MCAC Transformation Update

Jay Ludlam, Assistant Secretary
Department of Health and Human Services
April 20, 2018
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 entities**
  – Network Adequacy- **2 Associations**
  – Health Plan Quality Performance & Accountability- **8 entities**
# Upcoming Program Design Documents

<table>
<thead>
<tr>
<th>Document</th>
<th>Timeline for Release</th>
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<tbody>
<tr>
<td>Provider Experience</td>
<td>early May 2018</td>
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<tr>
<td>Transformation Impacts on DSS</td>
<td>May 2018</td>
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<td>Licensure and Solvency</td>
<td>TBD</td>
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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
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 in 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 leaves 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