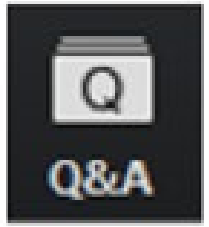
Fireside Chat: Hot Topics in Medicaid Transformation

March 18, 2021

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here: https://www.captionedtext.com/client/event.aspx?EventID=4743751&CustomerID=324

Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

01 AMH, Panel, HOSAR, Glidepath, Quality Updates

02 Other Updates

03 What Ifs

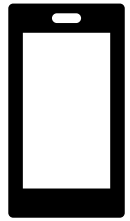
04 Questions

Statewide Open Enrollment

NCDHHS announced on Monday 3/15 the launch of statewide open enrollment for NC Medicaid Managed Care. Beneficiaries can enroll through one of **four channels**:

Online

Calling the NC Medicaid Managed Care Call Center at 833-870-5500 (TTY: 833-870-5588)



The free NC Medicaid Managed Care mobile app available on Google Play or the App Store

Using the mail-in forms sent to them in an enrollment packet

Panel Management—New Functionality in NCTracks

Office Administrators will get a monthly message in NC Tracks Provider Message Center with a link to a report with their Medicaid Direct (FFS) and Health Plan panels.

REPORT: PM02429-R0010 NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROCESS DATE: MM/DD/YYYY
PAYER: XXXXX NCTRACKS PROCESS TIME: HH:MM:SS
PAGE: XXX,XXX

AMH MEDICAID DIRECT/MANAGED CARE PCP ENROLLEE REPORT
AS OF MM/DD/YYYY

NPI/ATYPICAL ID: XXXXXXXXX
PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS LINE 1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS LINE 2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY, STATE ZIP: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

- Program
- Start/End Dates of Assignment
- Date of Last Visit*
- Total Visits*

MID	RECIPIENT NAME	DOB	ACTIVE	ASSIGNMENT PROGRAM	EFF DATE	END DATE	LAST OFFICE VISIT	TOTAL VISITS
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	Y	MED-DIR	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XXX
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-MGD	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-MGD	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-DIR	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK

PCP Reassignment

- DHB will do primary care reassignment in late March for ***some*** members
- Member Selection Criteria:
  - Managed Care Eligible
  - Enrolled in Medicaid before 09/01/2020 (enrolled for 6 months)
  - Currently assigned to a PCP practice
  - Does not have any primary care claims with their assigned PCP between 01/01/19 AND 02/28/21
  - Has primary care claims with another PCP practice who is active CA 2/AMH 2 or 3
  - At least one of the PCP practices the member saw is in the same county or an adjacent county to the beneficiary
  - At least one of the PCP practices the member saw for primary care was <u>not</u> an urgent care

- **~175,000 members meet these criteria**

- Each PCP practice the member saw for primary care is assigned a score that factors in the following:
  - The number of visits the member had with the respective PCP
  - The number of days since the member's most recent visit with the PCP
  - Whether the beneficiary lives in the same county as the PCP
- **Member is assigned to the PCP practice with the highest score (best fit)**

- DHB will distribute new Medicaid ID cards to affected members in April 2021

Healthy Opportunities Screening, Assessment and Referral Payment (HOSAR)

~1000 claims billed to date.

- Effective January 1, 2021, NC Medicaid and NC Health Choice is temporarily covering **Healthy Opportunities screenings** to encourage providers to gain capacity for screening Medicaid beneficiaries for unmet health-related resource needs and referring them to appropriate community-based resources, prior to the launch of Medicaid managed care.

- **Current Carolina Access (CAII) providers** are eligible to bill code **G9919** for positive healthy opportunities screenings conducted using the Department's standardized screening questions or equivalent questions. Coverage of this code will continue through June 30, 2021; continued coverage after managed care launch will be at the discretion of the Health Plans.

HOSAR Payment Issue has been identified. NCTracks issue will be fixed by 3/28. Look for Medicaid Bulletin on re-billing instructions.

Please visit the DHHS website for more information about HOSAR

AMH Glidepath Attestation Is LIVE: AMH 3s can Receive $8.51 PMPM for 3 Months After Contracting with 2 PHPs and Completing Data Integration Testing

Attest by March 30 for the April Payment. Providers only need to Attest once (by site).

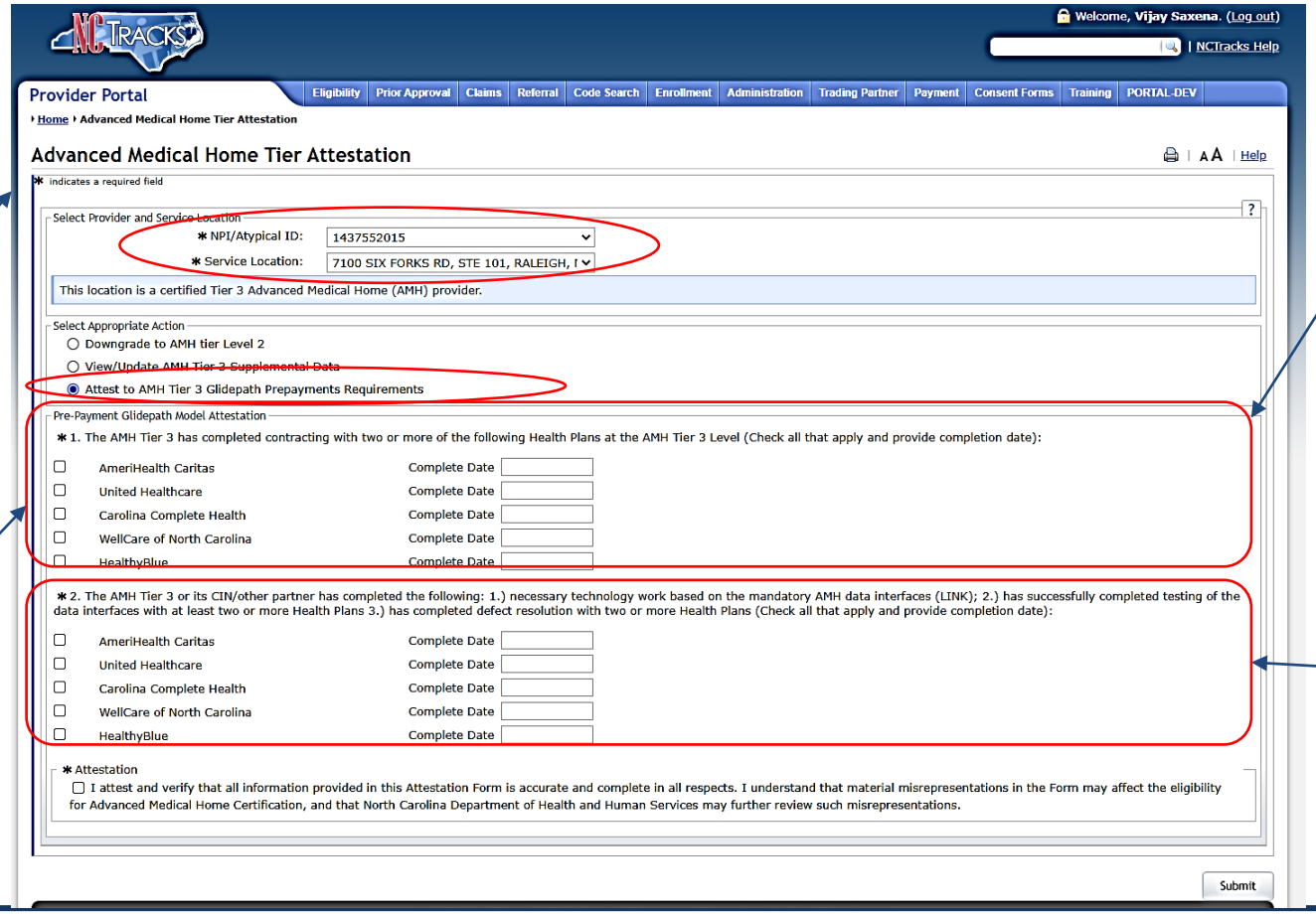
The AMH Tier 3 Glidepath Attestation is part of an updated set of AMH functionalities within the provider portal in NCTRACKS.

408 AMHs have attested (as of 3/15)

To Attest:

1. Input NPI and location for the practice attesting to glidepath requirements

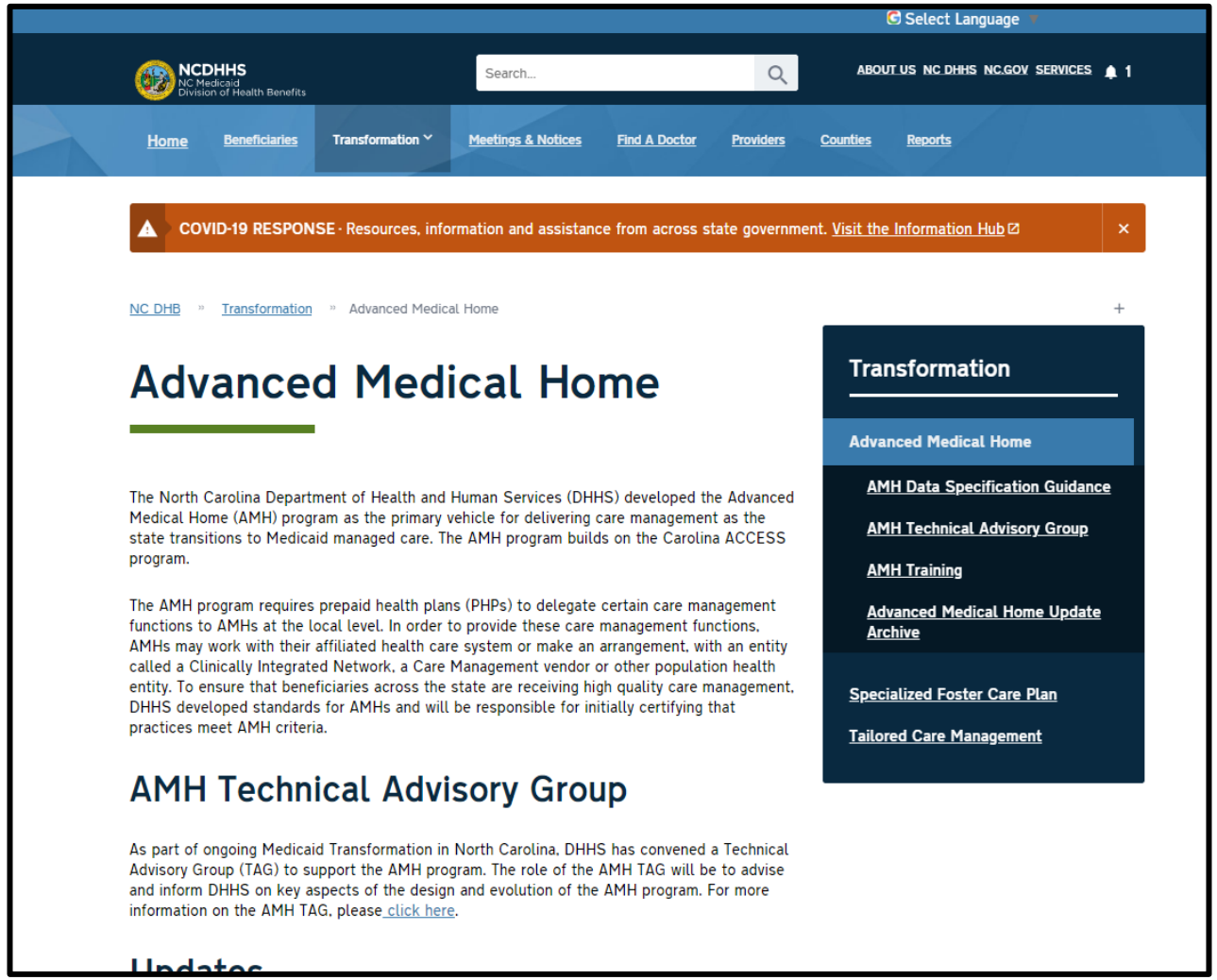
2. Select "Attest to AMH Tier 3 Glidepath Payments Requirements"



3. Practices should select the PHPs they are contracted with at the Tier 3 Level and date contracts were completed

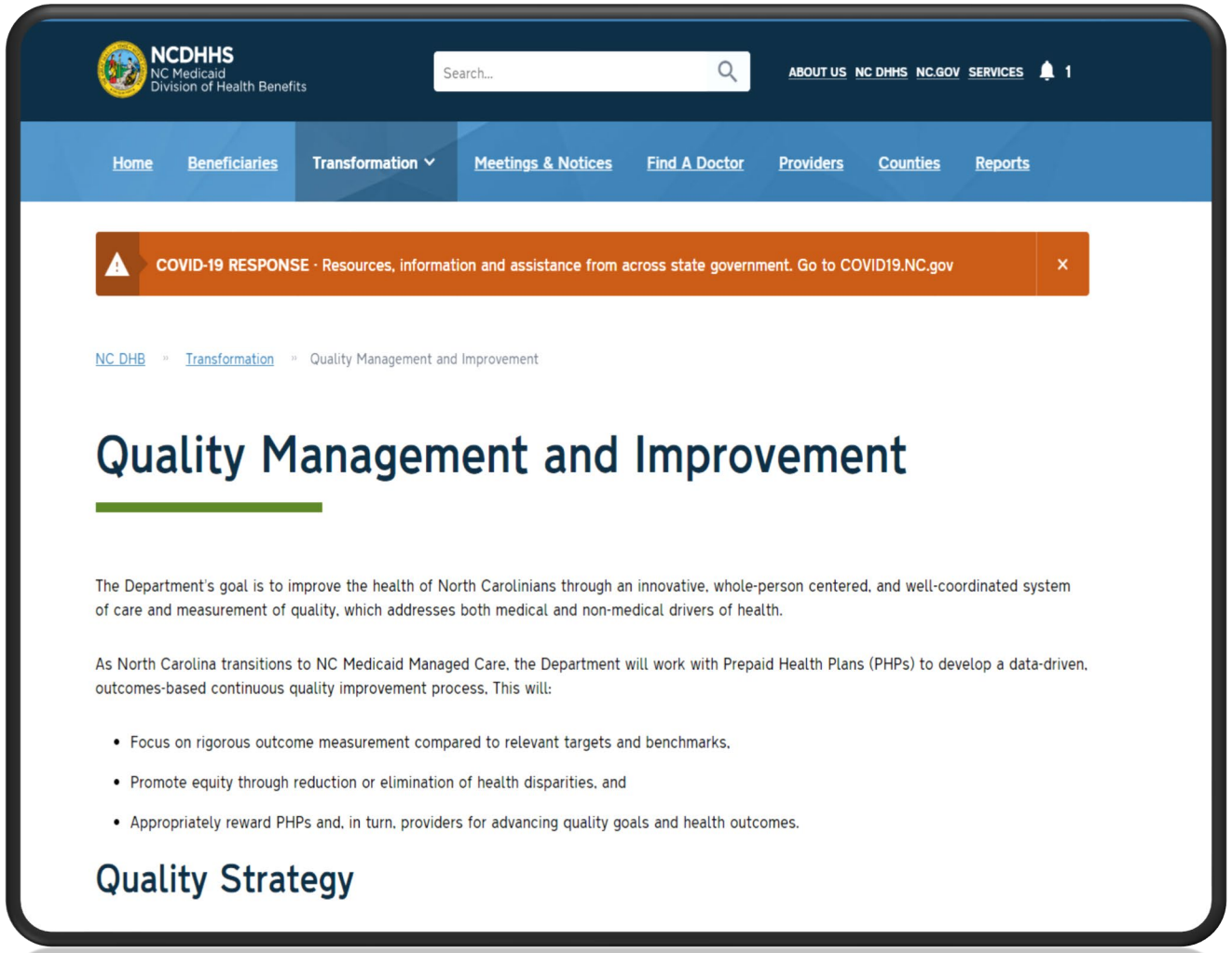
4. Practices should select the PHPs they have tested with and testing completion date

AMH Implementations



- AMH Provider Manual 2.0 posted All AMH Tier 3 requirements
- Advanced Medical Home Data Specification Page

Quality Management and Improvement



- ✓ ***Medicaid Quality Strategy***—outlines aims, goals, objectives and interventions to assure, monitor, and improve quality
- ✓ ***Annual Quality Report***—4 years of data on Medicaid quality
- ✓ ***Quality Measure Technical Specifications:*** Standard Plan and Tailored Plan measure sets with technical specifications and targets

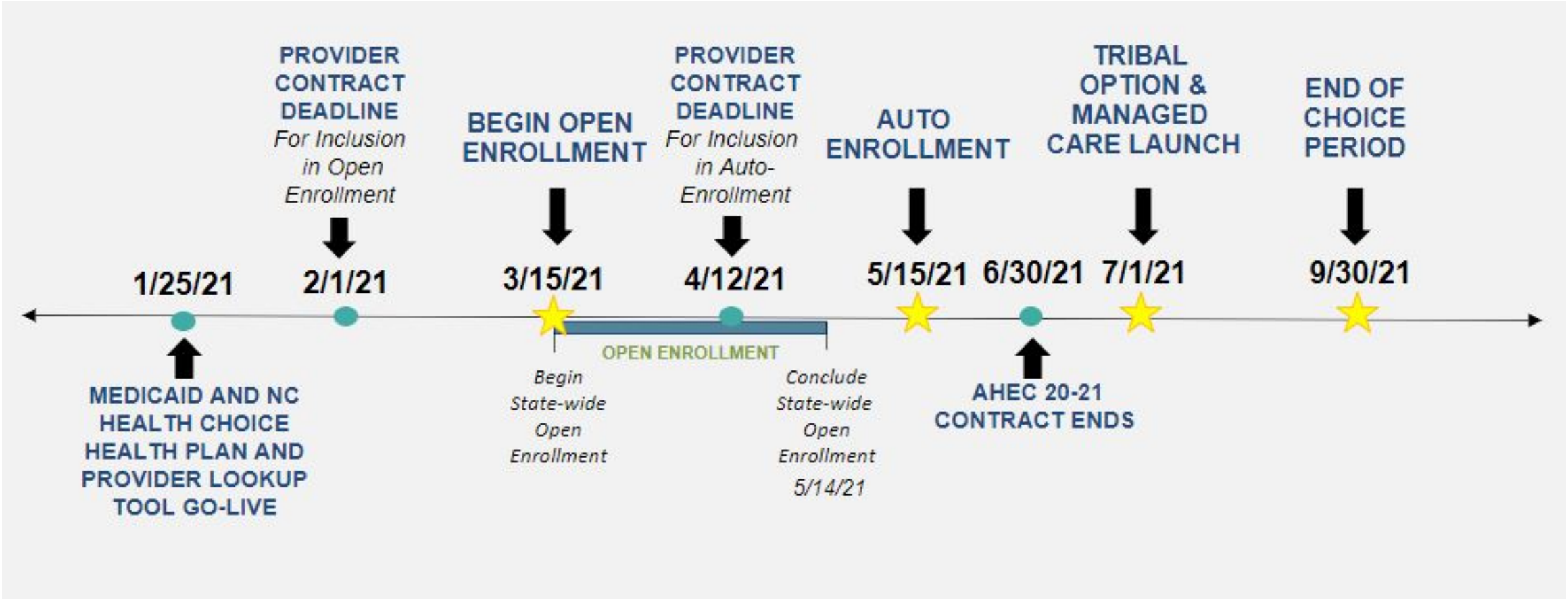
Proposed Carolina Access Temporary Health Equity Payments

- Available: April – June 2021
- Eligible providers: Carolina Access I and II providers serving beneficiaries from high needs areas.
- Increased PMPM based on practice's mix of beneficiaries (measured by poverty rate at beneficiary's census tract).

Source: Robert Wood Johnson Foundation:
https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html#/download

Provider Contracting

Providers are encouraged to contract with all PHPs. Contact information each PHP to engage in contracting is available here.



Network Adequacy Oversight

What are the network adequacy standards based upon?

- Network adequacy standards are established as either:
  - A maximum travel time or distance from a member's residence to one or more providers of a certain type

  or
  - A minimum number of providers of a certain type within a geographic boundary (county or region)
- Network accessibility standards are established as the maximum amount of time a member should have to wait to obtain an appointment with a participating provider based on the type and urgency of the service being requested.

What does the Department measure?

- For the time/distance standards, the Department uses software to calculate the distance in travel time and miles from a member's residence to providers.
  - A PHP's network must demonstrate that at least 95% of members in a county live within the adequacy standard in order to be compliant in that county for that standard.
  - A PHP must request an exception from any standard with which they cannot comply.
- For the standards based on a minimum number of providers within a geographic boundary, PHPs' must demonstrate that their networks have the correct number of providers of the correct type in the specific area in order to be compliant.
- Appointment wait time standards will be monitored through secret-shopper analysis, provider surveys, and analysis of member complaints after managed care launch.

When will the Department release network adequacy status publicly?

- The Department expects to release Standard Plan network adequacy information in April 2021.

Newborn Coverage Changes

To ensure the best health outcomes for newborns, and to support adherence to the Bright Future Guidelines on newborn visits and immunizations, PHPs shall treat all out-of-network providers the SAME as in-network providers for purposes of Prior Authorization and shall be paid in alignment Medicaid fee-for-service for services rendered through the earlier of:

- 90 days from the newborn's birth date

OR

- Date the PHP is engaged and has transitioned the child to an in-network PCP or other provider.

Newborn Coverage Changes

The Department recommends 90 days to ensure completion of all well-child visits through the 2nd month when critical vaccines are administered, while providing leeway for visits that may be scheduled a few days or weeks past 60 days. Prior Authorization is NOT required for well-child visits and will be reimbursed in alignment with Medicaid fee-for-service. Visits beyond well-child visits will be subject to in-network prior authorization requirements and paid in alignment with Medicaid fee-for-service for services rendered. PHP Transition of Care (TOC) policies should be updated for review and approval to include the transition of care of newborns to in-network providers during the first 90 days of life.

Bright Future Guidelines which align with HEDIS W-30 require:

- Newborn Visit
- First Week Visit (3 to 5 days)
- 1 Month Visit
- 2 Month Visit
- Immunizations 0-2 months: RV, DTaP, Hib, PCV13, IPV

What Ifs

Managed Care What Ifs: General Scenarios

I have a small practice and many of my patients have Medicaid. If I don't get paid in a normal speed, I won't make payroll. How can I make sure I get paid right away?

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 am contracted with?

What if I see someone who is on a plan I don't accept? Will I still get paid?

What if a clinic has smaller satellite sites that don't meet Tier 3 after hours coverage?

What if a patient is dismissed from a practice, will the patient still be assigned to that practice?

What if I do all the right things and see the right patients and I still don't get paid?

Managed Care What Ifs: Newborn & Technology Dependent Children

What if a newborn needs to be transferred to a higher level of care emergently? How do I know if the hospital will take the plan the child will have?

How will the hospital/practice bills be paid when a newborn is aligned to a health plan that is not part of the hospital/practice network?

What if I have a technology-dependent child and the managed care plan denies request for durable medical equipment (DME) they currently have? What if the home care agency has not contracted with their plan?

Managed Care What-Ifs: Transition of Care

What if a patient on a standard plan moves into Foster Care? What if they move to a new county overnight and are moved without their medicines?

What if kids/families move to another county/region, how quickly will health plan and PCP transition happen?

What if my patient enrolled in a plan I don't contract with?
How long will it take after they call to change their plan to one I am enrolled with?

Managed Care What Ifs: Provider Contracting/Network Adequacy

I am an employed physician in a health system, and no one seems to know what plans we are accepting. What do I do?

When will I know what plans the hospital and specialists in my community will take so I can start to understand my network options?

What if the behavioral health providers I am used to working with don't accept Medicaid anymore? Who will see the patient?

How many times can a person change their plan in the first 60 days? How about their PCP?

What if there is not a pediatric specialist in my community that my patient needs, and the plan wants to send my patient to an adult provider?

What if my patient sees a specialist, and has for a long time, that does not take their new plan? Do I have to find them a new specialist? Can they see them out of network?

Managed Care What-Ifs: Quality Measurement

What if a patient switches plan but has continuous enrollment? How do I manage quality performance?

What if a patient is not continuously enrolled in a Medicaid plan? What happens to their quality data when they are on and off Medicaid?

What if a patient's PCP is not in network, will it take a long time for the patient to switch PCPs or plans?

When will it start costing my practice money if our withhold metrics are not good?

Virtual Meet & Greets with Health Plans

- NC AHEC will host virtual sessions with NC Medicaid and each of the health plans to answer questions from providers across the state. The topics and their dates are as follows:

Primary Care & Specialty Care	March 23 & April 6
Long Term Services & Supports	March 24 & April 7
Behavioral Health	March 25 & April 8

VIRTUAL OFFICE HOURS

- Offered monthly on the fourth Thursday at 4-5pm by NC Medicaid & NC AHEC.
- Next topic is Carolina Access Health Equity Payments on March 25th.
- More information & registration

QUESTIONS?

APPENDIX

NC Medicaid Managed Care Timeline

March 1, 2021

Mailings Started
EB Call Center

March 15, 2021 – May 14, 2021

Open Enrollment

April 15, 2021

Reminder Postcard

May 15, 2021

Auto-Enrollment

July 1, 2021

Health Plan Coverage Starts

July 1, 2021– Sept. 30, 2021

90 Day Choice Period

Managed Care Populations

While most Medicaid beneficiaries will enroll in NC Medicaid Managed Care, some people will not. The table below outlines who must enroll, who may enroll, and who cannot enroll.

MANDATORY	EXEMPT	EXCLUDED[1,2]
Must enroll in a health plan	**May enroll** in a health plan or stay in NC Medicaid Direct	**Cannot enroll** in a health plan; stay in NC Medicaid Direct
Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled	Federally recognized tribal members/IHS eligible beneficiaries, beneficiaries eligible for behavioral health Tailored Plans	Family Planning Program, Medically Needy, Health Insurance Premium Payment (HIPP), Program of All-Inclusive Care for the Elderly (PACE), Refugee Medicaid

[1]Some individuals are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, Community Alternatives Program for Children (CAP-C), and Community Alternatives Program for Disabled Adults (CAP-DA).

[2]Some federally recognized tribal members/IHS eligible beneficiaries are excluded and may enroll in the EBCI Tribal Option.

Enrollment Broker Call Center is LIVE!

Enrollment Call Center

Enrollment Specialists are available at the Call Center for support.

Beneficiaries can call toll free: 1-833-870-5500.

We are available to:

- Provide choice counseling
- Support search for preferred PCP
- Discuss health plan services
- Enroll beneficiaries in selected health plan
- Assist with some demographic changes
- Disenroll members as needed
- Process Enrollment Broker complaints and grievances
- Facilitate appeals process
- Provide support for the website and mobile app
- Aid with deaf and non-English speaking beneficiaries