STATE OF NORTH CAROLINA **Department of Health and Human Services** **Division of Health Benefits**	**REQUEST FOR INFORMATION NO.** 30-DHB-110217-18-O – Managed Care Program Operations **Due Dates/Times:** 1. Reponses to Section III, Questions for Respondents, due November 22, 2017 at 2:00 PM ET 2. Reponses to Appendix A, Non-Binding Statement of Interest, due December 1, 2017 at 2:00 PM ET
Refer <u>ALL</u> Inquiries to: Ken Dahlin, Contract Specialist Telephone No. 919-855-4054 Fax No.: 919-733-5957	**Issue Date:** November 2, 2017 **Commodity:** 948-07 – Health Administration Services
E-Mail: ken.dahlin@dhhs.nc.gov	**Using Agency Name:** NC Department of Health and Human Services, Division of Health Benefits (DHB)

This Managed Care Program Operations Request for Information (RFI) is available electronically on the NC Interactive Purchasing System (IPS) at https://www.ips.state.nc.us/ips/.

The purpose of this RFI is to survey the market for information requested herein and not to award a contract. Submission of a response does not create an offer, and no award will result by submitting a response. The State recognizes that considerable effort may be required in preparing a response to this RFI. However, the Respondent shall bear all costs for preparing and submitting a response. Information obtained through this RFI process may be used to develop a future solicitation, such as a Request for Proposal (RFP).

Responses to Section III of this RFI will be received until **2:00 PM ET, November 22, 2017**. Statements of Interest outlined in Appendix A should be submitted by **2:00 PM ET, December 1, 2017.**

EXECUTION

RESPONDENT NAME:	E-MAIL:	
STREET ADDRESS:	P.O. BOX:	ZIP:
CITY & STATE & ZIP:	TELEPHONE NUMBER:	TOLL FREE TEL. NO:
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING:	FAX NUMBER:	
AUTHORIZED SIGNATURE:	DATE:	

TO SUBMIT A RESPONSE: It is the responsibility of the Respondent to have the RFI in this office by the specified date and time of opening. Address the envelope and clearly note the RFI number as shown below.

DELIVERED BY US POSTAL SERVICE	**DELIVERED BY ANY OTHER MEANS**
RFI NO. 30-DHB-110217-18-O NC Department of Health and Human Services Office of Procurement, Contracts, and Grants Attn: Ken Dahlin Hoey Building, Dorothea Dix Campus 2008 Mail Service Center Raleigh, NC 27699-2008	**RFI NO.** 30-DHB-110217-18-O NC Department of Health and Human Services Office of Procurement, Contracts, and Grants Attn: Ken Dahlin Hoey Building, Dorothea Dix Campus 801 Ruggles Drive Raleigh, NC 27603

Section I: Response Content and Instructions

A. Please review all Sections of this RFI. Due to various deadlines, the Department will not have the opportunity to respond to questions about this RFI prior to the Due Dates**.** When responding, include the RFI's question numbers, subsections, and other identifiers to allow the Department to clearly understand the specific items being addressed. While the Department encourages Respondents to respond to all questions and items within this RFI, there is no obligation to do so. The Department reserves the right to contact any respondent and request additional information. Therefore, include the contact information for the individual(s) best suited to engage with the Department.

B. Instructions for responding to Section III: Questions for Respondents

1. When submitting a response, include pages 1-15 of the RFI, with the EXECUTION SECTION on Page 1 completed and signed.

2. Number of Copies

   The following copies are required to be provided to the Department as part of responses to Section III of this RFI:

   a) One (1) signed, original executed response;
   b) One (1) copy of the signed, original executed response;
   c) One (1) electronic copy of the signed, original executed response on CD, DVD, or flash drive marked ***RFI 30-DHB-110217-18-O***, and
   d) One (1) electronic copy of the signed, original executed response redacted in accordance with Chapter 132 of the North Carolina General Statutes (NCGS), the Public Records Act, on a separate CD, DVD, or flash drive marked ***RFI 30-DHB-110217-18-O – Redacted.*** For the purposes of this RFI, redaction means to edit a document by obscuring or removing information that is considered confidential and proprietary by the Respondent and meets the definition of Confidential Information set forth in NCGS §132-1.2**.** If the response does not contain Confidential Information, Respondent should submit a signed statement to that effect on ***RFI 30-DHB-110217-18-O – Redacted***.

   The electronic copies of the response must not be password protected.

C. Instructions for submitting a Non-Binding Statement of Interest as provided in Appendix A

1. To assist with continued planning for the implementation of Medicaid managed care in North Carolina, the Department requires that Respondents who are potential PHPs return a completed non-binding Statement of Interest (SOI) as found in Appendix A.

2. When submitting a statement, Respondents should redraft the content from Appendix A into their Statement and respond to each question contained therein as applicable and include the EXECUTION SECTION on Page 1 completed and signed.

3. Number of Copies

   The following copies are required to be provided to the Department as part of your response to Appendix A, Statement of Interest:

   a) One (1) signed, original executed statement;
   b) One (1) copy of the signed, original executed statement;

c) One (1) electronic copy of the signed, original executed statement on CD, DVD, or flash drive marked ***SOI* 30-DHB-110217-18-O**, and

d) One (1) electronic copy of the signed, original executed statement _redacted_ in accordance with Chapter 132 of the North Carolina General Statutes (NCGS), the Public Records Act, on a separate CD, DVD, or flash drive marked ***SOI* 30-DHB-110217-18-O – Redacted**. If the statement does not contain Confidential Information, Respondent should submit a signed statement to that effect on ***SOI* 30-DHB-110217-18-O – Redacted**.

The electronic copies of the Statement of Interest must not be password protected.

D. Confidentiality

1. As provided for in the North Carolina Administrative code (NCAC), including but not limited to 01 NCAC 05B .0210, 09 NCAC 06B .0103 and 09 NCAC 06B .0302, all information and documentation relative to the development of a contractual document for a proposed procurement or contract shall be deemed confidential in nature, except as deemed necessary to develop a complete contractual document. In accordance with these and other applicable rules and statutes, such material shall remain confidential until the award of a contract or until the need for the procurement no longer exists. Any proprietary or confidential information, which conforms to exclusions from public records as provided by North Carolina General Statutes Chapter 132, **must be clearly marked as such and reflected in the redacted copy submitted on *RFI 30-DHB-110217-18-O – Redacted* or *SOI 30-DHB-110217-18-O – Redacted*, as applicable.** By submitting a redacted copy, the Respondent warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors that the portions marked confidential meet the requirements of Chapter 132 of the North Carolina General Statutes. The Respondent must identify the legal grounds for asserting that the information is confidential, including the citation to state law.

2. Except as provided in Section I.D.1 of this RFI, pursuant to NCGS. §132-1, et seq., information or documents provided to the Department in response to this RFI are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute, including, but not limited to, NCGS §132-1.2. Redacted copies provided by Respondents to the Department may be released in response to public record requests without notification to the Respondent.

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Section II. Introduction

A. Purpose

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 the NC Department of Health and Human Services (DHHS) prepares to transition to Medicaid managed care, it will work with stakeholders and experts to refine program design and implementation approach.

The purpose of the Managed Care Program Operations RFI is for DHHS to solicit feedback from potential Medicaid managed care plans and other interested stakeholders on options and considerations related to Medicaid managed care design and implementation.

B. Background

DHHS's 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's 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.

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.

1. Overview of Types of Managed Care Plans

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 will offer products statewide.
- **Provider-Led Entities.** Provider-led entities (PLEs) will offer up to twelve regional contracts in six regions. PLEs must cover a region in its entirety, and may bid for more than one region, provided the regions are contiguous.

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. 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.

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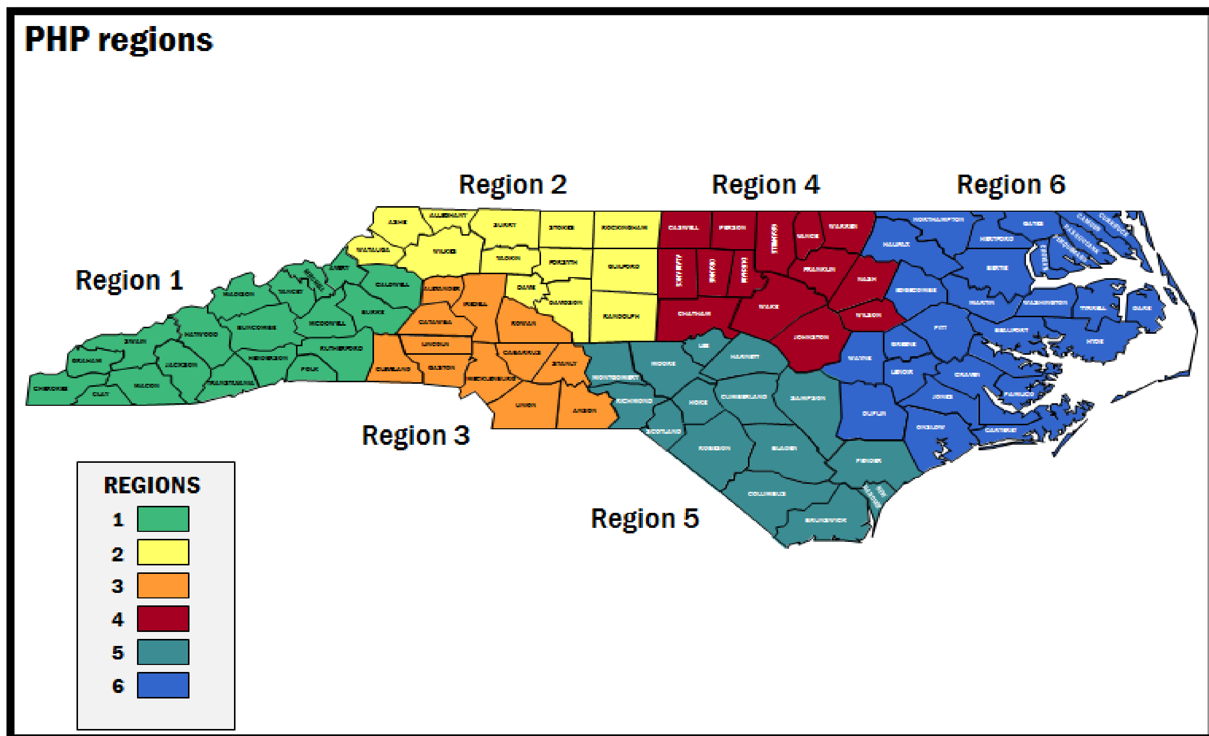
2. Regions

DHHS has defined six total regions within the state, as depicted in the figure below. Table 1 outlines the counties included in each of the six proposed PHP regions. Figure 1 illustrates the PHP regions in map format.

Table 1: List of Counties by PHP Regions

PHP Regions	Counties
Region 1	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Region 2	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
Region 3	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
Region 4	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
Region 5	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
Region 6	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

Figure 1: **Map of PHP Regions.**



3. Implementation of PHPs

Both regional PLEs and statewide Commercial Plans must be licensed by the North Carolina Department of Insurance (NCDOI) and will be subject to NCDOI's solvency standards and financial oversight. Both types of plans 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.

4. Provider-led Entities as PHPs

Because only PLEs may compete at the regional level, it is important to ensure that they are affiliated or governed by providers. Thus, consistent with statute, 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 may require the following of Commercial Plans and PLEs:

- **Anti-exclusivity provisions**: DHHS may prohibit exclusivity provisions in contracts between PHPs and providers and may 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 rules will be in addition to applicable antitrust laws enforced by federal authorities, which prohibit entities from abusing their market power by engaging in anti-competitive conduct.

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5. Amendment from Session Law 2016-121

Section 2.(b) of Session Law 2016-121 amended Section 4.(2)b. of Session Law 2015-245 to read as follows:

(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this section. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:

a. Commercial plan or CP. – 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 Department of Insurance.

b. Provider-led entity or PLE. – An 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 capitated contracts described in subdivision (3) of this section ***or*** *Medicaid and NC Health Choice providers.*

2. A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program.

3. Holds a PHP license issued by the Department of Insurance.

DHHS has received questions from interested parties seeking its interpretation of the language added in Session Law 2016-121 and the operation of the highlighted "or" in Section 4.(2)b.1. DHHS reads this provision to designate two valid options for the structure of a PLE, i.e., 1) a PLE may have as its primary business purpose the ownership or operation of one or more capitated contracts **OR** 2) a PLE may have can have as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers. Of course, the provisions of sub-subsections 2. and 3. also would apply to all PLE entities. DHHS intends to use the RFP process to require submission of a demonstration from all PLE respondents that the PLE has a significant level of involvement of North Carolina providers in leading and making decisions for the entity.

6. Standard Plans and Tailored Plans

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

- **Standard Plans** are proposed to 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** are proposed to be specifically designed to serve special populations with unique health care needs. 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 Serious Mental Illness, 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.

7. Populations in Managed Care

Most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs, although not simultaneously. There may 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. All excluded populations will receive health benefits outside of PHPs.

Pursuant to Session Law 2015-245 as amended by Session Law 2016-211, excluded populations include but are not limited to beneficiaries dually eligible for Medicaid and Medicare, PACE beneficiaries, and medically needy beneficiaries. Exempt populations include members of federally recognized tribes.

8. 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. DHHS will work with the General Assembly on this proposed phase-in. During the transition period, to avoid care disruption, special populations will continue to have access to their existing provider networks.

9. Additional Background

Additional background and detail about the proposed program design may be obtained from North Carolina's Proposed Program Design for Medicaid Managed Care paper which is linked in the footnote below. The paper includes additional details about the proposed program design, including details around excluded and exempted populations, delaying mandatory enrollment for special populations, and Standard and Tailored Plans.

10. Attached Reference Materials

- **Appendix A** – Required Non-Binding Statement of Interest (for PHP Respondents Only).

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Section III. Questions for Respondents

A. Benefits

DHHS may require PHPs to use existing Medicaid fee-for-service clinical coverage policies (i.e. criteria under which a service is covered, prior authorization requirements, utilization management, etc.) for a limited number of services. Refer to DHHS's website for a full list of existing Medicaid fee-for-service clinical coverage policies[1].

Considering the existing Medicaid fee-for-service clinical coverage policies, please provide response to the following:

1. For which services, or categories of services, should PHPs be permitted to develop their own clinical policies? For which services, or categories of services, should PHPs be required to follow existing DHHS clinical policies? Describe the operational, financial, or clinical benefits and issues that allowing PHPs to create their own clinical policies would present.

B. Pharmacy

In addition to the statutorily required use of a single formulary and setting a pharmacy dispensing fee floor, DHHS may develop pharmacy reimbursement requirements and pharmacy clinical coverage policies for managed care companies that mirror Medicaid fee-for-service.

1. Based on experience in other state's or populations, please provide input on the operational and fiscal considerations related to DHHS prescribing these key components of the pharmacy program.

C. Enrollment into PHPs

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 Primary Care Physician (PCP) selection process – is critical for Medicaid and NC Health Choice applicants and their families. DHHS's goal is to reduce the administrative burden of enrolling into a PHP, provide beneficiaries with the tools and resources to make a well-informed choice, and particularly to ensure beneficiaries have up-to-date and accurate information about PHPs' provider networks. As managed care launches, DHHS may contract with an enrollment broker to provide educational materials and support beneficiary enrollment into PHPs.

1. How can DHHS and the enrollment broker help beneficiaries understand and make educated choices when selecting a PHP that will meet their needs (e.g., publish PHP clinical performance data, provider network, etc.)?
2. What special considerations should DHHS be aware of with respect to supporting PHP enrollment for:
   a) Medicaid beneficiaries with qualifying behavioral health and intellectual/developmental disabilities diagnoses who are eligible for the Behavioral Health I/DD Tailored Plans;
   b) Foster care children;
   c) Newborns
   d) Members of federally recognized tribes (for those who elect to enroll in a PHP);
   e) Individuals accessing State Plan LTSS (excludes CAP/DA and CAP/C and long term Skilled Nursing Facility services over 90 days) services?

[1] https://dma.ncdhhs.gov/providers/clinical-coverage-policies

D. PHP Care Management and Advanced Medical Homes (AMHs)

A core responsibility of PHPs will be care management. PHPs may be expected to delegate certain care management functions to Advanced Medical Homes (AMHs) that would, in turn, provide enhanced services to enrollees beyond direct medical services and could receive additional payments for these services. DHHS seeks input on how to ensure coordination and continuity between the PHPs and AMHs so that care management is seamlessly provided and roles and responsibilities are clearly delineated.

1. What support would providers need from the community, DHHS or the PHPs to develop needed capacity to meet the requirements of the AMHs models?
2. Describe any operational or financial considerations needed for successful implementation and support of care management through AMHs related to geographic area, participant populations, or provider types in North Carolina.
3. What data strategies should DHHS consider to ensure the right data and information flow between entities (e.g., providers, PHPs, DHHS) at the right cadence and with the right ownership and accountability for both the various components of IT infrastructure facilitating these data exchanges and the various processes of submitting timely, accurate data between entities. What data model(s), data sharing, standardized data sets, or data portals would best support a seamless model of care management and coordination between PHPs and AMHs?
4. What is the appropriate ratio of patient panel size to number of care managers? How should that change based upon clinical burden or patient population mix?
5. What issues or strategies should DHHS consider to ensure PHPs establish a supportive care management infrastructure for special populations such as individuals with mild to moderate mental health issues or individuals receiving LTSS services?
6. How can PHPs ensure beneficiaries understand who their primary, care management point of contact is and how to effectively use the care management benefit? What role would AMHs play in addressing the same issues?

E. Access to Providers in Rural and Underserved Areas

DHHS is committed to building health care capacity in rural and underserved areas. DHHS has published a list of provider types that are proposed to be subject to the specialist network adequacy standard (based on time and distance from providers and appointment wait times).[2]

1. How can DHHS build a program that ensures access to quality care in (a) rural and (b) underserved areas? Are there special considerations which DHHS should weigh for particular beneficiary populations?
2. What specific strategies are necessary to ensure sufficient access to behavioral health, I/DD, OB, and LTSS services in rural areas?

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[2] https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf

F. Workforce, Provider Supports and Telehealth

DHHS is invested in ensuring we have an adequate and well-trained workforce. To further support providers, DHHS may use Regional Provider Support Centers (RPSC) to provide data and training to practices. DHHS would continue to partner with providers to work toward easing administrative barriers during and through the transition to managed care.

1. How should PHPs contribute towards regional and statewide workforce development?
2. What are the top three supports that providers will need to better transition into managed care? (Please specify provider type when describing needs.)
3. What types of data and training are most important to practitioners or clinics participating in a Managed Care program?

North Carolina's Medicaid program has covered telemedicine as a benefit for almost 20 years, and the continuation of coverage under managed care can play a crucial role in increasing beneficiary access to care, improving outcomes, and decreasing costs.

4. What have been unique obstacles or barriers to adopting telehealth statewide? What are issues, best practices and lessons learned which DHHS should consider when implementing and administering telehealth, telemedicine and telemonitoring in NC?
5. How may DHHS and PHPs encourage use of telemedicine, telehealth, and telemonitoring to reach managed care goals?

G. Social Determinants of Health (SDOH)

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, such as healthy food, safe housing, reliable transportation, employment supports, and community supports[3]. In North Carolina, 15.9% of households are food insecure -- one of the highest percentages in the U.S.[4] 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.[5] More than 1.2 million North Carolinians, in rural and urban communities alike, cannot find affordable housing.[6] 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.[7]

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[3] 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. 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.

[4] USDA Economic Research Service, "Food Security Status of U.S. Households in 2015."

[5] http://ncfoodbanks.org/hunger-in-north-carolina/

[6] Robert Wood Johnson, County Health Rankings, http://www.countyhealthrankings.org/app/north-carolina/2017/overview

[7] 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.

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.

1. How can health plans use flexibility with “in lieu of services”[8] to address members’ social determinants of health? What impact can the use of “in lieu of” services have on cost savings and/or members’ health outcomes?
2. In what ways can plans partner with alternative provider types (like community health workers) or community-based organizations to address members’ social determinants of health? What impact can this have on cost savings and/or members’ health outcomes?
3. DHHS seeks information on what SDOH pilots DHHS should consider implementing through managed care while considering the clinical impact on beneficiaries and potential return on investment or fiscal impact of a regional or statewide program?

H. PHP and Provider Contracting and Payment

Contracting. In addition to the three state-wide commercial plans offered under state law, the law indicates that up to twelve qualifying provider-led entities (PLEs) may be offered. To protect against anticompetitive behavior, DHHS may prohibit exclusivity provisions in contracts between PHPs and providers and require that providers that partially own or control a PHP to negotiate with rival PHPs in “good faith”.

1. Generally, how should DHHS define “good faith” related to contracting negotiations between PHPs and providers?
2. How can DHHS ensure that providers who partially own or control a PHP negotiate acceptable contract rates or terms in “good faith” with PHP “competitors”?
3. How can DHHS ensure that provider-led PLEs, acting as payors, negotiate acceptable contract rates or terms in “good faith” with providers or practitioners who may be “competitors” of the providers leading the PLE?

I. Medical Loss Ratio

The Medical Loss Ratio measures the proportion of premium revenue that a PHP spends on clinical services and quality improvement. From a policy perspective, 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 is permitted to establish a minimum MLR above the federal minimum of 85% and plans to require a rebate if PHPs report an MLR less than the minimum MLR.

1. In addition to the potential federal and state requirements, what factors should DHHS consider when establishing a minimum MLR?
2. What other standards (such as a rolling measurement) should DHHS consider when setting the MLR reporting requirements?

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[8] 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.

J. Information Technology and Data Exchange

DHHS seeks input on how best to share data across all of the entities participating in the Managed Care program, including: DHHS, PHPs, AMHs, Enrollment Brokers, Tailored Plan behavioral health & I/DD care management providers, and other providers and vendors.

1. What type of shared or interoperable infrastructure should be established for sharing data?
2. In support of PHPs' care management and coordination activities, what health IT and HIE capabilities (e.g., event-notification services, longitudinal clinical records, care management systems, data analytics) are most valuable?
3. Which data types (e.g., beneficiary demographic data, notifications, laboratory values, medication information, utilization history, cost, social determinants) should be prioritized and made available in an automated, readily accessible format in the near term (i.e., Year 1 and 2) vs. the longer term (i.e., Year 3 and 4) for AMHs or other network providers?
4. DHHS seeks input on the most pressing IT and health information exchange needs for success in emerging value-based purchasing arrangements. For example, such needs might include automatic event-notification via hospital ADT data, access to beneficiary medication histories, or access to beneficiary utilization and cost data.

DHHS currently utilizes an Enterprise Service Bus (ESB) for our service-oriented, message-oriented, and event-driven data sharing to provide a standards-based messaging infrastructure. The ESB employs the National Information Exchange Model (NIEM) that enables information exchange across DHHS public and private partners.

5. What data sharing standards should be considered?

DHHS seeks to modernize and simplify the citizen portal access to support application and renewal for Medicaid and NC Health Choice eligibility to find out if they may be eligible for programs and to take the steps to start receiving services. DHHS may partner with an enrollment broker to handle enrollment of managed care eligible beneficiaries in PHPs with the goal to make enrollment in PHPs quick and easy for beneficiaries. DHHS wishes to improve the gateway to all online program applications and access to eligibility and enrollment case information through a secure portal access to the existing eligibility and enrollment integrated case management system, North Carolina Families Accessing Services Technology (NC FAST), and provide multiple channels to access services.

6. Citizen Portal:
   a) What web-based technologies offers are available to provide seamless access to Medicaid application and renewal processes?
   b) What self-services tools are available to serve a mobile-first population and provide availability day or night, on any device?
   c) What standardizations would be recommended to provide improved citizen experience?
   d) What languages should be supported?
   e) What online help capabilities are available (LiveChat, multilingual documentation, etc.)?
7. Enrollment Broker:
   a) Describe the expected process, timeline and operational considerations for an enrollment broker to integrate plan selection and choice counseling services with an existing eligibility and enrollment integrated case management system, like NC FAST, a streamlined citizen portal, and the PHPs.
   b) What dependencies should DHHS address to support the enrollment broker services and or technology solution(s)?

K. PHP Licensure

Session Law 2015-245 provides that Commercial Plans and PLEs must hold a PHP license issued by NCDOI in order to contract with DHHS to provide Medicaid managed care. Currently pending House Bill 156[9] contains the PHP licensure proposal. DHHS will continue to work with NCDOI, 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 Health Maintenance Organizations (HMOs). DHHS and NCDOI are proposing both a stand-alone PHP licensure process and a streamlined approach for entities that are already a NCDOI licensed health organization, to limit duplication. In the absence of the adoption of specific PHP licensure legislation, DHHS encourages unlicensed entities who wish to become PHPs to begin to pursue HMO licensure through NCDOI as a glide path to PHP licensure.

1. What barriers do you anticipate with this policy?

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[9] http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2017&BillID=h156&submitButton=Go

Appendix A, Managed Care Program Operations RFI

North Carolina's Medicaid Managed Care Non-Binding Statement of Interest for Potential PHP Respondents Only

RESPONSE TO THIS DOCUMENT IS REQUIRED FOR RESPONDENTS WHO ARE POTENTIAL PHPs

Please provide answers to the following questions to indicate your non-binding interest to participate in North Carolina's Medicaid Managed Care as a Prepaid Health Plan.

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1. Provide the full and legal name of the potential PHP.
2. Are you interested in becoming a PHP in North Carolina's Medicaid Managed Care?
    a. If so, please describe your interest in becoming a PHP, including your interest in becoming a Commercial Plan or a Provider-led Entity (PLE).
    b. If not, you may skip questions #2 through 4.
3. If you are intending to be a PLE PHP, please identify the region(s)[10] in North Carolina you would be interested in serving.
4. Is the entity named in #1 a currently authorized insurer under Chapter 58 of the NC General Statutes? If so, please identify what type of license is currently held – HMO, Hospital/Medical Service Corporation, or Other (please specify).
5. Please describe the population(s) your PHP would serve, i.e. Standard Plan, Tailored Plan, or both.

I understand the purpose of the Request for Information (RFI) and this Statement of Interest is to survey the market for information described therein and not to award a contract. Information obtained through the RFI and Non-Binding Statement of Interest processes may be used to develop a Request for Proposal (RFP).

____

<Authorized Signature>

____

<Typed Name of Signee>

____

<Title>

____

<Company>

____

<Date Signed>

[10] Refer to Section II.B.2. of the Managed Care RFI for a description of the regions.