NC Medicaid Transformation

Overview and Perinatal Care

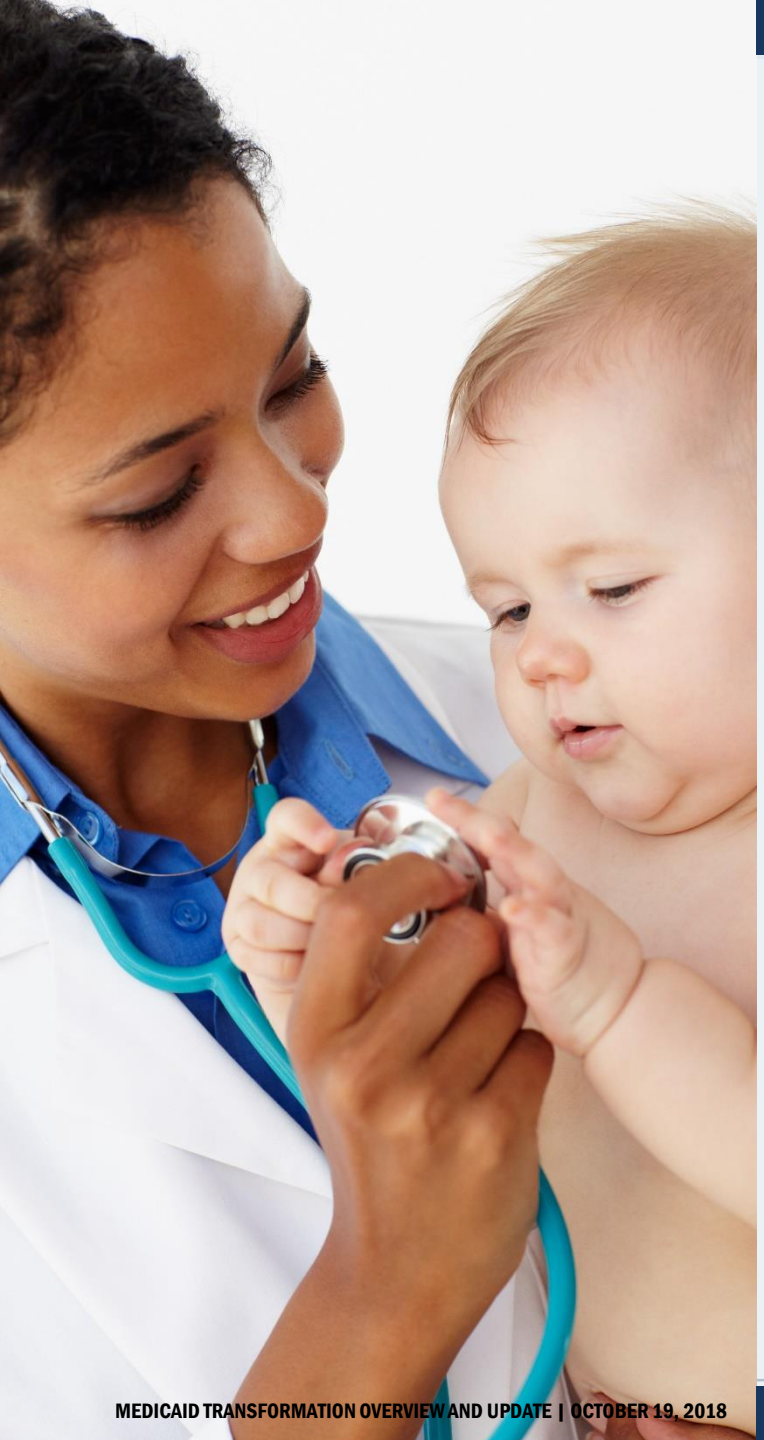
March 21, 2019

What we'll cover today

- Medicaid Managed Care Overview
  - Vision
  - Goals
  - Key Components of Program
  - Managed Care Service Carve outs
- Transition of Current Programs to Managed Care
  - Pregnancy Management Program
  - High-Risk Pregnant Women
  - At-Risk Children
- Additional Information

Medicaid Transformation Vision

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



North Carolina's Goals 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.

Overview of Managed Care Transition

North Carolina is preparing to transition to managed care which will advance high-value care and improve population health—especially for pregnant women and high-risk children

- The majority of Medicaid beneficiaries will receive Medicaid through Prepaid Health Plans (PHPs). Transitions ~1.6 million individuals from FFS into managed care.
  - NC Medicaid providers will need to contract with PHPs and will be reimbursed by PHPs rather than the state directly
  - Two types of PHPs:
    - Commercial plans
    - Provider-led entities
- PHPs will offer two types of products:
  - Standard plans for most beneficiaries; scheduled to launch in 2019–2020
  - Tailored plans for high-need populations; will be developed in later years

Note: Certain populations will **continue to receive fee-for-service (FFS) coverage** on an ongoing basis; Carolina ACCESS will continue for these populations

** Note: References to "Medicaid" hereafter are intended to encompass both Medicaid and NC Health Choice.*

Medicaid Transformation Timeline

Timeline	Milestone
October 2018	1115 waiver approved
February 2019	PHP contracts awarded
June - July 2019	EB sends Phase 1 enrollment packages; open enrollment begins
Summer 2019	PHPs contract with providers and meet network adequacy
November 2019	Managed care Standard Plans launch in selected regions; Phase 2 open enrollment
February 2020	Managed care Standard Plans launch in remaining regions

Services "Carved out" by Legislation

- Dental services
- Services documented in specific plans and provided or billed by a Local Education Agency (LEA)
- Services included in child's plan and provided and billed by Children's Developmental Service Agencies (CDSAs)
- Fabrication of eyeglasses including complete eyeglasses, lenses and ophthalmic frames

Standardization

DHHS has worked to mitigate administrative burden for clinicians.

PHPs will be subject to requirements designed to ease clinician administrative burden, including:

- Standardizing and simplifying processes and standards across PHPs wherever appropriate
- Incorporating a centralized, streamlined enrollment and credentialing process
- Ensuring transparent payments for PHPs and fair contracting and payments for clinicians
- Standardizing quality measures across PHPs
- Using standard prior authorization forms
- Establishing a single statewide preferred drug list that all PHPs will be required to use
- Covering the same services as Medicaid Fee-for-Service (except select services carved out of managed care)
- Requiring PHPs to use DHHS' definition of "medical necessity" when making coverage decisions and set FFS benefit limits as a floor in managed care

Advanced Medical Homes

The AMH program provides a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations.

Goals of AMH Program

- Build on strong foundation and preserve broad access to primary care services for Medicaid enrollees
- Strengthen the role of primary care in care management, care coordination, and quality improvement
- Allow practices to implement a unified approach to serving Medicaid beneficiaries, minimizing administrative burden
- Provide clear financial incentives for practices to become more focused on cost and quality outcomes for populations, increasing accountability over time

DHHS Care Management Strategy

Robust care management is a cornerstone of the State's managed care transition

Care Management Guiding Principles

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ Care managers will have access to **timely and complete enrollee-level information**
- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

Transition of Current Programs for High-Risk Pregnant Women and At-Risk Children to Managed Care

Review of Current Programs

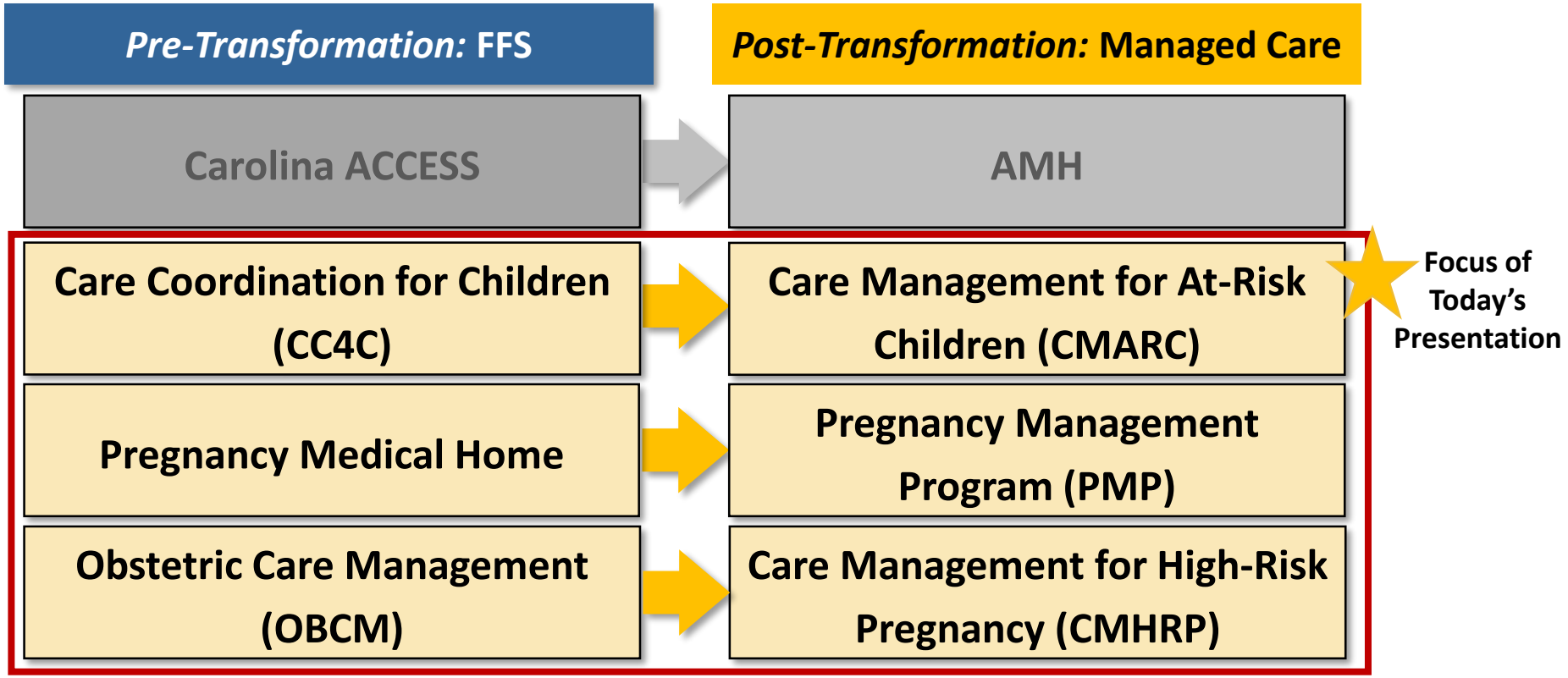
Maternity care providers, pediatric providers and Local Health Departments (LHD) have long played a critical role in the provision of health care and care management services for high-risk pregnant women and at-risk children, and will continue to do so under managed care

- Currently, North Carolina provides high-quality maternity care for all women. Care management services for high risk pregnant women and at-risk children are managed by locally administered programs
  - Pregnancy Medical Home ("PMH")
  - Obstetric Care Management ("OBCM")
  - Care Coordination for Children ("CC4C")
- The PMH, OBCM and CC4C programs were designed with significant leadership from clinicians across the state

The PMH Program is the result of input from the obstetrics community, working in conjunction with CCNC and the Department, from the overall design of the program to the development of clinical pathways

Evolution of Existing Programs Under Managed Care

The State will build on existing care management infrastructure under managed care



*Note: These programs will **remain in place post-transformation** for populations that remain in FFS coverage*

Note: Local Health Departments, Pediatric providers and Maternity Care providers can also be AMH providers

Key Elements of the Transition to Managed Care

Goal of the Transition to Managed Care: Continue to provide high-quality services to women and children in close partnership with providers across the state

1. **PHPs will administer each program locally and have overall accountability for program outcomes**
2. **Populations not moving into managed care will continue to be served by the programs in the same manner as today**
3. **Maternity providers will still receive incentives* and all maternity and pediatric providers will still have direct access to care managers to help manage patient populations**
4. **DHB requires PHPs to offer LHDs right of first refusal under the current model during the transition period, starting from the implementation of managed care**
5. **After the end of the transition period, PHPs will negotiate program terms with care management providers of choice, which could be LHDs or other providers**

* Incentive structure remains the same through transition period; in addition to regular payments for services.

Overview: Pregnancy Management Program

The Pregnancy Management Program will continue providing comprehensive, coordinated services to pregnant women

Participation & Standard Contracting Terms

- **Participation Requirements:** There will no longer be a process to opt into the program
  - All providers that bill global, packaged or individual maternity services will contract with PHPs under standard contracting terms
- **Contracting Terms:** Remain the same and include:
  - Complete the standardized risk-screening tool at each initial visit;
  - Decrease primary cesarean delivery rate;
  - Monitor and report on quality measures related to maintaining or lowering elective deliveries;
  - Ensure comprehensive post-partum visits within 56* days of delivery

*Change from 60 days to align with quality measurement.

Risk Screening Tool for High-Risk Pregnancies

Maternity care providers will use a State-developed risk screening form that is consistent with today's tool

- Providers will be required to adopt and administer a State-designated screening tool to identify high-risk pregnancies
- The content of the tool will be standardized across the State and will be the same as the tool currently used by providers enrolled in the PMH program *
- PMPs are required to share results of screening with LHD and PHP

In conjunction with an Advisory Group (developed later), DHHS will be responsible for maintaining updates to the risk-screening tool.

*See Appendix D for current risk screening tool

Tracking the Quality of Maternity Care in North Carolina

PHPs will provide additional insights to providers on their performance against key measures

PHPs will provide regular reports to PMP practices on the following measures:

- Prenatal and Postpartum Care: NQF 1517
- Live Births Weighing Less than 2,500 g: NQF 1382

As part of public reporting, PHPs will calculate and share the following measures (for each participating practice that receives an incentive payment)

- Rate of high risk screening as a function of total pregnant population according to PHP data
- Rate of post-partum follow-up within 56 days of delivery as a function of total pregnant population according to PHP data

Note: the transmission and frequency of the reports is still being considered

Overview: Care Management for High-Risk Pregnancies

During the transition period, LHDs will continue to provide care management services for high-risk pregnant women

Similarities to today's program

- The CMHRP program will be similar to today's OBCM program. For example:
  - LHDs will continue to provide care management services to high-risk women, not subject to preauthorization from the PHP
  - Program eligibility and the risk screening form will be the same as the one used today
  - Care management staffing requirements will remain consistent with current policy
- PHPs will incorporate a series of standard program requirements into their contracts with all LHDs in the CMHRP program
  - **The contract terms are generally the same as those that exist today** and include:
    - Requirements related to outreach, patient identification and engagement, assessment, and deployment of interventions

Key Differences in CMHRP in Managed Care

LHDs must for account for key differences under the transition to managed care

Key Programmatic Differences

- Differences in standard contract terms:
  - Requirements incorporate the changes of moving to managed care (e.g. collaboration and integration with PHPs).
  - LHDs will be required to coordinate with the PHP/AMH in cases where a woman has more than one care manager
  - LHDs are required to accept referrals from the PHP for the CMHRP program
- LHDs will be required to contract with each PHP to provide care management services
  - PHPs will give LHDs the “right of first refusal” as contracted providers of care. LHDs will have 75 business days to accept the contract
- LHDs will receive payments from PHPs
- LHDs will be required to share data with PHPs*

*Data strategy for HRP/ARC under development for release in early 2019.

CMHRP Quality Measures

LHDs will be evaluated against several process and outcome measures to ensure high quality care for high risk pregnant women

#	Process Measures
1	Percentage of women engaged (patient given a case status and goal developed) in CMHRP services among patients meeting eligibility criteria (priority patients) during the month
2	Percentage of patients identified as priority who are “deferred”
3	Percentage of engaged patients who are receiving intensive care management with a face-to-face intervention in the past 30 days

#	Outcome Measures
1	Prenatal and Postpartum Care: NQF 1517
2	Live Births Weighing Less than 2,500 g: NQF 1382

Overview: Care Management for At-Risk Children

During the transition period, LHDs will continue to provide care management services for at-risk children

Similarities to today's program

- The CMARC program will be similar to today's CC4C program. For example:
  - LHDs will continue to provide care management services to at-risk children, not subject to pre-authorization from the PHP
  - Children who are the target population for today's program will be the target population in CMARC.
  - LHDs will continue to accept referrals for CMARC from providers, social service organizations, their own outreach efforts, community agencies and direct referral by families.
  - Care management staffing requirements will remain consistent with current policy.
- PHPs will incorporate a series of standard program requirements into their contracts with all LHDs in the CMARC program.
  - **These terms are generally the same as those that exist today, and include:**
    - Provisions related to outreach, population identification, family engagement, assessment and stratification of care management service levels, plan of care development, integration with health providers, service provision, training, and staffing.

Key Differences in CMARC in Managed Care

LHDs must for account for key differences under the transition to managed care

Key Programmatic Differences

- Similar to HRP, the key differences of the program under managed care include:
  - Requirements incorporate the changes of moving to managed care (e.g. collaboration and integration with PHPs)
  - LHDs will be required to coordinate with the PHP/AMH in cases where a child has more than one care manager
  - LHDs are required to accept referrals from the PHP for CMARC
  - LHDs will be required to contract with each PHP to provide care management services
    - PHPs will give LHDs the “right of first refusal” as contracted providers of care. LHDs will have 75 business days to accept the contract
  - LHDs will receive payments from PHPs
  - LHDs will be required to share data with PHPs*

*Data strategy for HRP/ARC under development for release in early 2019.

Referral Criteria for CMARC Eligibility

- Many children currently receiving CC4C services will be exempt from managed care, and will continue receiving FFS benefits (e.g. children in foster care)

- **The referral criteria will be identical to today's program**

- **Children will be identified for the CMARC program using a form consistent with today's, and through the following methods:**
  - Direct provider referrals;
  - Social service agency referrals (e.g. Women, Infants and Children [WIC], Division of Social Services [DSS]);
  - Community agencies;
  - Direct referral by enrollees or families; and
  - Risk stratification or other identification methods by PHPs
    - *LHDs must accept referrals made by PHPs*

CMARC Quality Measures

LHDs will be held accountable to several process and outcome measures to ensure high quality care for at-risk children

#	Process Measures
1	% of children identified and referred for CMARC services who had a completed contact
2	% of children identified and referred for CMARC services who are engaged in active care management

#	Outcome Measures
	Children 0-5 engaged in CMARC
1	Well visits 3-6 yrs old
2	2 year old immunizations (Combination 3)
3	Annual dental visit

More Opportunities for Engagement

DHHS values input and feedback and is making sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website: https://www.ncdhhs.gov/assistance/medicaid-transformation
- Comments, questions, and feedback are all very welcome at Medicaid.Transformation@dhhs.nc.gov

Members & providers will receive education and support during and after the transition to managed care.

Q&A

Additional Information

Beneficiary Eligibility for Managed Care

The majority of Medicaid beneficiaries will transition to standard plans beginning in November 2019. Other populations will have delayed enrollment or will be exempt or excluded from managed care (remaining in FFS coverage):

Excluded from Medicaid Managed Care:

- Partial dual eligibles
- Qualified aliens subject to the five-year bar
- Undocumented aliens
- Medically needy
- Presumptively eligible, during the period of presumptive eligibility
- Health Insurance Premium Payment (NC HIPP) program
- Family planning
- Inmates of prisons
- Community Alternatives Program for Children (CAP/C)**
- Community Alternatives Program for Disabled Adults (CAP/DA)**
- Program of All-Inclusive Care for the Elderly (PACE)

Delayed until Behavioral Health Intellectual/Developmental Disability (BH I/DD) Tailored Plan launch:

- Qualifying beneficiaries with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or a traumatic brain injury*

Temporarily excluded for up to 5 years:

- Beneficiaries with long-term nursing facility stays
- Dual eligibles

Exempt from Medicaid Managed Care:

- Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI)

*DHHS is in the process of finalizing eligibility criteria for the BH I/DD TPs; **Will require legislative change

NC Medicaid Managed Care Regions and Rollout Dates

REGION 1
FEB. 2020

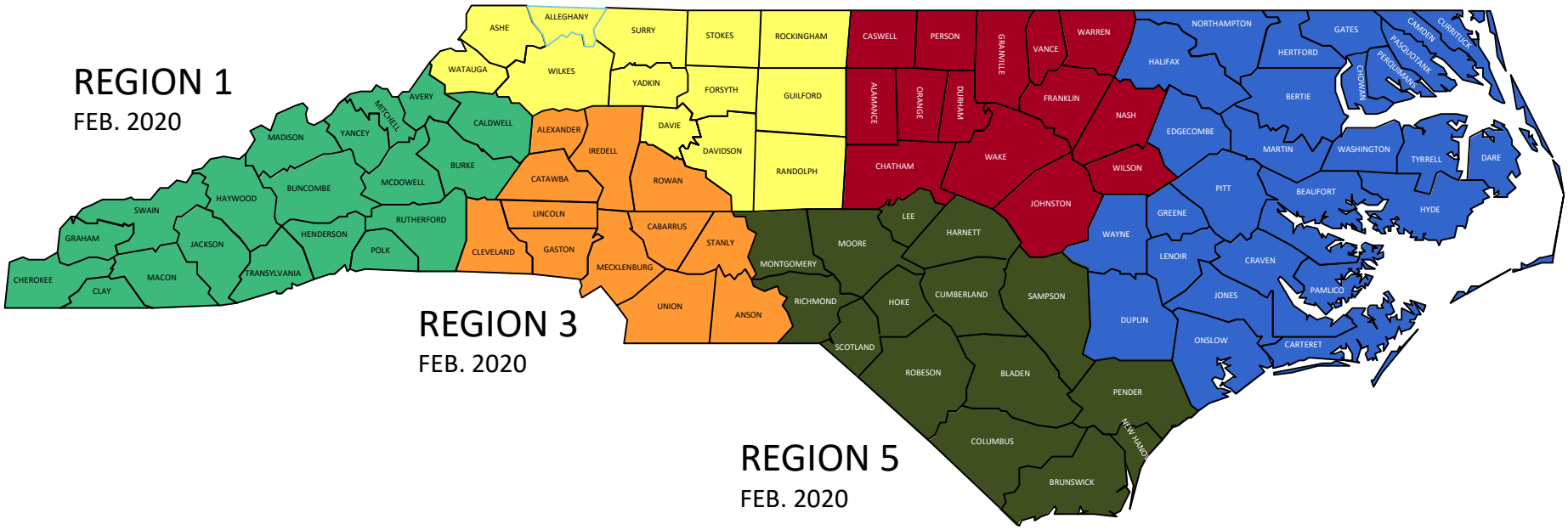
REGION 2
NOV. 2019

REGION 3
FEB. 2020

REGION 4
NOV. 2019

REGION 5
FEB. 2020

REGION 6
FEB. 2020



Rollout Phase 1: Nov. 2019 – Regions 2 and 4
Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6
Contract Year 1 runs through June 30, 2020 for all regions

Plan Selection and Auto-Assignment

DHHS will conduct extensive outreach to encourage beneficiary plan selection and will auto-assign those that do not choose a plan according to a transparent process.

Plan Selection

DHHS, in partnership with enrollment broker (Maximus), will provide choice counseling, enrollment assistance and education to beneficiaries. Maximus will work with county departments of social services to educate beneficiaries at local level.

Plan Auto-Assignment

The State will auto-assign all beneficiaries who do not select a plan according to the following algorithm:

- Beneficiary's geographic location
- Beneficiary's membership in a special population (e.g., member of federally recognized tribes or BH I/DD Tailored Plan eligible)
- PCP/AMH selection upon application and PCP/AMH historic relationship
- Plan assignments for other family members
- Previous PHP enrollment during previous 12 months (for those who have "churned" on/off Medicaid managed care)
- Equitable plan distribution with enrollment subject to:
  - PHP enrollment ceilings and floors, per PHP, to be used as guides
  - Increases in a PHP's base formula based on their contributions to health-related resources
  - Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment

Beneficiaries have 90 days after PHP enrollment to switch PHPs "without cause." After 90 days, beneficiaries may switch PHPs at annual redetermination.*

Note: *Certain populations may be able to change PHPs more frequently. Additionally, beneficiaries may change PHPs "with cause" at any time. More details available in enrollment broker RFP, available at: https://files.nc.gov/ncdma/documents/Transformation/RFP%2030-180090%20-%20Enrollment%20Broker%20Services%20-%20Final%20%283-2-18%29.pdf

AMH/PCP Selection and Auto-Assignment

Under managed care, enrollees may choose their AMH/primary care provider (PCP) or they will be auto-assigned.

AMH/PCP Selection

- The enrollment broker (Maximus) will provide beneficiaries with information and assistance in selecting their AMH/PCP at the time of PHP enrollment.
- Subsequent changes to AMH/PCP assignment are managed by the beneficiary's PHP. Enrollees can change their AMH/PCP **without cause** within 30 days of notification of assignment, and up to one additional time every 12 months; enrollees may change their AMH/PCP **with cause** at any time.

AMH/PCP Auto-Assignment

- Enrollees that do not select a AMH/PCP during the plan selection period will be assigned a AMH/PCP by the PHP in which they enroll.
- All enrollees will have a 30-day "grace period" after notification of their AMH/PCP assignment to change their AMH/PCP without cause.
- AMH/PCP auto-assignment will consider:
  - Enrollee claims history
  - Family member PCP assignment
  - Geography
  - Special medical needs
  - Language/cultural preference

Overview of the AMH Program

The AMH Program will serve as the primary vehicle for delivery of local care management under Medicaid managed care.

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Practices will need to interface with multiple PHPs**, which may employ different approaches to care management

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors

Tier 3

- PHP delegates primary responsibility for care management to the AMH
- Practice must meet all Tier 1 and 2 requirements, plus additional Tier 3 care management responsibilities
- Practices will have the option to **provide care management in-house** or **through a single CIN/other partner** across all Tier 3 PHP contracts

*PHPs should **attempt to contract with all certified Tier 3 AMHs** and must **demonstrate a contract with at least 80% of certified Tier 3 AMHs** in each of the PHP's regions.*

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors
- **PMPM Care Management Fees**
  - Negotiated between PHP and practice
- **Performance Incentive Payments**
  - Negotiated between PHP and practice
  - Based on AMH measure set

Note: Tier 4 will launch on a later date and will allow practices to enter more innovative, advanced payment arrangements.

Behavioral Health Integration

As part of Medicaid transformation, physical and behavioral health benefits will be administered by one managed care plan, under two types of products: Standard Plans and BH I/DD Tailored Plans.

Behavioral Health Integration in Standard Plans

Standard plans will offer integrated physical and behavioral health services upon managed care launch.

The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower-intensity behavioral health needs, will receive integrated physical health, behavioral health, and pharmacy services through Standard Plans when managed care launches.

Standard Plans will offer a robust set of benefits, but certain higher-intensity behavioral health, I/DD, and TBI benefits will only be offered under Tailored Plans.

Rationale for Integration

Currently, NC Medicaid beneficiaries have their behavioral health benefit administered separately from their physical health benefit through LME-MCOs.

Integrating behavioral and physical health benefits will better enable care managers and providers to deliver **coordinated, whole-person care**.

Healthy Opportunities in Medicaid Transformation

North Carolina is committed to improving health outcomes and lowering healthcare costs by delivering "whole person" care and addressing non-medical factors of health.

Embedding Healthy Opportunities in the Managed Care Program:

- All PHPs will have a role in addressing non-medical factors that drive health outcomes and costs, including:
  - Screening for non-medical needs
  - Connecting beneficiaries to community resources using North Carolina's new platform for closed loop referrals, NCCARE360
  - Providing additional support for high-need cases, such as assisting members who are homeless in securing housing

Healthy Opportunities Pilots:

- PHPs in two to four geographic areas of the state will work with their communities to implement the "Healthy Opportunities Pilots," as approved through North Carolina's 1115 waiver.*
- Pilots will test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress for eligible Medicaid beneficiaries.

*For additional detail on North Carolina's Approved 1115 waiver, please visit DHHS informational 1115 wavier website, available at: https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design