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SUMMER 2019 NEWSLETTER

North Carolina is in the midst of a major change in its Medicaid program. The traditional fee-for-service Medicaid and Health Choice programs will transition to Medicaid Managed Care. Under the change, the North Carolina Department of Health and Human Services (DHHS) will retain responsibility for all aspects of these two programs while delegating the direct management of certain health services and financial risks to both statewide and regional prepaid health plans (PHPs). This newsletter outlines key aspects of the program changes to assist your practice in making the transition.

Margie Satinsky

MANAGING THE MEDICAID TRANSITION

The transition to Medicaid Managed Care is in full swing. The launch dates are November 2019 for Regions 2 and 4 and February 2020 for Regions 1,3,5 and 6. (See our **Late Winter 2019 Newsletter** for background information and a calendar of important dates for the transition.) During the past months, providers have had the opportunity to attend multiple educational sessions held across the state. They raised many questions about the new program. For an in-depth look at responses by DHHS, see **www.ncdhhs.gov/Medicaid-transformation**.

In an effort to address some of the most frequently asked questions, we have selected seven important components of the transformation:(1) building networks; (2) provider enrollment; (3) provider credentialing; (4) provider contracting; (5) provider reimbursement; (6) care management; and (7) beneficiary issues. Because the transition to Medicaid Managed Care is a work-in-progress, we encourage readers to continue to check the official website for additional information.

BUILDING NETWORKS

PHPs have already started building their networks. By law, they cannot exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. For example, a provider history of malpractice concerns or fraud, waste, or abuse enforcement actions would disqualify a provider from participation. There are no limits on the number of providers with which each PHP can contract. Small providers that are not part of large healthcare systems or large specialty-specific practices are not at risk of exclusion because of their size and/or independent status.

Even before the selection of statewide and regional PHPs and the approval of the PHP Provider Contract Templates, many PHPs initiated the network-building process by reaching out to providers and

asking them to sign a non-binding Letter of Intent (LOI). Some providers signed the LOI while others preferred to postpone signing until after the selection of PHPs. A decision not to sign a LOI is not grounds for exclusion from a PHPs network.

Providers have no obligation to join every statewide and regional PHP. They should base their decisions about network participation on their unique business needs.

PROVIDER ENROLLMENT

All providers who will be providing billable services to Medicaid beneficiaries must be credentialed and enrolled as a Medicaid provider. The rule applies to providers who provide fee-for-service and/or Medicaid Managed Care. It also applies to mid-level providers who may not have been enrolled and credentialed with the managed care plans prior to the introduction of Medicaid Managed Care.

Speech-Language Pathologists (SLPs), Physical Therapists (PTs), and Occupational Therapists (OTs) who provide care to those Medicaid beneficiaries who are required to enroll in Medicaid Managed Care will need to contract directly with the PHPs to continue receiving reimbursement for their services. In those instances when these professionals provide services in an Individualized Education Program (IEP) in which schools or Local Education Agencies prescribe the services, PHPs will not cover the services.

PROVIDER CREDENTIALING

Credentialing is a central part of the federally regulated screening and enrollment process. All credentialing will be done through the state's centralized credentialing process. A nationally recognized third-party credentialing verification organization (CVO) will verify information. CAQH (Council for Affordable Quality Healthcare), the national database on which many of the managed care plans rely for non-Medicaid plans, will not play a role in Medicaid Managed Care. PHPs are not permitted to delegate any part of the credentialing process, including information collection and the quality determination, to other entities.

Providers who are already enrolled in Medicaid or NC Health Choice do not need to re-enroll. They must, however, update information or documentation at their normal re-validation anniversary in order to maintain their Medicaid provider status. In addition, they must provide the PHPs for which they are network providers with additional information beyond that which is already required for the existing credentialing process. Provision of the additional information will enable the PHPs to meet both PHP and national credentialing standards.

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PROVIDER CONTRACTING

Contracting Process

Each PHP is handling its own contracting with providers who are properly enrolled and whose credentials have been validated. Within each PHP, a Provider Network Participation Committee (PNPC) will make decisions on network participation. PHP network development staff will then secure provider contracts. All contracts between PHPs and providers must comply with the terms of the State Contract. Each week, NDHHS publishes a list of approved contracts. As of June 18, 2019, DHHS had approved 17 contracts.

Community Care Physician Network (CCPN), a statewide network of 2,500 primary care clinicians, already has contracts with four Medicaid Managed Care plans and is in discussions with a fifth plan. CCPN participants do not have to contract directly with the PHPs unless they wish to opt out of the CCPN contract and negotiate their own terms.

Contract Term

Unlike most of the existing managed care contracts, the Medicaid Managed Care contracts will not have evergreen clauses that extend the contract term on an ongoing basis. Under the waiver permitting DHHS to create the Medicaid Managed Care Program, future changes to the program are possible. Also, providers must be re-validated as Medicaid providers every three years.

PROVIDER REIMBURSEMENT

DHHS will establish rate floors for providers in the PHP networks. Each PHP then has the option of negotiating different rates with providers. Over time, DHHS will monitor the PHP/provider contracts to determine the need for rate ceilings.

PHPs will be required to comply with DHHS prompt-pay requirements.

In the event that a PHP is not able to provide necessary services under its contract, it can authorize the provision of out-of-network services.

Out-of-network emergency or post-stabilization services will be reimbursed at a level no higher than Medicaid fee-for-service rates.

CARE MANAGEMENT

A key component of Medicaid Managed Care is care management. PHPs will assume responsibility for care management, dividing the task into four components: (1) care needs screening; (2) risk scoring and stratification; (3) comprehensive assessment; and (4) care management for high-need enrollees. Under comprehensive assessment, PHPs may delegate primary responsibility to practices that certify into

Advanced Medical Home (AMH) tiers. Detailed information on AMH tiers and the way in which it relates to the current Carolina Access program is provided in the **DHHS Medicaid Managed Care Proposed Concept Paper, North Carolina's Care Management Strategy under Managed Care (March 9, 2018)**.

BENEFICIARY ISSUES

Medicaid Managed Care vs. Medicaid Fee-for-Service

Medicaid Managed Care will be mandatory for most but not all Medicaid beneficiaries. DHHS has divided the Medicaid population into three categories:

- *Required to Enroll in Medicaid Managed Care:* most Family & children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, and Disabled
- *Stays in Medicaid Direct:* Family Planning Program, Medically Needy, Health Insurance Premium Payment (HIPP), Program of All-Inclusive Care for the Elderly (PACE), and Refugee Medicaid
- *Option of Enrolling in Medicaid Managed Care or Remaining in Medicaid Direct:* Federally recognized members, beneficiaries who would be eligible for behavioral health tailored plans when they become available in mid-2021

Each Medicaid beneficiary will receive a personalized communication from DHHS that explains the new Medicaid program. The communication will specify the category into which the beneficiary falls and provide appropriate instructions for selecting a Primary Care Provider (PCP), choosing a PHP, and enrolling. Medicaid beneficiaries for whom participation in Medicaid Managed Care is mandatory will not be "grandfathered" into the new program. Beneficiaries can learn more by calling (833) 870-5500 or by accessing the website when it is up and running. They can also download the NC Medicaid Managed Care mobile app.

PHP Selection

Each beneficiary who is required to participate in Medicaid Managed Care or has the option to do so will start by selecting a PCP. If the beneficiary does not make a selection, he/she will be assigned to a PHP through an auto-assignment process. Once a beneficiary has selected or been assigned to a PHP, he/she may only receive services from providers in the chosen PHP. If the chosen PHP is unable to provide necessary services within its network, it will coordinate with out-of-network (OON) providers to deliver medical care and treatment.

Changing PHPs

Regardless of whether or not a beneficiary selects a PHP or is assigned to one, he/she will have a 90-day grace period following effective PHP coverage date to change PHPs without cause. At the time of annual renewal, this same grace period will apply. After the completion of the 90-day period, a

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beneficiary may request a change in PHP by demonstrating cause (e.g. moving out of a PHP service area or complex medical condition better served by a different PHP).

WHAT'S NEXT?

DHHS continues to provide resources through webinars and information posted on its website. Likewise, organizations like Community Care Physician Network (CCPN) will continue to provide information on its role in Medicaid Managed Care. Keep checking, as will we!

More Information About Medical Practice Management

For more information on medical practice management, contact us at **Margie@satinskyconsulting.com** or **919.383.5998** or visit our website at **www.satinskyconsulting.com**.

We provide services to start-up and established medical practices. These previous newsletters provide insight into just a few of the many issues with which we can assist.

- **Staying Afloat in Your Own Medical Practice**
- **Important Changes in NC Medicaid Program**
- **Medical Practice Start-up – Tips for Success**
- **Practice Start-up – 7 Tips for Seeking Bank Financing**
- **Antidiscrimination Laws – Patient and Workforce Protection**
- **HIPAA Audits in 2016 – What You Need to Know**
- **Direct Pay Primary Care – Is It Right for You?**
- **HIPAA Access to PHI – Are You in Compliance?**
- **Your EHR Experience – SOS or Smooth Sailing?**
- **Concierge Medicine: Is It Right for You? For Your Patients?**
- **On Your Own or Part of a Larger Healthcare System?**
- **Preparing for Space and Payer Contracts**
- **Tips for Managing Risk in Your Medical Practice**
- **Five Focus Areas for a Prosperous Practice**

Satinsky Consulting, LLC
201 Cedar Ridge Way
Durham, NC 27705-1981
919.383.5998
Fax 919.309.0109
www.satinskyconsulting.com