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Supporting Provider Transition to Medicaid Managed Care

While providers in the BH/I-DD public system have had a taste of managed care through the 1915(b)(c) Medicaid waiver, the complexity and number of partnerships with local funders/MCOs/Prepaid Health Plans (PHPs) is going to dramatically increase, particularly for statewide providers and providers who will serve the mild-to-moderate BH/I-DD population. NC DHHS appears to recognize this shift for providers across the healthcare spectrum and is creating resources to assist providers in this transition. They recently published a concept paper ***Supporting Provider Transition to Medicaid Managed Care*** that lays out many of the expectations of the relationship between Prepaid Health Plans (PHPs or funders) and providers as well as their intentions to build assistance and support for providers. Some of the points made regarding the PHP and Provider relationship include:

- Because an 1115 Medicaid waiver requires an open network and contracts with any willing providers, PHPs must contract with any provider at or above the lowest rate set. PHPs do not have to contract with providers when the provider does not meet "objective quality" standards.
- PHPs will have to meet specific requirements with essential providers such as federally qualified health centers, rural health centers, local health departments, veterans homes and free clinics. These essential providers are expected to be a fundamental part of every provider network.
- PHPs and providers will have contracts in place that are likely to be framed around template components that are provided by NC DHHS.
- PHPs will receive incentives for engaging in value-based payment arrangements with providers.
- Provider appeals (this does not include recipient service appeals) will be done through the Department when it is related to enrollment as a provider and through the PHP when it is related to objective quality contracting decisions. PHPs will be following State and federal requirements for contract appeals. Note that the Office of Administrative Hearings is not involved in the contract appeals.
- There are several areas of the paper where NC DHHS encourages providers to educate themselves on the contract and reimbursement policies of PHPs prior to the contract negotiations.
- Out-of-network providers will receive 90% of the allowable Medicaid reimbursement.
- There will be prompt payment requirements for PHPs to reimburse providers.

The framework, support and assistance NC DHHS will provide includes:

- A new, integrated Provider Data Management solution and Credentials Verification Organization (PDM/CVO) that will do statewide credentialing and other functions. This role will not be in place when Medicaid managed care begins and will transition into place. Because PHPs need additional information beyond credentialing in order for them to meet national accreditation standards, NC DHHS is working to include a component to standardize the additional information so that providers only submit it once.

- NC DHHS will have a template PHP/Provider contract in place [along with the contracts they will have with the PHPs].
- NC DHHS identifies several types of organizations such as Advanced Medical Home, pharmacies, public ambulances and safety net hospitals that will have special arrangements with the PHPs.

This concept paper also reviews several requirements for PHPs that were previously stated in the "Centralized Credentialing and Provider Enrollment" concept paper released on March 20, 2018. Concept papers build upon each other and provide more and more detail to the structuring of the public system under managed care. In the application to the federal CMS for the 1115 Medicaid waiver and in past concept papers, NC DHHS has also proposed additional components of assistance and support for providers. The 1115 Waiver application and concept papers include ideas such as:

- Conducting a thorough workforce evaluation and the creation of an Innovation Workforce Fund (projected need is $45 million) to address shortages in the public service system. *(citation: Amended 1115 Medicaid waiver application, November 2017)*
- Establishing a Telemedicine Alliance and creating a Telemedicine Innovation Fund (up to $80 million) to encourage the use of telemedicine as a means for integrating care. *(citation: Amended 1115 Medicaid waiver application, November 2017)*
- Selecting Regional Provider Support Centers (RPSCs) through a competitive bid process to support providers in: (1) obtaining advanced medical home certification and advancing into higher levels of certification, and (2) continuous quality improvement. The RPSC entities will be not-for-profit organizations, overseen by DHHS, responsible for delivering these support services, including for small providers, rural providers, and essential providers. *(citation: Medicaid Managed Care Proposed Program Design, August 2017)*

Provider Webcast Opportunity

NC DHHS is also offering a webcast on three different days in June for providers to hear more information about the transition to managed care. Providers are required to sign up for the webcast of their choice to get the access information.

Prepaid Health Plans in NC Managed Care

Not to be forgotten, the Prepaid Health Plans have also been given some attention in a concept paper that was published on May 16th. Prepaid Health Plans will be licensed under the NC Department of Insurance. The 2015 Medicaid Transformation legislation included two types of PHPs that may compete for contracts under the Standard Plan and eventually under the BH/I-DD Tailored Plan as well: Commercial Plans (CPs) that can include non-profit and for-profit entities and Provider-Led Entities (PLEs) that must, by definition, have the majority of their voting members made up of certain medical professionals. Per statutory requirement, there will be three Commercial Plans with statewide contracts and up to twelve regional contracts that may include Commercial Plans and Provider Led Entities. While LME/MCOs are currently licensed as Prepaid Inpatient Health Plans, they can seek PHP licensure in order to bid for RFPs in the future. Currently there is not NC statutory language that categorizes a Prepaid Health Plan under the Department of Insurance. That will require a legislative change to Chapter 58 of the NC

General Statutes, Article 93. In addition to this legislative change, some statutory language allowing for alternative entities to bid may be needed to accommodate some of the innovative funder structures that are being established, e.g. Carolina Complete—a partnership of the NC Medical Society, Centene and the NC Community Health Care Centers Association.

The following points are made in this concept paper that add to the detail of the statewide PHP structure:

- PHP licensure is not a requirement for bidding on the RFP
- Proposed enrollment ceilings and floors by region are established.
- PLEs are encouraged to bid for more than one region to achieve higher efficiency.
- Financial costs and savings of PHPs will be tracked by NC DHHS.
- PHPs will be encouraged by NC DHHS to reinvestment into the communities.
- NC DHHS will use Medical Loss Ratio national standards to monitor use of funds toward services.
- Withholds will be used (up to 5% of PMPM withheld) to incentivize PHPs to achieve set goals.
- As part of the mitigation of risk, PHPs will be required to have a reinsurance policy that will protect them against financial instability due to high need beneficiaries.
- PHP experience in Medicaid managed care will be considered in the RFP process.

Medical Care Advisory Committee Continues Subcommittee Work on Medicaid Transformation

The MCAC serves as an advisory group to the NC Department of Health and Human Services (NC DHHS). Such an advisory group is mandated in federal statute. NC DHHS Secretary Mandy Cohen has designated the MCAC as a mechanism for further developing concepts that are included in the restructuring of the entire Medicaid program to managed care. MCAC developed four subcommittees specifically to address components of the Medicaid restructure. The subcommittee memberships include a wide spectrum of stakeholders and each have met at least one time.

The subcommittees and their missions are:

- Beneficiary Engagement Mission: Review Beneficiaries in Managed Care concept paper and comments received; Review recommendations for operations of Beneficiary Support System; i.e., PHP member services, Enrollment Broker, Ombudsman; Address strategy and methods for engaging beneficiaries including the identification of new engagement method, conducting evaluation and making recommendations for leveraging existing bodies; i.e., Consumer Family Advisory Committee; discussing strategies for communicating with beneficiaries; reviewing marketing and member materials.
- Credentialing Mission: Review and provide feedback on proposed centralized credentialing approach; Give feedback that will assist with planning and preparing for Credentials Verification Organization (CVO) procurement; Provide input on parameters for "quality concerns" regarding a PHP contracting decision; Provide feedback on transitioning current Medicaid providers to the new verification process.

- Network Adequacy Mission: Review and provide feedback on network adequacy and accessibility standards for Standard Plans; Review and provide feedback on provider directory requirements; Review and provide feedback on plan for PHP compliance and oversight.
- Quality Mission: Review and provide feedback on the draft Quality Strategy to ensure goals are considered and incorporated, including: maintain provider engagement; drive patient-centered and whole person care; promote wellness and prevention; improve chronic condition management; improve population health with some focus on LTSS and behavioral health.