MCAC Transformation Update

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Department of Health and Human Services

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Agenda

- Transformation Update
- Procurement Update
  - Enrollment Broker Request for Proposal
  - PHP
  - CMS negotiations update
- Concept Paper comments
- Subcommittee Status Report

Medicaid Managed Care Procurement Status Report

Considerations

- Additional statutory authority needed for
  - Integrated care
  - Tailored Plans
  - Licensure
- Short Session
  - Timing
  - Engagement with G.A

Concept Papers on Medicaid Transformation

- Nine (9) papers incl. Quality Strategy released in last 2 ½ months
- Comment Period Closed
  - Network Adequacy and Accessibility Standards released 2/2018
  - Managed Care Benefits and Clinical Coverage released 3/2018
  - Beneficiaries in Managed Care released 3/2018
  - NC Care Management Strategy released 3/2018
  - Provider Health Plan Quality Performance & Accountability 3/2018
  - Centralized Credentialing and Provider Enrollment 3/2018
  - Draft NC's Medicaid Managed Care Quality Strategy 3/2018
- Papers with open Comment Period
  - Social Determinants of Health Screening Tool and Paper released April 5, 2018 comments due April 27, 2018
  - NC's Vision for Long Term Services and Supports under Managed Care released April 5, 2018 comments due April 27. 2018

Overall comments

- Comments
  - Received from EBCI, associations, health plans, LME-MCOs, service providers, accreditation and analytics companies
  - Currently under review by the Department
- Volume of responses received
  - Care Management received largest amount of feedback from most diverse groups- 25 entities
  - Beneficiaries in Managed Care- 18 entities
  - Clinical Coverage and Benefits- 15 entities
  - Centralized Credentialing – 14 entities
  - Quality – 4 entitles
  - Network Adequacy- 2 Associations
  - Health Plan Quality Performance & Accountability- 8 entities

Upcoming Program Design Documents

Document	Timeline for Release
Provider Experience	early May 2018
Transformation Impacts on DSS	May 2018
Licensure and Solvency	TBD

Subcommittee Status Report

- Meetings Held
  - Network Adequacy (x2); Final Meeting next week
  - Credentialing (x3); Final meeting 4/30
  - Beneficiary Engagement (x1), May 7th
  - Managed Care Quality (x1), quarterly
- General update
  - Participation
  - Managing Feedback Rec'd
  - New Technology implemented
    - Initial technical difficulties

Network Adequacy Subcommittee Key Takeaways

- Consider adding provider-to-enrollee ratios to best assure that beneficiaries have access to providers.
- Consider how pediatric providers are defined in the standards, and how children's varying needs across the spectrum of ages are addressed through a spectrum of providers specializing pediatrics.
- Consider the needs of special, high-needs populations and how to make sure such individuals have access to the specialists they need. How to define "special health care need".
- Have plans demonstrate how they are educated providers to think more about managed care and integration.
- Consider adding a psychiatrist to the list of providers who can be recognized as primary care physician.
- Could the time/distance adequacy standards and/or appointment wait time accessibility standards be applied in a manner with some reason and across time to assure that members are getting access .
- Reconsider how the Department is defining "Rural"; suggest that the State use Metropolitan Statistical area standards. More aligned with other data sources and standards used in other markets.
- Consider how out-of-network providers are treated under the design and how beneficiaries are protected in such instances.
- Consider how provider is defined – could it be practices rather than individual practitioners.
- Be sure to consider individual, independent practitioners and how the numeric standards can disadvantage these providers in negotiations.
- Consider how the network adequacy standards apply to NEMT.
- Consider instead of having a larger list of specialties subject to the standards applicable to access to specialists, group certain specialist and apply a standard to a group of specialists to prevent the necessity of using the exception process because a standard cannot be met for some specific specialty.
- Education of beneficiaries on the use of out-of-network providers;
- Beneficiary rights – including access to an adequate network of providers.
- Appointment wait time for specialists needs to be revisited – particularly with regard to access to OB/GYNs.
- Consider the connection between participation and payment.
- The state should consider executing a direct contract with certain specialists that serve special populations that are very small, in order to assure that high need beneficiaries get access to the need providers.

Network Adequacy (cont.)

- Self-referral to one mental health and substance use disorder screening per year may violate mental health parity requirements.
- Assure direct access to vaccines.
- Adopt standards for specialty referrals and how quickly a provider must see a beneficiary who has received a referral from a PCP.
- Consider how to assure cultural sensitivity
- Have clear definitions of who is responsible for what during transitions of care when a provider leaves a network or a PHP leaves
- Suggest that all beneficiaries with special health care needs get a treatment plan.
- Utilize time frames for improvements in compliance as found in corrective actions plans.
- Encourage the use of secret shoppers, provider surveys and beneficiary surveys.
- With regard to appointment wait time oversight, expect submission of data that has actual service and time data.
- How to consider consumer complaints in oversight activities.
- Consider publication of the EQRO reports.
- Consider if the network adequacy data that is provided by PHPs is realistic – does it have a basis in reality.
- Be sure data collected on providers is replicable by the provider.
- Consider special needs of TBI beneficiaries.
- Consider prohibitions on a provider accepting new patients – do not permit limits by plans.
- Consider how uses the directory and how to provide the information needed to address that populations needs

Credentialing Subcommittee Suggestions

- Consider the requirements related to credentialing of resident physicians, particularly given the time crunch for such providers to be assigned to a program and get credentialed in a timely fashion.
- Adopt standards around prior authorizations so that such would apply across a group when a provider leavers a group I order to be sure that beneficiaries are protected.
- Establishing standard criteria that plans use to make contracting decisions.
- Establish a standard for how a PHP would have to treat a provider who was previously rejected by a plan due to "objective quality" concerns
- Develop a credentialing system which eliminates duplication such as that which exists in the LME/MCO situation.
- Suggest that the State to reconsider its decision to not permit delegated credentialing, because this is a way to help eliminate duplicative efforts and facilitates individual practitioner credentialing.
- Suggest that the State reconsider the three year recredentialing requirement since the state just went to a 5-year renewal recently. (Note the three year period comes from the requirements of the nationally recognized accreditation organizations, and would require permission from the organizations to use a longer time period.)
- Consider what happens to a beneficiary if a provider loses credentialing during the treatment of a beneficiary; how is the beneficiary protected?
- Supported provider education from the state in advance of managed care launch to prepare providers and through the transition to managed care.
- Suggest testing groups to test the CVO solution to establish the best solution possible and one that best meets providers' requirements.
- Concerned about affiliation and how that information is currently captured in the system; suggest protections to assure that a provider's information is not hijacked by an affiliated group.
- Consideration of how non-contracted providers are treated under credentialing process.
- Publish the PHPs standards for contracting
- Assure IT issues are addressed so that the sharing of data meets all standards and the needs of the plans.
- Assure that the procurements of the CVO eliminates respondents who are potential PHPs.

Beneficiary Engagement Subcommittee

- More information on asking LOC about delayed populations/exempt
- Flow charts to next meeting – and SDOH(?)
- What algorithm will be used to determine auto-assign to plan manager for providers?
- Next Meeting – May 7
- Follow-up for next meeting
  - specific recommendations on beneficiary enrollment, dis-enrollment, appeals, grievances, and beneficiary communications
  - expectations of PHPs around beneficiary engagement communications

Managed Care Quality

- Report from first meeting
- Acknowledge Linda Burhans
- OBGYN- approval for Dr. Menard to join group