Transcript for Clinical Quality Webinar Series: Hot Topics in Medicaid Transformation
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5:30 - 6:30 p.m.

Presenters:
Dr. Shannon Dowler
Dr. Tom Wroth
Melanie Bush
Kelly Crosbie
Dr. Julia Lerche
Carolyn McClanahan
Hugh Tilson

Hugh Tilson:

Good evening everybody. And thank you for participating in our webinar tonight for Medicaid providers. As a reminder, our webinars is part of a series of informational sessions put on by North Carolina Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care, we'll put on these fireside chat webinars until we changed the name which Shannon I think we'll talk to us about on the first and third Thursdays of the month, and they will focus on hot and timely topics on Medicaid transformation. Just as a reminder, we also put on a webinar the second Thursday of the month on advanced medical homes, and we hope you can join us for that as well. Before I turn it over to Dr. Dowler, let me run through some logistics, a couple of quick things. You can adjust the proportions of the slides and the speaker by clicking on the gray bar, just to the right of the slide and dragging it to either side, uh, that'll adjust the size of the slide. You can also adjust your video settings to hide people who aren't speaking, uh, and just get the speaker to do so there's a view button on the top. If you click on that, um, then, uh, click, click the side by side speaker, uh, icon. Uh, that'll do that for you. We will put these instructions in the Q and a, so you don't have to take notes. Um, also want to let you know that we should have time for questions at the end. Uh, we have a great conversation today that will provide lots of information, um. For questions uh, just know that all of our presenters are mute everybody except our presenters is muted. So there are two ways you can submit questions. One is using the Q and A feature on the black bar on the bottom of the screen. And second is, uh, if you go to questionscovid19webinar@gmail.com. Uh, then we can get your questions that way that will work. If you're on the phone. For example, as a quick reminder, we've learned in the past, the presenters will often address your questions during their presentation, especially if it's about something that's on the agenda, which you'll see in just a second. So, um, I encourage you to wait until the presenters are through their presentation before submitting a question, please know that we'll send all the questions to Medicaid. And so, um, if we can't get directly to them tonight, they'll either respond to you or they'll inform future content for webinars down the road.

Uh, we will post these slides on the AHEC website and, uh, there's a link that I'll put in the Q and A in just a second. We're record this webinar, add that link to the recording and a transcript of it also on the NC AHEC website probably tomorrow morning. So without further ado, I'll turn it over to Dr. Dowler.

Dr. Dowler:

Thanks. You great to see you again. Great to see all of you out there, thanks for joining us tonight. We've got a great turnout. Um, for a spring day, we expected to have lower numbers. So, so glad to see we've got almost 300 people on so far and still adding up, uh, joined today by the experts from the Medicaid team of which we have many who are going to enlighten you on some questions and updates from the Medicaid side. Um, just wanted to mention to Hugh's point that this is our last fireside chat, because in fact, no, one's going to be sitting by the fire in April. So we will change our series name when to the back porch chat, where we hope to spend a lot of time in the spring, um, followed by the poolside chat, which will be in the summer. So we will continue meeting with you at being available to you. If you are interested in joining us to answer your questions and try to provide updates. Um, really breaking information on managed Medicaid as well as all things Medicaid.

So with that, let's go on to our first agenda item that is open enrollment who noticed on the 15th, we had a statewide open enrollment. So we've already had over 15,000 beneficiaries sign up, um, which is exciting. Um, and just a couple of days. So just wanted to make sure you are aware of it, um, because you're probably going to be getting questions and your teams will be fielding questions as well. So 15,000 in the first couple of days. Pretty exciting. Next slide. All right, Kelly.

Kelly Crosbie:

Hey there everyone. Kelly Crosbie, Director of quality and population health at Medicaid. So tonight I'm just going to give an update on things that we've been talking about in the last couple of fireside chats. So first the panel management functionality is now live in NC TRACKs. We've talked about this on the last couple of chats. So office administrators will get a monthly message and NC TRACKs in the message center. And we'll have a link to your practice panel report. The first links went out Sunday night. We've already gotten some feedback on the reports. And so we're going to have some calls with some providers just to walk them through the report and to clean up anything. This is the first iteration. There might be some mistakes, but if you look at the call out box, the blue call out box, you see that we're going to have your, your patient panel list. We're going to say if they're a Medicaid direct patient or they're enrolled in managed care in the future, that will actually tell you the plan. It will tell you the effective dates of their enrollment. The last time they had it, an office visit with you and the total number of visits. So again, a lot of this is a work in progress. It's the first report. So, um, uh, we'll work with you to, to make them really meaningful and helpful. And we'll probably actually publish a Medicaid bulleton pretty soon that just says, here's how you can read your report and what it tells you. Uh, so you have a handy fact sheet for that next slide, please. So we've been talking so much too about the exploration we were doing around PCP reassignment prior to managed care launch. So we're doing it. That's essentially it. We finished our testing with all of our beta practices. Thank you again to those practices that help us help us test our reassignment algorithm. So here, this is a fairly dense slide, but it tells you. The select set of members that we are actually going to reassign, um, towards the end of this month, as a reminder, these are folks just going into managed care. They've been enrolled in Medicaid

for at least six months. They're currently assigned to a primary care practice. They don't have any primary care claims with that practice. But they do have primary care claims with another practice. And that look back period is for two years, we are also trying to maintain a closeness of care so we're going to look in the County or adjacent counties. And of course we've excluded things like urgent care. We're not going to reassign someone to an urgent care practice.

About 175,000 members meet this criteria. And for reassignment again, we looked at the number of visits they had with other PCPs. How soon in time that visit actually was at the PCP. So who's the most recent PCP they saw. And again, whether they lived in the same or an adjacent County, once we added all those factors together, we got a score and we assigned the individual to the practice with the highest score. So again, we tested that algorithm rhythm out with quite a few practices and it seems to hold. Um, so those new member cards with a new PCP will go out in the beginning of April, but again, it's only about 175,000 members, but thanks again to all the folks that helped us test our algorithm. Next slide. So, um, I know folks, hopefully, um, well we know that folks are billing the healthy opportunity screening assessment and referral payment. That's the payment for doing the healthy opportunity screening and getting a positive response, which then hopefully you're able to do a referral for services for the member. We've had about a thousand claims billed so far. I know folks are holding in claims and that's because the claims are not paying correctly right now. So we know that, um, uh, Medicaid bulletin is either going up today or tomorrow, just letting folks know that we've isolated, the issue, the fix should be ready in NC tracks by the end of the month. And there'll be a subsequent bulletin and with rebuilding instructions. So please look for that in the Medicaid bulletin. Totally appreciate that folks are holding their claims right now, but in subsequent fireside chats, we want to give folks updates on the number of claims that we're seeing come in for this time limited program. Next slide.

Remember Glidepath at a station is live. Uh, you have until March 30th, uh, to a test for the first Glidepath payment that goes out in April. Remember to attest you need to contract as an AMH tier three with at least two PHPs, and you need to complete the integration testing with at least two PHPs as well. If you're able to do that, you get an additional $8.51 pmpm for all of the patients assigned to your practice and that’s so you can get ready to be an AMH tier three as of three 15, we've had 408 AMH tier threes at test, and that represents about a fourth of the AMH tier threes. Um, so, um, we're very excited about that number. And again, next fireside chat we'll give you an update because we actually expect to see a lot more attestations by the next fireside chat. Next slide. Just wanted to, again, draw folks' attention to the AMH website at those AMH. So, um, uh, uh, Thursday evening seminars, uh, that we have that, uh, um, you mentioned we did walk through all the websites for AMHS, but here's another snapshot of it again, and there's a link to two important documents. One is the AMH provider manual it's version 2.0, please look at that. Those are all the requirements for being an advanced medical home, use that in your negotiations with your health plans and to prepare. And the second thing is just the link to the data specifications page. So again, that has all the data that needs to be exchanged to be an AMH all the files, formats, frequencies. So as you're doing testing and integration with the health plan, please refer to that data specification page. Next slide.

And the last thing I wanted to give you an update on was the quality management webpage as well. So here's a screenshot of the webpage, but I want to draw your attention to it because it has three really important things that are going to be posted. The first is the Medicaid quality strategy that's been posted for over a year, but it has been refreshed to incorporate our tribal option to incorporate our tailored plans. Um, so please look at that. That's just the overall strategy for quality and Medicaid. These

two are really important. The first ever annual quality report is about to be published that will have four years of Medicaid data, Medicaid quality data. So please look at that. See how we're doing on the rates, especially if you're an AMH look at how we're doing on those specific rates. And think about that. As you negotiate performance targets with PHPs. We're also publishing the quality measure technical specifications, so that we'll have every measure that PHPs are accountable for it. It will have the AMH measure set in it. It will have the technical specifications for the measure, and it will also have a section on targets. So the targets we set with PHPs, again, you want to know that as a practice, as you think about negotiating your targets with health plans, next slide. And I think I'm trying it over.

Dr. Julia Lerche

Hi, good evening everyone. I'm Julia Lerch. I'm the chief strategy officer and cheif actuary for North Carolina Medicaid. I hope everyone is staying safe out there. We wanted, we share this with the last fireside chat and went into some level of detail, but wanting to give us a high level overview of the temporary health equity payment initiative that we will be rolling out shortly. And you'll see a bulletin coming out on this, um, either today or tomorrow, the Carolina access temporary health equity payments aligns with, uh, the department's goals to achieve health equity. We're introducing this enhanced payment, which will be available to Carolina access primary care practices that meet certain poverty benchmark thresholds. And I'll talk about in a minute. And really these are focused towards Carolyn access practices that are serving beneficiaries from areas of the state with high poverty rates, the initiative aims to improve access to primary care and preventive services for Medicaid and health choice beneficiaries in North Carolina at a time when historically marginalized populations are facing challenges highlighted by the COVID-19 public health emergency. These payments will be available for three months from April to June of 2021, to be eligible for the payments. The practice must be a Carolina access one or two practice, and must meet a minimum beneficiary poverty score, which is calculated as the average poverty rate for the census tracks of beneficiaries assigned to each practices location eligible practices will receive either a $9 per member per month enhancement to their current Carolyn access payment. For April through June. Um, if they have a poverty score between 17 and 21% our Medicaid average is around 19%. And for practices with a poverty score of 21% or higher, uh, there will be an $18 per member per month enhancement for those three months, the payments will be automatic, but practices receiving the payments must complete a practice survey following the initiative failure to complete the survey may result in us recouping payments, and the survey will be provided over email and we'll seek information that will help us understand how the payments were used and will help inform future initiatives. Practices are directed to use the funds to enhance primary care medical home services, to support beneficiaries, to ultimately address health equity. Some of the recommended uses of the money of the payments include making permanent enhancements to telehealth access, engaging patients to close care gaps, staff training on implicit bias, trauma informed care and health equity, quality and clinical data analysis and action plans. Again, to support health equity, recruitment of key staff to reduce health inequities, such as clinical pharmacists, dieticians, community health workers, health coaches, and doulas, a COVID-19 specific response, improving practice infrastructure to address non-medical drivers of health and investing in behavioral health supports and integration of behavioral and physical health. We will be sharing more information during virtual office hours, which will be hosted by AHEC next Thursday, March 25th, from four to five, the bulletin will provide additional information on how to register for the virtual office hours. And you can find more information in the bulletin and I will stop there and hand it over on the next slide. Okay.

Jean Holliday:

Good evening everyone. My name is Jean Holliday. I'm a senior program manager in the standard plan, uh, administration area. Uh, and my responsibilities are provider contracting and network adequacy. Um, we want to, of course, remind you that, uh, it is not too late to contract with a PHP if you're still sitting on the fence and wondering whether to do that, uh, there is contact information available for each of the PHPs at the link on this slide. And, um, we certainly encourage everyone to consider contracting with as many PHPs as you believe is appropriate for your business. Um, would like to just point out a couple of dates, of course, we're past, um, the initial provider contract deadline and our past beginning, uh, you know, open enrollment, which began earlier this week as, uh, as, um, someone had mentioned earlier and, uh, the next deadline that's coming up is April 12th. And that's the date we'd, uh, encourage you to have your contracts completed with the PHPs in order to ensure your information is provided back to the department. And we, um, include that as part of our auto enrollment, excuse me, auto enrollment algorithm. So, uh, please, uh, if you're in negotiations, then keep that April 12th date in mind. Of course, um, the, uh, managed care launches on the 1st of July and then, uh, the 30th of September will be the end of the period during which the member can, uh, switch to a different PHP. Next slide.

Uh, I'm sorry. This one, uh, is about network adequacy. We just wanted to give you a highlight of what we do in network adequacy oversight. Our hope is to actually present some of the PHP data, um, and their results in the next, uh, what are we calling it? A back porch chat. So hopefully we'll be able to do that on the next, uh, on the next call. Um, basically network adequacy is measured in several different ways. Under our program, we have what we call maximum travel time and distance standards, where a person should not have to travel more than a certain time or, um, miles distance in order to get to, to a certain number of providers of a certain type. We also, um, have, uh, in some cases, uh, just a minimum number of providers have to be contracted with within some geographic boundaries, such as a County or region. And then, um, we also utilize, uh, appointment wait times to help, uh, define how quickly a member should be able to get a, uh, excuse me, get an appointment based on the urgency of that particular appointment, the needs, the need for the appointment. And, um, That you know, is based on, uh, different type different standards for different types of services that are being sought. We also, uh, just as part of our, of our oversight of the measurements, um, of network adequacy, we look at for those, uh, standards that use time and distance, we use some software that helps us calculate how long it should take a person to travel from their home to, uh, to the providers on the roads that are there. Um, you know, it's not just using some sort of a radius. Um, so that software gives us that information and a PHP has did to them demonstrate that at least 95% of the members in the County live within the adequacy standard, uh, in order to be compliant for that County for that standard. Counties also have different standards based on whether or not they're a rural County or an urban County. Um, they've also got to, uh, if the PHP is unable to meet a standard in a particular County, then they must accept, or they must ask us for an exception from that standard and give us information as to how they're going to assure members, get the services that they need. Maybe they'll use tele-health or some other ways of making sure that people get the access that that is, uh, guaranteed under the contract. Um, and, um,

the, uh, appointment, wait, time standards are something that will take some time before we start measuring them. But when we do things like secret shopper analysis, provider surveys and analysis of members, complaints will help us do oversight there. Uh, the last thing is, is the bullet at the bottom.

It mentions that we hope to release, um, standard plan network, adequacy information publicly, beginning in April. Next slide. And I think I'm handing it off to Melanie. Is that right?

Melanie Bush:

Well, There. Sorry about that. I was a little delayed, um, good evening, everyone. My name is Melanie Bush. I am the chief administration officer here at North Carolina Medicaid. Um, based on significant stakeholder feedback and internal conversations that we've had here at North Carolina Medicaid. We wanted to let you know that we have amended our newborn coverage. Um, for our PHPs, we will be issuing them guidance. And, um, having them resubmit their transition of care, um, to reflect these changes. But essentially our recommendation to them was to ensure that the best health outcomes for newborns and to support adherence to the bright futures guidelines on newborn visits and immunizations. PHP shall treat all out of network providers the same as in network providers for purposes of PA and shall be paid in alignment with Medicaid fee for service. Um, through the earlier of 90 days from the newborn's date of birth or the date in which the PHP is engaged and has transitioned the child into an in network PCP or other provider. We do leave it open like that because, um, There is of course, a gap between when a newborn is enrolled in the Medicaid program sometimes. Um, so we wanted to cover that, but it is also our expectation that the PHPs will, um, once the child is assigned to them actively try to engage that family and make sure that they are and, um, moved to an in network provider. Next slide.

So we are recommending 90 days, um, to ensure the completion of all well-child visits, um, through the second month and providing a little bit of leeway because you can't always necessarily get those visits scheduled within 60 days. Um, prior authorization, just a reminder prior auth is not required for well-child visits, and those will be reimbursed the same as Medicaid fee for service. Any visits beyond well-child visits will be subject to end network prior authorization requirements and will be paid in alignment for fee Medicaid fee for service. So, um, an out-of-network provider will be subject to the same in-network prior auth requirements as an in-network provider for anything beyond a well well-child visit, but they will be paid the fee for service rate. Um, their PHP transition of care policies will be updated. As I said, to reflect this guidance. And then here we just list the bright futures guidelines. That we are working. We hope this policy will help us achieve for all newborns, um, and includes of course the newborn visit the first week visit, first month, second month visit and, um, the zero to two month immunizations next. And I think I'm turning it over to Shannon.

Dr. Shannon Dowler:

Yeah. Great. Thanks. Um, so everybody's heard about some pretty cool stuff tonight. A lot of these changes are thanks to you and the feedback from the field that we've gotten a lot of advocacy, um, making sure that our transition to managed care means the best thing happens for our beneficiaries. So thank you. Thanks for all the energy that has gone into sharing feedback and coming back to us with what your needs are out in the field. I think this newborn change is a big, significant change, and that's a

lot really due to leadership from the North Carolina Academy of family physicians and the, um, PEDS society who have meet with us on a regular basis and are always giving us feedback. But that was one that was particularly, I think, a change related to their leadership and making sure we were doing the right thing. So we appreciate that.

And one of the things I wanted to tell you about this is kind of late breaking news, but there'll be a special bulleting coming out tonight or tomorrow. Um, and that we are going to change our reimbursement for the COVID vaccine. Uh, we recognized several months ago that it was taking a lot more to give a COVID vaccine than the admin rate really paid for. It's it's just not your average vaccine. And so we've been looking at ways to how we could supplement that rate within the, um, the bounds that we're under, um, with, with federal authority and other things. But luckily Medicare announced a change rate. So effective March 15th, the reimbursement rate will be $40, whether it's a first or second shot. So if it's a one dose vaccine is $40. If it's a two dose vaccine is $40 for each, um, vaccination, um, just a reminder, you can't charge patients for the vaccine itself, it's a federal resource that is being provided at no cost to everyone. But that vaccine administration fee is you can charge to a payer. Um, and you should build to us if you're taking, getting COVID vaccines that are Medicaid beneficiaries. So next slide.

All right, what ifs? So, um, the team has been meeting with your colleagues around the state. Hopefully some of you are on the call tonight that have been meeting with us, um, in a series of sessions, we're calling the what if session and we're asking folks to bring to us all the things that are stressing them out about the transition. Um, and what's going to happen July 1st. What if, what if I don't get paid? What if my beneficiary can't get an insulin that they need critically. What are the things keeping people up at night? And because we figure if they're having these concerns, they represent you and your concerns. So Tom and I are going to take you through a series of questions to the theme that we have heard from our colleagues around the state, um, with these questions and, uh, do the best we can to answer them and help you hopefully have peace of mind that we do have answers to a lot of these questions.

All right. So the first what if question is one we've heard a lot and it's from someone that says, Hey, I've got a small practice. A lot of my patients have Medicaid. Um, if I don't get paid at a normal speed, I can't make payroll. Like this is a big deal. Um, and so how do we make sure that I'm getting paid right away after managed care launch? Wo who wants to take that one?

Jean Holliday:

I'll take that. Okay, go ahead, Melanie. I'm sorry. It was on my list, but I'll take it and you can, then you can add. Um, well, the first thing I wanted to mention is the PHPs are subject to a state law that requires their claims to be paid on a prompt basis, whether you're a participating provider or a non participating provider. And if they don't meet those time standards, then the PHP has to pay interest to the provider, as well as, uh, as a penalty that's based on the, uh, percentage of the claim. Uh, you will get those interests and those penalty payments without having to request them. And, um, hopefully that will help make sure that the PHPs pay you on a, on a very timely basis, um, Melanie, you wanna,

Dr. Shannon Dowler:

Jean Jean, let me ask you, what does prompt mean? Is, is prompt six months or nine months prompt.

Jean Holliday:

Um, cause you're, you're gonna really test me Shannon, uh, off the top of my head. I believe that it is within 30 days, once they have established that they have all the information that they need on the claim. Uh, but even before they pay it, they should acknowledge that they have it and let you know, is it clean, um, and, uh, and ask for additional information if they need it, a clean claim doesn't mean it'll be paid. It means they've got the information they need to make the consideration.

Dr. Shannon Dowler:

That's great. Great clarification, Melanie, anything you'd add to that. All right.

Dr. Tom Wroth:

Hey everyone, I've got a question for the Medicaid team. So it's about the provider directory. So what if I can't get the provider ombudsman to change my information in the provider directory tool to correctly reflect the PHPs that I'm contracted with?

Melanie Bush:

So I will take this one. Sorry, Jean. That last question was on my first list. Um, so if you're calling the provider ombudsman, um, really the provider ombudsman should be seen as the last resort. You should be making sure that your information is correct in NC tracks and working with NC tracks to make those changes, you should be working with your CIN to make sure that your health plan information is correct. Um, and making sure that that information is reflected accurately, or you should be working directly with the PHP. If, if all of those avenues, um, still result in information that is displaying incorrectly, then at that point you can call the provider ombudsman and they will help escalate the issues to the appropriate vendor either you know, the CIN, the PHP or GDAT. So, so that's sort of. They're really the last resort and really a point of escalation. They can't change your information. We're still going to have to work with, with the vendors that we have.

Dr. Tom Wroth:

So Melanie, they would sort of gather the people together that can make the changes and close the loop and make sure that it gets done.

Melanie Bush:

Yes, absolutely. Guide you through the process.

Dr. Shannon Dowler:

Right. Yeah. Kelly. So, um, w what did the clinic, and I've been a CMO in clinics like this, they have one sort of hu, the mothership, and then lots of satellite clinics that are spread out around the community or multiple communities. And the mothership has, um, meets all the tier three after hours, um, coverage

requirements, but maybe some of the hubs, the spokes don't some of the satellite clinic. Um, what should, what should they do then, as far as meeting the tier three requirements?

Kelly Crosbie:

Yeah. It's pretty important to ensure that that hub site. Meets all the tier three requirements, but remember the, the tier three requirements start with the tier two requirements and that's really the issue. The two, two requirements have all the Carolina access standards. So they've gotta be up in 30 hours a week and have to have 24 seven call. So really that's the site you really want your patients assigned to. They can absolutely be seen at the satellite sites, no issue whatsoever, but to strictly be in compliance with this, the AMH tier three, which is built on the Carolina access two standards, you need to have the right access requirements. So you really want to make sure that's at the hub. And the hub has, uh, they're, they're certified as a tier three site, but again, we totally appreciate that patients are seen at the satellite sites all the time.

Dr. Shannon Dowler:

So they would need to have their satellite clinics registered as the medical home is really that hub that's right. And then they would get their care at these other satellite sites and they would make, they would meet the criteria that way. That's right. Awesome. All right, Tom.

Dr. Tom Wroth:

Great. Okay. So a lot's going to be going on on July 1st and let's say, I end up seeing a patient. Um, but I don't accept their plan. How will I still get paid or will I still get paid?

I'll take that one. Um, basically that, that certainly we recognize that during the time that, um, you know, when we moved to managed care, there's going to be a period of what we're calling transition of care, um, where there's going to be people moving from obviously the fee per serve pro fee for service program, into managed care. And, um, during that period, basically, as I think Kelly had mentioned in one of her presence, or it was, um, Melanie that was talking about the newborn, uh, similarly. Just across all of our members, um, you know, out of network providers will basically be allowed to be continued to be seen, particularly if a person's in an episode of care or has some, excuse me, some kind of critical illnesses or, or, uh, like even a pregnancy for that matter during this transition period. And I think a transition period is 90 days, uh, in some cases, depending on the condition, but generally speaking, it will be 60 days. Um, after that additional out of network, um, uh, safeguards will exist for beneficiaries, um, experiencing ongoing special conditions or undergoing ongoing care, uh, courses of treatment, as I mentioned.

Dr. Shannon Dowler:

So, um, Jane, um, what if, what if it's not like July 1st? So what if we've gone live? Um, I am in a primary care practice that happens to have an opening on my schedule. It's October 15th. Someone comes in and wants to be seen for strep throat. And I want to see him cause I said I would, but we realized that there was a miscommunication and I don't, I'm not contracted with their plan. What would happen then?

Jean Holliday:

Um, generally speaking, we, we want, you know, we expect benefits will be an access through participating providers. However, we obviously recognize that it's not always going to happen. Right. Um, and I believe that it's correct. And Kelly step in here if I'm getting this wrong, um, that primary care will, will never require prior authorization even from an out of network provider. Um, but. Um, you know, care beyond that point is obviously, um, something that the plans may require prior authorization for, and certainly encourage providers to be aware of what those different, um, requirements are. They can, you know, uh, find that information from the PHPs. I think we're also working toward trying to publish something that will help explain out of network benefits prior authorization requirements. And I think that's due to be published sometime later, uh, maybe later this month or next month, uh, on the provider playbook out on our website.

Dr. Shannon Dowler:

All right. Um, so Kelly, I'm going to pitch this one to you. This one comes up a lot. So, um, what if a patient's dismissed, they've been dismissed from my practice, but in the auto assignment process, they get assigned to my practice.

Kelly Crosbie:

Yeah, that's still going to happen prior to, to launch. I mean, and because it's really hard sometimes for the Medicaid agency or the, or the GDAT or NC track system to know that someone was dismissed from your practice, um, after launch, um, you know, after launch, I there's a couple things I want to say. I think it's really important, especially if you're a tier three to remember that, um, we really hope that you're utilizing those care management resources to help patients with barriers. We do think a lot of times people have barriers. Um, and they can be hard to engage because of the barriers in the life. So we encourage you to help individuals pass those barriers. We encourage you to work with the health plan because they can help, uh, with patients who have barriers to getting in for care. But yes, there will be times absolutely where you're working with a member in your practice, and you've decided that it's best to part ways. In that case, you really need to work with the health plan. They will, uh, they need to maintain the care management for that member if they're in care management and that will help that member transition to a different primary care practice. But you, you hear them describing it as a pretty hands-on process because I think we want it to be acknowledged that members have barriers where we're embedding lots of care management, that the system at the health plan at the provider level, uh, because we really want to help members engage. We know that can be challenging, but we're really encouraging you to leverage those care management resources, leverage the health plan. Um, and again, at the end of the day, the best for all might be to transition that patient to another practice. Um, but you know, please work with the health plan and your care management on that.

Dr. Tom Wroth:

All right. Great. I think a question for Carolyn. So I've got, uh, a patient and, um, they, uh, signed up with a plan that I don't take and they want to change the plan so that they can continue to see me. How long will it take for them to change the plan?

Carolyn McClanahan:

If it is before July 1st, they can change their plan and it will be effective from the beginning, from July 1st, after July 1st and we've launched, uh, if a beneficiary requests a plan change, it will be effective the first of the following month after their requests.

Dr. Shannon Dowler:

Right? So, so what if, what if I do all the right things and I see all the right patients, and I only see the ones that are I, that I take their plan and I'm still not getting paid. What do I, Jean you wanna take that one?

Jean Holliday:

Sorry. Yes. That's something in my mouth. I was drinking. I took a drink right at the wrong time. Um, so I'm sorry. Shannon, can you, can you repeat it again?

Dr. Shannon Dowler:

Yep. Sorry. If I do all the right things and I see all the right patients, or I see people in my plan that I'm contracted with and I'm still not getting paid. What are the, what do we do?

Jean Holliday:

Well, first of all, it certainly would encourage you if you're contracted with the plans to see what your contract indicates in terms of resolving disputes, whether that's, you know, an appeal process, a grievance process, is there some other way that they want you to contact them in order to, um, try to get, you know, resolution to any kind of dispute, um, failing any of that, resolving the issues uh, certainly there are legal. Even, you know, additional legal, um, rights that you might have certainly can advise you on those. But also I would like to, you know, plug the departments ombudsman program while we can not necessarily negotiate any kind of settlement on a claim. Um, perhaps you know, that that program may be able to assist in understanding what's going on and what may you know, how to help facilitate moving the issue forward.

Dr. Shannon Dowler:

Great. All right. I think we're ready to advance the slide.

Dr. Tom Wroth:

Uh, I have a newborn question for Melanie. What if I'm caring for a newborn and I need to transfer them to a higher level of care emergently. How do I know if the hospital where I usually transfer them to, uh, takes the same? Uh, we'll take the plan that the child has.

Melanie Bush:

So thanks to the revised newborn policy, all providers within the first 90 days, um, or until the health plan has engaged, um, and an emergent situation isn't necessarily a PCP, but if, um, but then the first 90 days, we're, we're sort of issuing a blanket policy that. Um, providers will be considered as in-network providers the same in terms of, um, requirements for prior authorization. So if there is a requirement for an in, um, an in network requirement for prior authorization, then the out of network provider would,

um, follow that process and still be able to see that patient. Um, and then they would get reimbursed regardless. Um, whether they're in network or out of network, they'll be paid the negotiated rate in network, if they're in network. And if they're out of network, they'll be paid the Medicaid fee for service. So the end result is that newborn should be seen at any hospital in North Carolina. Um, that is our goal to make sure that they get the care that they need and our new newborn policy does that.

Dr. Shannon Dowler:

And that really actually takes the next question as well. Um, what if I see somebody a newborn and they're not part of my plan, we've got this new 90 days, um, where everyone gets the full reimbursement, whether or not they're in that work for these newborns to make sure that we don't miss any critical visits, um, for those, uh, babies.

Melanie Bush:

Yeah. So they'll need to build a health plan that the child is enrolled in. Um, but they will be reimbursed on the fee for service rate basis. All right, Tom, I'm going to kick it over to you for this technology dependent child.

Dr. Tom Wroth:

All right. This is complicated. I'm going to therefore give it to gene. So what if I have a technology dependent child and the managed care plan denies the request for durable medical equipment they currently have. And what if the home care agency is not contracted with that plan?

Jean Holliday:

Okay, because it is complicated. It is a rather lengthy response. And, um, I, you know, I think we want to note that first of all, um, some, uh, technology dependent children will not be part of the managed care population. They are, I believe, and I am not the, uh, eligibility expert, maybe Carolyn can weigh in on that. Um, maybe in one of our waiver programs and therefore will not be participating in managed care. So that's the first thing to keep in mind. Um, although we know that a lot of people are not in those programs, um, for those that will be standing or staying in, uh, or will be going to the standard plans, um, there, um, you know, certainly the PHP contract basically requires there to be some uh, continuity of, of services and benefits to our members and, um, you know, basically covering and furnishing covered services in an amount, duration and scope. That's no less than what is happening in the fee for service, um, uh, program. So, uh, that along with, you know, ensuring that there's sufficient, um, service, that services are sufficient in amount and duration and scope, um, all of those things together, hopefully we'll, will create a, uh, a network that the PHPs will be able to, uh, provide the services without any kind of difficulties. Um, I also want to, you know, stress, um, that, um, sorry, I'm looking at my notes because this is an answer that is, that is complicated, um, that the PHPs cannot adopt more stringent restrictive standards, um, around utilization management for this particular, uh, for this particular child, um, then is already authorized under our clinical policy for that particular thing or that particular service. Um, and, um, let's see. See, I think I've already covered the other parts I'm talking about that they've got to continue to services for that, you know, that we're under the Medicaid direct program for the first 90 days after managed care launch, just as we talked about those, uh, transition of care situations. And of course we know, um, you know, not everything is that's, that's not the magical time period. Things will

happen after that, but, um, hopefully I've I've answered or at least addressed some of the concerns. Uh, Kelly or Carolyn y'all have anything to add, please do Melanie.

Dr. Shannon Dowler:

And also remembering that a lot of these kiddos are Capc. Um, and they're gonna not be in standard plans. They're they're going to remain a Medicaid direct a lot of our kids. That's my understanding. Carolyn, can you confirm that? Correct? She looks like she correct. Okay. I knew some things let's go on to the next slide.

Um, what if a patient on a standard plan routes into foster care? So they are plugging along and then they have a crisis at home. They get moved to a new County overnight and they're moved without their medicines or anything cause there's a big crisis. What happens to them? How do they get their medicines? Are they, could they be seen by somebody in a new County? That's never seen him before.

Kelly Crosbie:

So I'll take that one. There's a lot to unpack on this one. And I would say that our transition of care working group has actively been engaged around seamless transition for children in the foster care system. Um, because children in the foster care system will not automatically, but over time they might move from a standard plan back into fee for service. But again, that's not an automatic thing. So in this particular scenario, it's quite likely the child is still enrolled in a health plan. They are in emergency placement. Um, and what we're establishing with all the PHPs is actually, um, if a child is identified, they're immediately prioritized for care management. But again, that that's behind the scenes. What will happen in these cases is each of the health plans will actually have a dedicated 24/7 DSS resource. So those will be published. And so the DSS care worker, the practice can call this dedicated 24 seven resource to be able to say like, this is my scenario and need you to help me facilitate this scenario, find out what meds the child is on, authorize something if something needs to be authorized, um, because these are really, uh, critical care moments. Um, and so, um, uh, standard plans in those cases, we'll be able to help in those, those, those, uh, uh, critical situations. So more info forthcoming on this.

Dr. Tom Wroth:

Great. So I have, uh, another, what if, what if a family moves from one part of the state to a whole other region of the state, how quickly does that, uh, transition to the new PCP and health plan happen?

Jean Holliday:

Well, luckily most of the plans are statewide. And so moving from one County to another or one area of the state to another does not change their health plan. The exception to that is, uh, Carolina Complete, who are, who serves region three, four, and five. So if they were happening, if they happen to be enrolled with CCH and they moved to a region that they did not cover, then we would assign them to a different plan. Uh, the PCP, uh, assignment can be changed by the plan. So, uh, if they move and need a new PCP, the plan can do that. But as long as the PCP is in network with that plan, regardless of if you know, they could, they would be able to see them and get paid.

Dr. Shannon Dowler:

All right. I think the next, I think we moved to the next slide. Um, so, uh, we've, we've heard this a lot, um, from the field, I'm an employed physician. I'm in a health system and no one seems to know what plans we're accepting and I'm trying to get my patients to pick of the plans, but what, what am I supposed to do?

Melanie Bush:

Yeah. So there's a lot there. It's kind of terrifying. All right. So I think the first thing that I would do is contact your health systems, contracts office, and find out, um, from there. Um, hopefully they will have the information that you need, um, failing that you can also check online. Um, our provider directory will have the information that the health plans are sending us about which, um, help, which providers they have contracted with. And so, um, that's also another Avenue. Um, you can contact your, your, um, Um, look in the provider directory, you can con can contact your, um, health system. I've already said that or failing all of that. You can, um, contact the provider ombudsman, and we will try to find someone who can get you an answer. Um, but I would start with your, your contract's office as the first point of, of, um.

Dr. Shannon Dowler:

Yeah, it's been employed physician and the health system sometimes it's you might not know how to find that person. So I would go to the, um, the, your quality whoever's over quality fair clinics is probably going to have that inside information. If you're chief medical officer for your employee network, um, someone along that line isn't they should be talking to you about it. If they're not talking to you all about whether you're what your AMH level is, who they're contracting with. You need to be asking those questions because it's really important for your practice and for your patients that they stay connected with you. Um, so, so I would encourage you to bother your administrative teams, um, to get that information out into your clinic.

Dr. Tom Wroth:

Carolyn, I heard that, uh, beneficiaries can change plans, uh, within the first 60 days. How many times can I do that? Um, with the plan and also the PCP.

Carolyn McClanahan:

So actually, uh, right now in an individual can change their plans as many times as they want before launch. And then once we launch, they have 90 days. To change their plans without any cause. So during that first 90 days of their plan membership, they can change again, as many times as they want. After the 90 days there must, they must have a reason to change. Most folks will, some will be able to change at any time, but others will need to have a reason, but during the first 90 days that they are a member of a plan, they can change.

Dr. Shannon Dowler:

All right. Um, sounds like someone could, well, that could be a really busy part of someone's life. Just change plans and seeing what happens. Let's hope they don’t that. But, um, all right. So when will I know as a practicing provider, um, but I'm in a community and I need to know who to refer to you. And I

got to know who in the community is taking the plan that the plans that I have and my patient paths. So what am I going to know what the hospital's taking or the specialists in the community you're taking? So I know what my network options are.

Melanie Bush:

So on in our provider directory in the public facing provider directory, you should be able to look up any Medicaid enrolled, um, provider and specialist, hospitals. All of that should be listed there with the affiliated plans. Um, similarly, each of our PHPs will be posting their own in-network provider directories on their websites. And so that is also another option that you might use.

Dr. Shannon Dowler:

And I am noticing the time guys, when you speed round, I'll ask you questions so we can take some other questions from they're timeless speed rounds.

Dr. Tom Wroth:

All right. It's really quick Jean. Um, pediatric subspecialists can be rare. Pediatric urologists. I think there's only so many in the state. Um, what if there's not a pediatric specialist in the community? Uh, and the health plan wants to send them out of the community to let's say an adult. Uh, specialist that covers both adults and kids. What's the situation there.

Jean Holliday:

Yeah. Yeah. Um, the networks adequacy standards, um, particularly for specialists, we measure at adequacy on both the adult population as well as the child population. So, um, so we will be confirming that they do have, uh, adequate network, uh, for a pediatric specialist. Um, I had a question that came through that asked, um, you know, if they had, if they can ask for exceptions, what's the penalty. I want to make it clear that the exceptions aren't guaranteed to be approved. Um, but they are a tool for the department, uh, that we thought was necessary given what we know to be the distribution of providers in some areas in the state. And let me just stress one more thing. If there isn't, if there isn't a sufficient network, the PHP must provide out of network benefits, um, and, uh, you know, make sure that the member gets the services that they need.

Dr. Shannon Dowler:

Right. Thanks, Dean. Um, so what is the behavioral health provider that I'm used to contracting with decides they're not going to take Medicaid anymore. What happens to my patients?

Jean Holliday:

Yeah. Um, if a provider is no longer participating in Medicaid than it is the PHPs responsibility, uh, the previously contracted PHP to make sure that there is transition of the members to participating providers. So the members should be able to be moved to, um, to, to, you know, to the right place. Uh, if it's during a transition period, again, there might be some ability for you to continue seeing that particular individual, depending on the circumstances of the cover of the services you're providing.

Dr. Tom Wroth:

Jean another specialist question. What if my patient's been seeing the same specialist for a long time, there's continuity there, but that specialist does not take their plan? Uh, do I have to find them a new specialist?

Jean Holliday:

Uh, again, yes. I, I think we, we, you know, these are sort of all around the same theme. Um, under transition of care, the idea is to provide some sort of ability for a person to continue seeing a provider that they've historically seen while there is work to try to get the, um, member to, to a participating provider. So in this case, I think it's about trying to make sure that that transition of care period is, is respected. And, and, um, and then, uh, the member would of course, uh, try to be, um, put into a network situation.

Dr. Shannon Dowler:

So, so in a perfect world, everyone would contracts with every plan. So the patients don't have to choose to either change their specialists or change their primary care providers. Um, but, but in reality, in practice, there are going to be times when potentially someone's gonna, a patients going to have to make the choice about whether they want to stay with their primary care, who takes plans, a, B and C or their specialist who takes only D and E. Um, right. Am I asking you that right? Yes, absolutely.

Jean Holliday:

And, and, um, you know, that's the way networks work that's, you know, unfortunately, uh, that's uh, that is a tough decision for someone to face. Um, and of course, as I said, I think the department hopes to have robust participation across all of the PHPs. So those kinds of decisions will be rare, but, um, certainly we recognize it's possible and, and, uh, hope that they, uh, you know, patients will be able to get the care that they need. Uh, you know, even from out of network, if that's necessary.

Dr. Shannon Dowler:

Right. So what about the patients? Um, we're this is, we're talking about quality metric, um, and patients that has they've continuous enrollment. So they're counted in the quality match strict, um, but they switched their plan. Um, and what happens with the quality responsibility for those patients?

Kelly Crosbie:

Yeah, and no, and I think we're on the next side. So quality in general, remember those technical specs that I told y'all to look at? Um, so, um, the vast majority, the overwhelming majority of our measures are standardized quality measures that have measure stewards like Heatus and the measures themselves have continuous enrollment and other eligibility criteria for who can even count towards the measure. So there's several levers of attribution, all members who meet eligibility attribution to the Medicaid program. That's one bucket, that's one universe and we'll calculate those rates. Um, we'll use the same attribution standard, just say it's 11 months of continuous enrollment for a particular measure. We'll use the same continuous enrollment criteria for attribution to a health plan performance. And we'll ask health plans to use the same attribution criteria for advanced medical homes. So again, that means for Medicaid, they've got to be enrolled for 11 out of 12 months. They've got to be enrolled in that particular health plan for 11 out of 12 months. And in that AMH for 11 out of 12 months. So we're going

to try to use a uniform, a standardized continuous enrollment protocol based on what the measure actually is. We don't want to customize it.

Dr. Tom Wroth:

So Kelly, that sort of gets to, if someone's on and off for Medicaid, um, yeah, that's rough, right?

Kelly Crosbie:

So we know a lot of folks go on and off Medicaid. They, they become other in shorter, unfortunately uninsured in some cases. And we don't have that data, but that's what happens today, right? Um, and that's why there are different continuous enrollment standards because we understand there are gaps sometimes in the data. And sometimes when a patient was other insured, they got a visit when they had Medicare or maybe tri care for those three months. And so we'll, we won't have that data, unfortunately. So we would have to exclude them from the quality measure if they did not meet continuous enrollment standards. All right.

Dr. Shannon Dowler:

And I think the next question we had answered already, so Tom, if you want to switch over to the withhold question.

Dr. Tom Wroth:

Great. So, Kelly, another question for you. So when will it start costing my practice money? If our withhold metrics are not good.

Kelly Crosbie:

You've got to look at your contract, like honestly, like what did you agree to? Um, uh, that's the, the, you know, did you agree to, uh, in six months you're going to start having to meet targets or otherwise you lose money in general though, we want folks to know we shared it in the quality fireside chat. It's in the technical specifications manual. The plant's first measurement year is calendar year 2022. So they'll run from January to December. By law, the state can not hold PHPs financially accountable for those measures until 18 months after go live. So the first time we would start to hold PHPs is accountable for quality measures financially is around January of 2023. We'll probably start that in July of 2023 those withholds. And that will reflect performance on calendar year 2022. So we all want to do really well on performance in 2022, but that's how the state is going to hold the PHPs accountable. Again, you know how you contract with the PHPs, but we're trying to share how we are doing withholds. So you can align with that if you want to.

Dr. Tom Wroth:

So looking at our contracts, all right, next slide.

Hugh Tilson:

Well, this is me. So a couple of quick updates for y'all and then we'll turn to questions and Dr. Dowler, we have 63 questions in the Q and A. So if you have some, you want to make sure that we hit, or your team now would be a time for you to start looking at those in the next couple of minutes. So, um, wanna remind everybody of some virtual meet and greets that we're having with the health plans. So

we're, you can see the dates that are on there and the topics of primary care and specialty care long-term services and supports and behavioral health. And you see those dates. And then with each of the health plans also want to remind everybody goes virtual office hours that you heard about earlier that Julia was mentioning, uh, the next one is, uh, the Thursday. Um, and it's on the equity payments. That's on the 25th. So you can enroll in and find more information there. So now we come to question, Oh, go ahead.

Dr. Shannon Dowler:

Yeah, why don't we each take a, just take it, one of the questions that you want to answer and let's throw them out there from the things you've seen already. Um, I see a question that says, wait, I thought behavioral health wasn't going live right away. Um, and going, they were going to stay into Medicaid direct until July of ‘22. Um, that's true for the, the severe persistent mental illness that is not true for routine, um, mild to moderate substance use disorder and behavioral health needs. Those are now part of our whole integrated that's the big goal and managed care is to do integrated care so that medical and, um, the physical and behavioral will be together. Some people will qualify for the tailor plans and that will be delayed until July of 22. All right. Somebody else want to go from when they do that, they want to answer.

Jean Holliday:

This is Jean I'll answer the questions. I had a couple of them around, um, basically, uh, if, uh, if a plan's network is not adequate, are there no penalties? Um, and, uh, how does it impact auto enrollment, um, and wanted to stress that we're monitoring them the, the networks right now on a, on a frequent basis and are analyzing the progress that the PHPs are making toward having compliant access. Uh, and if they do not meet certain goals that we have set for them, then it's possible that the department will, um, utilize, uh, our ability in the auto-enrollment, uh, algorithm to limit the assignments that a PHP may get on a regional basis. Um, the, the decisions will be based on what's happening in the counties in that region, but it would be applicable across the entire region. And that's basically limitations on how many people get assigned.

Kelly Crosbie:

Yeah. Maybe a forecast, something that we're coming back. There's a lot of questions around if I'm not the assigned PCP and I see someone, can I still get paid. Just a lot of questions there. Um, and so, yes, I mean, if you're not the assigned PCP, you can see a patient as long as you're in network, um, and still get paid. So I want to emphasize that in network and in, um, um, but, um, we're going to publish more information about that next time. Cause we've had a lot of questions about, how do I manage my panel in managed care. So we're going to come back with some more information on how, how to do that and what the rules are in managed care.

Carolyn McClanahan:

Yes. There is one about, well, Medicaid only patients who live in adult care homes. The cut out of managed care remain in Medicaid direct. So whether they are Medicaid only or essay recipients, If they live in an adult care home, they're treated the same as anyone who's living out in the community. So it depends on their managed care status. So an adult care home could have individuals who are required to enroll who have the option to enroll or who can not enroll. And so they get the same status assigned

as anyone else in the community. And what I'd like to do is point you to the website and the provider playbook. There is a managed care overview that provides the different statuses and that kind of thing I think would be very helpful, but it, their status as living in adult care home does not determine and whether or not they are in, in managed care.

Melanie Bush:

So I saw a quick question about how long does it take to make changes in NC tracks? Generally these changes happen, um, 24 to 48 hours. If it is taking longer than that, that it may be a change that requires you to go through recredentialing. And that usually takes one to two weeks. Um, if you do have any issues, um, continue to have issues with your information not being updated, um, please contact NC tracks. And if that fails, then of course our provider ombudsman. Um, the other question that I saw was, you know, it's the, or in the newborn policy that people have concerns about, um, a PCP may very well be backdated because coverage will be backdated to the first day of the month that the child is born, but it is our expectation that until that child goes to see that PCP, they have not engaged with that health plan. And so any services that are provided in the interim will be paid the same as in network and at the fee for service rate.

Dr. Shannon Dowler:

Great. That takes us to 6:31 we're one minute over. Um, we will be back again. We're with you every other week. Just answering questions, doing hot topic, trying to get everybody up to speed as much as we can. All the recordings are available online. So you can look at prior fireside chats. I really encourage you to do that if you're, if you've been really focused on COVID and haven't been thinking about managed care, go back and listen to some of our older fireside chats to get up to speed, because we've been sharing a ton of information over the last several months. Um, if you any final comments from you.

Hugh Tilson:

Um, only the fact that y'all got a number of shout outs about how great this webinar was, how great the information is, the newborn policy, the vaccine, uh, reimbursement policy. And as many of these questions may not necessarily have been thank you's. It's important that y'all hear that the decisions that you make are appreciated the time and energy that you put into these as appreciated. So I just want to make sure you heard that before we signed off. So thank you all. Very thanks. You we're all in it together. Um, we'll talk to you at the next one. Thank you.