approximately 88 percent that will be used to trigger premium remittance to NC DHHS. Additionally, NC DHHS expects to set an overall minimum MLR threshold of approximately 90 percent that will be used to trigger required community reinvestments as described below.

NC DHHS notes that the setting of MLR thresholds is closely linked to the development of capitation rates. For example, MLR and capitation rates are based on the inclusion of current hospital supplemental payments in the rate paid to PHPs. (See “Addressing Hospital Supplemental Payments in the Transition to Managed Care” policy paper.<sup>8</sup>) The inclusion of these payments reasonably results in a higher MLR; the MLR would be lower than reflected here if those payments were not included.

NC DHHS intends to adjust the MLR thresholds by PHP based on the specific population mix covered by each PHP. This is to recognize the fact that populations with lower premiums (such as children) generally have a higher MLR

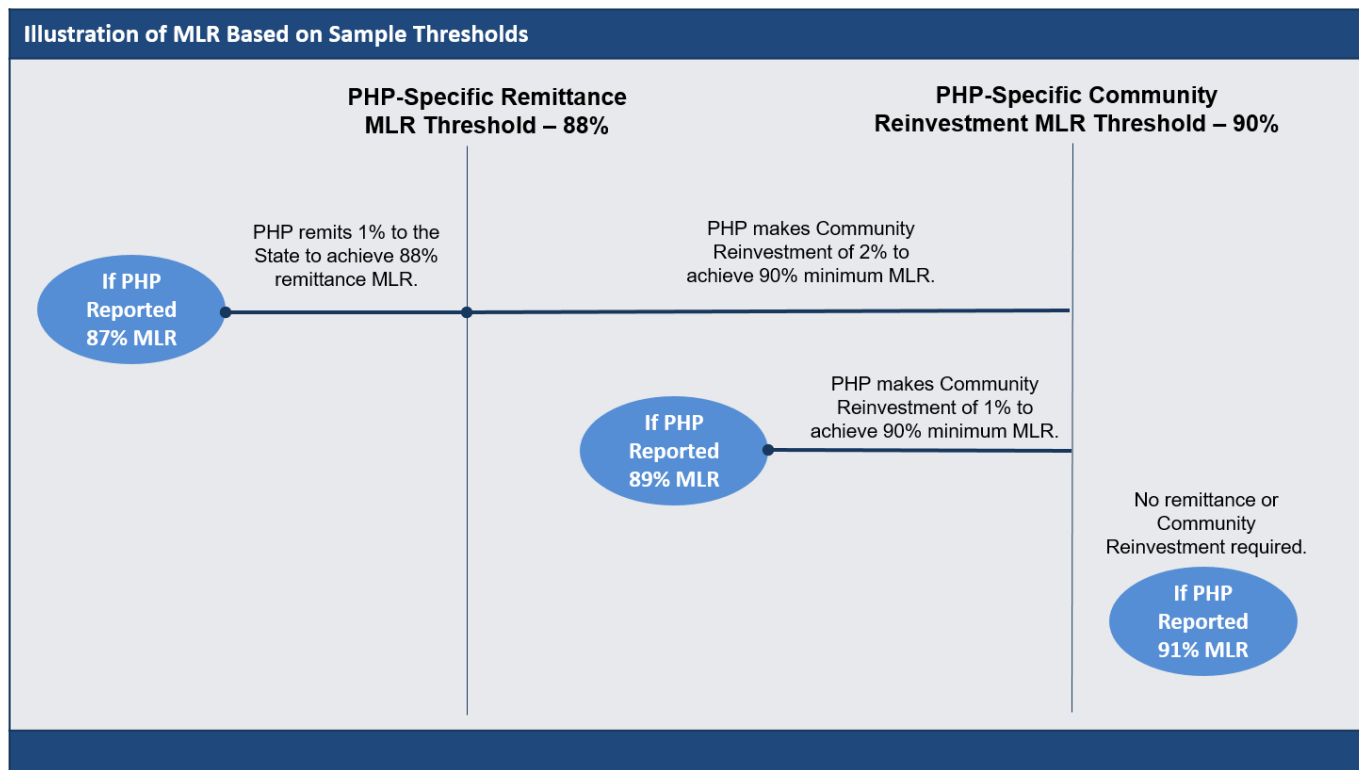
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<sup>8</sup> Addressing Hospital Supplemental Payments in the Transition to Managed Care, [https://files.nc.gov/ncdhhs/documents/files/SupplementalPayments\\_ConceptPaper\\_20181121.pdf?iF8fZ4JaEz6GH.Tjx\\_ZENf7xI9Xg4Bd](https://files.nc.gov/ncdhhs/documents/files/SupplementalPayments_ConceptPaper_20181121.pdf?iF8fZ4JaEz6GH.Tjx_ZENf7xI9Xg4Bd)

than populations with significantly higher premiums (such as individuals with disabilities) because fixed administrative costs for the lower cost groups comprise a higher percentage of total premium.

Refer to Figure 2. for an illustration of how NC DHHS envisions MLR interaction with required community reinvestment and remittance.

**Figure 2. MLR Interaction with Required Community Reinvestment & Remittance**



### Voluntary Community Investments and Required Reinvestments

NC DHHS expects PHPs to maintain strong relationships within their communities and to invest resources in supporting their communities. In other states, the relationship between managed care plans and the communities in which they operate has fostered the long-term success of managed care, and enabled managed care companies to respond to the needs of their beneficiaries. Consistent with this experience, NC DHHS will encourage PHPs to reinvest in community services and supports. Specifically, NC DHHS will require PHPs to provide evidence during the procurement process of their prior experiences supporting and working with communities and community-based organizations. NC DHHS expects that most PHPs will voluntarily make significant efforts to support and engage with communities and community-based organizations. NC DHHS will ensure that all appropriate investments are counted in PHPs’ MLR numerator to the maximum extent allowed under federal regulations.<sup>9</sup> In addition, if a PHP’s MLR falls below a minimum threshold as described above, NC DHHS will expect the PHP to make a required community reinvestment of premium dollars.

NC DHHS’s goal is to see PHPs’ voluntary investments and required community reinvestments dedicated to high-impact initiatives that improve health outcomes and the cost-effective delivery of care. Required community reinvestments will be obliged to meet the conditions below. Additionally, NC DHHS will support voluntary

<sup>9</sup> Activities that improve health care quality are permitted to count in the numerator of the MLR if they are consistent with 45 CFR 158.150 and state guidance.

investments by allowing them to be categorized as “activities that improve health care quality,” thereby counting in the numerator of the MLR,<sup>10</sup> if they meet the following conditions:

- Meet federally required standards for activities that improve health care quality, such as being designed to improve health quality, increase the likelihood of better health outcomes in ways that can be objectively measured and be grounded in evidence-based medicine or widely accepted best practices.
- Meet NC DHHS-established standards that such investments reflect meaningful engagement with local communities and are non-discriminatory with respect to individual beneficiaries and North Carolina geographic regions, including rural areas.
- Meet NC-DHHS-established standards that the expenditures are spent directly in the community to improve outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.

Although PHPs will have some discretion, dollars spent on selected activities, such as those listed below, will be explicitly barred from the definition of activities that meet required community reinvestment standards:

- Administrative costs and salaries for PHPs’ full-time or part-time employees unless strictly limited to the portion of time an identified employee spends directly interacting with community-based organizations to plan and implement required community reinvestment activities;
- Technology or infrastructure investments that are owned or predominantly used by the PHPs; and
- Marketing or branding materials, including those that describe the required community reinvestment activities and their outcomes primarily for the benefit of the PHP.

*The Department is seeking comment on this approach to encourage that sufficient premium dollars are used for improving beneficiary health.*

## Withholds

NC DHHS will use a withhold program to incentivize PHPs in a range of possible areas, including quality improvement, advancement of initiatives to address unmet resource needs and accreditation, Advanced Medical Home Tier 3 contracting goals, and operational effectiveness. Under this program, NC DHHS will “withhold” a share of each PHP’s capitation payment, up to five percent, which will be paid to the PHP on achievement of specific program goals. The withholds are expected to be “reasonably achievable” and compliant with all federal requirements related to capitation rate-setting and actuarial soundness. For more information on the withhold program, see the “Provider Health Plan Quality Performance and Accountability” policy paper.<sup>11</sup>

## Reinsurance Requirement

PHPs will be required to purchase reinsurance to protect against the financial risk of high-cost individuals or propose an alternative mechanism for managing financial risk. This is consistent with the requirements NC DOI is expected to impose as part of the licensure process (pending legislation).

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<sup>10</sup> Dollars spent on a required community reinvestment (assuming they meet all federal and state standards) will count toward the MLR only for the year in which the MLR was below the threshold, not for the MLR in the year in which the dollars were spent. Dollars spent on voluntary community investment (assuming they meet all federal and state requirements) will count toward the MLR in the year in which they are spent. If a PHP chooses to spend more than its required reinvestment amount on community services, the dollars above the required amount would count toward the MLR in the year they are spent.

<sup>11</sup> <https://www.ncdhhs.gov/medicaid-transformation>



To protect against unforeseen events, NC DHHS reserves the right to revisit reinsurance requirements annually and modify the deductible threshold and coverage levels required by NC DHHS, if, on review of financial and encounter data or other information, fiscal concerns arise that such a change in the threshold is deemed warranted by NC DHHS.

In the Actuarial RFI released in November 2017, NC DHHS requested feedback on PHP reinsurance requirements. NC DHHS received a range of responses that contributed to this approach.

### Managing Program Costs

Session Law 2015-245 requires NC DHHS to include in the terms of its contracts with PHPs a requirement that “risk-adjusted cost growth for its enrollees must be at least two percentage points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states.”

NC DHHS intends to track annual growth in each PHP’s expenditures by region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary’s “Actuarial Report on the Financial Outlook for Medicaid,” published annually by CMS. To address an issue where a PHP may have excessive growth, NC DHHS might take such actions as issuing liquidated damages against the PHP, adjusting the auto-assignment process and/or amending the contract.

Session Law 2015-245 also requires that “PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs.” PHPs will be required to utilize a common formulary per State Law, and NC DHHS intends to set reimbursement for prescription drugs to the same level as Medicaid fee-for-service for a limited time. To achieve net savings, PHPs must ensure NC DHHS maintains similar levels of pharmacy rebates achieved under the current Medicaid fee-for-service program. As such, NC DHHS will monitor PHP compliance with the North Carolina Preferred Drug List, and with pharmacy claims encounter reporting standards as a proxy for net savings. PHPs that fail to meet these standards will be subject to liquidated damages and may also be penalized in the auto-assignment process and future contracting decisions.

## VI. PHP Licensure

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***This section is the only part of this policy paper that NC DHHS and NC DOI developed together, and to which NC DHHS and NC DOI agreed.***

Pursuant to Section 4.(2) of Session Law 2015-245, as amended, an entity who holds a capitated contract with NC DHHS must also hold a PHP license issued by NC DOI. Section 6 of the session law specifies, in part, that licensure by NC DOI is based on solvency requirements developed in consultation with NC DHHS that are similar to solvency requirements for similarly situated regulated entities. NC DOI and NC DHHS have worked together to propose legislation giving NC DOI specific authority to license PHPs.

The agencies’ agreed-upon approach would establish a process for an entity to become licensed as a PHP. This would be accomplished by enacting a new article in Chapter 58 of the North Carolina General Statutes, Article 93, entitled the “Prepaid Health Plan Licensing Act.”<sup>12</sup> The new article would establish the solvency and licensing requirements for PHPs. Below are some of the key elements of the proposed legislation:

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<sup>12</sup> While the version of HB 156 Medicaid PHP Licensure/Food Svcs in State Bldgs. passed by the Senate on June 22, 2017, includes a PHP licensing proposal to be located in a new Article 93 of Chapter 58, that proposal differs slightly from the two agencies’ proposal developed in spring 2017 and with more recent discussions.

- To obtain a PHP license, an entity would be required to make an application to NC DOI and pay an application fee.
- A health organization holding a current license from NC DOI would not be required to file an application or pay the application fee but would be recognized as a PHP and issued a PHP license upon showing that it meets the requirements of the proposed Article 93 of Chapter 58.
- PHPs would be required to maintain a minimum capital and surplus equal to the greater of one million dollars or the amount required under the risk-based capital provisions of Article 12 of Chapter 58. For a licensed health organization, the capital and surplus requirement of one million dollars would be in addition to its existing static capital and surplus requirement.
- All PHPs would be required to make a deposit of at least \$500,000 to be administered in accordance with Article 5 of Chapter 58. For a licensed health organization, the deposit requirement would be in addition to its existing deposit requirement.
- The proposed legislation includes a provision allowing NC DOI to utilize consultants and other professionals in the application review process, and to be reimbursed by the licensee or applicant for the costs of such reviews.
- The proposed legislation outlines actions NC DOI could take if an entity with PHP licensure is in a hazardous financial condition.
- The proposed legislation outlines the circumstances under which NC DOI could suspend or revoke a PHP license, or take any other action against a PHP.
- The proposed legislation provides that NC DOI will notify NC DHHS before taking certain adverse actions against any entity operating as a PHP.
- The proposed legislation provides for the confidentiality of information shared between NC DOI and NC DHHS in the oversight of the licensure and solvency of PHPs and apply relevant provisions relating to licensure, solvency, and financial oversight from Chapter 58 to entities that hold a PHP license.

These provisions are based on, and very similar to, the authority of NC DOI to take similar actions against Health Maintenance Organizations (HMOs).

At this time, no legislation has been enacted giving NC DOI authority to license PHPs. Without statutory authority, NC DOI cannot issue PHP licenses or accept applications for PHP licenses. Once licensure legislation is enacted, depending upon the quality of the application and staffing resources available, NC DOI estimates that the review of a PHP license application may take up to 120 days.

Because NC DOI currently does not have the authority to license PHPs, NC DHHS does not expect to require PHP RFP respondents to have a PHP license at the time the entity responds to the PHP RFP. NC DHHS prefers to award a PHP contract only to respondents (who have been selected for a contract award) that hold a PHP license at the scheduled award date. However, should NC DOI's review of licensure applications be negatively impacted due to a delay in the enactment of licensure legislation or due to the volume of applications, NC DHHS and NC DOI will work together to assure that no PHP RFP respondent will be disadvantaged in the RFP evaluation or contract award process because of such delays. Nonetheless, in no case will NC DHHS permit an unlicensed PHP to participate in open enrollment or operate as a North Carolina Medicaid PHP. Therefore, NC DHHS will reserve the right to terminate the contract award should a selected PHP not obtain licensure within the required period following the award date or lose its license at any point during the contract period.

In addition to collaborative efforts to establish a legislative framework for PHP licensing, NC DOI and NC DHHS have proposed the following as other legislative changes relating to licensing and oversight of PHPs' Medicaid operations:

- Requiring certain sections from Chapter 58 to be incorporated by NC DHHS regarding its regulation of PHPs.
- A proposal to amend G.S. 58-67-95 to provide an entity who is solely licensed as a PHP with authority to organize and operate a HMO under Chapter 58, Article 67 subject to NC DOI's prior approval, the same as insurers and hospital and medical service corporations.
  - The process would require the PHP to prove compliance with all the applicable standards for HMO licensure.
  - To further facilitate reviews of this type, the proposed legislation would include a provision allowing NC DOI to utilize consultants and other professionals in these reviews, and to be reimbursed by the licensee or applicant for the costs of reviews.

***This ends the section that NC DHHS and NC DOI developed together, and to which NC DHHS and NC DOI agreed.***

## VII. PHP/Provider Contracting

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Per state law,<sup>13</sup> PHPs must include “all willing providers” in their networks, except when the provider refuses to accept network rates or where the provider fails to meet “objective quality” standards. Providers who want to continue receiving reimbursement for beneficiaries enrolled in Medicaid managed care will be required to contract with PHPs. Information relating to “objective quality” standards and how PHPs will use provider information collected under the centralized credentialing process in contracting decisions can be found in the the previously issued “Centralized Credentialing and Provider Enrollment” policy paper.<sup>14</sup>

NC DHHS expects to require PHPs, through the PHP contract, to use NC DHHS-approved provider templates in contracting with providers. Those state-approved contract templates, which are expected to be initially submitted as part of the PHP RFP technical response and subsequently whenever material changes are made, will be required to include specific provisions that address certain key issues and situations. NC DHHS plans to produce a checklist of standard and mandated provisions for PHPs to use in drafting contract templates, but may require certain provisions be included in the contract templates.

As the PHPs must use only approved contract templates in their provider contracting activities, it is expected that PHPs will classify contracts with identifying contract template numbers located in the lower left-hand side of the first page of the contract to assist with tracking approved templates. PHPs will be expected to resubmit a contract for approval whenever there is a material change to contract template language. NC DHHS expects to develop a standard time frame for its review of provider contract templates that will apply when reviewing templates outside of the PHP RFP response review. PHPs are encouraged to plan their provider contracting activities accordingly. PHPs may be subject to liquidated damages or other penalties for failure to obtain prior approval of a contract or for the use of an unapproved contract template.

NC DHHS expects to require PHPs to include standard provisions based on those required in commercial insurance provider contracts as found in Title 11 North Carolina Administrative Code 20.0202. The checklist, which is

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<sup>13</sup> Section 5.(6)d. of Session Law 2015-245, as amended.

<sup>14</sup> <https://www.ncdhhs.gov/medicaid-transformation>

expected to be published concurrently to the PHP RFP issuance, will contain additional detail on the specific provisions in the administrative code that will be required. Examples of possible standard provisions include explaining what constitutes the contract; setting the requirements for written notice of termination; and how a provider may not bill a beneficiary for covered services except for cost sharing as provided in the PHP RFP.

NC DHHS expects to also require PHPs to include certain provisions where the text of the provision is prescribed. The checklist will contain additional detail on the provisions and the expected content for the contract templates. Examples of possible topics to be addressed through dictated content may include claims submission and prompt pay expectations, provider appeals, and PHP and NC DHHS access to records.

*NC DHHS is seeking comment this approach on the topics where it should mandate language for inclusion in provider contracts; recommended contract provision language is preferred.*

## VIII. Payments to Out-of-Network Providers

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As is required by federal law, PHPs will cover out-of-network services for enrollees if unable to provide necessary covered services within their network and must coordinate with those out-of-network providers for payment. If a PHP has made a good faith effort to contract with a provider that has refused that contract, or if the provider is excluded from contracting for failure to meet objective quality standards, PHPs will be prohibited from reimbursing the provider more than 90 percent of the Medicaid fee-for-service rate for services. PHPs and providers will have flexibility to mutually agree to alternative payment arrangements on a case-specific basis.

As required by federal law, PHPs will also cover family planning services and supplies regardless of a provider's network status, and will cover and pay for emergency services without regard to prior authorization or network status. For out-of-network emergency or post-stabilization services, PHPs will pay no more than the Medicaid fee-for-service rate. For out-of-state hospitals (that are not part of a PHP's network) PHPs will pay the Medicaid fee-for-service rate.

Information on other requirements around provider payments will be released in a future policy paper.