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Medicaid Reform

The Goals of Medicaid Reform

- To create an innovative, integrated, well-coordinate system of care;
- To support clinicians throughout the process;
- To promote access to care;
- To promote quality and value and;
- To ensure a successful managed care program.

Medicaid Reform

All Benefits currently provided to Medicaid recipients will be covered under managed care.

All plans must pay current Medicaid fee for service rates that exist today but are encouraged to create value based payment contracts.

There will be one state wide Preferred Drug Plan.

There will centralized credentialing of providers.

There will be standardized quality measures across plans.

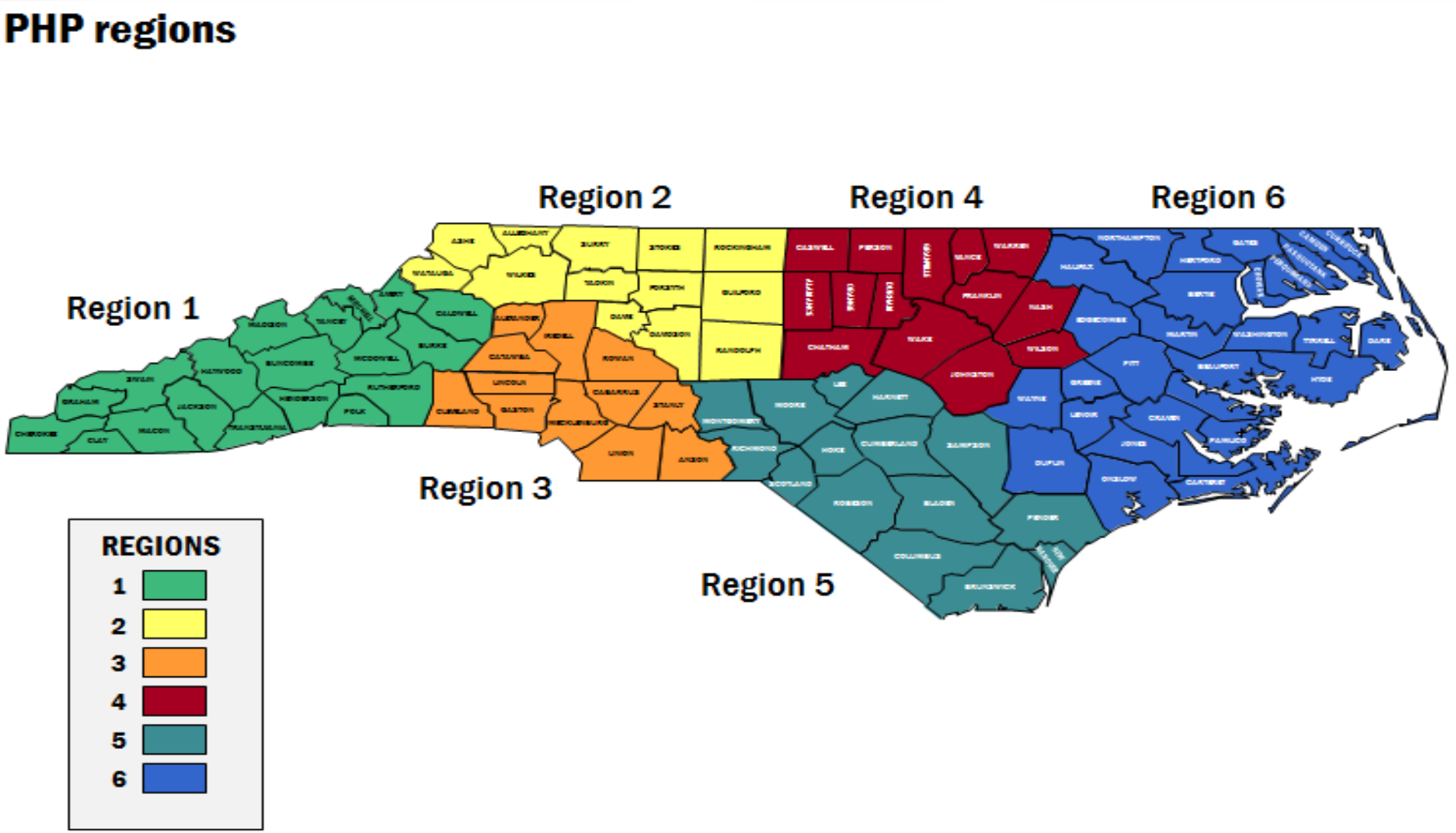
Enrollment Broker contract has been awarded.

Prepaid Health Plans (PHP) – Standard and Tailored

- PHP Standard Plans launch the first year. Two types of PHPs- Commercial Plans (CPs) and Provider Lead Entities (PLEs). There will be 4 Statewide PHPs and possibly as many as 2 PLE's for Durham's region (Region 4). Regional PLEs should have 45-50K beneficiaries (i.e. half the state/3 Regions).

- Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH/IDD TP) launch one year after standard plans. The Tailored Plans will cover individuals diagnosed with severe and persistent mental illness (SPMI e.g. schizophrenia), serious emotional disturbance (SED), intellectual and/or developmental disabilities (I/DD) and traumatic brain injuries (TBI). There will be 5-7 Tailored Plans for 80,000 beneficiaries across the state.

Map of PHP Regions



Anticipated Timeline for Providers

- **Now and ongoing.** Care providers may be contacted by potential PHPs who wish to initiate contract discussions.
- **February 2019.** NC will award contracts to the selected health plans to be PHPs in managed care.
- **Summer 2019.** PHPs must have contracted with enough care providers for their network to meet DHHS standards.
- **July 2019.** PHPs must have all call centers operational and all relevant staff located in North Carolina.
- **July-September 2019.** Managed care will start in two phases. For regions of the state in Phase 1, this will be the window in which beneficiaries select a PHP.
- **November 2019.** The Medicaid managed care program will launch in regions in Phase 1.

  Anticipate Beneficiary enrollment 3 months prior to launch of each Phase
- **October-December 2019.** For regions of the state in Phase 2, this will be the window in which beneficiaries select a PHP.
- **February 2020.** The Medicaid Managed Care will launch in regions in Phase 2.

Overview (Murphy's Law)

- Prepaid Health Plans (PHP's) population represents 75% of all beneficiaries – 1.5 Million.
- PHPs responsible for Medical and Mental Health issues (except those covered under the tailored plans) as well as transportation.
- DSS will be responsible for Transportation for beneficiaries remaining in Fee For Service (25% of all Beneficiaries).
- State will attempt to evenly distribute population among PHPS including utilizing auto-assignment to plan. PHPs can have up to 40% of the market within a region.
- Local DSS responsible for Medicaid Eligibility.
- Local DSS enrollment process will include choice of primary care practice.
- Independent Enrollment agency will facilitate selection of PHPs.

Overview Continued

- Local Health Departments can continue providing OBCM and CC4C if they choose to; for up to two year or more. The reimbursement rate remains the same.
- Dental is carved out – not included in the PHPs.
- Cost settlement goes away for Health Departments and Hospitals.
- Cost Settlement remains for FQHC.

Excluded and Exempt Beneficiaries in Phase 1 and 2 of Medicaid Managed Care

- "Excluded" populations include: Children in Foster Care and Adoptive placement, CAP-DA and CAP-C, Medicaid only beneficiaries in a nursing home for 90 days or more, DUALs, PACE, Medically Needy, Presumptive eligible, Emergency care only, Family Planning and prison inmates. Some of the populations (underline) will phase into PHPs over 5 year period. The only exempt population is the Cherokee Nation.
- **Excluded and Exempt population** Transportation and other Medicaid Eligible services will continue to be provided by the current delivery system.

Beneficiaries in Medicaid Managed Care

- DSS will continue to take, process and determine eligibility. DSS hands off to PHP selection process managed by Enrollment Broker (MAXIMUS).
- MAXIMUS will offer counseling in choosing a PHP and enroll beneficiaries in PHPs. The counselors will be expected to provide resources, education and assistance in the following: Services covered under the Plan, lists of PHPs, Comparison charts, and instructions on how and by what deadline to select PHP, and education about non-emergency medical transportation.
- MAXIMUS will auto enroll individuals who do not choose a PHP.

The Advanced Medical Home Program

- Tier 1 and 2 is every CA I and CA II practice. Tier 1 is phased out within a year (Very few practices remain in CA I).
- Tier 3 is designed to be more advanced practices ready to take on care management responsibilities by itself or through its CIN (Clinically Integrated Network).
- CIN provides Data, risk stratification and care management services if the AMH chooses to use it. A practice in a CIN will be automatically certified as an AMH.

The Advanced Medical Home Program Payment Models

- DHHS will set standardized payments for each Tier that the PHP will be required to adhere.
- Clinical Service Payments – PHPs will be required to comply with minimum rate floors set at the Medicaid fee-for-service levels; practices will be free to negotiate higher amounts or alternative payment models.
- Medical Home Fees – Practices will continue to receive payments equivalent to today's CA payments.
- Care Management Fees – available to Tier 3 practices to be negotiated with PHPs.
- Performance-based payments - In the first 2 years, PHPs will be contractually required to design and offer performance – based payments in Tier 3 only and only upside payments.

Care Management Roles and Responsibilities

- PHPs will be required to complete care screenings and to perform claims analysis and risk scoring to identify enrollees at risk; stratify their population by level of need; perform comprehensive assessments for those identified as part of “priority population”; and ensure that care management tasks place in as local a setting as possible.
- PHPs will be required to submit “local care management plan”.
- Local Health Departments will remain crucial in providing care management for high–risk pregnant enrollees and at risk infants and young children (OBCM and CC4C for a minimum of 2 years).

Roles and Responsibilities continued

- DHHS will ensure accountability by setting clear clinical, quality and administrative priorities and objectives.
- DHHS will standardize certain requirements to ensure consistent care management approach across PHPs.
- DHHS will standardize formulary and PA (Prior Authorization), *although it is unclear if the standardized PA list is only a ceiling and PHPs will be allowed to have fewer PAs than the Department standard.*

Roles and Responsibilities continued

- Local Care Management: Occurs in a hospital or emergency department, a physician's office, a local health department, an enrollee's home, or on other community – based settings where face to face care management is available.

- Designated Care Management Entity – AMH (Advance Medical Home practice), Local Health Department, Other contracted entities capable of performing care management for a designated cohort.

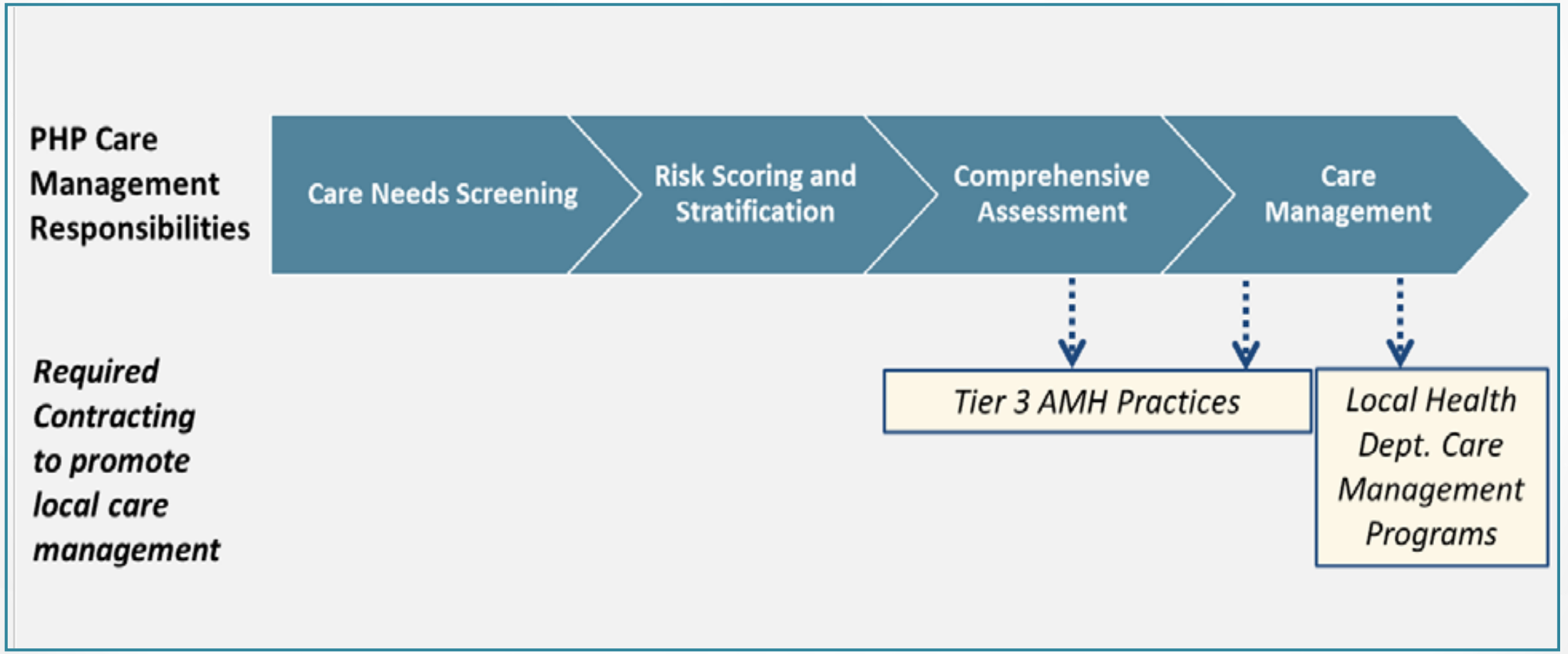
Care Management Strategy under Managed Care

- DHHS will stablish a single, statewide set of standards for practice eligibility for the AMH program and for each Tier. **Current PMPM remains for the first two years – pass through the PHPs**.
- Providers may chose not to participate in the AMH program or may choose to participate in the AMH through a PHP, a network or alone.
- The AMH program offers four tiers of participation, with practice requirement, payment models, and performance incentive payment expectations differing by tier. Tier 4 will be phased in in Year 3 of managed care.

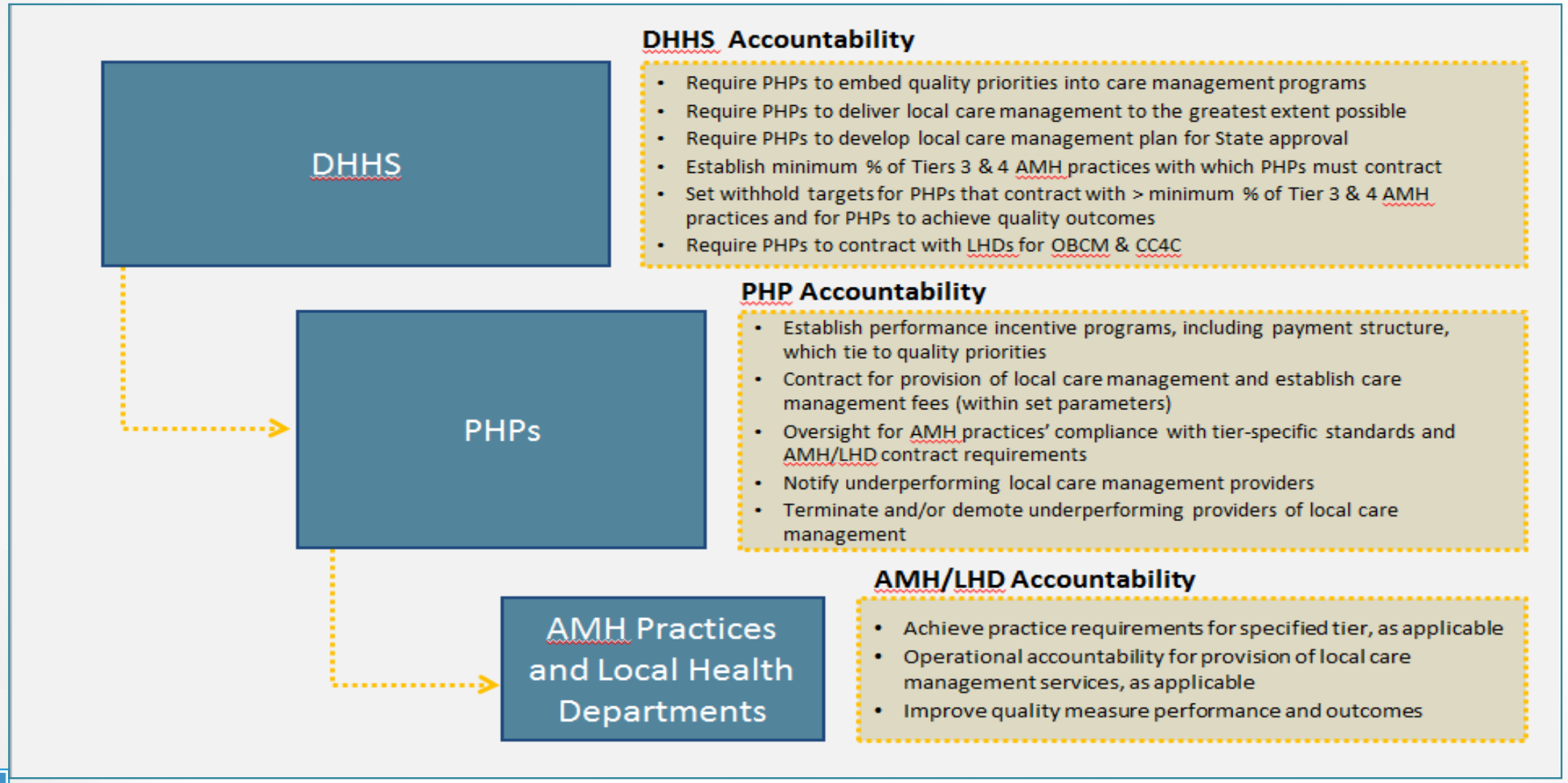
The Advanced Medical Home Program Data Sharing

- PHPs will be required to share the following types of information
  - Assignment/attribution list.
  - Results of PHPs; risk stratification, including cost and utilization outliers
  - Initial enrollee level of care needs screening data.
  - Enrollee level summary of information, including gaps, medication summaries, and pertinent utilization events;
  - Practice level quality measures performance information.
  - For Tier 3 and 4 practices enrollee level claims and encounter data.

PHP Care Management Functions Required to be held at the local level



Structure for Accountability of Care Management



Social Determinants of Health and ACEs – Adverse Children Experiences

- Standardize Screening tool (to occur once a year).
- Resource data base (NCCARE 360). Platform will be open to the public.
- Social Service Integrated platform.
- Geographic information system Hot Spot SDOH.
- Public – Private partnership pilots (Local Pilot Entity – LPE). Two statewide SDOH Private –Public Partnership pilots will be funded; if CMS agrees to finance the pilots with a separate allocation. LPEs have to encompass at least 3 counties.

PHPs will be required to use these screening questions as a part of fulfilling their overall care management.

Social Determinants of Health and ACEs – Adverse Children Experiences

SDOH Four Priority Areas are: Food Security, Housing Stability, Transportation, and Interpersonal Violence.

<u>SDOH questions include:</u>

- 2 from Hunger Vital Sign
- 3 From PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)– related to Housing
- 1 from PRAPARE related to Transportation
- 1 From PRAPARE related to family intimate partner or community violence
- 1 from Pregnancy Medical Home related to interpersonal violence
- 1 from HARK (Humiliation, Afraid, Rape, Kick) tool related to emotional abuse

Social Determinants of Health and ACEs – Adverse Children Experiences

- The SDOH screen will be implemented as part of the “Care NEEDs” Screening Instrument - All enrollees to be screened within 90 days of enrollment.

DHHS Requirements;

- PHPs share results of screens with PCP within 7 days of assignment.
- PHPs will put forth a definition of “High unmet resource needs”; a minimum definition includes: homeless, domestic violence/lack of personal safety, individual screening positive for 3 of 4 core SDOH domains.
- PHPs will incorporate into their risk stratification individuals who score as “high unmet resource need”.
- PHPs must include the four SDOH core domain in their Comprehensive assessment form.
- PHPs as part of their Care Management Platform must have the following:
  - Comprehensive understanding of local resources.
  - In-person assistance in securing health-related.
  - Access to medical-legal partnership for legal issues adversely affecting health.
  - Housing specialist.

Thank You and any Questions

Please email Gharris@dconc.gov, Wrose@dconc.gov and f.johnson@duke.edu

Thank You!

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