Medicaid Transformation Update

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North Carolina’s Vision for Medicaid Transformation

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”
Moving to Managed Care

• 1.6 of 2.2 million Medicaid beneficiaries will enroll in Standard Plans.

• Beneficiaries will be able to choose from 5 Prepaid Health Plans (PHPs), including a Provider-Led Entity – AmeriHealth Caritas, Healthy Blue, United HealthCare, WellCare, Carolina Complete Health (Regions 3, 4, 5)

• Some beneficiaries will stay in fee-for-service because it provides services that meet specific needs or they have limited benefits. This will be called NC Medicaid Direct.
NC Medicaid Managed Care Regions
Current Status – Managed Care Suspended

• Managed Care cannot go-live under a Continuing Resolution Budget. A new budget must include:
  – Authority to pay capitation payments and claims run-out
  – Authority to utilize Transformation dollars
  – PHP tax authorization which is already included in the capitation rates
  – Authority for the appropriate Hospital assessments
Managed Care Progress (as of November 2019)

**Key Milestones Achieved**

- Enrollment Broker contract awarded
- Health Plan contracts awarded
- Managed Care Waiver approved from CMS
- Choice counseling made available to members
- Open Enrollment began
- Enrolled member information sent to PHPs
- Encounters development and testing performed
- Provider information sent to health plans for contracting
- Health plan readiness reviews in progress
- Initial readiness documents sent to CMS
Managed Care Progress (as of November 2019)

Program Progress Summary

- Over **109,000 Medicaid Members selected a PHP** as of November 8
- The formal PHP Readiness Review Process included 111 Medicaid Staff, evaluation of **4,431 readiness criteria**, and **148 individual onsite readiness review sessions**
- 38 provider sessions - webinars, meet and greets, virtual office hours, and webinar training - attended by over **15,000 providers**
- Over **2,400 end-to-end test conditions executed** satisfactorily for Provider and Member Open Enrollment, PHP Auto Enrollment, PCP Auto Assignment, Transition of Care, Capitation Payment, Encounter Processing, and Claims Processing
- **5,682 of 5,911 deliverable documents** received from PHPs reviewed and feedback provided as of mid-November (e.g., annual compliance plans, call scripts, member marketing, value added service materials, and clinical coverage policies)
- 86 training sessions attended by **5,862 DSS county staff**
Suspension activities

• Managed Care Implementation suspended as of 11/20/19
• Open Enrollment cancelled - Notified 1.6 million beneficiaries about the suspension
• Enrollment Broker Call Center remained open through 1/31/20
• Held webinars, all-state calls and other engagement activities with provider and members explaining what was happening and what to expect
• Continue to meet regularly with the health plans to move forward
• Reduced vendor contracts with specialized skillsets
• Engage with counties and other stakeholders to continue to facilitate the transition to managed care, including non-emergency medical transportation, ambulance, behavioral health crisis, health care systems
• Moving forward with managed care related procurements including Member Ombudsman, External Quality Review Organization (EQRO), Healthy Opportunities Pilots
Standard Plan Readiness Assessment

Prior to the suspension, the Department was assessing PHP readiness across 5 key areas. Some of these assessments will continue, while others are slowed or suspended until a later date:

- **CMS Readiness Review:** Assess ability/capacity to operationalize Managed Care
- **Inbound Deliverables:** Review and/or approve contractual deliverables as part of DHHS oversight (e.g., clinical coverage policies, annual compliance plans, etc.)
- **System Testing:** Assess ability to ingest, process and transmit data and information with DHHS and vendors
- **Network Adequacy:** Ensure we have sufficient providers contracted to provide services to Medicaid beneficiaries
- **Technology Operations:** Monitor call center/website issues and technology-related defects/issues (e.g., daily file exchanges, file defects)

**Key Inputs to Go-Live Decision**

- Readiness Review (Desktop and Onsite)
- Inbound Deliverable Review
- Testing (System Interface, End-To-End)
- Network Adequacy
- Technology Operations
Restarting Managed Care Implementation – Highlight of Activities

- Update all stakeholder materials, websites, smart phone apps and technical systems across multiple platforms (Enrollment Broker, health plans, NCTRAKKS)
- Formulate capitation rates and submit to CMS for approval
- Re-review and resubmit to CMS for approval several health plans’ contractual policies and procedures deliverables (annual compliance plans, call scripts, member marketing, value added service materials, and clinical coverage policies)
- Upgrade the Consolidated Provider Directory (NC DHHS, Enrollment Broker, health plans)
- Complete key testing activities to finalize data, analytics, reporting functionality including Transition of Care (NC FAST, Enrollment Broker, NC TRACKS, health plans, LME-MCOs, UM Vendors & CCNC) and Data Warehouse
- Re-review and re-validate Enrollment Broker readiness including call center staff and scripting once rehired
- Re-evaluate internal Division of Health Benefit staff readiness
- Complete provider contracting (health plans and providers)
- Analyze health plan network adequacy to ensure adequate provider networks and processes