

Transcript for Medicaid Managed Care Back Porch Chat Webinar Series: Hot Topics in Medicaid Transformation  
April 1, 2021  
5:30 – 6:30 p.m.

Presenters:

Dr. Shannon Dowler  
Melanie Bush  
Krystal Hilton  
Emma Sandoe  
Dr. Velma Taormina

Hugh Tilson

Let's get started. So good evening everybody and thank you for participating in this evening's webinar for Medicaid providers. Tonight's webinar is part of a series of informational sessions put on by North Carolina Medicaid and North Carolina AHEC support providers during the transition to Medicaid managed care. We will focus on put on these back porch chats, you know, as the name change on the first and third Thursdays of the month and will focus on hot and timely topics in Medicaid transformation. Just as a reminder, we also put on a webinar on the second Thursday of the month on advanced medical homes and hope you can join us for that as well. I'll turn it over to Dr. Dowler in just a second. But for some logistics, 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 to adjust the size of the slide. You can also adjust your video settings to hide people who aren't speaking. To do so click on the View button at the top of your screen and select the side by side speaker icon. With these instructions in the q&a for your convenience, I want to also let you know we will have time for questions at the end. Everybody other than our presenters is muted. So you can ask questions or make comments either by using the q&a feature on the black bar on the bottom of the screen. Or if you're dialing in, send an email to [questionscovid19webinar@gmail.com](mailto:questionscovid19webinar@gmail.com)? We've learned in the past that our presenters will often address your questions during their presentation. I encourage you to wait until the presenters are through their presentation before submitting a question. We're going to try something new tonight to be more efficient. Our panelists are only going to discuss questions that have been submitted after we open the webinar to questions. So if you submit a question before then our panelists may respond in writing to the questions. But we may not be able to get to those we're going to focus on the questions that are submitted after we open it up for q&a. Please know that we'll send all the questions to the DMA, including me we might not get through this evening. So they can respond to the questions or use them to inform our next webinars. Also want to let you know that we will put these slides on the NC AHEC website. We'll hope to put a link to that in the q&a soon. We'll record this webinar or add that recording to a written transcript with the website as soon as possible. So now let me turn it over to Dr. Dowler.

Dr. Shannon Dowler

All right, thank you. I so I think my big April Fool's joke today is the weather is supposed to be spring, which is why we moved to the back porch chat. And instead it has been snowing all day up here in the mountains. Nothing has stuck, but it's quite cold. So we actually do have a fire going in the fireplace. Ironically, I did get to spend my day helping out the local health department at a vaccine event at a local college. I said I'd be happy to stay there and man the event and be ready for emergencies as long as they gave me an office that I could work out of which they were kind enough to do I spent the entire day in the men's locker room of the gym working. So I'm excited to be back home for this back porch chat tonight. Thanks Hugh for bringing up the issue with questions and answers. We have so many questions that we get that we want to answer the all But a lot of times we answer them in the content that comes later in the presentation. So we want to make sure we're answering the things we haven't already answered. So we can get to as much information as possible. So we're going to ask you to please, please, please hold your questions. All the way through. We get through all the what if questions that we're going to answer a bunch for you tonight, and then we're going to open it up to you. But please hold on to them, if you don't mind. And with that, I think I will turn it over to the amazing Krystal Hilton, are you here?

Krystal Hilton

Yes, I am. I am Krystal Hilton the Associate Director for population health. I'm going to be talking with you tonight a little bit about price panels, panel management, the HOSAR payment program and amh glide path. We'll start with panel management. Just wanted to share that there is a new functionality within NC tracks that by which practices can go in sorry, there are on a monthly basis they get an email with a link where they can go in and look at their fee for service and their health plan patient panel. This functionality is active the first reports are available. And we have received some feedback on ease of use in regards to the report and that functionality. So we're going to be publishing a how to read your enrollmeee report in an upcoming bulletin. Next slide. DHB has completed primary care reassignment it for some beneficiaries, these beneficiaries fall into a category that meet the four following criteria, they are moving into managed care, they have enrolled for 6 months in NC Medicaid, they did not have primary care claims with their assigned PCP from January one of 2019 through February 28th of 2021. But these beneficiaries did have a primary care claim with another PCP practice, that's the group that has been reassigned. This affects about 150,000 beneficiaries and these beneficiaries have been assigned to the PC practice which is considered to be the best fit. This is based on their recently visited practices, the practices which has the most visits wit, if they're are more than one and geography. Medicaid will be distributing new Medicaid ID cards and that will be happening during the month of April and if you're interested in looking for information on how beneficiaries can change their PCP. The webpage that's here on this slide will take you there. We'll talk a little bit about what we're calling HOSAR which is our healthy opportunity Screening, Assessments and Referral payment. This payment will temporarily run from January 1 through June 30 and it encourages providers to build the capacity for providers, better screening for unmet health related resource needs then and then they will refer to the appropriate community based resources. Current Carolina Acces two providers are eligible to bill the code G9919 for a positive screening that are conducted using sanitized screening questions or equivalent questions. We've identified a slide payment issue and we have worked with NC Tracks and

gotten that fixed as the 31st we appreciate your patience we thank you for holding those claims that you did and you will be able to resubmit very soon. Out of our timeframe we've had about 913 claims for the HOSAR screening to be billed to date.

And lastly we'll talk about the AMH glidepath. Just wanted to share that the glide path attestations are live. And the attestations were due for the first month on March the 30th to receive a payment April and this is a payment of once \$8.51 PMPM for up to 3 months after contracting with two health plans and completed the data integration testing. Alright, this is a screenshot that shares where you will be able to go into NC Tracks to make those attestations, what we want to share is that you can go in and attest to it and you only have to accept one time for the up to 3 month coverage. If you would attest by the end of March you will receive the payments April, May and June and if you attest in April you'll receive May and June payment and also in May, you will receive the June payment. To date we've had about 1205 AMHs to attest.

Dr. Shannon Dowler

Krystal I want to say first thanks for this work. This has been a tremendous amount of work for the whole team to come up with some of these creative payments. I mean, I think what you're hearing out there in virtual webinar land is all the different ways that Medicaid has been working over the last year to try to sure you up and to try to support you through what is a major transition. And not only have we had a pandemic, which has been big and we've used a lot of different Medicaid levers to prove your payments during the pandemic to expand our telehealth to do the things we can do to help you give care to people the best way possible. But then we have these other payments that we've been talking about the Healthy Opportunity screenings, the glide path, the equity payments, all sorts of things. It's also a lot and we recognize and we recognize that and so you're not probably using all of these options, if you are great. We did get about 1205 people that attested by the deadline for this extra payment, they do go through a validation process, so you look see that you attested that you contracted then you tested we then go to the plans to validate that, in fact you did, you are contracted and you did test. So actually we're happy to say that about 95% of those are going to get paid out, that's a really high rate for especially for our first month of doing this, those of you who won't get the payment, when everybody else does in April, we will let you know in advance we are going to let you know in advance, we're going to try and get that information out to everybody next week even before the payments come. If there's something that we can work out, so if you if there was something that was glitchy or funny, and we can show that you clearly had done those things, we will still get you the payment for March, it'll just happen in the following month. Some people aren't, the nature of the beast is you have to do the things, but if you have done the things and there was a miscommunication between you and a plan we will give you a little time to sort that out so they can then validate it and you will get paid, if it's appropriate. So just letting you know, if you are one of the practices, that is not going to get the payment in April, we are going to let you know, we've also gotten requests from several people in the last 24 hours saying they missed the deadline they're busy doing COVID work, other things happen, so we're talking amongst ourselves in the team to sort out what we're going to do in those situations. And if we're going to have some other way that people can attest if they missed that deadline. Great opportunity here and the glide path, part of the reason we're doing is to sure you up and have you be ready to be tier three

practices by go live in July. I'm so excited that so many of you went through the attestation process. And with that, i'm going to let you hear more about the super cool equity payments from Emma Sandoe.,

Emma Sandoe

Thanks to Shannon so hi I'm Emma Sandoe I'm the Associate Director of Strategy & Planning um, in case you've missed the last couple of Fireside Chats the health equity payments are going out starting the month of April through June. These payments will be automatically added to Carolina Access 1 and 2 providers who meet a poverty score, the poverty score is based on where the beneficiary lives, and the poverty level in that area. These payments are meant to be used for investments in improving health equity and practices that qualify for these payments will be told via NC Tracks very soon they are working on it as of when I stopped checking my email to get on this webinar. So they will be letting you know via NC track nctracks very soon whether you qualify for these payments. Approximately 1720 practices will be qualifying for some sort of payment through through this and in total we will be distributing over 17 million dollars in April and this goes through the normal checkrate process. So there's no additional action that a practice needs to take in order to see the increase payments.

We had a wonderful virtual office hours, thank you for anyone that attended that for your wonderful questions. A few points that came out of that that I just want to share, we will be determining a practices poverty score so there's no need for a practice to make any calculations or any sort of things. We have the beneficiary information that are assigned to you and their addresses, so DHHS will be handling that. And let practices know if they meet that poverty score, we also will be distributing a survey in the summer, to find out how practices are using these payments, and a wonderful suggestion was included to post the survey in case email address for nc tracks might go to a different person. And you want to see what the questions are. So we're working to get that as soon as possible. Um, and we got a lot of questions related to, does this qualify as an investment in health equity? We are more than happy to respond to individual questions, but a general rule of thumb is if it improves access to health care services, and it improves the practices functionality that would ultimately reduce disparities, that is it probably is an investment in reducing disparities. So have that mentality as you're making decisions on how to use these payments and I do want to note we have a provider fact sheet up on the provider manual located on the NC Medicaid website with more information and that link should be easy to find in the provider manual. And with that I'll turn it over to Velma.

Dr. Velma Taormina

Hey, I'm Dr. Velma Taormina, I'm the Senior Policy consultant for Women's health. We're here to provide a quick update on what's happened in maternal health. A quick overview, what we have previously known as the pregnancy medical home and the obstetric care management program is going to transition to the new names of Pregnancy management program or the PMP, or the care management for high-risk pregnancies. Next Slide. So as before, we want you to do the excellent clinical work that we have been doing for the last ten years for this program, so the only difference on the requirements for participating is that there will no longer be a process to opt into the program. So

those of you that can remember filling out that form every time a provider left your group, joined your group or if you changed sites, that no longer will be in place. The contracting terms and the work we want you to provide is still the same, we want you to follow the current clinical pathways, we want you to complete the standardized risk screening tool, we want you to work on decreasing your primary cesarian delivery rate and to continue to do the same work. But of note though, remember the providers of pregnancy care, must contract with each of the health plans to receive payment for the services.

Next Slide. And speaking of payments and incentives, those will remain the same. So as you can see on the slide, all of the payments and incentives that are currently in place will continue. The difference is that the health plans may offer additional contracting terms and provide additional incentive payments to the individual practices. So again, you have to contract with the respective health plans in order to continue to receive the payments and the incentive payments. Next slide please. On the care management side, then similar to today all of the maternal health providers will continue to send the referrals to the local health department's for care management. And they will continue to provide that care and they can still be embedded in your practices in order to continue that collaboration. What will be different though is that the network ob nurse coordinators and the data will no longer be coming as they are today from CCNC. Each of the respective health plans will offer practice coaching resources and data individually to each of you. The other thing that's different is that in the past, you may have gone to your ob champion or to your ob nurse coordinator to ask them questions about the policy, billing questions, payments, etc. after July 1, you will take all of these concerns directly to each of the health plans. Next slide. So many of you have asked what's going to happen with the OB champion component of that. And over the last few weeks, we have been talking to several different groups and entities that are in the maternal health space. And the decision we've made is we are going to partner with the perinatal quality collaboratives of North Carolina. This is a statewide collaborative that has been working pretty much in parallel with the current pregnancy Medical Home program. But they engage with stakeholders in perinatal care across all of the different sectors. So they've involved clinicians of all types. They've worked with the hospital and clinic administrators, the government entities, patients, and families and payers. And as you can see, on the bottom, they've been working on several quality improvement initiatives that are designed to make North Carolina the best place to give birth and to be born. Next slide.

So in that light, they have offered to host or to convene some advisory groups for Medicaid, these groups are going to provide direct input to Medicaid on current projects or any other topics as they come come up. One of the things that we noticed over the last 10 years is that having a group of ob providers that were there to talk through issues directly with Medicaid brought a lot of value to the table. So what we want to do moving forward is to create two advisory groups, one for the pediatric population and the other for the maternal health population. So we want to shift from thinking about just ob but to the entire spectrum of the woman's reproductive life cycle. So ideally, we'd like to have providers from all six regions in the state, we'd like to have providers that are working in all the different types of practice settings. So private practice, local health departments, FQHCs, Academic Training Centers, and then we want all clinicians involved in that work to be offered a spot. So if you look at the

maternal health group, historically, that was just providers that were working in the prenatal and the pregnancy space. But we also want to extend that to other family medicine Docs and to the certified nurse midwives. And then same thing on the pediatric side. So we'll be issuing some more information on this. Again, picnic has agreed to convene the group on a quarterly basis. So we don't anticipate the first meetings to be until September. But in the next few weeks you'll see some more information going out about how you can join our groups. So at this time, I think I'm going to turn it over to Shannon.

Dr. Shannon Dowler

Thanks for this, you, you folks will remember, we changed our series to be hot topics, and then questions. And so we are going to just race through all these hot topics, get folks updated on the latest and greatest on things, then we're going to dive into some questions that we got from out in the field, some what if scenarios about July 1, and what's going to happen? And then we will open it up to questions and answers for everybody else. One of the things around our transition in June, or July, there are all these required clinical policies, a slew of them that in the legislation, it states very clearly that the plants have to follow our exact policy. Now the other clinical policies, they have the ability to just they have to at least be the floor so they can offer more services and we offer but they have to meet our floor requirements. So that also has to be taken with the understanding that they can apply utilization management that's an important part of the managed care process. For these required clinical policies, they have to follow everything about the way we do it. And it's important to know which policies those are. It is very difficult, however to remember. So I've written a song and this is how I remember them. Nevin, if you go to the next slide, and this could help all of you. This is a tune that my son learned his prepositions to in fourth grade, and it works very well. Alright, BH, MH, SUD, inpatient BH for all, ASD and CME family planning to the best call, fluoride auditory implants RH drugs and OTC, hemophilia, anti psychotic and the BDP. So now you have it, you will remember all these clinical policies. But these are the things that you should not feel any difference or changing from the clinical policy standpoint, as we go live. And it's important each Hot Topic session, we're going to be focusing on different aspects of this to make sure you're really in the know and you understand what's going on. And for that reason, tonight, we have Rhonda who is our auditory and optometry specialist guru, the eyes and the ears of Medicaid and she's going to get you all caught up on that.

Ronda Owen

Oh, before I get started, I have to say that is a very hard act to follow. Good evening, everybody. I'll just tell you in advance that this portion of the presentation is not going to be nearly as entertaining as Dr. Dowler singing and the song that she wrote, but I hope that you find the information helpful. My name is Ronda Owen, and I'm the program manager in clinical policy for auditory implant parts services, hearing aid services and optical services. So those are the services that I'll be talking about tonight. And let's start with auditory implant parts. I'll draw your attention first to the right hand side of the slide. for Medicaid, we cover external parts for cochlear implants, auditory brainstem implants, and for implantable bone conduction, hearing, hearing aids, and the eligible population, these are covered for any Medicaid or health choice beneficiary who is implanted with an auditory implant. And the qualified providers are the device manufacturers. Next slide, please. And so looking at this slide, we'll look at

what will change and what won't change. What will not change, if you remember Dr. Dowler song and what she just said, these two policies are in that group of required policies. And that means that health plans must follow these policies exactly. One important aspect of this is that the device manufacturers, they'll continue to be the enrolled providers, that means that they do all of the legwork, they seek the prior approval, they file the claims. This means that the clinicians are able to continue being the liaison between the beneficiary or the member and the device manufacturer. So all of that will stay the same. What will change is that because these services are fully carved in, they will all be managed about the health plans. Next slide.

So the next service category is hearing aids. You can see again on the right side, that hearing aid services cover more than just the hearing aid devices. Supplies, accessories, repairs, all the things that are necessary to keep that hearing aid functional, are covered under hearing aid services. The eligible population, that's children under 21. Qualified providers, there are three different types of qualified providers. There can be an individual with a North Carolina hearing aid dealer and fitters license. And that's the only license that they have. Or it can be an individual who is a licensed audiologist in North Carolina, who also carries a North Carolina hearing aid dealers and fitters license. And then there are doctors of Audiology. And the only thing that's required for them is a North Carolina license for audiology. And next slide. So for hearing aids, what will not change is, although this policy is not on the required list, it's it's it's what Dr. Dowler said earlier for all of our policies, the PHPs are required to offer coverage that's not more restrictive to our current policy. So members and providers should expect to see at a minimum the same clinical coverage. And again, the population is children under 21. What will change is this service is also fully carved in so the health plans will manage all of the hearing aid services. And another exciting thing that will change it's very exciting is a new value added service through wellcare. They're offering one hearing aid every two years for adult members who meet the medical necessity criteria. So we're excited that adult Medicaid beneficiaries will have access. Although it's just one hearing aid, it's better than no hearing aid. So this is an exciting new value added service. And then the next slide.

So here we're going to talk about optical services. But before we talk about these services, I want to ask you to just stop for a minute and think about your own insurance. You are probably have major medical insurance, dental insurance, vision insurance. Your vision insurance might be a company like Davis vision, Superior Vision or VSP. These plans generally cover a routine eye exam, and a pair of glasses or contact lenses. So when we think about optical over the next few slides, just remember that your vision insurance is to you what these optical services are to Medicaid beneficiaries. So if you look to the right optical services include eye exams, eyeglasses and medically necessary contact lenses. So that differs a little from your vision insurance plan. It's not other or Medicaid covers only medically necessary contact lenses that would be when a beneficiary has a condition such as keratoconus or anisometropia. And contact lenses are required. But because they're medically necessary, Medicaid also provides a pair of backup eyeglasses to prevent over wear and all of the contrary indications that can occur because of that. So Medicare covers those three services. The eligible population, it's all beneficiaries. Every enrolled Medicaid and health choice beneficiary is eligible for these services. But the frequency of those services differs based on age. So for children, it's every year, and for adults it's every two years. But even

that frequency of exceptions are allowed based on medical necessity. Qualified providers for optical services are ophthalmologist or optometrist, and opticians who are licensed in North Carolina. And then the final slide.

The next slide, unlike auditory implant parts and hearing aid services, optical services are not fully carved in. So I'm going to start on the right hand side of this slide. The services that are carved in, this is what will change routine eye exams, medically necessary contact lenses, and then the dispensing phase is me the dispensing pays for medically necessary contact lenses and for eyeglasses. So all of these services will be managed by the health plans. For eyeglasses providers will build a health plans for the eyeglass dispensing fee. But if you look at the original list, you'll see that eyeglasses themselves are not carved in services. One other thing that will change is we have several PHPs or health plans who are offering a value added service for optical services. So there are additional services for adults that involve routine eye exams and eyeglasses. So that's exciting to that there'll be additional provisions to several of the health plans. But what is carved out in the optical services umbrella is the fabrication of eyeglasses and frames and lenses. So providers who are enrolled Medicaid providers will continue to follow the sections of the North Carolina clinical coverage policy six A and six B that are specific to eyeglasses. They'll continue to enter prior approval request in nctracks. And they will obtain the eyeglasses through Nash optical plant. And they'll provide by eye exams and eyeglasses to Medicaid members if they provide those services to non Medicaid patients. So the unique thing about optical is that you have this one device, you have a single pair of glasses that are just split down the middle half of that service is carved out and is still managed by North Carolina Medicaid, and their partner, the optical State Optical laboratory. And then the dispensing fee is carved in. So what that would look like if I'm speaking only to optical providers tonight, if I were an optical provider in a private practice, and my Medicaid beneficiary comes in as an eye exam, that's going to be billed to the PHP, they walk over to the optical shop, and I fit them with a pair of glasses, I'm going to follow everything I'm doing now, I'm going to follow the clinical coverage policy that the state has, I'm going to use nctracks, I'm going to expect glasses from Nash, that patient will come back in once the glasses arrive and our fitness glasses and dispense them. And that patient leaves and at that point with regard to glasses as to something new. And that new thing is I'm going to bill the health plan for the dispensing fee. So that's what the eyeglasses will look like in the managed care world. So this concludes my portion of the exam. And I Hope this information is helpful. And I'm going to hand it over to Melanie bush.

Melanie Bush

Thank you, Rhonda. My name is Melanie Bush, I'm Chief administration Officer here at North Carolina Medicaid. We wanted to share our coverage changes once again, we talked about this last time but for those of you that may not have heard it, we wanted to let you know that based on significant provider feedback and then also internal conversations with clinical experts at Medicaid. We are changing our newborn coverage to ensure that the best health outcomes for newborns and to meet Bright Futures guidelines are met. So all health plans shall treat all out of network providers the same as in network providers for purposes of prior authorization and they'll be paid in alignment with Medicaid fee for service for those services. All services rendered through the earlier of 90 days from the newborns birth date, or the date in the health plan has engaged that mother and child in his transition to childhood in



network PCP or other provider that they may need. Next slide. So we've recommended 90 days, instead of 30, or 60, to ensure the completion of well child visits that are crucial during those first two months of birth, when critical vaccines are administered, and we give it an additional 30 days, because we know that those things can't always be scheduled. We do want to remind folks that prior auth is not required for wellchild visits, and those will be reimbursed on a Medicaid fee for service basis, or at Medicaid fee for service rates, excuse me for misspeaking visits that are beyond well child visits are subject to in-network prior authorization requirements just like any other provider, and they will be paid in line with an alignment with Medicaid fee for service. And they will be updating the health plans, the PHPs will be updating their transition of care policies to reflect this. And these are the bright features guidelines, which we're hoping to improve upon the newborn visit first week, first month and second month visit. And then immunizations, did want to let folks know that we do have provider fact sheets, we've updated our newborn fact sheets on our website. We've also released five more factsheets on a host of provider focused issues, we encourage you to visit our website at North Carolina Medicaid. There is an entire Medicaid provider playbook on managed care and we urge you all to visit that and read for further information. I think I am now transitioning it to Dr. Dowler.

Dr. Shannon Dowler

So I told you guys were at our last meeting about our 'What if' sessions and these are sessions that we're holding with stakeholders from around the state that join us for an evening to just pummel the team with questions of what is it that they're worried about what ifs for July 1. And so each time that we have one of our hot topic updates, we're going to be bringing you some of the what ifs that your colleagues from around the state have been pushing the team on to make sure we have good answers, we're going to be answering them and hopefully that will just take us to the next level. The first round of what ifs was to for more of a general practice audience was more of a primary care audience. Although we did have some specialists in the room. this coming week, we have a what if session focused on pharmacy and DME. So our next presentation, our next hot topics, webinars gonna have that focus. A couple of weeks later, we have one on behavioral health. So the first webinar in May is gonna have a really strong focus on behavioral health in the what ifs section. And then we're gonna do a section on specialized therapies after that. So just so you know that we have a cadence of different what if sessions. If you're interested in being one of our stakeholders that give us your feedback and your what ifs that you're worried about, reach out to whatever professional association that you're part of. So if you're a family Doc, you reach out to them a friend Academy of Family Physicians with your pediatrician on North Carolina Peds society, if you're in behavioral health, I've reached out to the psychiatric association. Just reach out to that entity that interfaces with us as a stakeholder and we'd be happy to get you invited to one of our what ifs sessions. So with that, we will go to the next slide and start answering some of your questions. This whole round of panel management slides. These questions are going to go to Krystal Hilton. So Krystal, do I need an authorization to provide primary care for a member who is not assigned to me?

Krystal Hilton

No, members does not need an authorization to see an in network PCP. Even if it is not the assigned PCP. We do encourage all PCP to help members engage with their assigned practice or help members change their assignment. Members will however, need a prior authorization to see a PCP who is not in the network.

Dr. Shannon Dowler

Okay, so let's take the same person and they say I keep saying this person I really want to be their PCP I want them assigned to me. So how do I help them member change their assignment in my practice?

Krystal Hilton

You can help them member by encouraging them to call Member Services number on the back of their car and also within the Member Handbook.

Dr. Shannon Dowler

And so how will that member's assignment how soon will they actually get changed for me after they go through that process?

Emma Sandoe

The members assignment will change the first of the following month. According to DHB policy. The member can still have services provided by that PCP prior to the reassignment without the authorization as long as the PCP is in the network.

Dr. Shannon Dowler

So what if we're not sure about who our patient panelists, how do we get that list of assigned members and then how often will that be sent to me?

Krystal Hilton

PCPs are encouraged to use their care management resources to help members with barriers, which we call barriers to engage and PCPS should also work with their health plans to help members with those areas. to find a better PCP fit the follow options have been exhausted. We're able to find as we shared earlier, through the NC tracks functionality we can find what the practice panels are by going to going into NC tracks and and getting that practice panel month on a month before excuse me, on a monthly basis.

Dr. Shannon Dowler

Alright thanks and I'm going to take the last one. Um, it's about people because I hear this a lot from colleagues around the state, wanting to know how they can remove panels from the patient. From there, they can't remove patients from their panels, you can't actually do that directly so it's member beneficiary choice on this, and what we encourage you to do is take those disengaged members and help them engage, whether it's working with a care manager or someone else in your community health worker, especially if you're a tier three connecting with the plans and so if you're not in tier three let's say your tier two practice you don't have a care manager in your office that's taking care of this reach out to the plan and say help me I really want to engage, I promise you the plans want you engaged as well. They know that the beneficiaries are going to have the best health outcomes if they're seeing their provider. So I think there are going to be a lot of resources to help you get folks engaged, and then ultimately the patient would need to change practices. Okay, next slide, I think we're gonna throw some over to Melanie, and these are some billing questions, so this provider is saying, currently we bill Medicaid on a weekly basis and we get a weekly payment. Will the health plans follow that model.

Melanie Bush

So it'll vary by health plan. Essentially, I think that I've heard that one health plan will be paying bi weekly, and other health plans will pay, paying weekly. But that is something that you will need to make sure that you're clear on when you sign your contracts with the PHPs so that you can plan for that ahead.

Dr. Shannon Dowler

All right, and then there's a question around financial penalties for patients or for providers if they see the wrong person.

Melanie Bush

So in Medicaid, there are no financial penalties penalties, I cannot speak tonight I'm tripping over my tongue. Alright so in Medicaid, there are no financial penalties for patients, ever. But there could be a discounted rate paid if you are an out of network provider. So if you're an in network provider and primary care provider for example, and, and you're in the plan that the member is assigned to, then you can provide primary care services, and you'll be paid the 100% rate that you've negotiated and there's no out of network discount, but if you're not in the, the network that that the patient is in, then and you have tried to contract with the PHP and then refuse that contract, you will be paid at 90% of the out of network payment rate, and you will also be subject to prior authorizations.

Dr. Shannon Dowler

Okay, so we got several questions that our last one is session around patients with Medicaid and private insurance, third party liability, do they do co pays for both plans. So can you tell us first can a patient have Medicaid and private insurance at the same time.

Melanie Bush

Yes, absolutely.

Dr. Shannon Dowler

And so when that happens, do they bill the co pays to both of those plans?

Melanie Bush

They should build the copay for the primary payer and in this case it would be the private insurance. Medicaid is always the payer of last resort, so the co pays that would require to apply to their primary insurance, and then we would submit the claim to the primary insurance, And then, if it is not paid in full, then you would submit the balance to Medicaid, to see whether it was an allowable charge in the Medicaid program.

Dr. Shannon Dowler

All right, and if someone wanted to learn more about third party liability rules with Medicaid is there a place on the website or, where would you send somebody I'm throwing this one at you.

Melanie Bush

It's on our website. I'm sure that we do somewhere. I can take that back.

Dr. Shannon Dowler

And we're gonna yeah we're gonna follow up on that because I really need to learn this myself. Alright thanks live quality measurement that the Krystal. So, practices, I have to explain how to use the health equity payment that is part of the deal, you've got to, if you're going to take the money we want you to just fill out a survey and let us know how you used it well practices have to also attest to how they use their glide path payments.

Krystal Hilton

No practices will not have attest on how the glide path funds are used.

Dr. Shannon Dowler

All right. How to practices cap the number of patients their practice or an individual provider can accept is this governed by the house, health plans will it vary.

Krystal Hilton

Okay, the provider should use its contract to refer to its contract with the PHP for this information and or contact the contract specialist at the PHP, about the their processes and requirements.

Dr. Shannon Dowler

Yeah, so there's variability in this, it depends on what you agreed to in your contracts this really comes down to what your practice contracted with the plans around new patients and accepting patients. So what do we do if we've already put in a change request, but things aren't getting changed through nctracks.

Krystal Hilton

Okay. With that, we first have to make sure that the form that was submitted. The CCNC CA enrollment form for Medicaid recipients. We have to make sure that that was signed and completed by the benefit excuse me was completed and signed by the beneficiary, because Postal Service is only able to process PCP changes with that signature. The next thing we want to make sure is we want to note that has the month change. If the form is submitted, and the form is processed within the same month the change goes into effect, the very next month. However, if the form is submitted one month and then process the next month. The change will only take effect the month following the end of the process. So that takes a little longer time. If we find that time has elapsed and those things have been verified to be true and accurate. Then the next best course of action is to contact to get the beneficiary to contact their local social service department or the Medicaid Contact Center to make those changes. We want to know that this PCP changes will continue to be requested to this process within Medicaid direct. But beginning July 1 with managed care enrolling enrolled beneficiaries, they will contact their health plan to request those changes, so best course of action is to work with those beneficiaries.

Dr. Shannon Dowler

How does a practice know what tier status they are I've actually seen that question pop up a few times in the q&a already today, how do they, how does somebody find out what's your status they are?

Krystal Hilton

Practices have the ability to attest to the tier status and review that tier status within NC tracks in 2019 at Carolina access to practice was grandfathered into the AMA program as a tier two, and like I said before, you'll be able to see what the status is currently and through the nctracks portal, and then make those changes within the portal from tier two to three as appropriate.

Dr. Shannon Dowler

All right, and then another thing is quality can the health plan set a minimum quality rating scale for the quality instead of payments and refuse to pay any incentives to a tier 3 practice who doesn't meet the minimum.

Krystal Hilton

That is the question similar to as we spoke about before about capping, this is one that you would have to refer to your contract with. But yes, PHPs are able to set targets as they deem appropriate, DHB, we set targets for the PHP.

Dr. Shannon Dowler

Alright, so you go to your plan and find out what you agreed to. All right, next slide. All right, we got some maternal health and pediatric questions. Let's see here. What if a patient has started prenatal care with us before manage Medicaid doesn't enroll and is auto enrolled in a plan that we're not contracted with, do we still get paid if we see the patient.

Melanie Bush

Yes, if you see that patient within the first 90 days of transition to managed care launch, if that, if you are out of network for that patient at that time, and there's still an authorization outstanding, there is a 90 day transition of care, period where we're recognizing and authorizing visits that have already been scheduled and already been planned, but after that 90 days, we do hope that the health plan that this patient has engaged with, or been assigned to does engage with that patient. I do want to let folks know too that that that beneficiary also has 90 days to change the health plan so they may be able to change the health plan to a plan that you are contracted with.

Dr. Shannon Dowler

Great, um, well women that are covered by Medicaid for pregnant women transition to managed care.

Melanie Bush

Most women who are on Medicaid for pregnant women will transition to managed care, there are caveats just like everything in Medicaid. If they are dually eligible for Medicare and Medicaid, or if they are eligible for a tailor plan or if they're eligible for the tribal option. Those pregnant women will have more options, but most pregnant women, these are very limited populations but most pregnant women will transition into managed care.

Dr. Shannon Dowler

Alright, so many pediatric patients will transition to adult providers when they're 18. What is the process to ensure that the patient maintains coverage during that transition. I think Krystal that one might be for you.

Krystal Hilton

Yes, that one I can answer. The PHP will support a member's transition to an adult provider which also includes any assistance in helping to identify a new provider, they also will help to ensure that the member's health record is shared in accordance with professional standards and state law. If that member is transitioning between or to an AMH tier three practice a number of health claims will begin transmitting a number of claim and risk information to the new PHP, prior to that transition, some of this work will be facilitated through assistance with the member call line, or through the Care Management supports that are in place.

Dr. Shannon Dowler

Women's Health we were running out of time. Women's Health Department's considered a specialist and not a PCP. Will patients be required to obtain a referral for their PCP to continue receiving services from that women's health department?

Melanie Bush

No, per federal law, and our PHP contracts. If you are in network provider for that patient. Then she does not need a referral, if you are not in a contract of the health when she's in then yes, you would need some sort of prior authorization.

Dr. Shannon Dowler

All right, next slide. We've got some network adequacy we're going to zoom through so for contracted with all plans. Can we still see members not assigned for our practice.

Melanie Bush

Yes, if you're a primary care physician can see people in network for all the plans, yes you can see those individuals.

Dr. Shannon Dowler

If the practice isn't currently accepting new Medicaid patients will they have to open up for open enrollment.

Melanie Bush

So this is something that PHPs can negotiate with practices or contracts, it's something that practices should be thinking about during the open enrollment process. Patients of yours maybe choosing plans that you're not contracted with so you will be losing members, and then when we go into auto enrollment. Those members will not be assigned to you and then you will not get them back. And then if you're not accepting patients then you also won't be getting new patients assigned to you through Medicaid so it's something practices should think about but it's also something I believe that the PHPs can require in the contract, or as part of the negotiations.

Dr. Shannon Dowler

Let's get on to the next slide, man, because I want to make sure we get to some of the audience questions. Today, we did want to focus on a few things that we're getting a lot of questions on from our Help Center. So one is around how does managed care impact the provision of dental services and beneficiaries trying to get dental services.

Melanie Bush

So managed care does not apply to dental services Dental is carved out dental providers will bill nc tracks on the fee for service basis for those services and those are outside of what the managed cares are responsible for although the managed care should be coordinating the care for you if you need dental services.

Dr. Shannon Dowler

All right, and a slightly more nuanced question that help center is hearing is, what is the difference between the health plans, giving a standard authorization decision, and an expedited authorization decision.

Melanie Bush



So the difference is time right expedited is within 72 hours, they can extend that thing more information but an expedited authorization is within 72 hours, a standard authorization is as soon as possible but no more than 14 days for the authorization may be extended if they need additional information. But yeah, 72 hours versus up to 14 days.

Dr. Shannon Dowler

All right, so let's go on Hugh, and let's hit some of these questions everybody that's on all this means our subject matter experts, turn your cameras on so you're ready to take one of these questions that gets thrown to you. And I want to I'm going to start off with one I saw early on, it said what if we, the governor's budget doesn't pass. Are we going to go live July 1 And, yeah, we're not worried about budgets passing We're going live July 1 so, it is, it is a thing, it is coming. So I see a question too around glide path payments and the timing of those Krystal do you want to mention that again. When those first payments are coming through?

Krystal Hilton

Sure. The initial payments will be coming out if based on the check right the normal nctracks check right flow, though the attestation that was due on March the 30th that that attestation the payments will be out on April the 13th with in accordance with that check right for the subsequent month of the end of April, you'll get a payment in the middle of May, check right, and the same thing for May the end of May, you'll get it for the June check right.

Dr. Shannon Dowler

All right Hugh you want to throw somewhere out there.

Hugh Tilson

So is there a contact for us to engage if we have a contract more than 14 days ago and our providers are still not listed as enrolled with PHPs within the provider lookup tool.

Melanie Bush

So I would first have you contact your clinically integrated network if you are a member of one of those to make sure that that information has been finalized. Second I would have you contact the PHP, to make sure that they have loaded your information. And then finally, if you haven't done those things, then I would encourage you to contact our provider ombudsman at Medicaid to help bring that to resolution.

Hugh Tilson

Thank you. How about this one, our local social services office told us to stop sending in the change forms and sounds. Here we can continue to send those, can we still send in the forms.

Melanie Bush

Yes, you can still send it in the forms that if you want to drop into the chat which county is telling you that, that would be much appreciated.

Dr. Shannon Dowler

Yes, please do this this is what I think one of the biggest things and the reason we did this special reassignment process, was because we want to go live in July, we want this to be as smooth as possible. And so if people are with the right PCP it's going to make it so much easier on day one. So change forms are really important. Please keep doing those and like Melanie said, let us know if someone's telling you not to.

Hugh Tilson

Got a couple follow up questions about glide paths did Krystal say April glide path payments will be in the April 13 check right and when will we know if my practice will get glide path payments.

Krystal Hilton

There will not be a notification that you will get glide path payment. However, as Dr. Dowler share if you are in, if you are in category where it appears that you may not get them you will get a notification at that point, and we will be able to work with you to sit there at that all at work with you and the health plans that you've contracted with to ensure that eligibility.

Dr. Shannon Dowler

So the payments will lag. So you'll attest, and then the payments will come a couple weeks after that, for the prior month.

Hugh Tilson

Did I understand that private practice cannot discharge a patient if they're having issues with them after the patient threatened staff, causes scenes, is disrespectful.

Dr. Shannon Dowler

Um, now I think I'm in and might get in trouble so Melanie or Sandy or someone correct me if I answered this wrong, but for me I think you have to do what you need to do for your practice and if you have a patient that's threatening someone I know when I was the CMO of an FQHC we had, we've tried very hard not to fire people from our practice but if they threaten the lives of a staff member or they committed a felony, against our practice then we were, we felt like the physician patient relationship had been damaged. So there are definitely situations where that is appropriate.

Melanie Bush

Yeah and I would just direct you in those cases to reach out to our provider ombudsman. And in urgent and emergent conditions. The patient needs to be treated for urgent and emergent conditions.

Hugh Tilson

Got this question. Most patients do not carry their insurance cards their central search location determine which plan patients were enrolled in at the time of service.

Melanie Bush

Yes, so all practices have access to the nctracks portal, where you should be confirming patient eligibility at the time of service, every single time they visit because their patient expiration date is not on their card. So we really do want to reinforce the provider should be checking the NC Tracks portal for every patient visit. Also an NC tracks you will be able to see what health plan that beneficiary is enrolled in.

Hugh Tilson

Question about can you provide a virtual presentation or overview for agencies. Do you know yeah?

Dr. Shannon Dowler

Yeah so I think absolutely, if there's a request that you want to set someone from our team to come and speak to a group to whether it's the state association or a regional group or whoever we're happy to do that we really are trying to get especially now that we live in virtual land, we can get to a lot more places than we could before and so we really want to be able to get out there and communicate with you, so please do reach out and say you're interested. Melanie whats the best evening, or best way to request.

Melanie Bush

I mean we can put it in the chat here. I think that would be a good start. Otherwise, I would have folks, reach out to the provider ombudsman and they will pass it to the right person.

Dr. Shannon Dowler

Yeah, great call provider advisement or just if you're interested one and put it now in the question and answer. And we'll take that back and put your contact information and we're happy to set something up, and let us know what your focus area is that you're interested in.

Hugh Tilson

Where can we find a PCP change request form.

Dr. Shannon Dowler

We covered this in our last webinar, but I don't remember Melanie Can you direct to where it is.

Melanie Bush

The PCP change request form should be on our website in the provider section under forms. But I can try to locate it and put it in the chat,

Dr. Shannon Dowler

And patients can also call to change.

Melanie Bush

Absolutely. They're the ones that have to initiate the change of course and so they have to sign the form. They also can call their local, county DSS, to make that change, or they can call the Medicaid contact center and that number is located on their Medicaid card.

Dr. Shannon Dowler

And we did do a trial run and we'd heard some feedback that DSS is weren't doing that by the phone. And so we did a bunch of cold calls and secret shoppers and they almost all to a one, we're willing to change the beneficiary's information when they call. So, offering that in the office where they standing there is a great way to do it, because by the time they get home and they're busy doing 5 million things if they're like me, they will have forgotten to do it.

Hugh Tilson

Well, we need to continue completing Carolina access forms after July.

Melanie Bush

So Carolina access will still be in place, we will still have individuals that are not transitioning to managed care. And so there will be still be individuals that are receiving services through the CCNC Medicaid fee for service program. So to the extent that you have those patients, then those that information will be needed.

Dr. Shannon Dowler

And then here we are at 630 I don't know where the time goes. But we have once again man there's just been an hour on this.

Hugh Tilson

Well then, why don't we stop asking questions, and why don't we thank you and your team for the great preparation and work that you've done to provide such great information and thank all the people who participated tonight for joining us, and all the work that they're doing for their patients and to prepare for this transition and then I'll turn it back over to you for any final words.

Dr. Shannon Dowler

Yeah, I want to double down on thanking the team I think everybody that works in Medicaid is trying so hard right now to make this transition as smooth as possible. Everyone is working, extended extra hours, all the time trying to make this go as well as possible for everyone in the state. We got a lot of people counting on us to get this right, and thank you to everybody that is taking this time away from your families or doing your charts or what you should be doing right now to get caught up, we know this is a huge transition for everybody so thanks for engaging with us, please know that we are stand ready to serve and we want to help in any way we can. And with that we'll see in a couple weeks we're gonna have a heavy focus on pharmacy and DME and our next hot topics.

Hugh Tilson

Thanks everybody. Have a great evening.