

Transcript for Medicaid Managed Care Fireside Chat Webinar Series
January 7, 2020
5:30-6:30pm

Presenters:

Dr. Shannon Dowler

Sarah Gregosky

Jean Holliday

Hugh Tilson

Tonight's webinar is the third in a series of informational sessions put on by North Carolina Medicaid to support providers during the transition to manage Medicaid in this fireside chat series the first Thursday of the month on Medicaid and the third Thursday of the month Tom Wroth will join us to discuss relevant clinical and quality issues. I want to remind everybody Division of Health Benefits has partnered to ensure healthcare providers across all 100 counties of the information and support you need to adapt and thrive under Medicare. Webinars like these and virtual office hours across a variety of relevant topics and in addition practice support coaches are available to provide assistance.

Our focus tonight is behavioral health and managed care. I will be moderating tonight. Turning over in just a second but some quick logistics. If you need technical assistance email technicalassistanceCOVID19@gmail.com, we hope to have time for questions at the end. As a reminder, everybody is muted except for the presenters you can ask questions by using the Q&A feature or if you are on the phone send us an email. We want to remind you we have learned in the past presenters will often address questions during the presentation. Tonight, we gathered questions in advance, we did pre-questioning. So we will ask those questions during the webinar. I encourage you to wait to submit your relevant question so hopefully we get to that in advance. We will send any questions we do not get answered to DHHS and when you send a question it appears behind the firewall and we will respond to what we can but we will get all the questions through the answers we provide. The slides are on the website so there is a link in the Q&A, sometimes you cannot access it through the link so you can copy and paste in your browser or go to the website and look at the website for those slides. We will post a recording in a transcript with slides as soon as possible probably tomorrow. I'm going to turn it over to Shannon.

Dr. Shannon Dowler

Thank you. Welcome everybody to our fireside chat. I am excited tonight because we're supposed to get snow at my house so I hope tomorrow I will be able to get on a sled. Tonight we are focusing on behavioral health. In the standard plan and tailored plans to help you understand the differences with a focus on the standard plan. We will talk about network adequacy, how beneficiaries transition between plans and hopefully answer questions you may be wondering about. We did do some pre-work and send questions to colleagues around the state to ask them what they were thinking about for behavioral health and hopefully we will have done some advanced thinking on answering questions but we will have time at the end for questions and answers. As questions come in we have several subject matter experts on the line and they will be helping to answer questions that we don't cover.

I will say I have to admit I have a little bit of webinar envy. So I'm going to confess although I am super impressed we are at almost 350 people on tonight's webinar, we usually have 700 or 800. I know everybody is underwater with COVID and the vaccine and your practices are fielding phone calls and messages so I will accept that Betsey Tilson gets 1200 or 1400 people for webinars but thank you for being here tonight. We are going to be talking about standard plans and tailored plans and how behavioral health fits in. We want to mention dates. Go live July of 21 for standard plans, July of 22 for tailored plans. Also remembering our tribal option goes live at the same time as the standard plan and we are working on the foster care plan now. The first subject matter expert I am going to turn things is our leader from the managed-care space and someone who was out for several months because she had a beautiful baby but we did miss her. So glad she is back, Sarah Gregosky.

Sarah Gregosky

Thank you. Excited to be here tonight for my first fireside chat. Unfortunately, you missed the prep part of the meeting where the baby was on the video. Wanted to talk a little bit about behavioral health benefits today and the difference between standard plans and tailored plans related to behavioral health services. Both types of plans will be fully integrated managed-care products covering physical health, behavioral health, long term services and pharmacy benefits. Standard plans will typically cover non-dual eligible Medicaid population while behavioral health I/DD plans cover populations with significant behavioral health conditions including serious mental illness, emotional disturbance or substance abuse disorder as well as developmental and intellectual disabilities. Within the tailored plan we will offer a more robust set of behavioral health and I/DD benefits but those will cover both medical and behavioral health services. Next slide.

There are similarities beyond the services provided between the two types of health plans so when we think about standard and tailored plans we try to have some key things that will remain consistent. They will both be fully integrated care, operating under the DHBs 1115 waiver and the authority that allows us to offer managed-care in North Carolina. We will implement consistent oversight across those plans holding them to the same standards. Collecting the same information, setting similar expectations so beneficiaries will have the same oversight for the department to ensure the plans are offering and delivering for beneficiaries in a consistent way that meets our expectations. Both plans allow providers to contract directly with the plans. With the opportunity for rate negotiation. Both will focus on community-based care management. And then they will both have robust network adequacy requirements across to ensure beneficiaries have appropriate access to services.

In terms of differences, the regions that the individual plans will cover are different. Standard plans we have statewide and regional plans with tailored plans it will follow the same regions that exist with LMC/MCOs today, so a little different approach. In terms of network participation. Standard plans have opened networks for both physical and behavioral health services. Tailored will have for physical but closed networks for behavioral health. As we talked about on the prior slide, tailored services will have enhanced behavioral health services that are state-funded through block grants as well as B3 services. We have already procured the standard plans and they were awarded in 2018 and we are in the midst of doing the RFA to procure the tailored plan. It's a different type of procurement, so one was a truly competitive in the RFA was limited to the current LME's that operate in NC Medicaid. Next slide. If we think about what we are seeking to achieve, it is a focus on integration. Today behavioral health benefits are administered through the LME/MCOs and physical are through fee-for-service. The goal is moving the plans to have a true integrated product so the beneficiary can expect to receive services that are coordinated across a spectrum of services and make sure that it's whole person care that they are receiving.

Next slide. If we talk more about standard plans, the services they provide are the low intensity behavioral health and substance abuse services for things like outpatient behavioral health, peer support and emergent BH and substance abuse services so if someone needs to move or has an emergent behavioral health issue they can get mobile and facility based crisis services and they can have services like opioid and ambulatory detox. The goal is to make sure standard plans can serve emergent needs if someone has a new issue and they don't have time to transition to a tailored plan. We have included a full list of services that are offered in the standard plan and tailored plan in the document we will share after the webinar and you can see the comparison of all the services. Which are in standard and tailored plans and then the enhanced services included just in the tailored plan. Next slide.

Dr. Shannon Dowler

First question is from one of our pediatricians. He currently takes care of a lot of anxiety and depression in his practice as do many providers. He has a therapist who works in the office so it is integrated behavioral health environment. Right now his therapist bills the LME/MCO for the work that they do so what's going to happen on July 1st?

Sarah Gregosky

If those individuals are enrolled with the standard plan then you would bill the standard plan, the services are covered by the standard plan so you would bill the standard plan, if the person is not enrolled in a standard plan you would continue to bill the LME that is covering the services.

Dr. Dowler

Great. You mention mild to moderate behavioral health. This feels like it should be an easy question but it is a hard question. How do you answer the question of what counts as mild to moderate?

Sarah Gregosky

It's really the individuals who don't meet the criteria for tailored plans. So it is those enhanced, those individuals that don't meet the criteria for tailored plans and don't need those enhanced behavioral health services. We will have a slide listing all the services but it's really the enhanced I/DD, B3 services and anything related to the TBI waiver.

Dr. Dowler

Excellent, thank you for the overview. Sarah will be on for the whole call and be around to answer the questions. We are shifting now to our Jean Holliday, our Queen of adequacy. She make sure networks are adequate and we will have enough providers to take care of all the business and she holds us to a high standard. With that come over to you.

Jean Holliday

Thank you, good evening. Next slide please. We are going to talk about standard plan and tailored plan networks. First of all they are both required to maintain a network of providers that is sufficient to ensure the covered services are available and accessible to all members on a timely manner. I wanted to read that. I feel like it's important because that is the standard we hold the PHP to.

Basically the standard is designed to ensure that the plan members have access on a timely basis and offers us an important tool to monitor that access and the standards that we utilize are basically three different types. The first is what we call a time distance standard with a maximum time or distance in miles that a beneficiary must travel in order to get to a certain number of doctors of a certain type. I'm going to tell you that the standards we utilize in behavioral health services in the standard plan are found in the appendix at the end of the slides. Also within this deck there is a link to all network adequacy standards including physical health and pharmacy standards. Please feel free to go look at those. In addition to the time distance standards we also have standards that are in some cases that require the plans to contract with a minimum number of providers of a certain type within a specified area. For example, we may indicate there has to be at least two providers in a PHP region of a certain type of provider or service, behavioral health service. So that's the second type and the third type of access accountability is what we call appointment wait times. What is the maximum amount of time a person should have to wait in order to get an appointment with a provider and those appointment wait times will vary by the urgency of the specific needs of the beneficiary. So something for a regular checkup type appointment versus an urgent care type appointment versus emergency.

The standards other than the appointment wait times are set by the county and vary by whether the county is designated as an urban or rural county. The designation is based upon the population density of the county. Currently in NC we have about 80 counties that are designated as rural and about 20 designated as urban. Next slide. So, we have this what we believe is a robust behavioral health network adequacy standard and we use that to ensure access to behavioral health members who need to get that and we will use that for monitoring plan compliance. Part of the oversight involves collecting the plan's networks themselves and then we do things like performing what is called geo-mapping analysis against the data. Looking at every provider, where they are located from a physical address standpoint and mapping that against where the beneficiaries live. And the analysis will tell us how far the beneficiary has to go to get to a certain number of providers. Also for those where the standard is more about having contracted with a certain number of providers in a certain area then we confirm that is actually occurring and not only do you have like two providers in the region but you have full access across the entire region so you know it's not just any two providers. It is those providing across you have coverage across the region.

Before managed-care launch we will be doing readiness reviews around network and trying to assure the PHPs are making adequate progress across the network adequacy spectrum to be sure that we are one, identifying where there are problems, two, making sure they are making adequate progress and then step in and ask for mitigation strategies or corrective action plans or whatever we might need in order to be sure that the plans are reaching adequate networks in advance of managed care launch. Next slide. So basically this is going to recap. We will use the network analysis to assist in decisions around auto enrollment and managed-care launch and by that I mean as we get closer to those two events we will be looking at the plan networks. Where are they? What's the progress? How are they doing in terms of standards related to certain providers? And you know decisions, we may ask for mitigations. We may ask for some sort of corrective action plan or we may make decisions on limiting a plan's ability to participate in certain areas. We are hoping networks will be very robust and adequate and not an issue but obviously we also need to be realistic you know and have a plan if things don't work out the way we would like. We will determine when and whether to require a plan to submit the mitigation strategies and determine when to take other steps for to mitigate deficiencies. After managed care launch, standard plans will make what we call the official submission of their network and this is something that's required from CMS and so they will make you know about one week or so after launch the official network. When they do that, they have to tell us anywhere that they cannot meet network adequacy within a county and then have to ask for an exception from the standard and give us information to help us understand how they ensure people

get the services and how they expect to address the deficiency. We are not in any obligation to approve those. If we don't approve them then PHPs will have to go on corrective action plans or other mitigation strategies but we will review each of those, they each kind of standalone and we monitor those. They are only approved for one year and if they are approved it would be for one year and then they have to be resubmitted each year if the PHP is unable to fill the gaps. I think that was everything that I had.

Dr. Dowler

Let's go to some of the questions we had. The first is from a behavioral health provider asking what if they are unable to finalize their contract with the standard plan by the deadline? Will contract efforts cease on the deadline?

Jean Holliday

We have established two deadlines in terms of providers returning side contracts to the plans in order to ensure they appear within the enrollment broker's provider directory that will be utilized during open enrollment or that they are included in the information we utilize when we do auto enrollment, the auto enrollment algorithm after open enrollment. These dates are not intended to stop contracting or contracting efforts. Providers should continue to negotiate with the PHP. We would like you to do it in those timeframe we have given in order to ensure we are participating and your information is getting into the system but we also want you to continue if you're unable to make the dates and we certainly hope contract negotiations will continue as necessary.

Dr. Dowler

The next question is from a primary care provider. What if I have a patient I am caring for for mild depression and I want to make a referral but there is nowhere in my community in the plan that is accepting patients. How do they get the services they need?

Jean Holliday

I'm sorry. If there is not a provider that you are familiar with that is accepting patients, I would suggest you go to the enrollment broker's provider directory to find providers in the area. You should be able to search based on the area or go to the plan if you know the beneficiary's plan and they will have information on participating providers.

Dr. Dowler

Alright and this question, a lot of people have this question. Will waived MAT physicians begin in first option to continue services for patients in their panel or will they have to relinquish care due to non-contracting?

Jean Holliday

For members enrolled in the standard plan, the physician or provider must be enrolled with or have a contract with the standard plan in order for the individual to continue to be seen by the provider.

Dr. Dowler

That goes to the idea of my philosophy is contract with as many plans as you can. So you don't have to sever those relationships, particularly for critical things where the continuity of care is so valuable and important. Let's move ahead now to the Queen of quality, our very own Kelly Crosbie who is going to talk about care management.

Kelly Crosbie

I like the queen of quality, that's nice. I'm going to quickly talk about standard plan care management. If you can go to the next slide. As a reminder, standard care plan management needs to address the needs of individuals with behavioral health needs, substance use disorders and developmental disabilities. Individuals with co-occurring health, I/DD and physical health conditions from a priority population for care management within the standard plan. You will see at the bottom the other requirements so of course plans have historically and will always look at high cost and high need members but we require again individuals with co-occurring disorders, individuals with long-term service and support needs, individuals with rising risk and high resource needs are also prioritized. It's important to break apart the care management process a little bit to talk about ways behavioral health is screened for and addressed during the care management process. All members are required to have a screening and in the care needs screening all members are screened for possible behavioral health, substance use disorders, developmental issues and a host of issues. All members are required to have screening so the health plan is able to pick up individuals who may not be picked up in claims or otherwise. Health plans then do risk scoring and stratification based on claims and the care screening to identify individuals that need care management. After that, individuals will have a conference of assessment and again requirements are to ensure the health plan is assessing behavioral health needs, I/DD needs, substance use needs and then care planning involves making sure those needs are addressed.

An important role of the health plan and the standard plan is transitional care management including individuals who are hospitalized for behavioral health episodes or behavioral health crisis episodes. Detox or substance use conditions. Those individuals receive prioritization for transitional care management so they are able to get back to services, get their medications, get into the right behavioral health or substance use provider for the treatment they need. They also receive general care coordination. If you think back to the question, sometimes people will be looking for behavioral health providers or a primary care provider will be trying to help an individual find a behavioral health provider so that is a fundamental function of the standard plan. They can help provide the care coordination and referral. Health plans have to do prevention and population of health management programs for things like tobacco cessation counseling. That is a benefit that should be available to all. People with behavioral health I/DD and SUD. This is emphasizing we have tried to in all components of the care management process make sure we are trying to identify and highlight behavioral health, substance use or I/DD or developmental needs of standard care plan members. You can go to the next slide.

Dr. Dowler

So we have got a question for you. How does the standard plan design support population management and quality for folks of behavioral health conditions?

Kelly Crosbie

This slide talks about how we try to make sure we are keeping out the early intervention but also addressing through the care management behavioral health I/DD or substance use needs of members

in standard plans. In addition and this came up in the chat questions, health plans are responsible for not just quality measures looking at physical health conditions and physical health processes, standard plans are accountable for a variety of measures that are specific to behavioral health treatment. For example, standard plans are responsible for the quality measure around follow-up after timely follow-up after mental health hospitalization. They are also responsible for depression screening and follow-up for adolescents. They are responsible for ensuring children on antipsychotics have psychosocial care. They are also responsible for a variety of opioid prescribing and treatment measures. So we have tried to ensure the measures for the standard plan is inclusive of both measures that will look at physical health processes and treatment and also behavioral health and substance use standard of care measures. One of the things that was highlighted really is the idea of the integrated benefit. We know integrated care should be permitted to the extent, to great extent and hopefully the ability of a provider to bill one entity for integrated services can promote that more level of integrated care. So that something we hope the health plans continue to promote with good evidence-based care. I think those are the three things I wanted to highlight.

Dr. Dowler

Awesome all right. So we're going to move onto the next topic. Transitioning patients between standard and tailored plans. For this we're going to Deb Goda.

Deb Goda

Thank you. Next slide please. So, there will be a process whereby you can move from the standard plan into the tailored plan or before tailored plan launch back into Medicaid direct and the LME/MCO so individuals will be notified they are eligible for enrolling in standard plans or they are exempted from or excluded from enrolling in standard plans. That is going to come in advance in the spring in advance of the July 2021 standard plan implementation date. Those notices are going to give you the beneficiary information in the timelines, how they select a PCP, how they go about selecting a health plan. The steps they need to take if they feel that they have a condition such as a developmental disability, mental illness, a brain injury, substance use disorder. That would qualify them to stay out of the standard plan or whether or not it is something that can be addressed within the standard plan. And contact information for the enrollment broker who can provide them with additional information and choice counseling. For those who are eligible for the behavioral health tailored plan, it is going to let them know that they have an option to remain in Medicare direct and wait for the tailored plan because that is something they qualify for but it's also going to say that you can enroll in the standard plan if you wish. It is important to note that if this person does roll in the standard plan, they may be missing out on services that they are otherwise eligible for in the tailored plan. For example, intensive outpatient for substance abuse, intensive in-home for children. Those are not services covered under the standard plan. So if a beneficiary or Guardian chooses to enroll in the standard plan, they need to be aware that they could not receive those services in the standard plan. They are only available on the tailored plan and those notices will include information for the enrollment broker to give more insight and insight information for choice counseling options. Next slide please.

So what if a member is in the standard plan and they need to move to the tailored plan? Either they feel that their needs are such that they need the enhanced care management or tailored care management that is offered in the tailored plan, or they need a service that is not offered within the standard plan. There are two ways. So the provider's pathway, the member of course can submit the member form asking to remain in Medicaid direct. And that is a form that can be signed off on by the member and their legally responsible. And then submitted with no information attached other than

the form and the phone number for the provider. And our vendor will seek that information from the provider. If a provider fills out the form, it must be cosigned by the member or the guardian, but they will submit the form and the information on behalf of the member to the enrollment broker. If it is for a service that is in the tailored plan only, it is an automatic acceptance into the tailored plan. So the individual needs -- it is not available under the standard plan. The form is submitted with a service authorization request for that service and the individual will be enrolled in the tailored plan to get that service. If it is for a reason other than that, then it will be assessed based on what needs they have and what is not being met or any anticipated needs in the future for a tailored plan only. So the provider will submit the form and the enrollment broker will send it to a vendor that we are contracting with to review those forms. It is an eight day turnaround time for the beneficiary form being submitted, a five day turnaround for the provider form being submitted and as I said, if it is service authorization related request then it is within one business day. Next slide please.

Dr. Dowler

All right questions for you. A primary care provider says they only see, can I only see individuals enrolled in the standard plan if they don't have BH or I/DD, do I specifically need to have a contract with a BH tailored plan? What is the primary care office do?

Deb Goda

The office should enroll with both the tailored plans and the standard plans and serve as many people as they feel they can serve. But, you don't have to be in a tailored plan if you have an intellectual disability, mental illness or substance use disorder. It will depend on the severity of it.

Dr. Dowler

This is a question I know there is anxiety about. Will PCPs be required to relinquish BH services to a subcontracted entity?

Deb Goda

No, if you have the capacity to provide behavioral health services within your practice then please that is a higher level of integration and we want that to continue.

Dr. Dowler

Okay and then a question around the transition between standard plans and the LME/MCO future tailored plans and how we make sure that works without dropping the ball and how we make sure the patient stays safe during the transfer.

Deb Goda

We have a transition of care guideline that speaks to how these transfers occur between the standard plan and the tailored plan. How the authorization information travels between the two. How folks get hooked into care coordination and care management on the other side so we do have processes for this.

Dr Dowler

Excellent. Let's go to the next slide. These are next steps. Next slide please. This is the timeline. You've seen this in a lot of variations and a few people might jump in on the timeline. Things I would point out is what you are doing now, this is what I've been saying for the past 3 months, is your information right. Make sure your practice's information is accurate so in the provider directory in the lookup tool it is as accurate as it can be. I have been harping on that since last August so I'm hoping everyone did that and your information is perfect but in the next couple of weeks we need to be asking whether or not you have your contract signed. So this is something that should be on your mind right now. Open enrollment begins in March and then auto enrollment begins not long after in May. That is an important thing so are your contracts signed? Are you in the registry plan and can your patient pick you? What else should people be thinking about? Kelly, do you have anything to add?

Kelly Crosbie

You know I think it's really important I have to put in a plug to make sure Advanced medical homes paying attention to contracting. If you are in an advanced medical home you are a very important primary care providers. We want your members to pick you to be the primary care provider so we want advanced medical homes to get in network as soon as they can.

Dr. Dowler

Anybody else want to point out anything on the timeline they want us to be thinking about? All right. Next slide. We have some key takeaways to run through really quickly. Now you are muted. Try again.

All right so we are not hearing, we having some technical difficulties so we will just run through these. Anybody else want to jump through them or should I read through them? Behavioral health providers need to contract with standard plans and LME/MCOs until the tailored plan launch to be in network for both plans. This is so important, I am worried that behavioral health colleagues around the state do not understand this so we need you to be contracting with standard plans now.

Contracting with both type plans will help to have better continuity of care, make sure you get paid the right amount for the care you give, contracting is important. There is a subset of high intensity behavior health I/DD and TBI benefits only offered in the tailored plan. It will be important to understand which are offered in each plan to make sure you guide your patients to the right place. In the appendix we will have this listed. Standard plans will have open provider networks for physical and behavioral health. Tailored plans will have closed networks for behavioral health and open network for physical health. Once managed care launches, providers will go the appropriate plan, it may be Medicaid direct, the LME-MCO or the standard plan for services.

Next slide. Most non-dual beneficiaries including mild to moderate needs will enroll in standard plans so the majority are going to the standard plan. They may be coming to you, beneficiaries may come to you to understand their options so it is important for you to understand but also know who to refer people to. So we will have folks willing and ready to help our beneficiaries know the right place to go. Providers do play a key role in helping beneficiaries understand what they will be best served by so it's important you think about the best interest of your patients. We will not be launching these tailored plans until July 2022, so those going into the tailored plans will stay on Medicaid direct between the go live for standard plan and for tailored plans.

Next slide. Okay we have a few questions. The first one is for Kelly. What is plan B if the patient cannot get into regular behavioral health providers after July 1st so it is July 4th okay not July 4th, July 6th and the patient needs to go see their regular person and they are in crisis but they have a regular person what happens if they cannot get into the regular provider?

Kelly Crosbie

The expectation is the plan is there to help them find someone as soon as possible, so the beneficiary should be able to call the plan, especially if they are in urgent need. That plan should be able to connect to behavioral health provider ASAP and that really is the expectation. Now that may be a person also getting care management so again the care manager can help them find another in network behavioral health provider but again the expectation is the plan is there and it will be there to help in exactly these kinds of situation.

Dr. Dowler

Excellent. Okay. This is a question from a primary care provider. I don't think most of my behavioral health providers are signed up for standard plans, is there a list folks can check to make sure that their goto folks are signed up for the standard plan?

Darryl

Absolutely, providers can use the enrollment broker provider directory tool containing all active Medicaid and NC health choice providers including primary care providers, specialists, hospitals and facilities. When the tool is live at the end of January the tool can be used to search for behavioral health providers and the health plans to which they are contracted. In addition to this, the department is publishing a weekly report starting this month where providers can view the information before the directory is live. More information will be sent out at the end of the week in a Medicaid bulletin.

Dr. Dowler

Awesome. Great. A question about the payment rate standard plans will use for behavioral health. Will be less than the current LME/MCO payment? There is some frustration. They feel like they cannot get fee schedules for BH services from the plan.

Darryl

There is no floor rate for behavioral health services other than for psychiatrists who fall under the physician rate floor. Each standard plan will develop their own fee schedule for behavioral health. Providers should work with the standard plans during contracting to negotiate behavioral health rates.

Dr. Dowler

All right. How do I know, the provider wants to know how do they know what standard plan a member is enrolled with.

Darryl

They should rely on the member Medicaid ID card or Tracks. This will be on the Medicaid ID card or they can look it up via NC tracks.

Dr. Dowler

The last question we have to go through before we open it up is will standard plans offer telehealth for behavioral health and I/DD services?

Sarah Gregosky

Yes and yes they will.

Dr. Dowler

We have worked too hard getting these telehealth services turned on. So yes. The telehealth is staying with us. All right. I think we have one more slide. This is where we open up for general questions. Turn your cameras on, get ready to answer questions and Hugh, take us through some of those questions.

Hugh Tilson

There are a couple you have indicated you want to respond to. I will start with those. Sarah, you wanted to respond to this question. I wanted to confirm while physical and behavioral health will be together for many tailored plan members, for dual eligibles physical health will remain the fee-for-service in the short term. Is this a correct understanding?

Sarah Gregosky

Yes, for the most part the dual will remain in fee-for-service. When we get to tailored plan implementation in 2022, a small number of duals will be enrolled in tailored plans, those that receive CAP/DA, Innovations or waiver services because those can only be offered through the tailored plans but the rest of duals will be out of managed care this time.

Hugh Tilson

Jean, I saw a couple that you tagged to respond to. Are all the PHP's meeting network adequacy standards at the moment?

Jean Holliday

Yeah. The PHPs, we are measuring their progress toward meeting the standards. At this point we do see that they are not 100% compliant across all categories but we know that they are actively negotiating with providers and we are checking their networks on a monthly basis at this point. So we're monitoring that carefully.

Hugh Tilson

A question about what software to use to measure network adequacy.

Jean Holliday

For time and distance standards we use quest analytics which does the magic behind determining how far it is from point A to point B and how long it takes to drive that on the road.

Hugh Tilson

Since I have got you, we have not yet been contacted by the PHP's we originally signed contracts with. When should they be reaching out to us again?

Jean Holliday

I have not asked that specific question but I would suggest if you have the name of someone you worked with on contracting at the PHP that you reach out to them and find out what's necessary in order to keep everything straight and right for you to start providing services as of managed care launch.

Hugh Tilson

Sounds great. A lot of other questions. Shannon there were a couple you wanted to answer. Do you want to get to those?

Dr. Dowler

I think there was one that I tagged. A question about are we definitely moving forward with managed care essentially? We are in the middle of a pandemic so are we really doing this and I will tell you that the team, we have wrestled and thought, for one thing it is not our choice. So I have to tell you that up front. This is a legislative thing but the team feels strongly that it is the right thing to do and the best thing for beneficiaries. There are some amazing resources we will bring to North Carolina with managed Medicaid to be honest. It will step up the medical home environment. We would do better integration and there is value added services that managed care plans can offer to our beneficiaries that we cannot. We literally are not allowed to by the federal government so those are some positive things.

Also we have worked incredibly hard to create a unique model different from any other in the country and I think every plan will tell you the oversight and the intensity we are putting on the plans to do this is pretty phenomenal. It is a lot in the middle of the pandemic. It is my hope by the time we get to launch in July we have people vaccinated, the numbers are going down and we think of this pandemic as the awful thing that happened. Right now there are no indicators at all that we are not going live in July. Again, this is not a decision we make. We are at the will and we serve with what the legislature tells us to do. I don't see any signs it is not happening so I encourage people to continue to work with your practice supports that you have through AHEC and with your CINs and ACO partners and continue on understanding what you can do now for managed care.

Also know that I got pulled this week for DHSS to lead the provider response for vaccines and I'm working really really hard 16 hours a day this week on making sure we're getting vaccines flowing. We are getting them out to the field so that federally qualified health centers and primary care providers can get the vaccine out so we don't have a single dose sitting on the shelf. The sooner we get vaccinated the sooner we get past the pandemic. And of course we all remembering our parts on not doing crazy silly things like walking around without masks. Anyway that was a really long answer and you may have heard a little bit of apology in my tone. I know it is a lot, an incredible amount for your practices to be dealing with so I want you to know we know that. That's why we're

doing the webinars and all this extra stuff this time around because we are really trying to support you.

Hugh Tilson

Thank you and thank you for all you all are doing. You mentioned CIN's, our CIN says they are only contracting with three plans so will this mean we lose behavioral health patients if they signed with other plans for standard care?

Jean Holliday

I want to point out the program designed for standard plans is such that benefits are intended to be provided by with providers who participate in the plan's network. So if you're not participating on certain plans, then yes it is possible you will lose patients because they will be encouraged to utilize in network providers. Out-of-network services generally will be subject to prior approval and may have other utilization review type limitations upon them.

Dr. Dowler

I will jump in on this one. This is so important for those of you that are out there in health systems where people are making decisions. Big decisions like the contracting with and they may not realize how that will affect you and your patients in the clinic. So it is important you use your voice to talk to the leaders and administrators in your health system to help them understand delaying contracting and choosing not to contract will fragment your relationship with your patient because I myself would be devastated to lose patients that I care for a long time so we don't want that to happen. We don't want the patient to lose you and vice versa. Please make sure if you're part of a bigger system you're talking to the folks making those decisions helping them understand how it's going to impact you and work with your patients to make sure if your hands are tied, and you have no say, it is clear and the direction is the direction than help your patient pick the plans that your contracting with so they can stay with you.

Hugh Tilson

A related question. I am a LCSWA independent contractor working with community mental health clinic in Raleigh. Is there anything I need to do to transition or does my agency take care of the process. It is related but they are an independent contractor. Is there any difference in how you would recommend they approach that?

Dr. Dowler

I will phone a friend on that one.

Sarah Gregosky

I would have Deb answer that. Although did we lose her?

Deb Goda

Can you guys hear me now? I switched headsets. It will depend upon how you are billing now. So if you are billing through your group, you are enrolled as a provider in Medicaid and you are the rendering provider in the billing but if your group, your group is going to be contracting with the

standard plan. If you are currently enrolled with the LME/MCO and you are billing them then you have a contract with the plan. So I would advise you to go to your group and talk to them about whether or not they're contracting on your behalf.

Hugh Tilson

Great question great answer. We have time for a few more.

Any that you want to respond to?

Dr. Dowler

How do we make sure practice information is correct? Darryl do you want to take that one? Or does someone got that one?

Hugh Tilson

While you are thinking about that can I ask one? Is Darryl on?

Sarah Gregosky

I can take it. So, right now we want folks to be insuring they are making sure that their information is accurate in Tracks and that information flows down to the standard plan and to the tailored plans so making sure it's right in Tracks is the first step. As we get closer to enrollment the directory will launch and you can check your information there. If there are issues you can follow up in Tracks to confirm it is there so that information can flow through.

Dr. Dowler

And this is something a practice manager type person will do. Back in my clinical CMO days we constantly had provider changes. It was a moving target so it's important that stuff is getting updated in real-time so it's as accurate as possible.

Darryl

In addition, provider operations will proactively reach out to providers to ensure that their information is up-to-date. So we will begin directing resources to target providers to ensure those records are correct.

Hugh Tilson

We have a couple questions related to behavioral health providers and standard plans. There is a comment I am concerned plans are not reaching out to enroll mental health professionals and this question is if BH providers provide care management for a member but the member selects PCP for their AMH medical home how do we support the behavioral health provider during care management since primary care will get the PMPM support? How are they going to intersect with each other in the real world when the patient centered medical home, since they get the PMPM How do we envision that working?

Sarah Gregosky

I really appreciate the question. Ryan is a hero in the behavioral health world and that is great question. I know his practices go above and beyond in caring for beneficiaries right now. I want folks to not think advanced medical home and think medical model because expectations are very different than that. Our requirements and if you are an AMH and you're providing care management for members in standard plans if you have a comprehensive care team that you have behavioral health experts, community health workers, you are looking holistically at the individual not focusing on physical health needs or all of your care management is provided by an RN. So the expectation is the care is comprehensive, the care team is comprehensive and the care team includes providers, especially if it's an individual's behavioral health or substance use needs are part of that care provider so you're coordinating care with that BH provider as well. Yes the care management fee will typically go to the medical home provider and it may stay at the PHP but the expectation regardless of where management comes, is that it is comprehensive and there is a multidisciplinary care team and their coordinating with any specialty providers like behavioral health or substance use disorder. So that's important to highlight, thank you for that.

Dr. Dowler

Great response, we are at the end of our time which is too bad because there are great questions I would love to get into. Some are pokey and political and the kind of thing I love to answer and get in trouble for with my true transparent nature. We will take these questions back to the Medicaid team, we will answer them and get answers back to you so know that your questions will not be ignored. In two weeks we have our clinical update. We were going to cover diabetes and do a deep dive on diabetes but we felt like the timing was not right for that, instead we will be vaccine updates. I will let you know where we are with vaccinations, how we are working with the field on getting out vaccinations. We will talk a lot about vaccine resistance and cultural barriers to vaccine adoption. Talk about debunking myths. It's going to be really good session. We are bringing in folks from the field who have been giving vaccines to talk to best practices and lessons learned on setting up drive through vaccine services and other things so I can be valuable for those of you that are interested in the vaccine space. That will be the third Thursday which is our clinical topic.

Hugh Tilson

One quick reminder next Thursday we have an advanced medical home webinar. Those of you interested in AMH and learning more please join us next Thursday. So, the whole team, thank you so much for great information. All that you are doing. The providers that participated, thank you for your interest. We hope the information you got tonight was helpful and will help you better understand issues and challenges and opportunities that managed Medicaid faces. We hope this helped and we look forward to talking to you again soon. Thank you very much.

Dr. Dowler

Thank you for joining us this evening and looking forward to seeing you next week. Take care.