JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Medicaid Transformation

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Recent Transformation Milestones

Medicaid Publications

- August 2017
  - Proposed Program Design
- November 2017
  - Amended 1115 Waiver Application
  - Tailored Plans
  - Supplemental Payments
  - Managed Care Operational and Actuarial RFIs
- February 2018
  - Network Adequacy
- March 2018
  - Enrollment Broker RFP
  - Benefits & Clinical Coverage Policies
  - Beneficiaries in Medicaid Managed Care
  - Care Management & AMH
- March/April 2018
  - Quality Strategy
  - Quality – PHP Accountability
  - Credentialing
  - Vision for Long Term Service and Supports
  - SDOH Screening

Policy Paper: Supplemental Payments

- After managed care launch, DHHS will not have authority to make hospital supplemental payments
- DHHS and NCHA have engaged in collaborative process to revise payment structure so:
  - All payments move through “base rate” (i.e. payment for health care service delivered)
  - Plans are required to use these base rates for some period of time after managed care launch
  - Base rate is calculated so hospitals are “kept whole” for service delivery
- November 2017 concept paper laid out how these new base rates would be calculated
- Assessment mechanism will need technical updates to reflect new payment mechanism

Policy Paper: Network Adequacy

- DHHS will review PHP networks to ensure access to sufficient number of providers
- November 2017 concept paper discussed what DHHS would examine during these reviews – including draft numeric thresholds for various provider categories
- Oversight Focus will be on:
  - **Availability**: provider networks are sufficient to meet the needs of enrollees.
  - **Accessibility**: the proximity of providers to enrollees, based on geographic time and distance.
  - **Accommodation**: how provider's operating hours, appointment policies, language and cultural competencies, awareness, and communications meet enrollees' constraints and preferences
  - **Realized access**: enrollees' actual use of services
- PHP RFP will reflect final network adequacy standards

Policy Paper: Benefits and Coverage

- Today, DHHS defines covered benefits and the clinical policies that govern their use
  - Clinical coverage policies define the utilization management and other criteria that determine circumstances for beneficiary to receive service
- PHPs are required to cover all benefits that would otherwise be covered in FFS (unless carved out from managed care)
- PHPs cannot impose benefit limits more stringent than FFS, e.g. if FFS covers 10 physical therapy visits, PHPs must also cover at least 10 visits
- PHPs may generally design their own clinical coverage policies (that may be different from FFS and different from plan to plan)
  - Concept paper identifies a small number of services where DHHS policies will be required
- PHPs will use standard prior authorization forms to minimize provider burden
- PHPs will use DHHS prescription drug list and drug coverage criteria

Policy Paper: Care Management

- Today, care management is conducted by DHHS and CCNC
- Under manage care, PHPs will be responsible for care management
- March 2018 concept paper laid out vision for care management functions in managed care
- Primary care providers will continue to receive small payments from PHPs for supporting care management functions
- Primary care providers that wish to take on a more active role in care management can contract with PHPs to conduct this work
  - PHPs will be encouraged to contract with interested primary care providers
  - Primary care providers may perform care management functions directly (e.g., with staff that work in their offices or health systems) or may partner with other local primary care practices in clinically integrated networks
- PHPs will contract with local health departments for certain care management functions

Policy Paper: Quality

- In March 2018 DHHS published a concept paper describing our approach to health care quality in managed care as well as an official quality strategy for CMS
- Main aims of Quality Strategy:
  - Better Care Delivery/Access
  - Healthier People
  - Smarter Spending
- PHPs will be monitored on 33 quality measures against national benchmarks and state targets
- Small subset of measures will be linked to PHP Financial Withholds & Incentives
- DHHS will require that PHPs implement annual Quality Improvement Projects
- An External Quality Review Organization (EQRO) will also measure each PHP's compliance and quality annually

Policy Paper: Upcoming Work

- Additional policy papers forthcoming
- Continue conversations with CMS and are making progress to close down issues
- PHP RFP
- Existing DMA staff will change status and transition to DHB, consistent with requirements of SL 2015-245, on August 1
- Operational RFPs
  - Enrollment Broker responses are due April 13
  - Additional RFPs forthcoming