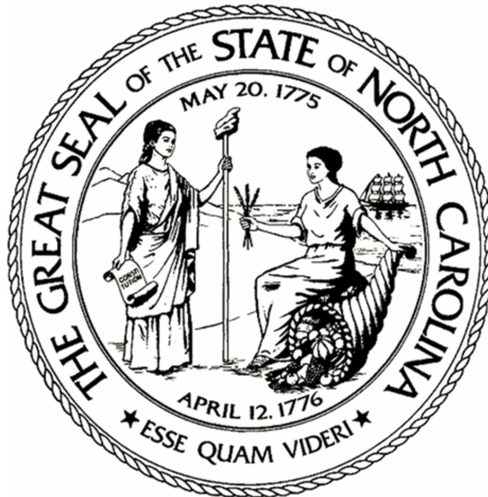
Evaluation of NC Department of Health and Human Services' Functional and Staffing Needs Under Medicaid Transformation

Session Law 2021-180, Section 9D.18(a)



Report to

The Joint Legislative Committee on
Medicaid and NC Health Choice

and

The Fiscal Research Division

By

North Carolina Department of Health and Human Services

June 8, 2022

Table of Contents

Introduction and Context 3

Executive Summary 4

Overview of Managed Care Transition and Impact on DHHS and DHB 6

Medicaid Transformation Aims, Program Design, and Implementation Timeline 6

Impact on DHB's Role and Staffing Needs 9

1. Program Leadership 9
2. Operational Oversight 9
3. Maintenance of Legacy Functions 10

Interactions with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services 10

Requirements for DHHS in Managing Successful Transformation 12

Overview of Comprehensive Organizational Design Effort 12

Operating Oversight Model and Staffing Requirements for DHHS During Medicaid Transformation 12

1. Federal and State Partner Engagement 13
2. Member Eligibility, Enrollment, and Support Services 14
3. Plan Management 15
4. Provider Management 16
5. Finance 17
6. Claims Payment and Utilization Reporting 17
7. Population Health: Care Management, Clinical Policies, Quality/Compliance, and Value-Based Purchasing 18
8. Program Support Functions 21

Conclusion 23

INTRODUCTION AND CONTEXT

This report is in response to Session Law 2021-180 Section 9D.18.(a) that requires the North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) to conduct a two-part evaluation of administrative functions and staffing needs for the Medicaid and NC Health Choice programs and how staffing needs and administrative functions will change as the Medicaid and NC Health Choice programs move further into a managed care service delivery environment.

Section 9D.18.(b) requires the Division of Health Benefits (DHB) to report to the Joint Oversight Committee on Medicaid and NC Health Choice (JOCM) and the Fiscal Research Division (FRD) on the evaluation required by Section 9D.18.(a) as it pertains to the implementation of capitated contracts for standard benefit plans for prepaid health plans (PHPs). In 2024, DHHS will prepare and deliver a follow-on report to further update JOCM and FRD on administrative and staffing changes under Medicaid transformation, including impacts from the implementation of tailored plans, which will begin later this year.

EXECUTIVE SUMMARY

North Carolina's Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) is in the midst of the most significant transformation of the North Carolina Medicaid program in 50 years, which will result in a fundamental shift in how Medicaid services are delivered to North Carolinians. To implement this shift, DHB is undergoing its own transformation, ensuring that it has the organizational and operating capacity necessary to manage the transition and to support the new oversight and regulatory responsibilities under a managed care model.

DHB is grounded in its mission 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."** DHB, has worked tirelessly to design the new program, which launched in part on July 1, 2021, with the Standard Plans, and will continue to implement new products and programs across the next three years, including Tailored Plans for individuals with significant behavioral health needs and intellectual/developmental disabilities (I/DDs), a proposed Children and Families Specialty Plan for children and youth currently or formerly served by the child welfare system, and an approach for individuals dually eligible for Medicaid and Medicare. DHB anticipates continued changes to its staffing and administrative needs to balance the continued responsibilities as the Single State Agency accountable for the Medicaid program with the complexity of transitioning NC Medicaid populations to new managed care programs.

Fundamentally, Medicaid Transformation creates a more complex operating and contracting model for DHB to manage and oversee, requiring procurement and oversight of several vendors that will administer aspects of the program under the managed care model, while maintaining continued operation of the fee-for-service (FFS) program (Medicaid Direct) for some populations. Transformation will require a shift across almost every function of the program to a focus that is more strategic and centered on contractual oversight and regulatory monitoring; resolving beneficiary and provider issues; identifying financial, clinical and programmatic risks; and ensuring accountability of entities to which operational responsibilities have been delegated. And lastly, while the contracted health plans will take on many of the day-to-day operational functions of ensuring delivery of Medicaid services to beneficiaries enrolled in managed care, DHB must retain much of its existing legacy structures, processes, and capabilities to support beneficiaries who remain in the FFS delivery system even though volumes are reduced.

The move to managed care has resulted in a decrease or reduction in the need for some services which DHB performed itself or contracted for (e.g., claim payment for physical health fee-for-service services) as the health plans are delegated that function for a portion of NC Medicaid's beneficiaries. In many cases, DHB re-trained or transitioned staff from those legacy roles to ones which support the new managed care model. For example, a core function of NC Medicaid is our Program Integrity (PI) unit which monitors provider enrollment and claim payment for potential fraud, waste or abuse. In the managed care program, the health plans are expected to manage a Special Investigation Unit (SIU) which similarly monitors health plan claim payment. DHB trained PI staff to understand the SIU programs, develop and monitor monthly or quarterly health plan reports for compliance, share best practices across health plans, in addition to continuing their responsibilities to coordinate with the NC Department of Justice (NCDOJ). There are other examples where DHB did not "backfill" staff who left the organization or where DHB retrained staff to support new managed-care specific roles.

Continued success during and after the Medicaid Transformation is contingent upon the Department's ability to adequately staff teams that can perform proactive contract and regulatory oversight, ensure operational success and protect the continued integrity of the program in this new model. Under the State's new Medicaid program, clinical, financial, and compliance risks are growing – and will continue to grow – more complicated. The ability of DHB to appropriately execute its oversight role and achieve the aims set out by the State is paramount. Therefore, at its most basic, staffing levels impact how frequent, detailed and responsive the program can be to issues raised by beneficiaries, providers and other interested stakeholders like the Legislature or CMS.

This report summarizes the impacts of Medicaid Transformation on DHB's needed clinical, operational and oversight capabilities & staff and the requirements for DHB to continue to deliver on the charge from the Legislature to implement managed care successfully over the next three years.

Overview of Managed Care Transition and Impact on DHHS and DHB

Medicaid Transformation Aims, Program Design, and Implementation Timeline

In 2015, the NC General Assembly enacted legislation directing DHHS to transition Medicaid and NC Health Choice to incorporate a managed care model for several populations. DHB is the primary division of DHHS that is managing the transition. Under managed care, the State delegates responsibilities to contracted insurance companies (prepaid health plans, or PHPs), which are paid an actuarily certified monthly rate per enrolled person to manage a specified scope of Medicaid services. NC Medicaid Managed Care launched on July 1, 2021, with the Standard Plans and will continue to expand with implementation of new products across the next three years, including Tailored Plans for individuals with significant behavioral health needs and intellectual/developmental disabilities (I/DDs), a proposed Children and Families Specialty Plan for children and youth currently or formerly served by the child welfare system, and potentially a plan for individuals dually eligible for Medicaid and Medicare.

From the initial program design through implementation, DHB has remained focused on the overall vision set forth by DHHS 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.

DHB leveraged the move to managed care to build an innovative health care delivery system focused on the health of people enrolled in Medicaid. Features of the State's program include establishing a payment structure that rewards better health outcomes, integrates physical and behavioral health, and invests in non-medical interventions to reduce costs and improve the health of Medicaid beneficiaries. Implementation of the program is well underway.

In leading Medicaid Transformation, DHHS and DHB are committed to delivering on the following aims:

Aims for Medicaid Transformation in North Carolina

1. Budget predictability for the State through shared risk and accountability and overall program savings.
2. Nation-leading programs, particularly in the areas of the Eastern Band of Cherokee Indians Tribal Option and whole-person care through programs like Healthy Opportunities.
3. Strong program oversight of the PHPs to ensure they are delivering high quality clinical and financial results for North Carolina.
4. High-quality services and beneficiary satisfaction balanced with total cost management.
5. Sustainability and resiliency for the health care delivery system in North Carolina.
6. Efficient and cost-effective administrative services that underpin all programs.

DHB has prioritized stakeholder engagement and transparent communication to ensure those most impacted by this change have an opportunity to participate in the design of the program, including

developing benchmarks for quality care that PHPs must meet, building systems to share data across organizations, ensuring plans have enough providers to maintain access to care, and developing policies to support beneficiaries as they transition to this new model. This engagement has also proven essential to ensuring the readiness of the many program partners critical to the transition's success. A network of partners dedicated countless hours of work to support the design and launch of the transformation, including:

- The North Carolina General Assembly, which set the original vision, passed an enabling managed care framework, and authorized associated transformation funding.
- The provider community, which shared experiences and best practices from other states and worked with DHHS to identify and solve problems.
- Beneficiaries and advocates, who helped identify key features of managed care that needed special focus and have provided real-time feedback on what parts of the system are working well and where challenges exist.
- The Eastern Band of Cherokee Indians (EBCI), which enabled DHB to support the EBCI goals of self-determination and health independence while advocating for the unique health and cultural needs of the ECBI population.
- Prepaid health plans, acquired through competitive procurement, which have partnered with DHB in the development and deployment of new programs.

Leveraging this input, DHB and its staff rapidly developed and initiated a Medicaid managed care transition plan while continuing to fulfill its responsibility to deliver high-quality services to people enrolled in the existing FFS and managed behavioral health delivery systems. DHB managed this transformational work through the height of the COVID-19 pandemic, taking on and leading aspects of the State's response that added substantially to its existing workload. The success of DHB in the transition thus far is a reflection of the tireless effort of staff across the Division and supporting contractors, marking the most significant change to the State's Medicaid program since its inception more than 50 years ago.

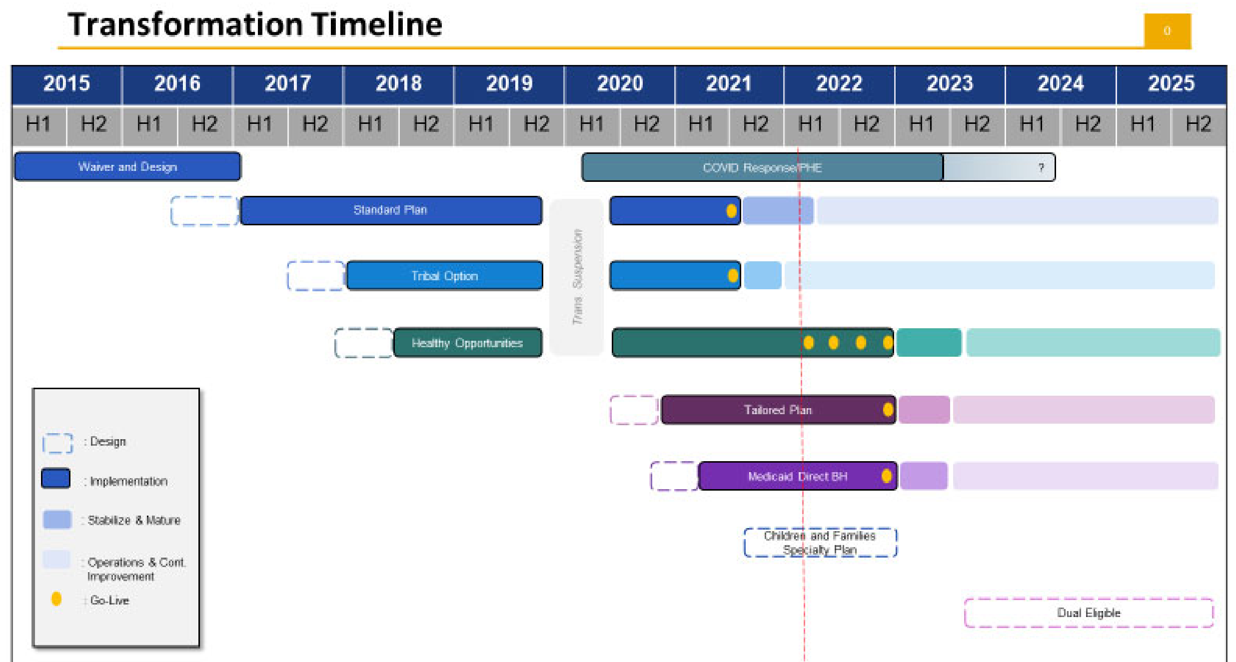
The first phase of Medicaid Managed Care in North Carolina launched on July 1, 2021. At that time, more than 1.6 million beneficiaries transitioned to one of five prepaid health plans, called Standard Plans, or the EBCI Tribal Option. At the same time, changes were implemented to ensure the continued successful operation of the remaining FFS delivery system, now called Medicaid Direct. Most recently, in March 2022, the Healthy Opportunities Pilot, which provides health-related services to address social drivers of health in the managed care program, were launched in three regions of the state.

At a high-level, the operation of these programs relies on a complex set of retained and delegated responsibilities among DHB, the various health plans and the EBCI Tribe, and other vendors supporting North Carolina's Medicaid program. These retained and delegated responsibilities must be overseen as individual components but also integrated by DHB to work together, for technology alone there will be over 2,000 integrations between systems after the launch of Tailored Plan and this does not include points of business integration. The capability of managing integrations is one that DHB has had to develop and will need to continue to enhance with each new program.

To implement Medicaid Transformation, DHB will remain in a critical transition phase until at least 2025, as DHB plans for the launch of Tailored Plans in December 2022 and subsequent launches of other products, such as the proposed Children and Families Specialty Plan and a potential program for dual-eligible beneficiaries, which will be implemented over the coming years, moving more beneficiaries into Medicaid Managed Care. Therefore, there are a number of beneficiaries who will need to be served in

the fee-for-service delivery system for several years and will need to be supported by DHB staff. During this transition phase, NC Medicaid staff will need to focus on the design, development and implementation of new health plans, will remain responsible for the administration in fee for service of hundreds of thousands of beneficiaries and will be responsible for the oversight of the existing managed care plans.

Figure 1: Transformation Timeline Overview by Program

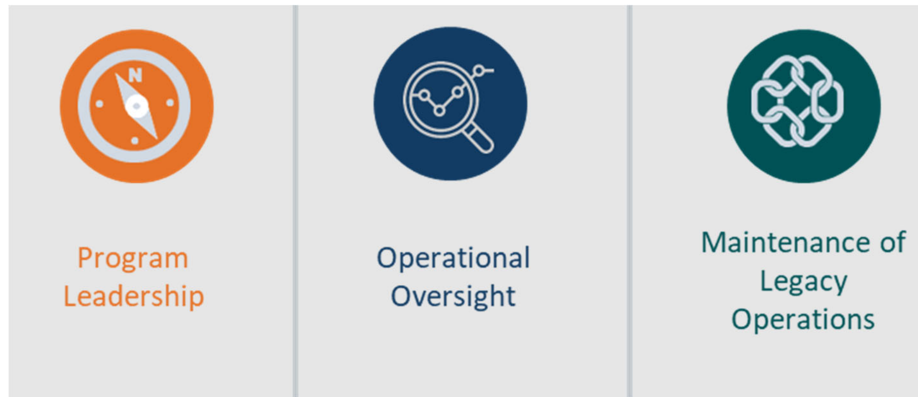


The success of North Carolina's transition and sustained operations under its new operating model cannot be taken for granted. As experience in other states has shown, the transition to managed care brings high-stakes risks for consumers and providers alike, as well as substantial financial risk for the state. The state of Iowa, for example, continues to face complaints from consumers reporting barriers to care and providers reporting inadequate and delayed payment five years after its launch. North Carolina has taken a different approach, working collaboratively with the legislature and program partners to chart a careful and tightly managed path toward implementation of the program on which the lives of North Carolinians and the stability of our health providers depend. This approach in North Carolina, for example, had a tangible benefit for members transitioning to managed care as 97% Standard Plan beneficiaries were able to maintain their existing primary care provider from fee-for-service to managed care. The State's continued success depends on an adequately resourced and highly skilled DHB team to execute program objectives.

Impact on DHB's Role and Staffing Needs

Fundamentally, Medicaid Transformation creates a more complex operating model for DHB, characterized by three key features that collectively necessitate maintenance of and, in some cases, enhancements to DHB operational resources.

Figure 2: Key Features of the Future State Operating Model



1. ***Program Leadership*.** DHB will maintain overall responsibility for achieving the vision, ensuring compliance and protecting the integrity of the NC Medicaid program, including setting program direction, interfacing with and responding to the directives of the legislature and federal regulators, and overseeing the fiscal management of the program. The increased operational complexity of the Medicaid program (described below) will require increased sophistication and expertise among the leadership team to achieve program responsibilities. For example, changes in regulatory and sub-regulatory requirements issued by the Centers for Medicare & Medicaid Services (CMS) must be understood and operationalized within the context of multiple products within managed care and the FFS delivery system to ensure the State maintains compliance with federal expenditure authority. For example, DHB continues to have responsibility for effectuating Legislative changes such as S.L. 2021-180, s. 9D.10 that require detailed, statutory, regulatory and programmatic understanding of the NC Medicaid program & managed care to effectively implement the statutory change across both Medicaid Direct and prepaid health plans. In addition, DHB must continue to provide strategic leadership in times of crisis, including the ongoing COVID-19 response and efforts to address the ongoing opioid epidemic.

2. ***Operational Oversight*.** NC Medicaid is accountable as the Single State Agency to CMS for operational and administrative oversight of the program regardless of whether DHB uses managed care plans or continues to operate a fee-for-service delivery model. Across almost every operational function of the Medicaid program, DHB is acquiring substantial new program oversight, monitoring, and enforcement roles over entities to which certain functions have been delegated recognizing that this increase is in part offset by a reduction in volume in the FFS program This requires procuring and integrating contracted partners into the vast array of business processes and technical systems necessary to operate the program. Once the initial transitions are complete, DHB will be responsible for five Standard Plans, the EBCI Tribal Option, six Tailored Plans, a proposed Children and Families Specialty Plan, and a potential product for individuals dually eligible for Medicaid and Medicare, as well as a FFS program for those who will remain permanently outside of managed care. In addition to managing health plans, DHB

will be responsible for managing substantial vendor relationships (e.g., the Enrollment Broker responsible for outreach and enrollment of people newly eligible for or renewing Medicaid coverage, a member ombudsman who helps resolve consumer disputes with manage care plans, a pharmacy benefit manager, Community Care of North Carolina who continues to provide care management for the Medicaid Direct population, vendors responsible for accrediting providers who participate in Medicaid Direct and Managed Care, and various IT vendors), each with their own procurements, contracts, and operational requirements.

From an individual human resources point of view, successful oversight of this complex range of program functions requires staff with new skill sets (e.g., agile project management, distributed data analysis) and experiences (e.g., managed care expertise). From an organizational human resources point of view, achieving an efficient and seamless health care delivery system requires doing business differently (e.g., delegating some functions previously operated internally or transferring delegation from one to multiple entities) or more intensively (e.g., scaling up contract oversight to manage $7 billion in annual vendor contracts for the standard plans alone). Training and/or recruiting new staff to perform a broader and more sophisticated array of oversight will require competitive hiring practices and thoughtful planning around career development, retention, and succession planning to ensure DHB can deliver on the State's mission and protect needed institutional knowledge over time. State staff must be prepared to ensure that vendors adhere to all State and federal guidelines in order to support providers and to protect the health and safety of beneficiaries.

3. ***Maintenance of Legacy Functions.*** As the health plans take on some day-to-day operational functions of ensuring delivery of Medicaid services to beneficiaries, there is a decrease in, for example, claim or prior authorization volume. The decrease in volume does free up some staff capacity and DHB has shifted staff work to focus on the rollout and oversight of the health plans. In many cases, DHB must retain much of its existing structures, processes, and capabilities to support beneficiaries who are *not* enrolled in the Managed Care program, either because they are waiting to transition to managed care or because they have been excluded or exempt from participation. While some of those capabilities and staff will be reassigned, the infrastructure and select supporting staff will need to remain even following Transformation to perform key functions the State will retain.

DHHS' continued success during and after the Medicaid Transformation is contingent upon the Department's ability to adequately staff teams primarily within DHB that can deliver services, oversee vendor performance and protect the continued integrity of the program in this new model. Under the State's new Medicaid program, clinical, financial, and compliance risks are growing and will continue to grow more complicated. The ability of DHHS to appropriately execute its oversight role and achieve the aims set out by the State is paramount.

Interactions with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services[i1]

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DM/DD/SAS) will continue to play a key role in executing Medicaid Transformation goals, particularly as the State continues to integrate health and behavioral services for individuals in Standard and Tailored Plans. DHB

[1] This section of the report is intended to satisfy the reporting requirements within Session Law 2018-5, Section 11H.8.(b) in addition to addressing the requirements of Session Law 2021-180, Section 9D.18.(b).

and DM/DD/SAS have worked closely to develop a common understanding of each division's responsibilities and functions in order to leverage each Division's unique expertise and capabilities to ensure continued high-quality care for all Medicaid beneficiaries during the Medicaid Transformation. For example, DHB will have primary responsibility for oversight of the Standard Plans and Tailored Plans, including ensuring access to behavioral health and I/DD services as part of those plans. DM/DD/SAS will continue to play a key role in developing State policy for individuals with behavioral health and I/DD needs, as well as managing the budgeting and financing of State-funded services provided through the Tailored Plans. Functions like public communications or policy directives to Standard Plans and Tailored Plans on behavioral health and I/DD issues are coordinated between divisions to ensure consistency in external messaging and clarity in responsibilities. In many respects, Medicaid Transformation has helped clarify the roles of these agencies and enabled the teams to work more collaboratively in advancing an agenda that best serves North Carolinians with behavioral health and/or I/DD needs.

Requirements for DHHS in Managing Successful Transformation

Overview of Comprehensive Organizational Design Effort

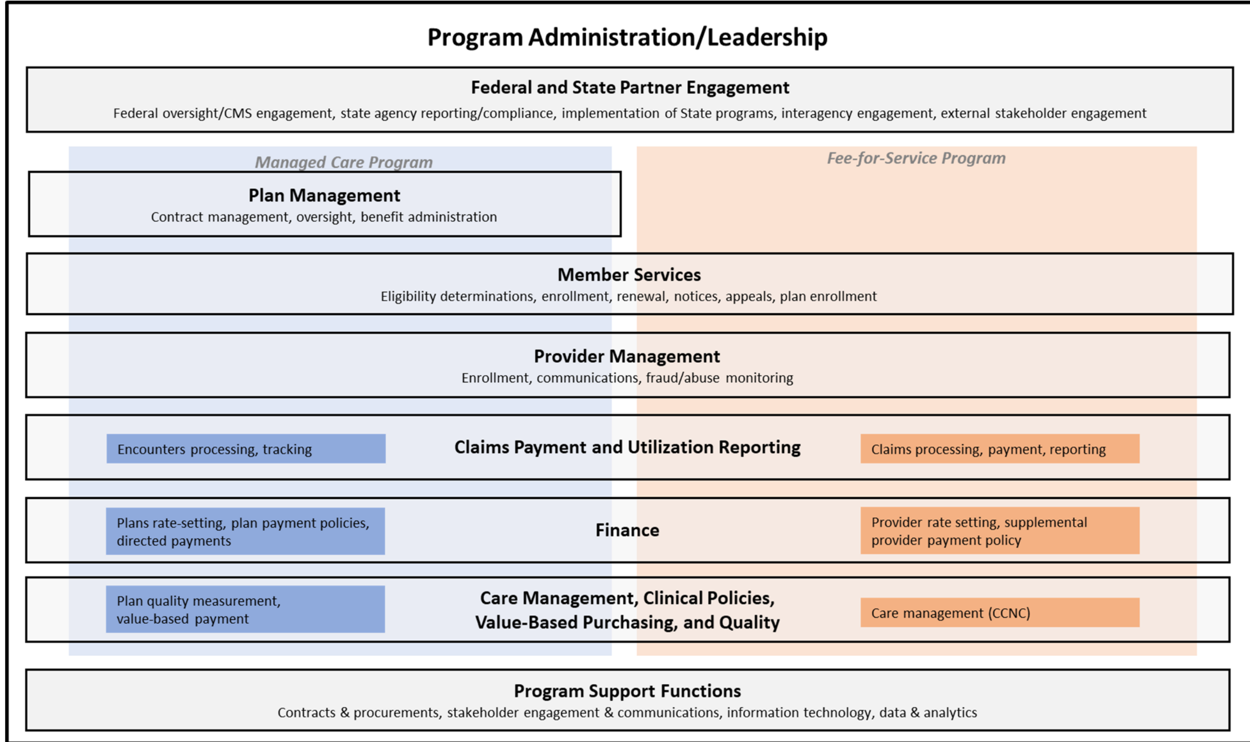
DHHS has reviewed the current state of NC Medicaid administration and projected organizational needs into the future in an effort to ensure alignment between the State's overall vision and the developing oversight model and functions to be performed by all entities involved. Functions were analyzed to avoid duplication, determinations were made to retain or delegate functions where more efficient and effective to do so, and common functions were standardized to create continuity across the portfolio. Three phases of Medicaid Transformation were defined (see Figure 3).

Figure 3: Phases of Medicaid Transformation

Operating Oversight Model and Staffing Requirements for DHHS During Medicaid Transformation

Medicaid Transformation has significantly impacted DHHS and DHB's operating requirements and associated need for staff. Because Medicaid Transformation will continue for a number of years as new populations are added to managed care, DHHS and DHB will not have a precise view of *long-term* staff needs until managed care is fully implemented. However, our experience indicates that the most significant changes during implementation of the transformation will occur in several key areas. Figure 4 summarizes the functions necessary for DHHS and DHB to successfully complete the transition.

Figure 4: Functions and Staffing Requirements for DHHS/DHB



The following sections provide more detail about each function, how each is evolving during Medicaid Transformation, and the capabilities and expertise required by DHB staff in each area. An underlying theme is that DHB will have (at least) two sets of roles and responsibilities across Medicaid functions – one for the managed care programs and another for the FFS program – with varying degrees of overlap. Such duality will continue as long as beneficiaries remain outside of Medicaid Managed Care.

1. Federal and State Partner Engagement

Function Overview. DHB is responsible for managing compliance with State legislative directives, ensuring compliance with federal authorities, and negotiating with federal officials to obtain waivers and programmatic flexibility. This requires interfacing with federal and State partners on behalf of the program and implementing regulatory and sub-regulatory guidance to execute its oversight and compliance obligations in all program operating models in coordination with the PHPs and vendors. While DHB holds primary responsibility for these functions, they require intensive collaboration with other divisions of DHHS to design and implement federal and State health policy directives.

Changes Under Medicaid Transformation. As the Medicaid program has evolved under Transformation, the complexity of the relationship between DHHS/DHB and its federal and State partners has substantially increased. Managed care brings new federal regulatory mandates, operational imperatives, and reporting obligations, different than those for the FFS delivery system, described further below. This has required securing new and amending existing Medicaid waivers, including 1115 and 1915(c) waivers, as well as amendments to North Carolina's Medicaid State Plan. This work is intensive and requires both strategic vision and technical expertise to ensure ongoing compliance, as well as alignment with State goals for the Medicaid program. At the same time, DHB must ensure the

financial integrity of its evolving Medicaid program, that it meets CMS' complex budget neutrality and other fiscal requirements, and that it complies with all Medicaid managed care and FFS reporting, oversight, and evaluation requirements under State and federal laws.

Beyond increased federal oversight and reporting, DHHS now has a more diverse array of programs to modify in response to State legislative and policy directives. Critical State health policy initiatives – such as combating the opioid crisis, increasing access to behavioral health services for young beneficiaries, and responding to the COVID-19 pandemic – require *more* work to appropriately implement these mandates and initiatives across multiple Medicaid delivery systems and plans.

2. Member Eligibility, Enrollment, and Support Services

Function Overview. Member eligibility, enrollment, and support services refers to a collection of complex business processes associated with determining and redetermining program eligibility and assisting North Carolinians with their enrollment in Medicaid generally, and a related business process to enroll beneficiaries in Medicaid Managed Care. In some areas, the State works closely with county departments of social services, which are responsible for determining Medicaid eligibility and conducting the local level hearings on eligibility adverse determinations. The eligibility and enrollment functions give rise to due process appeal rights coordinated and overseen by DHB staff.

Changes Under Medicaid Transformation. Medicaid Transformation has added complexity to the eligibility and enrollment process, requiring not only a determination of Medicaid eligibility in order to access health services but also determination as to whether the individual is required, permitted, or not permitted to enroll in a managed care plan. For individuals eligible for managed care, it must be determined which product (Standard Plan, Tailored Plan, etc.) the individual is eligible for, and when eligible for the Standard Plan, which particular plan the individual chooses or is assigned. Ensuring consumers understand these choices requires support from a newly procured Enrollment Broker and complex data transmissions and reconciliations among the counties, state, health plans, and the Enrollment Broker to ensure seamless enrollment into the appropriate Medicaid delivery system and, if applicable, health plan. The Department is now responsible for collecting and transmitting member eligibility and enrollment data to a variety of partners including Standard Plans, Tailored Plans and the Enrollment Broker. As more populations are enrolled in managed care and more Medicaid products become available, the number of integrations required to transfer member data will increase along with the analytical capabilities required to reconcile across entities and systems. Staff with the expertise and capacity to maintain and test these business processes and information systems are critical to ensuring the eligibility and enrollment process is as close to error-free as possible, minimizing disruptions in care relationships and ensuring compliance with federal requirements related to timeliness, plan marketing, member education, and more. Enrollment and disenrollment from the health plans must adhere to stringent federal regulatory requirements, and in some cases, due process appeal rights.

DHB will also maintain a significant member services function that is critical to helping beneficiaries navigate the program, access care, and resolve issues and oversee the beneficiary facing programs (i.e., NC Medicaid Ombudsman or Enrollment Broker). DHB staff are charged with oversight of managed care plans; all beneficiary-facing vendors with enrollment responsibilities, including the Medicaid Contact Center and the NC Medicaid Ombudsman; and direct member services capabilities offered through the county offices. In addition, DHB has built a "no wrong door" approach to member management and services so that no matter where a member seeks support – from their health plan, from another vendor, from the county, or from a State entity – member navigation is seamless and coordinated. Standard Plan open enrollment provides a good example of DHB's role in this new model – in this case,

using data collected through new infrastructure, DHB identified that more beneficiaries than forecasted selected a Standard Plan and therefore were giving up unique services only provided through LME/MCO's. NC Medicaid staff retrained Enrollment Broker staff to address these special cases, validated the Broker's readiness and restarted Medicaid Managed Care enrollment for those 7000 beneficiaries.

3. Plan Management

Function Overview. DHB is now responsible for comprehensive oversight and management of the health plans tasked with administering $7 billion in Medicaid services for North Carolinians enrolled in Medicaid Managed Care Standard Plans, with increasing responsibility as more plans are rolled out. This new and expanding responsibility involves the development and oversight of large and complex contracts, clinical policies to which plans must follow to ensure appropriate access to care, plan payment and provider rate-setting, and wide-ranging performance standards that will apply across managed care programs, to name a few – all in compliance with robust federal and State laws, regulations, and guidance. Strong DHB oversight of the plans is *foundational* to a strong Medicaid Managed Care program, particularly one as young as North Carolina's.

Changes Under Medicaid Transformation. Pre-Transformation, DHB was responsible for the development and implementation of program-wide policies and procedures, provider rate-setting, and performance standards within the FFS program, with most plan management functions narrowly focused on the limited-benefit LME-MCOs[2]. Under Medicaid Transformation, plan management has become much more complex and extensive, with responsibilities including but not limited to the development and oversight of plan contracts as well as actuarially sound capitation rates (the per-member rate the State pays plans). Each of these responsibilities are ongoing – for example, the capitation rates must be updated multiple times in a year to ensure adequate payment to providers, access to care, and compliance with federal managed care rate requirements. Additional clinical and business oversight activities have been implemented to ensure contracted health plans are following requirements as outlined in the PHP contract. DHB also has extensive financial oversight responsibilities to verify the health plans are spending and accounting for money in ways that are contractually appropriate and regulatorily required. Continuous improvements are being identified to strengthen the Medicaid program and streamline the process to administer this oversight. A good example of the effectiveness of the oversight model developed was shortly after the launch of Managed Care where DHB staff worked closely with health plans to correct issues stemming from incorrect primary care provider (PCP) assignments and in another example, developed corrective action plans to address challenges in the delivery of non-emergency transportation services.

While DHB is actively working on standardizing processes and implementing lessons learned from the Standard Plan implementations to support upcoming administration of the Tailored Plans, each program has nuances and specialties that require uniquely tailored approaches to implementation and oversight. Plan management teams must work across the Department to ensure contracted plans meet the needs of all business functions.

---

[2] DHHS contracts with Local Management Entities – Managed Care Organizations (LME-MCOs) to provide a limited set of Medicaid benefits to people who need behavioral health and I/DD services, including the State's 1915(c) Innovation Waiver.

4. Provider Management

Function Overview. Provider management encompasses two critical functions: 1) provider credentialing, enrollment, and communications, and 2) provider appeals, grievances, and termination processes. These are the essential functions necessary to prevent fraud and abuse and to ensure that the community of providers – hospitals, physicians, and others – are prepared to deliver quality care to North Carolinians enrolled in Medicaid.

Changes Under Medicaid Transformation. The State through DHB will remain responsible for the application process, credentialing, enrollment, and revalidation of providers. Each provider contracting to provide services under a Managed Care Plan must be enrolled as a Medicaid provider. The DHB provider operations staff assisted in the managed care transition by providing companion guides to the health plans, supported provider call flows, and reviewed policies and procedures, among other deliverables, from the health plans to ensure their processes would be implemented appropriately and to ensure each Plan had an adequate network to provide services to beneficiaries across the State. The DHB provider operations staff continue to support providers who have questions or concerns about health plan contracting and help troubleshoot claim payment issues that providers experience with the plans in addition to fielding concerns about claims with NC Medicaid Direct.

DHB provides provider data to the Enrollment Broker, which maintains responsibility for the public-facing provider directory required under federal regulation, which provides a consolidated repository of provider information for people on Medicaid to use during enrollment and redetermination and while receiving Medicaid coverage. DHB worked with the Enrollment Broker to design, develop, and test this application before Standard Plan launch, which included user acceptance testing with a subset of the provider population. DHB will continue to work with the Enrollment Broker to roll out new materials as populations continue to be transitioned into managed care. A good example of DHB's role in the Medicaid Managed Care is how DHB staff worked with hospitals and other providers to create tools and provide technical assistance to resolve discrepancies in provider data between NC Medicaid's systems and the systems of each of the health plans. In other examples, DHB held plans accountable for ensuring the quality of the provider data the health plans provided was accurate and represented to beneficiaries the providers who were available in each of the health plan provider networks.

DHB is still responsible for final determinations in provider appeals, grievances, and termination processes as it relates to the enrollment in NC Medicaid. This is done by the provider operations staff and in partnership with the managed care plans, as they are required to monitor and identify needs for potential provider termination for various reasons and to notify the State. A number of new system and process changes were developed and deployed and are now maintained to accommodate the State's managed care delivery system. DHB is now responsible for oversight of these new processes and the managed care plans.

To facilitate transparency and oversight, the Department also added a new Help Center, which intakes member and provider issues and questions, which are resolved in partnership with NC Medicaid and vendor staff. The business units across the Department are responsible for reviewing the cases submitted to their business area and responding or triaging and routing to other vendors for resolution. Provider operations staff bring knowledge of the Medicaid program – including how it should work in managed care – to facilitate oversight of the Standard Plans, maintain network adequacy, and assist Tailored Plans in preparing for launch.

5. Finance

Function Overview. This function is focused on five primary tasks: 1) ensuring that payments to providers and health plans are budgeted, completed, and tracked (including accounts payable, accounts receivable, and fiscal management activities); 2) defining and tracking to the Medicaid budget, including assessing opportunities to increase the federal medical assistance partnership (FMAP) funding from the federal government; 3) health plan rate setting; 4) accounts receivable activities such as managing drug rebates that the State collects from manufacturers, recouping overpayments from providers and health plans, and managing estate recoveries from deceased members; and 5) enrollment, budget and cash-flow forecasting.

Changes Under Medicaid Transformation. As a result of Medicaid Transformation, the State is now setting rates for Standard Plans and Tailored Plans, requiring new rate-setting processes and procedures. To put this in context, before Medicaid Transformation, the State was only paying LME-MCOs. Now the State is paying 11 health plans different rates based on geography, clinical acuity, and health plan and member eligibility category, which adds tremendous complexity to financial operations. Setting accurate rates is a critical function, as these funds are needed to pay health plans in a timely fashion. Also, the State relies on information submitted from managed care plans to secure drug rebates and manage cost settlements. The finance team is also responsible for administering supplemental payment programs, such as Disproportionate Share Hospital payments. Federal funds drawn down based on certified public expenditures are critical to Medicaid funding across all program types and the maintenance of the health care system in North Carolina. The supplemental payments available under managed care differ from those available under a fee for service model, requiring that the finance team properly oversee payments across the various program models. As part of its responsibilities under the Medicaid 1115 waiver, the State must manage “budget neutrality,” which is a CMS-required calculation to ensure that the State does not spend more than it would have otherwise spent were it not for the 1115 waiver. Finally, DHB leverages information from health plans to calculate third-party liability recovery, ensuring that Medicaid is the payer of last resort. Across Medicaid transformation, the State’s finance role has grown exponentially.

6. Claims Payment and Utilization Reporting

Function Overview. Claims adjudication and payment processes continue to be required for FFS claims through the full transition to managed care and beyond. Data provided on the claim, member data, provider data, and clinical policy coverage is used to determine the payment amount. Health plans perform similar processes when they adjudicate and pay claims to providers in their networks. Encounter processing allows the State to receive claim details for claims processed by the health plans for use in program oversight.

Changes Under Medicaid Transformation. Prior to managed care, claims payment was performed by one vendor for FFS, GDIT, in addition to the seven LME-MCOs which paid for behavioral health services. Before Standard Plan launch, NC Medicaid staff provided guidance and oversight of these other claim payment platforms – for example, providing business requirements for updated program or fee schedule changes, managing reprocessing of FFS claims, and coordinating with providers and the vendors on unresolved claim payment issues. With the transition to managed care, NC Medicaid staff and our consultants now provide technical assistance to the health plans to understand NC regulatory requirements, in addition to providing oversight because the plans have some flexibility to process claims differently than FFS. While the transition to managed care has seen a higher volume of claims

that have been transitioned to health plans, there are also now more "encounters" which come back from the health plans. Health plan submitted encounters are a federal requirement of every Medicaid managed care program and provide NC Medicaid with information about what services are being provided, the quality of services provided, whether services are being paid or denied by the health plans, and the clinical status of the beneficiary. Encounters are a key administrative function that must be maintained and supported by staff to verify that the plans are submitting information timely, accurately, and completely.

While the Managed Care Plans perform their own claims adjudication, federal law requires the State ensure due process appeal rights for all Medicaid beneficiaries. Managed Care Plans provide an initial level of appeal on adverse claims or benefits determinations, the State is required to give Managed Care beneficiaries appeal rights to a State Fair Hearing if they disagree with the Managed Care Plan determination. The State Agency also provides appeal rights and oversees the appeal process for Medicaid Direct members who disagree with an adverse benefit determination made by the State Agency.

A robust oversight program must have information regarding the performance of the managed care organizations. Data drives decision making. Therefore with Transformation, there is an increasing reliance on data analytics and reporting to monitor contract and financial performance of the health plans. NC Medicaid staff develop and update reporting dashboards and reporting templates, which are used to track performance, identify red flags, and support enforcement actions. Staff are also tasked with resolving data discrepancies and verifying that the health plans have the technical capabilities to provide the State with the information it needs to oversee PHPs and support the program.

Therefore, the impact of Medicaid Managed Care as it relates to the business function of claim payment and encounters does not translate to a direct decrease in staffing. For example, to oversee the transition to Medicaid Managed Care staff have focused on verifying that the health plans are paying providers timely, accurately and completely. NC Medicaid has developed a claims dashboard which is updated regularly from encounter data and provides insight for providers into what the Standard Plans are paying for or denying, the payment amounts, and the most common provider billing errors that result in a claim denial. Staff work closely with individual providers and hospitals to identify claim issues they are experiencing and then staff manage the health plans to make the necessary system updates and reprocess claims consistent with the policy aims of NC Medicaid. As NC Medicaid moves to implement other Managed Care programs, including Tailored Plans, we anticipate a similar need to oversee health plans and assist providers.

7. Population Health: Care Management, Clinical Policies, Quality/Compliance, and Value-Based Purchasing

Function Overview. At its core, the purpose of North Carolina's Medicaid Transformation is to improve the health of North Carolinians. To achieve this, it is critical to ensure that the transition to managed care results in robust care management services for the Medicaid population and that the State is able to track the performance of the care system against access and quality goals.

Changes Under Medicaid Transformation. Under Medicaid Transformation, DHB has taken on an enhanced role in development and oversight of a statewide care management approach and performance management responsibility in the areas of quality and compliance.

Care Management. Prior to Medicaid Transformation, North Carolina relied on Primary Care Case

Management (PCCM) provided through the Carolina ACCESS Program. An external organization, Community Care of North Carolina (CCNC), was used to provide these services to the Medicaid beneficiaries. Aside from the Carolina ACCESS Program, there was no standardized program to manage transitions of care, and proactive utilization management approaches were limited. The LME-MCOs also provided limited case management services.

Under Medicaid Transformation, the Advanced Medical Home (AMH) program serves as the primary vehicle for delivering care management for individuals in Standard Plans. The AMH program builds on the Carolina ACCESS Program and requires PHPs to delegate certain care management functions to primary care practices certified as AMHs at the local level. In order to provide these care management functions, AMHs may work with their affiliated health care system or make an arrangement with a Clinically Integrated Network, a Care Management vendor, or another population health entity. To ensure that beneficiaries across the State are receiving-high quality care management, DHB developed standards for AMHs and will be responsible for initially certifying that practices meet AMH criteria. This shift in care management delivery reduces the funding provided by the Department to CCNC and allows staff to transition time spent overseeing the Carolina ACCESS program for those programs which are sunsetting to overseeing PHPs to ensure they are providing required, high-quality care management.

To enable effective care management through the AMH providers, the AMHs must have timely access to complete, individual-level data to help them seamlessly manage care, and population health activities across their Medicaid patient populations. During Transformation, DHB developed a detailed data strategy to support the exchange of data between the PHPs and AMH providers.

To date, this program has enabled 1,650 primary care practices to become AMHs by developing care management and technology capabilities to exchange data and use that to drive high-quality care. As Transformation continues, the DHB will continue to mature and stabilize the AMH program. In order to advise and inform the Department on the key aspects of the design and evolution of the AMH program, DHB has convened a Technical Advisory Group (TAG). The AMH TAG has 15 members, including members from all the Standard Plan PHPs and a diversity of providers participating in the AMH program.

The Department has also established Tailored Care Management as North Carolina's specialized care management model targeted toward individuals with a significant behavioral health condition (including both mental health and severe substance use disorders), an I/DD, or a traumatic brain injury (TBI). Under Tailored Care Management, members will have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all of their needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, long-term services and supports (LTSS), and unmet health-related resource needs. An intensive care management program also will be deployed through the Children and Families Specialty Plan to meet the unique needs of the population served by the Child Welfare System.

Lastly, the Department launched the first in the nation comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions relating to housing, food, transportation, and interpersonal safety to high-needs Medicaid enrollees. The Healthy Opportunities Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of health care. Network Lead agencies, the PHPS, and health service organizations throughout the pilot regions to ensure members receive supportive services in accordance with a CMS-approved waiver. If shown to be effective after rigorous evaluation, DHB will look to systematically integrate pilot services statewide through NC Medicaid Managed Care.

Clinical Policies. DHB has also worked with the managed care plans to implement national standards of care related to prior authorization (PA) and utilization reviews. Prior to Managed Care the Department, with contracted vendor support (i.e., Evicore), issued prior authorizations, a function that will now be largely performed by the PHPs and overseen by staff that previously played a more direct role in the process This change has been an adjustment for providers in the field, but as the program grows and develops, the improvements are designed to ensure that our members are all getting necessary care with more proactive management by the PHPs. The PHPs and providers are still learning the new processes as they relate to the different requirements for PA for each of the plans. PHPs are also working with providers to ensure that they are able to leverage the multiple systems needed for PA. The PA requirements for PHPs differ from Medicaid FFS, and how providers request PA differs, as each PHP has their own PA portal. DHB is supporting providers and plans operating in this new system to ensure that care is provided to all beneficiaries. DHB is also responsible for ensuring plans are approving medically necessary services that beneficiaries need and are not applying utilization requirements that are more restrictive than services provided under Medicaid FFS.

Quality. DHB has engaged multiple vendors to support evaluation of quality and has engaged the PHPs to support quality efforts to support better quality of care delivered to beneficiaries. NC Medicaid developed a robust quality strategy to outline the quality aims and strategies requiring feedback from internal and external stakeholders. Additionally, an external quality review organization has been engaged to oversee the PHPs, and review all services provided by the PHPs to ensure that quality care is delivered by the PHPs. DHB continues to grow and evolve in ensuring the provision of quality care by partnering with the PHPs and providers to improve the quality of care beneficiaries receive. DHB continues to monitor and improve beneficiary experience as it relates to equity, health disparities and leveraging available resources to improve the quality-of-care beneficiaries receive. Utilization management, within quality, is another example of where DHB staff, supported by a contract vendor, has transitioned the operational work to the PHPs thereby creating DHB staff capacity for oversight. Under Managed Care DHB staff review utilization management data and reports from PHPs to ensure high quality care is being provide to beneficiaries. DHB is working with PHPs and other stakeholders to set standards for quality focuses and to oversee the plans quality improvement efforts to ensure that members are getting quality care and that the care received improves over time.

Compliance. In addition to state fraud, waste and abuse oversight responsibilities, DHB has begun to invest in an enterprise risk management approach led by the Director of Compliance, who is a member of the Executive Leadership Team. This move to enterprise risk management is in addition to existing statutory audit or internal review responsibilities (e.g., county eligibility audits) that are placed on DHB to address specific risks. The vision is realized through development of tools and allocation of staff to the work of compliance monitoring, audit facilitation, and compliance oversight of the health plans. DHB developed a Compliance Program inclusive of the compliance plan and risk assessment tool. Division business units are being engaged in enterprise risk discussions, control identification, and initial risk rankings. The risk assessment tool incorporates multiple areas of the business that are being refined through collaboration with various teams, with the goal of risk-ranking each area before implementing internal compliance reviews. This tool is integral to the development work on the governance and regulatory compliance integrated risk management digital platform that will ultimately be used to manage risk analysis and identify appropriate workflows.

Value-Based Purchasing. DHB has set forth a vision to move away from traditional FFS payments between managed care and providers to incentivize healthcare outcomes and quality care. This requires

health plans evolve their payment models over time and requires robust oversight by DHB to ensure that plans are meeting the State's goals. DHB is also engaged in provider education and readiness activities to assist the provider community in making this transition.

8. Program Support Functions

Function overview. Program support functions combine cross-cutting capabilities and teams that deliver a broad set of tools and services to various constituencies. In addition to their increased role in ensuring timely and accurate communication to providers and beneficiaries under the fee-for-service program and during COVID-19 pandemic, the program support functions undertaken by DHB are essential to ensuring beneficiaries receive timely notification about their health care benefits and rights. During Transformation, three components of Program Support Functions performed by DHB staff were critical to managed care launch success: Contracts & Procurements, Stakeholder Engagement & Communications and Information Technology, Data, and Analytics.

Changes Under Medicaid Transformation.

Contracts & Procurements: DHB relies heavily on its Contracts & Procurements team to support the transition to managed care. The Contracts and Procurements team is responsible for working with the NC Medicaid staff to develop contracting language that supports the regulatory and business requirements of the program; for developing a Service Level Agreement framework for contract enforcement; for working with the business areas to enforce contract language where there may be possible contractual violations; and for negotiating and executing contract amendments. Furthermore, NC Medicaid acquires its contracts through competitive state procurements and with each procurement there is a risk of protest. Having knowledgeable staff who can understand and run these unique procurements is imperative. DHB contracting staff also plays a critical role in modifying, reducing the scope of work expected to be performed by vendors, and closing or terminating contracts with existing vendors ensuring that DHB reduces vendor support where it is no longer needed in an effort to maximize funding.

Stakeholder Engagement and Communications. To ensure the success of Medicaid Transformation, external stakeholder engagement and communications services were combined into one DHB capability/team to ensure successful messaging and information sharing during Medicaid Transformation. A robust engagement strategy was developed with a single framework used to ensure comprehensive transformation updates reached external stakeholders (e.g., counties, provider associations, advocacy groups, community-based organizations), including engagement strategies, roadmaps/key message development, and engagement and communications plans/trackers. A Help Center was launched for stakeholder issue resolution across DHB and its partners. DHB is providing oversight of health plans' website content, marketing plans and materials, local community collaboration and engagement strategies, outreach reporting, and other public-facing materials. As required by federal regulations, DHB produced templates and approved PHP developed materials to ensure consistent messaging and compliance with federal regulatory requirements, an on-going function that will expand with the launch of each phase of managed care. DHB provides guidance for entities communicating managed care information, including an expanded Medicaid Style Guide to ensure terminology is consistent across all beneficiary populations. DHB developed, launched, and is continuing to oversee the beneficiary ombudsman program (NC Medicaid Ombudsman). This team fields calls and resolves issues on behalf of beneficiaries and monitor trends in managed care that impact beneficiaries, allowing the state to address issues.

As new Transformation plans roll out and new vendors are brought online, DHB will need to expand communication channels (e.g., more web content to review, new vendor communication materials to oversee, more provider bulletins to prepare). Continued collaborative partnerships among divisions (DHB, DM/DD/SAS, and the Division of Social Services) and partners to accomplish plan engagement oversight and strategic engagement goals is needed and will require a robust staff.

Information Technology, Data, Analytics. Through Medicaid Transformation, the State is responsible for overseeing and regulating an increasingly complex managed care market, ensuring enrollees have access to quality health care services, populations are being managed to better health outcomes, and contracting reflects rigorous stewardship of taxpayer dollars. To support these responsibilities, the State is building a workforce capable of deriving actionable information from the data it receives from many entities including plans, providers, enrollment broker, technology vendors, and individuals; a significant change from FFS where the majority of data came from a single, integrated MMIS system. These functions include:

- Overseeing plan and provider data collection compliance, including developing rigorous processes to ensure data timeliness, completeness, and accuracy.
- Guiding strategic investments in modular and flexible data and information systems that maximize use of federal matching funds and are capable of efficiently consuming, curating, linking, and analyzing a diverse set of data received from plans, providers, individuals, and health information exchanges, as well as human-service data from other programs to support whole-person health.
- Developing data dashboards and reports in partnership with data users/program owners that profile priority population health and system performance metrics and trends.
- Analyzing population health and system performance information to identify potential market disconnects and concerns for resolution.
- Communicating information about data quality or health system deficiencies back to relevant stakeholders for resolution.

Staffing will comprise a combination of permanent staff and contractors and is being developed in alignment with a broader departmental data and system investment strategy. The change will create a distributed data analysis model where individuals across DHB will perform data analysis, requiring development of new skills but also placing data at the center of operations, oversight, and decision making.

CONCLUSION

DHHS appreciates the support of the Legislature during this period of transformation in the NC Medicaid Program. DHB is through the first implementation phase and our continued success requires that we maintain and, in many areas, enhance the capacity and skill sets of our staff. NC Medicaid staff are the front-line of a successful oversight program of health plans. The amount of support which NC Medicaid can provide to beneficiaries or providers and the quality and amount of oversight that DHB can perform of health plans is directly tied to the number and quality of DHB staff. DHB remains focused on maximizing the impact of our staff in oversight and will continue to shift staff focus and responsibility from areas shrinking due to the reduction of the FFS program to high impact areas associated with Managed Care implementation, operations and oversight. An adequately prepared and resourced workforce is critical to ensuring the health and safety of North Carolinians enrolled in Medicaid, to maintaining the stability of our health providers, and to ensuring the continued efficiency and integrity of North Carolina's Medicaid program. We look forward to our ongoing partnership with the Legislature as we achieve continued success.