Medicaid Transformation

Debra C. Farrington
Senior Program Manager
NC Department of Health and Human Services

October 25, 2017

Agenda

- NC Proposed Design for Medicaid Managed Care
  - Vision
  - Comments
- Background
  - Managed Care in N.C.
  - Supporting Legislation/Waiver
- Procurement
  - Activities
  - Timeline
- Managed Care
  - PHPs, Integration, E&E, Beneficiary Supports
  - Social Determinants of Health
  - High Functioning System

Medicaid Transformation: Detailed Design for Medicaid Managed Care

- "North Carolina's Proposed Program Design for Medicaid Managed Care"
- Released Aug. 8, 2017; Comments received through Sept. 14
- Presents State's vision for managed care
- Developed with significant stakeholder input received over the past year, including public input sessions in April/May 2017
- Provides details broader than Section 1115 waiver submitted to CMS in June 2016
- Drafted with health care professionals in mind
- Accompanying documents
  - Fact Sheet for Medicaid and NC Health Choice providers
  - Fact Sheet for people with Medicaid

Vision and Goals

- 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 innovation (integration of services for primary and behavioral health care and social determinants of health)
  - Support beneficiaries and providers during transition
  - Promotes access to care (combat opioid epidemic, telehealth, access to Medicaid)
  - Promote quality and value
  - Setting up relations for success (transparent and fair payments, to PHPs and providers)

High Level Overview of Comments

- Comments still coming in
- Responses received – 250+
  - Most responses received from health plans and associations/organizations
- General themes
  - Positive Support for
    - Physical/behavioral health integration.
    - Considering social determinants of health.
    - Improving credentialing process.
    - Increasing access to Medicaid coverage.
  - Confirmation on go live, dental exclusion
  - Maintaining viable, profitable practices
  - Reduce administrative burden
  - Varied stakeholder engagement approaches

American Heart Association/American Stroke Association Comments

Support

- 1115 waiver amendment
- Access to affordable health coverage
- Advancing whole person care by creating innovative, integrated and well coordinated system of care
- Use of evidence based care to improve outcomes
- Strong network adequacy requirements

Recommendations

- Cover all USPSTF A&B benefits
- Leverage AHA/ASA public health education programs and utilize them with providers and recipients
- Close insurance gap for individuals at or below 138% of federal poverty level
- Offer evidenced based telehealth interventions
- Statewide standards for utilization of stroke and ST-Elevation Myocardial Infarction registries
- Regular ongoing meetings with diverse consumer advocates

Next Steps re: Public Comments

- All reviewed by design team members
- Considering questions/recommendations in future design decisions, documents
- Feedback consolidated
- Publish summary with Department response mid-Oct 2017

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; estimated July 2019
- 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

Procurement Details

RFI

- Solicits information from potential PHPs to assess interest in participation and market readiness
- Targeted questions
- Providers and Stakeholder response anticipated
- Release Fall 2017

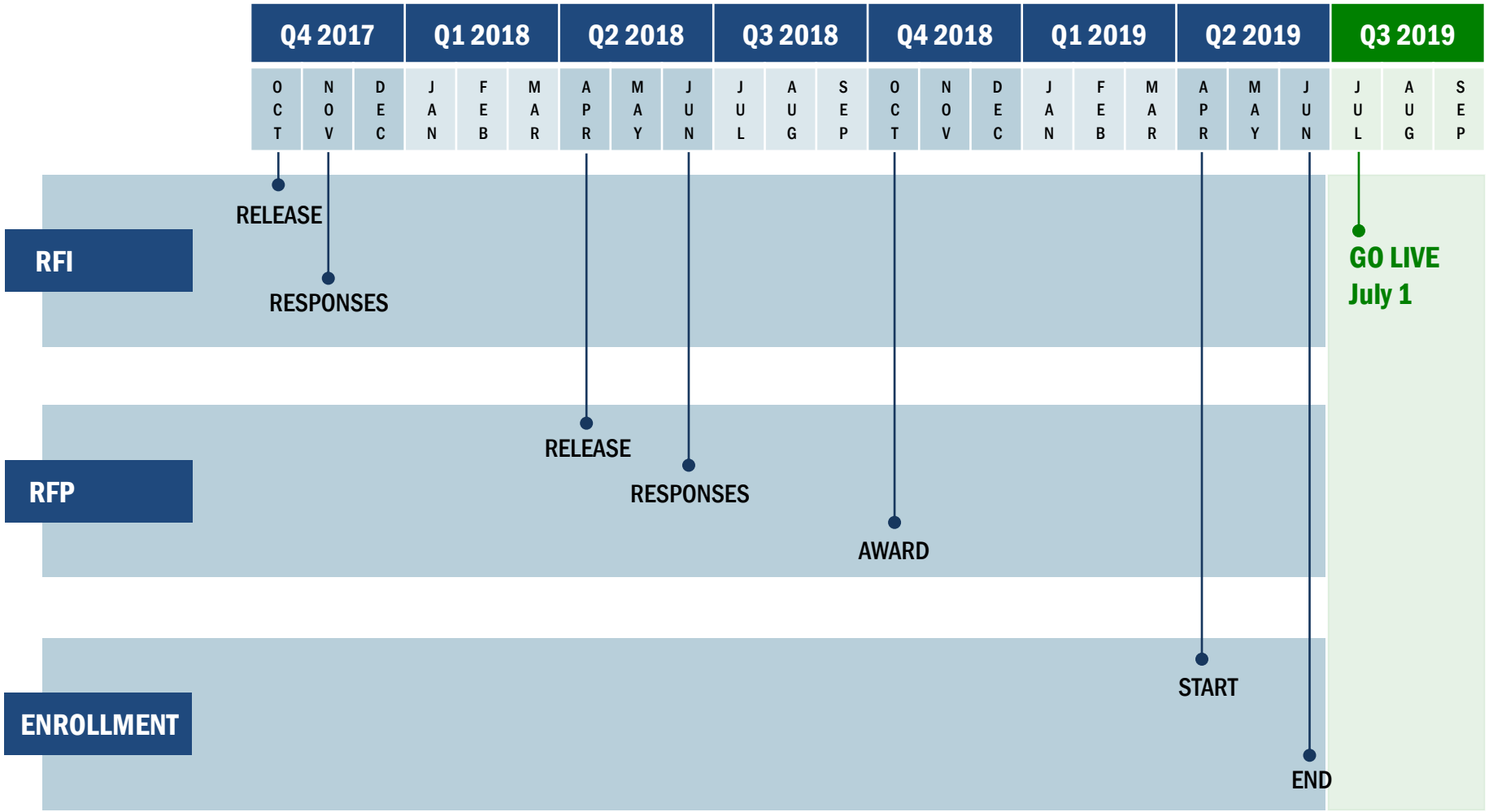
RFP

- Formal solicitation which will outline contract expectations
- Released Spring 2018
- Responses requested early Summer 2018
- Award Fall 2018

Enrollment Broker

- Participants have 60 days to enroll
- Enrollment ends selected number of days before go live
- Draft RFP winter 2017
- Release Spring 2018
- Award Summer 2018

PHP Procurement: RFI/RFP Tentative Timeline



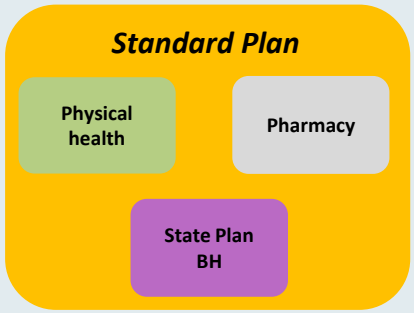
Timeline is subject to CMS Section 1115 waiver negotiations.

Prepaid Health Plans

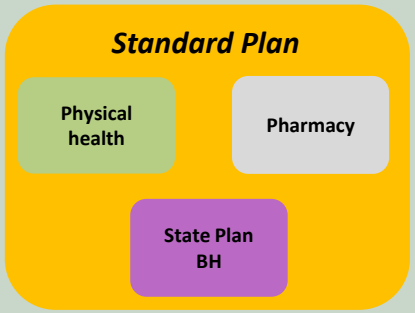
- Beneficiary chooses plan that best fits personal situation
- Health Plans offer 2 different plan or product types
  - Standard plans
    - Integrated physical, behavioral and pharmacy services
  - Tailored plans
    - Integrated physical, behavioral and pharmacy services for special populations
    - Includes Innovations waiver, 1915(b)(3), 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 providers in geographical area that are designated as essentials

Integrated Behavioral Health

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

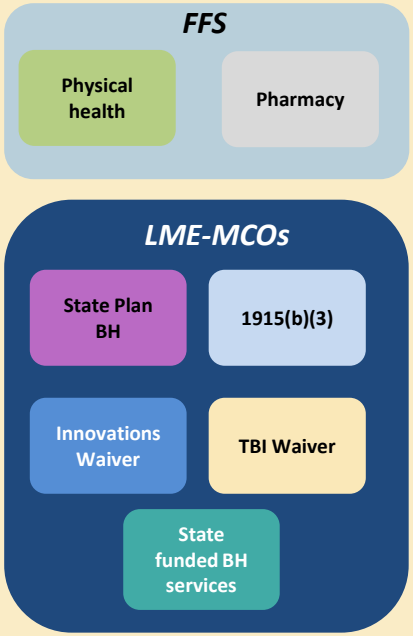


No changes; beneficiaries remain in integrated managed care product

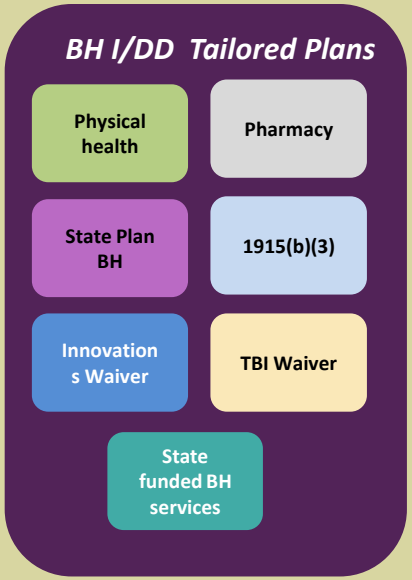


Initial Phase **Second Phase**

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



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



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.

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/90 days provision for OON services during transition
- PCP will be auto-assigned if not selected
  - Auto assignment prioritizes preserving provider relationships

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

Delayed Mandatory Enrollment*

SPECIAL POPULATION	ENROLLMENT	AFTER MANAGED CARE BEGINS up to
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

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

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

Unmet Social Needs (Social Determinants of Health- SDOH)

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
  - Build on current resource manage databases, like 211 or Wake Network of Cares

- Standardized screenings
  - Use instrument with questions related to food insecurity, housing instability and transportation needs
  - Health plans measured on rate of screenings conducted

- Health innovation investment
  - Request funds from CMS to support SDOH initiatives
  - Fund evidence-based interventions including referral and navigation services, collocated and embedded services, and use of flexible supports

- Support public-private pilots that address known unmet resource needs

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
- Provider Supports
  - Regional Provider Support Centers
  - Advanced Medical Home Certification
  - Practice transformation and education
- Managed Care Plan Accountability
  - PHP accreditation
  - Network Adequacy standards
  - Plan and Provider payments
  - Clinical Coverage Policies

Discussion