



MCAC Network Adequacy Subcommittee Meeting #1

March 26, 2018

Welcome

Ted Goins, MCAC Representative
David Tayloe, MCAC Representative

Debra Farrington, NC DHHS Stakeholder Engagement Lead

Jean Holliday, NC DHHS Subject Lead

Agenda

- Subcommittee Member Introductions 10 mins
- Subcommittee Charter 10 mins
- Logistics and Member Participation (included above)
- Meeting Schedule and Work Plan 10 mins
- Managed Care Overview 10 mins
- Network Adequacy Standards & Discussion 60 mins
- Public Comment 10 mins
- Next Steps 10 mins

Subcommittee Member Introductions

- **Name**
- **Organization**
- **How will your experience benefit the MCAC Network Adequacy Subcommittee?**

Charter

- **Review and provide feedback upon the network adequacy and accessibility standards for Standard Plans**
- **Review and provide feedback upon the provider directory requirements**
- **Review and provide feedback upon the plan for PHP compliance and oversight**

Logistics and Member Participation

- Meetings will be available in-person and by webcast/teleconference
- Meetings are open to the public
- Public will have time at the end of each meeting to comment
- Direct written comment to Medicaid.Transformation@dhhs.nc.gov

MEMBERS:

Active participation during meetings will be key to informed input

Offer suggestions, information and perspective

Engage with other members

Ask questions

Meeting Schedule and Work Plan

Schedule

	MEETING #1	MEETING #2
DATE	Thursday, March 29, 2018	Monday, April 9, 2018
TIME	12:00 pm – 2:00 pm	12:00 pm – 2:00 pm
PLACE	Dorothea Dix Campus McBryde Building, Room #444 820 South Boylan Avenue Raleigh, NC	Dorothea Dix Campus Kirby Building, Room #297 1985 Umstead Drive Raleigh, NC

Work Plan

	MEETING #1	MEETING #2
TOPICS	Subcommittee Charge	Accessibility Standards and Measures
	Orientation: Charter, Expectations, Logistics, Schedule	Provider Directories
	Managed Care Overview	Oversight and Monitoring
	Network Adequacy, Standards and Measures	

Medicaid Managed Care

Vision

- High-quality care
- Population health improvement
- Provider engagement and support
- Sustainable program with predictable cost

Goals

- Focus on integration of services for primary care, behavioral health, intellectual and developmental disorders, and substance use disorders
- Address social determinants of health (unmet social needs, such as employment, housing and food, and their effect on health)
- Support beneficiaries and providers during transition

SL 2015-245, as amended, directed transition from fee-for-service to managed care for Medicaid and NC Health Choice programs

Medicaid Managed Care Already Exists in NC

WHAT NORTH CAROLINA HAS NOW

PRIMARY CARE CASE MANAGEMENT (CCNC)

- Primary care provider-based
- State pays additional fee to provide care management

PACE

- Comprehensive, capitated
- 55 years old and older
- Available in certain areas, not currently statewide

LME/MCOs (BEHAVIORAL HEALTH PREPAID HEALTH PLAN)

- Cover specific populations and specific services
- Provides care coordination for identified and priority groups

WHAT MANAGED CARE WILL BRING

MCOs will take two forms:

- Commercial Plans
- Provider-led Entities

Participating MCOs will be responsible for coordinating all services (except services carved out) and will receive a capitated payment for each enrolled beneficiary.

Medicaid Managed Care Background

- **Timing: Go live within 18 months of CMS approval**
- **Prepaid health plans (PHPs)**
 - 3 statewide contracts
 - Up to 12 regional contracts to PLEs in 6 regions
 - Beneficiary chooses plan that best fits situation, or will be auto-assigned according to assignment algorithm
 - At managed care launch, PHPs will offer standard plans with integrated physical, behavioral and pharmacy services (requires enabling legislation)
- **PHPs must accept any willing and able provider, including all essential providers (as defined in legislation); exceptions: quality, refusal to accept rates**
- **Rate floors for physicians**

Overview of Network Adequacy and Accessibility

Federal regulations require DHHS to ensure that PHPs maintain a network of appropriate providers that is “sufficient to provide adequate access” to all services covered under the contract for all enrollees.

Network adequacy and accessibility standards help to ensure that beneficiaries have access to providers and offer an important tool for DHHS to monitor that access.

In establishing network adequacy standards, the DHHS internal work group contemplated three factors beyond those required by the federal regulation (42 CFR 438.68(c)):

- 1) The distribution of North Carolina’s Medicaid population in rural areas;
- 2) “Any willing provider” and “essential provider” provisions of the authorizing legislation (SL 2015-245, as amended); and
- 3) Other states’ network adequacy standards.

County Designations – Rural vs Urban

- Used the North Carolina Rural Economic Development Center 2015 Impacts Report to define “rural”.
 - Counties designated as “regional cities or suburban counties” or “urban counties” will be considered “urban” for network adequacy purposes.
- “Urban” is defined as non-rural counties, i.e. counties with average population densities of 250 or more people per square mile.
 - Includes 20 counties
 - Account for 59 percent of the state’s population.
- “Rural” is defined as counties with population densities below 250 people per square mile.
 - Includes 80 counties
 - Account for 41 percent of the state’s population.
- The time and distance standards and appointment wait time standards vary according to the county population designation, i.e., “urban”, “rural”.

“Any Willing Provider” and Essential Providers

- Pursuant to S.L. 2015-245, as amended, PHPs may not exclude providers from their networks except for failure to meet objective quality standards (conditions for participation in the network) or refusal to accept network rates.
 - The “objective quality standards” will be used by the PHPs to determine if a provider may be added to the PHPs network and be a participating provider in the network.
 - PHPs will be expected to negotiate in good faith; a rate floor equal to 100% of the Medicaid fee for service rate for in-network primary care physicians, specialist physicians, and physician extenders will apply.
- North Carolina statute (SL 2015-245, as amended) requires PHPs to contract with all “essential providers” in their geographical coverage area, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.
- Essential providers include: FQHCs; RHCs; rural health centers overseen by DHHS; free/charitable clinics; State veterans’ homes; and local health departments.

Network Adequacy Standards – Time/Distance Standards

Provider Type	Urban Standard	Rural Standard
Primary Care (adult and pediatric)	≥ 2 providers within 30 minutes or 10 miles for at least 95% of enrollees	≥ 2 providers within 30 minutes or 30 miles for at least 95% of enrollees
Specialty Care (adult and pediatric)	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of enrollees
OB/GYN	≥ 2 providers within 30 minutes or 10 miles for at least 95% of enrollees	≥ 2 providers within 30 minutes or 30 miles for at least 95% of enrollees
Hospitals	≥ 2 hospitals within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 hospitals within 30 minutes or 30 miles for at least 95% of enrollees

Network Adequacy Standards – Time/Distance Standards

Provider Type	Urban Standard	Rural Standard
Pharmacies	≥ 2 pharmacies within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of enrollees
Outpatient Behavioral Health Services	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of enrollees	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of enrollees
Location-Based Services	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of enrollees	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of enrollees
Behavioral Health Crisis Services	≥ 1 provider of each crisis service within each PHP region	

Network Adequacy Standards – Time/Distance Standards

Provider Type	Urban Standard	Rural Standard
Inpatient Behavioral Health Services	≥ 1 provider of each inpatient BH service within each PHP region	
Behavioral Health Specialized Services	≥ 1 provider of specialized services (partial hospitalization) within 30 minutes or 30 miles for at least 95% of enrollees	≥ 1 provider of specialized services (partial hospitalization) within 60 minutes or 60 miles for at least 95% of enrollees

Network Adequacy Standards – Time/Distance Standards

DHHS requires PHPs to meet the requirements in the chart below to ensure access to LTSS services for which providers travel to beneficiaries.

Provider Type	Urban Standard	Rural Standard
All State Plan LTSS (except nursing facilities)	PHPs must have at least two LTSS provider types, identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHPs must have at least two providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
Nursing Facilities	PHPs must have at least 1 nursing facility accepting new patients in every county.	PHPs must have at least 1 nursing facility accepting new patients in every county.

Network Adequacy Standards – Time/Distance Standards

- **PHPs will demonstrate compliance with these standards through data submission using standardized reporting formats.**
- **As is true with all network adequacy standards, if a PHP cannot meet a standard in a county in the PHP's service area, then DHHS will develop an exception request process for a PHP to demonstrate the need for an exception. That process will include a requirement the PHP detail patterns of care and other relevant information to explain why it provides reasonable access to enrollees in the identified area(s). The process will require the PHP to specifically demonstrate how the PHP meets the reasonable access standard, despite not meeting the time and distance standard.**
- **List of specialties subject to the Specialty standards and the identified Essential Providers is included in Appendix B**

Time/Distance Standards - Notes

- Outpatient behavioral health services” includes outpatient behavioral health services provided by direct-enrolled providers (e.g., psychiatry) for adults and children.
- “Location-based behavioral health services” includes: psychosocial rehabilitation (for adults); substance abuse comprehensive outpatient services (for adults); substance abuse intensive outpatient programs (for adults and children); opioid treatments (for adults).
- A behavioral health crisis is defined as a non-life-threatening situation in which a person experiences an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event. The person may be at risk of harm to self or others, disoriented or out of touch with reality, functionally compromised, or otherwise agitated and unable to be calmed. If this crisis is left untreated, it could result in a behavioral health emergency. For purpose of time and distance standards, “crisis services” does not include mobile crisis services. See the Community/Mobile Services Appointment Wait-time Standards below for a standard for mobile services.
- “PHP region” refers to the six regions identified in the N.C. Legislative Report: “Transformation and Reorganization of North Carolina’s Medicaid and NC Health Choice Programs,” March 1, 2016, <https://files.nc.gov/ncdhhs/Medicaid-NCHC-JLOC-Report-2016-03-01.pdf>. (Note that Alamance County is included in Region IV.)
- North Carolina does not cover any State Plan LTSS services that would require beneficiaries to travel to a provider, and therefore time and distance standards do not apply.

Primary Care Access Standards

“Primary care” means basic or general health care provided by a medical professional (such as a general practitioner, pediatrician or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist.

Visit Type	Definition	Standard
Preventive Care	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears.	Within 30 calendar days
Urgent Care Appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
Routine/Check-up Appointment without Symptoms	Non-symptomatic visits for health check.	Within 30 calendar days
After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

Specialty Care Access Standards

“Specialty care” means specialized health care provided by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics and other specialized fields.

Visit Type	Definition	Standard
Urgent Care appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
Routine/Check-up Appointment without Symptoms	Non-symptomatic visits for health check.	Within 30 Calendar days
After-Hours Access – Emergent and Urgent Instructions	Care requested after normal business office hours.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)
Urgent Care appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours

Behavioral Health Care Access Standards

“Behavioral health care” means health care services provided for treatment and services in the community for behavioral and/or substance use disorders. Standard plans cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs. The access standards that follow apply to the services standard plans cover for the mild to moderate population. Pending legislative authority.

Visit Type	Definition	Standard
Community/Mobile Services for Behavioral Health Care	For adults and children, direct and periodic services that are available at all times, 24 hours a day, seven days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency’s facility.	Within 30 minutes
Urgent Care appointment for Behavioral Health Care	Urgent behavioral health services include urgent mental health services and urgent SUD services. Urgent mental health services are those services for conditions in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, will progress to the need for emergency services/care. Urgent SUD services are those services for conditions in which a person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person’s substance use is in need of prompt assistance to avoid further deterioration in the person’s condition which could require emergency assistance.	Within 24 hours

Behavioral Health Care Access Standards (cont.)

Visit Type	Definition	Standard
Routine Behavioral Health Care appointment	Routine behavioral health services include Mental health services provided when a person describes signs and symptoms resulting in impaired behavioral, mental, or emotional functioning, which has impacted the person’s ability to participate in daily living or markedly decreased the person’s quality of life; and SUD services provided when a person describes signs and symptoms consequent to substance use resulting in a level of impairment, which can likely be diagnosed as an SUD according to the current version of the Diagnostic and Statistical Manual.	Within 14 calendar days
After-Hours Access through Behavioral Health Practitioners - Emergent and Urgent Instructions	Emergency behavioral health services include emergency mental health services (i.e., services for life-threatening conditions in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations, and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention) and emergency SUD services (i.e. services for life-threatening conditions in which a person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; and includes crisis intervention).	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

Out-of-Network Providers

- In the event the PHP's provider network is unable to provide necessary covered services to an enrollee, the PHP must adequately and timely cover these services out-of-network for the enrollee for as long as the PHP's provider network is unable to provide them.
- In certain cases where there may be a longer-term need, the PHP and out-of-network provider may be encouraged to engage in single case agreements to ensure both parties understand what is administratively and financially expected and to minimize potential disputes which may disrupt the beneficiary care.
- Beneficiaries may switch PHPs under certain conditions during the lock-in period to obtain medically necessary services that are not all available within the PHP's network.

Exceptions to Network Adequacy Standards

- PHPs that are unable to meet the network adequacy standards may request an exception for a specific provider type in a specific region. PHPs are required to submit to the State a request for an exception with corresponding information in support of that request. Criteria for State review and acceptance of an exception includes but is not limited to:
 - Utilization patterns in the specific service area;
 - The number of Medicaid providers in the relevant provider type/specialty practicing in specific service area;
 - The history of beneficiary complaints regarding access; and
 - Specific geographic considerations;
 - The proposed long-term plan by the PHP to address the access to care gap in its network; and The comprehensiveness and appropriateness of the PHP's plan for addressing beneficiary needs, including the PHP's process for making referrals to out-of-network providers, as relevant, and the PHP's use of telemedicine and other telecommunications technology, as appropriate.
- Where exception requests are approved, DHHS will monitor beneficiary access to the relevant provider types in the relevant regions on an ongoing basis and annually report the findings to CMS, in line with federal regulations.

Telemedicine

- **PHPs may use telemedicine as a tool for ensuring access to needed services in accordance with their own telemedicine coverage policies, as approved by the State.**
- **When an enrollee requires a medically necessary service that is not available within the State's expected driving distance, the PHP will be expected to ensure that enrollee has access to that service and could utilize either an out-of-network provider or could access the service through telemedicine, if applicable and medically appropriate.**
- **The enrollee must have a choice between an out-of network provider and telemedicine and cannot be forced to receive services through telemedicine.**
- **While PHPs may not use telemedicine to meet the State's network adequacy standards, they may leverage telemedicine in their request for an exception from the State's network adequacy standards.**

Discussion

Public Comment

Next Steps

Next Meeting: Friday, April 13, 2018, 12:00 pm – 2:00 pm
Kirby Building, Room 297

Homework:

- Review “PHP Network Adequacy and Accessibility Standards Concept Paper (https://files.nc.gov/ncdhhs/documents/NetworkAdequacy_ConceptPaper_Final_20180215.pdf)
- DHHS Draft Quality Strategy (https://files.nc.gov/ncdhhs/documents/DRAFT_QualityStrategy_20180320.pdf)
- Today’s Presentation

Next Topics: Accessibility Standards and Measures, Provider Directories, and Oversight and Monitoring