

# **North Carolina's Proposed Program Design for Medicaid Managed Care**

**August 2017**

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## Submit Feedback by September 8

The Department welcomes feedback on the Medicaid managed care proposed program design outlined in this document. Please send written input by Sept. 8, 2017, to:

**Email:** [Medicaid.Transformation@dhhs.nc.gov](mailto: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

Send feedback about North Carolina Medicaid transformation to

[Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov). For more information, visit [ncdhhs.gov/nc-medicaid-transformation](http://ncdhhs.gov/nc-medicaid-transformation).

# North Carolina's Proposed Program Design for Medicaid Managed Care

## Executive Summary

*The Department of Health and Human Services (DHHS) is publishing this detailed proposed program design for Medicaid managed care because we welcome and encourage feedback from providers, health plans, elected officials, advocates, beneficiaries, and other stakeholders. Though elements of this proposed program design will need additional statutory authority from the North Carolina General Assembly to implement, this document lays out the strongest possible program design for Medicaid managed care based on best practices in other states and building on the existing resources and infrastructure of North Carolina's current health care system and Medicaid program. DHHS has also published fact sheets on Medicaid managed care for beneficiaries and providers to update them on the status of implementation.*

**Background:** In September 2015, the General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a fee-for-service structure to a managed care structure. As DHHS prepares to launch Medicaid managed care in 2019, it will work with stakeholders and experts to refine program details.

**Vision:** This proposed program design seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. DHHS' goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

**Overview:** In Medicaid managed care, DHHS will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice programs. As directed by the General Assembly, DHHS will delegate the direct management of certain health services and financial risks to Prepaid Health Plans (PHPs). PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program.

The proposed program design covers five broad aspects of the transition to Medicaid managed care:

1. Creating an innovative, integrated, and well-coordinated system of care
2. Supporting providers and beneficiaries during the transition
3. Promoting access to care
4. Promoting quality and value
5. Setting up relationships for success

The executive summary includes a high-level summary of each of these aspects of the transformation, while additional detail on specific policy proposals and program design elements can be found in this document.

## 1. Creating an innovative, integrated, and well-coordinated system of care

**Integrate physical health, behavioral health, substance use disorders, and intellectual and developmental disability (I/DD) services:** Consistent with best practices, DHHS will continue to work with legislators to advance whole-person care so that all plans will include physical health, behavioral health, and substance use services for beneficiaries. Beginning in the second year of Medicaid managed care, DHHS envisions that individuals with serious mental illness (SMI), substance use disorder, and I/DD will be covered by Tailored Plans, a separate product designed for the unique needs of these populations that will also integrate physical health services and habilitative supports. *See section IV.*

**Address unmet social needs as part of overall health:** Addressing unmet social needs (sometimes called the “social determinants of health”) is key to DHHS’ vision, given evidence linking these needs to health. DHHS will standardize screening for unmet social needs (such as food or housing), seek to leverage existing investments in addressing these needs through Medicaid, and build upon efforts to map and codify resources to help identify gaps and opportunities. *See section VI.A.7.*

**Strengthen and support care management:** Care management helps beneficiaries and their families manage health conditions more effectively. Though this will be a shared responsibility of providers and PHPs, the emphasis will remain on care management delivered as close as possible to the site of care. Many primary care practices will be certified as Advanced Medical Homes (AMHs) and will provide certain enhanced services to enrollees beyond direct medical services (such as care coordination) and will receive additional payment for this. *See section VI.A.5.*

## 2. Supporting providers and beneficiaries during the transition

### Support providers through the transition

- **Provider supports:** To ensure providers are prepared for the transition to Medicaid managed care, DHHS will provide a support infrastructure including education and training, with special support given to small providers. DHHS also will contract with Regional Provider Support Centers (RPSCs) to assist providers in clinical transformation and care improvement efforts. *See section VI.A.6.*
- **Provider credentialing:** DHHS will implement a “one stop shop” centralized credentialing process, building on the current system and including uniform policies and a single electronic application. Contract negotiations will be directly between PHPs and providers, using state-approved contracts with standardized language for select sections. *See section VI.C.2.*

**Streamline beneficiary eligibility and enrollment processes:** DHHS wants applicants to experience a simple, timely, and user-friendly eligibility and enrollment process that will be available online, by telephone, in-person, or by mail. Over time, DHHS envisions that beneficiaries apply, receive a determination, and select a PHP and primary care provider in one sitting. *See section VI.B.1.*

**Give beneficiaries choice of plans:** Beneficiaries will have a choice of plan and primary care provider. Beneficiaries who do not choose a plan will be auto-assigned by an algorithm that prioritizes preserving provider relationships and keeping families in the same PHP. *See section VI.B.1.*

**Focus on member services and education:** After beneficiaries enroll, PHPs will support their transition to Medicaid managed care. PHP member services departments will explain how to access services, provide information on covered benefits, assist members with making appointments, and perform a variety of other related functions. *See section VI.B.2.*

### 3. Promoting access to care

**Support workforce initiatives:** DHHS will seek to continue existing loan repayment, community grant, and AHEC residency programs. DHHS may also create new programs to support provider retention and may seek federal funds to support community-based residency programs, including programs to increase the number of providers offering behavioral health and substance use disorder services. *See section VI.A.8.*

**Support telehealth initiatives:** DHHS also wants to ensure rural enrollees have access to quality services by investing in enhanced technologies such as telehealth, telepsychiatry, and technologies used in care for long-term services and supports (LTSS) populations. PHPs will be encouraged to use telemedicine as a tool for ensuring access, including through innovative pilots. *See section VI.A.9.*

**Increase access to Medicaid:** Proposed state legislation aims to increase access to affordable health care by creating the Carolina Cares program, allowing low-income individuals to enroll in Medicaid if they demonstrate work activities, pay required premiums, and meet personal responsibility requirements. If passed, this program would begin with the launch of Medicaid managed care. *See section VII.*

**Combat the opioid epidemic:** Medicaid managed care will continue to build on existing policies as a vital part of statewide efforts to address the opioid crisis. DHHS is considering expanding the substance use disorder service array; strengthening pain management treatment capacity; strengthening provider education around correct prescribing and managing chronic pain; providing care coordination for chronic pain beneficiaries; increasing access to substance use disorder services through Carolina Cares legislation; and eliminating prior authorization for an initial prescription of suboxone; and other proposed initiatives. *See section V.*

### 4. Promoting quality and value

DHHS seeks to strike a balance between providing standardization to ensure all stakeholders are working toward common goals, and providing the flexibility required to foster innovation and adapt to the needs of North Carolina's diverse communities. To ensure transition to Medicaid managed care improves the quality *and* value of care, DHHS proposes to implement several inter-related strategies:

- A robust **statewide quality strategy** with a standard set of quality goals and measures, and incentivize plan performance on desired outcomes. *See section VI.A.1.*

- A **value-based payment (VBP)** strategy to encourage accelerated adoption of payment arrangements between PHPs and providers that are focused on improving population health, ensuring appropriateness of care, and promoting value. *See section VI.A.1.*
- Enhanced **care management and provider supports**, including the launch of Advanced Medical Homes. *See section VI.A.5.*
- Enhanced **data collection and sharing capabilities** to support quality and value. *See section VI.A.4.*
- A **Medicaid managed care incentive** program to encourage investment in evidence based health outcomes and strategies. *See section VI.C.5.*
- Policies to encourage innovation and collaboration among providers, social services and plans, including using technology to improve health, and to **address health-related social needs and reduce health inequities**. *See section VI.A.7.*

## 5. Setting up relationships for success

**Ensure transparent and fair payments for PHPs:** PHP capitation payments will be actuarially sound and DHHS will provide as much information as early as possible on the rate setting data and methodology. DHHS will implement a rate cell structure based on eligibility group and region and will implement prospective risk adjustment. Rates will incorporate reasonable administrative costs and margin and DHHS will establish a Medical Loss Ratio for PHPs. *See section VI.C.5.*

### Ensure transparent and fair payments for providers

- **Plan payments to providers:** DHHS seeks to balance PHP flexibility in determining reimbursement levels for providers in their networks by mandating PHPs maintain a certain level of payment, including by setting a rate floor of 100% fee-for-service rates for select providers. DHHS will also set guidelines for rates, contracting, and timeliness of payment. *See section VI.C.5.*
- **Supplemental payments:** As North Carolina moves to Medicaid managed care, DHHS will no longer be permitted to make most supplemental payments. DHHS will work with hospitals to develop an alternative payment approach that maintains funding for Medicaid and uninsured patients at current levels and supports DHHS' transition to value-based payment. *See section VI.C.5.*

**Ensure provider access:** PHPs will be subject to strict requirements regarding provider contracting, access, and network adequacy. Under state law, PHPs must include all willing providers in their networks, except when a PHP is unable to negotiate rates or where there are quality concerns. PHPs must contract with all "essential providers" in their area unless DHHS approves another arrangement. PHPs must regularly submit their provider networks to DHHS. *See section VI.C.1.*

**Take a thoughtful approach to pharmacy policies:** DHHS will build on North Carolina's successful Medical Pharmacy program, maintaining a high preferred drug list (PDL) compliance rate and generic dispensing rate. In accordance with statute, DHHS plans to develop a single formulary that will

incorporate all drugs on the fee-for-service PDL and all covered outpatient drugs with a rebate agreement for which DHHS provides coverage. *See section VI.C.3.*

**Ensure compliance and program integrity:** To ensure that PHPs comply with requirements, DHHS is designing rigorous requirements and oversight protocols. PHPs must support the collection of timely encounter, quality and performance data and will submit reports on other metrics, such as network adequacy, value-based contracting arrangements, and grievances/appeals. In addition, each PHP will be required to develop compliance and fraud, waste, and abuse prevention programs. *See section VI.C.6.*

**Build fair grievance and appeal processes:** DHHS is committed to helping beneficiaries resolve problems, including pursuing formal appeals. Upon exhaustion of PHP processes for resolving adverse determinations, beneficiaries have the right to a State fair hearing. For other issues (e.g., care quality concerns), they may file a grievance with their PHP. DHHS will monitor PHP grievances and appeals and will establish an ombudsman program to support beneficiaries in these processes. *See section VI.B.3.*

## Next steps

DHHS will continue working with providers, health plans, elected officials, advocates, beneficiaries, and other stakeholders to refine this proposed program design based on feedback. Through the end of 2017, DHHS will supplement the invitation for written comment on this Medicaid managed care proposed program design with targeted outreach to specific stakeholders and groups.

In late fall 2017, DHHS will release a PHP Request for Information intended to solicit additional information from potential PHPs to assess interest in participation and market readiness. The RFI will include additional details about the DHHS plan for implementing Medicaid managed care. Also this fall, DHHS will submit an amended waiver to the Centers for Medicare & Medicaid Services (CMS), which also will be posted for public review and comment.

## I. Overview of Managed Care

North Carolina's Medicaid and NC Health Choice programs provide health coverage to approximately two million North Carolinians. This coverage benefits one in two births, two in five children, three in five people residing in nursing homes, and thousands of individuals with disabilities.<sup>1</sup> More than one in three dollars provided to safety-net hospitals and health centers, and half of funds spent on long term care in North Carolina are provided by Medicaid and NC Health Choice.<sup>2</sup> Ensuring the continued improvement in beneficiaries' health and financial sustainability of these programs is crucial to the health of our communities, our health care providers, and our State.

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<sup>1</sup> Kaiser Family Foundation. Medicaid State Fact Sheets. North Carolina. <http://files.kff.org/attachment/fact-sheet-medicaid-state-NC> and DHHS Medicaid website at <https://dma.ncdhhs.gov/reports>.

<sup>2</sup> Id.



This document outlines North Carolina’s detailed proposed program design for Medicaid managed care. This proposed program design builds on the June 2016 waiver submission and reflects extensive comments received in writing and through open public input sessions, as well as discussions with legislative leaders and extensive study of national best practices and experiences of other states.

DHHS will continue to engage with beneficiaries, providers, plans, elected officials, local agencies, communities, and other stakeholders throughout the health care and social services systems to shape, implement and monitor program changes. More detail on North Carolina’s ongoing stakeholder engagement efforts can be found in the “*Continued Stakeholder Engagement*” section.

DHHS is offering this detailed proposed program design for comment and feedback. Several aspects of the proposed design require legislative authorization, some require federal approval, and some will be fine-tuned based on stakeholder feedback. DHHS will work closely with the North Carolina General Assembly and with the federal Centers for Medicare and Medicaid Services to shape the program.

## **(A) Key Goals and Objectives for Transformation Efforts**

DHHS seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses both medical and non-medical drivers of health. With this goal in mind, DHHS is committed to the following key objectives and responsibilities in its transformation efforts:

- Establish a clear **statewide vision and standards** for transformation focused on an innovative, whole-person centered, well-coordinated system of care, and ensure through aligned incentives and strong oversight that all stakeholders are driving toward common objectives.
- Engage actively with **DHHS, county and local agencies and community-based organizations** who are crucial partners in determining eligibility, engaging with beneficiaries, addressing unmet resource needs, and supporting the delivery of coordinated, person-centered care.
- Ensure **beneficiaries** and their families are supported in the transition to Medicaid managed care and have the tools and resources they require.
- Facilitate a smooth transition for **providers of care** that minimizes administrative burdens, and provides education and support
- Ensure **health plans** reflect the values and priorities of DHHS, assist with practice transformation and can innovate and drive value through their relationships with beneficiaries, providers, community partners, and State agencies.
- Ensure **equitable access** to services for all beneficiaries, including individuals with disabilities

As DHHS embarks on its transformation efforts it is crucial to recognize where North Carolina’s Medicaid and NC Health Choice programs are performing well, and where there is room for improvement. North Carolina has effectively managed cost growth.<sup>3</sup> North Carolina also boasts high rates of beneficiary

participation in primary care medical homes and strong provider participation with over 65,000 enrolled providers<sup>3</sup>. North Carolina is home to some of the nation's leading health care institutions, which have been historic partners in program improvements.

At the same time, there is substantial room for improvement. North Carolina's Medicaid program is behind the curve on tying payments to value. Despite pockets of innovation, North Carolina lacks a comprehensive strategy for addressing the social determinants of health. And in the face of overwhelming evidence of the value of integrated care, the management and delivery of physical and behavioral health services across the state are largely siloed. Rural swaths of North Carolina need more provider capacity. As in most of the nation, primary care providers, particularly small and rural providers, require support to adapt to the growing role they need to play in managing and improving the health of their patients.

As North Carolina undertakes these transformation efforts, DHHS, the legislature and program stakeholders must seek to both preserve what works well, and to look for opportunities to do better. North Carolina can and must build upon its successes to achieve even more – by innovating and evolving to improve the health of North Carolinians.

## **(B) Key Stakeholder Roles under Managed Care**

The transition of the Medicaid and NC Health Choice programs from a predominantly fee-for-service model with Primary Care Case Management (PCCM) to Medicaid managed care will transform the roles and responsibilities of many key stakeholders in North Carolina's health delivery system. In fee-for-service, the Medicaid agency is the direct payer, managing provider contracting and ensuring timely payment is made. Managed care in North Carolina today is predominantly limited to behavioral health services. All behavioral health services are currently provided through capitated arrangements with Local Management Entities – Managed Care Organizations (LME-MCOs).<sup>4</sup>

Most Medicaid beneficiaries are also enrolled in the Primary Care Case Management (PCCM) system, which is comprised of primary care medical homes (Carolina Access practices) and the Community Care of North Carolina (CCNC) networks. Primary care medical homes are paid a per-member-per-month (PMPM) payment to provide care coordination for enrolled patients while CCNC networks are paid a PMPM to support Carolina Access practices and their patients through complex care management. Medical home services fees are still paid on a fee-for-service basis.

The following describes, at a high-level, the programmatic features and roles and responsibilities of key stakeholders in North Carolina's future Medicaid managed care environment:

- **DHHS.** DHHS remains ultimately responsible for all aspects of DHHS' Medicaid program, and will continue to administer Medicaid for populations remaining in fee-for-service. However, under the Medicaid managed care program, DHHS delegates the direct management of health care

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<sup>3</sup> NC Medicaid and NC Health Choice, Annual Report for State Fiscal Year 2016

<sup>4</sup> NC Health Choice beneficiaries are not enrolled in LME-MCOs.

services and financial risks for participating populations to Medicaid managed care plans. DHHS' primary role in Medicaid managed care is to hold plans accountable for providing high quality care and improving outcomes. This is accomplished by setting clear priorities and objectives, establishing standards (e.g., having adequate provider networks), and evaluating plans against those standards. DHHS is designing rigorous requirements, incentives, oversight structures, and protocols for Medicaid managed care plans to ensure that beneficiaries' health care needs are met and that DHHS' policy priorities and programmatic goals are met. DHHS will mandate some aspects of plan functions.

- **Prepaid Health Plans.** Managed care plans—which are called Prepaid Health Plans (PHPs) in North Carolina—will be paid actuarially-sound capitated payments by DHHS to manage the care of eligible Medicaid and NC Health Choice beneficiaries. PHPs will be required to meet minimum standards set by DHHS, but will also be given sufficient flexibility to innovate to improve quality and efficiency of care. PHPs will be responsible for establishing and maintaining an adequate network of providers to meet the health care needs of their beneficiaries by contracting with a diverse range of providers and establishing provider payment rates, subject to certain rules set by DHHS. Beneficiaries will be able to choose to enroll in one of several PHPs available to them.
  - In North Carolina, there will be two types of PHPs: statewide **commercial plans** and regional **provider-led entities**. DHHS will work with the General Assembly to amend the Medicaid managed care authorizing statute to allow both types of PHPs to offer different types of products. This includes **Standard Plans**, which will cover physical, behavioral and pharmacy services for most Medicaid and NC Health Choice beneficiaries, and **Tailored Plans**, which will be targeted to serve special populations with unique health care needs. This will include a behavioral health and intellectual/developmental disability Tailored Plan, which will provide integrated physical health, behavioral health, intellectual and developmental disability (I/DD) and pharmacy services to enrollees with significant behavioral health and I/DD needs.
  - Like private, commercial Medicaid managed care plans already in North Carolina, PHPs will be licensed by the **Department of Insurance** and must meet solvency and other financial requirements to participate and remain in the program.
  - PHPs will be required to **submit data and reports** to DHHS across many program metrics, (including demonstration of adequate networks, quality metrics, and outcomes of beneficiary grievances and appeals) to enable DHHS to monitor PHP performance.
  - To facilitate continuity as North Carolinians experience life changes that cause them to move across the coverage continuum, PHPs will be encouraged to participate in both Medicaid and the Health Insurance Marketplace.
- **Providers of Care.** Providers will continue to be the linchpin for delivering high-quality care to Medicaid beneficiaries and DHHS wants to maintain strong provider participation in Medicaid. In Medicaid managed care, providers will contract directly with PHPs to continue receiving reimbursement for those beneficiaries enrolled in Medicaid managed care. DHHS will help facilitate a smooth and successful transition to Medicaid managed care for providers through:
  - Ensuring the availability of education and training on Medicaid managed care and practice transformation

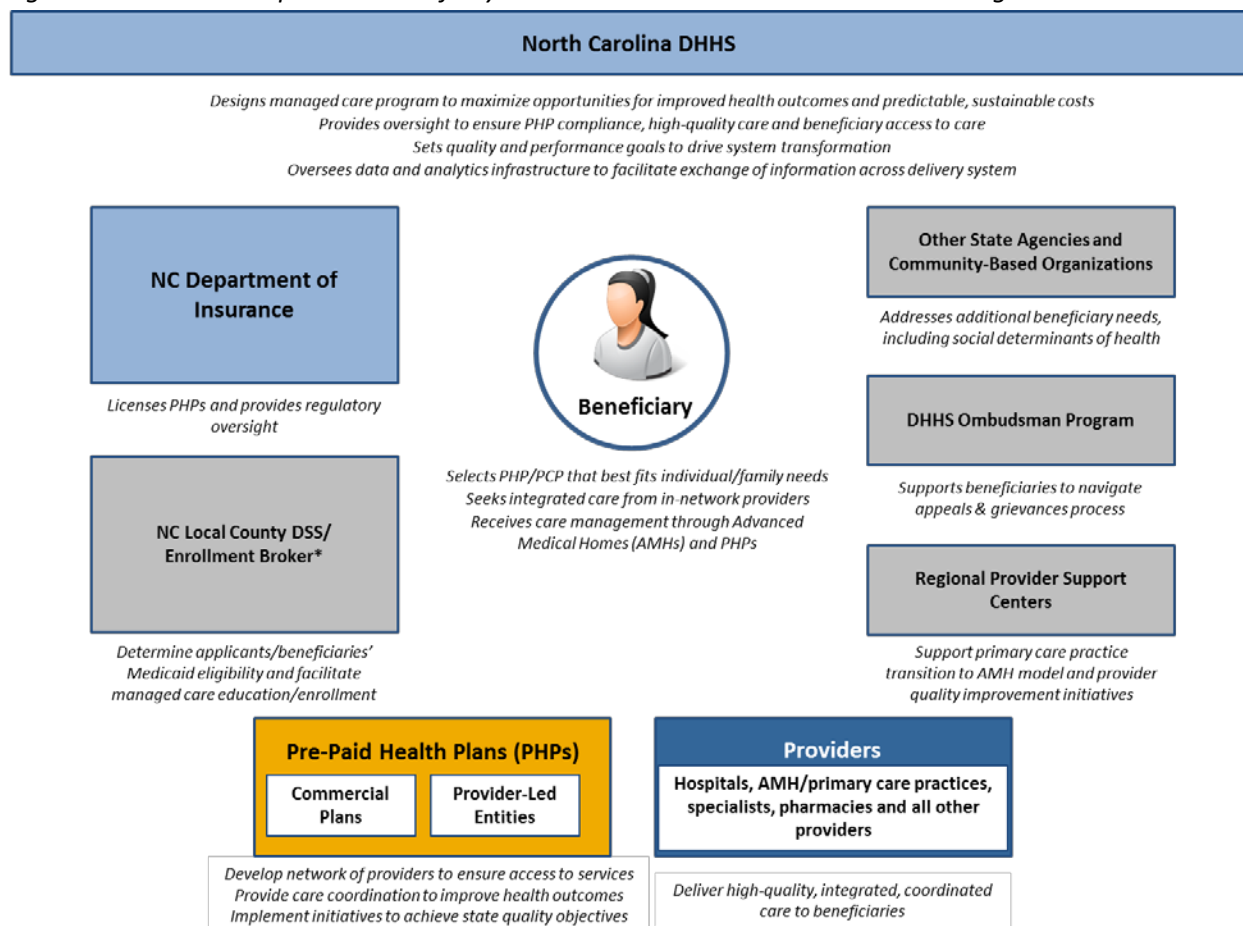
- Standardizing and simplifying administrative processes and standards across PHPs wherever appropriate, including with a centralized and streamlined credentialing process;
- Selecting **Regional Provider Support Centers (RPSCs)** through a competitive bid process to support providers in: (1) obtaining advanced medical home certification and advancing into higher levels of certification, and (2) continuous quality improvement. The RPSC entities will be not-for-profit organizations, overseen by DHHS, responsible for delivering these support services, including for small providers, rural providers, and essential providers.
- **Beneficiaries, Families, and Caregivers.** North Carolina is committed to ensuring that Medicaid and NC Health Choice beneficiaries, their families, and caregivers are supported in the transition to Medicaid managed care from enrolling and reenrolling into the program, to selecting a PHP and Primary Care Provider (PCP), to resolving grievances or appeals.
  - The **county Department of Social Services (DSS) offices**<sup>5</sup> will continue to play a pivotal role in eligibility and enrollment. They will provide the front-line support for beneficiaries. DHHS envisions an eligibility and enrollment system that allows applicants to apply online, over the phone, in-person, or through the mail—as is done today—with programmatic and systems improvements that strengthen program integrity and enable eligibility determinations to be made in real or near-real time. At the time of application, applicants also may select a PHP and PCP from the options available to them.
  - To ensure the capacity for Medicaid managed care education and PHP/PCP selection support at Medicaid managed care launch, DHHS will procure an **enrollment broker** to assist beneficiaries in choosing a PHP that meets the beneficiary’s health care needs. DSS caseworkers will facilitate seamless transitions to the resources available via the enrollment broker, and may provide these services directly upon implementation of the upgraded eligibility and enrollment system.
  - DHHS’ goal is to ensure beneficiaries in fee-for-service and Medicaid managed care can resolve problems or questions quickly and with minimal burden. DHHS will establish an **ombudsman program** focused on providing advocacy, assistance and education to fee-for-service and Medicaid managed care beneficiaries navigating the grievances, appeals and the fair hearing processes.

A depiction of key stakeholders involved in the delivery of care in North Carolina’s future Medicaid managed care program can be found in Figure 1.

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<sup>5</sup> Includes tribal eligibility and enrollment functionality.

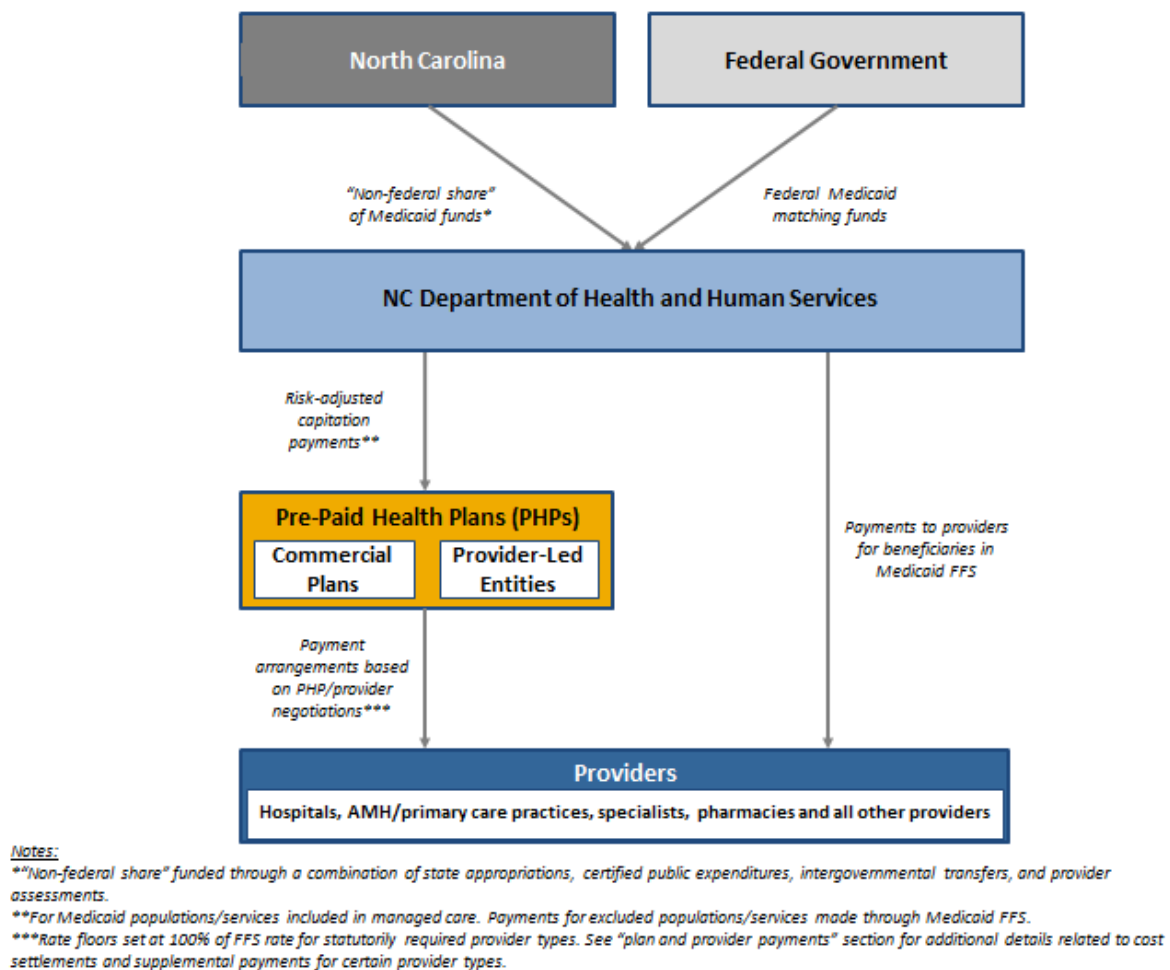
**Figure 1. Roles and Responsibilities of Key North Carolina Stakeholders under Managed Care**



### **Funding Flow in Managed Care**

As depicted below in Figure 2, State funds will continue to be matched by the Federal government to fund the Medicaid and NC Health Choice programs. DHHS will use this funding to make actuarially sound, capitated payments to PHPs based on both the number of beneficiaries enrolled and beneficiaries' eligibility group, age, health status and region (as described further in the *"Plan and Provider Payments"* section). PHPs, as risk-bearing organizations, are responsible for using these capitated payments to manage care for beneficiaries and pay providers for the services provided to Medicaid beneficiaries, while covering PHP administrative costs.

Figure 2. North Carolina Managed Care High-Level Funding Flow



Most populations will enroll in PHPs upon the launch of the Medicaid managed care program. DHHS will work with the General Assembly to enact changes in the authorizing legislation that will ensure that vulnerable populations experience a smooth and successful transition. DHHS envisions allowing certain targeted populations with complex and unique health care needs to phase into the program over a four-year period after Medicaid managed care launch. In total, approximately 90 percent of current beneficiaries<sup>6</sup> will be required to enroll in Medicaid managed care.

DHHS will work with the General Assembly to enact legislative changes to enable PHPs to manage the integrated and coordinated delivery of physical and behavioral health and pharmacy services for beneficiaries. Today, North Carolina has separate delivery systems for physical health services and behavioral health and intellectual and developmental disability (I/DD) services. For most beneficiaries, physical health services are managed through the Medicaid fee-for-service program, while behavioral health and I/DD services are delivered by local management entity-managed care organizations (LME-MCOs). Consistent with emerging best practices and trends across other states, North Carolina is

<sup>6</sup> Based on DHHS analysis of SFY 2015 data

planning to work with the General Assembly to include behavioral health and I/DD services in its Medicaid managed care program and create integrated managed care products capable of providing whole-person care.

### **(C) Continued Stakeholder Engagement**

Stakeholder engagement is central to the successful implementation of North Carolina's Medicaid managed care program. Because of the size and nature of the transformation effort, DHHS is committed to transparent and on-going communication with beneficiaries and their advocates, tribal populations, rural and urban providers, hospitals, health plans, elected officials, community based organizations, and local agencies and officials, and others. This input is crucial not only during the planning and design phases, but throughout Medicaid managed care launch and ongoing operations. DHHS will rely on stakeholders' on-the-ground experience to adapt the Medicaid managed care rollout to ensure the best possible result. Stakeholder engagement will evolve over time. Early stakeholder engagement will focus on design decisions, with later efforts supporting education, readiness and implementation.

Stakeholder engagement has already begun. In April and May 2017, DHHS hosted listening sessions across the state, and solicited written and verbal public input on key policy issues. A summary of the comments received is posted on the DHHS Medicaid Transformation website at [ncdhhs.gov/nc-medicaid-transformation](http://ncdhhs.gov/nc-medicaid-transformation).

Over the next six months, DHHS will continue to facilitate stakeholder input into the process:

- DHHS encourages public comment on this proposed program design by Sept. 8, 2017.
- This fall, DHHS will submit a waiver concept paper to CMS and post it for public review and comment. The concept paper will align with the proposed program design, but focus specifically on programmatic initiatives requiring federal approval.
- Through the end of 2017, DHHS will supplement the open invitation for written comment with targeted outreach to stakeholders representing consumers and their advocates, rural and urban providers, hospitals, potential PHPs, and members of the Eastern Band of Cherokee Indians (EBCI) on policy and strategic topics and implementation issues.
- In late fall 2017, DHHS will submit an amended waiver to CMS, which also will be posted for public review and comment.
- In late fall 2017, DHHS will release a PHP Request for Information (RFI) intended to solicit information from potential PHPs to assess interest in participation and market readiness. The RFI will include additional details about DHHS' plan for implementing Medicaid managed care. DHHS will also request Letters of Intent as part of the RFI response.

Starting in August 2017 and continuing throughout the design, implementation and ongoing operational phases, DHHS will engage the standing Medical Care Advisory Committee (MCAC) which is open to the public, as the formal stakeholder engagement body charged with providing feedback and comment on

the wide range of transformation efforts.<sup>7</sup> The diverse membership of the MCAC, including beneficiaries, advocates, urban and rural physicians and hospitals with representation from each region, will help ensure DHHS is sharing information with and receiving feedback from a wide-range of perspectives. DHHS will ensure accessibility for individuals with disabilities to participate in stakeholder engagement wherever possible.

DHHS will facilitate monthly teleconference and quarterly in-person MCAC meetings, with the option to participate by telephone for those unable to travel. DHHS contemplates the role of the MCAC extending beyond the launch of Medicaid managed care for on-going monitoring of roll-out and operations.

#### (D) Managed Care Implementation Principles

The scale and complexity of the transition to Medicaid managed care demands careful planning and forethought, active, real-time monitoring, and the capacity to adapt quickly to account for the unexpected. With this in mind, DHHS has established the following principles for ensuring a smooth technological and procedural transition to Medicaid managed care:

- **Communicate clearly and consistently** with all stakeholders, particularly beneficiaries and providers, to ensure they are well-prepared and informed in advance of the transition.
- Create live feedback loops **for ongoing communication and collaboration** with all impacted stakeholders to ensure stakeholders can serve as partners in planning, implementation, troubleshooting, and solutions development.
- Ensure DHHS' information technology vendors are **communicating and coordinating with DHHS and with one another** to create a successful and well-integrated system.
- **Leverage existing infrastructure, systems, and practices** where possible to ensure functional processes on Day 1, with a glide path toward streamlined, integrated systems.
- Fully test and prepare all systems prior to the Medicaid managed care go-live date to ensure readiness for a smooth launch.

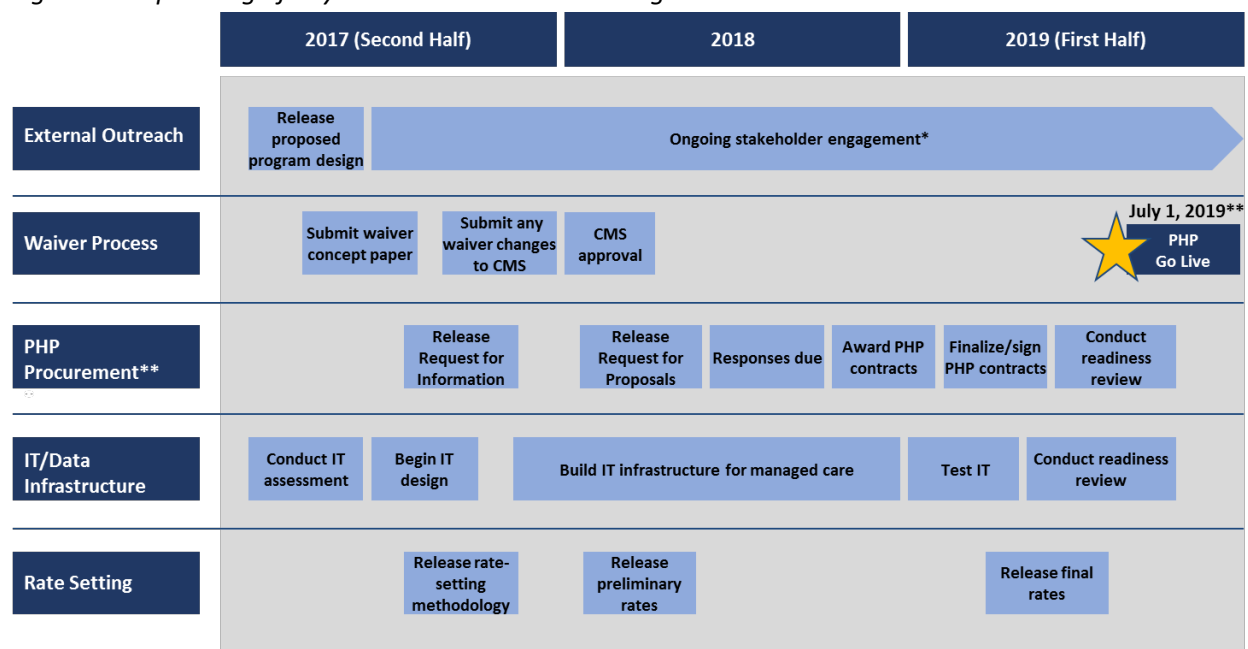
Below, Figure 3 depicts the key activities and their sequencing that are required for a successful Medicaid managed care launch.

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<sup>7</sup> Transformation materials will be posted at [https://dma.ncdhhs.gov/get-involved/committees-work-groups#Medical\\_Care\\_Advisory\\_Committee](https://dma.ncdhhs.gov/get-involved/committees-work-groups#Medical_Care_Advisory_Committee)



Figure 3. 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.

The remainder of this document describes in more detail the proposed features and preliminary approach for implementing Medicaid managed care and transforming North Carolina’s Medicaid and NC Health Choice programs.

## II. Types of Managed Care Plans

### (A) Overview of Types of Managed Care Plans, Regions

To ensure consumer choice, leverage the experience and commitment of Medicaid providers in North Carolina, and maximize opportunities for innovation, DHHS will contract with two types of PHPs:

- **Commercial Plans.** Under State law, three commercial plans (CPs) will offer products statewide.
- **Provider-Led Entities.** Provider-led entities (PLEs) will offer products in up to 12 regions. PLEs must cover a region in its entirety, and may bid for more than one region, provided the regions are contiguous.

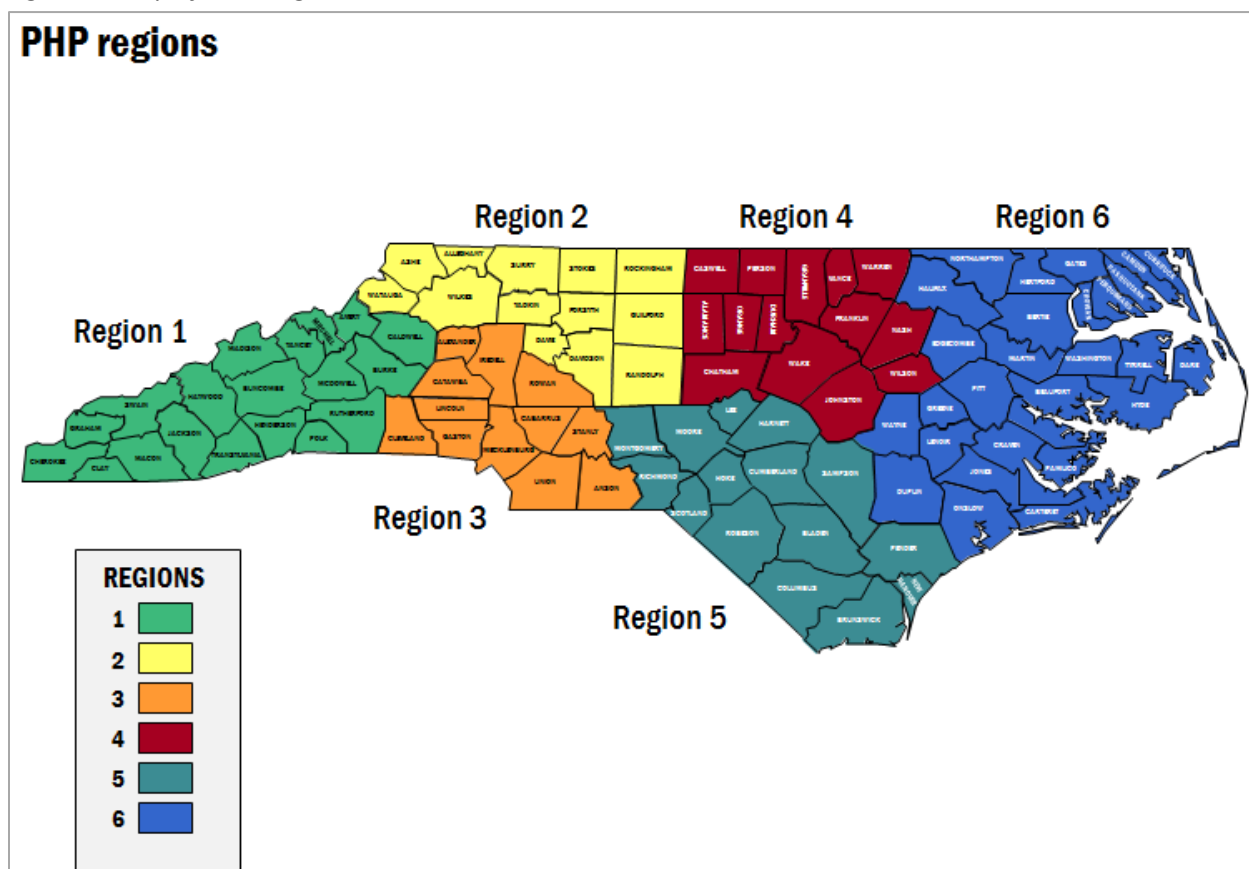
Providers with a history of serving Medicaid beneficiaries may seek to own and operate risk-bearing Medicaid managed care plans and participate as a PHP in the Medicaid managed care program.

Managed care plans sponsored by providers may either constitute “regional provider-led entities” –

plans that are offered only on a regional basis – or “statewide commercial plans” —plans that are offered statewide.

DHHS has defined six total regions within the state, as depicted in Figure 4 below.

Figure 4. Map of PHP Regions.



## (B) Implementation of PHPs

Both regional provider-led entities (PLEs) and statewide commercial plans (CPs) must be licensed by the North Carolina Department of Insurance (DOI) and will be subject to DOI’s solvency standards and financial oversight. DHHS will continue to work with DOI, stakeholders, and the legislature to define the licensure process and requirements for PHPs. PHPs will be required to meet solvency requirements that are substantially like the solvency requirements of HMOs. DHHS and DOI are proposing both a stand-alone PHP licensure process and a streamlined approach for entities that are already a DOI licensed health organization, to limit duplication.

CPs and PLEs must cover the same benefits and populations and must meet the same DHHS Medicaid managed care requirements. Those requirements include but are not limited to Medicaid managed care payment requirements, network adequacy requirements, program integrity requirements, grievances and appeals rules, cost sharing limitations, accreditation requirements and marketing restrictions.

Because only PLEs may compete at the regional level, it is important to ensure that they are affiliated or governed by providers. Thus, PLEs will be required to comply with specific governance standards:

- North Carolina law specifies that a PLE must be controlled by individuals or entities, most of whom have as their primary business purpose the ownership or operation of one or more PHP contracts or Medicaid and NC Health Choice providers.
- Most of the entity's governing body must be composed of individuals who: are licensed in the state as physicians, physician assistants, nurse practitioners or psychologists, AND have experience treating beneficiaries of the North Carolina Medicaid program.

To protect against anticompetitive behavior, DHHS will require the following of CPs and PLEs:

- **Anti-exclusivity provisions:** DHHS will prohibit exclusivity provisions in contracts between PHPs and providers and will require providers that partially own or control a PHP to negotiate with rival PHPs in good faith if those rival PHPs seek to contract with them.
- **State review:** DHHS will have authority to review contracts between PHPs and providers and require modifications if any term is deemed anti-competitive.

These State-level tools will be in addition to antitrust laws enforced by federal authorities, which prohibit entities from abusing their market power by engaging in anti-competitive conduct.

### (C) Standard Plans and Tailored Plans

Pending legislative authorization, DHHS intends to permit CPs and PLEs to develop and offer two types of products: Standard Plans and Tailored Plans.

- **Standard Plans** will serve most Medicaid and NC Health Choice enrollees, including adults and children. They will provide integrated physical health, behavioral health, and pharmacy services at the launch of North Carolina's Medicaid managed care program.
- **Tailored Plans**<sup>8</sup> will be specifically designed to serve special populations with unique health care needs. As described further below, North Carolina is considering launching a behavioral health and intellectual/developmental disability Tailored Plan (Behavioral Health I/DD Tailored Plan) no later than two years after the launch of Medicaid managed care. The plan will provide integrated physical health, behavioral health, I/DD, and pharmacy services to enrollees with SMI, substance use disorder, and/or I/DD needs. In future years, DHHS may create additional tailored plans for other high-needs populations, such as individuals dually eligible for Medicare and Medicaid.

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<sup>8</sup> Previously DHHS referred to these plans as Special Needs Plans (SNPs) or Specialty Plans (SPs).

### III. Populations in North Carolina Managed Care

#### (A) Populations in Managed Care

Most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs, while allowing adequate time for thoughtful planning and a smooth transition.<sup>9</sup> There will also be limited exceptions to mandatory enrollment for certain populations who may be better served outside of Medicaid managed care. These populations may be either exempt—meaning that they may choose to enroll in either fee-for-service or Medicaid managed care—or excluded—meaning they must remain enrolled in fee-for-service.

- **Excluded:** Session Law 2015-245 as amended by Session Law 2016-121 excludes a limited number of populations:
  - Beneficiaries dually eligible for Medicaid and Medicare<sup>10</sup>
  - PACE beneficiaries<sup>11</sup>
  - Medically needy beneficiaries<sup>12</sup>
  - Beneficiaries only eligible for emergency services
  - Presumptively eligible enrollees, during the period of presumptive eligibility
  - Health Insurance Premium Payment (HIPP) beneficiaries

Experiences in other states, as well as review of North Carolina’s practices and conversations with stakeholders, indicate that in addition to populations already excluded from Medicaid managed care in current statute, family planning enrollees and prison inmates should also be excluded. Family planning beneficiaries receive a limited benefit package and are entitled under federal rules to seek family planning services in and out of a PHP provider network.<sup>13</sup> PHPs would have few opportunities to more effectively manage care and would have a potentially costly administrative burden to develop and administer a separate capitated product with a partial benefit package. Similarly, prison inmates are not eligible for Medicaid other than for inpatient hospital stays of 24 hours or longer.<sup>14</sup> PHPs would have no opportunity to manage care for such a limited benefit. DHHS will work with the General Assembly to seek exclusion of these populations to avoid incurring unnecessary administrative costs.

All excluded populations would continue to receive health benefits on a fee-for-service basis or through their existing delivery system.

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<sup>9</sup> DHHS is proposing to stagger the managed care launch dates by region to ensure beneficiaries, stakeholders and systems can manage, adjust to and successfully roll-out managed care. This is discussed further in section “*Eligibility and Enrollment*” below.

<sup>10</sup> See section on delayed mandatory enrollment for more information on the proposed approach to coverage of dual eligibles.

<sup>11</sup> PACE beneficiaries will be excluded from PHPs and will continue to be enrolled in their current managed care delivery system.

<sup>12</sup> Medically needy beneficiaries are those whose income or assets exceed the categorically needy income limits are classified as medically needy. Reference <https://www2.ncdhhs.gov/info/olm/manuals/dma/abd/man/>;  
<https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man/MA3415-01.htm>

<sup>13</sup> 42 CFR 431.51

<sup>14</sup> SSA 1905(a)(29)(A); 42 CFR 435.1010

- **Exempt** populations include members of federally recognized tribes. North Carolina consulted with its only federally-recognized tribe – the Eastern Band of Cherokee Indians (EBCI)—and concluded that tribal members will benefit from having the choice between Medicaid fee-for-service or enrollment in a PHP. DHHS is in discussions with the EBCI Tribe on pathways to becoming the first Native American managed care entity in the country and is exploring options for Tribal enrollees who elect to participate in PHPs. The Department will work with the General Assembly on the changes necessary to allow the EBCI to offer a managed care plan. Current estimates indicate there are approximately 4,000 EBCI members enrolled in Medicaid.<sup>15</sup>

## (B) Delayed Mandatory Enrollment for Special Populations

The transition of high-need populations to Medicaid managed care requires special care and planning to ensure that provider relationships and care regimens transition smoothly. DHHS believes that certain targeted populations with complex health care needs should be allowed more time to make the transition to Medicaid managed care. This would mean phasing in mandatory enrollment of some vulnerable populations after the Medicaid managed care program is fully established. The Department will work with the General Assembly to implement this proposal to allow the timeline and processes described below and in Table 1. During the transition period, to avoid care disruption, special populations will continue to have access to their existing provider networks.

*Table 1. Enrollment of Special Populations into Managed Care*

Special Population	Estimated Enrollment	Expected Phase-In Timeline (no later than):
Children in foster care and adoptive placements	22,000	1 year after managed care implementation
Certain Medicaid and NC Health Choice beneficiaries with an SMI, SUD or I/DD diagnosis and those enrolled in the TBI waiver	~85,000 <sup>[1]</sup>	2 years after managed care implementation
Medicaid-only beneficiaries receiving long-stay nursing home services	2,000	4 years after managed care implementation
Medicaid-only Community Alternatives for Children (CAP/C) and Community Alternatives for Disabled Adults (CAP/DA) waiver beneficiaries	3,500	4 years after managed care implementation
Individuals who are dually-eligible for Medicare and Medicaid <sup>[2]</sup>	245,000	4 years after managed care implementation

<sup>15</sup> Other American Indian/Alaska native members of Federally recognized tribes in North Carolina are also exempted; however, estimates on the size of the population impacted are currently unavailable.

Children in foster care and adoptive placement.<sup>16</sup> An estimated 22,000 children in North Carolina are in foster care or adoptive placements and enrolled in Medicaid. Children in foster care and those who are adopted after being in foster care are a vulnerable population with specialized physical and behavioral health needs. Nationally, children in foster care use both inpatient and outpatient mental health services at a rate 15 to 20 times greater than that of the general pediatric population;<sup>17</sup> approximately 60 percent of children in foster care have a chronic medical condition.<sup>18</sup> Managing the needs of children in foster care is further complicated by several factors, including frequent changes in placement and caregivers, higher risk of over-use of psychotropic medications, and multi-system involvement which may result in poor cross-agency coordination and lack of access to relevant data.

To ensure a smooth transition for this high-needs population, North Carolina intends to launch a Statewide Tailored Plan for children in foster care that will include the following features:

- Specialized capitation rates targeted to the foster care population;
- Individualized care management, building from best practices identified under Fostering Health North Carolina. This will ensure overall responsibility for the health of the child and facilitate referrals and appointments to appropriate physical and behavioral providers and community-based social services;
- Personnel with specialized trauma-informed expertise and responsibilities, including a Foster Care Medical Care Director and Foster Care Behavioral Health Clinical Director, who will oversee the PHP's delivery of services to children in foster care;
- PHP foster care liaisons who will serve as a single point of contact between the PHP and foster care agencies and be responsible for the oversight of foster-care specific functions
- 90-day transition period of continued services when transitioning from fee-for-service to a PHP or from one PHP to another to avoid gaps in services;
- Care managers to ensure enrollees' care coordination plans continue to be followed and implemented during placement transitions (e.g., from home to foster placement, from hospital setting to community, or from foster care to permanent adoption)
- Medication management services based on Fostering Health North Carolina's protocols.

To allow more time for DHHS to develop these specialized requirements, and for a PHP to demonstrate readiness including building adequate provider networks and a care coordination infrastructure, DHHS proposes to launch this specialized product for children in foster care one year after the launch of managed care. During the interim period, foster children will receive care as they do today. DHHS will ensure children continue to have access to the same network of providers, medical home, and care coordination services offered through Fostering Health of North Carolina.

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<sup>16</sup>Individuals up to age 26 who were formerly in foster care may also enroll in the statewide tailored plan

<sup>17</sup> Medicaid Managed Care for Children in Foster Care," Manatt Health, 2013; "Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit," Center for Health Care Strategies, 2012.

<sup>18</sup> Id.

Medicaid-only beneficiaries receiving long-stay nursing home services. Nursing home services will be covered by Medicaid managed care for “short-stays” (e.g., post-acute) less than 90 days. However, non-dual Medicaid beneficiaries utilizing nursing facilities for more than 90 days should be temporarily excluded from Medicaid managed care enrollment and continue to receive services through the fee for service system. DHHS estimates that approximately 2,000 beneficiaries (not including those who also are eligible for Medicare) are in long-stay nursing home arrangements.<sup>19</sup> Coverage for long-stay nursing home services and beneficiaries under Medicaid managed care will be phased in to align with enrollment of dual eligibles in year 4 of Medicaid managed care implementation.

Community Alternatives for Children (CAP/C) and Community Alternatives for Disabled Adults (CAP/DA) Waiver Medicaid-only beneficiaries.

DHHS seeks to phase-in mandatory Medicaid managed care enrollment for an estimated 2,000 CAP/C and 1,500 CAP/DA non-dual Medicaid enrollees.<sup>20</sup> DHHS will align the timing of mandatory Medicaid managed care enrollment for CAP/C and CAP/DA Waiver beneficiaries with the enrollment of dual eligibles in year 4 of Medicaid managed care implementation. A phased approach will ensure beneficiaries maintain access to existing service providers and case management support while DHHS and stakeholders develop a Medicaid managed care product to meet the specialized needs and services of these populations.

Individuals who are dually eligible. North Carolina’s Medicaid managed care legislation excludes individuals who are dually eligible for Medicaid/Medicare from PHPs. However, the legislation established a dual eligible advisory committee<sup>21</sup> to develop a strategy for inclusion of full dual eligibles in Medicaid managed care at a later date.<sup>22</sup> Based on the recommendation of this committee, DHHS proposes to phase-in mandatory Medicaid managed care enrollment of dual eligibles in year four of Medicaid managed care implementation. This will allow DHHS and the PHPs to gain experience in running its Medicaid managed care program, and to create a plan specially tailored to the needs of the population. In the interim, dual eligibles with serious behavioral health or intellectual/developmental disability needs may be enrolled in a behavioral health and intellectual/developmental disability Tailored Plan. DHHS will work with the General Assembly on any additional statutory authority that might be required to eventually include dual eligibles in Medicaid managed care.

In North Carolina, 52 percent of dual-eligibles had three or more chronic conditions and 61 percent used institutional care.<sup>23</sup> Because of the population’s intensive health needs and because payment for their care is divided across Medicare and Medicaid, the best approach for managing the care and achieving State savings for dual eligibles is an integrated model using special products for individuals who are dually eligible, which will have special requirements related to provider network development, care

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<sup>19</sup> Approximate estimate based on DHHS data from SFY 2015.

<sup>20</sup> Based on DHHS data from SFY 2015.

<sup>21</sup> Medicaid Transformation Law (SL 2015-245)

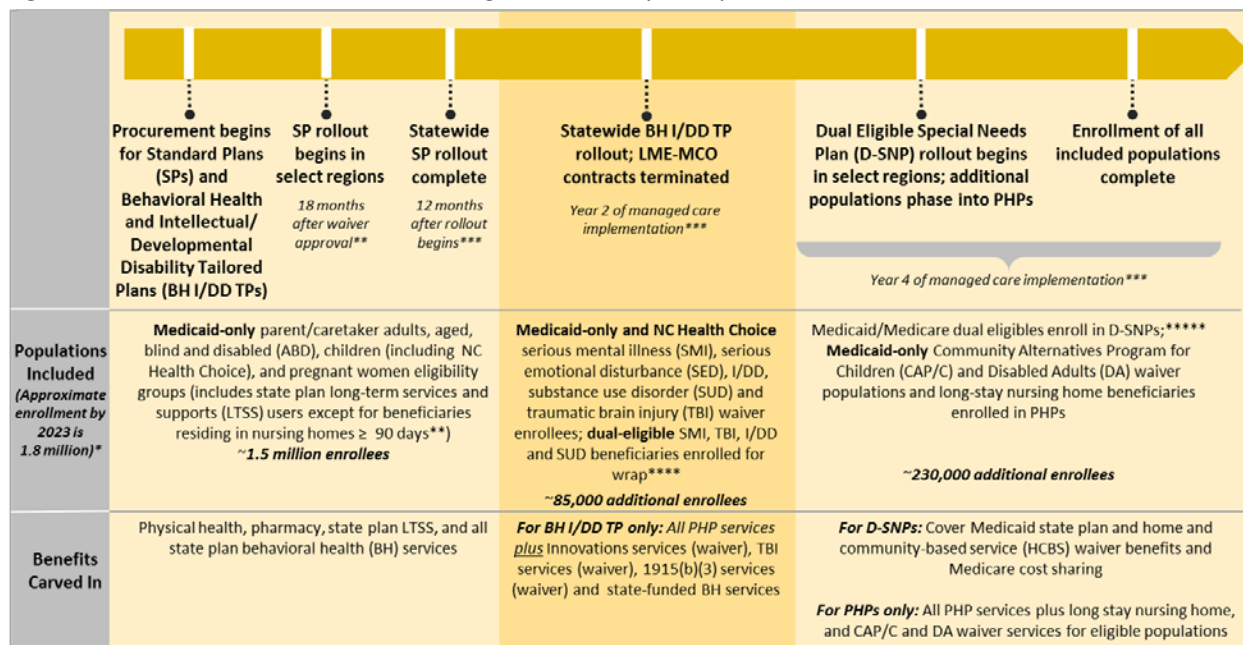
<sup>22</sup> “Partial dual eligible” beneficiaries enrolled in one of the Medicare Savings Program (MSP) categories, in which Medicaid pays for a portion of Medicare premiums and/or cost sharing depending on the program category, would remain excluded from managed care.

<sup>23</sup> Dual Eligible Advisory Committee Report, January 2017.

coordination, utilization management and other functions to provide high-quality care and achieve cost savings for this population.

Figure 5 depicts an approximate pathway for special populations enrolling into Medicaid managed care.

Figure 5. North Carolina Medicaid Managed Care Sample Implementation Path



**Populations permanently excluded:** Family planning, qualified aliens subject to the five year bar, undocumented aliens who qualify for emergency services, medically needy recipients, individuals covered through presumptive eligibility, HIPP enrollees, PACE enrollees, partial dual eligibles, and inmates with an inpatient hospital stay

**Benefits permanently carved out:** Dental, PACE services, services documented on an individualized educational program (IEP) and provided or billed by Local Education Agencies, CDSA-provided services, services provided during retroactive eligibility

Notes: \*Estimates based on average SFY 2016 member months. \*\*Required by current statute; \*\*\*Would require statutory change; \*\*\*\*BH I/DD TP eligible Medicaid enrollees will remain in FFS for their physical health needs and receive BH and I/DD services through the LME-MCOs until BH I/DD TP roll-out \*\*\*\*\* Individuals who opt out of D-SNPs would be mandatorily enrolled in Medicaid managed care, based on current dual eligible advisory committee report. \*\*\*\*\*Members of federally recognized tribes are exempt from mandatory PHP enrollment but can voluntarily enroll in PHPs.

## IV. Integration of Physical and Behavioral Health

### (A) Integration of Physical Health, Behavioral Health, and Intellectual and Developmental Disability Services

To realize the full benefit of Medicaid managed care and consistent with the best clinical evidence and best practices in others states, DHHS will work with the General Assembly to include behavioral health services in all Medicaid managed care products, creating integrated physical and behavioral managed care products for all enrollees.<sup>24</sup>

<sup>24</sup> Am J Manag Care. 2013;19(5):e175-e184



Today, North Carolina has separate payment and delivery systems for physical health services and behavioral health and intellectual/developmental disabilities (I/DD) services. Physical health services are managed through DHHS' Primary Care Case Management (PCCM) program, while behavioral health and I/DD services are delivered by local management entity-managed care organizations (LME-MCOs). LME-MCOs have standardized delivery of services and managed behavioral health and I/DD service costs, but the current bifurcated structure limits DHHS' ability to provide whole-person care. This bifurcation presents a serious flaw in the delivery of integrated clinical care.

To further build on previous improvements and consistent with emerging best practices and trends across other states, DHHS will work with the General Assembly to include behavioral health and I/DD services in the broader Medicaid managed care program and create integrated managed care products for all enrollees. By pursuing an integrated approach, DHHS aims to:

- Establish designated managed care plans as the entities accountable for costs, quality of care, and outcomes for individuals with significant behavioral health needs and I/DDs;
- Minimize barriers for all beneficiaries to access services
- Incentivize plans and providers for the successful delivery of whole-person care, including implementation of integrated physical health, behavioral health, and I/DD care models and care management;
- Align purchasing strategies for physical health, behavioral health, and I/DD services, including value-based approaches.

With an integrated approach, approximately 1.8 million Medicaid beneficiaries will ultimately receive coordinated physical and behavioral health services, as well as Traumatic Brain Injury (TBI) waiver, Innovations waiver, and other I/DD services through a single plan.<sup>25</sup>

## **(B) Approach for Delivering Behavioral Health and Intellectual and Developmental Disability Services**

All beneficiaries with behavioral health conditions and/or I/DDs—ranging from those with mild to severe needs—benefit from integrated managed care products. Those with serious behavioral health and I/DD needs benefit from receiving care through a managed care entity that is designed for their specific needs and complexities, while those with less severe needs are best-served if they can access all needed services (whether behavioral or physical health) at a single point of care.

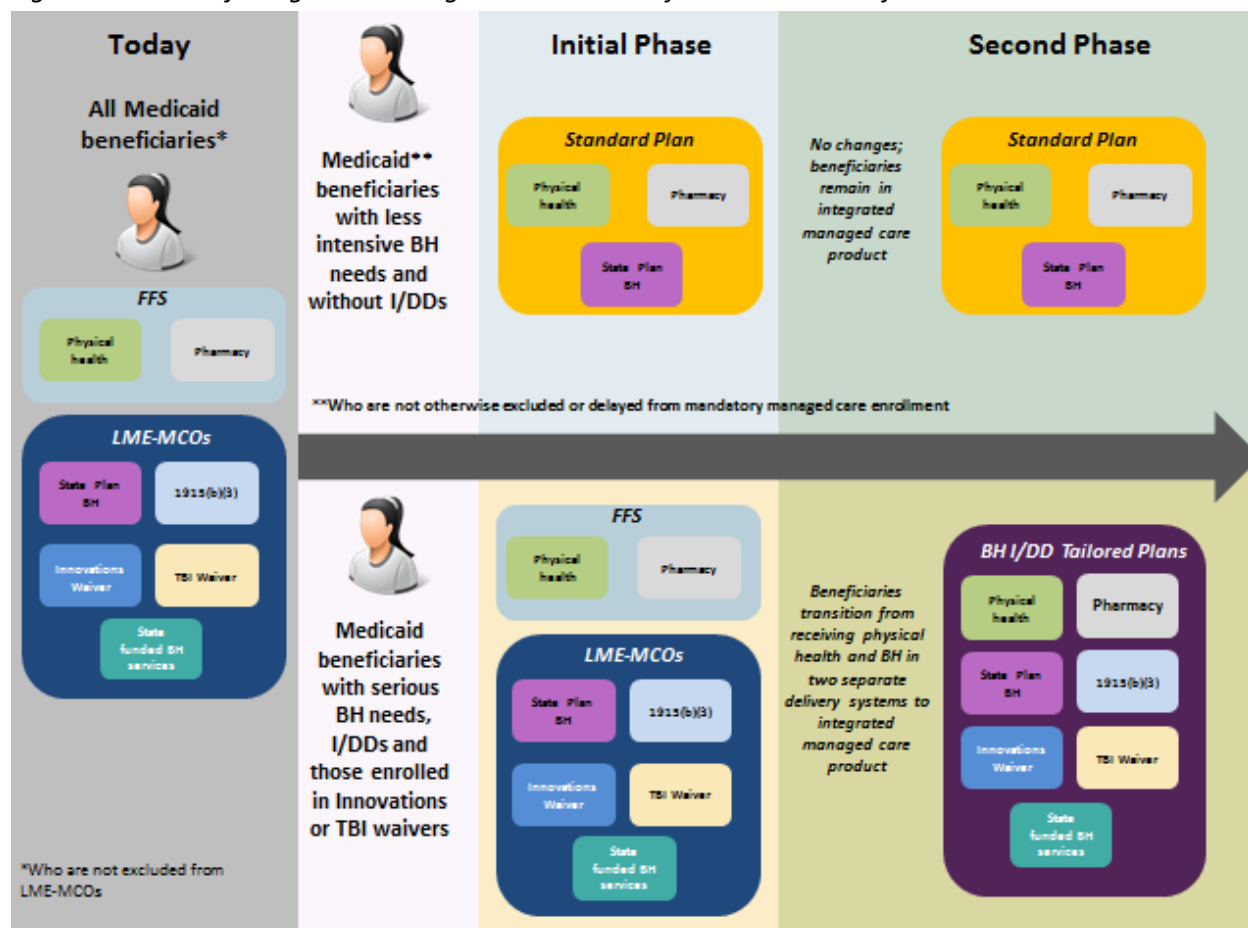
DHHS will work with the General Assembly to transform North Carolina's existing system so that all beneficiaries can receive integrated services. DHHS will incrementally implement changes to the delivery of Medicaid services to minimize care disruption. As shown in figure 6, at the launch of North Carolina's Medicaid managed care program, DHHS envisions that Standard Plans will provide integrated physical and behavioral health services (including substance use disorder services) to those with lower intensity

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<sup>25</sup> The TBI Waiver will launch pending CMS approval for qualifying individuals enrolled in the Alliance Behavioral Health LME-MCO (Cumberland, Durham, Johnston and Wake counties).

behavioral health and I/DD needs. During a one-year transition period, beneficiaries with more serious needs will continue to receive care as they do today (via fee-for-service and LME-MCOs). At the end of that transition period, DHHS envisions rolling out Tailored Plans<sup>26</sup> providing integrated care to those with serious behavioral health and I/DD needs. Figure 6 illustrates this approach.

Figure 6. Rollout of Integrated Managed Care Products for Medicaid Beneficiaries



DHHS believes that this approach will build on North Carolina's historic investment and success in managing costs for those with serious behavioral health and I/DD needs, while also moving us toward a future where managed care entities can be held accountable for delivering whole-person health outcomes and individuals can receive the integrated care that will best promote their health and well-being.

<sup>26</sup> Previously referred to as Special Needs Plans or Specialty Plans.

### **Defining the Population with Serious Behavioral Health (including Substance Use Disorder) and I/DD Needs**

As described above, DHHS envisions that those with serious behavioral health (including substance use disorders) and I/DD needs would be covered in a different way than those with less intense behavioral health needs. Specifically, this population with serious needs would include:

- Beneficiaries with I/DD diagnosis
- Beneficiaries with a SMI or SED diagnosis in need of an enhanced behavioral health service
- Beneficiaries with a severe substance use disorder diagnosis in need of an enhanced behavioral health service

DHHS is developing a list of diagnoses, as well as the process that will be used in identifying the populations above. Enhanced services include facility-based crisis services, partial hospitalization, ambulatory detoxifications, outpatient opioid treatment, and substance abuse intensive outpatient services. This population represents approximately 85,000 beneficiaries<sup>27</sup>, but there would not be a cap on the number of individuals served in Tailored Plans.

### **Initial Phase: Delivery of Behavioral Health Services in Standard Plans**

At the outset of North Carolina's Medicaid managed care program, DHHS envisions that Standard Plans will be integrated managed care products covering physical health, behavioral health, and pharmacy services and will serve the vast majority of Medicaid managed care enrollees. Individuals in Standard Plans will have access to all State Plan behavioral health benefits, including inpatient behavioral health services, outpatient behavioral health services, and enhanced behavioral health services.

Individuals with serious behavioral health and I/DD needs, as defined above, will not enroll in Standard Plans. Instead, they will receive care exactly as they do today (fee-for-service and LME-MCOs) during a transition period, and after a transition period, through Behavioral Health I/DD Tailored Plans. If a Standard Plan enrollee newly qualifies as having serious behavioral health or I/DD needs, or has a need for medically necessary services that are not covered by Standard Plans, DHHS will transition the individual to Behavioral Health I/DD Tailored Plan. If this situation occurs prior to the launch of Tailored Plans, the beneficiary will transition to the fee-for-service and LME-MCO delivery systems. (details on this transition period and the Behavioral Health I/DD Tailored Plans are described below).

Individuals enrolled in Standard Plans will be enrolled in and receive care management services through the PHP and Advanced Medical Homes (AMHs) (discussed further in the "Advanced Medical Home" section). These will include financial incentives at the AMH-level to provide care coordination for individuals with behavioral health or I/DD conditions based on evidence-based care models.

DHHS also will establish behavioral health network adequacy standards for Standard Plans to ensure access to State Plan behavioral health services. Standard plan network adequacy standards will specify the types of behavioral health providers that must be in-network and requirements related to the

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<sup>27</sup> DHHS is working to refine this figure.

geographic location of behavioral health providers. Standard Plans will also be required to have staff expertise in the management of behavioral health benefits and populations with behavioral health or I/DD needs. Further details on behavioral health-specific requirements will be developed in the coming months and shared with stakeholders for input.

### **Second Phase: Behavioral Health and Intellectual and Developmental Disability Tailored Plans for High-Needs Enrollees**

Beginning in the second year of Medicaid managed care, DHHS envisions that beneficiaries with serious behavioral health and I/DD needs will be covered by Behavioral Health I/DD Tailored Plans — separate integrated managed care products targeted toward this population. Through Behavioral Health I/DD Tailored Plans, these enrollees will receive physical health and pharmacy services as well as the behavioral health and I/DD benefits that they received through LME-MCOs. Only Behavioral Health I/DD Tailored Plans will cover Innovations, TBI, and current 1915(b)(3) waiver services. In addition, to reflect the high severity of enrollee needs, DHHS is considering providing Behavioral Health I/DD Tailored Plans enrollees with enhanced care management services, which may be delivered through behavioral health and I/DD health homes.

Behavioral Health I/DD Tailored Plans will be required to offer physical and behavioral health networks. DHHS will establish network adequacy standards for Behavioral Health I/DD Tailored Plans, and may incentivize providers to join Behavioral Health I/DD Tailored Plan networks through rate floors and any willing provider provisions (similar to Standard Plans). A Behavioral Health I/DD Tailored Plan may partner with a Standard Plan to leverage its physical health network or “lease” a physical health network. DHHS’ centralized and streamlined credentialing system (detailed below) will apply to the Behavioral Health I/DD Tailored Plans.

To promote integrated care and administrative efficiency, DHHS envisions that Behavioral Health I/DD Tailored Plans will assume a number of responsibilities currently performed by LME-MCOs, including:

- **Waiver Slot Management:** Behavioral Health I/DD Tailored Plans will manage Innovations and TBI waiver slots. The State will maintain its current slot allocation methodology; slots will be allocated to each Behavioral Health I/DD Tailored Plan based on the number of Medicaid enrollees in each region and Behavioral Health I/DD Tailored Plans will allocate waiver slots to qualifying beneficiaries based on reserve status (e.g. Money Follows the Person) and waiting list position.
- **Management of Funds for the Uninsured:** DHHS intends to transfer responsibility for managing federal block grant services and State-funded non-Medicaid services from LME-MCOs to the regional Behavioral Health I/DD Tailored Plan. This includes overseeing the provider network authorizing services, paying providers, submitting “shadow claims” through NCTracks, and monitoring provider performance. DHHS envisions that counties will have the option to manage certain services for remaining uninsured individuals themselves or to contract with Behavioral Health I/DD Tailored Plans.

Entities offering Behavioral Health I/DD Tailored Plans must meet all PHP licensure and solvency requirements. Additionally, because non-Medicaid federal grant dollars will be managed by Behavioral Health I/DD Tailored Plans, only non-profit or governmental entities will be able to offer them. LME-MCOs that meet all requirements will be eligible to respond to the RFP and may seek to offer a Behavioral Health I/DD Tailored Plan.

DHHS recognizes that local involvement is crucial in delivering care to individuals with behavioral health conditions or I/DDs, and accordingly, may require Behavioral Health I/DD Tailored Plans to incorporate county involvement in the organization's governance. In addition, Behavioral Health I/DD Tailored Plans will be required to establish and maintain relationships with local agencies, such as local Department of Social Services offices. Finally, Behavioral Health I/DDs will include consumer and/or family representatives as part of their governance structures.

### **Transitioning to Behavioral Health I/DD Tailored Plans**

DHHS is still working with stakeholders and the legislature to design the best possible transition for populations entering Behavioral Health I/DD Tailored Plans, with a focus on minimizing care disruption. In the interim, between the launch of the Medicaid managed care program and the launch of Behavioral Health I/DD Tailored Plans, DHHS envisions that individuals with behavioral health and I/DD needs will continue to receive their physical health and pharmacy services through Medicaid fee-for-service and their behavioral health and I/DD services through LME-MCOs. To ensure these individuals are not enrolled in Standard Plans upon launching the Medicaid managed care program, DHHS is considering how to best identify these individuals using claims and encounter data.

During this initial period, LME-MCOs will continue to manage slots for the Innovations and TBI waiver services. In addition, LME-MCOs will maintain their current responsibility for managing State single stream, federal block grant, and county funding for behavioral health and I/DD services for North Carolina's uninsured and underinsured populations. Duals and those enrollees not enrolled in PHPs will receive their behavioral health services through the LME-MCOs, if they currently do so. The capitation rate for LME-MCOs will be modified during this transition period, to reflect the fact that they will be caring for a more complex population.

### **Clinical Interventions to Improve Care Delivered to Behavioral Health I/DD Tailored Plan Population**

To ensure that Behavioral Health I/DD Tailored Plans are providing the maximum benefit to beneficiaries enrolled in Behavioral Health I/DD Tailored Plans, DHHS is considering implementing a range of interventions specifically targeted toward improving the care delivered to this population.

To build on the LME-MCO population-based Care Coordination system and to address the more intensive level of care coordination required for high-needs enrollees with behavioral health conditions and/or I/DDs, DHHS is considering developing behavioral health and I/DD health homes to serve these populations. To further promote physical and behavioral health integration for these high needs individuals, DHHS is considering using waiver funds to support community-based behavioral health providers in adopting best practices, as defined in SAMHSA'S Certified Community Behavioral Health

Clinic (CCBHC) model.<sup>28</sup> Practices that achieve CCBHC standards would be better equipped to provide crucial community-based behavioral health services.

DHHS also recognizes that individuals dually diagnosed with mental health and I/DD disorders have further complex care management needs and require specialized behavioral health services. DHHS is considering expanding treatment models and benefits targeted toward individuals dually diagnosed with mental health conditions and I/DDs such as the START (Systemic, Therapeutic Assessment, Resources and Treatment) model, a national, evidence-based crisis prevention and response model.

## **V. Medicaid Opioid Strategy**

Like many states, North Carolina is facing an opioid crisis that has worsened over the last decade.<sup>29</sup> From 1999-2016, unintentional opioid deaths increased tenfold from approximately 100 deaths to 1,200 deaths. North Carolina's efforts to address this epidemic have intensified as it has worsened. The State recently developed an Opioid Action Plan to reduce opioid addiction and overdose deaths from 2017-2020 by (among other strategies):

- creating a coordinated infrastructure between State agencies, stakeholders and local coalitions;
- expanding treatment and recovery-oriented systems of care
- reducing the oversupply of prescription opioids;
- increasing community awareness and prevention of opioid abuse<sup>30</sup>

The recently passed Strengthen Opioid Misuse Prevention (STOP) Act and a federal grant of \$31 million to expand access to prevention, treatment and recovery supports and reduce opioid related deaths have also bolstered the state's efforts.<sup>31</sup>

Medicaid, specifically, plays a vital role in supporting the statewide efforts to address the opioid crisis. North Carolina's Medicaid opioid strategy will build on the policies and programs that have been developed to address the opioid epidemic to date. North Carolina's Medicaid State Plan benefit package already covers a wide-range of substance use disorder and pain management services, including physical therapy, occupational therapy, and chiropractic services. DHHS is reviewing clinical policies related to prevention of opioid misuse and effective chronic pain treatment to ensure alignment with evidence-based best practices. Effective August 2017, DHHS will reduce the permitted maximum daily dosage of opioids and require prior approval for certain prescriptions or supply sizes. DHHS has also recently

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<sup>28</sup> Certified Community Behavioral Health Clinics (CCBHCs) are designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs

<sup>29</sup> North Carolina's [Opioid Action Plan](#), 2017-2020.

<sup>30</sup> See the Opioid Action Plan for more detail

<sup>31</sup> The STOP Act seeks to reduce drug addiction and overdoses through smarter prescribing practices by doctors and dentists and expanding the availability of naloxone. Source: See Session Law 2017-74 for more detail.

strengthened its beneficiary lock-in program by increasing the number of beneficiaries to whom the lock-in program applies and by lengthening the duration of enrollment in the program to two years.<sup>32</sup>

DHHS also is exploring how to maintain and strengthen the components of two care management programs led by CCNC that help address the opioid crisis, the Chronic Pain Initiative and the Pregnancy Medical Home, in a Medicaid managed care environment.

To build on and enhance current efforts, DHHS will consider implementing the following strategies subject to State and federal financing availability:

- **Expanding Substance Use Disorder Service Array to Full Continuum.** DHHS is considering adding low intensity residential services (such as substance abuse halfway houses as a bridge between inpatient and outpatient care and recovery services to prevent relapse following completion of treatment) as covered Medicaid benefits.
- **Increasing Capacity of Covered Services.** DHHS is exploring expansion of the use of preventive services to screen for individuals with or at risk of developing substance use disorders, including opioid use disorders, (e.g., use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool). DHHS also is exploring increasing the capacity of substance use disorder providers and treatment services, including ambulatory detoxification, community crisis stabilization services and residential treatment providers. DHHS may also continue seeking to waive the Institutions for Mental Disease (IMD) exclusion, thereby enabling DHHS to receive federal matching funds for stays of up to 30 days in IMDs with more than 16 beds.<sup>33</sup>
- **Increasing Access to Substance Use Disorder Care through Implementation of Carolina Cares:** The General Assembly is currently considering the proposed Carolina Cares program, which would make childless adults and parents with low incomes and who meet work requirements eligible for Medicaid. This change to Medicaid would ensure that 150,000 more individuals with substance use disorder needs have access to necessary treatment including Medicaid-covered behavioral health services, physical health services, and pharmacy benefits.<sup>34</sup>
- **Suboxone Clinical Coverage Policy.** DHHS is considering eliminating prior authorization for the initial prescription of suboxone, building on efforts championed by the law enforcement community to increase the availability of suboxone.
- **Controlled Substances Reporting System.** DHHS operates the Controlled Substances Reporting System (CSRS) to collect opioid prescription data within 72 hours of being dispensed and share this data with prescribers and dispensers. DHHS will explore leveraging CSRS for use in care

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<sup>32</sup> The program restricts beneficiaries who meet at least one of the following criteria to a single prescriber and pharmacy: beneficiaries with six claims of opiates, benzodiazepines and certain anxiolytics; beneficiaries receiving prescriptions for these drugs from more than three prescribers in two consecutive months; or referral from a provider, DMA or CCNC. NCHC enrollees are not subject to lock-in provisions.

<sup>33</sup> Historically, the federal IMD exclusion has prohibited the use of federal Medicaid financing for mental health and substance use disorder residential treatment services in facilities with greater than 16 beds. The May 2016 final Medicaid managed care rules eased that restriction by allowing Medicaid coverage for stays of up to 15 days in an IMD of any size when it is provided as an in-lieu of service.

<sup>34</sup> Estimates provided by DHHS staff

management to issue care alerts to providers for patients with multiple prescribers, including any associated costs.<sup>35</sup>

- **Integrated Office-Based Opioid Treatment Coverage Policy.** DHHS recognizes that integrated prescription and counseling services are critical for effective buprenorphine treatment of opioid addiction. To achieve this, DHHS is considering working with PHPs to incentivize providers by bundling payments for care management, medication and counseling services.
- **Community Pharmacy Programs.** DHHS is exploring opportunities to leverage pharmacists and technicians to help screen, identify, and link to care individuals with, or at risk of developing substance use disorders. DHHS will consult with the Community Pharmacy Enhanced Services Network (CPESN) when developing strategies that AMH care teams can implement to prevent opioid abuse.
- **PHP Requirements.** DHHS will require PHPs to implement specific DHHS policies addressing the opioid crisis, including beneficiary lock-in programs and the STOP Act provisions. DHHS may also consider requiring PHPs to deliver specific education and training programs to providers to promote best practices for chronic pain management and opiate prescribing. To minimize provider burden, required education and training programs would follow a standardized curriculum across PHPs. As part of its proposed quality strategy, DHHS is considering evaluating PHP performance on opiate prescribing measures and requiring PHPs to hold network providers accountable for their performance on opiate prescribing.
- **Coverage of Alternative Pain Management Services.** While North Carolina's Medicaid program already covers non-pharmacological services for pain management (such as physical therapy, occupational therapy, and chiropractor services), DHHS may also consider covering alternative chronic pain management services, subject to available financial support.
- **Care Management Targeted Toward Individuals with Chronic Pain and Complex Physical Health Care Needs.** DHHS recognizes the importance of providing holistic care management services that promote effective pain management for individuals with chronic pain and other physical health co-morbidities. DHHS is exploring providing specific training to AMH care teams to promote effective care for patients in need of pain management services.
- **Behavioral Health Home.** To address the more intensive and unmet level of care management for individuals with substance use disorders, DHHS is considering developing behavioral health homes to provide enhanced care management services to individuals with SMI, SED and substance use disorders (also discussed in the *"Integration of Physical and Behavioral Health"* section).

## VI. High-Functioning Managed Care System

DHHS will craft a set of statewide policies that guide plans and providers toward implementation of a whole-person centered, well-coordinated system of care, which addresses both medical and non-

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<sup>35</sup> Session Law 2017-57



medical drivers of health. These policies must strike the right balance between providing sufficient standardization to ensure all stakeholders are working toward common goals, and providing the flexibility required to foster innovation and adapt to the needs of North Carolina's diverse communities. The following sections describe how the Medicaid and NC Health Choice program will operate in a future Medicaid managed care environment to achieve these goals.

- *"Quality, Value and Care Improvement"* describes the inter-related strategies and the data collection infrastructure needed to adopt value-based payment arrangements, a statewide quality strategy, an enhanced care management strategy, and the strategies to support providers in their transition to Medicaid managed care.
- *"Beneficiary Protections"* outlines the education and support that will be available to beneficiaries during their eligibility determination and PHP/PCP selection process, and after they are enrolled in a PHP. This section also describes beneficiaries' continued rights to submit grievances and appeal adverse determinations.
- *"Managed Care Plan Accountability"* offers detailed descriptions of PHP requirements, designed both to ensure access to high-quality care and the flexibility PHPs require to innovate and leverage their expertise through evidence based practices.

#### **(A) Quality, Value, and Care Improvement**

To ensure North Carolina's transition to Medicaid managed care improves both the quality and value of care, DHHS will implement several inter-related strategies:

- A robust statewide quality strategy with a standard set of quality goals and measures, and to incentivize plan performance on desired outcomes.
- A value-based payment (VBP) strategy to encourage accelerated adoption of payment arrangements between PHPs and providers focused on improving population health, ensuring appropriateness of care, and promoting value.
- Enhanced care management and provider supports, including the launch of Advanced Medical Homes.
- Enhanced data collection and data sharing capabilities to enable value-based payment.
- A Medicaid managed care incentive program to encourage investment in evidence based health outcomes and strategies.
- Policies to encourage innovation and collaboration among providers, social services, and plans, including use of technology to improve health, and to address health-related social needs and reduce health inequities.

Figure 7. Overview of Quality and Value Initiative Development and Implementation Timeline

	Now Through RFP	Year 1	Year 2	Years 3 – 5
<b>Quality Strategy</b>	Develop Year 1 Quality Strategy to Align Value/Innovation Initiatives Finalize Provider Support Initiatives	Evolve and Update Quality Strategy Annually with Stakeholder Input Require PHP Accreditation		
<b>VBP Strategy</b>	Finalize Definition of VBP for Contracts, Baseline Assessment Request and Reward PHP Strategies to Advance VBP in RFP Disseminate and Seek Input on State VBP Strategy Thinking	Develop VBP Baseline Solicit PHP Short-Term Plans to Advance VBP Launch Stakeholder Process to Set VBP Goals	Finalize VBP Goals Hold PHPs Accountable on Short-Term Plans to Advance VBP	Hold PHPs Accountable for Achieving VBP Goals
<b>Data Strategy</b>	Develop Data and Infrastructure Plan to Manage Encounter Data and Support the Use of Other Information	Incorporate Other Data Sources and Linkages to State Agencies Develop Longer-Term Roadmap for Additional Functionality in Support of Quality and Value Goals		
<b>Innovation Plan</b>	Develop Plan for Innovative Initiatives Including: Telehealth, Addressing Unmet Social Determinant Needs, Workforce	Deploy Innovation Initiatives	Evaluate Impact of Policies on Advancing Quality, Value, Care Management Agenda and Adapt Plan to Continue Innovation Initiatives	

## (1) Quality Strategy

If North Carolina is to realize its transformation goals, it is crucial that a cross-cutting quality strategy for Medicaid align efforts by PHPs, providers and DHHS to measure and achieve value with a set of clear priorities for quality improvement and innovation. North Carolina's quality strategy must: (1) identify a single set of statewide quality priorities, (2) tie those priorities to a streamlined set of measures and metrics, and (3) use those measures and metrics to assess performance and drive progress on State transformation efforts.

Key quality priorities and initiatives will be derived from existing performance on quality measures and outcomes in North Carolina and build on the work of the North Carolina Institute of Medicine (NCIOM). Initial domains under preliminary consideration closely align with the NCIOM's work and include: (1) Population Health/Preventive Care, (2) Chronic Disease Treatment, (3) Patient-Centered Care, (4) High Value Health Care, (5) Workforce Wellbeing, (6) Social Determinants of Health, and (7) Health Disparities. Further work will be undertaken to define domains, and specific initiatives that will be undertaken in each domain area. Priorities must be actionable and achievable, and therefore limited in number and scope.

DHHS will also leverage existing quality efforts underway today to develop these metrics. DHHS will draw upon the work of the NCIOM to identify specific measures;<sup>36</sup> the work conducted by CCNC to measure outcomes, support provider practices, and inform care management efforts; and existing quality reporting priorities and measurement efforts within DHHS. DHHS expects to identify a concise set of metrics, to be used to assess progress against quality priorities, in the domains identified above. In addition to these measures, PHPs will be required to report a larger selection of measures, in alignment with accreditation and other federal requirements, and DHHS will review and track progress against these measures to inform future quality initiatives and priorities.

<sup>36</sup> NCIOM's draft measure recommendations are included in the appendix.

Finally, the quality strategy will tie quality reporting and performance to financial incentives for PHPs and providers. PHP contracts will include payment terms tied to outcomes derived from the quality strategy. PHPs and providers will be incentivized to innovate on quality efforts with quality aims in mind.

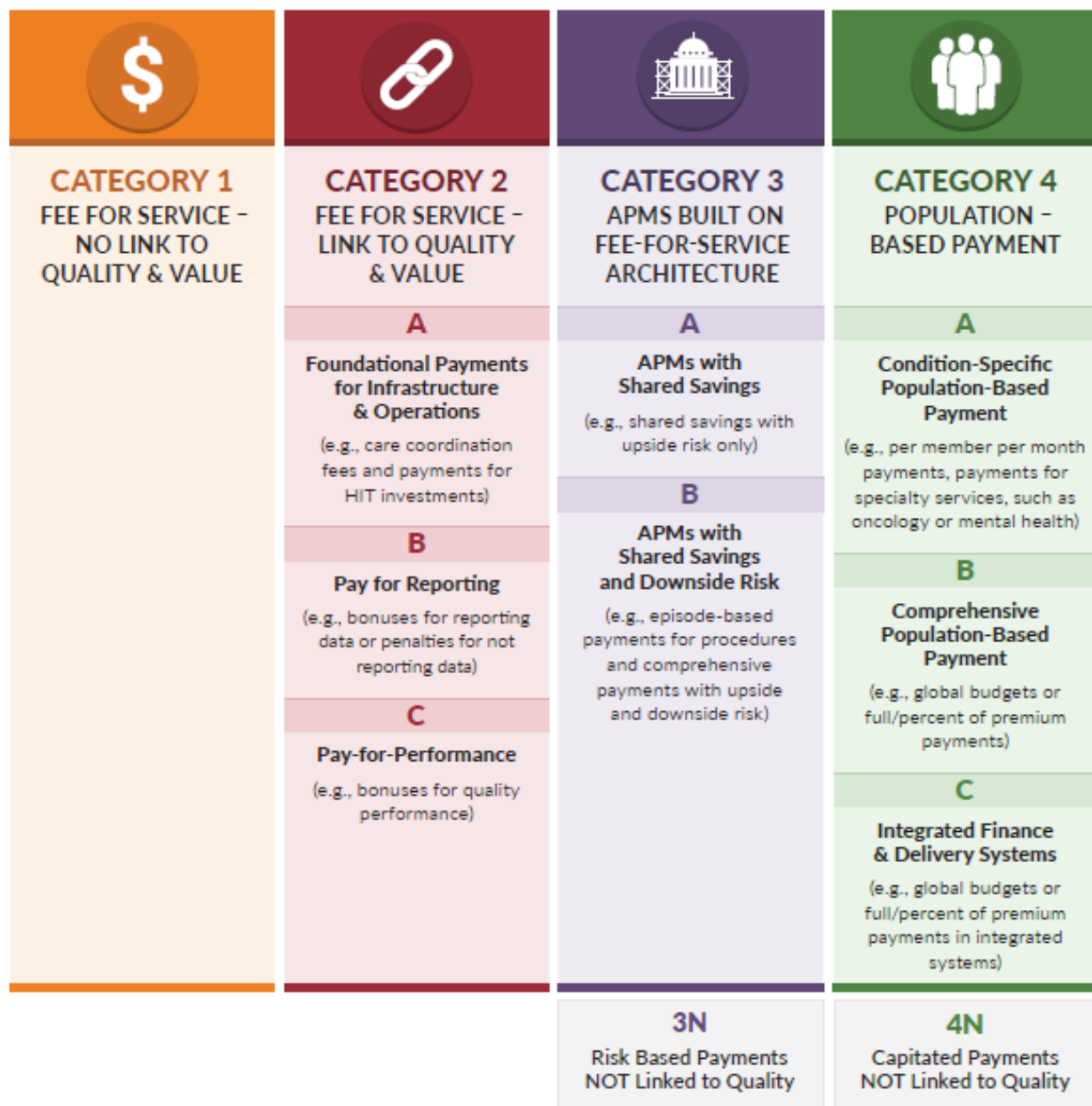
To help support this strategy, DHHS is building capacity to measure and oversee quality, drive continuous quality improvement, and coordinate support for providers on quality priorities (especially among small and rural providers). The mechanism for collecting quality measures is under consideration, as part of the data collection, exchange and analysis efforts described in the corresponding section of this proposed program design. Also under consideration is determining how the quality strategy can address the needs of special populations. A stakeholder engagement process will be deployed to ensure the quality strategy, which will be inclusive of quality priorities, initiatives and measures, are informed by input from across the health care system.

## **(2) Value-Based Payment**

DHHS plans to encourage accelerated adoption of Value-Based Payment arrangements between PHPs and providers in Medicaid that tie to quality strategy priorities. The goal of pursuing VBP is to ensure that payments to providers are increasingly focused on population health, appropriateness of care, and other measures of value, rather than on a fee-for-service basis. PHPs will be encouraged to develop and lead innovative strategies to increase the use of VBP arrangements over time and to submit their VBP strategies to DHHS and report on their use of VBP contracting arrangements each year. Over time, PHPs will be rewarded for having both a strong VBP baseline and making measurable improvements against their baseline from year to year.

DHHS expects to use the Health Care Payment Learning and Action Network (HCP-LAN) Framework of Alternative Payment Models (APM) to define and assess the baseline use of value-based payment by PHPs to providers. The framework will be used to track different VBP initiatives and to assess PHPs' progress against their VBP plans. The HCP-LAN is a federal HHS-convened stakeholder group with representation from multiple public and commercial payers and other health industry representatives and is focused on shifting payment in health care away from fee-for-service to value-based payment. Use of the Framework will ensure a consistent and measurable assessment of progress against VBP goals, without mandating the specific ways in which PHPs must contract with providers.

Figure 8. Overview of HCP-LAN Framework<sup>37</sup>



As Medicaid managed care matures in North Carolina, DHHS expects to pursue an increasingly accelerated trajectory to advance VBP in Medicaid. Providers, payers, policy experts and patient advocates will all play an instrumental role in developing an achievable but ambitious VBP Roadmap. This roadmap will stipulate specific goals for progress on value-based payment in future years, including considering ways to incorporate the social determinants of health and other priorities into VBP arrangements.

<sup>37</sup> Health Care Payment Learning & Action Network. Alternative Payment Models: The APM Framework. 2017. <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

### **(3) Accreditation**

PHPs will be required to attain accreditation from a nationally-recognized accrediting body (e.g., NCQA, URAC) within the first three years of operations. A single accrediting body will be selected by DHHS to ensure the use of a consistent standard for PHP performance. Attaining accreditation can be a lengthy process and requires plans to fully launch operations. While plans will not be required to achieve accreditation until the third year of operations, they will be incented to achieve key accreditation milestones (e.g., PHPs will be permitted to market their accreditation status to enrollees). Failure to attain accreditation by the required timeframe may result in termination or sanctions until accreditation is attained.

DHHS will work with the single selected accrediting body to streamline DHHS, accrediting body, and External Quality Review Organization (EQRO) requirements related to plan operations, quality measurement and improvement, and compliance with DHHS and federal requirements to establish a consistent standard to which all PHPs are aligned. By synchronizing these efforts, DHHS will decrease the administrative burden placed on PHPs and providers.

### **(4) Data Collection, Exchange and Analysis**

Data will play a crucial role in North Carolina's Medicaid transformation. DHHS will need to develop the infrastructure and processes to support timely data collection and to produce and disseminate data and information. Such data are needed to ensure appropriate program oversight and operations, as well as to support its quality, VBP, care management, and population health strategies.

The transition from fee-for-service to Medicaid managed care will require new infrastructure and protocols for claims data collection, exchange and analysis. Today, DHHS' Medicaid data infrastructure leverages a combination of fee-for-service claims and encounter data from LME-MCOs, and a significant amount of the analysis and reporting of data to providers is managed through DHHS' contract with CCNC. To manage utilization, outcomes, and quality in Medicaid managed care, DHHS will need to collect and process encounter data from PHPs<sup>38</sup> and to integrate these data from plans with fee-for-service claims for carved-out populations and services. As the claims processor, PHPs will be required to report encounter data to DHHS on a regular basis, and will be held accountable for submitting timely and accurate encounter data. PHP contracts will provide guidance specifying the format, frequency, quality review, and other standards for encounter data submission. Contracts will specify incentives and financial penalties for plans to submit timely and accurate encounter data.

DHHS will support the infrastructure development required to receive and validate the data. Providers in North Carolina currently have access to a range of information systems that support management and coordination of patient care. These include tools such as the NC HealthConnex Clinical Portal and CCNC's

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<sup>38</sup> DHHS will also continue to collect and process encounter data from LME-MCOs

Care Management Information System (CMIS), Provider Portal, and quality performance reports. With these, clinicians and care managers can access actionable aggregate and patient-level information as well as alerts on hospital admissions/discharges and patient assessments, risk stratification, and care plans. A key decision will be which of these functions DHHS conducts directly through a contracted vendor or through PHPs with DHHS guidance.

In either case, DHHS will be responsible for establishing appropriate data governance and processes to assure data quality, consistency and appropriate protections for patient health information. DHHS will work with stakeholders to establish communication between parties involved in encounter data exchange and to plan for other types of information exchange and reporting which might be required.

DHHS has begun the development of the basic data system components that will be needed to support the required data processing and payment functions at the launch of Medicaid managed care. DHHS is also developing a longer-term roadmap for the additional functionality that will support broader quality and value goals. As the infrastructure for encounter data is being established, DHHS will assess how best to incorporate other data sources (e.g., other clinical data, data from AMHs, data from State agencies).

DHHS intends to maintain the effective processes now in place to combine various data sets to produce important maternal and child health process and outcome measures and measures related to infectious diseases. DHHS is also exploring opportunities to: (1) develop a standardized social needs screening instrument, with a primary focus on food insecurity, housing instability, and transportation, (2) assess how best to ensure these data are integrated with physical and behavioral health services, and (3) provide training and support so that the tools are used efficiently and effectively.

## **(5) Care Management and Advanced Medical Homes**

North Carolina Medicaid has long been known for its successful PCCM program, including a strong care management infrastructure for mainstream beneficiaries, transitional care populations, high-risk/high-cost patients, and supports for pregnancy care and other programs. DHHS is considering how to maintain and expand the best elements of today's programs, which are primarily run through CCNC and in partnership with providers, while establishing appropriate flexibility for the PHPs to innovate. DHHS also wants to maintain strong provider participation in Medicaid through medical homes—a key hallmark of the current program. Additional work is underway on the development of the care management infrastructure, and stakeholders will continue to be engaged throughout the development process.

The overall care management strategy under the new system will follow certain key principles:

- All beneficiaries will have access to appropriate care management and coordination support across multiple settings of care, including connections to primary and specialty care and direct linkages to programs and services that address social determinants of health, along with follow-up and ongoing planning;

- Beneficiaries with complex needs (social or medical) will have a care plan and person-centered goals that are visible to all care team members;
- Care management and care coordination will be delivered by Advanced Medical Homes (AMHs) at the local level to the fullest extent possible. This should leverage the existing medical home infrastructure and be consistent with access, quality and financial viability.

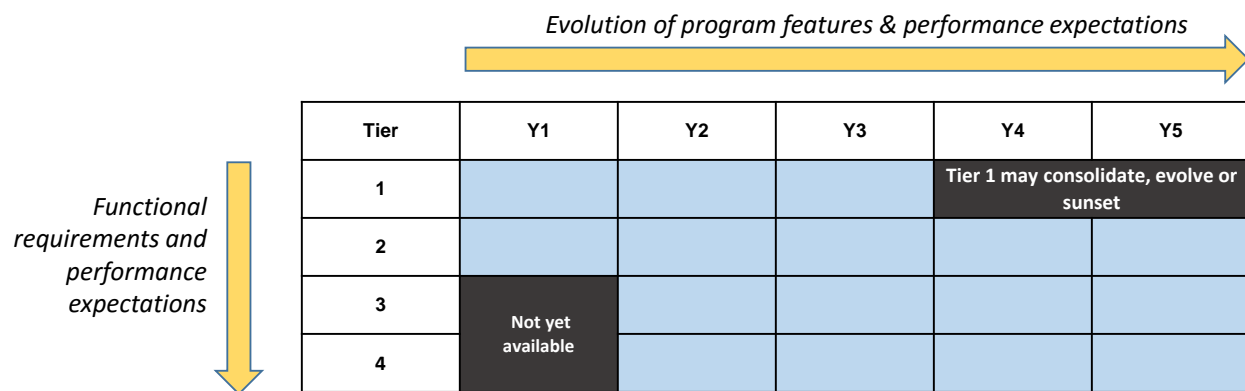
Under this system, care management will be a shared responsibility between PHPs and AMHs, which are further defined below, with an emphasis on maintaining an important role of providers at the site of care where possible and relevant.

Care management and care coordination are shared responsibilities among payers, provider teams and community-based organizations. PHPs will be responsible for ensuring that each beneficiary has access to appropriate care and that a person or entity (such as an AMH) is primarily responsible for locally addressing care and coordinating services accessed by the beneficiary. DHHS will establish care management and care coordination requirements that all PHPs must follow. These will balance across-the-board expectations that preserve provider-led care coordination functions that currently exist in North Carolina with flexibility for PHPs to innovate and manage the health of members. PHPs will assume responsibility for monitoring high and rising risk within their populations and may deploy staff and resources toward both long-term and episodic forms of care management and care coordination, working with AMHs as appropriate.

Practices able to demonstrate advanced primary care capabilities through a certification process will be known as Advanced Medical Homes. AMHs will provide comprehensive primary and preventive care services to PHP enrollees, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high risk populations. AMH requirements and recognition will initially be based on the current Carolina Access program, and, over time, additional options will be introduced for enhanced care management services and features as well as financing support under AMH tiers. DHHS will be responsible for both defining the criteria for different AMH tiers and for conducting the certification process. As providers advance to higher tiers, they will be responsible for additional care management activities and will receive additional compensation, as described in more detail below.

Through the certification process, each AMH will be categorized into one of up to 4 tiers being contemplated over time. As the figure below demonstrates, not all tiers will be available in Year 1, defined as the first year of Medicaid managed care operation. The initial tiers for year one will be based off the current Carolina Access program which, over time may consolidate, evolve or sunset. Before and during Year 1, DHHS will convene stakeholders to further define the criteria for each tier. Priorities for higher-tier practices will include: advanced care management capabilities; addressing social determinants of health; integration of behavioral health services into primary care; addressing opioid addiction; and having robust strategies for chronic pain.

Figure 9. Evolution of AMH Tiers and Functions Over Time



Regardless of tier, all AMHs will initially be eligible for regular fee-for-service payments from PHPs plus minimum Medical Home Payments, which DHHS will require PHPs to pay at a level that is at least comparable to what Carolina Access practices receive today. As AMH practices take on additional functions with specific performance expectations, they will also become eligible to receive additional Performance-based Payments from PHPs which will be above and beyond minimum Medical Home Payments required by DHHS. In return, AMHs will be encouraged and equipped to meet enhanced outcomes based on quality and utilization performance. For the first time, AMHs will be eligible for additional Performance-Based Payments based on their performance. Both Performance Based Payments and Medical Home Payments will allow eligible practices to receive additional support when they attain high levels of cost and quality performance (on a risk-adjusted basis).

To mitigate provider burden, certain aspects of the AMH program will be standardized, such as a tier status, quality and utilization measures across all PHPs, reporting mechanisms, and minimum Medical Home Payments. DHHS will encourage PHPs and AMHs to collaborate directly on additional innovative models designed to meet Medicaid transformation goals and objectives.

Several programs have not yet been addressed within the context of care management design. These programs include the pregnancy medical home and care management programs for pregnant women and for children with special health care and social needs, which are run in collaboration with the local health departments. DHHS is considering how to build off the success of those models and leverage them in the newly designed system. Additionally, programs that remain under current consideration, such as care management programs for populations that will likely remain temporarily in fee-for-service have also not been fully addressed within the care management design.

It is expected that for the general Medicaid population, care management or care coordination—whether episodic or chronic—should directly involve where possible the AMH care team. The PHP will play a crucial backstop role, monitoring care management activities and taking direct responsibility for managing the care of any beneficiary not enrolled in an AMH or for whom the AMH is not able to meet his/her needs. PHPs will also take on care management functions that augment what AMHs can provide directly.



## **(6) Provider Supports**

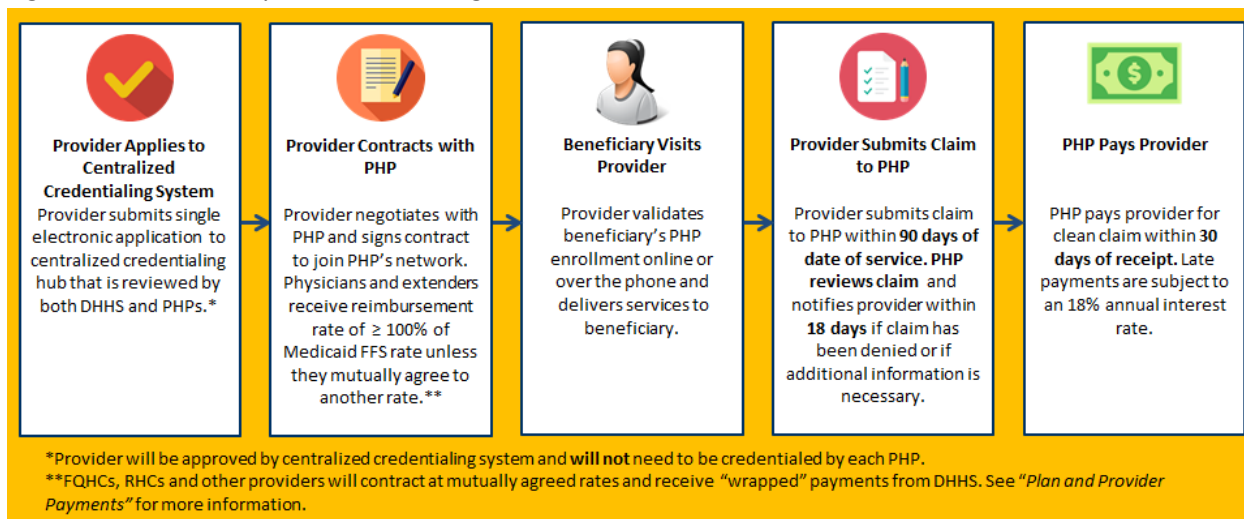
Providers are crucial partners in ensuring a successful transition to Medicaid managed care. DHHS will continue to partner with providers to work toward easing administrative barriers during and through the transition [See *Managed Care Plan Accountability* below]. In addition, to ensure that providers are prepared to adapt their practices and support their patients throughout the transition, DHHS will have a provider support infrastructure which will initially include:

- Managed care education and training (e.g. contracting strategies, changes to administrative and operational processes, changes to State systems, etc.);
- Practice transformation and education (e.g. continuous quality improvement, evidence-based practice models, best practices around addressing beneficiaries' unmet social needs, etc.); and
- Advanced Medical Home Certification (e.g., maintenance and track migration support)

Additionally, other forms of support will be considered as the needs of practices evolve and as DHHS considers and builds out additional concepts.

Providers will have varying needs for practice supports, depending on geographic location and the type, size, and capacity of the practice. Providers operating in small practices (regardless of location), rural and essential providers may require more intensive support to prepare for new PHP contracting, reporting, and administrative responsibilities. Primary care practices may require support for AMH certification. Many providers, including specialty providers, may require support to develop comprehensive, data-driven quality improvement functions to improve outcomes, drive population health efforts and support value-based reimbursement models. In addition, providers will need tailored supports to serve special populations, such as LTSS or Behavioral Health populations. And all providers will need at least a basic understanding of the systems and processes that facilitate their patients' enrollment in PHPs and selection of PCP. See Figure 10 for a depiction of the provider experience in the future Medicaid managed care environment.

Figure 10. Provider Experience in Managed Care Environment.



PHPs will have a role in supporting providers' transition to Medicaid managed care. As described in the "Access to and Oversight of Network Services" section, PHPs will be required to offer education and training to all network providers. The PHPs will be required to develop a broad training plan and schedule on topics that will be reviewed by DHHS, and which must include training on special populations.

In addition to supporting provider readiness for Medicaid managed care, DHHS will contract with Regional Provider Support Centers (RPSCs) to assist providers in clinical transformation and care improvement efforts. DHHS will have a competitive bid process to select RPSCs that will supplement other provider support efforts in North Carolina, such as those offered by Area Health Education Centers (AHEC) which offer electronic health record and health information exchange connectivity services, and other supports. The RPSC entities will be nonprofit organizations with substantial experience and/or current capabilities delivering the types of practice support envisioned. This includes assisting provider practice in meeting different "tracks" of AMH certification, providing support in reviewing and quality reports and enhancing performance, and assisting practices in accessing and using any data and information systems designed to support their efforts.

DHHS will determine a total budget available to support providers in each year, and will make payments directly to the competitively designated RPSCs to deliver provider support services. Small, rural and essential providers will be given priority in the delivery of RPSC services. RPSCs will be expected to track and report on items that demonstrate measurable improvement in priority focus areas, such as the number of practices achieving AMH status, the number of practices undertaking quality improvement efforts, and the quality changes in those practices.

## **(7) Social Determinants of Health**

In designing its Medicaid transformation, North Carolina is committed to optimizing health and well-being for all beneficiaries by effectively stewarding our collective resources to unite our communities and health care system. Central to these efforts is a commitment to address unmet social needs or the social determinants of health—“the structural determinants and conditions in which people are born, grow, live, work and age.”<sup>39</sup> These can include things like access to healthy food, safe housing, reliable transportation, employment supports, and community supports. Research shows that while access to high-quality health care is vital, up to 70 percent of health outcomes are tied to non-medical social determinants, and these social determinants contribute twice as much as health care to premature death.<sup>40</sup> Even with a growing body of research highlighting the need to address social determinants of health, we have not yet designed our health care system – or its interface with our social service systems – to address these realities.

In North Carolina, 15.9% of households are food insecure -- one of the highest percentages in the U.S.<sup>41</sup> Eighty-one percent of North Carolina households receiving food assistance don't know where their next meal is coming from -- and 73 percent of households receiving food assistance have had to choose between paying for food or paying for health care or medicine.<sup>42</sup> More than 1.2 million North Carolinians, in rural and urban communities alike, cannot find affordable housing.<sup>43</sup> Stakeholder feedback from across the state has consistently cited food insecurity, housing instability, and transportation challenges as crucial barriers to health. These and other social determinants disproportionately impact Medicaid beneficiaries, increase the risk of developing chronic conditions, and drive cost.<sup>44</sup>

Given the compelling body of evidence linking social determinants to health and well-being, any call for Medicaid transformation that aims to improve health and reduce cost must address these factors tied to 70 percent of health outcomes.

### **Resource Mapping and Resource Database**

Understanding the real-time community need and resource landscape is imperative to addressing unmet social needs. In partnership with community-based organizations, North Carolina will build upon existing efforts to map social determinants of health indicators at the community and zip code level to display areas with the highest disparity. It will also map and codify food, housing, transportation, and

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<sup>39</sup> Michael Marmot et al., “Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,” *The Lancet* 372, no. 9650 (Nov. 8, 2008):1661–1669.

<sup>40</sup> McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)* 2002;21:78–93

Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. *Am J Public Health*. 2011;101:1456–65.

<sup>41</sup> USDA Economic Research Service, “Food Security Status of U.S. Households in 2015.”

<sup>42</sup> <http://ncfoodbanks.org/hunger-in-north-carolina/>

<sup>43</sup> Robert Wood Johnson, County Health Rankings, <http://www.countyhealthrankings.org/app/north-carolina/2017/overview>

<sup>44</sup> Linkins KW, Brya JJ, Chandler DW. Frequent users of health services initiative: final evaluation report. 2008  
Institute of Medicine. 2015. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: National Academies Press.

other essential resources – those in the community and those embedded or co-located within institutions of care. Utilizing this need and resource landscape map will enable North Carolina to prioritize areas of high need and low resource density for resource development and enhanced community partnerships.

In addition, North Carolina will build on current resource management databases, like 211 or Wake Network of Care, to have an up-to-date list of all benefits and community services. This database can be used to refer people to the appropriate service who screen positive for social needs to resources. An effective and efficient resource database with the appropriate infrastructure and investment is needed to establish and maintain high quality resource listings. DHHS intends to work with key stakeholders to establish the source and structure of inputs to a resource management database.

### **Social Determinants of Health Innovation**

Delivery system reform must focus on addressing social determinants of health. When people's medical and socioeconomic needs are met in an integrated way they will have a better experience of care and will ultimately have better health. Many communities across North Carolina have demonstrated the potential and benefit of addressing essential needs like housing and food. Through focused investment, DHHS will scale, strengthen and sustain existing innovative initiatives that aim to more closely link the healthcare and social services systems to deliver better health for individuals and families. DHHS will focus on evidence-based interventions including referral and navigation services, co-located and embedded services, and the use of flexible supports to address social needs and improve health outcomes. All funded demonstration projects must meet data collection and reporting requirements and will be evaluated to determine effects on health outcomes and health care spending.

## **(8) Workforce Initiatives**

North Carolina has long been focused on building health care capacity in rural and underserved areas. Continued progress in this and other areas, including addressing the shortage of para-professionals and direct care workers for long-term supports populations, needs to be ensured as DHHS transforms its Medicaid program. DHHS will work to expand programs that reduce long-standing health workforce shortages in rural and underserved communities and ensure the availability of the team-based workforce required to transform health care delivery and reimbursement.

DHHS proposes to expand, and is seeking federal funding to support, community-based residency programs that promote essential workforce training with a primary focus on ambulatory and preventive care. These programs advance the goals of higher-value health care that can reduce long-term costs. Part of this expansion will include training about the social determinants of health, especially within rural, underserved and high-risk populations. It will also include targeted training to increase the numbers and types of providers who can provide high-quality behavioral health and substance use disorder-related services. For example, DHHS is considering providing more specialized behavioral health training opportunities for advanced practice nurses and other physician extenders. Pharmacists and pharmacy technicians could serve as effective front-line providers to assist with identification of

individuals with or at risk of developing a substance use disorder, and linking those individuals with coverage and treatment. With training opportunities, DHHS intends to better equip a broader range of providers with knowledge of evidence-based practices in behavioral health and substance use disorder-related treatment.

Recruitment and retention of a well-trained, multi-disciplinary workforce will be crucial to ensuring adequate access to services in rural and underserved communities. Incentives must attract and retain a diverse and interdisciplinary care team including physicians, nurse practitioners, physician assistants, therapists, substance abuse counselors, care managers and others. This effort will include continuation of existing loan repayment, community grant, and AHEC residency programs, and may also include new community-based graduate medical education and fellowship programs.

DHHS will also examine the feasibility of introducing a community health worker model to assist in addressing social determinants of health. To expand existing and implement new programs, DHHS is requesting federal matching funds as part of the 1115 Waiver for existing State-only funded community-based initiatives. This includes Area Health Education Centers Teaching Health Centers, Graduate Medical Education, and new community-based programs and residencies.

DHHS will also work to ensure beneficiaries in rural areas have enhanced access to quality services by investing in rural health care provider initiatives. Such initiatives will include enhanced technologies intended to improve access to primary and specialty care, including telehealth and telepsychiatry. The initiatives will also enable an improved exchange of member health information that will reduce redundant care, enhance timeliness of care and improve overall care coordination. Through provider support efforts, DHHS will also work with rural practices to ensure the staff employed by those practices are equipped to transition to Medicaid managed care and engage in Medicaid transformation efforts.

## **(9) Telehealth**

Recognizing the potential of telemedicine to increase access to care and improve health outcomes — especially across rural areas of the state—North Carolina’s Medicaid program has covered telemedicine for almost 20 years.<sup>45</sup> The current policy reimburses a broad array of providers for services rendered via telemedicine—at the same rates as in-person visits—when both beneficiaries and providers are located at Medicaid-enrolled sites. As DHHS’ Medicaid program transitions to Medicaid managed care, telemedicine can play a crucial role in increasing beneficiary access to care, improving outcomes, and decreasing costs. These benefits are particularly relevant in rural areas with physician shortages, especially for specialists, and poorer overall health outcomes.

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<sup>45</sup> North Carolina Division of Medical Assistance, “Telemedicine and Telepsychiatry Clinical Coverage Policies,” Policy 1H. Available at: <https://dma.ncdhhs.gov/document/telemedicine-and-telepsychiatry-clinical-coverage-policies>. The clinical coverage policy defines telemedicine as “the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations.”

PHPs will be encouraged to support the use of telemedicine as a tool for ensuring access to needed services.<sup>46</sup> When a PHP enrollee requires a medically necessary service that is not available within the PHP network, the PHP may provide access to the service via telemedicine.<sup>47</sup> Accordingly, PHPs will be permitted to leverage telemedicine in their Request for Exception to DHHS’ network adequacy standards, as referenced in the *“Access to and Oversight of Network Services”* section.

DHHS also plans to encourage PHPs to implement pilots that test additional telemedicine strategies and will invite PHPs to propose innovative pilots related to telemedicine in their responses to DHHS’ Medicaid managed care procurement.

DHHS recognizes that the field of telemedicine is rapidly evolving and plans to work with PHPs, providers and other stakeholders to develop a comprehensive strategy related to telemedicine during the coming months. This strategy will contemplate use of other types of telemedicine, including smart home technology and enabling assistive technology that can be helpful to aging and long-term supports populations, in addition to providing access to underserved areas.

## (B) Beneficiary Protections

### (1) Eligibility & Enrollment

It is important that Medicaid and NC Health Choice applicants and their families experience a simple, streamlined eligibility and enrollment process—one that ensures both a timely and accurate determination of Medicaid eligibility as well as a user-friendly PHP and PCP selection process. The eligibility and enrollment system must also advance the goal of helping beneficiaries enter or maintain lasting care relationships with crucial providers, including a PCP that can serve as their medical home.

In the future, DHHS envisions beneficiaries applying for health coverage, receiving an eligibility determination, and selecting a PHP based on their preferred PCP with the help of educational resources within a one-stop application process. Much work must be done at the county and state level to realize the vision of an integrated, web-enabled enrollment platform. DHHS is in the process of re-evaluating both its eligibility determination process and the development of PHP/PCP selection capability:

- **Eligibility Determination.** DHHS is re-evaluating its current application and verification policies and technology capabilities to identify changes needed to enable real or near to real time eligibility determinations and annual redeterminations. DHHS seeks to reduce the need for manual intervention to verify information in applications, embed automated verifications into the online application, and use a broader set of data sources to verify information. These changes can improve accuracy and strengthen program integrity while improving efficiency. As

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<sup>46</sup> 438.68(c)(ix)

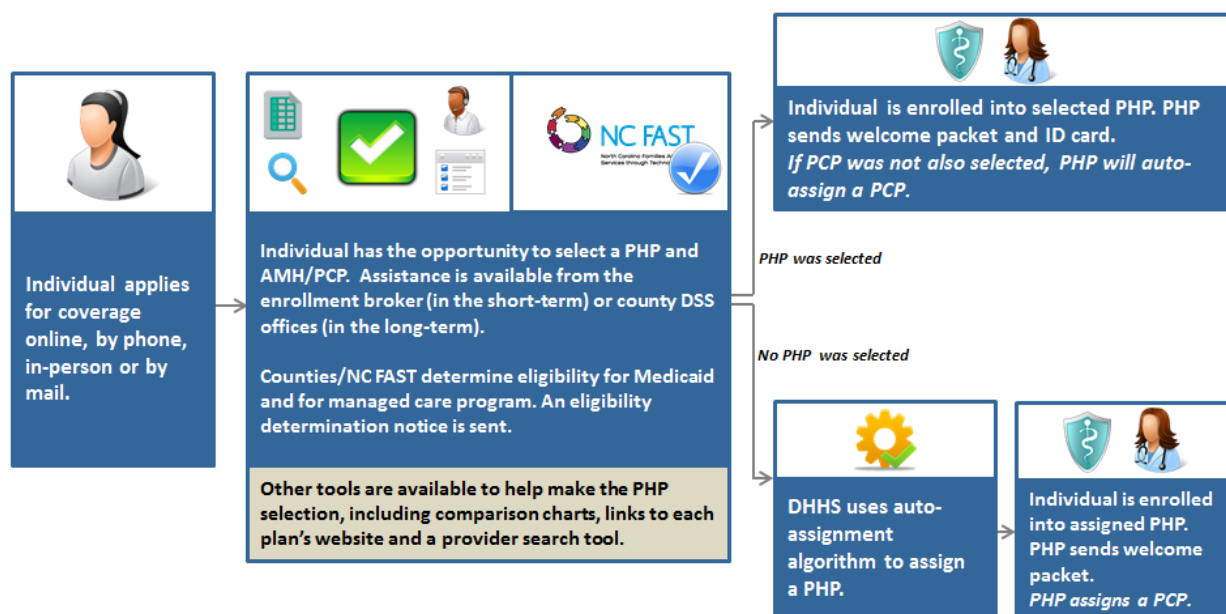
<sup>47</sup> The enrollee must have a choice between telemedicine and an out-of-network provider and cannot be required to receive services through telemedicine.

part of these upgrades, DHHS will seek input on how to improve these processes and ensure the availability of training and support for workers who use these systems.

- **PHP and PCP Selection.** DHHS is also evaluating the best way to provide beneficiaries with a “single stop” experience, enabling them to shop for, compare across, and select a PHP in which to enroll at the time of initial application. DHHS is committed to providing beneficiaries with the tools and resources to make a well-informed choice, particularly to ensure beneficiaries have up-to-date and accurate information about PHPs’ provider networks.

DHHS is committed to leveraging enhanced federal funding to build a high-performing, user-friendly and integrated eligibility determination and PHP/PCP selection system that would be available online, by telephone, in-person or by mail. The below visual (Figure 11) and narrative describe the key features of this future eligibility and enrollment pathway. While DHHS works to enhance and upgrade state systems to achieve this long-term vision, DHHS will procure an enrollment broker to assist with some of these services at the launch of Medicaid managed care.

*Figure 11. High-Level Eligibility & Enrollment Pathway for New Enrollees in Managed Care Environment*



**Medicaid Eligibility Determination.** County Department of Social Services (DSS) offices will continue to process and determine eligibility for Medicaid and NC Health Choice applications and renewals submitted online, over the phone, through the mail or in-person. As noted above, DHHS and the county offices will collaborate to ensure these applications and renewals are processed efficiently and effectively with near-to-real time capabilities.

Upon launch of the Medicaid managed care program, it must be determined whether an individual is mandated to enroll in Medicaid managed care or whether the individual is exempt or excluded (see

*“Populations in Managed Care”* for population-specific details). For the most part, NC FAST will make this categorization based on an individual’s eligibility category. In limited circumstances, manual verification may be needed. Should an individual wish to appeal a denial of Medicaid or Medicaid managed care eligibility, the process to do so remains the same as today. Appeals of Medicaid eligibility determinations can be made through DHHS.

*Selecting a PHP.* It is vital that Medicaid beneficiaries maintain relationships with PCPs, medical homes and other preferred providers. DHHS is committed to creating a one-stop-shop experience that allows beneficiaries to select a PHP and PCP during the application process, whether the individual applies online, over the phone, through the mail or in-person. This includes in the interim period before upgrades to achieve our long-term vision are fully functional.

At Medicaid managed care launch, DHHS will contract with an enrollment broker. With the future upgraded eligibility and enrollment system, applicants will move seamlessly from the application process to the PHP/PCP selection process with support from county DSS offices.

While DHHS anticipates that most applicants will select their PHP/PCP at the point of application, some beneficiaries may want additional time to consider their options. As such, DHHS will permit applicants and beneficiaries determined eligible for Medicaid to use a 30-day “plan selection period,” a window of time after the application process to make the PHP/PCP selection. At the beginning of this period, beneficiaries will be aware of which PHP they will be auto-assigned to as they consider their options. From the date the beneficiary application is submitted until PHP enrollment becomes effective, individuals will be enrolled in Medicaid fee-for-service and able to access all covered benefits.

*Supporting an Informed PHP Selection.* At Medicaid managed care launch, applicants and beneficiaries will receive support and educational materials to make a well-informed PHP selection. This includes:

- Explanation of the Medicaid managed care program;
- Services covered through Medicaid managed care (and how to access services covered outside of the PHP);
- List of PHPs available to that individual (based on geography and other criteria);
- Comparison charts explaining the distinctions between PHP options; and
- Instructions on how and by what deadline to select a plan.

North Carolina will continue its historical focus on ensuring all beneficiaries are served by a primary care provider under Medicaid managed care and will therefore emphasize in the materials the importance of selecting a plan in which the beneficiaries’ preferred providers are “in-network.” Beneficiaries will be able to use an online or telephone provider search tool that will be available on day one of the Medicaid managed care launch.

Medicaid beneficiaries will continue to reach out to their local DSS offices with questions about Medicaid managed care and PHP/PCP selection. DHHS will ensure that DSS caseworkers receive



extensive training and education to enable them to seamlessly support beneficiaries with the EB and PHPs.

Over time, DHHS will build an integrated eligibility determination and PHP/PCP selection IT infrastructure that support the goal of a one-stop application process and provide the same educational and plan selection functionality of the enrollment broker

*Special Considerations for Current Beneficiaries Transitioning to Managed Care at Program Launch.*

Current Medicaid beneficiaries need a seamless transition from fee-for-service to Medicaid managed care at program launch, including continued access to preferred providers and medical care. DHHS will conduct additional and targeted outreach to current fee-for-service beneficiaries transitioning into Medicaid managed care and will provide them an extended plan selection period. DHHS will work with the General Assembly on designing an effective approach to rolling out Medicaid managed care for current beneficiaries. To best support Medicaid enrollees, DHHS envisions staggering the Medicaid managed care launch dates by region.

*Auto-Assignment to PHP.* Beneficiaries will be informed in the application and PHP selection process that if they do not select a PHP by the end of their choice period, they will be auto-assigned to a plan. They will also be informed to which plan they will be assigned. DHHS will design an auto-assignment algorithm that prioritizes keeping families in the same PHP and preserves beneficiary-provider relationships. In addition to considering which PHPs are available in an individual's region, the auto-assignment algorithm will consider the following criteria:

- Eligibility category, to identify special populations (e.g., tribal member, foster care child)
- Enrollment of other family members, to ensure family members are enrolled in the same PHP
- Previous PHP enrollment (when applicable)
- Provider-beneficiary relationship (to the extent obtainable)
- Equitable distribution among PHPs taking into account appropriate enrollment minimums and maximums for CPs and PLEs

Beneficiaries in Medicaid managed care undergoing annual renewal will be auto-assigned to the PHP in which they were already enrolled (if they do not actively select a different PHP) to ensure continuity of care. In the future, North Carolina will consider incorporating PHPs' quality ratings and progress toward value-based purchasing goals to allocate auto-assignment membership.

*Switching PHP Enrollment.* All Medicaid managed care beneficiaries—whether they selected or were assigned to a PHP—will have a 90-day period following the PHP effective coverage date to switch PHPs without cause. This “grace period”—applicable both at initial application and at annual renewals—allows beneficiaries to re-assess their decision or assignment into a plan after experiencing the plan's provider network and clinical coverage policies. However, after the completion of the 90-day period, most beneficiaries must remain enrolled in their PHP for the remainder of their eligibility period unless they can demonstrate cause for switching (e.g., moving out of PHP service area, complex medical

condition better served in different PHP). Certain special populations may switch PHPs without cause at any time. All beneficiaries will have the option to switch plans annually at the time of eligibility redetermination.

*Selecting a PCP.* As noted above, North Carolina has a long history of serving beneficiaries through the medical home model. DHHS recognizes how important it is to preserve beneficiary-provider relationships in the transition to Medicaid managed care. Therefore, beneficiaries will be encouraged and given tools to help them base their PHP selection on their provider relationships, and then select their PCP during the plan choice period via the same modes as PHP selection (online, phone, by mail and in-person). Beneficiaries will have access to choice counseling (initially from an enrollment broker and in the future from county DSS workers) and a provider search tool to identify and validate in-network PCPs.

*Auto-Assignment of the PCP.* Beneficiaries that do not select a PCP during the plan selection period will be assigned a PCP by the PHP in which they enroll. The criteria that PHPs will be required to use for the PCP auto-assignment algorithm reflect DHHS' long history of use of the medical home model and will favor advanced medical homes. Criteria that will be a part of the PCP auto-assignment algorithm include enrollee claims history, family member provider, geography, special medical needs, medical home status, and language/cultural preference.

*Switching PCPs.* To ensure beneficiaries are ultimately satisfied with their PCP, North Carolina is building in additional protections and allowances to change PCPs after enrollment into a PHP. Beneficiaries will have 30 days from the receipt of notification of their PCP assignment to change their PCP without cause. Beneficiaries will also have 30 days to change their PCP without cause after their initial PCP visit, and up to one additional time every 12 months. Beneficiaries may change their PCP with cause at any time.

## **(2) Member Services and Education**

Once beneficiaries have selected and enrolled in a PHP, it will remain crucial to ensure that they have continued access to customer-centric information and assistance. This will allow them to navigate the new Medicaid managed care environment and their PHP, understand the benefits and services that are available to them, and maximize their access to appropriate care. North Carolina will require that PHPs operate a member services department that is readily accessible via a toll-free telephone line and adequately staffed with well-trained service representatives.<sup>48</sup> Key PHP member services functions will include:

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<sup>48</sup> As described in the section that follows, North Carolina also will establish an independent ombudsman program that will complement the other forms of enrollee supports provided by the Enrollment Broker and PHP, including by serving as an advocate for enrollees navigating the managed care system and the appeals, grievance and fair hearing process, and by providing direct issue resolution assistance to enrollees.<sup>49</sup> As defined by federal law, marketing means any communication from a PHP to a Medicaid beneficiary not enrolled in that PHP that can reasonably be interpreted as intended to influence the beneficiary's enrollment in that PHP's Medicaid product or to not enroll in, or disenroll from, another PHP's Medicaid product (42 CFR 438.104). <sup>50</sup> As defined at 45 CFR 155.20

- Explaining operation of the PHP, including the role of the PCP and what to do in an emergency or urgent medical situation;
- Providing information on covered benefits;
- Assisting members with making appointments and obtaining services;
- Assisting with arranging non-emergency transportation for members;
- Assisting members in selecting or changing PCP/AMH;
- Fielding and responding to members' questions and complaints;
- Clarifying information in the member handbook for members;
- Advising members of the PHP's appeal and grievance program, the utilization review process, and member's right to a fair hearing, as applicable;
- Referring members to DHHS' Enrollment Broker if an individual requests information regarding how to enroll in or select a new PHP; and
- Referring members to and, as applicable, working in partnership with DHHS' Ombudsman program to resolve enrollee issues.

PHP member services departments will be required to adequately respond to member needs in as close to real-time as possible. This includes providing access to live service representatives during regular business hours and periodic windows of extended business hours. PHPs must also ensure that telephone lines have the capability to handle calls from Limited English Proficiency members, as well as from beneficiaries with communications impairments (e.g., hearing and/or speech disabilities). Departments also will have the capacity to resolve emergency member issues on a 24-hour, 7-day-per week basis.

DHHS will require PHPs to meet call center performance standards and regularly report performance on key metrics which DHHS will use to ensure that enrollees receive high-quality customer service.

*Beneficiary Education Related to Health Promotion, Wellness, and Disease Prevention.* A high-performing Medicaid managed care system requires education for beneficiaries on health promotion and disease prevention. To assist in this effort, PHPs will develop health education and promotion programs that address prevention, wellness and early intervention of illness and disease that are offered at no charge to their members. To inform evaluation of the success of related initiatives, PHPs will regularly report to DHHS on their enrollee education efforts and as applicable link such activities to quality outcomes.

### **(3) Grievances and Appeals**

North Carolina will ensure that Medicaid beneficiaries can resolve problems quickly and with minimal burden. North Carolina is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their Medicaid managed care plan, or upon exhaustion of the Medicaid managed care plan appeal process, through timely access to a State fair hearing. Beneficiaries also will be provided the opportunity to file a grievance with their PHP to express

their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or PHP employee). DHHS will require PHPs to report on their appeal and grievance processes and outcomes, and monitor plan performance to ensure compliance with related requirements and address any issues that may arise.

**Beneficiary Grievances.** An enrollee may file a grievance, with a PHP at any time. The PHP must acknowledge receipt of each grievance in writing within 5 calendar days and must resolve the grievance within 30 calendar days from the date the PHP receives the grievance. If a grievance relates to the denial of an expedited appeal request, PHPs must resolve the grievance and provide notice to all affected parties within 5 calendar days from the date the PHP receives the grievance.

**Beneficiary Appeals.** As required by federal law, enrollees in Medicaid managed care will first seek to resolve appeals with their Medicaid managed care plan and will have 60 days from the date of the notice of an adverse benefit determination to file a request for an appeal with the PHP. Plans will be required to send written acknowledgement of the request within five calendar days for a standard appeal and within 24 hours for an expedited appeal request. To ensure access to services, enrollees may request that their benefits be continued or reinstated while the appeal is pending.

PHPs must provide written notice of resolution as expeditiously as the appellant's health condition requires and within 30 calendar days of receipt of a standard appeal request. For an expedited appeal request, PHPs must provide written notice of resolution, and make "reasonable effort" to provide oral notice within 72 hours of receipt of an appeal.

If the PHP upholds the adverse benefit determination, the enrollee may request a hearing through DHHS or seek a contested case hearing at the Office of Administrative Hearings after receiving the notice of resolution; the request must be made no later than 120 calendar days from the date of the notice. Beneficiaries will have the right to request a continuation of benefits while the appeal is pending.

**Ombudsman Program.** North Carolina is committed to providing enrollees with support and active preparation related to the appeals, grievance and fair hearing process, as well as to facilitating real-time issue resolution. DHHS will seek funding to support the establishment of an ombudsman program focused on providing advocacy, assistance and education to beneficiaries while navigating the Medicaid managed care system and the appeals, grievance and fair hearing process. The ombudsman program also will serve an oversight function, monitoring trends in PHP performance or enrollee concerns, and proactively providing feedback to DHHS regarding any issues that arise.

#### **(4) PHP Marketing**

PHP marketing activities can serve as a useful tool to publicize North Carolina's new Medicaid managed care program and educate potential enrollees about health plan options, but must be balanced against

the need to protect beneficiaries from coercive practices.<sup>49</sup> DHHS will seek to strike this balance by permitting PHPs to engage in specific types of marketing activities while establishing adequate oversight mechanisms that protect enrollees from aggressive or misleading marketing practices.

*Permitted Marketing Activities.* PHPs will be allowed to begin marketing activities eight weeks prior to the launch of Medicaid managed care. Within specified parameters, PHPs will be permitted to distribute written marketing materials (e.g., posters, brochures), participate in community-based marketing events (e.g., health fairs or community health events), sponsor outreach activities and events, undertake media campaigns, and offer nominal gifts of less than \$10 in value to potential members. To limit the potential for coercion, any marketing that takes place at provider sites can occur only in common areas and all PHPs must have equal opportunity to be represented.

*Prohibited Marketing Activities.* In accordance with federal law, PHPs will be prohibited from:

- Direct or indirect cold-call marketing activities;
- Practices that seek to influence enrollment in conjunction with the sale of any other insurance product (except for qualified health plans<sup>50</sup>);
- Activities that could mislead, confuse or defraud members;
- Offers of material or financial gain or other inducements to enroll; or
- Practices that are discriminatory or that target prospective members based on health status.

To further protect beneficiaries from potentially coercive or particularly aggressive marketing practices, PHPs will be prohibited from offering coupons for products of value and targeting individuals that are currently enrolled in another PHP. PHPs will be required to refer any individuals interested in enrolling to the DHHS enrollment broker or DSS, as applicable. To limit confusion following program launch, PHPs also will be prohibited from sending direct mailings to potential enrollees.

*Marketing Materials.* Marketing materials will comply with federal and State information requirements including those related to accessibility, reading level, font size, cultural competency and literacy standards. Materials will be distributed throughout the PHP's entire service area, and will not contain any statements that the PHP is endorsed by any government agency or that the beneficiary must enroll in the PHP to obtain or maintain benefits.<sup>51</sup> Marketing materials will not use the DHHS or State logos and will not reference any providers who are not part of the plan network.

*DHHS Prior Approval and Oversight.* PHPs will submit an annual marketing plan to DHHS for review and approval that describes its planned marketing approach. DHHS will evaluate all proposed marketing

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<sup>49</sup> As defined by federal law, marketing means any communication from a PHP to a Medicaid beneficiary not enrolled in that PHP that can reasonably be interpreted as intended to influence the beneficiary's enrollment in that PHP's Medicaid product or to not enroll in, or disenroll from, another PHP's Medicaid product (42 CFR 438.104). <sup>50</sup> As defined at 45 CFR 155.20

<sup>50</sup> As defined at 45 CFR 155.20

<sup>51</sup> 42 CFR 438.104

activities and materials prior to their implementation or use.<sup>52</sup> To facilitate this review process, DHHS will establish and consult with a new Marketing Committee comprised of relevant stakeholder representatives.<sup>53</sup>

### **(C) Managed Care Plan Accountability**

North Carolina's Medicaid program enjoys strong participation from a range of providers, including over 1,900 primary care practices, 2,400 pharmacies and 130 acute care hospitals. Moving to Medicaid managed care, it is crucial to ensure continued participation of Medicaid providers and to monitor access, while balancing the PHPs' ability to manage both their networks and patient care.

#### **Network Access and Out-of-Network Protections**

States with Medicaid managed care are required to ensure that PHPs maintain a network of appropriate providers that is "sufficient to provide adequate access" to all services covered under the contract for all enrollees.<sup>54</sup> North Carolina's Medicaid managed care legislation also requires PHPs to "not exclude providers from their networks"<sup>55</sup> except for inability to negotiate rates or quality concerns. Additionally, North Carolina requires PHPs to contract with all "essential providers"<sup>56</sup> in their geographic service area unless DHHS approves an alternative arrangement for service delivery.<sup>57</sup>

If a PHP is unable to provide covered services to a particular enrollee, the PHP must adequately and timely cover these services out-of-network (OON) for if the PHP's network is unable to provide them. To ensure appropriate access to OON services, DHHS will require PHPs to follow a streamlined process for OON requests, which will be formally tracked and are subject to beneficiary appeal. Both the request and the appeals will be monitored by DHHS.

#### **Transitions in Managed Care**

To ensure individuals with ongoing, special conditions do not suffer a disruption in care when transitioning into Medicaid managed care or between different PHPs, such individuals will be permitted to continue seeing his/her out of network provider for up to 90 days after joining the plan. Women who are pregnant and in their second or third trimester may continue seeing their provider(s) through their pregnancy and up to 60 days after delivery. In addition, counseling will be provided by the Enrollment Broker to help beneficiaries smoothly navigate such transitions.

#### **Network Adequacy Standards**

Network adequacy standards are an important tool to ensure beneficiaries have access to providers and care. In these draft standards—which comply with federal rules and which include both time and

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<sup>52</sup> 42 CFR 438.104

<sup>53</sup> 42 CFR 438.104

<sup>54</sup> 42 CFR 422.112

<sup>55</sup> NC S.L. 2016-121; 5(6)(d)

<sup>56</sup> Per NC S.L. 2016-121; 6(5), essential providers are Federally qualified health centers, Rural health centers, Free clinics, Local health departments and State Veterans Homes.

<sup>57</sup> NC S.L. 2016-121; 6(5).

distance standards and appointment wait-time standards—PHPs are required to take geography into consideration. See Tables 2 and 4 for DHHS’ draft standards.

*Table 2: North Carolina Draft Network Adequacy Standards – Time and Distance Standards*

Provider Type	Urban Standard	Rural Standard
<b>Primary Care (adult and pediatric)</b>	≥ 1 provider within 30 minutes or 10 miles	≥ 1 provider within 30 minutes or 30 miles
<b>Specialty Care (adult and pediatric)</b> <i>see Table 3</i>	≥ 1 provider (per specialty type) within 30 minutes or 15 miles	≥ 1 provider (per specialty type) within 60 minutes or 60 miles
<b>Hospitals</b>	≥ 1 hospital within 30 minutes or 15 miles	≥ 1 hospital within 30 minutes or 30 miles
<b>Pharmacies</b>	≥ 1 pharmacy within 30 minutes or 15 miles	≥ 1 pharmacy within 30 minutes or 30 miles
<b>OB/GYN</b>	≥ 1 provider within 30 minutes or 10 miles	≥ 1 provider within 30 minutes or 30 miles
<b>Behavioral Health</b>	<i>Under development</i>	<i>Under development</i>
<b>LTSS</b>	<ul style="list-style-type: none"> <li>All State Plan LTSS (except nursing facilities): Providers are not required to live in the same county in which they provide services.<sup>58</sup></li> <li>Nursing facilities: PHPs must have at least 1 nursing facility accepting new residents in every county.</li> </ul>	<ul style="list-style-type: none"> <li>All State Plan LTSS (except nursing facilities): Providers are not required to live in the same county in which they provide services.</li> <li>Nursing facilities: PHPs must have at least 1 nursing facility accepting new residents in every county.</li> </ul>

*Table 3: North Carolina Draft Network Adequacy Standards – Specialists Subject to Network Adequacy Standards*

Specialist Types	
Allergy/immunology	Nephrology
Anesthesiology	Neurology
Cardiology	Ophthalmology
Dermatology	Optometry
Endocrinology	Orthopedic surgery

<sup>58</sup> State Plan LTSS is defined as: Nursing facility, Home Health, personal care, hospice, home infusion therapy, private duty nursing, and durable medical equipment.

Specialist Types	
ENT/otolaryngology	Psychiatry
Gastroenterology	Pulmonology
General surgery	Radiology
Hematology/oncology	Urology

*Table 4: North Carolina Draft Network Adequacy Standards – Appointment Wait-Time Standards*

<b>Emergency services</b>	<b>Immediately</b>	<b>Routine Primary care</b>	<b>30 days</b>
<b>Urgent care</b>	<b>24 hours</b>	<b>Specialty care</b>	<b>30 days</b>

These standards remain in draft form, as DHHS continues to conduct analyses of fee-for-service experience and leverage other information to test the standards.

DHHS will have an exceptions process for PHPs that are unable to meet the network adequacy standards set forth by DHHS in a specific region for a specific specialty (e.g., due to utilization patterns, the number of relevant providers, the history of enrollee complaints, and the comprehensiveness of the PHP's plan for addressing enrollee needs through OON referrals or telemedicine).

DHHS will accept exception requests on an ongoing basis. Further, it will monitor enrollee access to the relevant provider types in the relevant regions on an ongoing basis and annually report the findings to CMS, in line with federal regulations.

#### **Network Data Reporting/Provider Directory Tool**

PHPs must submit their provider networks on a regular basis to DHHS, which will develop and utilize a standardized, detailed file layout for network submission to ensure network data are consistently tracked across all PHPs. Among the data fields required of plans are provider names and contact information, provider type/specialty and group affiliation. PHPs will also be required to submit variables that include but are not limited to:

- Whether the provider is accepting new enrollees;
- The provider's linguistic capabilities;
- Select services features (e.g., if a family practice provider delivers babies)
- Whether the provider has completed cultural competency training; and
- Office accessibility (e.g., if the location has accommodations for people with physical disabilities).

DHHS will integrate all provider network information into a single, centralized provider directory tool, which will be accessible to beneficiaries and the public, the enrollment broker and county DSS workers.



For the purposes of State review for monitoring and oversight of network adequacy and other requirements, PHPs will be required to submit their provider networks monthly and at times of “significant change” as defined in federal regulations. DHHS will also set forth a model provider directory that all PHPs must use in developing their provider directories for enrollees or potential enrollees. PHPs will be required to submit their consumer-facing provider directories to DHHS annually and at the time of significant change.

### **Provider Relations and Appeals**

PHPs will be required to have a provider relations function for in-network providers to answer questions and resolve issues, and a mechanism for provider appeals. For provider relations, PHPs will be required to have a provider services call center, dedicated provider relations staff and offer an on-line portal to help providers access information. PHPs will also be required to develop, maintain and distribute a provider manual that provides information and education to providers about the PHPs’ policies and procedures. Additionally, as discussed in the “*Provider Supports*” section, PHPs will play a role in providing Medicaid managed care education and training to providers.

PHPs also will be required to establish a provider appeal process through which providers can appeal PHP actions related to termination or non-renewal of contract for quality reasons or violation of terms between the PHP and provider (e.g., prompt pay, denial of claims). Written documentation of PHPs’ provider appeal processes will be submitted to DHHS for review and approval and will be clearly articulated in provider manuals. To request an appeal, providers will have 30 days from the date on which the PHP takes adverse action against the provider, or fails to take required action, to submit a written request for appeal to the PHP. The PHP, in turn, will be required to send written acknowledgement of the request within five days of receipt, and written notice of resolution of the appeal within 30 calendar days from the date the PHP receives the appeal request. Providers will not have the ability to request a hearing before DHHS or through the state fair hearing process before North Carolina Office of Administrative Hearings if dissatisfied with the results of the PHP’s appeal process, unless the appeal relates to program integrity issues and DHHS takes separate action based on PHP action.

### **Monitoring and Oversight**

To monitor network adequacy, PHPs will be required to submit reports that summarize how the PHPs’ network is in compliance with network adequacy standards in addition to submitting network data to DHHS. DHHS’ monitoring and oversight strategy will also include reviewing beneficiary satisfaction survey findings regarding access and monitoring beneficiary network complaints from the PHPs and across other entities, including the enrollment broker, DSS and Ombudsman.

To monitor provider relations and appeals, PHPs will be required to report on call center metrics, and information regarding provider appeal processes. This includes information on the volume, nature, and outcomes of provider appeals, as well as information on any provider appeals that proceed to litigation.

## **(2) Provider Credentialing**

Historically, a key frustration for providers in the move to Medicaid managed care is the administrative burden of submitting similar information to multiple PHPs to become credentialed with each PHP. DHHS seeks to avoid this situation by developing a centralized credentialing process, including a standardized application and centralized verification process.

Additionally, a new federal requirement requires that all Medicaid providers that participate in PHPs also must be enrolled in the fee-for-service Medicaid program.<sup>59</sup> Thus, there is a significant opportunity to build on the infrastructure DHHS already has in place.

DHHS will implement a “one stop shop” centralized credentialing (and re-credentialing) process with joint DHHS and PHP oversight. The features of this approach build on the current system and will include:

- Development of uniform credentialing policies in conjunction with a DHHS-led work group of plans and providers;
- Use of a single electronic application, which will provide a single point- of-entry for all providers to submit all credentialing information;
- Verification of credentials through a process that is certified by a national accrediting organization;
- Joint PHP-State decision making on each provider application; and
- An information infrastructure that supports sharing of credentialing information and decisions between DHHS and each PHP.

Individual contract negotiations will be directly between PHPs and providers, using State-approved contracts with standardized language for select sections.

Centralized credentialing will require changes to current systems as well as careful design planning and education and training for all providers, State agency officials, vendors and stakeholders. A stakeholder engagement process to initiate planning will begin later this summer.

## **(3) Clinical Coverage Policies and Utilization Management**

PHPs will be required to cover the same services as in Medicaid fee-for-service, except for a small number of services carved out of Medicaid managed care by statute.<sup>60</sup> Consistent with federal

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<sup>59</sup> 42 CFR 438.602, effective for contracts starting on or after January 1, 2018

<sup>60</sup> North Carolina Session Law 2015-245, as amended by Session Law 2016-121, excludes dental services; services provided through the Program of All-Inclusive Care for the Elderly; audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or

regulations and approaches in other states, North Carolina will develop an approach to PHP clinical coverage policies and utilization management (UM) that safeguards beneficiary access to services while encouraging PHP innovation.

PHPs will be required to use the Department's definition of "medical necessity" when making coverage determinations, like the approach taken in many other states.<sup>61</sup> PHPs also will be prohibited from setting benefit limits that are more stringent than in the Department's fee-for-service program, consistent with federal requirements. For example, if the fee-for-service program covered 10 visits for a specific service, PHPs could cover 12 visits, but could not limit a beneficiary to only six visits.

For a limited number of services, the Department will require PHPs to use existing Medicaid clinical coverage policies. The Department also will develop a common prior authorization request form for use by all PHPs. Finally, the Department also will encourage PHPs to use "in-lieu-of services" (ILS), services or settings that are not covered under the State Plan but are a medically appropriate, cost-effective alternative to a service that is covered.

### **(3) Pharmacy**

North Carolina's Medicaid Pharmacy program has a history of effective program management, utilizing drug rebates and careful selection of drugs on a Preferred Drug List (PDL) to acquire the correct mix of drugs at the most advantageous cost. DHHS wants to continue providing the best overall value to beneficiaries, providers, and North Carolina. This includes maintaining a PDL compliance rate of 95 percent as well as maintaining DHHS' generic dispensing rate of approximately 87 percent.<sup>62</sup> This approach will assist DHHS in meeting the statutory requirement that PHP spending for prescribed drugs, net of rebates, ensures DHHS realizes a net savings.

*Single Statewide Formulary.* As required by Session Law 2015-245, DHHS intends to develop a single formulary that will incorporate all drugs on the fee-for-service preferred drug list (PDL) and all covered outpatient drugs for which the manufacturer has a rebate agreement and for which DHHS provides coverage. All PHPs will be required to use the same drug formulary, but PHPs will be allowed to suggest changes through a State-developed uniform review and approval process.

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individuals contracted with Local Education Agencies; services provided directly by a Children's Developmental Services Agency (CDSA) or by a provider under contract with a CDSA if the service is authorized through the CDSA and is included on the child's Individualized Family Service Plan; and services for Medicaid program applicants during the period of time prior to eligibility determination. DHHS also recommends that eyeglasses and the provider visual aid dispensing fee be carved out of managed care, which would require a statutory change.

<sup>61</sup> All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. 10A NCAC 25A .0201 (1990).

<sup>62</sup> DHHS, "Pharmacy Generic Dispensing Rate Report," March 25, 2017. [https://ncdma.s3.amazonaws.com/s3fs-public/Pharmacy\\_Generic\\_Dispensing\\_Rate.pdf](https://ncdma.s3.amazonaws.com/s3fs-public/Pharmacy_Generic_Dispensing_Rate.pdf)

*Pharmacy Reimbursement.* PHPs will be required to reimburse pharmacies, both dispensing fees<sup>63</sup> and ingredient costs, at the DHHS fee-for-service rates. For ingredient costs, these rates include, but are not limited to, the National Average Drug Acquisition Cost, the State Maximum Allowable Cost list and other DHHS financial arrangements. In year two of the contract, DHHS will consider permitting PHPs to develop their own pharmacy reimbursement contracting for ingredient costs, if the PHP can demonstrate that the reimbursement results in overall savings to DHHS and does not materially impact access to care. If this is allowed, PHPs would be required to present an access monitoring plan.

*Prior Approval (PA)/Clinical Policies.* PHPs will be required to follow the same clinical coverage policies and prior authorization criteria as those used in the PDL/PA program (for both preferred and non-preferred classes). After year one (13 months after North Carolina’s Medicaid waiver go-live date), PHPs will be allowed to propose plan specific PDL/PA clinical coverage policies for review and approval by DHHS. For those drugs/classes not listed in DHHS’ PDL, PHPs will be allowed to develop their own clinical policies upon receiving State approval.

*Other Pharmacy Policies.* PHPs will be required to operate prospective and retrospective drug utilization review (DUR) programs, implement a comprehensive opioid misuse prevention program, and establish a medication therapy management program and clinical programs to promote medication adherence. PHPs shall develop clinical programs to support pharmacy quality measures and that are consistent with the Community Pharmacy Enhanced Services Network and other DHHS and PCCM pharmacy program initiatives when developing pharmacy clinical programs. If a PHP utilizes a PBM, the PHP will develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor pharmacy benefit manager performance, and ensure the confidentiality of information. PHPs will be required to follow DHHS’ 340B drug policies and reimbursement approach for 340B covered entities.

#### **(4) Plan and Provider Payments**

To enable a high-functioning and sustainable Medicaid managed care system, DHHS will establish payment parameters that will encourage plan innovation while ensuring adequate reimbursement for providers. DHHS aims to strike a balance between giving plans flexibility in determining the level of reimbursement for providers in the PHP networks while, in some cases, mandating that PHPs maintain a certain level of payment to providers. Plans also will be encouraged to contract with providers under other types of alternative payment models.

*Rate Floor Protections.* DHHS will establish rate floors of 100 percent of the Medicaid fee-for-service rate but will not establish set rates, for statutorily required provider types (i.e., in-network primary care and specialist physicians) and will expand rate floor protections to include physician extenders. PHPs and providers will be permitted to mutually agree to a different rate or alternative payment arrangement.

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<sup>63</sup> For dispensing fees, North Carolina Session Law 2015-245 requires “appropriate rate floors...to ensure the achievement of transformation goals.”

DHHS will also consider imposing rate floors for other provider types, such as hospitals, as appropriate to assist in the transition to Medicaid managed care.

*Cost-Settled Providers.* Under federal law, states are required to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) according to a prospective payment (PPS) methodology. Rather than require PHPs to pay the required rate, PHPs will pay negotiated rates (if payment is at least the same amount they would pay if those services were furnished by providers other than FQHCs and RHCs). DHHS will provide wrap payments to cover the difference between negotiated PHP rates and the state-determined PPS or cost-based rate. This approach enables PHPs to have rate setting flexibility while sustaining funding for FQHCs/RHCs.

Additionally, DHHS currently cost settles local public health departments, public ambulance providers, and State-owned or –operated skilled nursing facilities (SNFs). Federal regulations prohibit states from making payments outside of Medicaid managed care to most providers (except for FQHCs and RHCs listed above). Accordingly, DHHS is developing an approach to ensure that these providers continue to receive comparable reimbursement rates.

*Supplemental Payments.* Under current federal rules, states operating Medicaid managed care programs generally may not make payments directly to providers for services and populations covered under Medicaid managed care. As North Carolina moves to Medicaid managed care, DHHS will no longer be permitted to make most supplemental payments to hospitals and other providers that are authorized under State law today. DHHS envisions collaborating with North Carolina hospitals to develop an approach to hospital supplemental payments that maintains funding for Medicaid and uninsured patients at current levels and supports DHHS’ transition to a value-based payment and delivery system.

*Payments to Out-of-Network Providers.* As is required by federal law, PHPs will cover out-of-network services for enrollees if unable to provide necessary covered services within their network and must coordinate with those out-of-network providers for payment. If a PHP has made a good faith effort to contract with a provider who has refused that contract, or if the provider is excluded from contracting for failure to meet objective quality standards, PHPs will be required to reimburse that out-of-network provider at 90 percent of the Medicaid fee-for-service rate for services.

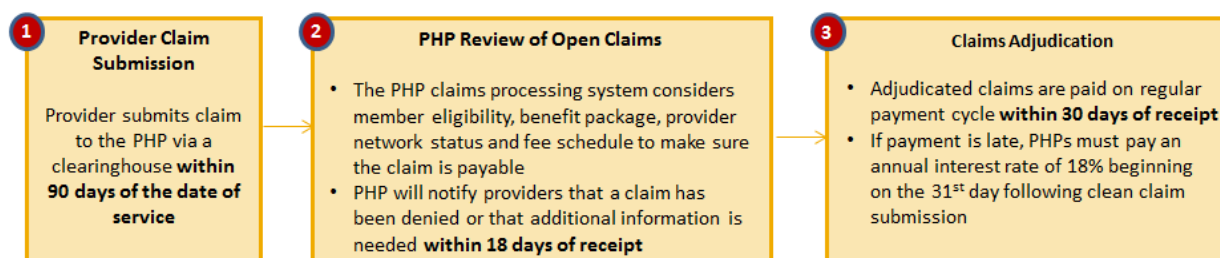
As required by federal law, PHPs will also cover family planning services and supplies regardless of a provider’s network status, and will cover and pay for emergency services without regard to prior authorization or network status. For out-of-network emergency or post-stabilization services, PHPs will pay no more than the Medicaid fee-for-service rate. For out-of-state hospitals (that are not part of a PHP’s network) PHPs will pay the Medicaid fee-for-service rate.

*Payment Processing.* PHPs will be responsible for claims processing and payments to providers, and must make timely payments to providers if a claim is submitted within 90 days after the date of service. In alignment with national standards, such as requirements for Medicare claims processing and existing state approaches for LME-MCOs and commercial plans, PHPs must send payment for claims that require

no further information or substantiation within 30 days of receipt or claims will be subject to interest payments.

To ensure that providers are given the opportunity to submit an accurate claim, the PHP also must notify providers within 18 days of receipt that a claim has been denied or requires additional information. To facilitate prompt reimbursement to pharmacies for high cost drugs, PHPs will be required to pay 90 percent of pharmacy claims within 14 calendar days, 99.5 percent within 21 calendar days and 100 percent of claims within 90 calendar days of receipt. Consistent with other states, payments that are not made in accordance with requirements will bear interest at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid.

Figure 12. PHP Claims Processing and Payment Process.



**PHP Capitation Rate Setting.** DHHS will ensure that capitation rates are set in accordance with actuarially sound principles and reflect specific program design considerations, covered populations and benefits, and PHP payment requirements including rate floors and payments to special provider types (e.g., FQHCs/RHCs). The payments to the PHPs under Medicaid managed care are in the form of prospective per member per month (PMPM) capitation rates. DHHS, in consultation with its actuary, will develop the capitation rate methodology through a transparent process that solicits information from potential PHPs and other stakeholders. A draft methodology will be released in the fall of 2017. DHHS will make available additional rate documentation and draft PHP rates in the PHP procurement. The PHP payments will use a rate cell structure that will likely differentiate payments for beneficiaries by eligibility group, age, and region. Initial rates will consider service costs based on historical North Carolina Medicaid utilization as well as expectations of utilization change under Medicaid managed care. DHHS will also incorporate reasonable administrative costs and margin into the capitation rates. Actual rates will be set annually and updated, as needed, to reflect programmatic changes.

**Risk Adjustment/Mitigation Approaches.** DHHS will implement risk adjustment at the onset of Medicaid managed care and will evaluate its approach and methodology in future years to ensure the model reflects the variation of risk across the PHPs. Risk adjustment is used to prospectively adjust the base capitation rates paid to the PHPs based on differences in the relative health risk of each PHP's enrolled population. This provision is crucial to appropriately compensate PHPs that may attract enrollees with different health care conditions. DHHS intends to provide more detail about risk adjustment in the draft capitation rate setting methodology document referenced above.

DHHS is also considering additional risk mitigation techniques, including requiring PHPs to purchase reinsurance to mitigate the impact of high-cost individuals and will solicit feedback from stakeholders to inform its approach. Risk mitigation approaches attempt to mitigate the financial risk of high-cost beneficiaries or services for the PHPs participating in the program.

*Medical Loss Ratio.* DHHS will require its PHPs to report their Medical Loss Ratio (MLR) consistent with federal regulations. The MLR measures the proportion of premium revenue that a PHP spends on clinical services and quality improvement. By requiring PHPs to report on and meet a minimum MLR standard, DHHS seeks to ensure that PHPs are spending most of their premium revenue on medical care and activities that improve health care quality. DHHS will determine the minimum MLR standard (reflecting costs included in the capitation payment) and the numerator and denominator reporting requirements for purposes of rate setting and rebates as part of the development of the rate methodology. The minimum MLR will be set to account for the treatment of supplemental payments. If supplemental payments currently made to certain providers are included as part of the capitation payments to PHPs, the minimum MLR will be higher than if DHHS makes those payments directly. DHHS will require a rebate (i.e., payback to DHHS) if PHPs report an MLR below the minimum MLR.

*Quality Incentives and Withholds.* DHHS intends to adopt a phased incentive/withhold approach that is tied to compliance measures in year one (including the timely submission of encounter data and financial reports) and expand to include performance on quality measures in future years. DHHS will explore the potential use of waiver funding and Medicaid program savings to fund a payment pool that would reward high performing plans in future years to support the transition to Medicaid managed care. Consistent with federal rules, DHHS will link any payments made through incentive arrangements or withholds to DHHS' Medicaid managed care quality strategy, including related quality measures.

## **(5) Oversight, Compliance and Program Integrity**

While some of the Department's operations change with the transition to Medicaid managed care, DHHS remains responsible for all aspects of North Carolina's Medicaid program. To ensure that PHPs comply with Medicaid managed care requirements and align with State-defined program goals, DHHS is designing rigorous requirements and oversight protocols for the Medicaid managed care program. PHPs will be contractually required to collect timely encounter, quality and performance data. PHPs will submit reports on a range of other metrics, such as demonstration of network adequacy, value-based contracting arrangements and volume, nature, and outcomes of grievances and appeals. These reports will be essential to DHHS' evaluation of the program, and hold PHPs accountable. In addition to DHHS' Program Integrity audits and monitoring, the Department of Insurance will license PHPs and ensure they meet solvency standards through processes similar to what is used for existing commercial managed care plans.

DHHS will uphold Medicaid's program integrity, which ensures that federal and State dollars are spent appropriately on delivering quality, necessary care. Today, the Program Integrity Section of DMA is

responsible for identifying and investigating non-compliance by providers and fraud, waste and abuse by providers and beneficiaries. The Attorney General's Medicaid Investigation Division prosecutes criminal fraud engaged in by providers and beneficiaries, and there is close collaboration between these agencies. Under the new federal rules, states operating Medicaid managed care programs must ensure that PHPs implement and maintain arrangements to ensure provider compliance and detect fraud, waste and abuse by providers and beneficiaries. DHHS will ensure that the PHPs are meeting these obligations.

PHPs will have increased compliance and program integrity obligations to the DHHS Program Integrity unit. Each PHP will be required to develop compliance and fraud, waste and abuse prevention programs. The PHP's compliance program must ensure its own compliance with the federal, state, and contractual requirements, such as data reporting, marketing, and processing of grievance and appeals. In addition, PHPs must monitor to ensure that its contract providers comply with the terms of its provider contracts.

Each PHP must also establish a Special Investigations Unit ("SIU"). The SIU will be responsible to the DHHS Program Integrity unit for pre- and post-claim reviews, visit verification, onsite and desk audits of suspect providers, and providing education on federal and State fraud and abuse law. SIU responsibilities also include PHP's detection and prevention activities, a list of reports used to profile network providers to aid in developing program integrity activities, and investigating reports of alleged fraud or abuse by providers or enrollees. PHPs will also include information in enrollee materials on how beneficiaries can assist in fraud and abuse prevention efforts.

DHHS will continue to be the gatekeeper to the Medicaid program through screening providers for enrollment in the Medicaid program. This is based on the provider's assignment into risks categories, collecting and evaluating the provider's ownership and control disclosure forms, and performing monthly screenings of all Medicaid enrolled providers against:

- The Social Security Administration's Death Master File
- The National Plan and Provider Enumeration System (NPPES)
- The List of Excluded Individuals/Entities (LEIE)
- The System for Award Management (SAM)
- DHHS Excluded Provider List

All providers will also be subject to criminal background checks by DHHS. No provider can contract with a PHP unless they are enrolled in North Carolina Medicaid.

DHHS will oversee PHP program integrity activities through frequent communication and receipt of detailed reports of the PHP's compliance and program integrity activities. DHHS will also conduct operational audits and data reviews of PHPs and providers. Through these activities, DHHS will share information amongst PHPs regarding potential fraud or abuse by providers. DHHS will have the right to direct that a PHP perform a specific audit or monitoring activity if it determines there are certain high



risk providers or activities. DHHS will still review all credible allegations of fraud, as the SIUs will be legally and contractually required to promptly refer those matters to DHHS. If DHHS determines that allegations appear credible, as required under federal regulation, NC DHHS will refer the matter to the North Carolina Department of Justice Medicaid Investigations Division (“MID”) or other law enforcement agencies for review. MID will evaluate the matter and determine whether it or the PHP should continue the investigation.

In addition, NC DHHS will perform a full review of the PHP’s compliance program and program integrity activities at least every three years through its EQR process. DHHS will also annually performing tracer audits of each PHP to ensure that the PHP is following its NC DHHS-approved processes and Fraud Prevention Plan in carrying out its program integrity obligations.

While providing oversight and compliance auditing of the PHP fraud, waste and abuse efforts, the DHHS Program Integrity unit will continue to provide mandated fraud, waste and abuse investigations and auditing for the fee-for-service services not transitioned to Medicaid managed care.

## **VI. Increased Access to Medicaid**

Proposed legislation in the North Carolina General Assembly aims to increase access to affordable health care under Medicaid by requiring DHHS to design the Carolina Cares program. Carolina Cares would allow eligible low-income individuals to enroll in Medicaid if they demonstrate work activities, pay required premiums, and comply with personal responsibility requirements.<sup>64</sup> If passed, this program would begin at the same time as the launch of the Medicaid managed care program.

Carolina Cares would provide a comprehensive benefit package of physical, behavioral and pharmacy services. Included in this benefit package would be services crucial to the prevention, identification and treatment of opioid and other substance use disorders. This increased access would aid North Carolina’s public health priorities while bringing billions in both new federal funding and increased economic activity into the state’s economy.<sup>65</sup>

As currently outlined in the proposed legislation, Carolina Care enrollees with incomes greater than 50 percent of the federal poverty level would be required to pay a monthly premium, set at 2 percent of household income, as a condition of eligibility.<sup>66</sup> Carolina Care enrollees would be subject to the same

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<sup>64</sup> This expansion of coverage would cover the parents of children in foster care contemplated as a coverage expansion in the June 2016 waiver submission.

<sup>65</sup> Ku, Leighton, Bruen, Brian, Steinmetz, Erika and Bysshe, Tyler. “The Economic and Employment Costs of Not Expanding Medicaid in North Carolina: A County-Level Analysis.” Cone Health Foundation and Kate B. Reynolds Charitable Trust. December 2014.

<sup>66</sup> Additional populations exempt from the premium requirement include enrollees with a medical hardship, with a financial hardship, members of a federally recognized tribe, and veterans in transition who are actively seeking employment.

co-payment requirements as the rest of the Medicaid population. Most enrollees would also be required to be employed or engaged in activities to promote employment.

Financing for Carolina Cares would not require additional State appropriation and would consist of federal Medicaid funds, enrollees' premium contributions and funds generated via health care-related assessments on hospitals and potentially other healthcare providers.

## VII. Submitting Feedback

DHHS compiled this detailed proposed program design for Medicaid managed care to solicit valuable feedback from providers, health plans, elected officials, advocates, beneficiaries and other stakeholders.

This proposed program design seeks to advance high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses both medical and non-medical drivers of health.

Feedback on the Medicaid managed care proposed program design is welcome. Please send written input by Sept. 8, 2017, to:

**Email:** [Medicaid.Transformation@dhhs.nc.gov](mailto: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 Dr., Raleigh NC

Send questions about North Carolina Medicaid transformation to [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov). For more information about transformation efforts, visit [ncdhhs.gov/nc-medicare-reform](http://ncdhhs.gov/nc-medicare-reform).

## APPENDIX: Task Force on Health Care Analytics Selected Measure Set

Measure Selected by Task Force on Health Care Analytics	Measure Definition/Notes
<b>Improving Population Health</b>	
<b>Population-Level Measures</b>	
<b>Healthy Days</b>	4-question patient survey capturing overall health status and number of days in past 30 when physical or mental health was not good or prevented usual activities.
<b>Live Births Weighing Less than 2,500 grams (NQF 1382)</b>	The percentage of births with birthweight <2,500 grams
<b>Obesity Screening and Follow-Up</b>	<ol style="list-style-type: none"> <li>1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Ages 3-17 years) (NQF 0024)</li> <li>2. Body Mass Index (BMI) Screening and Follow-Up (Ages 18 years and older) (NQF 0421)</li> </ol>
<b>Infant Mortality</b>	Rate per 1,000 births
<b>Chlamydia Screening in Women (NQF 0033)</b>	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
<b>Social Determinants of Health</b>	<p>The Task Force selected the following domains for measurement, but did not identify specific screening tools or questions.</p> <ol style="list-style-type: none"> <li>1. Food insecurity: limited or uncertain access to adequate and nutritious foods</li> <li>2. Housing instability: homelessness, unsafe housing, inability to pay mortgage/rent, frequent housing disruptions, eviction</li> <li>3. Transportation: difficulty accessing/affording transportation (medical or public)<sup>5</sup></li> </ol>
<b>Preventive Care</b>	
<b>Immunizations</b>	<ol style="list-style-type: none"> <li>1. Childhood Immunization Status (NQF 0038): Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.</li> <li>2. Immunizations for Adolescents (NQF 1407) (current HEDIS measure includes Human Papillomavirus Vaccine in this measure): The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine and three doses of human papillomavirus (HPV) vaccine by their 13th birthday.</li> </ol>

Measure Selected by Task Force on Health Care Analytics	Measure Definition/Notes
<b>Well Child Visits</b>	<p>1. Well-Child Visits in the First 15 Months of Life (NQF 1392): The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.</p> <p>2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (NQF 1516): The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.</p> <p>3. Adolescent Well Care Visits: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</p>
<b>Percentage of Eligibles Who Received Preventive Dental Services (CMS)</b>	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.
<b>Tobacco Use: Screening and Cessation Intervention (NQF 0028)</b>	Assesses different facets of providing medical assistance with smoking and tobacco use cessation
<b>Screening for Clinical Depression and Follow Up Plan (NQF 0418)</b>	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen
<b>Cervical Cancer Screening (NQF 0032)</b>	<p>Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:</p> <ul style="list-style-type: none"> <li>- Women age 21–64 who had cervical cytology performed every 3 years.</li> <li>- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.</li> </ul>
<b>Contraceptive Care – Postpartum Women Ages 15-44 (NQF 2902)</b>	<p>Among women ages 15 through 44 who had a live birth, the percentage that is provided:</p> <p>1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery</p> <p>2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care."</p>

Measure Selected by Task Force on Health Care Analytics	Measure Definition/Notes
<b>Behavioral Health Risk Screening for Pregnant Women (CMS)</b>	<p>Proportion of women who had at least one prenatal visit who received behavioral health risk screening assessment (for depression, tobacco use, drug use, alcohol use, intimate partner violence)</p> <p>Suggested tool: Community Care of North Carolina Pregnancy Medical Home Risk Screening Form</p>
<b>Prenatal and Postpartum Care (NQF 1517)</b>	<p>The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:</p> <p>Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.</p> <p>Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery</p>
<b>Care of Acute and Chronic Conditions</b>	
<b>Medication Management for People with Asthma (NQF 1799)</b>	<p>The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed appropriate medication that they remained on during the treatment period. Two rates are reported:</p> <p>1) Percent of patients who remained on an asthma controller medication for at least 50% of their treatment period.</p> <p>2) Percent of patients who remained on an asthma controller medication for at least 75% of their treatment period.</p>
<b>Comprehensive Diabetes Care: HbA1c poor control (NQF 0059)</b>	<p>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.</p>
<b>Controlling High Blood Pressure (NQF 0018)</b>	<p>The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year.</p>
<b>Hospital-Acquired Conditions</b>	<p>The rates of acute care hospitals of the following conditions: 1) Foreign object retained after surgery; 2) Air embolism; 3) Blood incompatibility; 4) Falls and traumas; 5) Manifestations of poor glycemic control; 6) Catheter- associated urinary tract infection; 7) Vascular catheter- associated infection; 8) Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG); 9) Surgical site infection following certain orthopedic procedures; 10) Surgical site infection following cardiac implantable electronic device; 11) Deep vein thrombosis/pulmonary embolism following certain orthopedic procedures; 12) Iatrogenic pneumothorax with venous catheterization</p>

Measure Selected by Task Force on Health Care Analytics	Measure Definition/Notes
<b>Use of Opioids at High Dosage (NQF 2940)</b>	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.
<b>Follow Up After Hospitalization for Mental Illness (NQF 0576)</b>	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: 1) The percentage of discharges for which the patient received follow-up within 30 days of discharge 2) The percentage of discharges for which the patient received follow-up within 7 days of discharge
<b>Patient Experience of Care</b>	
<b>Consumer Assessment of Healthcare Providers and Systems (Selected Key Indicators) (NQF 0005)</b>	1. Getting timely care, appointments and information: Percentage of patients who answer "Always" or "Usually" to CG-CAHPS questions on their ability to get urgent care, routine care, or needed information from a physician's office. 2. How well providers communicate with patients: Percentage of patients who report the highest level of satisfaction (Always or Usually) with their provider's communication 3. Access to specialists: The percentage of patients who report the highest level of satisfaction (Always or usually) to the question, "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?"
<b>Cost and Utilization</b>	
<b>Total Cost of Care Population-based PMPM index (risk-adjusted index) (NQF 1604)</b>	Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Total Cost Index when viewed together with the Total Resource Use measure (NQF-endorsed #1598) provides a more complete picture of population based drivers of health care costs.
<b>Inpatient Admission Rate (risk-adjusted index)</b>	Inpatient admissions per 1,000 member months
<b>Emergency Department Utilization (risk-adjusted index)</b>	This measure is used to assess the risk-adjusted ratio of observed to expected emergency department (ED) visits, for members 18 years of age and older.

Measure Selected by Task Force on Health Care Analytics	Measure Definition/Notes
<b>Use of Imaging for Low Back Pain (NQF 0052)</b>	The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.  Assesses low value care
<b>NTSV Cesarean Delivery (NQF 0471)</b>	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section
<b>Workforce Wellbeing</b>	
<b>Job Satisfaction</b>	Percentage of clinicians who respond 'agree' to select indicators of job satisfaction
<b>Measurement of Burnout</b>	TBD; explore RAND question or Maslach scale
<b>Overall satisfaction with the prepaid health plan</b>	Providers reporting by, "Extremely satisfied, Satisfied, Dissatisfied, Extremely Dissatisfied."

## APPENDIX: Glossary

**1915(b) waiver**—Named for the section of the Social Security Act that authorizes it, this is a type of Medicaid waiver, also known as a “managed care waiver,” that is available to states to implement managed care.

**1915(b)/(c) waiver**—The waiver that allowed DHHS to restructure the management responsibilities for the delivery of services to individuals with mental illness, intellectual and other developmental disabilities, and substance use disorders through managed care arrangements with local management entity managed care organizations (LME-MCOs).

**1915(c) waiver**—Named for the section of the Social Security Act that authorizes it, this is a type of Medicaid waiver, also known as a “home and community based services (HCBS) waiver,” available to states to provide long-term care services in home and community based settings as an alternative to institutional services.

**ACO (Accountable Care Organization)**—A health care organization characterized by a payment and care delivery model that seeks to tie provider reimbursements or shared savings and losses to quality metrics and changes in the total cost of care for an assigned population of patients. A group of coordinated health care providers forms an ACO, which then provides care to an identified group of patients.

**AHEC (Area Health Education Centers)**—Starting in 1974, the North Carolina General Assembly approved and funded a plan by the University of North Carolina at Chapel Hill (UNC-CH) School of Medicine to create a statewide network of nine AHEC regions. These centers provide educational programs and services that bridge academic institutions and communities to improve the health of the people of North Carolina with a focus on underserved populations.

**AMH (Advanced Medical Home)**—Patient-centered Medical Homes meeting certain tiered criteria for certification designated by DHHS.

**Behavioral Health I/DD Tailored Plan**—Behavioral Health Intellectual/Developmental Disability Tailored Plan is a plan specifically designed to provide targeted care for individuals with intellectual and/or developmental disabilities.

**CAP-C (Community Alternatives Program for Children)**—A North Carolina Medicaid 1915(c) waiver program that provides home and community based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.

**CAP-DA (Community Alternatives Program for Disabled Adults)**—A North Carolina Medicaid 1915(c) waiver program that allows elders and disabled adults aged 18 and older to receive support services in their own home, as an alternative to nursing home placement.

**CCBHC (Certified Community Behavioral Health Clinics)**—Entities designed to serve individuals with serious mental illnesses and substance use disorders that provide intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services.



**CCNC (Community Care of North Carolina)**—A North Carolina nonprofit organization that works collaboratively with physicians and other health care professionals to improve health care quality and restrain costs. CCNC services and grants target Medicaid and Medicare beneficiaries. Partnerships include universities and private sector organizations, such as Blue Cross and Blue Shield of North Carolina. This term was the longtime name for North Carolina PCCM's and PCMH program and is still used informally. The official PCCM contractor name changed to N3CN in 2012.

**CDSA (Children's Developmental Services Agency)**—A local North Carolina agency that provides help to families, caregivers, and professionals who serve children with special needs through the Infant Toddler Program. The program offers early intervention services for children birth through 36 months of age with a developmental delay or disorder. Services include evaluation, treatment, service coordination, and consultation services. Administered by the North Carolina Division of Public Health, this program delivers services as outlined in federal law under Part C of the IDEA.

**CMS (Centers for Medicare and Medicaid Services)**—The federal agency responsible for Medicare and parts of Medicaid.

**CP (Commercial Plan)**—A type of prepaid health plan defined in Session Law 2015-245 as any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the North Carolina Department of Insurance.

**DHHS (Department of Health and Human Services)**—Manages the delivery of health- and human-related services for all North Carolinians, especially our most vulnerable citizens – children, elderly, disabled and low-income families. The Department works closely with health care professionals, community leaders and advocacy groups; local, state and federal entities; and many other stakeholders to make this happen. DHHS is made up of several divisions, which include but are not limited to the following:

- **DHB (Division of Health Benefits)**—A new division with DHHS responsible for implementing Medicaid transformation and administering the transformed Medicaid and NC Health Choice programs as described in SL 2015-245.
- **DMA (Division of Medical Assistance)**—Division within DHHS that is currently responsible for managing the North Carolina Medicaid and NC Health Choice programs.
- **DMH/DD/SA (Division of Mental Health, Developmental Disabilities and Substance Abuse Services)**—Provides quality support to achieve self-determination for individuals with intellectual and/or developmental disabilities and quality services to promote treatment and recovery for individuals with mental illness and substance use disorders.
- **DSS (Department of Social Services)**—Department of Social Services are federally mandated, county administered social service systems which provide a range of direct services that address poverty, family violence and exploitation.
- **ORH (Office of Rural Health)**—Assists underserved communities in North Carolina by improving access, quality and cost-effectiveness of health care.

**D-SNP (Dual Eligible Special Needs Plans)**—Health plans that enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

**DOI (Department of Insurance)**—Regulates the insurance industry in North Carolina. Pursuant to SL 2015-245, the Department of Insurance will license and provide solvency oversight of PHPs.

**DSRIP (Delivery System Reform Incentive Payment) Program**—A federal/state partnership initiative authorized as part of broader Section 1115 waivers that allows federal matching dollars for project driven milestones to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.

**EBCI (Eastern Band of Cherokee Indians)**—A federally recognized Indian Tribe located in southwestern North Carolina.

**Enrollment Broker**—An individual or entity that performs choice counseling or enrollment activities for beneficiaries enrolling in prepaid health plans.

**Essential Provider**—Provider that either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of a particular service utilized by Medicaid and NC Health Choice recipients within a region. Per SL 2015-245, essential providers include federally qualified, rural health clinics / centers, free clinics, and local health departments. DHHS can designate other providers as essential providers if the provider meets certain requirements defined in the law.

**Fee-for-Service**—A payment model in which providers are paid for each service provided. North Carolina’s current Medicaid program for physical health care is a fee-for-service model.

**Fostering Health NC**—A statewide, multidisciplinary initiative that is charged with making measurable improvements in health outcomes for North Carolina’s foster population. Fostering Health NC has developed targeted implementation tools, online resources to maximize collaborative partnerships among local Departments of Social Services, primary care providers, and Community Care of North Carolina networks, and provides the on-the-ground technical assistance and consultation to bring about system changes in the health care of foster children. The initiative is led by the North Carolina Pediatrics Society and currently funded by DHHS.

**FQHC (Federally Qualified Health Center)**—An organization that receives a grant under Section 330 of the Public Health Service Act or an organization that meets the eligibility requirements of Section 330 but does not receive grant funding (referred to as an FQHC look-alike). FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. These are also commonly called Community Health Centers.

**GME (Graduate Medical Education) Payments**—Medicaid payments to fund the period of residency and fellowship that is provided to physicians after they receive a medical degree.

**Health Insurance Marketplace**—Also known as the Health Insurance Exchange, is the place where people who purchase their own health insurance can find information about health insurance options and purchase health care insurance. Information can also be found regarding eligibility for help with paying premiums and reducing out-of-pockets costs.

**Home and Community Based Services (HCBS)**—Services that provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted population groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

**In Lieu of Services**—Alternative services in a setting that are not included in the State Plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for State Plan services included within a contract

**Innovations waiver**—The 1915 (c) portion of the 1915(b)/(c) waiver that serves people who would otherwise live in an intermediate care facility for people with intellectual disabilities. This program gives people the opportunity to live in a community setting instead of an institution or group home.

**LEA (Local Education Agency)**—A local school system or a local school district located in North Carolina, indicating that a public board of education or other public authority maintains administrative control of the public schools in a city or county. LEAs enrolled with North Carolina Medicaid provide treatment and assessment services to Medicaid-eligible children through a child’s Individualized Education Program (IEP). Services include: audiology, speech/language therapy, occupational therapy, physical therapy, nursing services, and psychological/counseling services.

**LME-MCO (Local Management Entity/Managed Care Organization)**—A local management entity that is paid a capitated rate by DHHS to provide mental health, developmental disability, and substance abuse services to Medicaid beneficiaries pursuant to a combination of a section 1915(b) and a section 1915(c) waiver. For the Medicaid population, these entities are recognized under CMS Medicaid managed care rules and are known as a Prepaid Inpatient Health Plans (PIHP). LME-MCOs also manage federal block grant, State, local and county funds for other behavioral health services.

**LTSS (Long-Term Services and Supports)**—Includes institutional care and home and community based long-term services and supports provided to individuals with functional limitations or chronic illnesses who need assistance to perform activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping).

**Medicaid**—A joint federal-state health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities.

**Medical Care Advisory Committee (MCAC)**—A committee that advises on health and medical care services that may be covered by the North Carolina Medicaid program. Federal law requires that State Medicaid agencies have a MCAC.

**MCO (Managed Care Organization)**—As defined in 42 CFR 438.2, an entity that has, or is seeking to qualify for, a comprehensive risk contract and meets specified requirements, including the solvency standards of 42 CFR 438.116.

**MLR (Medical Loss Ratio)**—The percent of the capitation payment a PHP spends on claims and programs that improve health care quality.

**N3CN (North Carolina Community Care Networks)**—A subsidiary of CCNC that contracts with DHHS to provide PCCM services including development of quality care initiatives for population management, reporting, and analytics, and clinical oversight of the PCCM program and participating PCMH for Medicaid and NC Health Choice beneficiaries. Sometimes referred to as CCNC.

**NC Health Choice**—A program that extends health care coverage to approximately 87,000 children ages 6 through 18 whose family income exceeds Medicaid financial eligibility criteria but is at or below 200 percent of the federal poverty level. The federally-recognized name for this program is the Children’s Health Insurance Program (CHIP).

**NCIOM (North Carolina Institute of Medicine)**—An independent, quasi-state agency that convenes task forces of knowledgeable and interested individuals to study complex health issues facing the state to provide balanced, nonpartisan information on issues of relevance to the health of North Carolina’s population.

**Ombudsman Program**—A new program established with managed care implementation to provide education, advocacy and issue resolution for Medicaid beneficiaries accessing fee for service and Medicaid services. Note: This program will be different from the Long-Term Care Ombudsman Program.

**PACE (Program of All-Inclusive Care for the Elderly)**—A federal program that provides a capitated benefit for individuals age 55 and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

**Person-Centered**—A care philosophy that focuses on the needs of the person, including physical, behavioral health, and social determinants and support needs, rather than specific disease-oriented episodes, and is coordinated and tailored to the needs of the individual. Person-centered care is based on accumulated knowledge of the person, which provides the basis for better recognition of health problems and needs over time and facilitates appropriate care for these needs in the context of other needs.

**PCCM (Primary Care Case Management)**—The CMS term for the constellation of services provide by N3CN under the current NCDMA State Plan provision for PCCM. A system under which a primary care case manager contracts with a State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

**PCMH (Patient-Centered Medical Home)**—An existing model of care that emphasizes care coordination and communication to transform primary care. The PCMH model focuses on core attributes and functions of comprehensive care, patient-centeredness, coordinated care, accessible services, quality and safety.

**PCP (Primary Care Provider)**—A provider who is trained to give basic care and is typically seen first for most health problems. The PCP makes sure that the beneficiary gets the care that is needed to keep them healthy, and may coordinate referrals to other doctors and health providers when needed.

**PHP (Prepaid Health Plan)**—Pursuant to Session Law 2015-245, an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of covered services.

**PLE (Provider-Led Entity)**—Defined in Session Law 2015-245 as “[a]n entity that meets all of the following criteria: (1) a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers; (2) a majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists; and (3) holds a PHP license issued by the Department of Insurance.

**RHC (Rural Health Center)**—State-designated and supported community-owned, non-profit centers that provide primary medical services in underserved rural North Carolina communities. Rural Health Centers are not for profit providers that serve their entire community. In addition, some are CMS designated Rural Health Clinics

**RPSC (Regional Provider Support Center)**—Regional, non-profit organizations that will provide support and practice transformation assistance for quality and performance measurement, electronic health record adoption and training, and advanced medical home certification preparation.

**Safety Net**—Not-for-profit agencies that deliver a significant level of health care for low income vulnerable patients that include Medicare, Medicaid, dual eligible, underinsured, and uninsured.

**SBIRT (Screening, Brief Intervention, and Referral to Treatment)**—An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and other substances.

**SP (Standard Plan)** – A Medicaid managed care plan that will provide integrated physical health, behavioral health and pharmacy services to most Medicaid and NC Health Choice beneficiaries.

**SDOH (Social Determinants of Health)**—The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

**Tailored Plan** - A Medicaid managed care plan specifically designed to provide targeted care and limit enrollment to special needs individuals.

**TBI (Traumatic Brain Injury) waiver**—A proposed 1915(c) waiver that would provide home and community based services to individuals with TBI, if approved by CMS.

**Telemedicine**—Use of two-way real-time interactive audio and/or video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine.

**Telepsychiatry**—Use of two-way real-time interactive audio and/or video between places of lesser and greater psychiatric expertise to provide and support psychiatric care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telepsychiatry.

**VBP (Value-based Payment)**—Payment arrangements between providers and prepaid health plans that focus on population health, appropriateness of care, and other measures of value, rather than on volume-based or fee-for-service reimbursement.