NC Medicaid Transformation Overview

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Background

2015	Session Law 2015-245 directs DHHS to transition to managed care
2015-2018	Extensive collaboration with and feedback from stakeholders
August 2018	PHP RFP released
October 2018	CMS approves 1115 waiver
February 2019	PHP selection announced

North Carolina's Vision for Medicaid Transformation

"To improve the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health."

Highlights of the Authorizing Legislation

- Transformation goals
  - Ensure budget predictability through shared risk and accountability
  - Ensure balanced quality, patient satisfaction, and financial measures
  - Ensure efficient and cost-effective administrative systems and structures
  - Ensure a sustainable delivery system

- Defined role of the General Assembly, NCDHHS, PHPs, and NCDOI

- Defined a timeline for transformation

- Defined which beneficiaries would be transitioned to managed care and when

- Defined which benefits would be covered under managed care and which would remain as part of FFS

- Defined that the capitated contracts with PHPs would be awarded as a result of a competitive proposal process.

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 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

Moving to Managed Care

- 1.6 of 2.2 million Medicaid beneficiaries will enroll in Standard Plans.

- Beneficiaries will be able to choose from Prepaid Health Plans (PHPs)

- Some beneficiaries will stay in fee-for-service because it provides services that meet specific needs, or they have limited benefits. This will be called <u>NC Medicaid Direct</u>.

Types of PHPs per S.L. 2015-245

Commercial Plan (CP)

"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 the Department of Insurance."

Provider-led Entity (PLE)

"Provider led entity or PLE. – An entity that meets all of the 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 for the delivery of Medicaid and NC Health Choice services or Medicaid and NC Health Choice providers.

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."

Section 4.(2) of S.L. 2015-245, as amended by Section 2.(b) of S.L. 2016-121

Standard Plan PHP RFP Guidelines

Offerors' could submit proposals:

- CPs: statewide only
- PLEs: statewide, regional or both

Offerors' proposal guidelines

- Total of 4 statewide contracts (CP or PLE)
- Up to 12 regional contracts (PLE only)
    - PLEs encouraged to propose for more than 1 region (contiguous)
    - Only 1 regional contract for Regions 1 and 6
    - Up to 2 regional contracts for Regions 2, 3, 4 and 5

Section 4.(6) of S.L. 2015-245, as amended by S.L. 2018-48 and PHP RFP II.A.6-8

Standard Plan PHP Evaluation and Selection Process

- RFP issued Aug. 9, 2018; responses opened Oct. 12, 2018

- Department Procurement & Contracts section reviewed proposals for completeness per RFP requirements

- Over several months, Evaluation Committee of Department professionals:
  - Screened proposals for minimum qualifications outlined in RFP
  - Reviewed proposals and developed consensus scoring
  - Used scoring to develop award selections

# Standard Plan PHPs for NC Medicaid Managed Care

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 provider-led entity

- Carolina Complete Health, Inc.

- Regions 3, 4 and 5

NC Medicaid Managed Care PHP Regions for Standard Plans
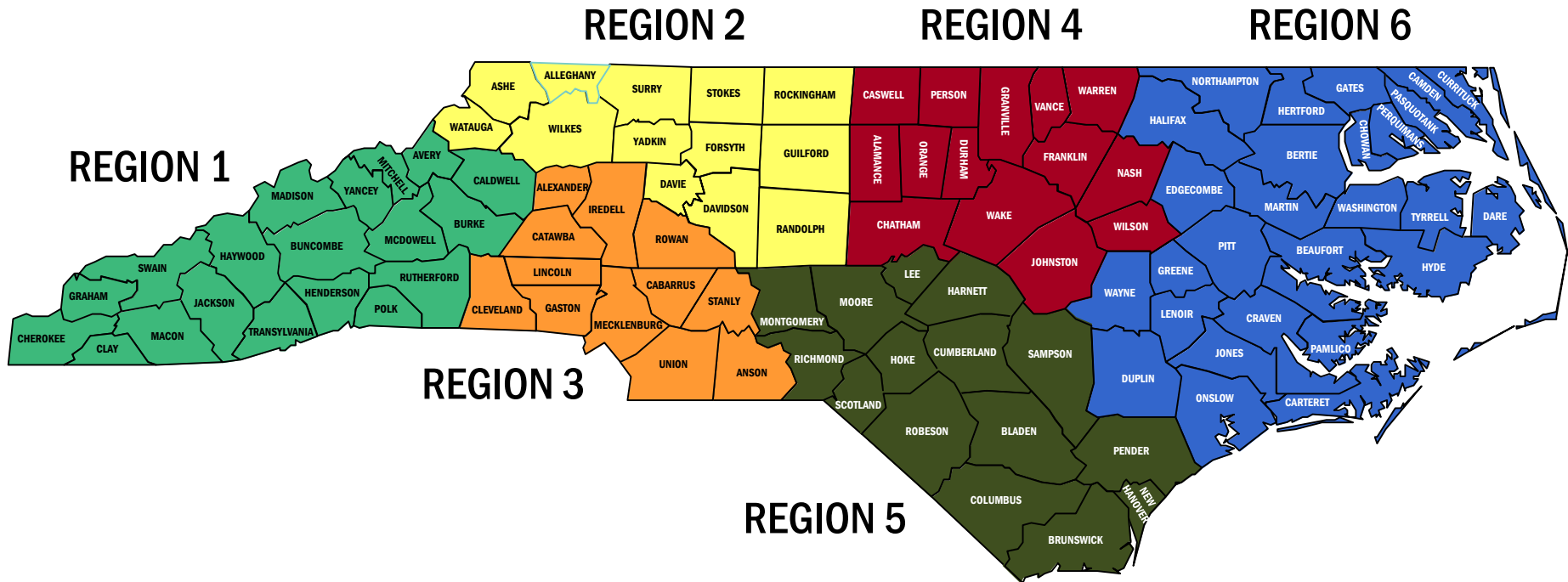
Department Oversight

All Standard Plan PHPs will be subject to rigorous oversight by DHHS to ensure a successful managed care program.

- DHHS leading intensive onboarding through the end of February, including introducing key staff, reviewing contract requirements and aligning on key milestones and deadlines

- Will need to pass a Readiness Review before Medicaid Managed Care launch

- Inability to fulfill contract provisions can result in corrective action plans, financial penalties and other sanctions

Integration Necessary for Improved Health

- Integration of primary, behavioral health and pharmacy services
- Three types of products:
  - **Standard Plans** for most Medicaid and NC Health Choice beneficiaries
  - **BH I/DD Tailored Plans** for qualifying high-need populations with a serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury; tentatively scheduled to launch about 1 year after SPs
  - **Statewide Foster Care Plan** for children in foster care; tentatively scheduled to launch shortly after the launch of BH I/DD Tailored Plans
- All three types of products will offer a robust set of behavioral health benefits; however, certain more intensive behavioral health benefits will only be available through BH I/DD Tailored Plans
- Continued focus on high-quality, local care management in all three types of products

> *Note:* Certain populations will **continue to receive fee-for-service (FFS) coverage, also known as NC Medicaid Direct,** on an ongoing basis. In addition, certain benefits, such as those provided by Children's Developmental Services Agencies (CDSAs), will be carved out of managed care.

Improved Provider Engagement & Support

- Incorporating a centralized, streamlined enrollment and credentialing process

- Standardizing and simplifying processes and standards across Health Plans

- Ensuring transparent payments for Health Plans and fair contracting and payments for clinicians

- Standardizing quality measures across Health Plans

- Using standard prior authorization forms

- Establishing a single statewide preferred drug list that all Health Plans will be required to use

- Covering the same services as Medicaid Fee-for-Service (except select services carved out of managed care)

- Requiring Health Plans to use DHHS' definition of "medical necessity" when making coverage decisions and set FFS benefit limits as a floor in managed care

- Transition of Care Requirements related to data exchange, honoring authorizations

Medicaid Transformation Opportunities

- Focus on Population Health

- Focus on Quality

- Address Unmet Social Needs

- Pilot new initiatives i.e. Telemedicine, access to SUD and behavioral health treatment through IMD, in-lieu and value-added services

Current Status – Managed Care Suspended

- Managed Care cannot go-live under a Continuing Resolution Budget. A new budget must include:
  - Authority to pay capitation payments and claims run-out
  - Authority to utilize Transformation dollars
  - PHP tax authorization which is already included in the capitation rates
  - Authority for the appropriate Hospital assessments

Managed Care Progress (as of Nov 2019)

Key Milestones Achieved

- Enrollment Broker contract awarded
- Health Plan contracts awarded
- Managed Care Waiver approved from CMS
- Choice counseling made available to members
- Open Enrollment began

- Enrolled member information sent to PHPs
- Encounters development and testing performed
- Provider information sent to health plans for contracting
- Health plan readiness reviews in progress
- Initial readiness documents sent to CMS

Suspension Activities

- Open Enrollment cancelled - Notified 1.6 million beneficiaries about the suspension

- Held webinars, all-state calls and other engagement activities with provider and members explaining what was happening and what to expect

- Continue to meet regularly with the health plans to move forward

- Reduced vendor contracts with specialized skillsets

- Engage with counties and other stakeholders to continue to facilitate the transition to managed care, including non-emergency medical transportation, ambulance, behavioral health crisis, health care systems

- Moving forward with managed care related procurements including Member Ombudsman, External Quality Review Organization (EQRO), Healthy Opportunities Pilots

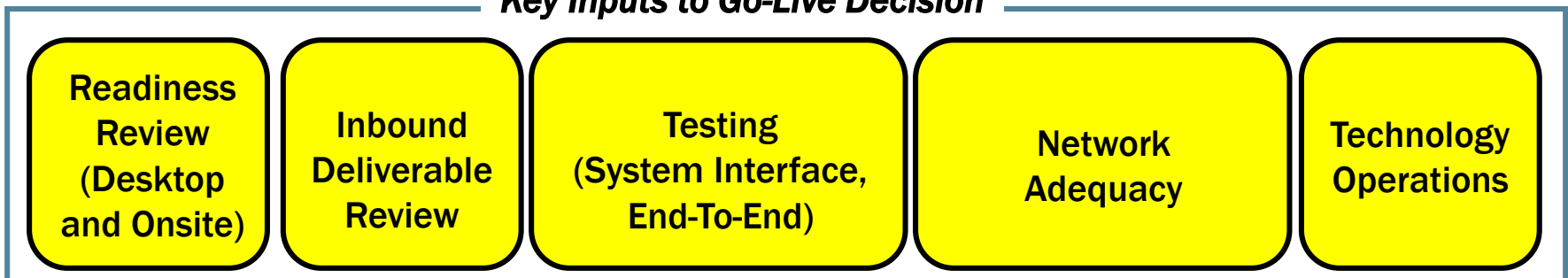# Restarting Managed Care Implementation – Highlight of Activities

- Update all stakeholder materials, websites, smart phone apps and technical systems across multiple platforms (Enrollment Broker, health plans, NCTRACKS)

- Formulate capitation rates and submit to CMS for approval

- Re-review and resubmit to CMS for approval several health plans' contractual policies and procedures deliverables (annual compliance plans, call scripts, member marketing, value added service materials, and clinical coverage policies)

- Upgrade the Consolidated Provider Directory (NC DHHS, Enrollment Broker, health plans)

- Complete key testing activities to finalize data, analytics, reporting functionality including Transition of Care

- Re-review and re-validate Enrollment Broker readiness including call center staff and scripting once rehired

- Re-evaluate internal Division of Health Benefits' staff readiness

- Complete provider contracting (health plans and providers)

- Analyze health plan network adequacy to ensure adequate provider networks and processes

Standard Plan Readiness Assessment

Prior to the suspension, the Department was assessing PHP readiness across 5 key areas. Some of these assessments will continue, while others are slowed or suspended until a later date:

- **CMS Readiness Review:** Assess ability/capacity to operationalize Managed Care

- **Inbound Deliverables:** Review and/or approve contractual deliverables as part of DHHS oversight (e.g., clinical coverage policies, annual compliance plans, etc.)

- **System Testing:** Assess ability to ingest, process and transmit data and information with DHHS and vendors

- **Network Adequacy:** Ensure we have sufficient providers contracted to provide services to Medicaid beneficiaries

- **Technology Operations:** Monitor call center/website issues and technology-related defects/issues (e.g., daily file exchanges, file defects)

Key Inputs to Go-Live Decision

| Readiness Review (Desktop and Onsite) | Inbound Deliverable Review | Testing (System Interface, End-To-End) | Network Adequacy | Technology Operations |

Questions/Discussion