MEDICAID TRANSFORMATION

Sheps Center for Health Services Research

Presentation by: Pam Silberman, JD, DrPH

November 7, 2018

AGENDA

- **Understand existing NC Medicaid system**
- Understand proposed efforts to “transform” Medicaid*

*Contingent on CMS approving NC’s 1115 waiver

EXISTING NC MEDICAID PROGRAM

Medicaid is an entitlement program that provides health insurance coverage to some low-income populations

- Federal government pays ~67% of program costs
- Provides a comprehensive array of services

In Nov. 2018, there were more than 2 million people covered by Medicaid in North Carolina (out of ~10.3 million)

- There were an additional ~103,000 children covered by NC Health Choice

Currently, Medicaid operates through fee-for-service (with state paying most of the bills)

- Community Care of North Carolina helps coordinate care for physical health services
- Mental health, substance abuse services, and services for people with intellectual and developmental disabilities (IDD) "carved out" and paid/managed separately through Local Management Entities/Managed Care Organizations (LME/MCOs)

AGENDA

- Understand existing NC Medicaid system
- **Understand proposed efforts to "transform" Medicaid**
  - **Background**
    - **Prepaid Health Plans**
    - **Eligibles and Covered Services**
  - Improving Patient Experience with Care
  - Improving Health Outcomes and Population Health
  - Enhanced Care Management Pilots/Social Determinants of Health
  - Improving Provider Experience in Care
  - Reducing Health Care Costs
  - Tailored and Specialized Plans
  - Other Key Points

MEDICAID TRANSFORMATION BACKGROUND

NC General Assembly directed NC DHHS to change NC's current FFS Medicaid structure to one that relies on managed care organizations (called Prepaid Health Plans or PHPs) to deliver care (Session Law 2015-245)

DHHS submitted 1115 waiver to CMS in 2016, amended waiver in Nov. 2017.

- **Waiver approved October 19, 2018.**

MEDICAID TRANSFORMATION BACKGROUND

Legislation requires NC DHHS to contract with four statewide PHPs and up to 12 regional PLEs to cover 6 regions. PHPs could be either:

- Commercial plans (eg commercial HMOs), or Provider Led Entities (PLEs)* that are controlled by North Carolina providers for standard plans (see below)
- LME/MCOs are authorized to serve as the PHP for the tailored plans (see below)

Three types of health plans (Session Law 2018-48; CMS Medicaid waiver)

- Standard plans—for most Medicaid enrollees, including those with mild-to-moderate behavioral health problems (enrollment: Nov. 2019/Feb. 2020)
- Tailored plans—for people with serious mental health or substance abuse needs, intellectual and developmental disabilities (IDD), or traumatic brain injury (TBI) (enrollment July 2021)
- Specialized plan for children in foster care (enrollment: July 2021)

* *PLEs are similar in concept to ACOs.* For PLEs a majority of voting members of the governing body must be NC physicians, PAs, NPs, or psychologists, at least 25% whom must have received Medicaid reimbursement sometime in last 24 months.

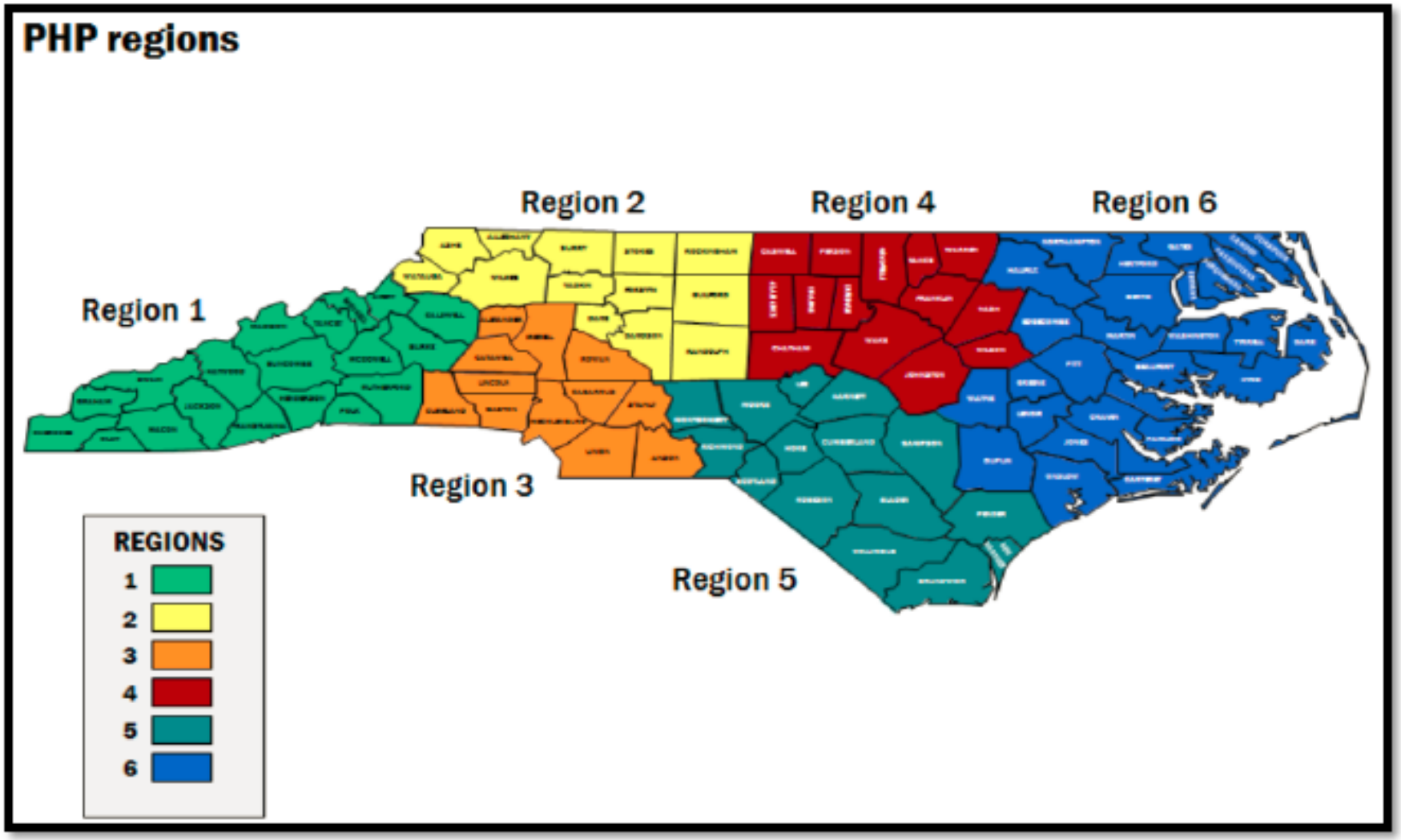
MANAGED CARE ORGANIZATIONS WHO SUBMITTED BIDS TO PARTICIPATE AS PREPAID HEALTH PLANS

Eight organizations submitted plans:

- Aetna
- AmeriHealth Caritas North Carolina
- BCBSNC Healthy Blue
- Carolina Complete Health (partnership between Centene and NC Medical Society, NC Community Health Center Assoc)
- My Health by Health Providers (partnership of 12 NC hospital/health systems)
- Optima Health, part of Sentara
- United Health Care
- WellCare Health Plans

REGIONS

Figure 1 – Map of PHP Regions



Request for Proposal Section I

ELIGIBLE POPULATIONS (RFP, RFP SEC. V)

Most Medicaid recipients will be enrolled into a Standard Plan

- Roll out across the state (currently scheduled to start Nov 2019 in some parts of the state, and Feb. 2020 in other parts)

Excluded populations include:

- Dual eligibles who only receive Medicare cost sharing, PACE beneficiaries, those enrolled in the state's 1915(c) HCBS programs for disabled adults or children, medically needy, people eligible for emergency services only or who are presumptively eligible or only eligible for retroactive coverage, people only eligible for the family planning program, refugees, people receiving premium subsidies for private insurance, and prison inmates, Medicaid-only beneficiaries receiving long-term nursing home services
- Dual eligibles with full Medicaid (unless eligible for tailored plans)
- People with serious MH/SA problems, IDD, or TBI are exempt from enrolling in standard plans (will be enrolled in later, once tailored plans begin operations)
- Foster care children: State will create a plan for foster children (which may be one of the tailored or another specialty plan) (HB 403, Report to the NCGA, June 22, 2018)

Exempt populations include members of the Eastern Band of Cherokee Indians

ENROLLMENT

Patients will be given a choice of plans

- Initially, state will contract with independent enrollment broker (Maximus) to help Medicaid recipients select plans
- Medicaid recipients will have 60 days to select a PHP and PCP. Those who do not select a PHP will be auto-assigned
  - People have 90 days to change their PHP for any reason (eg, no cause).
  - Tribal members can disenroll at any time (because enrollment is voluntary)
- Members can disenroll for cause additional times in the year (RVP, Sec. VII, Attachment M)

Choice of providers: Each member will have a choice of AMH/PCP (RFP, Sec. V, Sec. VII Attachment M)

- If member does not choose a medical home, will be auto assigned. Can change AMH/PCP without cause twice/year, and more often if for cause.

COVERED SERVICES

PHPs will be required to cover all the same services offered through traditional FFS Medicaid (including nonemergency transportation) (RFP, Sec. V):

- PHPs must use the state's Preferred Drug List (PDL) and formulary for covered services*
- Some services (such as dental, PACE, CDSA remain FFS

PHPs may offer "in lieu of" or "value-added" services

Cost sharing will remain the same ($1-$3 for Medicaid, $1-$25 for NCHC)

*PHP can submit for approval alternative pharmacy clinical coverage and prior authorization requirements to DHHS in Year 2

AGENDA

- Understand existing NC Medicaid system
- Understand proposed efforts to "transform" Medicaid
  - Background
  - **Improving Patient Experience with Care**
    - **Access to Services**
    - **Consumer Protections**
  - Improving Health Outcomes and Population Health
  - Enhanced Care Management Pilots/Social Determinants of Health
  - Improving Provider Experience in Care
  - Reducing Health Care Costs
  - Tailored and Specialized Plans
  - Other Key Aspects

NETWORK ADEQUACY (RFP, SEC. V; NETWORK ADEQUACY IN SEC VII, ATTACHMENT F)

PHPs must meet DHHS' network adequacy standards (time/distance, and appt. wait times).

- Can use telemedicine to help increase access, but can't require individuals to use telemedicine
- Must provide out-of-network care (at no additional cost to member), if cannot provide in-network care in a timely manner
- Must maintain provider directory (updated at least monthly)
- Cannot exclude providers from the network, unless the provider fails to meet quality standards or fails to accept network rates

Must contract with all essential providers located in PHP's region, unless alternative arrangements approved by DHHS

DHHS will establish a centralized credentialing process (including standard provider enrollment application and qualification verification process)

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  - Improving Patient Experience with Care
  - **Improving Health Outcomes and Population Health**
    - **Quality of Care**
    - **Population Health**
  - Enhanced Care Management Pilots/Social Determinants of Health
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PROMOTING QUALITY AND VALUE (RFP, SEC VII, ATTACHMENT E)

Each standard PHP will be required to report on 57 quality measures (Sec. VII, Attachment E):

- 8 patient satisfaction questions (CAHPS), and 1 provider satisfaction measure
- 48 additional quality measures (including measures on use of preventive services, appropriate clinical treatments, intermediate and outcome measures, cost and utilization measures, and specific measures on behavioral health treatment) (RFP, Section VII, Attachment E)
- PHP shall report measures stratified by certain criteria, such as race/ethnicity, age, eligibility category, gender and shall address inequalities
- By Year 3, DHHS may implement a withhold program based on quality measures.

PHP must establish prevention and public health programs that focus on DHHS priorities

OPIOID USE/SUBSTANCE USE DISORDER (SUD) PREVENTION

State must submit a Opioid Use Disorder/SUD implementation plan to CMS within 90 days of approval of the SUD program. Plan must include, within 12-24 mos. of approval:

- Access to residential treatment and withdrawal management (includes coverage for short-term IMD for SUD treatment)
- Use of evidence-based SUD patient placement criteria (ASAM)
- Utilization management that assures access to SUD at appropriate levels of care
- Nationally recognized SUD specific program standards for residential treatment provider qualifications
- Review to ensure residential treatment providers deliver evidence-based care consistent with ASAM
- Residential treatment providers must offer MAT or facilitate access to MAT on/offsite
- Sufficient provider capacity at every level of care, including MAT for opioid addictions
- Comprehensive treatment and prevention strategies to prevent prescription drug abuse and expand coverage of and access to naloxone and to improve functioning of prescription drug monitoring programs
- SUD Health IT plan
- Improved care coordination and transitions between levels of care

CMS Approval STC, pp. 12-16. SUD evaluation design in Attachment A.

ADVANCED MEDICAL HOMES (RFP, SEC. V, VII, ATTACHMENT M)

Four tiers of "medical homes"

- Tier 1: Current Carolina Access providers. This tier may be phased out in the future
- Tier 2: Current CCNC providers who receive small pmpm payment, help manage the patients care and engage in some quality improvement activities
- Tiers 3 & 4: More actively engaged medical homes.
  - AMH Tier 3/4 have primary responsibility to conduct comprehensive assessment, provide care management, and transitional care management for high-needs members
  - PHP and AMH Tiers 3 & 4 can agree to have AMHs take on additional care management functions
  - Difference between Tiers 3 & 4 is type of payment arrangement (ie, level of financial risk)

PHPs must contract with at least 80% of AMH Tier 3 practices located in each PHP region

- Department will certify AMHs

ADVANCED MEDICAL HOMES (RFP, SEC. V)

AMH Tier	Base Payment Structure	Minimum Medical Home Payment	Care Management Fee	Outcome-based Payment
1) Basic: Care Coordination*	FFS	$1 pmpm	NA	NA
2) Additional requirements for care coordination, disease management, etc. (need to show some type of PCMH certification)	FFS	$2.50 pmpm (except $5 pmpm for ABD categories)	NA	Pay for reporting, leading to pay for performance
3) Additional requirements for AMH (above Level 2)	FFS	Same as Tier 2	Negotiated	Negotiated (in addition to medical home fees)
4) Same requirements for AMH (above Level 2)	Partial or full capitation		Flexibility to design own	Flexibility to design own payments

CARE MANAGEMENT

Medicaid enrollees will have access to care coordination and care management to address medical and nonmedical drivers of health care.

Local care management (in site of care, home, or community that is face-to-face) is preferred.

Local Health Departments will provide care management for:

- Pregnancy management
- High risk children

Sec. 13.3 of Section IX. Medicaid Managed Care Draft Rate book; Sec. V, VII Attachment M of RFP.

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ENHANCED CARE MANAGEMENT PILOTS TO INCREASE OPPORTUNITIES FOR PEOPLE TO BE HEALTHY (SOCIAL DETERMINANTS OF HEALTH)

CMS gave NC DHHS authority to spend up to $650M over 5 years to support public-private regional pilots in 2-4 areas of the state through a competitive procurement process.

- Expects to cover 25,000-50,000 people in the pilots

Aimed at creating the opportunities for people to be healthy by focusing on:

- Housing, transportation, food, and/or interpersonal safety/toxic stress

Pilots must target individuals with at least one health need (eg, chronic conditions, repeated use of ED) and one risk factor (eg, housing, food or transportation insecurity, or interpersonal violence)

Pilots must show:

- Increased integration across health and social services organizations
- Improved health care utilization and/or reduced costs for target population
- Improved health outcomes for target population

CMS Waiver Approval. pp. 22-31

ENHANCED CARE MANAGEMENT PILOTS TO INCREASE OPPORTUNITIES FOR PEOPLE TO BE HEALTHY

Of the $650M:

- $100M is available for capacity building to PHPs and Lead Pilot Entities (LPEs)
- Part of it must be used for incentive payments

LPE will pay for pilot services through either:

- Fee for Service
- Bundled payments
  - State will determine bundled payments

Pilots must be subject to independent evaluation

- Evaluation will include rapid cycle assessments to help pilots make timely changes
- Outcomes must be assessed in comparison to comparable control group

CMS Waiver Approval. pp. 22-31

ENHANCED CARE MANAGEMENT PILOT SERVICES

Need	Type of Authorized Services (Non-exclusive list)
Housing Insecurity	Housing supports (budgeting, credit counseling); connection to social services to find housing; assistance with housing application; developing crisis plan; assistance with reasonable accommodation requests; assessing potential health risks in the living environment, and help paying for remediation (if needed to address health conditions); housing modifications (if needed to make home accessible); Financial assistance to pay one-time payment for security deposit and first month's rent, help with utility set up, moving costs.
Short-term post-hospitalization	Up to 6 months post-hospitalization housing if needed due to individual's imminent homelessness.
Food	Help applying for SNAP/WIC or school based programs, referrals to food banks, nutrition counseling and education, funding for food support from community-based food resources

CMS Waiver approval. Attachment G.

ENHANCED CARE MANAGEMENT PILOT SERVICES

Need	Type of Authorized Services (Non-exclusive list)
Transportation	Transportation services to social services that support community engagement, account credits for private transportation when public transportation not available.
Interpersonal violence/Toxic Stress	Transportation services to IPV service providers, linkages to social services/mental health agencies with IPV expertise, linkages to high quality child care or after school programs, evidence-based parenting programs or home visiting programs
Legal Assistance	Help connect individual to legal assistance (but cannot pay for legal services)

CMS Waiver approval. Attachment G.

BROADER EFFORTS TO LINK INDIVIDUALS TO COMMUNITY RESOURCES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

(RFP, SEC. V)

PHPs must:

- Use standardized screening tool to identify unmet health-related resource needs
- Use the NC Resource Platform and track connections and outcomes through "closed loop" referral capacity.
- Examine the NC "Hot Spot" map to guide PHP contributions to health-related resources in the regions http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b
- PHPs that contribute at least 0.1% of capitation payments will be given preference in auto-assignment

PHPs must address these domains in their policies that govern care management, quality, value-based payment, in lieu of services.

- PHPs must participate in the Enhanced Case Management Pilots operating in their region.

RESOURCE PLATFORM

NC Foundation for Health Leadership and Innovation contracted with United Way (211), UNITE US, Benefits Data Trust, and Expound to create NCCARE 360, a new resource platform

- Web-based and links to health, behavioral health, social services, legal, transportation, housing, and employment providers (built off the United Way 211 platform)
- Participating organizations can identify community resources to address consumer needs (as identified in the screening tool) and submit referral and track if connection made
- Can also help consumers identify and apply for programs (such as TANF, SNAP, LIEHP)

System will help track unmet needs in community so to identify areas of needed investments

http://nciom.org/wp-content/uploads/2018/08/3_-Vendor_Platform_ACC-Task-Force_8.23.2018_2.pdf

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  - **Improving Provider Experience in Care**
    - **Protected Rates**
    - **Provider supports**
  - Reducing Health Care Costs
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PROVIDER PAYMENTS (IN-NETWORK)

Rate floors: DHHS will set rate floors (at FFS levels) for in-network physicians, physician extenders, hospitals and nursing facilities.

- Floor for in-network PCPs, specialists, NPs, and PAs is 100% FFS (RFP, Sec. 11.4.1; Sec. V)
- Nursing homes will be reimbursed no less than FFS rate in effect 6 months prior to state of capitation rating year (for
- PHPs are required to pay an enhanced rate for vaginal deliveries (RFP Sec. 11.2, Sec. V)

Hospitals: In initial years, PHPs will be required to pay hospitals a base rate (rate floor) that incorporate previous supplemental payments made to hospitals (outside of the claims payments) (Sec. 11.4.4, Sec. V)

PROVIDER PAYMENTS (IN-NETWORK)

FQHCs/RHCs will receive FFS reimbursement levels, state will provide wrap-around payments (Sec. 11.4.3, Sec. V).

PHPs required to pay pharmacists using the state's dispensing fee.

Not clear how the state will assure that Local Health Departments or other safety net providers receive adequate reimbursement.

- CMS rejected DHHS' attempt to require MCOs to pass through payments to safety net providers

VALUE-BASED PAYMENTS (RFP, SEC V)

DHHS encouraging accelerated adoption of value-based payment (VBP) arrangements between PHPs and providers, aligned with the state's quality strategy

- Financial incentives must be aligned total cost of care, health outcomes, and quality gains
- VBP is defined as those falling in Levels 2-4 of multi-payer Health Care Payment Learning Action Network (LAN) Alternative Payment model http://hcp-lan.org/workproducts/apm-framework-onepager.pdf.
- By end of year 2, PHPs must have increased the proportion of medical expenditures paid through VBP by 20 percentage points, or VBP must represent at least 50% of medical expenditures

PHP VBP strategy must incorporate incentive payments to AMHs, and may include other physician incentive plans

- PHP may develop Physician Incentive Plans outside of VBP and pregnancy management program that further the aims of the quality strategy.

PROVIDER SUPPORT

DHHS will contract with Regional Provider Support Centers (RPSCs) to assist providers in clinical transformation and care improvement efforts *(Proposed program design, August 2017)*

The state will credential providers (one-stop credentialing that will be recognized by all PHPs) (RFP, Sec. V, Sec. VII Attachment M)

PHPs must provide training to providers (including Medicaid managed care requirements), must provide a detailed provider manual, and conduct ongoing provider satisfaction surveys and quality assurance oversight. (RFP, Sec. V)

PHPs must meet prompt processing requirements (RFP, Sec V)

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  - **Other Key Aspects**
    - **Elements of the Waiver CMS Did Not Approve**
    - **Monitoring and Oversight**
    - **Evaluation**
    - **Penalties for Noncompliance**
    - **Timeline**

CMS DID NOT APPROVE

Coverage for short-term coverage for services in an Institution for Mental Diseases for mental health services (for individuals ages 21-64)

Workforce development program:

- CMS did suggest that the state conduct a workforce assessment to identify health care provider shortage gaps
- After the completion of the assessment, the state may seek a demonstration waiver to consider workforce development options (such as loan forgiveness or recruitment bonuses) to address workforce shortages

No work requirements or premiums (since state did not implement Carolina Cares)

Funding to create a telemedicine innovation fund, and telemedicine alliance

- CMS recommended other funding sources for these initiatives

CMS DID NOT APPROVE

Wrap-around payments to safety net providers to cover the difference between the PHP reimbursement and provider costs

- However, state will still provide cost settlement to FQHC/RHC

Advanced payments to support capacity building to health home providers for providers in tailored plans.

- CMS did not approve request, but will continue to work with the state on this request.

Tribal uncompensated care program to cover costs of serving uninsured.

INDEPENDENT EVALUATION

DHHS must contract for an independent evaluation (as part of the 1115 waiver)

DHHS and CMS agreed to three hypothesis in the 1115 demonstration:

1) The demonstration will measurably improve health
   - Implementation of tailored plans and specialized foster care plan will increase quality of care, increase the use of behavioral health services, decrease long-term use of opioids and use of medication assisted treatment

2) Demonstration will maximize high-value care to ensure sustainability
   - Implementation of Medicaid managed care will decrease use of EDs for non-urgent use and reduce hospital admissions for ambulatory sensitive conditions, increase numbers of enrollees receiving care management

3) Demonstration will reduce substance use disorder (SUD)
   - Expanding SUD services to include residential services furnished in IMDs as part of comprehensive strategy will decrease long-term use of opioids and increase MAT, as well as quality of care and health outcomes for people with SUD

EVALUATION PLAN (CMS APPROVAL, ATTACHMENTS A, B)

Must be submitted within 180 days of CMS approval

Must include:

- Evaluation questions and hypotheses (including driver diagram)
- Methodology, including evaluation design, target and comparison populations, evaluation period, evaluation measures, data sources, analytic methods
- Should include both process and outcome measures
- Methodological limitations

Timelines:

- Evaluation design: 180 days after CMS waiver approval
- Interim evaluation for each of the completed years of the demonstration and for subsequent renewals or extensions
- Summative evaluation report within 18 months of end of approval period (Nov. 1, 2019-Oct. 31, 2024)

ENCOUNTER DATA (RFP, SEC. V)

PHPs must submit timely, complete and accurate encounter data to the Department. Two types of encounter data:

- Medical including in lieu or, value added services, and ECM pilot services. Must be submitted no later than 30 days from claims adjudication.
- Pharmacy. Must be submitted no later than 7 calendar days after claims adjudication.

Encounter data must meet an acceptance rate of at least 98% for completeness and accuracy.

Must provide encounter data for providers who are paid under value-based payment model.

TIMELINE

Activity	Date
Request for Proposal for Standard Plan PHPs issued	August 9, 2018
Deadline to submit proposals	October 12, 2018
Contracts Awarded	February 4, 2019
Standard Plan Operational	Nov. 1, 2019, Feb. 1, 2020
Tailored and Specialized Foster Care Plans Operational	July 2021

Note: Demonstration Years different for Substance Use Disorder program and Medicaid Managed Care/Enhanced Care Management program

FOR MORE INFORMATION

CMS Waiver Approval
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

Medicaid managed care Requests for Proposals (for PHPs) and related resources
https://www.ncdhhs.gov/request-information

Amended waiver (Nov. 20, 2017)
https://files.nc.gov/ncdhhs/documents/files/NC-Amended1115DemonstrationWaiverApplication_GovCooperLtr_20171120.pdf?PpFJgK3wwi.BFkdX4t6e5L8oSXK6_c8B

NC Medicaid Transformation Policy papers
https://www.ncdhhs.gov/policy-papers

Advanced Medical Home information
https://medicaid.ncdhhs.gov/advanced-medical-home

QUESTIONS?

PHASE IN OF COVERED POPULATIONS

Populations	Demonstration Year 2-3	DY 4-6
Medicaid beneficiaries except excluded and exempt	Standard plan	Standards plan
Medicaid beneficiaries eligible to enroll in BH I/DD tailored plans (except as listed below)	Medicaid fee-for-service and LME/MCO	BH I/DD tailored plans
Legal immigrants eligible to enroll in BH I/DD tailored plans	Medicaid fee-for-service	BH I/DD tailored plans
Children under age 3 eligible to enroll in BH I/DD tailored plans	Medicaid fee-for-service (children 0-3 exempt from LME/MCO)	BH I/DD tailored plans
Beneficiaries dually eligible for Medicare and Medicaid and eligible to enroll in BH I/DD tailored plans	Medicaid fee-for-service and LME/MCO	Medicaid fee-for-service and may enroll in tailored plans for BH and I/DD services
Innovation waiver enrollees, TBI waiver enrollees	Medicaid fee-for-service and LME/MCO	BH I/DD tailored plan
Children in foster care, adoptive placements, former foster care children up to age 26	Medicaid FFS or LME/MCO	Specialized PHP for children in foster care

CONSUMER PROTECTIONS (RFP, SEC V)

Department must approve all marketing materials, PHPs cannot engage in direct solicitations

PHPs must provide language assistance services, including interpreters, translation services, and auxiliary aids.

PHP must operate member services line, behavioral health crisis lines, and a nurse line

Grievance, appeal and state fair hearing procedures, including timeliness standards

- Appeals are for denials of benefit determinations or denials of payment
- Grievances include all other complaints against the PHP or providers (including quality of care, denial of expedited appeals, etc.)

PHP must establish a member advisory committee, LTSS member advisory committee

PHP must facilitate transfers to different plans, or different providers, when appropriate

PREVENTION AND POPULATION HEALTH MANAGEMENT

(RFP, SEC. V)

PHP must establish prevention and public health programs that focus on DHHS priorities, including but not limited to:

- Diabetes, asthma, obesity, hypertension, tobacco cessation, infant mortality, low birth weight, early childhood health and development, and additional prevention and population health management programs to encourage health and wellness
- Must engage actively in Healthy NC 2020 and 2030 planning
- Must contract with QuitLine
- Must implement an Opioid Misuse Prevention program
- Must support other DHHS programs/initiatives such as referrals to WIC, newborn screening, hearing screening, vaccines for children, NCDPH early intervention program, informing and education members and providers about population health programs

PREGNANCY MANAGEMENT PROGRAM (RFP, SEC VII, ATTACHMENT M)

PHPs must follow the states' mandates for providers who offer prenatal, perinatal and postpartum services

- Providers in the program must meet certain requirements, such as completing standardized risk-screening tool during initial visits, committing to lowering the rate of elective deliveries before 39th week, commit to decreasing cesarean section rate among nulliparous women, ensure comprehensive post-partum visits within 56 days of delivery

PHPs will contract with local health departments to provide care management services for high-risk pregnant women

- Must do thorough assessment to determine level of need for care management services
- Must provide appropriate care management services, including face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach and other interventions as needed to meet the care plan
- Must utilize the NC Resource Platform to identify other community resources

CARE MANAGEMENT FOR YOUNG CHILDREN AT HIGH RISK (RFP, SEC V, ATTACHMENT M)

PHP must contract with Local Health Departments to provide care management for young children (0-5) at high risk

- LHDs must provide outreach to educate parents, AMHs, and providers and community organizations about the care management for at-risk children program.
- LHDs must include families (or legal guardian) and AMH/PCPs in developing a patient-centered care plan
- LHDs must provide care management services based upon the child's level of need as determined through a comprehensive assessment

MEMBER INCENTIVE PROGRAM

PHP may establish a member incentive program, if healthy behaviors aligned with objectives outlined in the Quality Strategy

- May not be in the form of cash or cash-redeemable coupons
- Total monetary value of health behavior incentives cannot exceed $75/year

ENHANCED CARE MANAGEMENT PILOTS TO INCREASE OPPORTUNITIES FOR PEOPLE TO BE HEALTHY

State must use part of the $650M in incentive payments, to be distributed:

- Yr 1: Based on meeting process standards (ie, establishing network, reporting systems)
- Yr 2: Based on meeting service delivery performance metrics (ie, enrolling beneficiaries and delivering pilot services)
- Yr 3: Withhold for exceeding resource outcome benchmarks (ie, whether LPE reducing unmet needs)
- Yr 4: Withhold for exceeding health and utilization outcome benchmarks (eg, reductions in hospital admissions for uncontrolled diabetes or pediatric pilot enrollees receiving medically tailored meal services)
- Yr 5: Shared savings for exceeding health and utilization outcome benchmarks and reduction in total cost of care.
  - Based on costs of subset of pilot enrollees whose services are likely to result in decreased medical expenses in short-term (eg, homeless people who are high ED utilizers)

CMS Waiver Approval. pp. 22-31

PROVIDER PAYMENTS (OUT-OF-NETWORK)

As general rule, PHP may pay out-of-network (OON) providers no more than 90% FFS rate if PHP made a good-faith effort to contract with provider, or provider excluded for failure to meet objective quality standards

Exceptions:

- Emergency and some post-stabilization services (until arrangements can be made to safety transfer patient to in-network facility) (100% Medicaid FFS rates)
- Transition of care requirements (100% Medicaid FFS rates)
- Out of state providers (if services are not reasonably available or member out of state and needs emergency/urgent care services and health would be endangered if care postponed until member returns to NC)

PHP must hold member harmless (cannot impose higher out-of-pocket costs) for out-of-network care

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    - **Capitation payments**
    - **Financial oversight**
  - Tailored and Specialized Plans
  - Other Key Aspects

CAPITATION

Year 1 Standard Plan capitation average (pmpm) (Exhibit 73, Section IX Medicaid Managed Care Draft Rate Book SFY 2020):

- Aged, blind and disabled: $1,355.46
- Infants <1: $695.20
- Children 1-20: $145.37
- Parents (AFDC/TANF category): $403.88
- Maternity event: $9,442.29 (one time per live birth)

The state will also impose a performance withhold (not for the first 18 months)

Payments to PHPs will be prospectively risk adjusted based on Chronic Illness Disability Payment System plus Pharmacy (CDPS+Rx) model

ENSURING FINANCIAL SOLVENCY AND MANAGING COSTS (RFP, SEC. V, SESSION L 2015-245)

PHPs must manage program costs while still meeting quality, access and other requirements

The risk-adjusted cost growth for the PHP's Members "must be at least two percentage (2%) 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." (Session Law 2015-245, Sec. 5(6)a)

PHP must have a Medical Loss Ratio of at least 88%. If PHP's MLR is less, must either pay rebate to DHHS, or contribute to health-related resources targeted to high-impact initiatives

AGENDA

- Understand existing NC Medicaid system
- Understand proposed efforts to "transform" Medicaid
  - Background
  - Improving Patient Experience with Care
  - Improving Health Outcomes and Population Health
  - Improving Provider Experience in Care
  - Reducing Health Care Costs
  - **Tailored and Specialized Plans**
  - Other Key Aspects

TAILORED PLANS: CHOICE OF PLANS AND PROVIDERS

Standard plans: Enrollees will have a choice of four statewide standard plans (either CP or PLE)

- May have 1-2 more choices of regional PLEs depending on whether PLEs seek to operate in one of the regions
- People who do not choose a plan will be auto-enrolled into a PHP (with 90 day choice period where member can change plans. Annual choice period during redetermination.)

People who are eligible for the tailored BH/IDD plan will be identified through claims record (diagnosis and prior use of enhanced services or in one of the current IDD/TBI waivers)

- People can transfer mid-year from standard plan to tailored plan if the person meets a "qualifying event" and is determined to be eligible by DHHS

Tailored plans: Only one tailored plan will be offered in each region (regions maybe different than for the PHPs)

- For the first 4 years, LME/MCOs will operate the tailored plans (Sec. 4(10)a.3 of HB 403)
- BH/IDD tailored plan enrollees can choose to enroll in a standard PHP instead of a tailored plan, but then are not eligible for enhanced services

Choice of providers: Each member will have a choice of AMH/PCP (RFP, Sec. V, Sec. VII Attachment M)

- If member does not choose a medical home, will be auto assigned. Can change AMH/PCP without cause twice/year, and more often if for cause.

MONITORING AND OVERSIGHT

PHPs must provide numerous reports to DHHS, including but not limited to:

- Quality assurance, marketing activities, appeal and grievance requests and dispositions, strategies to promote clinical integration of behavioral health and physical health services, pharmacy drug utilization program, EPSDT reports, advance medical home, prevention and population health, network access, provider grievances and appeal, quality performance measures, and total cost of care pmpm. (RFP, Sec VII, Attachment J)

PHPs must engage with different stakeholders, including federally recognized tribes, community and county organizations, other Departmental partners (eg, enrollment broker, DSS, Ombudsman)

PHPs must have compliance plans; methods to prevent, detect and report fraud, waste and abuse (program integrity), and procedures to recover costs from parties with third party liability

REMEDIES FOR NONCOMPLIANCE (RFP, SEC. VII)

DHHS has a range of remedies it can impose on PHPs (or other vendors) for noncompliance depending on the severity and frequency of the violations

- Noncompliance is assigned to 4 risk levels, with the highest level associated with actions (or inactions) that "seriously jeopardize the health, safety, and welfare of member(s), reduces member(s) access to care, and/or jeopardize the integrity of Medicaid Managed Care."

Remedies include:

- Remedial actions (such as immediate remediation and corrective action plan)
- Intermediate sanctions (such as civil monetary penalties, appointment of a temporary manager, notification of members rights to terminate their enrollment, suspension of new enrollment, recoupment of payments)
- Liquidated damages (DHHS has list of monetary damages that correspond with different types of violations)

ELIGIBILITY FOR TAILORED PLANS

People are eligible for the tailored plans (with enhanced MH/SA, IDD services) based on:

- Diagnosis, including:
  - Individuals with serious emotional disturbance, or diagnosis of *severe* substance use disorder or TBI
  - Individuals with developmental disabilities, as defined in GS 122C-3(12a)
  - Individuals with serious MH, as defined by the 2012 settlement agreement with DOJ, including those in the Community Living Initiative settlement
- Use of services, including*
  - Individuals with 2 or more psychiatric hospitalizations or readmissions within prior 18 months
  - Individuals who have had 2 or more visits to* the ED for psychiatric problems in the past 18 months
  - Individuals who have been involuntarily treated within prior 18 months

Individuals who are enrolled in standard plans, but who have two or more episodes which meet the tailored plan criteria, will first go through a comprehensive assessment to determine eligibility for the tailored plans

BEHAVIORAL HEALTH SERVICES (RFP, RFP, SEC. VII, ATTACHMENT M; BH-IDD TAILORED PLAN CONCEPT PAPER)

Standard Plans	Tailored Plans
Inpatient behavioral health services Facility-based crisis services for children and adolescents Nonhospital medical detox services Partial hospitalization Diagnostic assessment services Mobile crisis management services Professional treatment services in a facility based crisis program Medically supervised or ADATC detox crisis stabilization Outpatient behavioral health emergency room services Outpatient opioid treatment services Research-based intensive behavioral health treatment Outpatient behavioral health services provided by direct-enrolled providers Ambulatory detoxification services DRAFT: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder	All the same as Standard plan plus enhanced services: Residential treatment facility services Child and adolescent day treatment services Intensive in-home services Multi-systemic therapy services Psychiatric residential treatment facilities (PRTFs) Assertive community treatment (ACT) Community support team (CST) Substance abuse non-medical community residential treatment Substance abuse medically monitored residential treatment ICF/IDD Waiver services (TBI, innovation, 1915(b)(3) State-funded BH/IDD/TBI services

SPECIALIZED PLAN FOR CHILDREN IN FOSTER CARE (CMS WAIVER LETTER)

State will develop a specialized plan for children in county-operated foster care, children in adoptive placements, or children who aged out of foster care (up to age 26)

- Children will be automatically enrolled in the specialized plan, but may opt for a standard plan at any time.
- If children eligible for both the tailored plan and specialized plan, they can choose which plan in which to enroll (and have 90 days to switch, after enrollment).
  - If change to standard plan, the child will lose access to specialized services offered in the specialized plan. Can reenroll in the specialized plan at any time.

DEMONSTRATION YEARS

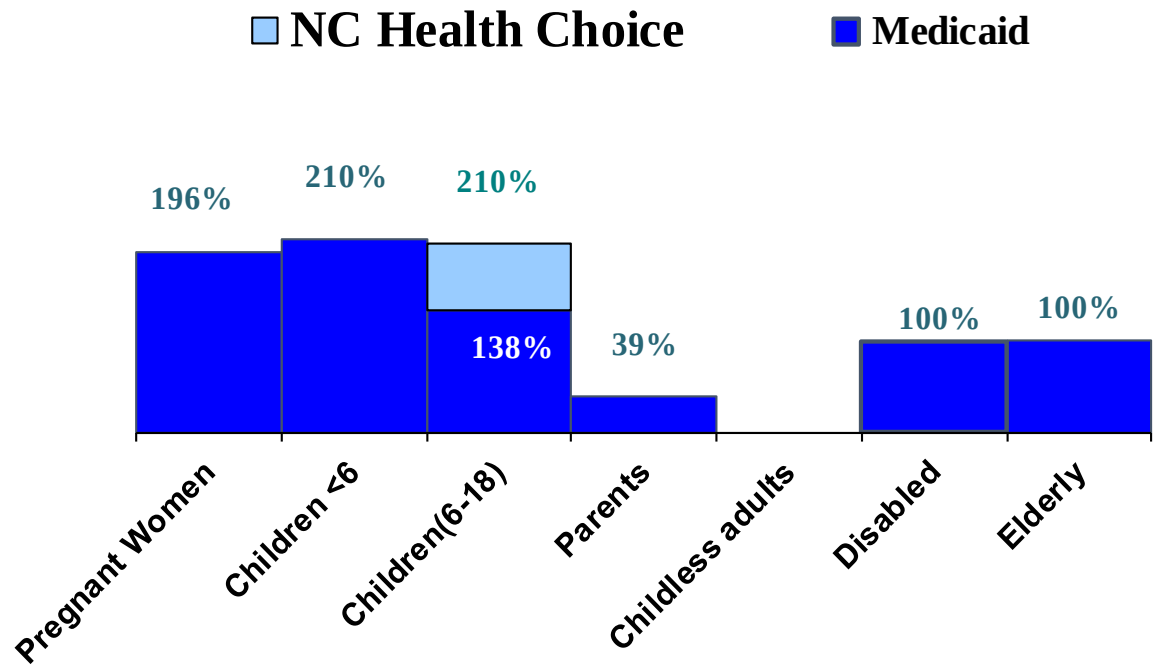
	Demonstration Year (DY)	Time Period	Total Time Per DY
Managed Care and Enhanced Case Management	2	11/1/2019-10/31/2020	12 months
	3	11/1/2020-10/31/2021	12 months
	4	11/1/2021-10/31/2022	12 months
	5	11/1/2022-10/31/2023	12 months
	6	11/1/2023-10/31/2024	12 months
Substance Use Disorder	1	1/1/2019-10/31/2019	10 months
	2	11/1/2019-10/31/2020	12 months
	3	11/1/2020-10/31/2021	12 months
	4	11/1/2021-10/31/2022	12 months
	5	11/1/2022-10/31/2023	12 months

CURRENT NC ELIGIBILITY RULES

To qualify for Medicaid, must:

- Be citizen or covered immigrant
- Fall into specific "category" of coverage:
  - Pregnant woman, child under age of 19, or parents of dependent child(ren), disabled or elderly
  - ***Childless, non-disabled, non-elderly do not qualify for Medicaid***
- Have income below certain income threshold
- Have resource limits below certain limits (depending on program category)

2018 NC Medicaid Income Limits (by eligibility group)



Because of categorical restrictions, Medicaid only covers 32% of low-income nonelderly adults in NC

CMS. State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2017. Calculations for parents based on a family of three. Note: 100% of the federal poverty levels (FPL) (2016) = $12,060/yr. (1 person), $16,240 (2 people), $20,420 (3 people), $24,600 (4 people).

CURRENT COVERED SERVICES

North Carolina Medicaid covers comprehensive health care services, including but not limited to:

- Providers (MD/DO, NP, PA, CNM, LCSW, etc.), hospitals, lab/X-rays, mental health and substance abuse, dental, rehabilitative services, long-term care (institutional and home and community based services), non-emergency Medicaid transportation

Nominal cost-sharing (eg, $3 for physicians visit or drugs)

- Certain groups of eligibles are not subject to any cost sharing (including children, pregnant women, people in nursing facilities)

CURRENT MEDICAID DELIVERY SYSTEM

Professionals paid on a fee-for-service basis for most services

- Most patients linked to a primary care provider
- Most primary care providers are part of a larger network of care for Medicaid recipients: Community Care of North Carolina

Mental health, substance abuse services, and services for people with intellectual and developmental disabilities (IDD) "carved out" to be provided separately through Local Management Entities/Managed Care Organizations (LME/MCOs)

- Behavioral health carve out has restricted the integration of behavioral health and physical health services

COMMUNITY CARE OF NORTH CAROLINA

Community Care of North Carolina (CCNC)

- 14 networks across the state that include primary care practices, local health departments, social services, hospitals, FQHCs, and LMEs established to manage the care of a Medicaid population
- Each network has a clinical director, quality improvement specialist, care managers, psychiatrist, and pharmacist(s) to help primary care professionals manage the care of their patient population
  - Some of the team members may be embedded in the primary care office (ie, care managers, behavioral health professionals in some practices)
  - Others are available for consultation to primary care practices (ie, psychiatrists, PharmD)

COMMUNITY CARE OF NORTH CAROLINA

- Statewide clinical and quality information system to provide feedback to physicians on quality of care for people with certain chronic conditions (ie, HbA1c, blood pressure, eye exams for diabetics)
- Primary care providers are paid $2.50 PMPM to provide care coordination for their regular Medicaid population (in addition to fee-for-service) and $5 PMPM to care for Medicaid population who are elderly or disabled
- Network receives $3.72 PMPM for regular Medicaid population, and an additional $13.72 PMPM for elderly and disabled
  - Network uses funds to pay for care coordinators, quality improvement specialists, psychiatrists, pharmacists, informatics, etc.

DATA FLOW (RFP, SEC V)