MEDICAID TRANSFORMATION

Supporting Provider Transition to Medicaid Managed Care

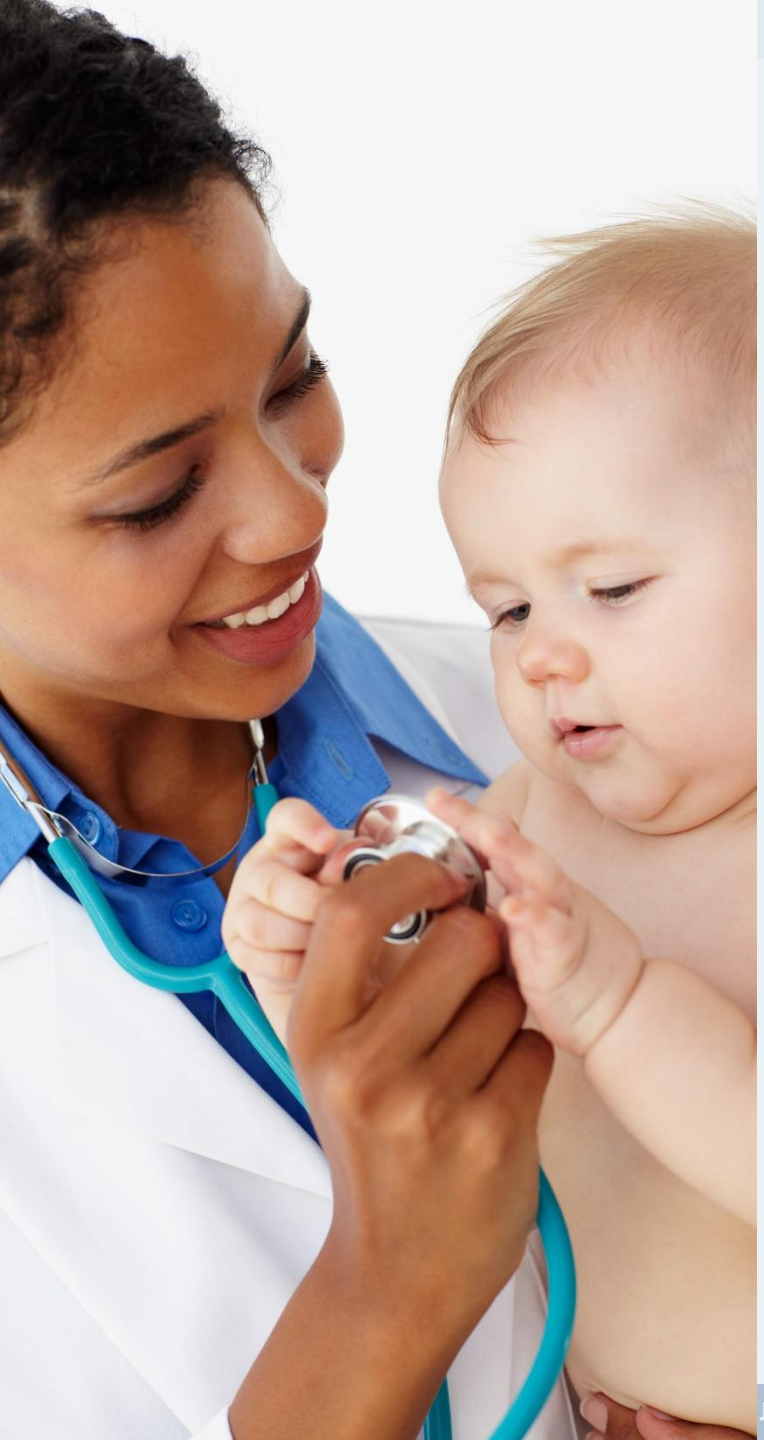
Department of Health and Human Services

June 2018

NC Medicaid Transformation website:
www.ncdhhs.gov/medicaid-transformation

What we'll cover today

- Medicaid managed care overview
- Provider enrollment and credentialing
- Provider contracting with Prepaid Health Plans (PHPs)
- Meeting Advanced Medical Home (AMH) requirements



North Carolina's Vision for Medicaid Managed Care

By implementing managed care, and advancing integrated and high-value care, North Carolina Medicaid will improve population health, engage and support providers, and establish a sustainable program with more predictable costs.

North Carolina's Goals for Medicaid Managed Care

1. Measurably improve health
2. Maximize value to ensure program sustainability
3. Increase access to care

Medicaid transformation status

Aug. 2017	Proposed Plan Design
Nov. 2017	Amended 1115 Waiver
Nov. 2017 opened Dec. 15, 2017	Operations & Actuarial RFIs
March 2018 opened April 13, 2018	Enrollment Broker RFP
Nov. 2017 to Summer 2018	Policy Papers

Medicaid managed care rumor #1

Some PHPs have already been selected to participate in NC Medicaid Managed Care

You may have heard…

Medicaid managed care rumor #1

FALSE

TRUE

- NO PHPs have been selected
- NO PHP contract has been drafted

Key milestones in progress

PHP RFP	PHP Licensure & DOI Chapter 58 Provider Protections	Behavioral Health Integration	1115 Waiver Approval by CMS

ONGOING: Listening to and talking with stakeholders

Recent and upcoming releases

- June 6: Beneficiary ombudsman program request for information
- Provider data management (PDM)/CVO request for proposal

Transition to Medicaid managed care

- Enrollment
- Credentialing
- Contracting
- Payments
- AMH Requirements

Changing how Medicaid benefits are delivered

From predominantly fee-for-service program to Medicaid managed care model

Provider enrollment and credentialing

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

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Provider Participation

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

Credentialing is a central part of the federally regulated screening and enrollment process

2016 Medicaid Managed Care Final Rule
21st Century Cures Act

Centralized credentialing–full implementation

APPLICATION & VERIFICATION

PROCUREMENT & CONTRACTING

Department Process

PHP Process

Provider applies

- Application is single point-of-entry for all providers
- Required to participate in Medicaid Fee-for-Service or Medicaid Managed Care
- Follows Medicaid rules

PDM/CVO verifies credentials

- Managed by accredited PDM/CVO
- Required to contract in Medicaid Managed Care
- Follows national accreditation standards (e.g., NCQA)

PHP PNPC reviews & approves/denies

- Established and maintained by PHP
- Reviews & makes "objective quality" determinations
- PHP Provider Network Participation Committee
- Cannot request more information for quality determinations
- Monitored by the Department

PHP and provider negotiate contract

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

Medicaid managed care rumor #2

There will be only ONE plan offering Medicaid managed care

You may have heard…

Medicaid managed care rumor #2

FALSE

TRUE

- DHHS may select up to 15 PHPs using established, thorough state procurement processes
- 3 statewide PHPs and up to 12 regional provider-led entities

Network adequacy

- PHPs must maintain sufficient provider networks for adequate access to covered services
- The Department will develop network adequacy standards; e.g., time/distance, “realized access”
- Law requires PHPs to contract with all “essential providers”
- Building provider networks is a standard business operation for health plans

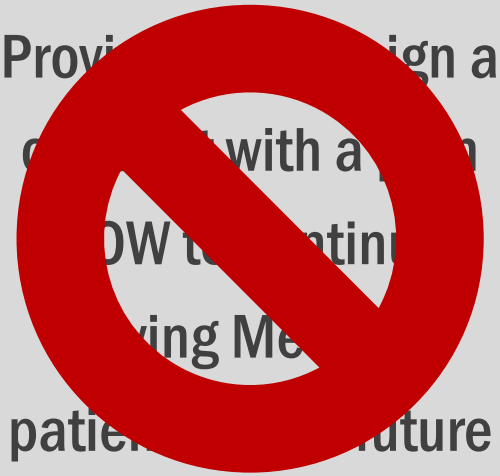
Medicaid managed care rumor #3

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future

You may have heard…

Medicaid managed care rumor #3

FALSE



TRUE

- PHPs must contract with DHHS
- PHPs must be licensed by the state
- PHPs must have their provider manuals, contracts and contracting policies and procedures approved by DHHS
- Medicaid Fee-for-Service program will remain operational to serve excluded populations – although a smaller program.

Before PHP contracts are awarded

Pre-Award Period

Build relationships with health plans

Understand contract terms, conditions, payment and reimbursement methodologies

Contracting Guidance

- **Letters of intent**
  Non-binding indication of health plan and provider's intent to enter into contract negotiations
- **"Any willing provider"**
  PHPs must contract with providers willing to accept reimbursement unless "objective quality" concerns
- **Department-approved contracts**
  Mandated clauses and specific provisions

Conflict resolution for enrollment & credentialing

Appeals process will be the same across all PHP contracts

Providers can appeal determinations, including enrollment and contracting

Submitting Appeals

Appeal to Department

Enrollment, including credentialing, as a provider in Medicaid ***only***

Appeal to PHP

"Objective quality" contracting determinations

Provider payments

- Rate floors/ceilings
  - PHPs will comply with Department-established rate floors for certain in-network providers
  - PHPs and providers can mutually agree to different rates through PHP/provider contract
  - Department will monitor PHP/provider contracts to determine if rate ceilings need to be established
- Department will hold PHPs to prompt pay requirements
- Out-of-network services will be covered if PHP provider network is unable to provide necessary services covered under the contract, subject to prior authorization
- Out-of-network provider of emergency or post-stabilization services will be paid no more than Medicaid fee-for-service rates

Contract monitoring & compliance oversight

Department Goal

Ensure PHP operations consistently provide reliable health care to Medicaid managed care members

External Quality Review Organization

- Federally required
- Performs external quality review of mandatory and optional activities (to be defined in upcoming EQRO RFP)

EQRO requirements are listed in 42 CFR Part 438, subpart E

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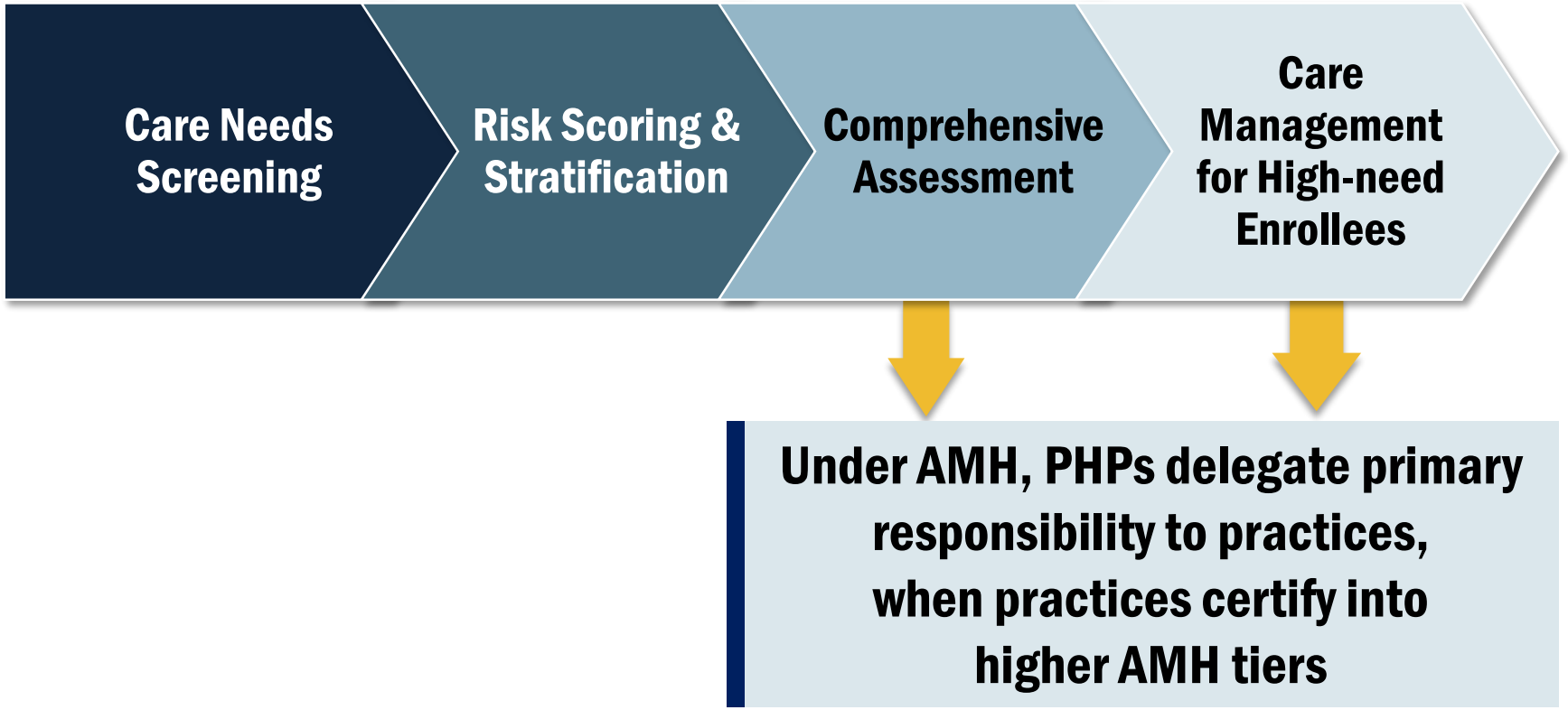
Population health: care management

PHPs will be responsible for care management of enrollees



Advanced Medical Home overview

AMH program will:

- Build on strengths of current primary care infrastructure
- Offer range of participation options for providers
- Emphasize local delivery of care management
- Offer opportunity for providers to be rewarded for high-quality care by aligning payment to value

Care management will be a shared responsibility of practices and PHPs, with division of responsibility varying by AMH tier

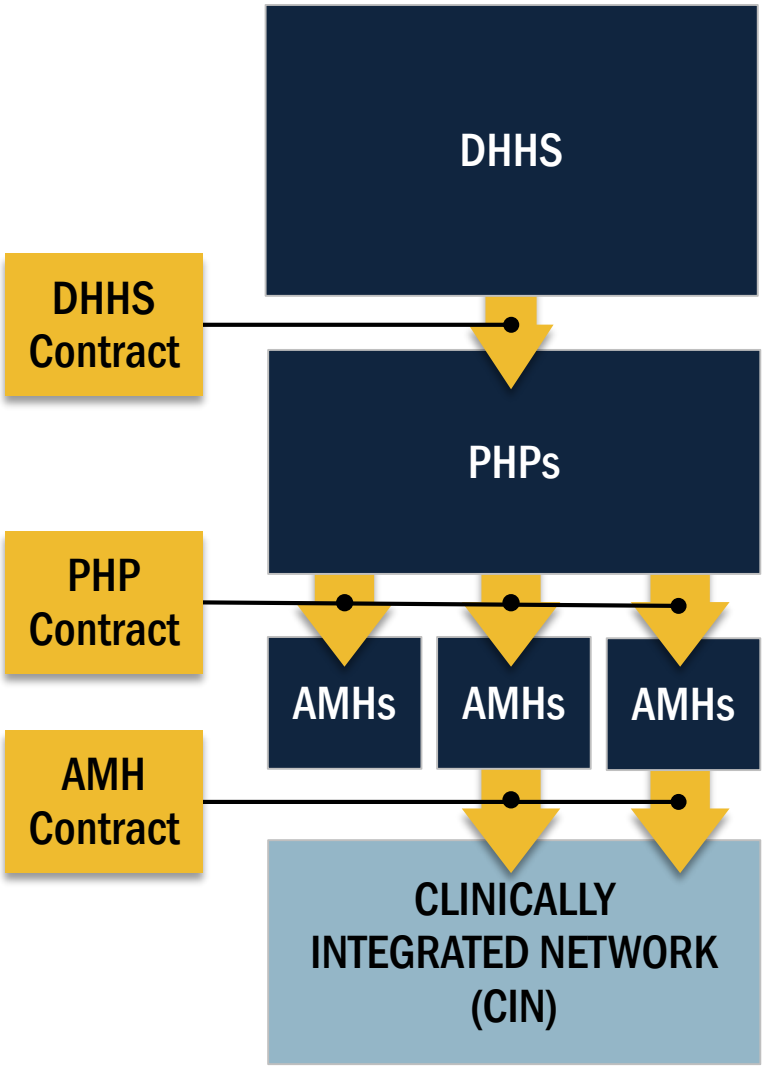
AMH program will launch concurrently with managed care, with a DHHS certification process for practices launching later this year

Transition plan for Carolina ACCESS practices

CAROLINA ACCESS STATUS	ELIGIBILITY FOR AMH PROGRAM			
	NOT AMH ELIGIBLE	AMH TIER 1 CERTIFIED (will phase out after 2 years)	AMH TIER 2* CERTIFIED	AMH TIER 3 CERTIFIED
NOT PARTICIPATING IN CA	Default placement	Not permitted	If successfully attests to Tier 2 requirements	If successfully attests to Tier 3 requirements
CA I	Choose: • Not to contract as an AMH, OR • Notify DHHS to be removed from master list	Default placement	Notify DHHS to be placed into Tier 2	
CA II		Not permitted	Default placement	

*Tier 2 requirements are same as Carolina ACCESS requirements **CAI providers are already meet Carolina ACCESS requirements

Tier 3 AMH oversight roles/responsibilities



- Place CM requirements in contract
- Conduct oversight/monitoring of PHPs
- Develop attestation; require PHPs to have selected terms/conditions in PHP/AMH contract
- Certify AMH practices

Establish specific terms/conditions in PHP/AMH contract

- Attest to requirements
- Contract with PHPs and, if applicable, CIN

- Support Tier 3 AMHs in meeting requirements
- Contract with AMHs

The Department does not place direct requirements on CINs or have an attestation/certification process for CINs

Next steps

- Policy paper comments (Monday, June 11)
- MCAC Provider Engagement Subcommittee (meetings begin summer 2018)
- Provider engagement and support training
  - Strategy, planning and rollout
  - AMH certification training (Q3 2018)
- Future Medicaid program announcements
  - PHPs
  - PDM/CVO
  - Enrollment broker
  - Beneficiary Ombudsman

QUESTION & ANSWER

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Next Webcasts:

Monday, June 11 – 1-2 p.m. Eastern time
Thursday, June 14 – 3-4 p.m. Eastern time

To Register:

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