

Transcript for NC Medicaid Managed Care Hot Topics Webinar Series – Behavioral Health

May 6, 2021

5:30 – 6:30 p.m.

Presenters:

Shannon Dowler

Melanie Bush

Keith McCoy

Melanie Bush

Jean Holliday

Deb Goda

Chris Weathington

It's 5:30 Let's get started. Good evening everyone and thank you for participating in this evening's Medicaid managed care back porch chat webinar. Tonight's webinar is put on by North Carolina Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care. As a reminder, we put on the back porch chat webinars on the first and third Thursdays of the month on a variety of Medicaid managed care hot topics. North Carolina Medicaid and AHEC have partnered to ensure that health care providers across all 100 North Carolina counties have the information and support they need to adapt to and thrive under Medicaid managed care. This collaboration produces educational webinars like these and virtual office hours across a variety of relevant topics. In addition, AHEC Practice Support coaches are available at no cost to provide one to one assistance directly to the practices. I'm Chris Worthington and now we'll moderate tonight's webinar. Before I turn it over to Dr. Shannon Dowler, let me just run through some logistics. If you need technical assistance with anything, please email us at technicalassistancecovid19@gmail.com That's technical assistance COVID-19 at gmail.com. You can adjust the proportion of speaker in slides by dragging the double grey lines between the slides and the speakers. You can also adjust your video settings to hide people who are not speaking to do so just click on the up arrow for the pulldown menu to the right of the stop video button in the black bar on the bottom of your screen. Select Video Settings, scroll down towards the bottom of the page and click the hide non video participants box.

We'll put these instructions in the q&a for your convenience. We'll also have time for questions at the end, everyone other than our presenters is muted and the chat function is turned off, you can ask questions or make comments, either by using the q&a feature on the black bar on the bottom of the

webinar screen, or if you're dialing in by sending an email to questionscovid19webinar@gmail.com, we've learned in past webinars that the presenters will often address your questions during their presentations. We encourage you to wait until the presenters are through with their presentations before submitting a question, please know that we will send any questions we do not get to our Medicaid team so that they can respond directly to you, and incorporate the questions into FAQs and other documents. These slides were just sent to you in the q&a box but they're also available on our NC AHEC website. There is a link to them in the q&a box that I just mentioned will record this webinar, and we'll add that recording and a written transcript of it with the slides on the AHEC website. Now I'll turn it over to Dr Dowler.

Dr. Shannon Dowler

Thanks Chris. It's great to be with you tonight, and we've given Hugh the night off I guess he deserves it every now and then, we have a tight agenda. The first thing we're going to do is do a quick high level overview of the behavioral health webinar that we did back in January sort of level setting, but we're going to go through it at workspace, and we're going to also incorporate questions that we've gotten from stakeholders, then we're going to go into our what ifs, we have, we've had a series of what ifs sessions where we've met with folks from around the state who has fired at our team all the questions they can think of everything that could possibly go wrong. And so they're saying what if this happens, what if that happens, and our goal today is to answer all the what ifs and help everybody feel reassured that July 1 will not be a totally apocalyptic time for everybody.

So I do have a few highlights unrelated to the weather sessions tonight that I'm going to hit, and then we're going to open it up for your questions and answers. I do want to go back to what Chris said, it is really important that if you can hold your questions till the end, we're probably going to answer them. We have so many answers to questions ready for you tonight. And then as you're listening be thinking about, okay, I got that but I don't have that wait and see if we don't get to your question, there's going to be time at the end to put it in there, and if we don't have time to answer them all. At the end, anything that's unanswered, we will take home as homework. So I mentioned the January 7 Fireside Chat. That was back when it was cold, so it was fireside not back porch. This is really important for everybody to go back to the behavioral health topics, I think are the most complex, with our transformation. It is such a drastic change from how we're doing it now, and it's affecting every one of the states, and so I think, in order to make sure you get the most out of tonight's webinar, go on and do some extra work afterwards, and go back to at least go through the slides if you don't want to listen to the whole session. But at least slip through the slides, and there will help I think everything we say tonight because we're sort of doing the advanced beginner version tonight, if not intermediate. Make sure you got everything from the basics. Alright, so with that, we're going to start with some super high level overviews and move through the slides quickly to get to the deeper questions. Next slide.

So we're here today to talk about the standard plan, both the standard plan and the eastern man Cherokee Indian tribal option will go live in July of 21, so I believe it's under 60 days. It is coming rapidly

upon us, and 2022, in one year July, 2022 will go live with the tailored plans, and then following that, the foster care plans. So we've had a lot of work coming up in the next few years, this is just the first stage. Next slide. When we think about our standard plans and our tailored plans. The vast majority of the non dual eligible Medicaid population we serve is going to fall on standard plans. We think probably 1.6 million people are going to fall into our standard plans, and that's what goes live in July. There aren't going to be a significant number who are going to remain in the BH IDD tailored plans. These are going to be folks that have more significant behavioral health conditions that includes serious and persistent mental illness, emotional disturbance, severe substance use disorders. Also, those with intellectual and developmental disabilities and traumatic brain injuries. So, little later on the slides I'm going to give you some examples of how we work through this next slide.

Some of the key takeaways we had at the end of our last session on this in January, I think we'll start with, because these are really core important things, behavioral health providers in the state are going to need to contract with both the standard plans the PHPs and the LME MCOs. This is really really important because patients are going to have to make choices, they might have to choose between their family doctor, and their behavioral health provider if folks aren't contracted with the same plans. So it's really important that we get as many of you out there have contracts, because many of the plans as you can negotiate a contract with that you feel good about, so that our patients at the end of the day, get what they need as far as services. So super important that you're out there contracting, and I think this is a piece that some, some in the field haven't quite understood because it is really, really different. If you're a behavioral health provider, you need to contract both with the standard plans, the PHPs and the LME MCOs. There aren't going to be a subset of high intensity behavioral health benefits that will only be available for those that are in the tailored plan. It's going to be important for providers to understand which benefits or which type of plan to help guide the folks that you're caring for. There are going to be open provider networks for physical and behavioral health and the standard plans. It is on integrated care services. The tailored plans will have closed provider networks for behavioral health, but they'll have an open network for the physical health piece. Once managed care launches you as a provider are going to bill the appropriate plan. Some people are going to stay behind the Medicaid direct, so we'll go to the LME MCO and some will go to the standard plan, it's going to be a significant change for you. Next slide.

Most non dual beneficiaries, include those with mild to moderate needs are going to be in the standard plan so again that's about 1.6 million people, it's a lot of people are going to stay in our standard plans. They might come to providers to help understand the difference between the plans and where they should go so it's really important that you're listening in tonight, so that you can provide some of that guidance, but we also have the enrollment brokers who are really skilled at this. So if you feel like you're not in a position to do it. Not to worry, we just want to make sure you connect folks, the right people. It's going to be important that as providers you help people end up in the right plans or they get the right basket of services that they need. Next slide.

When we talk about what's in one plan or the other, everything you see on the left part of the slide and the gray, those are standard plan services, but they're also available in tailored plans, but everybody that's in mild to moderate category staying in the standard plans, integrated behavioral health into their physical health should access these services, if they need other services that you see on the right side of the slide, that's probably the people that we're going to be thinking about moving into the tailored plans. Next slide. So I think one of the things that's important to understand is how we're integrating everything. It's really different than today's world where we have medical in one place and behavioral health in another place, we're bringing it all together. And so that means standard plans are going to offer outpatient mental health services, basic psychological services, peer support services, diagnostic assessments, a set of emergent services will also be available for standard plans, including mobile facility based prices services, inpatient hospitalization, partial hospitalization and really importantly, a subset of substance use services. So, outpatient Opioid Treatment, ambulatory detox and non hospital medical detox are going to happen in the standard plans. Now emergent services are really important. We want to make sure that any beneficiary that's in a mental health crisis gets their services immediately. One of the things that we've asked the plans to do. As a matter of fact we've told them to do, is that they have to contract with all of the crisis behavioral health providers because we want to make sure that we have access to real time needs and continuity of care.

Next slide. So as we think about integrating physical and behavioral health, we think both about the standard plans, and the tailored plans, and they're going to look actually more similar than different. They're going to have pharmacy services they're going to have outpatient and inpatient behavioral health services they're going to have crisis services and withdrawal management services. It's just those that have certain higher intensity behavioral health IDD and TBI, these will fall into the tailored plan and there'll be a subset of benefits for them, that aren't available in the standard plans. Next slide. So now we're going to get to some of the deeper what if questions, and I'm going to ask some folks to join me to answer some of these questions. So one of the things we heard from the field, there's a lot of concern around utilization management, particularly for hospitalizations and admissions and standard plans. Will it be consistent across plans or each bank and have their own criteria.

Keith McCoy

So, inpatient and other behavioral health, clinical coverage policies are not waived for the standard plans which means they've got to follow the clinical coverage policies that the state has developed, that sort of eight series clinical coverage policies. So, the standard plan must follow those, with the exception that they may be less restrictive with their priorities.

Dr. Shannon Dowler

So they can cover more, but they can't be in a more restrictive place than they are today. So, so will behavioral health services vary between the plans.

Keith McCoy

So the tailor plans will have additional enhanced residential and waiver services as we just previously covered in the immediately preceding slides. The standard plans will again have to follow the Behavioral Health Clinical coverage policies so they can be less restrictive on the formulary, and prescription Drug List will not differ across plans, and there'll be a single PDL which will be maintained across the health plans as well as Medicaid direct.

Dr. Shannon Dowler

And that's a really important thing we heard over and over again in our what if sessions are they going to have different meds different rules for the anti-psychotics it's one Pdl, We get one PDL which is great. What will change with a mobile crisis and assessment services and managed care.

Deb Goda

So, both of the plans have mobile crisis, it's going to be in Medicaid direct, it's going to be in the tailored plans and it will be in the standard plans. What's changing is we've looked at the rate. And, and what it would take to make sure that everybody has access to that so the rate will be increasing. On July 1.

Dr. Shannon Dowler

All right. So how's the state going to make sure that the plans are following the utilization management standards and guidelines so you're saying that they have to meet our floor and they can't be more restrictive, but how do we know that they're actually following our guidelines.

Deb Goda

So prior to go live, we've looked at at the policies. And we've also had the PHPs attest to what they are doing but afterwards we're going to be looking at the website to see what they've got posted, we'll be looking at the utilization reports that come in to see if they're using more or less of the service than we were using under Medicare direct, we'll still get complaints and comments from consumers and providers that we'll have to follow up on and we have a very comprehensive contract that outlines what happens if you don't meet the outcomes.

Dr. Shannon Dowler

Great. All right, next slide, then. So, how will the innovations waiver program work with standard and tailored plans.

Deb Goda

So the innovations waiver program will only be under the tailored plans, and it will continue be operated by the LME MCOs until tailored plans go live. The cap waivers will only be in Medicaid direct. So if somebody is waiting for a waiver slot, they can apply to be on the waiting list and then they can be in a standard plan. Once they get a slot they'll have to move to the tailored plan. If they want to go to a standard plan when they have a waiver slot under innovations, they would have to withdraw from the waiver first. So there won't be anybody who's accidentally coming off the waiver because they applied to be in a standard plan.

Dr. Shannon Dowler

Right. So what if a member qualifies for a tailor plan based on the severity of their behavioral health needs, but they're seeing a different provider for opioid use disorder treatment that's different than their behavioral health provider will they be able to continue seeing that person.

Deb Goda

So, there are going to be in the tailored plan there will be continued to be a closed Behavioral Health Network, but the physical health network will be any willing provider, just as Medicaid direct and the standard plans so they will be able to consider continue seeing their OBOT, as long as I just misquoted on that as long as the OBOT decides that they want to contract with the tailored plan. The tailored plan can't say no to the OBOT but of course the OBOT can decide not to be in the tailored plan.

Dr. Shannon Dowler

Great. Do patients have the right to refuse tailored plan, maybe they don't want to be on the tailored plan, but still get the specialized services.

Deb Goda

So there's actually a wide array of services and the standard plan for the treatment of autism resource research based treatment for autism spectrum disorders is a standard plan service. Also for children there are services that are available for EPSDT if they're not on the covered benefit. So an individual can choose to be served in the tailored plan, and unless they are on a waiver, and then they do not have that option unless they withdraw. Okay.

Dr. Shannon Dowler

What happens if a child presents to a primary care clinic with a mental health emergency, let's say they're suicidal, and that primary care provider is out of network, will they get paid in emergency

situations, out of network providers get paid at 100%. And just to be clear. And I think what I'm going to phone a friend on this show was, I think Sarah, I'm gonna call you on this one, if they're if they're in an ambulatory office with an emergency, will that be paid out of networkers or only when it's hospital emergency situations.

Sarah

So that's out of network 100% emergencies when it's truly an emergency setting for emergency services.

Dr. Shannon Dowler

Yeah, so it's gonna have to be in the hospital or the emergency room environment or an emergency environment, to get that 100% out of network. All right, next slide. So I have to phone friends all the time to make sure I have things right. All right, let's see, this is a great topic we just have with all the CMOs and behavioral health leaders from the plans and a meeting just before this one well providers still be able to bill the same collaborative care codes that they're currently billing

Keith McCoy

Medicaid direct allows reimbursement for behavioral health integration in primary care settings and covers the collaborative care codes, standard plans as well as the tailored plans in the future will also cover the collaborative care codes, and you can refer to the Medicaid bulletin on coverage for psychiatric collaborative care management for more information.

Dr. Shannon Dowler

So yes, collaborative care codes, two thumbs up. What a standard plan does not approve requests for peer support, will it be a covered service and what are the rights to appeal a plan decision.

Keith McCoy

So standard plans must cover your support services it's part of their benefit package and they've got to follow the same clinical coverage policy, as in Medicaid direct as with the other behavioral health services that are covered in the standard plans. If the plan denies tier supports or other services, and the beneficiary may appeal that decision, just as with any other Service and Medicaid. Yes.

Dr. Shannon Dowler

Well compliance with mental health parity regulations be enforced by the state, and if so what are the mechanisms to enforce them.

Keith McCoy

So each standard plan must submit reports about how their benefits and processes of managing those benefits meet the parity requirements, and those reports will be reviewed and approved or not approved by DHHS.

Dr. Shannon Dowler

Alright, so many BH providers support delivery of primary care and community health centers and other places through telehealth, will telehealth remain after the public health emergency.

Keith McCoy

So many telehealth flexibilities that we enacted associated with the public health emergency have been made permanent. And you can certainly see our updated clinical coverage policies, or what will be permanent. Beyond the public health emergency and you can specifically look at clinical coverage policy 1H, and then for fPh C's, you can look at clinical coverage policy 1D4, for those permanent changes.

Dr. Shannon Dowler

And I will say, if I brag on our teams, we are way ahead of the rest of the country saying we want to keep some of the gains we made in this public health emergency and make permanent changes and so, while other states are still trying to figure it out. We made these decision months ago, so they're in. Alright, next slide. All right, let's turn it over to Jean.

Jean Holliday

Let's see if I can get unmuted so, so sorry about that. My name is Jean Holliday, I'm a senior program manager in the Division of Health Benefits and my areas of responsibility are the provider network adequacy and provider contracting. So tonight we're going to mostly talk about the standard plans in terms of their network adequacy. I'm just going to hit a couple of high spots on some of these slides they are and were included in that previous fireside chat back in January. We of course have standards and they're, they're designed to, you know, ensure that members have timely access to all covered services, and specifically for behavioral health we have some standards that are applicable to send various behavioral health services. We were asked specifically, you know, what is the level of our oversight of these we have two types of standards, one is a time and distance standard where a probe, where a member has adequate access if they live within a certain distance in time, or miles from a certain number of providers, or we may tell the PHP they have to have a certain number of a certain type of providers within the region or a county, and each our oversight in both of those cases is to not just take the PHP is word for it we do confirm compliance through our own independent analysis of their networks. I'd also like to emphasize as Dr Dowler mentioned, we are especially concerned about being

sure that there is continuity of care for these for these members. And so we are analyzing and monitoring the contracting with historical crisis service providers as well as outpatient behavioral health providers, and using that to hopefully target or have the PHP target providers who have, you know, been seeing members in historically served this population. Next slide. So, again, just kind of our oversight. I guess I touched on this just couple of minutes ago we are you know have independent analysis of the networks that are sent to us we look to make sure that those time and distance standards are met. And we will be, you know, doing other types of oversight, particularly, you know, given, and, you know, concerning, you know, once, once we go live, then we'll be looking at complaints from from consumers inquiries that come into the member ombudsman program or those that may come in through the provider ombudsman, and how those may reflect upon the adequacy or the sufficiency of the network.

I would also like to mention that. Someone asked, what, you know what services, behavioral health services are not measured in network adequacy, we have a clickable standards for outpatient behavioral health specialty access to psychiatrists location based services crisis services, inpatient behavioral health services, and partial hospitalization services. So all of those have a specific standard whether it be a time and distance standard or a certain number of providers within a geographic area. Next slide. I think we, I think I've touched on this, I'm gonna let that one go and people can just review that let's go on to the next one. All right, this has the behavioral health standards that are applicable. Note that we have standards that are applicable for urban counties versus rural counties in North Carolina, there are 80 rural counties, currently and 20, urban. And so, the standards as you can see there, there's a couple that are or three of them that are based on time and distance and then there are two that are the kind of number of providers per a geographic region.

One of the things that we were asked again through the what if questions were pertained to what what some people call ghost networks and how those might impact and you know impact access. And what, what was the department's, you know, approach to trying to ensure that doesn't happen and I think that we're going to have to utilize and rely upon our members and in the provider community to keep us aware and abreast of these types of situations, so that we can address them. When we see issues, I perceive that, you know, we might identify these kind of issues through complaints from consumers where they're saying they're, you know, asking to see a doctor and they just can't get an appointment, or, you know, repeatedly, going through a list of providers from the PHPs directory and not finding a doctor that will answer the phone or or whatever kind of, you know, issues might identify providers who are there in name only. And certainly we will follow up to ensure that that the PHPs have directories that are accurate and, you know accurately reflect actively participating providers. Next slide, we also have what we call appointment wait time standards and again this will be something that we'll be measuring after we have some experience under our belts. But we have times in which we, you know, we expect that a provider will be able to see a patient who is asking for an appointment, and those appointment times are based on the urgency of the actual request for the appointment. And we'll be measuring these, as I said after we get a little bit of experience under our under our belts and having the PHP monitor to this on a regular basis, their contracts with the providers specify these timeframes and, and they'll be responsible for ensuring that compliance but we'll have the PHP report information to us

to assure that that is that there is compliance. Next slide. Okay, Doctor Dowler I think it goes back to you now.

Dr. Shannon Dowler

All right, thanks, I will confess Jean I got busy looking at the questions and answers in the q&a section. All right. So so what if questions and network adequacy. So for licensed independent practitioners, there's no rate for what happens if there's not enough contracted licensed practitioners provide services such as individual psychotherapy to children and adults.

Jean Holliday

Okay. There is no way for for behavioral health services, other than for psychiatrists to fall under the physician the physician rate floor, each standard plan will develop their own fee schedule for behavioral health providers. Providers should work with the standard plans during contracting to negotiate that behavioral health rate plans of course would be encouraged to raise rates to incentivize providers to participate, particularly when they may need providers in order to make sure that they, that they are providing appropriate access to members.

Dr. Shannon Dowler

Okay so, so how are health plans going to find the provider for beneficiaries. If the, if the providers is if their primary care trying to make a referral, no one's taking new patients what are the plans supposed to do.

Jean Holliday

The plan is when, when a network is not adequate and what that means is there's not timely access to a provider, the plan is supposed to cover out of network benefits, as, as an a network, you know, situation, and should, should facilitate allowing a member to get to those can't get to those services when, when that's when their network is not adequate.

Dr. Shannon Dowler

All right. Okay, let's see what we have next. Ah, some questions for Kelly, so we did get a handful of questions and our What if sessions around quality. So are there metrics that the state's tracking around integrated care that providers should know about.

Kelly Crosbie

Yes, we're actually tracking, a lot of different measures and I will put some, I will put a link in the chat. So we published our Technical Specifications Manual. It's big, big name but it actually lists all the measures that we're tracking for both health plans so with standard plans are going to report around integrated care. We're going to track also as the state on top of that, but also what providers are responsible for so very specifically if you're an advanced medical home. You are responsible for depression screening and follow up care. That's your measure where we're making sure that you're paying attention to integrated care in the practice. Now health plans are going to be tracking a lot of other things like follow up after mental health hospitalization, a suite of three different Opioid Treatment codes, they're tracking medical assistance with tobacco cessation. They're tracking first line psychosocial care for kids who are on antipsychotics. So they're tracking a lot more and then on top of that the stable track but again use a provider really really want folks to pay attention to depression screening and follow up care.

Dr. Shannon Dowler

All right, so does the AMH model support collaborative care teams that include psychiatrists and mental health professionals.

Kelly Crosbie

It absolutely does and as Keith already mentioned, the collaborative care codes are covered. Just broader than that of course, the plans are fully integrated so if you're an advanced medical home please our behavioral health professionals we absolutely support integrated models of care.

Dr. Shannon Dowler

Awesome. So, do we have the behavioral health metrics that primary care providers need to follow on a standard plan, and how are you tracking them.

Kelly Crosbie

Yeah, and I mentioned those already so there's a slew that that health plans will track will track them to it. This data will trend them month over month health plans will report them on an annual basis and if you are an advanced medical home, that depression screening and follow up care that I mentioned, you will get interim results from your health plan along with all your other things that you're tracking not just your integrated care measures, we'll send them to you every quarter and then once a year they're telling you how you're doing on all your measures.

Dr. Shannon Dowler

Great. and then this one's more around crossover for current peer support authorizations crossover at managed care launch.

Kelly Crosbie

They absolutely will. So your authorizations are good for 90 days, or, or less, if the authorization itself ends sooner. So if the authorization ends in 60 days after launch, it will end at that point and of course, the standard plan will reevaluate that authorization going forward.

Dr. Shannon Dowler

Awesome. All right, next slide.

Melanie Bush

Okay, good afternoon, good evening everyone. My name is Melanie Bush, I am the chief administration Officer here at North Carolina Medicaid, and I want to talk to you about our notices regarding managed care transition. So, we are currently in a period of open enrollment individuals are selecting health plans as you've heard this period of open enrollment last until May 14 of this year so next Friday. Individuals can make selections about whether they want to be in a standard plan or not. To jumpstart this process and March, we began sending notices to individuals, letting them know about their, their choices, whether they can choose Standard plans whether they have the option to be at a tailored plan, etc. And so these notices actually look a little bit different depending on which population you find yourself in. So the notices for the beneficiaries that have to enroll in standard plans. They include information about the timeline so they have from March until May 14, the process for selecting a primary care and health plan, the steps they need to take if they don't feel that they have to enroll in a standard plan, so we have something that I'll talk more about on the next slide, that does allow beneficiaries who think that they don't need to move to a standard plan to fill out a form and stay in Medicaid direct until we launch our tailored plans, and then contact, back just one minute and then contact information for the enrollment broker, the beneficiaries that are eligible to stay in the behavioral health IDD tailored plan. They received notices that told them about their continued enrollment and fee for service for the next year, they were also told about their options to enroll in standard plans, but that there may be benefits that we're not going to be available in standard plans that they may need. And then also contact information about enrollment broker.

I do want to just stress we've, We've seen something that is happening in the field that I feel we should have, we should touch on here. Providers are sending out letters or blasts through patient portals that say you must sign up with a health plan if you want to continue to see me. Any official notification comes from the state the providers are simply trying to let their patients that are supposed to move to managed care which health plans they are contracted with. Any notice from a provider about how you

have to sign up for managed care is not an official notice those official notices come from the state so I just wanted to underscore that. Okay, next slide.

So what if a member does need a service that is not covered by standard plans and this is the process that I was alluding to earlier. So right now we have instituted and it's available on our enrollment broker website or request to stay in North Carolina Medicaid direct and LME beneficiary or rolls right off the tongue, but basically this is a form that you can fill out that basically raises your hand and says, I don't think I need to move to a standard plan, and these are the reasons why, or if you find yourself enrolled in a standard plan and something about your health changes, then you can work with your provider, and also fill out this form at a later date, and transitioned into the behavioral health IDD tailored plan. So this process basically is the provider works with a member to complete the request, there's a service that's been identified that they feel is medically necessary that this beneficiary needs that they discuss it and discuss what's available within a standard plan, and whether it makes sense to move to the behavioral health IDD tailor plan. We do have to have members or guardians sign the request this is not something that providers can submit on behalf of their beneficiaries. So they have to be involved in the process of filling out the form and sign it, the provider can submit the request these requests will go to our enrollment broker, we have a vendor who will review their request, it will be sent to the appropriate vendor within 24 hours. Our vendor will review all the documentation that is submitted with the request any kind of medical documentation that is supportive of this transition will make the review go faster, of course, if documentation is not included if a beneficiary just fills out this form, then our vendor will contact that beneficiary for more information, or the provider for more information. We'll review the request and if it approves that transfer will happen within one business day. The idea is to get people in the right place at the right time so they're receiving the right services from the right plan. So that is the process that we have developed so that folks can get into the right place at the right time.

Dr. Shannon Dowler

I did it again I started with the Q and A's. They're very good questions out there, are plans going to be required to reinstate or expedite coverage for people in the prison system.

Melanie Bush

This is a good question. I do want to stress that plans do not determine eligibility. That whole eligibility process still resides with our local divisions of social services for individuals who are coming out of prison, they will have to apply to the local DSS is just like anybody else, if they were on Medicaid before entered into prison and had their eligibility suspended, then that they will be unsuspending upon release, and what will happen then is if that individual is determined eligible for Medicaid or their eligibility is unsuspending, and they are eligible for managed care, they will be auto enrolled into a plan, and then they will have 90 days to change that plan. If or, you know, fill out a form that says they shouldn't be in a standard plan, just the same as any other Medicaid beneficiary.

Dr. Shannon Dowler

Alright, so is there a safety net for beneficiaries to get services while they figure out what plan or PCP they want or been assigned to you and sort that out.

Melanie Bush

So there's a safety net, you're either enroll in a plan or you're not beneficiaries can get services, wherever they are in the Medicaid program. But what will happen after July 1 is individuals will be auto enrolled with a plan, they have a choice period of 90 days to change that plan, or to change their PCP, but in the meantime they can continue to get services, if they're in fee for service, same thing, they can continue to get services, but you're either enrolled or not there's not a, there's not a window of time where you're making a decision and there needs to be some sort of safety net, you're either in or you're out. And you can get services.

Dr. Shannon Dowler

Absolutely, no one's no one's going to fall through that gap, and there is that time period that 90 days where people can sort out if they ended up in the plan they didn't want to be in or they ended up the PCP they didn't want to be. Alright, next slide. Alright so we got some more general what ifs, are the number of visits providers currently have for year under Medicaid gonna say the same under all the different health plans.

Melanie Bush

So are our health plans are required. I'm sorry I was trying to think of the best way to say this easily our health plans are required to follow our clinical coverage policies and amount, scope and duration, our policies are the floor, they're the minimum of what they have to provide, but health plans can go above and beyond so if they wanted to they could increase the number of visits per year, that are available under their benefit.

Dr. Shannon Dowler

All right, are the documentation standards, different between tailored plans or standard plans.

Sarah Gregosky

And this is Sarah Gregosky guaranteed with managed care I'll jump in on that one. We're trying as much as possible to really streamline our provider requirements and reduce that administrative burden. We've implemented standard prior authorization forms for medical and pharmacy. We've tried to streamline the enrollment process so that health plans can ask for more data than they need to they're getting that from us already when he's enrolled with us, so we're trying to take those steps, and those

will be the same across standard plans and tailored plans, but open obviously to other suggestions on where we can try to simplify that documentation and examples.

Dr. Shannon Dowler

Alright, so how are commercial insurance companies really different from Medicaid, what's the difference between, let's say, commercial plans Medicaid products and then commercial services.

Sarah Gregosky

Yeah, so under Medicaid, we have a broader number of services typically available through a commercial plan including enhanced behavioral health services long term services --. And then our EPSDT program which is different than what you get in the commercial market from a commercial plan.

Dr. Shannon Dowler

I have always said Medicaid is the best insurance coverage that money can buy, especially in North Carolina, we have a very rich benefit. All right, providers like the current system of Medicaid and really that ability to talk to somebody who will listen to you and get you answers to your questions. So what if there's a problem, how do they escalate to a higher power or they're trying to work through issues,

Melanie Bush

We do have a Medicaid provider ombudsman and we encourage providers to work with the health plans and with, to the extent possible, and with their clinically integrated networks but if they can't resolve those issues please reach out to our Medicaid provider ombudsman, that is what it is there for, they have an email which is Medicaid.provider.ombudsman@DHHS.nc.gov They also have a provider line where you can leave a message, or talk to someone during business hours at 919-527-6666 This information is available on our website. It's also available in all of the provider manuals, manuals, with the health plans.

Dr. Shannon Dowler

And I think it's important to flag this is one of the things that's going to change folks are really used to coming directly to us with challenges and now they're going to be going to the plan, where they're having a challenge and that's your first line, but certainly we are going to be looking constantly we're going to be doing surveillance from day one, looking for where we see aberrations or challenges, things that don't look right and we're going to be looking at Cross plans and we're going to be troubleshooting along with you. Our goal is to fix things before you even have a chance to tell us there's something broken. Alright, next slide. So shifting really quickly before we open it up to broader questions and answers I wanted to go over a few things around payments that we're doing right now. One of those is

BiPAP payments so for those folks that are tier three AMH tier threes. You got another chance to get those glide path payments. Mel you want to give folks the new deadlines. Yes, so

Kelly Crosbie

The final glide path deadline is May, the 15th, so you need to get your last adaptation if you've not tested so far by May 15 That's for the June payment, but remember if you've already attested you do not need to attest but this is the last chance for people who have not attested yet. We've had great rate uptake of this so far over 75% of tier threes have applied for and received bypass payments but please get your final payment or your application in by may 15 but also for those who missed a deadline or had an issue you can apply for reconsideration. Look for a bulletin tomorrow and the final date for reconsideration will be may 23rd. That's just if you had an issue.

Dr. Shannon Dowler

Awesome, thank you, Kelly. We also have the healthy opportunities screening and referral that was a special payment that we created. January through June, looking at trying to help folks do more screening for social determinants of health and when they find positives making a referral for resources. We've had about 4000 people draft that code, we were prepared for way more to use it, than have. So, it is not too late. So please be thinking about screening for social determinants and making sure that you're billing us for those positives where you're doing an intervention. Also the equity payments if you're someone that received an equity payment, watch out when the surveys, a survey is going to be an important piece of this, and so it's gonna be important that you complete that survey when it comes to you, and we've talked about this very briefly, but Sarah did you want to mention something about the emergency crisis rate floor.

Sarah Gregosky

So, earlier. Last month, I was going to say earlier this month that we're in may already back in April we announced rate for that's going to apply for both LMEs as well as for standard plans for crisis services so that's for facility based crisis and mobile crisis services there been a lot of concern and consternation around contracting for those services and we really think that this has helped improve access for standard plans. Since we've announced it but if you folks have questions please let us know but we really need to look back on that on April 4 I'll put up a link to it in the chat if folks haven't seen it.

Dr. Shannon Dowler

Great. And as we go through this last few things this is a great time if you still have a question in the behavioral health space around transition to managed care. Go ahead and throw it in the question and answer sections we're gonna have time for q&a today. One of the things I've heard that I think there's some confusion out there in the field is around good faith contracting and getting payments, related to

being in network an out of network. And so I wonder Jean will you kind of help everybody understand what those good faith contracting rules are.

Jean Holliday

The first thing is that, if, if the PHP has engaged with you in a good faith contracting effort in accordance with a policy that they have developed and has been filed and approved by the Department as compliant with the expectations in the PHP contract, then that PHP can consider you out of network if you fail to get to the contract, or well let me put it this way if you reject the contract offered, or if you fail to respond to their inquiries after a certain period of time, providers who are continuing negotiating on a, you know, active basis will continue to be considered not contracted with and not, not, you know, not having failed a good faith contracting effort, and will continue to be paid that 100%. But it must be a truly active negotiation period in which you're trying to, you know eventually get to contracting.

Dr. Shannon Dowler

Yes, so even if you try really hard for six months and you decided no, I'm not signing with that contract. That does not mean that you get the 100% for good faith negotiating, even though you tried really hard. You have to be active negotiations, and that the plan agrees that you're actively negotiating and you're not just for not responding. So thank you Jean, I hope that helps clear that up for folks.

A couple COVID related things we are still in the public health emergency. We will be into July we think it's going to get extended till the end of the year, fingers crossed, they only have to do it 90 days at a time. So we wait with bated breath to see if it goes to the end of the year, but all of those policies that we have as part of our public health emergency are staying live, even after launch, as long as we haven't stopped them. And so some of them we stopped because we made them permanent policy, which means they're there into perpetuity, but quite a few are still alive and active and they will remain alive and active through the public health emergency. We're hearing that vaccines are getting ready to go down to the age of 12 for some in Pfizer land and keep your ears open on that, that's a great thing. And we've also made it as state DHHS a lot easier for providers to get vaccines in their clinics we're allowing for a lot more grace for the time that the vaccines were on your shelves. If they're doses that end up not getting us because vials are open and you don't have enough people, and then being able to select the type of vaccine you want so if you've been wanting to do vaccine and you haven't yet, now's a great time to raise your hand, we really need it out there in the field. Alright, with that, I think we are going to turn it over to Chris to ask some questions and why don't we have the team that's gonna be answering questions everyone's just going to put your camera's up so that we can see you and be ready to answer the questions.

Chris Weathington

great first Are there any questions that the panelists have received that they would like to call out to the audience tonight. If not I will go ahead and get started. Is it mandated for behavioral health outpatient entities to connect with NC health connects.

Melanie Bush

My understanding is right now behavioral health providers are have a temporary exemption from connecting with the HIE, until December 31 22 I believe, but I can I can circle back and issue that answer.

Chris Weathington

Many patients will not have guardians in place, nor will they have the capacity to sign the request for service not covered under the standard plan. If this happens, what is the procedure to the patient, so that they don't have to wait.

Melanie Bush

So I'll take a stab at this beneficiaries that don't have the capacity to sign the form should be identified in our system if they are already in the Medicaid program as tailored plan eligible or otherwise exempt. So hopefully that will not happen, if it does happen and somebody from the behavioral health team please jump in. We would encourage the beneficiary to contact the Medicaid contact center or contact a local DSS for assistance.

Chris Weathington

Thank you. Can someone with previous experience apply to be a tailored care management provider but they don't have a contract with the managed care organization or MCO.

Can someone with previous experience, apply to be a TCM provider, but they don't have a contract with an MCO.

Keith McCoy

We anticipate that the AMA plus, providers, likely will not have had a contract with an LME MCO. For the care management agencies, one of the requirements that we have as they demonstrate a history of directly serving the sorts of individuals who are in going to be in tailored plans. And so to do that, you oftentimes are going to need to have had a contract with an LME MCO, it'd be difficult to demonstrate that, but we certainly can review that as part of our desk review process, and you're welcome to submit all the information that you think is relevant to help us make that decision.

Melanie Bush

We have tons of questions around CMA and AMH plus we just answered them along the way. So I'm just wondering if you felt like there were any points to highlight. I think we got, um, I'm just trying to think I feel like we get a lot of questions around what the rates are going to be if we're going to extend the deadline, and we got questions that are around the collaborative care codes if you can still get the CMA or AMH plus rate in addition to collaborative care and the answer is yes. Currently the deadline for the application is June 1. You were asked if we're going to extend that anymore. We don't have any plans right now we are going to be releasing some information on the rates and the capacity building program next week, we hope, knock on wood, so we'll wait to hear feedback so providers may see that and feel like they need more time, I'm not sure but we don't have any plans to extend that right now. And there was one really key question I think that was asked which was, do you have to be certified as the Care Management Agency to get a contract with a tailored plan. And so just to be really clear, you'll need to be certified as a care management agency if you want to do care management. If you're an intensive in home provider outpatient provider, or SIOP just, you absolutely can get a count, you only need to be certified as a care management agency if you want to care management.

Keith McCoy

That's it, that's specifically tailored care. That's right. Obviously their care management aspects, tailored care management requires that certification. I think the only other thing I would add is that there will be a second desk review rounds. Later in the year, so even if you miss the June first deadline, there will be another opportunity. Within a few months. Great.

Chris Weathington

Thank you, Keith and Kelly. This question came in foster care kids who have gone into guardianship and thus not adoption. Are they also staying in NC Medicaid direct for now.

Keith McCoy

So individuals in DSS custody, are in the foster care system, are not going to be in the Standard Plan system they're exempt from, from that, kept in the Medicaid director process. Okay,

Chris Weathington

Will behavioral health IDD tailor plan services be statewide like standard plan services

Keith McCoy

Per legislation. The Tailored plans must be regional. Okay.

Chris Weathington

Can providers go into nctracks now, and view their current assigned Medicaid patient list.

Kelly Crosbie

It can, yeah. I think it's in the second check right of the month the office administrator will get a notice they can check their patient panel is for Medicaid direct currently there's a bulletin just came out, Melanie when was it sometime I think it was this week or maybe last week that said here's how you read the report. We've gotten feedback on enhanced functionality, and I'm in the July end of June, excuse me in the mid June report, we'll also start adding the your assigned patient panel from the standard plan. So you'll see your Medicaid direct panel and then your, you know, across all the plants, Melanie, I don't know if there's something you'd add to that.

Melanie Bush

No, I was looking for the bulletin. I'll let you know when it was published,

Chris Weathington

Well just chime in with that, if you have that information for Kelly, thank you. This question.

Dr. Shannon Dowler

Can I jump in Chris and I think this is a great question for Keith or Carrie. Someone's asking about the threshold for folks with substance use disorder being switched over to tailored plans, and what would take somebody over to a tailored plan they're worried about folks with obat that might have a lapse or an overdose or crisis event, getting switched all the way over to a tailored plan versus staying in the standard plan so can you speak to that.

Keith McCoy

Or so if someone needs a tailored plan only service, and it's available over the next year in the LME MCO system, then we have a service associated request process where they can submit a form to move from the standard plan system back to the Medicaid direct LME MCO system. If that provider submits a service authorization request with that then we will move them automatically into the fee for service LME MCO system, and in the future into the tailored plan system. Per legislation when it comes to substance use disorders, and they all they really need to have is a severe substance use disorder, and

part of the issue in our current diagnostic system is that we use the ICD 10 which uses substance dependence which includes both moderate and severe. But DSM uses severe so if a provider or a member says hey I've got opioid use disorder severe, and that is something that we can review and that would be enough to move someone into the tailored plan or LME MCO system.

Dr. Shannon Dowler

But on the other hand, if someone's got somebody that they've been managing for a while, they have a relapse though and they have a dark period, they're not no one's going to automatically move them over into a tailor plan for that as they are otherwise being served well with their moderate condition I think that's what the question was,

Keith McCoy

And unless they want to ask to be moved over, but, you know, we would like to keep people as stable as possible connected to their existing provider network but if they need something like that they're at high risk of needing something that's only available on a tailored plan, then it's certainly reasonable to ask for them to switch over if the state doesn't have the claims information that we need to know that to automatically switch.

Unknown

Thank you. I think there was one other caveat to the question which is, which is basically if you're being followed by an OBOT, but you go to the emergency department for an overdose. Will that trigger your switch. And if you have two visits within sort of reminder 12 or 18 month period for an overdose, then you would be automatically switched once those claims are processed however you will always have the option to decline, and go back to the standard plan.

Keith McCoy

And then, OBOT remember is a physical health service in our system and so that is an open network for the obviously in Medicaid direct but also in standard plan.

Chris Weathington

Okay, well, we have just a couple of minutes left. Is there are there any questions that the panelists see that they would like to emphasize to the audience tonight.

Jean Holliday

This is Jean, I did want to mention and failed to mention during the discussion on good faith contracting the prepaid health plans are expected to publish those policies on their website, and we expect that to be done by the end of next week. I have answered one of the questions in the chat to that effect, but we'd like you to contact the provider ombudsman, if that is not the case. Please give them about a week or so before you check that. Thank you.

Chris Weathington

Okay, just a quick reminder to our audience tonight that any questions that we were not able to get to, we will definitely get to you directly and also post the q&a transcript on our website at ncahec.net, in the Medicaid managed care section. We really appreciate all the questions that have come in and we've done our very best to answer as many as we possibly can. We'll just ask Dr Dowler. Any closing comments.

Dr. Shannon Dowler

So we've got a few more of these, we've got one more. What if session where we meet with stakeholders from around the state to try to understand what the questions are and that's coming up on transitions of care. Meanwhile, our next back porch chat which is the third Thursday of May is gonna be on specialized therapy so we're going to really be focusing in on specialized therapies like physical therapy, occupational Therapy those sort of things. And then in the beginning of June, we will be doing transition of care questions and really making sure everybody understands transition. The third Thursday in June, we're going to bring my partner CMOS from the plans back, and we're going to be talking about a lot of things we're going to be talking about Vaccines for Children and utilization management, all sorts of the things that are seem to be keeping people up at night, right now, we'll take a break for July 4 week, and then we'll be back the third Thursday of July, with our CMOs and their, their support folks from their plans to make sure that your questions are being answered so we are committed to being here for you every other Thursday night, second Thursday of the month is AMH night so advanced medical home so tons of content, the recordings are also available so if you've missed some go back and listen to them. There's just a ton of information out there. We know it's a lot and it's hard to find sometimes, so please let us know if we aren't getting you what you need, we're, we're trying really hard to answer your questions and relieve people's anxiety as much as possible, so that when we launched in July. It works as smoothly as possible.

Chris Weathington

Okay, well thank you everyone and thank you to our audience tonight we know you're working really hard and you can stay late with us and so we do appreciate the engagement and the collaboration, so take care everybody. We'll see you the next time we have a webinar.

Dr. Shannon Dowler

All right thanks Chris.