MCAC Medicaid Transformation

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Medicaid Transformation: Detailed Design for Medicaid Managed Care

- "North Carolina's Proposed Program Design for Medicaid Managed Care"
- Released Aug. 8, 2017
- Presents Department's vision for managed care
- Developed with significant stakeholder input received over the past year, including public input sessions in April/May 2017
- More details than broader Section 1115 waiver submitted to CMS in June 2016
- Drafted with health care professionals in mind
- Opportunity to comment on the proposed design through Sept. 8

Vision and Goals

- SL 2015-245, as amended by SL 2016-121, directed transition from fee-for-service to managed care for Medicaid and NC Health Choice programs
- Vision
  - High-quality care
  - Population health improvement
  - Provider engagement and support
  - Sustainable program with predictable cost
- Broad aspects of the transition to Medicaid managed care
  - Focus on integration of services for primary care, behavioral health, intellectual and developmental disorders, and substance use disorders
  - Address social determinants of health (unmet social needs and their effect on health); e.g., employment, housing, food)
  - Support beneficiaries and providers during transition

Medicaid Managed Care Already Exists in NC

What North Carolina Has Now

- PRIMARY CARE CASE MANAGEMENT (CCNC)
  - Primary care provider-based
  - State pays additional fee to provide care management
- PACE
  - Comprehensive, capitated
  - 55 years old and older
  - Available in certain areas, not currently statewide
- LME/MCOs (BEHAVIORAL HEALTH PREPAID HEALTH PLAN)
  - Cover specific populations and specific services
  - Provides care coordination for identified and priority groups

What Managed Care Will Bring

- MCOs will take two forms:
  - Commercial Plans
  - Provider-led Entities
- Participating MCOs will be responsible for coordinating all services (except services carved out) and will receive a capitated payment for each enrolled beneficiary

Background-Session Laws 2015-245 & 2016-121 - Requirements

Excluded Populations

- Individuals dually eligible for Medicaid and Medicare
- Populations with short eligibility spans (e.g., medically needy and populations with emergency-only coverage)
- Enrollees with periods of retroactivity and presumptive eligibility
- Health Insurance Premium Payment (HIPP) beneficiaries
- Program of All-inclusive Care for the Elderly (PACE) beneficiaries
- *Family planning
- * Prison inmates

*not in original legislation, will require a statutory change

Background-Session Laws 2015-245 & 2016-121

Services carved out of Medicaid managed care

- Dental
- Services prescribed by Local Education Agency (LEA) services
- Services provided by Child Development Service Agencies (CDSAs)
- Eyeglasses and provider visual aid dispensing fee*

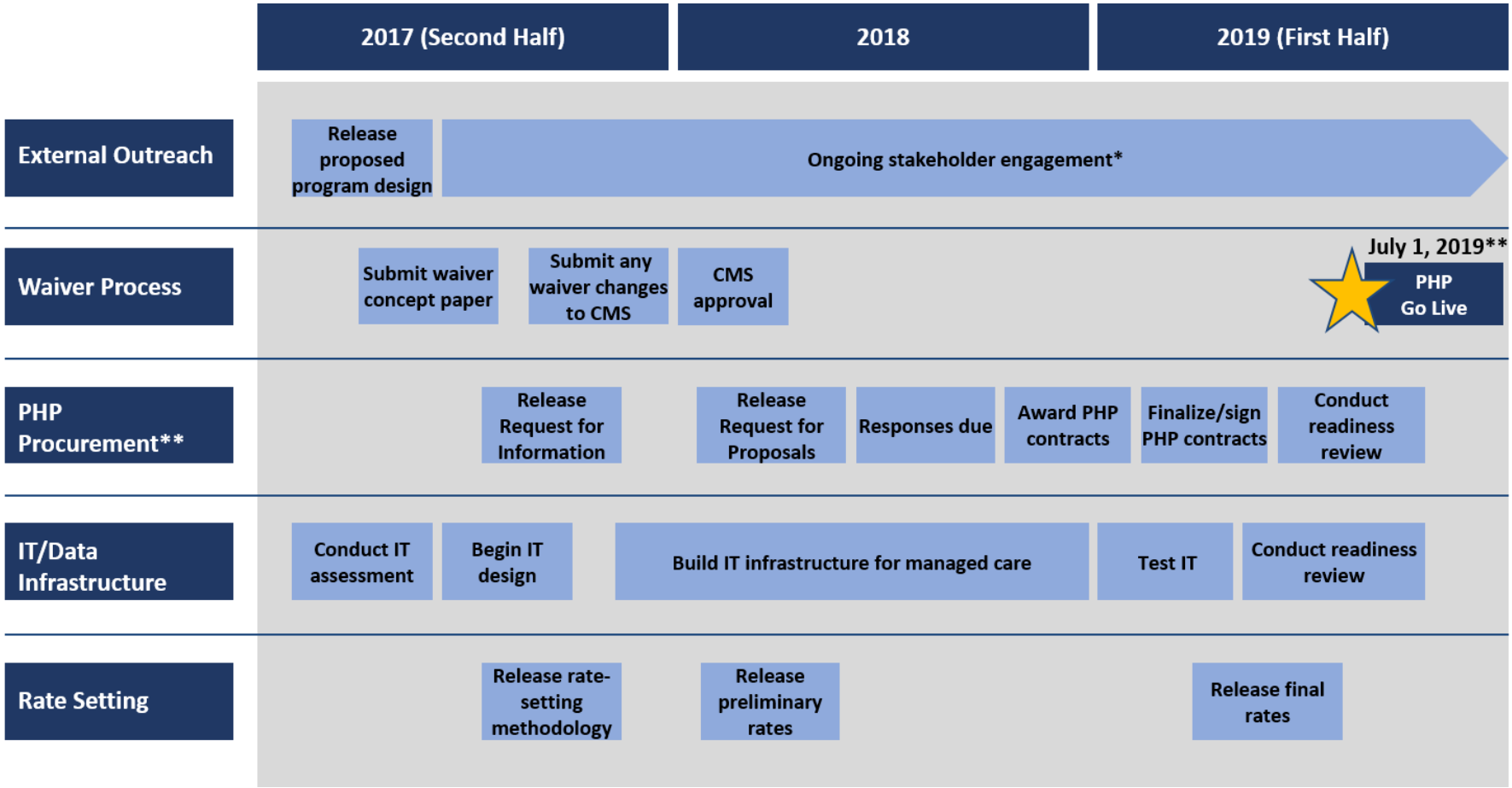
*not in original legislation; exclusion of dispensing fee will require enabling legislation

Background - Session Laws 2015-245 & 2016-121

Other Provisions

- Timing: Go live within 18 months of CMS approval
- Prepaid health plans
  - 3 statewide MCOs (commercial plans)
  - Up to 12 PLEs in 6 regions
- Maintain eligibility for parents of children placed in foster care system
- Identified essential providers
- Exempt population – members of federally recognized tribes
- PHPs must include all willing providers in their networks, limited exceptions apply
- Rate floors for physicians

Sequencing of Key Activities to Launch Managed Care



*Stakeholder engagement will continue past 2019.

**Represents the earliest go-live date for some segment of the Medicaid population. Approximate dates are contingent on factors outside of DHHS control, including CMS waiver approval.

***Additional procurement will be needed prior to managed care launch, including for enrollment broker, ombudsman program, and regional provider support centers, among others.

Prepaid Health Plans

- Beneficiary chooses plan that best fits personal situation
  - 3 commercial plans
  - Up to 12 provider-led entities
- Offer standard or tailored plans*
  - Standard plans
    - Integrated physical, behavioral and pharmacy services
  - Tailored plans
    - Integrated physical, behavioral and pharmacy services for special populations
    - Includes Innovations waiver, federal block grant and state funded services
    - 2 years post launch: serious mental illness, substance use disorders and I/DD
- Plans must accept any willing and able provider, including all essential providers
  - Exceptions: quality, refusal to accept rates

* Requires enabling legislation

Eligibility and Enrollment

Eligibility

- Goal: Simple, timely, user-friendly eligibility
- Online, mail, telephone, in person
- DSS offices continue to hold pivotal role
  - Determine eligibility; process renewals
  - NC FAST determines in or out of managed care
  - No change in eligibility appeals

Enrollment

- Beneficiary chooses PHP and PCP
- Enrollment broker
  - Support and education
  - Counsel beneficiaries in PHP/PCP selection
- 30-day plan selection period
- PHP and PCP will be auto-assigned if not selected

Future State

Beneficiary applies, receives determination and selects PHP and PCP in one sitting (real or near-real time)

- Upgrades to E&E system
- Web-enabled enrollment

Beneficiary Support

PHP

- Member services staff
- Explain PHP operation
- Explain role of PCP
- Assist with making appointments and obtaining services
- Arrange non-emergency medical transportation
- Fielding questions and complaints
- Advising appeal and grievance rights and options
- Education to promote health, wellness, disease prevention

Enrollment Broker

- Assist beneficiaries with enrollment
- Provide education about PHP plans and role of PCP
- Counsel beneficiaries as they select PHP and PCP that best fits their situation

Ombudsman

- Advocate for beneficiaries
- Provide support and active preparation for appeals, grievance and fair hearing processes
- Facilitate real-time issue resolution
- Monitor trends in PHP performance or beneficiary concerns, with feedback to DHHS

Delayed Mandatory Enrollment

SPECIAL POPULATION	ENROLLMENT	AFTER MANAGED CARE BEGINS (NO LATER THAN)
Children in foster care and adoptive placements	22,000	1 year
Certain Medicaid and NC Health Choice beneficiaries with an SMI, SUD or I/DD diagnosis, and those enrolled in TBI waiver	85,000	2 years
Medicaid-only beneficiaries receiving long-stay nursing home services	2,000	2 years
Medicaid-only CAP/C and CAP/DA waiver beneficiaries	3,500	4 years
Individuals eligible for Medicare and Medicaid (dual eligibles)	245,000	4 years

Enrollment numbers and phase-in dates are estimated and may change.

Foster Care PHP (1 year after implementation)

PHP Requirements

- Special personnel
  - Medical Director
  - Foster Care Liaisons
  - Foster Care Behavioral Health Clinical Director
- Care Management and Coordination requirements

Plan Features

- 90 day transition
- Medication management services based on Fostering Health NC protocols
- Health screenings and assessments

SOURCE:

Unmet Social Needs (Social Determinants of Health)

70% of health outcomes are tied to non-medical social determinants

16% households in NC are food insecure

81% receiving food assistance don't know where next meal is coming from

73% receiving food assistance have had to choose between paying for food or health care or medicine

1.2M North Carolinians, rural and urban, cannot find affordable housing

USDA Economic Research Service, "Food Security status of U.S. Households in 2015"
ncfoodbanks.org/hunger-in-north-carolina/
Robert Wood Johnson, County Health Rankings, countyhealthrankings.org/app/north-carolina/2017/overview

Unmet Social Needs: Resource Mapping and Innovation Support

Goal: Unite communities and health care system to optimize health and well-being

- Resource mapping
  - Map social determinants of health indicators at community and ZIP code level to display areas with the highest disparity
  - Map and codify food, housing, transportation and other essential resources in communities and within institutions of care
  - Build on current resource manage databases, like 211 or Wake Network of Care for up-to-date list of benefits and community services
  - Partner closely with community stakeholders

- Health innovation investment
  - Community efforts to scale, strengthen and sustain existing innovative initiatives
  - Evidence-based interventions including referral and navigation services, collocated and embedded services, and use of flexible supports
  - Required data collection and reporting; evaluated to determine effects on health outcomes and spending

Integrated Behavioral Health

Medicaid beneficiaries with less intensive BH needs and without I/DDs

Standard Plan

- Physical health
- Pharmacy
- State Plan BH

No changes; beneficiaries remain in integrated managed care product

Standard Plan

- Physical health
- Pharmacy
- State Plan BH

Initial Phase → Second Phase

Medicaid beneficiaries with serious BH needs, I/DDs and those enrolled in Innovations or TBI waivers

FFS

- Physical health
- Pharmacy

LME-MCOs

- State Plan BH
- 1915(b)(3)
- Innovations Waiver
- TBI Waiver
- State funded BH services

Beneficiaries transition from receiving physical health and BH in two separate delivery systems to integrated managed care product

BH I/DD Tailored Plans

- Physical health
- Pharmacy
- State Plan BH
- 1915(b)(3)
- Innovations Waiver
- TBI Waiver
- State funded BH services

Graphic displays Medicaid beneficiaries who are not excluded from LME-MCOs.

NC Health Choice beneficiaries currently receive behavioral health benefits through Medicaid fee-for-service.

High-functioning Managed Care System

Balancing standardization and plan flexibility

- Quality, Value and Care Improvement
  - Statewide quality strategy with goals and metrics
  - Enhanced care management strategy incl. AMH
  - Value Based Payments
- Beneficiary Protections
  - Grievance and Appeals provisions
  - PHP Member Services
  - Ombudsman Program
- Managed Care Plan Accountability
  - PHP accreditation
  - Network Adequacy standards
  - Plan and Provider payments
  - Clinical Coverage Policies
  - Licensure and Solvency requirements

Continued External Outreach

- Requesting MCAC serve as formal stakeholder engagement body
  - Monthly teleconference
  - Quarterly in person meetings
- Targeted outreach to stakeholders
- Provider Fact Sheet for Medicaid and NC Health Choice providers
- Beneficiary Fact Sheet for people with Medicaid

Medicaid Managed Care Proposed Program Design

Comments Welcome and Encouraged

- Medicaid transformation website: ncdhhs.gov/nc-medicaid-transformation
- Written input due by Sept. 8, 2017:
  - **Email:** Medicaid.Transformation@dhhs.nc.gov
  - **U.S. Mail:** Department of Health and Human Services, Division of Health Benefits,
    1950 Mail Service Center, Raleigh NC 27699-1950
  - **Drop-off:** Department of Health and Human Services, Dorothea Dix Campus, Adams Building,
    101 Blair Drive, Raleigh NC

Discussion