Transcript for Clinical Quality Webinar Series: Hot Topics in Medicaid Transformation

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Presenters:

Dr. Shannon Dowler

Hugh Tilson

Angela Smith

Black Cook

John Vitiello

Dr. Harita Patel

Melanie Bush

Hugh Tilson

Good evening everybody. Just wanted to see if anybody knew who wrote that music we're debating whether it was the black keys before we got started. So, if you think it is just shoot us a note. Thank you so much for participating in our webinar tonight for Medicaid providers, as a reminder that this webinar is part of an informational session, put on by Medicaid and they help to support providers during the transition to Medicaid managed care, put on these back porch chat webinars on the first and Thursdays of the month will focus on hot topics. And then on the second Thursday of the month will focus on advanced medical homes. So hope you can join us for those as well. I'll turn it over to Dr Dowler in just a second before I do a couple of logistical 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 either side to just see the side of the side of the speaker. You can also hide the non speakers. So if you do that at the very top there's a View button, click that and then you can select side by side and then speaker and then only the speaker will show up. While that speaker is speaking, put all that in the q&a For your convenience, it's going to give you some opportunities to maximize your experience. I also want to let you know that we will have time for questions at the end, everybody, other than our presenters is muted, so there are two ways you can ask questions or make a comment. One is using the q&a feature that's on the black bar on the bottom of the screen. If you're dialing in. You can't do that so you can send an email to questionscovid19webinar@gmail.com. One quick reminder is that we've learned in the past that presenters will often address your questions during the presentation, I encourage you to wait until the presenters are through their presentations before submitting a question, especially if it's about something that's on the agenda which Dr Dowler we'll get to in just a second. We'll send all the questions to Medicaid, so we can make sure there's a response to them. And lastly we've posted these slides on the AHEC website there's a link in the q&a. So, you can click on that and get the slides, we'll

record this and we'll add a recording and a transcript of it to the slides on the website probably tomorrow morning. Now let me turn it over to Dr Dowler.

Dr. Shannon Dowler

Thank you. Thanks for hosting, as always, we appreciate you. Um, today we are 77 days until managed care launch, that is not far off. So we have a really packed agenda, we have one of our What if listening sessions a couple of weeks ago where we have not only providers but pharmacists from around the state to peg the team with questions they had around the managed care launch and transition and we're going to answer dozens of those questions for you today and give you a lot of background and information that we got from them that you need to hear and so we are going to go to questions and answers at the end if we don't answer your question please know you'll have a chance, but hold off if you could on putting your question into the chat, until we get to at least the general update sections you'll have gotten the information your question might get answered. So, again, very glad to have you. We have our team from pharmacy and durable medical equipment, who are going to tell you so much that you want to hear. And I think you're going to have a lot of good news tonight, compared to some of the questions we heard in the anxiety, or what if session, I think this is an area where folks are going to feel better at the end of the backporch chat, so I sure hope so now I've set this up, I'm going to turn it over now to our director of pharmacy and fountain of wisdom, Angela. Angela, are you there.

Angela Smith

I'm here Dr Dowler. Good evening everybody. My name is Angela Smith and I'm serving as the DHB pharmacy director. I'm presenting tonight, along with Blake Cook, and -- Patel from our pharmacy team in the Division of Health Benefits. To get us started, I'd like to explain that the pharmacy benefit is carved into managed care, which means the plans will each provide and pay for pharmacy services, but some states have opted to carve out a pharmacy benefit but North Carolina has carved pharmacy in for this to be successful, North Carolina law mandates that the health plans will follow the same drug formulary as established by the department. So the plans by law will be using the same single PDL, that is used today in Medicaid direct after year one, the plans will be allowed to suggest changes to medications on the PDL, and to suggest changes to clinical criteria and coverage policies, those requests will be vetted by the department and carried through the same approval process that is in place today. So only if the department approves, will those changes go forward. All changes will be applied to that single PDL. Therefore all five plans will be operating with the same formulary, so you will not have to worry about each plan having a different preferred drug list. Clinical coverage criteria, that is not related to the PDL can be approved at the plan level, the department does not have to apply the same clinical coverage policy changes to all PHPs. This can be done at the health plan level, because these criteria are not legislated. Finally, the plans will pay pharmacies the same dispensing fee, approved by the state so the state conducts a cost of dispensing survey every five years to determine the dispensing fee. The plans may opt to use the flat dispensing fee as determined by that study, or the tiered payment system based on the generic dispensing rate, and all the plans have indicated that they will be playing paying that flat dispensing fee. The ingredient cost will be the same as well. Okay, so before we explore the

single PDL any further though, let's take a step back and review the current process for adding medications to the Pdl, and for adding clinical criteria, Blake?

Blake Cook

Thank you Angela. As Angela mentioned the PDO process after managed care loans will remain the same as it is today. This slide actually outlines that process and I want to clarify at the beginning that what I'm discussing are medications and categories that we do manage on the PDL that's always a confusing point. And as most of you know, we do not manage things like HIV, hemophilia, oncology products there's many products we don't manage on the PDL. So this process that I'm that's on the screen right now are for products that are the for categories that are on the PDL. The first one the left is kind of goes left to right, of course, when a new medication is released onto the market, FDA approves it, the state reviews all those products we get a weekly report of any product new to market. The default for these new market medications is for them to actually be non preferred as again as a default status, the state itself actually posts, a new PDL online sometimes every month, sometimes it's every three months, sometimes it's four months, depends on the, the magnitude or the amount of new market medications that have been released, but keep in mind that these products will absolutely process in the NC track system and going forward in the managed care systems as non preferred, even if you don't see them listed on that PDL, like I said on a weekly basis. We, these, these drugs are released and as they're released, they automatically default to new to market and unless state changes that.

The state does perform a full PDL review internally at least once annually. This review is the main way that medications can move from either non preferred to prefer or preferred back to non preferred. Once the state recommendations are then reviewed and commented on by the pharmacy and therapeutics committee, which is a subcategory, a subcommittee of the physicians advisory group. They are posted or a 45 day public comment period. The full PDL panel then convenes again it's a public meeting, and they provide final recommendations for the DHHS secretary to sign off. Again, that is our process and next slide.

And kind of, along with that we got a lot of questions about, we get a lot of questions and during the what ifs session about clinical criteria. So again the clinical criteria process that we're going to also have after managed care launch is going to be the same or plans to be essentially the same as we do have currently, the health plans medication clinical criteria process and our internal process again after July 1 is going to be what's on your screen. As with the PDL on the previous slide when a new medication is released, or in this case when you indications are approved by the FDA for any existing medications. State staff reviews these products for any potential for adding or updating of clinical coverage criteria. If criteria developed or updated, they are brought to the P and T committee and the physician advisory group, the same way that the PBL is wrong for those groups. And after these groups provide review and feedback. The proposed criteria is posted for a 45 day public comment period, the health plans are required to follow the same criteria as Medicaid direct for the first plan year. And like Angela mentioned

after year one, plans may propose different criteria, but any changes will have to be evaluated and approved by the state. And now we'll listen back to Angela.

Angela Smith

Okay, thank you, Blake. let's turn back to the single PDL again. All plans will follow the North Carolina single Pdl, and the existing Medicaid policies and clinical criteria. The PDL will not differ across the health plans, it will be the same. And the same criteria that we have, for example for hepatitis C meds today, those will remain the same and managed care. The same dermatological creams that you have access to today through Medicaid will be available through managed care. So the process for updating, and approving that Pdl, again, will be the same. After year one, the plans may make recommendations to add or remove drugs around on the PDL. But remember those are recommendations, they say they go through the same consideration and approval process that Blake just presented. Any changes that the state approves will be applied to that single North Carolina PDL will be implemented across the all five plans, and the Medicaid direct. Next slide.

So North Carolina Medicaid is going to provide oversight to the health plans to ensure that all the plans are appropriately, providing services to Medicaid beneficiaries as defined in the contract and this includes pharmacy, of course. Now this slide steps you through the lifecycle of a pharmacy claim. So there are steps along the way where things can happen, resulting in the beneficiary leaving the pharmacy without their medication in hand, our goal of course is for the beneficiaries to walk away from the pharmacy with their medications. So we're working very hard with the plans to ensure that the processes are in place, providers are enrolled with the plans the pharmacies are in network, the claims submit properly, the PBM on NC tracks approves or denies the claim, appropriately, and ultimately the pharmacy gets paid for the medications that they dispense, so there'll be a lot of coordination of course between the DHB pharmacy team and the plans and there has been, that will continue. We will ensure that all managed care plan Pharmacy Benefits mirror that of Medicaid direct and as issues present, we're gonna be working together to find those solutions. For example, if it's reported that claims are being denied for the roach free blood glucose meters. We're going to help problem solve that issue, and then we'll work with the five plans to be sure they're aware of the issue, and the fix actually that that just came up, or maybe here's another one. A plan is having issues with a pills because they're requiring patients to fail a preferred seizure medication before using a non preferred seizure med from the PDL. Well you're on that that's y'all know that's not how it works in Medicaid trek, we would immediately identify that as a clinical coverage issue and quickly work with that plan to make sure they understand that for treatment of seizures, beneficiaries do not need to try one medication and fail before obtaining a non preferred medication. So it's the state's vision that the pharmacy teams will partner to ensure that we have timely implementation of any changes, and timely resolution of issues. Next slide please.

So what can pharmacies expect pharmacies should expect timely reimbursement from the plans. The plan should pay claims within 14 days of submission or they should deny that or pin the claim. You should know that the contract includes interest and penalties for if providers are not paid in a timely

manner so hopefully this provides you confidence that pharmacies will indeed be paid. The COVID-19 flexibilities that are in place now during the public health emergency, those flexibilities are still in place and will continue to be covered by the plans throughout the public health emergency. The public health emergency is scheduled to end on April 20 But we're expecting any day, it will be extended for 90 days and we actually expect that it will be extended through the end of the year. The options to provide up to 90 day fills as well as the payments that are being paid for mailing and delivering prescriptions during the public health event. Those have been approved into permanent clinical policy so these changes will carry forward, even after the public health emergency ends. And then finally, their 340 B claims, those will continue to be processed, the same as they are today in Medicaid direct. Next slide please.

So we've received some questions about network adequacy when it comes to pharmacies. The state expects to see a broad pharmacy network across all the plans and we really encourage all pharmacies to enroll with the plans. It's important to note that per the contract, all plans must contract with any willing provider who is enrolled in NC Medicaid. So the plans cannot choose to exclude independent pharmacies from participating. The plans are not allowed for the contract to develop a narrow network pharmacies. The contract defines network adequacy, based on urban and rural areas. So if you're in an urban area, you must have at least two pharmacies within 30 minutes, or 10 miles for at least 95% of the members. And if you're in a rural area, then the plans must have at least two pharmacies within 30 minutes or 30 miles for at least 95% of the members. Next slide please.

So our goal on day one and beyond is that every beneficiary will get their meds and every pharmacy will be paid for medications dispensed regardless of any coverage discrepancies that may come up. There are several mitigation strategies that have been put into place to support the pharmacies, and the beneficiaries during this time. For example, 24 months of historical claims data, and prior authorization data will be sent to the plans in advance of July one. So the plans will have already have access to PA information on file, they'll honor those PAs for the life of the PA performance claims. And in the event of PA is not accessible for a new PA or, or a new PA is not ready. Pharmacies are real out and actually be expected to fill 72 Hour Emergency fills and the plans will pay for those fills. There will be a Medicaid call center where providers may call for assistance. When a beneficiary shows up without their new Medicaid card, which we expect they will, and providers and pharmacists, they may check for coverage as they do today in the nctracks portal. Pharmacists will also be able to contact the plans directly. DHHS and the plans will be distributing and posting help sheets or information sheets which will include the VIN, PCN and group numbers for each plan, as well as important contact numbers, and the plans and DHB will all have command centers that they'll be operating to triage issues as they arise. So as issues from providers and members come in that can be resolved as efficiently as possible. Additionally, for the first 60 days after managed care launch the plans will be required to pay claims and authorize services for Medicaid eligible non participating or out of network providers, equal to that of in network providers so that's for the first 60 days to successfully meet the needs of our members on July one and through the early days of transformation, we're going to need your help. We ask that you'll partner with us to help ensure we take care of our patients as timely and efficiently as possible. And we certainly hope that pharmacists and providers will use these mitigation strategies that you see here on the slide. Okay Dr. Dowler I think we're ready for questions.

Dr. Shannon Dowler

So you answered some of our what ifs. Can the plans have narrow networks nope they can't, is the PDL gonna change frequently No, we'll add new drugs and say come on and you'll see updates show up with the PDL itself will only change annually or occasionally twice a year. I mean won't differ there's one PDL for all the plans, new drugs that come into the market will get put into the PDL as non preferred, they have to follow our clinic followed our clinical criteria like for hep C drugs that are currently on the PDL as they are today and will, one of our what if questions was around providing a range of sort of creams and lotions, it's our same PDL, so that is not going to change moving forward next year. So the next slide we go into some questions that are were a little more complex and Angela I'll start with you on this one. What is the low English proficiency patient goes to pharmacy it's a Friday night, they need that prescription to be filled right away, and the name on the card doesn't match the prescription exactly what happens.

Angela Smith

Well, for most plans the patient's covered is linked to their ID number and their date of birth depends on the members card, and some of them also link to the group number. So generally, a misspelling on a hardcopy prescription really doesn't impact the ability for the pharmacist to fill the prescription. Of course it's up to the discretion of the pharmacist if they want to accept that prescription as written, compared to the members ID card, or other form of ID. But if the pharmacist puts it through using that card and the information on the card and they receive a rejection, their ID number and their date of birth, that's on the members card, and some of them also link to the group number.

Dr. Shannon Dowler

Awesome, Blake. Will the co pays be different for the medications for the different health plans?

Blake Cook

No medication co pays will all be the same for all the health plans and for Medicaid direct as they are today.

Dr. Shannon Dowler

Excellent, Angela, at launch. You're talking about the plans having information, will they have the information on what medicines people have tried and failed before to save the providers having to share that information again?

Angela Smith

They sure will, they'll have two years of historical claim data, so they'll be able to see what they've had failed what they've tried before.

Dr. Shannon Dowler

All right, Blake, so let's say a patient needs an urgent medicine like a nonpreferred insulin, and the PA hasn't been improved and the 72 hour fill has passed, what should they do then.

Blake Cook

That was actually a question I think I saw in the chat is something similar to that they, the health plans are required to give the 72 hours supply just like fee for service Medicaid directive, and those 72 hours supplies are actually unlimited there can be multiple back to back to back 72 hours supplies in case the prescriber hasn't gotten back. It's the weekend or something such as that.

Dr. Shannon Dowler

That's awesome and knowing that launch is happening over a holiday. You know these sort of questions are top of mind for people. So Angela if a pharmacy chooses to override a denial because they think it's in the best interest of the patient. Do they have any assurance, The plans are going to cover the costs retro actively.

Angela Smith

No not assurance, the pharmacist could of course appeal the denial decision, but the plan, since they denied it, nor the patient would be required to pay that, because the plan had denied the claim upfront. Now the plans will have a system for provider appeals and grievances and they will promptly, consistently fairly do that in compliance with state and federal laws and with department requirements, no assurance, they did deny it.

Dr. Shannon Dowler

Alright, um, Blake, so this is a pharmacist question What if a patient's got a prescription for a medicine from a doc that's not in the network of that of the plan and I fill the prescription, am I going to get paid.

Blake Cook

Yeah we have we, we polled everyone of the health plans and they almost the provider is a Medicaid enrolled provider prescriber, if you will. All the plans will use that as their basis for covered providers there will not they will not be just within their network, or only their network prescriptions are covered

so yes any provider that's a Medicaid enrolled provider, their prescriptions will absolutely be covered by all plans.

Dr. Shannon Dowler

Terrific. Let's go to the next slide, and we've got some more questions. We're getting harder, how do we build specialty drugs to health plans

Angela Smith

All medications are billed to the health plans.

Dr. Shannon Dowler

All right, directly billing to the health plans and Blake well pharmacies get paid a tiered dispensing rate.

Blake Cook

That option is out there but like Angela said earlier, all, all plans have told us they're gonna pay the flat rate that was based on the cost of dispensing survey.

Dr. Shannon Dowler

Okay, and Angela we got a lot of questions around the pharmacy lockin program, how's that going to change a managed care will it apply to children.

Angela Smith

It's going to be the same. The PHPs have legislative language specifying the criteria that would be used for member selection, and the legislation states that both Medicaid and Health Choice members are eligible for enrollment in lock in program, Medicaid direct doesn't currently lock in children. And since Medicaid direct doesn't lock in children under 18, we would expect the plans to operationalize their program in that same way.

Dr. Shannon Dowler

All right. Blake, so again, how does a pharmacy appeal a non payment decision.

Blake Cook

Okay, for this one, I'm going to actually read from an excerpt of the contract, and it's going to be kind of legalese but the PHP shall handle provider appeals and grievances promptly, consistently fairly in compliance with state federal law, and department requirements, PHP shall have in place a provider appeals and grievance system so that's probably your answer right there they have to have in place a provider appeals and grievance system that is distinct from the ones that members use, or can access, and that will, that process for providers, any issues they bring to the health plan. And again, they may appeal these decisions, and it's based on a state level review that goes through the office of administrative hearings. The PHP shall be transparent with providers regarding its appeals and grievance processes and procedures and actually the department actually has a probe provider ombudsman in place as well for any issues that might arise.

Dr. Shannon Dowler

Great, thank you. So Angela how quickly will plans respond to changes in the, in the price of medications.

Angela Smith

There'll be isn't the same ingredient cost pricing databases used by the state. So we would expect that they would be updated in the same manner, and at the same time as the state. This includes, for example Nadac and wack and the state Mac rates, there are any issues for Nadac appeals I'll just remind everybody that providers can appeal Nadac at directly to the national Nadac appeals vendor. And for state Mac appeals providers may appeal those rights using the form that's on the State's website.

Dr. Shannon Dowler

All right, and I believe this is our last What if for this section. If there's a coding error with a medicine on the shelf or some other situation that's going to pack them pack all five health plans, are the pharmacies or the providers gonna have to call each of the health plans to try to get it straight. How's that going to be handled.

Blake Cook

No they shouldn't, the state's gonna like Angela mentioned the states going to oversee all of the file transfer processes and that includes the weekly PDL or I'll call it the coverage file if you will, that's distributed all the plans basically the state's vendor, sends it to us and then we distribute it out to the plan so everybody should be using the same file so in case there is a provider that thinks there might be a some sort of price in DC error or something where drugs should be covered and it's not they can certainly call the plan, or if it's an NC tracks or Medicaid direct beneficiary there certainly can call that help desk and start as like a ticket I guess what then they each call it to start an investigation the states will state will be notified in any of those cases, no matter which provider that they call. Awesome.

Dr. Shannon Dowler

All right, thank you, thank you so now I think we're going to move to our pharmacists leader and reigning Smee over the PDP Harita Patel.

Dr. Harita Patel

Yeah, good evening everyone. So the PDP, which is a physician Drug Program, also known as a PADP, which is a physician administered drug program covers many but not all, primarily injectable drugs that are purchased and administered by a medical professional, in a physician's office or an outpatient clinic setting. The PDP does cover other things such as vaccines long acting reversible contraceptives, radiopharmaceuticals and even some oral products as well. PDP pays on a retrospective basis. So, a drug is administered, and then the claim comes to Medicaid for payment. If by chance a drug is procured from the pharmacy than only the administration charge would be built in. There are no prior authorization criteria or any sort of restrictions on PADP products but the drugs are programmed into NC tracks very closely to the FDA approved guidance for usage of the drug, and this relates to things such as age, gender, diagnosis, minimum or maximum dose limits, things like that. This information for each drug upon FDA approval is published in the form of a Medicaid bulletin article, and we publish our rates, or these drugs on the fee schedule and clinical criteria on our PDP catalog, found on our website. For the PDP drug claims is expected to be the same as the fee service program and as per the plans fee schedule.

Next slide please. The VFC program is a federally funded program that provides vaccines at no cost to children who might otherwise not get vaccinated because of the inability to pay. It's managed by the Department of Public Health, meaning that distribution and oversight is managed by the Department of Public Health, Medicaid does accept claims for VFC eligible Medicaid only children. They cannot be health choice, North Carolina Health Choice beneficiaries providers would only be paid for the administration of these VFC vaccine claims. Since vaccine has already been provided to them for free. Again, North Carolina Health Choice beneficiaries do not qualify for the VFC program, and so they must be administered vaccines from a separate private stock for which Medicaid would pay for both the vaccine and the administration charge payment for vaccines and administration charges are expected to be the same for all the plans as they are with fee for service today. However modifiers and technicalities of claims may be different so it would be important to check with the, with the plan when submitting a claim. Another difference is that pharmacy providers will have the option to build vaccines on either a medical or a pharmacy. Wait a fail claim. However, both will be reimbursed at the same rate. Out of network providers can bill for vaccines to the plans, but they may not get paid at the full 100%. An exception to this rule is for the COVID vaccine, and out of out of, out of network, did I say out of state I'm sorry I meant, out of network provider can and will be paid the full amount for COVID vaccines, as long as a provider is enrolled as a Medicaid provider, whether that is a medical provider or a pharmacy provider. And if there are any appeal that may be necessary for any of the PDP program drugs. What a provider can do is send the necessary information and documentation and rationale to the plans

regarding why a provider may feel that it's necessary to be covered if the claim is still being denied and you would like to appeal it further, you may contact the provider ombudsman, like, Blake mentioned earlier, plans have this information listed on their PDP policies on their website.

Dr. Shannon Dowler

All right, so let's make sure I got this right. So billing and payment for vaccines, they'll just bill to the plan for the beneficiary if it's an out of network provider their administration fee may not be the same if they're out of network they might not get that 100% rate an network provider would get and for VFC they would only build that administration fee. There's an appeal process that people can go through, if there's a concern around a medication that's usually covered and the procedures like IUDs, what happened the same way you just bill the benefit you would bill the beneficiaries PHP for that service. Did I get that right. That's right. All right, great, well let's shift gears then and talk next to our program manager for DME and specialized therapies, John, the calm in the storm Vitiello. I like working with John, particularly because he keeps me chill. All right, never. Next slide.

John Vitiello

Thanks. Sorry to Dr. Dowler. So based on some of the questions we have heard, I have a handful of statements on this slide that we'll talk through briefly, and then we'll expand on these points in subsequent slides. So to start us off for those who weren't sure, just like in pharmacy, DME and prosthetics and orthotics and supplies coverage is included in managed care it is carved into managed care, but of course you know let's keep in mind that we're launching standard plans on July one, which means that beneficiaries who don't enroll in a standard plans, because maybe they're not eligible or they're not required to enroll till next year when the teller plans launch, they'll continue to receive DME coverage on the Medicaid fee for service program, which will continue to run in parallel with managed care of course. In this third bullet, as I know you've heard by now and unfortunately we didn't get to hear Dr Dowler sing it tonight, but maybe she'll, if we have time at the end she'll she'll serenade us there are those 18 Medicaid policies specified in the Standard Plan managed care contracts that must be followed by the PHPs exactly. However, the DME policies are not among those 18 but, you know, that's okay. That does mean that the PHPs are permitted to employ different limits and Pa requirements. As part of the utilization management program, but there are guardrails in the Standard Plan Contract for clinical programs such as DME, whose policies aren't listed in those 18 And we'll talk about those in a minute. And because we've heard questions about access for all types of services including DME and this last bullet, were pointing out that there are not explicit time and distance standards outlined in the managed care contracts for DMD providers, but again, that doesn't mean that the contract doesn't have something to say about that as well.

So I'm here we'll talk a little bit about what guardrails do exist in the contract for programs like DME. First of all, on the far left, I pulled a couple of quotes from the Standard Plan Contract, demonstrating that we expect the plans to furnish covered benefits in an amount, duration and scope, no less than the amount duration and scope for the same services furnished to beneficiaries under the Medicaid fee for

service plans, and that those services are expected to reasonably achieve the purpose for which they are intended. So as an example, let's say in fee for service we cover maybe six different kinds of walkers to accommodate a different, a variety of functional needs. But maybe we find that in managed care we learn that a PHP is only covering maybe one type of walker, which doesn't seem to us to meet the needs of most members, we would we would see this PHPs walker coverage as being more restrictive in scope, and probably not achieving the purpose for which it is intended. So we would likely take some kind of action to correct this discrepancy in the middle rectangle we also mentioned that the contract doesn't include specific time and distance standards for DME providers like it does for pharmacy or for primary care providers that where we expect to see at least two within 30 minutes or 10 miles for 95% of members, but instead, there's contract language that requires each plan to establish and maintain a provider network sufficient to ensure that all services covered under the contract are available and accessible to all members in a timely manner. Of course will have specific oversight tasks that we'll perform at regular intervals to monitor this, for example, we might look at enrollment by taxonomy. I know some of our team members are doing that already. We might look at paid claims pa data, and of course we'll we'll be looking at beneficiary and provide our feedback as well.

Over on the right hand side of the slide. Another contract requirement that addresses network adequacy adequacy is PHPs are expected to negotiate with any willing provider in good faith, regardless of provider or PHP affiliation, and we would expect those stipulations to also apply to medical offices who might supply things like inhaler spacers out of their supply closets for example. Next slide please.

So on this slide we're talking a little bit about rate floors and COVID flexibilities of course all our COVID flexibilities in DME remain current, but on the left hand side of the slide I just wanted to talk a little bit about another network adequacy stipulation, which is a quote that I pulled from a bill passed by the General Assembly. This past summer, that establishes Medicaid the DME fee schedule as the rate floor for plans to follow for the first three years of managed care. This is expected not only to ensure the integrity of NC Medicaid to DME provider community, but also to facilitate network building for the plants. And on the right side of this slide, we just wanted to make sure everybody was aware that even after the public health emergency ends we'll still be covering automatic blood pressure cuffs and weight scales and portable pulse oximeters per some new medical necessity guidelines that we've added to DME policies. Five a two and five a three for these items. Next slide please.

So what do we think things will look like for DME, before and after managed care launch. So, again, I've gone to the contract because we want to, you know what I think is best to, to, you know, quote exactly what the contract says, and what we'll be following for our oversight program. So on this slide, I've included a couple of passages that help ensure continuity of care in the first bullet, we're pointing out that the managed care Standard Plan Contract requires the plans to honor existing PAs for enrolled members for up to 90 days after launch. And in the second bullet we're indicating that for the first 60 days after launch the PHPs are expected to work with out of network providers, as if they are in network. And I've also learned that even beyond that it's a PHP doesn't have an in network provider

reasonably available to a member without delay. Then the PHP is required to cover the service from an out of network provider, until such time as this deficiency can be addressed.

Next slide please. On this last slide I just wanted to talk briefly about items that might not be currently covered or listed for coverage in Medicaid fee for service, or that might also have limits and say quantities or lifetime expectancies, like for example, a wheelchair that a child might outgrow, and it needs to be replaced, earlier than expected. First thing to keep in mind is that the plans are permitted to cover DME items that we don't currently currently list for coverage in Medicaid direct, but for things that aren't listed for coverage, or that do have limits and quantity or lifetime expectancies like the wheelchair in our example, the contract requires that PHPs to follow EPSDT guidelines and review such items on a case by case basis for Medicaid members, until their 21st birthday, just like we do in fee for service. And on the right side of the slide I have a reference to the Home Health final rule at 42 CFR Part 440 point 70 This is a federal regulation, which is also mentioned in the in the standard planning contract. And this regulation prohibits states from having absolute exclusions of coverage on equipment supplies and appliances, without a medical necessity review and appeal rights for denials, so we would also expect the PHPs to comply be compliant with this regulation as well. I think that's my time. Dr Dowler I think this is yours. Yeah,

Dr. Shannon Dowler

So it's just make sure we got some of these questions right so limits for DME will they be the same as they weren't and Medicaid, direct, and so they have to cover the benefits in the same amount scope and duration but they also have the ability to have some different quantity lifetime expectancy, so it's sort of a blend of both those things. If a beneficiary has equipment before the launch it's still required after the launch, we've got the 60 day window that we make sure that they're covered while the transition can happen if it's needed, network adequacy you covered with saying, they, they better work with willing providers but also if they don't have an adequate network then they have to go to an out, out of network provider. And what about different preferred diabetic medical supplies will will plans have different diabetic medical supplies.

John Vitiello

Well in fee for service point of sale, and in managed care point of sale pharmacy, all health plans and Medicaid direct will have the same preferred Roche diabetic medical supplies. On the DME side, we also have Roche has the preferred diabetic medical supply but we also permit non preferred supplies as well and we expect that to be the same in managed care.

Dr. Shannon Dowler

All right. And next slide. So who will health plans cover any DME that's not currently covered by Medicaid.

John Vitiello

So we talked about this on slide 22 And we said that yes, that the PHPs may cover items not currently covered in Medicaid fee for service.

Dr. Shannon Dowler

So what if a child has a growth spurt, and they've got a wheelchair but it needs to be changed out or modified in the earlier than the usual lifetime expectancy, what would happen then.

John Vitiello

This is, this was also on slide 22 so this is a scenario where we might have a quantity, lifetime expectancy on a wheelchair so we might expect a wheelchair to last three or four years, let's say, maybe for kids, sooner than that because we know they grow and they outgrow their wheelchairs grow early. So, on the on the fee for service side and also on the managed care side we would expect the PHP to follow EPSDT guidelines and allow things like lifetime expectancy limits on wheelchairs to be overwritten for medical necessity, just like in fee for service.

Dr. Shannon Dowler

All right, and so let's say a doctor's office wants to provide a supply like a nebulizer from the Office of bill it is DME, because they do that now on fee for service, will the plans allow them to do that.

John Vitiello

Yeah, that's the that any willing provider provision we talked about on slide 19 so we would expect the PHP is to permit to permit this same sort of arrangement in managed care.

Dr. Shannon Dowler

All right. And then, I think this question was going to shift over to Melanie, how do we bill new health plans versus traditional Medicaid.

Melanie Bush

This is a great question and applies to all services really, first of all, your contract and the provider manual for the health plans that you have contracted with will include this billing information. Additionally, the Division of Health Benefits in our provider playbook on our website. We have quick

reference guides for each of the health plans that will include information about billing and how you can bill. And then finally we'll talk about it a little later in this presentation, but we're going to have, we're going to pull together a day one cheat sheet for providers that will include all of the information that you may need to get in touch with each of the health plans if you have questions about billing or other things so stay tuned.

Dr. Shannon Dowler

All right, great. So Nevin if you take us to the next slide, I wanted to give you a few general updates on numbers. So our current enrollment in North Carolina Medicaid is 2.536 845. So 2.5 million essentially, we expect about 1.6 million of those to move into our standard plans in July. I wanted to give you an update on some of the investments we've been making in medical homes. The Healthy opportunities screening and referral code that we made available for January through June. So far we've gotten about 2300 claims through the two highest needs that we've identified our food insecurity and help with utilities, the glide path the medical home glide path. We received 1205 submissions for that for our April payment 51 did not qualify, there is going to be a reconsideration process that you'll be hearing about so if you feel like you didn't qualify and it was an error, there's gonna be a chance for you to raise your hand and explain that. $9.3 million was invested in April in these medical homes, and they represent 70% of our tier three practices. The equity payments are getting ready to come out 1630 primary care medical homes will be receiving an equity payment, 196 are FQHC locations and 72 are rural health centers. I also wanted to give you an update on enrollment. We've gotten over 55,000 members have signed up for plans, we are seeing though that a lot of them aren't choosing a primary care provider so less than half of them are choosing their primary care provider. So that's something important you could be doing in your practices is helping your patients understand what plans you're working with and you're contracted with and how important it is that they, they choose you. Letting you know also, last week we had our behavioral health What if session. We've got another one coming up on specialized therapies and transitions of care. And then our next backporch chats will focus on these things. So the first of May we'll be talking about behavioral health in great detail. The third Thursday in May, we will be talking about specialized therapy so stay tuned. And just also wanted to give you a heads up on family planning, Medicaid, and making sure that everyone's aware of COVID-19 testing treatment and vaccines we've talked about this before, but these are sort of unique things that are covered under the Family Planning Medicaid program which aren't normally, things that we cover. All right, next slide.

This is off topic only slightly but it's only because we've gotten so much feedback, and that is on our new policy around medically necessary circumcision that started at the beginning of the year, the program decided to cover circumcision, I remember being a provider and Medicaid when this was covered and then I remember when it was taken away, it's gone, the pendulum has swung back and forth, but we felt like based on the prevailing evidence, and what we're seeing out there with the studies that there's a medical indication where there could be considered medically necessary based on a family's desire to prevent future infections, particularly HIV, the evidence that we use is broadly publicized information you can find it in a resource, there are a lot of studies that look at HIV, HPV, HPV associated cancers and other year genital infections. We are not directing the world to do circumcisions we are just making it a covered service when you feel as a provider that is medically necessary. Preventive care always requires

shared decision making and this is no different. When we're talking about prevention, it's that conversation you have whether you're talking about mammograms prostate cancer screening colonoscopies. This is a shared decision making conversation between you and the family, and Medicaid is not inserting any opinions into this. We do believe that health equity is a is a driver and part of this decision to change the policy, and I think many of you will agree with, with that, at the end of the day, the bottom line is we are the payer Medicaid is the payer, you are the doctor and you're the one that makes those decisions with the families of the people that you care for. So I just want to make it clear that we are covering the service. If you feel like in your professional opinion that's medically necessary and you billed for the service that way. We are happy to cover. And with that, we'll go on to the next slide.

And I think we're gonna turn it over to Melanie who you heard from moments ago, our Chief Administrative for Chief Administrative Officer and the holder of all Medicaid knowledge.

Melanie Bush

I'm not so sure about that, but I am certainly happy, and we wanted to let providers know that we have an issue to provide our bullets and I'll just go quickly because I see that we're running out of time, and I really want to get to the next slide, we have implemented a rate floor for facility based crisis and mobile crisis services. These are behavioral health services that as of July one we will have a rate floor for the following procedure codes we are directing folks to please check out our Medicaid bulletin for more information. Next slide. Right, this is what I really want to draw everyone's attention to. We are implementing a new process that will affect providers who have expiring credentials, either licenses certifications or accreditations. Our nctracks platform sends notices now to providers, letting them know that their credentials are expiring but nothing actually happens when they expire until you go and try to bill and then you are denied of we are now implementing a process and we want folks to know you'll get a notice that your credentials are expiring for 60 days in advance, then 45 days in advance and 15 days in advance, effective May 9th, so you will go into a suspended status if you do not update your credentials and then you will go into a terminated status if you refused to update those credentials, within the proper amount of time. We are really directing providers to update your information, it is important for our beneficiaries that they can make choices based on the providers that have the credentials that they say that they have. We want our beneficiaries to get the most high quality care that they need. So we really are really trying to push providers to update that information in our system, the health plans will also be getting this information. So if you were suspended or terminated from the Medicaid program you will be suspended or terminated from PHPs. So we are hoping to give you 60 days and 45 days notice. To update your information so that this does not happen so we wanted to let folks know that is happening next month. On May, 9, so please pay attention to nctracks portal, that's where your messages will arrive. Simultaneously we're asking everyone to update your provider information, this is the information we've mentioned is displayed in our provider directory where beneficiaries are making their choices about their health plans, this is the information that is transmitted to our health plans that they are using for contracting, if your information is incorrect, then our health plans are will have incorrect information and our beneficiaries will have incorrect information. So we're really encouraging all providers to go in and make sure that all of your information in NC tracks is

correct. We have issued two bulletins on this this week, so please check the nctracks portal or the Medicaid website for those bulletins for more information. Next slide.

I do. I also want to call out we have very detailed, very comprehensive very thoughtful fact sheets about managed care transition they answer a lot of the questions that I've seen in the chat today. We encourage folks to please when you have time, go to our website, we have put together a provider playbook, we have what to know about managed care in two parts, we have what to know on day one, fact sheets and two point parts we have eligibility for newborns fact sheet, we have the Eastern Band of Cherokee Indians tribal option if you're not familiar, we have information about payment and Health Equity it's anything that you think you can ask about, we probably have a fact sheet on it, our team has worked very hard and getting all the information that you need out there, so please look on Medicaid website, it's under the provider tab, you will see an entire playbook dedicated to managed care. Next slide.

Finally, this is something that our beneficiaries will receive, but we wanted to make sure that providers were aware and we are sending this out this is our North Carolina Medicaid choice guide for health plans. These are additional plan services that the plans are using to sort of market themselves to beneficiaries. These are called value added services. These are not paid for by the Medicaid program. These are actually additional offerings made by the health plans themselves. And you can see that we have a side by side so that each of the beneficiaries can compare the value added services for each health plan. This is also available online on our NCMedicaidplans.gov enrollment broker website is also available on the mobile application that beneficiaries can use to compare health plans, and then of course they can receive choice counseling if they call our enrollment broker and they will walk them through these different options, but we wanted folks to see that the health plans are providing additional benefits beyond just the regular Medicaid fee for service set of services that address social determinants of health and other needs. Next slide.

Finally, this is the provider Quick Reference Guide. This is something that I alluded to earlier in the presentation. This is going to be the cheat sheet that we are coming out with that will have websites and phone numbers for each of the health plans and the tribal option for NC tracks how to look up prior offs how to bill, what who to call about claims to call about emergency transportation, and then we do have like I mentioned very detailed quick reference guides on each of the health plans, separately on our website in the provider playbooks. With all of our other amazing fact sheets.

Dr. Shannon Dowler

Thank you Melanie and I just got corrected by one of my colleagues the family planning Medicaid for COVID is for testing and for vaccination treatment will become available it's not active and in place yet but it's something we're working on. So, spoiler alert. So thank you for that correction, it's important it takes a village. Alright, we got a few minutes for questions, so why don't we turn cameras on and Hugh

you've been able to look at the questions as I've come in for any themes. I will say I saw one about the HOSAR payment and how it's hard for practices because the, they bill Medicaid they're billing other patients for it and then patients are getting bills. We're actually would love for this to be a national model of reimbursement and we're putting that out to CMS to encourage them. For us it's just a temporary a temporary way to get people ready for managed care where that's going to be a required part of managed care for plans to make sure that everyone's screening for social determinants. So what do you have from the questions and answers you want to call out.

Hugh Tilson

Well let me ask your team to drill through and see if there's anything they particularly want to get to but while they're doing that. Here's kind of interesting when billing guidelines for PHP are not specific. Is there any way for the state to ask the PHPs to do more education on specific claim billing and prior authorizations.

Sarah

Hey there, Sarah, yeah. Hey, this is Sarah I'm our chief of managed care, we can absolutely do that they are starting there are they have started their training sessions around billing. They have a number of those listed on their websites and we link to them through our provider playbooks, but if there are specific things that you would like them to be more direct on it sounded like there are specific services we can help escalate that and follow up to make sure that they're including that their overall trading.

Hugh Tilson

Sounds great. Is there a website we can access that would tell us which plan our members were enrolled in.

Melanie Bush

So, you should be able you should be checking beneficiary enrollment through the NC tracks portal Provider Portal at every visit because beneficiaries do not have expiration dates on their Medicaid enrollment card so we encourage actually require that all providers, look up beneficiary eligibility in the nctracks portal. If you look up the portal you will also be able to see what plan that beneficiaries enrolled in.

Hugh Tilson

Can you repeat the conversation about VFC vaccines and PHPs will there be different rates possible with administrative fees with PHPs, how will this work with kids over 18 years of age with PHP and payment for vaccines for Medicaid through PHPs lots of lots in there that you need to read that again.

So will there be different rates possible with administrative fees with PHPs, how will this work with kids over 18 years of age with PHPs and payment for vaccines, by Medicaid through PHP's.

Melanie Bush

Right payment and the payment for the vaccine and the administration rate will be the same through the EHPs as for fee for service. That's for VFC vaccines, and for those who do not qualify for VFC vaccine.

Hugh Tilson

Gotcha. So, looks like Gene must respond to when these questions live so if a PHP has too few pharmacies the state won't assign patients to them.

Unknown Speaker

I think the answer, more accurately, is that we are looking at the PHPs entire networks as we make decisions around participation and as we go forward into the auto enrollment process. So, pharmacy is certainly part of our consideration of the of the PHPs overall readiness for managed care launch, and it could be part of the decision if we decided to limit any PHP enrollment.

Hugh Tilson

Sounds great. Thank you. So Shannon we're just about out of time. Is there anything in here that you want to respond to.

Dr. Shannon Dowler

No, I, as always, we have so much information that we want to share with you guys and it takes us longer to give it to you than we expect it will, we will answer your questions and the questions that remain in the chat that have gone unanswered we'll be. As always, answering those but anybody want to throw anything they saw in there that they want to make sure they get answered?

Hugh Tilson

As Shannon said, we'll send these questions over to Medicaid for them to respond. Thanks everyone.