Provider Rate Floor and Reimbursement Scenarios for North Carolina PHPs

May 31, 2018

Purpose of This Document

This document outlines the provider reimbursement requirements for Prepaid Health Plans (PHPs) under various scenarios based on the interaction among rate floors, in-network service availability, and a provider's in-network or out-of-network status in the context of North Carolina Medicaid managed care. The document addresses reimbursement for Medicaid covered benefits. Per member per month payment requirements for Advanced Medical Homes and care management functions are outside the scope of this document.

Payment Standards

The table below lays out requirements established by federal law, state law, or North Carolina proposed program design for Medicaid managed care.

Provider Type/Service	Policy
In-network primary and specialty care physicians (and extenders)	Rate floor set at 100% of Medicaid fee-for-service (FFS) rate[1]
In-network pharmacies	Rate floor set at 100% of Medicaid FFS rate for dispensing fees; required to use DHHS ingredient cost methodology unless DHHS authorizes otherwise
In-network hospital inpatient[2] (excluding BH)	Required to offer the Medicaid FFS inpatient rates and use the Medicaid FFS case weights and outlier methodology[3, 4]
In-network hospital outpatient[2] (excluding BH)	Required to offer the Medicaid FFS outpatient rate which will be charges multiplied by the hospital-specific Medicaid cost-to-charge ratio[3, 4]
Out-of-network (OON) providers who provide emergency and/or post-stabilization care services	Reimbursement at the applicable Medicaid FFS rates.
OON provider when the PHP is required to continue a member's ongoing course of treatment at initial PHP enrollment	Reimbursement at the applicable Medicaid FFS rates.

[1] In cases with applicable rate floor, an alternative payment arrangement applies if mutually agreed to by the PHP and the provider.

[2] PHPs will be allowed to negotiate inpatient and outpatient reimbursement for behavioral health claims with hospitals.

[3] Inpatient and outpatient payment requirements will be in effect for a limited time: five years for critical access hospitals (CAHs) and hospitals in Tier 1 counties, and three years for other hospitals. Additional utilization-based payments will be made for UNC/Vidant hospitals.

[4] PHPs may offer hospitals a different inpatient or outpatient rate (including value-based payment or other alternative payment methodology), or use a different methodology provided the arrangement is mutually acceptable to the hospital and PHP.

Provider Type/Service	Policy
Except for a member continuity of care circumstance, out-of-network (OON) providers who provide non-emergency or post-stabilization services where the PHP has made a "good faith" effort to contract with a provider who has refused that contract or where the provider was excluded from the PHP network for failure to meet objective quality standards	PHPs are prohibited from reimbursing at more than 90% of the Medicaid FFS rate
Including for a member continuity of care circumstance, out-of-network (OON) providers who provide non-emergency or post-stabilization services where the PHP has not made a "good faith" effort to contract with a provider who has refused that contract and where the provider was not excluded from the PHP network for failure to meet objective quality standards	In the absence of a negotiated agreement, PHPs are required to reimburse provider at 100% of the Medicaid FFS rate
Local health departments (LHDs)	Interim reimbursement is not lower than rates paid to non-public providers for similar services and additional payments are made in accordance with state requirements[5, 6]
Public ambulance providers	Interim reimbursement is not lower than rates paid to non-public providers for similar services and additional payments are made in accordance with state requirements[7]
Facilities that are state-owned and operated by Division of State Operated Healthcare Facilities (DSOHF)[8]	Reimbursement is set at the rates established by the DHHS Controller
Veterans homes that are operated by the Division of Military and Veteran's Affairs (DMVA)	Reimbursement is set at the rates established by DHHS in collaboration with DMVA
Federally qualified health centers (FQHCs) and Rural health centers (RHCs)	Reimbursement is not lower than rates prescribed by DHHS[9]

[5] Certain LHD services (e.g., LHD enhanced role registered nurses providing EPSDT well child exams, STD exams, and low-risk family planning and obstetrical services) will be reimbursed at the enhanced LHD Medicaid FFS schedule.

[6] North Carolina intends to require additional, utilization based payments outside PMPM and maternity event capitation to local health departments, public ambulance providers, and UNC/Vidant hospitals to ensure they are reimbursed at levels similar to FFS.

[7] PHPs will not make additional payments to public ambulance providers for NC Health Choice, which means that the negotiated rates will serve as the complete payment for these providers. Additional, utilization-based payments will be only made to in network public ambulance providers.

[8] It will be rare for standard plans to be paying for services in most DSOHF facilities.

[9] North Carolina will provide wrap payments to FQHCs and RHCs to cover the difference between the rate paid by the PHP and the state determined prospective payment system (PPS) rate or actual costs as applicable.

Provider Type/Service	Policy
Indian Health Care Providers (IHCPs) that are not enrolled as FQHCs (both in-network and OON)	Reimbursement is set at the encounter rate published annually in the Federal Register by the Indian Health Service or the Medicaid FFS rate for services that do not have an applicable encounter rate
Hospice services	Reimbursement shall be no less than the annual federally established Medicaid hospice rates[10]
Nursing facilities	Rate floor set at 100% of Medicaid FFS rate for a limited time

- Rate floor and mandate rules apply to *in-network services only* for physicians, physician extenders, pharmacies, nursing facilities and hospitals.
- The PHP will be required to develop policies and procedures regarding provider contracting, including defining a "good faith" contracting effort and the objective quality standards used in contracting decisions that will be subject to Department review. Each PHP will be expected to consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.
- Prior authorization (PA) may be required for OON services except for emergency services, family planning, services provided by IHCPs and other services as stipulated in the PHP contract.
    - A plan may deny PA if the beneficiary chooses to obtain a service from an OON provider, unless the service is not available in the network.
    - An OON provider may deny to treat a beneficiary except in emergent situations.
    - Providers may not balance-bill Medicaid enrollees for any unreimbursed services, including OON services.
- During the transition from FFS to managed care or from one PHP to another, enrollees who are in an ongoing course of treatment or who have an ongoing special condition are permitted to continue seeing their provider, regardless of the provider's network status, for up to 90 days.[11] PHPs will be required to reimburse OON providers for services provided during the transition period at 100% of the Medicaid FFS rate.

Example Reimbursement Scenarios (for providers other than public providers, FQHCs, RHCs, and IHCPs)

In the charts below, "**Good faith/quality"** means the plan engaged in a good faith effort to contract but the provider refused or the provider was excluded from the network for failure to meet objective quality standards. "**Not good faith/quality"** means the plan has not engaged in an effort to contract with the provider nor has the provider been excluded for failure to meet objective quality standards.

[10] For hospice patients residing in nursing facilities, the PHP shall reimburse hospice providers 95% of the Medicaid nursing home FFS room and board rate, in addition to the home care rate.

[11] These transition requirements also apply to (1) pregnant enrollees in the 2nd or 3rd trimester, allowing the enrollees to continue seeing their provider(s), regardless of the provider's network status, through the pregnancy and through 60 days after delivery, and (2) when an enrollee was determined to be terminally ill at the time of the transition, allowing enrollees to continue seeing their provider, regardless of the provider's network status, for the remainder of the enrollee's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

A. Service Available from In-Network Provider (Non-Emergent)

The chart below explains how providers are paid for non-emergent services that are available in-network, depending on whether the provider is in-network, whether there is an applicable rate floor for that provider type and, if the provider is out-of-network, whether the PHP has made a good faith effort to contract with a provider who has refused that contract or whether the provider was excluded from the PHP network for failure to meet objective quality standards.

Provider In-Network?	Rate Floor/Directed Payment for Provider Type?	Payment Amount
Yes	Yes	Directed payment or rate floor amount, unless alternative payment agreed to
Yes	No	Negotiated rate
No (Good faith/quality)	Yes	90% Medicaid FFS rate
No (Good faith/quality)	No	90% Medicaid FFS rate
No (Not good faith/quality)	Yes	In absence of a negotiated agreement, 100% Medicaid FFS[12]
No (Not good faith/quality)	No	In absence of a negotiated agreement, 100% Medicaid FFS[12]

B. Service Not Available from In-Network Provider (Non-Emergent)

The chart below explains how providers are paid for non-emergent services that are not available in network, depending on whether there is an applicable rate floor for that provider type and whether the PHP has made a good faith effort to contract with a provider who has refused that contract or whether the provider was excluded from the PHP network for failure to meet objective quality standards.

Provider In-Network?	Rate Floor/Directed Payment for Provider Type?	Payment Amount
No (Good faith/quality)	Yes	90% Medicaid FFS rate
No (Good faith/quality)	No	90% Medicaid FFS rate
No (Not good faith/quality)	Yes	In absence of a negotiated agreement, 100% Medicaid FFS[12]
No (Not good faith/quality)	No	In absence of a negotiated agreement, 100% Medicaid FFS[12]

C. Emergent or Post-Stabilization Service

The chart below explains how providers are paid for emergent or post-stabilization services depending on whether the provider is in-network, whether there is an applicable rate floor for that provider type, and, if the provider is out-of-network, whether the PHP has made a good faith effort to contract with a

[12] DHHS will consider whether this requirement is necessary at the end of Year 1, leaving plans and providers to negotiate reimbursement.

provider who has refused that contract or whether the provider was excluded from the PHP network for failure to meet objective quality standards.

Provider In-Network?	Rate Floor/Directed Payment for Provider Type?	Payment Amount
Yes	Yes	Directed payment, or rate floor amount, unless alternative payment agreed to
Yes	No	Negotiated rate
No (Good faith/quality)	Yes	100% Medicaid FFS rate
No (Good faith/quality)	No	100% Medicaid FFS rate
No (Not good faith/quality)	Yes	100% Medicaid FFS rate
No (Not good faith/quality)	No	100% Medicaid FFS rate

D. Transitions of Care (Time Limited)

The chart below explains how providers are paid during transitions of care depending on whether the provider is in-network, whether there is an applicable rate floor for that provider type, and, if the provider is out-of-network, whether the PHP has made a good faith effort to contract with a provider who has refused that contract or whether the provider was excluded from the PHP network for failure to meet objective quality standards.

***Transition of care** – A process for transitioning a member from one type of health care to another (e.g. FFS to managed care) or from one managed care organization to another (e.g. from PHP A to PHP B), where in certain circumstances an existing relationship with a provider is required to continue and be covered, even when the provider is not a network provider.*

Provider In-Network?	Rate Floor/Directed Payment for Provider Type?	Payment Amount
Yes	Yes	Directed payment, or rate floor amount, unless alternative payment agreed to
Yes	No	Negotiated rate
No (Good faith/quality)	Yes	100% Medicaid FFS rate
No (Good faith/quality)	No	100% Medicaid FFS rate
No (Not good faith/quality)	Yes	100% Medicaid FFS rate
No (Not good faith/quality)	No	100% Medicaid FFS rate