MCAC Credentialing Subcommittee

March 26, 2018

Welcome

Billy West, MCAC Representative
Jean Holliday, DHHS Program Lead

Agenda

• Subcommittee Member Introductions	10 mins
• Subcommittee Charter	10 mins
• Logistics and Member Participation	(included above)
• Meeting Schedule and Work Plan	10 mins
• Managed Care Overview	10 mins
• Centralized Credentialing Approach & Discussion (with break)	60 mins
• Public Comment	10 mins
• Next Steps	10 mins

Subcommittee Member Introductions

- Name
- Organization
- How will your experience benefit the MCAC Credentialing Subcommittee?

Charter

- Review and provide feedback on proposed centralized credentialing approach
- Give feedback that will assist with planning and preparing for Credentials Verification Organization (CVO) procurement
- Provide input on parameters for “quality concerns” regarding a PHP contracting decision
- Provide feedback on transitioning current Medicaid providers to the new verification process

Logistics and Member Participation

- Meetings will be available in-person and by webcast/teleconference
- Meetings are open to the public
- Public will have time at the end of each meeting to comment
- Direct written comment to Medicaid.Transformation@dhhs.nc.gov

MEMBERS:

Active participation during meetings will be key to informed input

Offer suggestions, information and perspective

Engage with other members

Ask questions

Meeting Schedule and Work Plan

Schedule

	MEETING #1	MEETING #2
DATE	Monday, March 26, 2018	Monday, April 9, 2018
TIME	10:30 am – 12:30 pm	10:30 am – 12:30 pm
PLACE	Dorothea Dix Campus Kirby Building, Room #297 1985 Umstead Drive Raleigh, NC	Dorothea Dix Campus Kirby Building, Room #297 1985 Umstead Drive Raleigh, NC

Work Plan

	MEETING #1	MEETING #2
TOPICS	Subcommittee Charge	Quality Reviews by PHPs
	Orientation: Charter, Expectations, Logistics, Schedule	Transition of Currently Enrolled Providers to Centralized Process and Managed Care
	Managed Care Overview	Planning and Preparing for CVO Procurement
	Centralized Credentialing Approach	

Medicaid Managed Care

Vision

- High-quality care
- Population health improvement
- Provider engagement and support
- Sustainable program with predictable cost

Goals

- 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, such as employment, housing and food, and their effect on health)
- Support beneficiaries and providers during transition

SL 2015-245, as amended, directed transition from fee-for-service to managed care for Medicaid and NC Health Choice programs

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.

Medicaid Managed Care Background

- Timing: Go live within 18 months of CMS approval
- Prepaid health plans (PHPs)
  - 3 statewide contracts
  - Up to 12 regional contracts to PLEs in 6 regions
  - Beneficiary chooses plan that best fits situation, or will be auto-assigned according to assignment algorithm
  - At managed care launch, PHPs will offer standard plans with integrated physical, behavioral and pharmacy services (requires enabling legislation)
- PHPs must accept any willing and able provider, including all essential providers (as defined in legislation); exceptions: quality, refusal to accept rates
- Rate floors for physicians

Overview of Centralized Verification Approach

To ease provider administrative burden, DHHS will implement a centralized credentialing & recredentialing process

- DHHS will procure, through a competitive bid process, a third-party, independent, primary contractor that will act as a CVO to coordinate necessary activities to support provider enrollment and verification
- Providers will use a single, electronic application to become a Medicaid-enrolled provider; providers will submit information once for enrollment in both Medicaid FFS and managed care
- CVO will be required to be certified by a nationally recognized accrediting organization
- CVO will collect and verify provider enrollment information and share information with PHPs
- PHPs will be required to accept verified information from CVO and will not be permitted to require additional credentialing information from a provider

Overview of Centralized Verification Approach

- Providers will have to negotiate a contract directly with any PHPs with whom they want to contract
- Centralized credentialing process will provide a PHP with information necessary to make a quality determination about contracting with a provider that is consistent with each PHP's approved quality review policy
- Although all providers must be enrolled in Medicaid FFS to contract with a PHP, per 42 CFR 438.602(b), a provider who contracts with a PHP is not required to render services to FFS beneficiaries; likewise, enrollment in Medicaid FFS does not obligate a provider to participate in managed care
- Providers will have the right to appeal adverse enrollment decisions to DHHS and adverse contracting decisions to PHPs

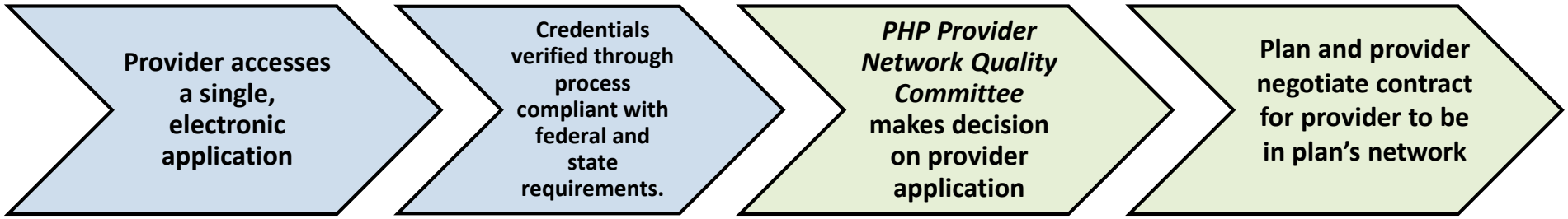
Centralized Credentialing Vision – Full Implementation

Ease provider burden by pursuing a centralized credentialing approach

PHP Procurement and Contracting Requirements

DHHS Process

Plan Process



A single point-of-entry for providers to submit all credentialing information, for *all* Medicaid payers (FFS and PHPs)

Implemented by CVO/PDM that is certified by national accrediting organization (e.g., NCQA, URAC); can help ensure centralized credentialing processes are meaningful, rigorous and fair

- Established and maintained by the PHP; reviews provider information and makes quality determinations
- Not permitted to request additional information from providers to be used in quality determinations
- Determinations will meet standards established by nationally recognized accrediting organization (e.g., NCQA, URAC)

PHP network development staff secures contracts with providers who have been credentialed and are enrolled in Medicaid

Uniformity with Plan Discretion

- Providers submit information centrally and PHPs will be required to accept the information and verification from the CVO.
- PHPs will review the information and make a quality determination to determine if it will move to contracting with the provider.

Appeals Rights

Providers will have access to two separate and distinct processes to appeal enrollment, quality, and contracting decisions:

1. **State Process:** Providers have the right to appeal to State on enrollment determinations.
2. **Plan Process**: Regardless of network status, providers have the right to appeal to PHPs on quality and contracting determinations.

Guidelines for PHP Quality Determinations
(Contracting Decisions)

DHHS guidelines:

- Each PHP will define, document and publish its policies for applying quality standards to make quality determinations
- Each PHP will ensure its quality standards:
  - Assess a provider's ability to deliver care
  - Include specific examples/thresholds for why a provider or type of provider would receive an adverse quality determination by the PHP (e.g., malpractice thresholds)
  - Describe the process by which standards are applied
  - Are not discriminatory
- PHPs will have discretion to make quality determinations, consistent with the written policy as approved by DHHS

PHP Provider Network Quality Committee

- PHPs will establish and maintain a Provider Network Quality Committee (PNQC) that makes quality determinations relating to providers
- PNQC will meet DHHS' requirements, including making quality determinations that meet the standards established by the accreditation organization; meet regularly to make quality determinations; and make quality determinations within the timeframes required by DHHS and CVO

Timeframes

- DHHS proposed to require PHPs to complete quality determinations for 90% of providers within 30 calendar days and for 100% of providers within 45 calendar days
- PHPs will then provide written notices of quality determination to providers within 5 business days of PNQC's decision
- Overall, DHHS expects enrollment, credentialing and quality review process to take no more than 75 days

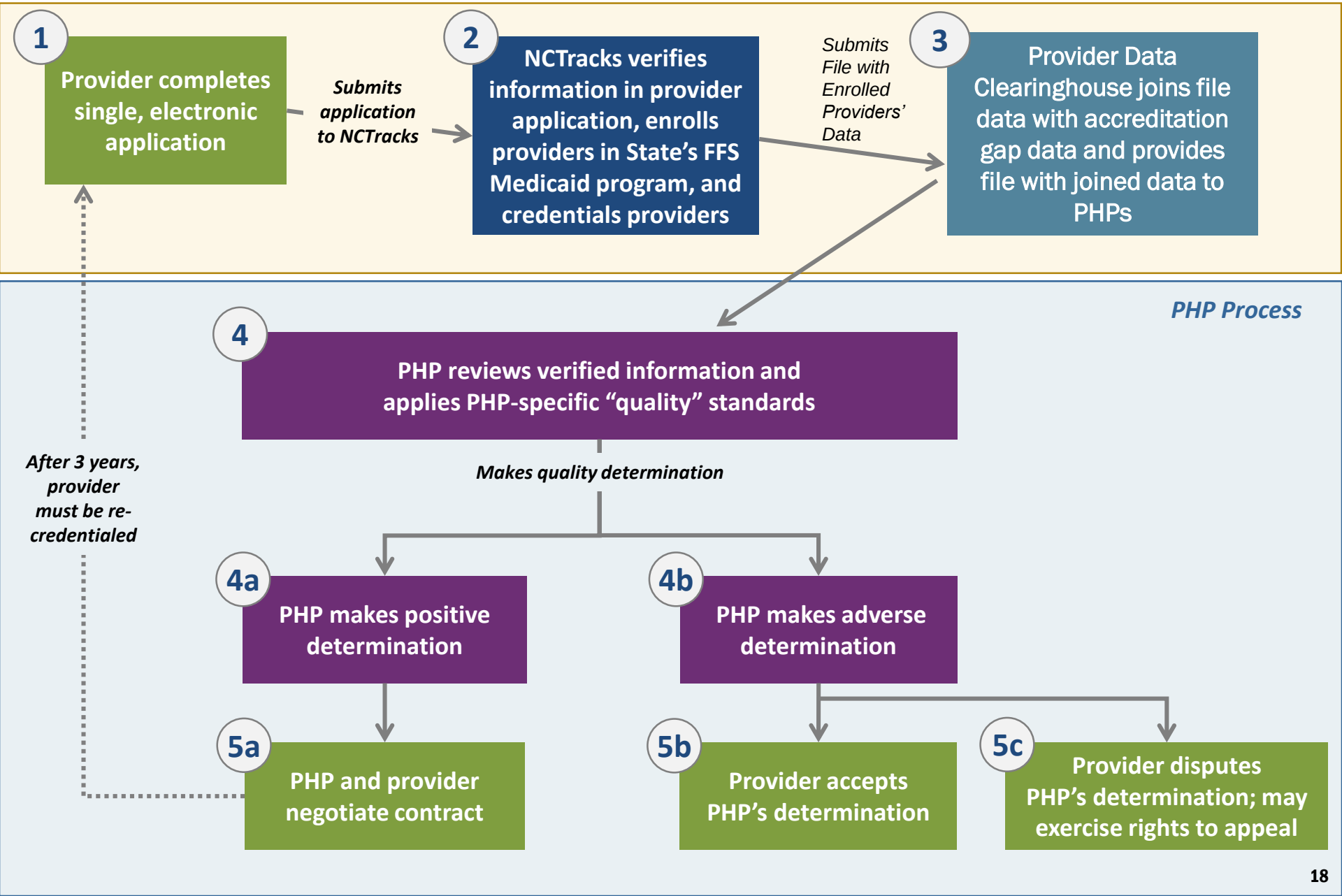
Accrediting Credentialing

- To ensure that PHPs are held to consistent, current standards for quality, access and timeliness of care, PHPs will be required to attain accreditation from a nationally recognized accrediting body, such as the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC), within first 3 years of operations
- DHHS will select a single accrediting body to ensure PHPs are held to a uniform standard, aligned with DHHS' quality goals and objectives
- As accrediting organizations establish standards for accredited plans, the centralized credentialing process must meet standards of accrediting organization to ensure that plans are able to meet that standard.

Transition

- Because analysis has identified deficiencies in the current process as compared to an accredited credentialing process, and a full solution cannot be implemented for around 2 years, DHHS will establish a provider credentialing transition period.
- Providers will continue to enroll in Medicaid through NCTracks and will have their information verified using the current processes
- Enrolled providers' information will be joined with data from a procured national provider data clearinghouse that will fill deficiencies in data and processing to provide PHPs with required verified provider information necessary for an accredited credentialing process
- During transition, PHPs will access all required verified provider information from a file that joins the DHHS Medicaid enrolled provider data with data from the national provider data clearinghouse
- Providers will continue on current 5-year recredentialing timeline until transitioned to a 3-year period
- Transition period will run from when PHP RFP is awarded until CVO solution is fully operational

Credentialing Straw Model at Transition



Discussion

Public Comment

Next Steps

Next Meeting

Monday, April 9
10:30 am – 12:30 pm
Kirby Building, Room 247

Homework

Review DHHS Credentialing concept paper (https://files.nc.gov/ncdhhs/documents/Credentialing_ConceptPaper_FINAL_20180320.pdf) and today's presentation, and be prepared to continue discussion

Next Topics

Continued discussion; quality decisions by PHPs; considerations for CVO planning and procurement; transitioning of existing providers to centralized process