North Carolina’s Transition to Medicaid Managed Care

"July 1 marks a significant milestone with the official launch of Medicaid Managed Care in North Carolina. From the start of this process, our goal has been to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care. Today moves us closer to that goal as we begin to implement this important program."

Former North Carolina Department of Health and Human Services Secretary Mandy K. Cohen, M.D., July 1, 2021 (MMC launch day)

In pursuit of better health care quality, better outcomes and reduced health care costs, North Carolina shifted the majority of its 1.6 million Medicaid beneficiaries from fee for service (FFS) to Medicaid Managed Care in July 2021. Medicaid members in FFS – individual adults, families and children, including children receiving NC Health Choice, pregnant women and people who are blind or disabled but not receiving Medicare, transitioned to managed care. These beneficiaries were automatically enrolled with one of five plans, called Prepaid Health Plans (PHP): AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health. Enrollment in a PHP is optional for federally recognized tribal members or others eligible for services through Indian Health Service (IHS), people with significant behavioral health needs, intellectual/developmental disabilities (I/DD), traumatic brain injury (TBI) and substance use disorders.

Medicaid Managed Care Program Flexibility Encourages Member Choice and Engagement in Care

Under North Carolina’s managed care model, the health care delivery system is working toward better integration of physical and mental health, better health quality and outcomes driven by an incentive payment program. This model allows more flexibility to address the non-medical health needs of Medicaid beneficiaries that will help accelerate improvements in overall health, quality of life and reduce associated costs. For Medicaid beneficiaries, this shift to a more comprehensive and holistic approach to care delivery will most commonly be felt through the addition of value-added benefits (VABs), in-lieu-of services (ILOS) options, and care management programs designed to have an impact on members’ social determinants of health and health-related social needs. Additionally, advocates

“Medicaid Managed Care allows our state to take a whole-person, all-factor, team-based approach to providing health care to beneficiaries, leading to better health outcomes for them and less strain on their families.”

Rev. Odell Cleveland, Public Health Advocate, CEO, Welfare Reform Liaison Project, Chief Administrative Officer, Mount Zion Baptist Church Greensboro
have noted the shift is expected to improve care for beneficiaries and ease burden on families.\(^2\)

At the same time, providers and plans alike also take on more accountability for the management of patient panels and population health outcomes, driven by a framework of performance measures, standards, and financial risk and penalties that ensure and encourage continuous quality improvement, and improved access and engagement with care for members.

In North Carolina’s managed care contracts, examples of standards and metrics for plans that are tied to performance incentives include, but are not limited to:

- Development and delivery of a care management policy
- Maintenance of an accurate provider directory
- Provider network adequacy (e.g., timely access, distance and wait-time standards)
- Timely member engagement at enrollment

Moving the Needle on Population Health and Health Equity by Addressing Social Determinants of Health

In North Carolina, the transition to managed care also introduced new standards and requirements around both population health and health equity goals. The intent is for PHPs managing care for member panels to address health status and health outcomes within groups of people, rather than on an individual member-by-member basis, and to do so while ensuring all members have equitable access to health care and equal opportunity to attain good health. In North Carolina’s managed care model, the North Carolina Department of Health and Human Services (DHHS) requires PHPs to align population health and prevention strategies with DHHS public health goals and quality strategy. This alignment is intended to spur quality and performance improvement efforts that will help to achieve DHHS public health goals, and DHHS encourages enhanced case management which includes consideration for social determinants of health and health related social needs in four primary domains – housing, food, transportation and interpersonal safety. These efforts, organized through DHHS Healthy Opportunities pilots, work to determine how evidence-based interventions will help improve health outcomes and lower overall health care costs, to inform service delivery improvements statewide.

CARE MANAGERS: A LOCAL LINE OF DEFENSE TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Plans are using different methods to engage members and populations. Care management strategies typically consist of a team of clinical and non-clinical staff to include: Registered Nurses, Behavioral Health Clinicians, Community Health Workers, Housing Specialists, Social Workers, etc. Care managers assist members in navigating the health system, removing barriers to health and well-being, as well as addressing physical, mental and social needs of the populations they serve.

Clinical staff can work closely with members to provide education about a disease process, help members understand their medications and ensure members are equipped with specialists and services that they need to stay well. Care managers often
coordinate with the clinical team to help members schedule appointments or arrange transportation to and from the pharmacy to pick up prescriptions.

A Healthy Blue care manager explains it well in an example of how she was able to assist a member, “I spoke with a member's mother who was having to pay for ‘Thick It’, which is used when members have swallowing difficulties. She was quite upset and distressed worried about not being able to purchase this for her son. I was able to work with the speech therapist to get her samples until I could coordinate with the provider to get an order sent to the medical supply company.”

In North Carolina, a large portion of care management is also currently done at the member's Primary Care Provider's office through their Advanced Medical Home Tier 3 (AMH3) program. This allows members with high medical, behavioral or social needs to have involvement of a multidisciplinary care team. Clinicians at both the PHPs and the AMH3s complete comprehensive assessments and create care plans to evaluate a member's needs and create measurable milestones and interventions to assist members in moving towards their health goals.

This is in alignment with the DHHS vision to allow members to have access to care management support across multiple settings. It will allow access to direct linkages to programs and services that address unmet health-related resource needs affect social determinants of health. This will assist in bringing statewide quality and value.

One example of this care management strategy is UnitedHealthcare of North Carolina’s use of Community Health Workers (CHWs), to engage members newly enrolled in managed care. CHWs check in on members’ enrollment experience and primary care provider selection, conduct health and social needs assessments, and determine what (if any) services or linkages are needed to support the member's health journey. CHWs then connect members to programs and services through either a plan’s value-added benefits or in-lieu-of services or other community resource.

CHWs are regionally based, focused on the area where most of the members they work with reside. Most CHWs utilize a combination of powerful tools like NC Care 360, a referral resource management platform, and personal, local expertise to match individuals with organizations in the community that can provide additional supports and help establish relationships. Leveraging those resources CHWs quickly identify aligned resources and refer members to potential sources of help to meet their needs.

However, merely referring a member to a resource isn’t always enough. CHWs note that having local knowledge and connections are what really make the difference in engagement for their most complex members. Additionally, CHWs ensure the connection is established and the member’s needs are being met to close the loop, documenting the impact these efforts may have on the member’s health status and outcomes.

Multiple CHWs reported that local expertise and relationships and being able to clearly connote familiarity with the community and its context are what mattered most for fomenting trust in the health plan, from both members and community service provider perspectives. By building
relationships with community leaders, service providers and organizations, UHC’s CHWs are sustaining the linkages that help their members get what they need.

As one CHW, Lauren*, put it,

“I happen to live in, and I’ve worked in this area for 20 years. I know a lot of the doctors, the pharmacies, the V.A. …and providers… would call me directly and say, “hey this patient really needs your help,” or “we have this Medicaid patient. I know you’ve never worked with them, but she hasn’t picked her medicine up in two months.” Then I would call the patient and find out why. Sometimes it was because of money; I would connect them with [organizations that can assist with managing] finances, because I know what churches here will help with medication and get them connected, so they’re on their medicine and it has a higher outcome.”

Another strategy, utilized by Healthy Blue, is employing housing specialists who are subject matter experts in assessing housing insecurities and addressing homelessness. The housing specialists are able to work closely with member's and their families to align them with benefits to help address their needs or align them with community resources that may help them bridge the gap, and hopefully prevent homelessness, or locate more permanent, stable housing. For example, one family with a chronically ill child relocated so that their child was able to get the medical care that they needed. This contributed to the breadwinner of the home having employment instability and ultimately living in a hotel, while struggling to make regular payments to stay in that living space. Healthy Blue’s housing specialist was able to work with the member’s family to provide a Value-Added Benefit (VAB) and funding for the family to stay in the hotel through the remainder of the school year, while the mom and dad both locate stable work and ensure they are still able to care for a medically fragile child.

Efforts like these can help engender trust from members, some of whom may be reluctant to put their trust in the health system or have difficulty navigating it on their own. One CHW, Debby*, a nurse by training, discussed getting members engaged and reconnected to necessary preventive care:

“COVID really threw a lot of our members for a loop. I have members who haven’t seen a dentist in over a year. We talk about why dental health is so important, “so let’s find you a dentist and get you an appointment.” I can say that, because I’ve talked to them, and explained… it helps ease their stress over “that test my doctor said I have to have.” I just tell them what’s going to happen. Once we get them set up [with appointments], their mammograms, pap smear, flu shot, those things are starting to happen again.”

But care managers aren’t only gaining member trust to address their direct health care needs. Multiple CHWs reported efforts that helped members address critical social needs, like newly accessed housing, or maintaining their existing home by providing linkages to housing vouchers and other community programs for financial assistance.
Alongside the social determinants of health screenings, referral resource management tools like NC Care 360, and linkages to community resources through CHWs’ knowledge and networks, members also have access to a full range of "value-added" benefits/services (VABs) and "in-lieu of service" (ILOS) to support their needs.

Medicaid Managed Care plans have flexibility under federal rules to offer payment for non-clinical services that may address health-related social needs via VABs, or for services or settings that are medically appropriate but not otherwise covered by the state plan through ILOS authority. The goal of providing services via either ILOS or VAB mechanisms is to provide a service that improves quality and health outcomes or reduce costs, that is in addition to State Plan benefits, but not part of the standard service array. During the procurement process, some states will specify which services they require a plan to provide as an ILOS; they may also specify a preferred set of VABs that the State would like to see an MCO offer. These are not benefits previously available to Medicaid members under the FFS delivery system. For example, in California, the Medicaid program, called Medi-Cal, permits MCOs to pay for medical respite for people experiencing homelessness as an ILOS, providing short-term residential care for people who need less than acute care but whose recovery would be jeopardized by their unstable housing.

In North Carolina, some services are offered as either an ILOS or a VAB, depending on the offering from the PHP to the State in their RFP response and subsequent contract. Table 1 provides examples of ILOS as offered by the NC PHPs and Table 2 provides examples of VABs.
IN LIEU OF SERVICES

North Carolina’s managed care model requires all PHPs offer the following ILOS:

- Institute for Mental Disease (IMD) as an alternative placement for acute psychiatric care or substance use disorder services.
- Behavioral Health ILOS:
  - Behavioral Health Urgent Care
  - Outpatient Plus (OPT Plus)
  - In-home therapy services for children with Mental Illness/Substance Abuse Diagnosis
  - Child First Outpatient
  - Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)
  - Rapid Care Services

PHPs may then offer their own menu of in-lieu-of-services to enhance enrollee experience by providing additional services not covered under NC’s traditional Medicaid program.

EXAMPLES OF ILOS OFFERED BY PREPAID HEALTH PLANS

Table 1 In-lieu of Services (ILOS) examples

<table>
<thead>
<tr>
<th>Prepaid Health Plan</th>
<th>ILOS Example(s)</th>
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<tbody>
<tr>
<td>AmeriHealth Caritas</td>
<td>Medical nutrition therapy</td>
</tr>
<tr>
<td>Carolina Complete Health</td>
<td>Telemedicine virtual visits; Room to Breathe (asthma home assessment and trigger mitigation); respite care; acupuncture</td>
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<tr>
<td>Healthy Blue</td>
<td>Supports for community living at home rather than institutional/ facility-based living; supports for community-based care at home rather than inpatient care. e.g., additional personal care hours, private-duty nursing, in-home therapy for children with mental illness or in need of SUD services</td>
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<tr>
<td>UnitedHealthcare</td>
<td>Behavioral Health Urgent Care (helps members with urgent behavioral health crisis needs see behavioral health professionals faster); placement in freestanding psychiatric centers for acute psychiatric care</td>
</tr>
<tr>
<td>WellCare</td>
<td>Community-based wraparound services; ambulatory detox; mental health services for high risk-populations; child welfare</td>
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Value-added benefits (VABs) vary from one PHP to the other, and during the enrollment period, North Carolina Medicaid beneficiaries received information to help them review and compare the VAB offerings from each plan. Beneficiaries then had the opportunity to engage with an enrollment broker for choice counseling to help further navigate options. Having that information and resource with which to make decisions about your plan provider was a major change from how enrollment was previously handled under fee-for-service and was considered by some enrollees as empowering. One community health advocate said:

"People see they have choices where they did not before, and the value-added benefits are important for helping people make those choices. Quality of care is higher when the plans are competing, and people like the fact that they have choices."

Offering and delivering on VABs and care management encourages a dynamic of beneficiary choice and empowerment in their care that encourages engagement and continued opportunity for improved health outcomes. For some Medicaid beneficiaries, comparing VABs is a critical part of their plan selection process. One health advocate reported being called upon by Medicaid beneficiaries to help them better understand the differences between plans and using the VABs to determine which plan might be a better fit for their personal needs by comparing the incentives between plans. The advocate also noted that Medicaid beneficiaries appreciated having choices and some beneficiaries perceive choice as drivers of quality and service.
Challenges and Opportunities in Medicaid Managed Care

ADMINISTRATIVE BURDEN FOR MEMBERS AND PROVIDERS

Although some Medicaid beneficiaries and advocates are happy to use VABs and ILOS to make plan enrollment decisions and celebrated it as an opportunity for more consumer choice, other beneficiaries felt their choices were constrained and difficult. These beneficiaries needed to make their plan selections based on which, if any of their existing providers were in a plan’s network. This is an area where consumer advocates and policy analysts had the most concerns. Such advocates spoke of certain families making either/or-based decisions, dependent on which providers were in the network, or which hospital was in the network, especially among families with children with special health care needs. In these cases, the advocates reported families had difficulty identifying which providers were in what, if any, network. They also reported some families had difficulty due to some providers taking a “wait
and see approach” to enrolling with any managed care plan, since provider enrollment is ongoing, and hospitals were not required to contract with all the plans. In the far west (Region 1) and far east (Region 6) regions of the State, which are more rural and have fewer providers overall, advocates noted this was especially problematic for families.

Consumer and health policy advocates also raised concerns about the initial communications about the transition from DHHS, and general confusion about enrollment of Medicaid beneficiaries, with as many as 7,500 beneficiaries incorrectly enrolled into standard managed care plans who should have remained carved out in FFS.

Advocates also noted that DHHS communications were not written in simple language, and that translated communications in languages other than English, and especially Spanish, were poorly translated. As a result of these and other miscommunications, some families were incorrectly enrolled into Medicaid Managed Care, and had to engage in additional conversations and steps with enrollment brokers and the State Medicaid Ombudsman to re-enroll in their prior plan.

As one advocate put it:

“Those are the experiences that are leaving a really sour taste in the mouth of beneficiaries: this feeling of having to go through extra steps; this feeling of this system on the back end as not coordinated, so they are having to hold the burden of then calling the plans and letting them know that they’ve been denied for something; calling the ombudsman is all put back on the beneficiary. Where that really needs to belong is [with] the State and the Plans to fix.”

At the same time, however, consumer advocates noted that members, particularly parents, are looking forward to the development of advisory councils by the plans:

“[Parents] are excited about having that direct feedback and being able to really communicate what it’s like to be on the ground with the services and implementation, because that has not been really afforded to them in the past under fee-for-service.”

The experience of increased administrative burden by Medicaid beneficiaries at the onset of the transition was echoed by providers. Providers are near uniformly having issues with claim denials due to missing taxonomy codes and billing codes. This is mostly an issue with practices that use clearinghouses for their billing, where the PHP is not receiving the information in sufficient time or the correct format to submit claims in the required manner. Guidance has since been developed and providers are working with their vendors to address the issue.

At the same time, because the system has shifted from one system to five individual plans, providers are looking to DHHS and plans to create standardized processes and common forms to continue to reduce burden for provider practices.
Among DHHS and plans’ efforts to address provider needs are several provider education and support tools and forums, including but not limited to dashboards, fact sheets, reference guides and monthly provider meetings with DHHS and plan leadership called Back Porch Chats. These events are a hallmark of the constant communication and collaboration across Plans and the State to improve the delivery of health services for North Carolinians. This culture of collaboration has enabled Plans to contribute to systemic problem solving in real time.

Adjusting to new methods and administrative tasks has been a rapidly evolving challenge for plans, providers and DHHS alike, but there are still significant successes throughout the transition to highlight In November 2021, DHHS reported:

- 80% of beneficiaries are enrolled in a Tier III advanced medical home practice, a model that provides holistic, integrated and coordinated access to physical and behavioral health care
- ~50-70% of providers surveyed reported a Good or Excellent overall experience with managed care
- Plans and DHHS have developed a standardized orientation binder for providers to ease the transition to managed care, reducing the number of slides from 128 to 37; and reduced the number of quality forum meetings from 24 to three

**OPPORTUNITIES FOR FURTHER ENGAGEMENT**

A story emerging from North Carolina’s transition to managed care is the critical importance of local knowledge and local engagement to support member health and member needs. Health advocates and CHWs agree — local knowledge and approaches to member and provider resource identification and engagement engender trust between members, providers, and the health plan.

Knowing the community and the context in which members live, work and receive care are critical for gaining and maintaining their trust in the health system and engagement with their care. Adding a community-based understanding and approach will help to connect individuals to more supports that can further enable positive health outcomes.

Advocates suggest that Plans can further maximize that trust in several ways, including creating inclusive and representative informational material that feels relevant to the community the Plan is trying to reach. Advocates also suggest leveraging the networks of community leaders and champions activated as part of the COVID-19 public health emergency response as part of Plans’ routine outreach on public health goals, identifying those leaders as potential public health champions that have the ear of their communities.

Medicaid Managed Care’s flexibilities offer strong opportunities for community-based care through a robust program of better integrated physical and mental health, improved health equity and outcomes, and more flexibly address non-medical health needs, through a menu of additional services and attentive care management. Driven by a performance incentive framework to improve health and reduce costs to the health care system, these goals can be achieved and reap benefits that affect members’ individual costs and quality of life, too. The tandem efforts to address social determinants of health and educate and engage members in their pursuit of health doesn’t just save the health system money, it can also make a meaningful difference in a member’s daily life.
Endnotes

1 Carolina Complete Health is a provider-led entity, a partnership with the NC Medical Society and Centene.


10 https://files.nc.gov/ncdhhs/medicaid/Managed-Care-Regions-and-Rollout.pdf