

May 6 NCMT Hot Topics Fireside Chat

What Ifs

Q: For children where the diagnosis alone may not be sufficient, how will we be able to identify if they are mild/moderate and when they cross the line to severe and persistent? Will these children go back and forth from standard plan to tailored plan?

A: Mild/moderate behavioral health means an individual does not meet the criteria for a behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan or Local Management Entities – Managed Care Organizations (LME-MCO) only services. See the appendix for a full list of behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan only services. Most individuals who meet Tailored Plan criteria will remain in the Local Management Entities – Managed Care Organizations (LME-MCO) system prior to Tailored Plan launch, then move to Tailored Plans after Tailored Plan launch, unless they choose to move to a Standard Plan or have an extended period of time without utilizing behavioral health services aside from outpatient therapy and medication management.

Q: What happens if a patient shifts from standard plan to tailored plan, but their primary care provider is still with standard plan, how do they navigate this leading up to tailored plan launch? How do you account for the physical health needs of beneficiaries that will go into tailored plans?

A: Standard Plans area accountable for a set of measures that address standard of care for individuals with behavioral health (BH) conditions (i.e., Follow-up after MH hospitalization; Depression screening for Adolescents; Proper Opioid Prescribing).

Q: How do we avoid disrupting the close relationship a child has with a therapist, when the child switches from standard plans to tailored plans or just switches from one standard plan to another and their therapist is not in network?

A: Behavioral health providers will need to contract with both standard plans and Local Management Entities – Managed Care Organizations (LME-MCO) until behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan launch to be in-network for both types of plans. When behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plans launch, providers will need to contract with both standard plans and behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plans. Contracting with both types of plans will better ensure continuity of care, as well as appropriate payment for the services you are providing.

Q: If a patient is trying to find a mental health provider (e.g., cognitive behavioral therapist (CBT) provider), how can they find that provider in the provider directory or how can I help them find the resources they need?

A: Beneficiaries may come to their provider to understand their options with regards to the managed care transition and the differences between Standard Plans and behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plans (or FFS/Local Management Entities – Managed Care Organizations (LME-MCO)s prior to behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan launch). Providers should refer any beneficiaries with questions to the Enrollment Broker.

Providers will play a key role in helping beneficiaries who believe they may be eligible for a behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan or need a service only offered in behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plans to complete the process to transition to a behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan (or FFS/Local Management Entities – Managed Care Organizations (LME-MCO) prior to behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan launch).

Q: Are practices going to be able to treat anxiety and depression with the resources they have in their practice versus referring those patients to the Local Management Entities – Managed Care Organizations (LME-MCO) and get paid for it?

A: Providers can more easily offer integrated (co-located services) in their offices since both physical and behavioral health (BH) providers in their offices can enroll and bill with 1 entity (Standard Plan) instead of splitting admin oversight between health plan and an Local Management Entities – Managed Care Organizations (LME-MCO). health plans are encouraged to develop and support more best practice integrated care work.

Q: Will patients with severe persistent mental illness and history of opioid use disorder go to Standard Plan or Tailored Plan?

A: Are practices going to be able to treat anxiety and depression with the resources they have in their practice versus referring those patients to the Local Management Entities – Managed Care Organizations (LME-MCO) and get paid.

Q: What is the utilization management criteria for behavioral health hospitalizations and admissions under Standard Plan? Will this be consistent across plans or will each plan get to use their own criteria?

A: Inpatient Behavioral Health Services are a required policy. The Standard Plan must follow the policy with the exception that they may be less restrictive with their prior approval.

Q: Will behavioral health services vary across health plans?

A: health plans have to follow the behavioral health (BH) clinical covered policies. The formulary or prescription drug list (PDL) will not differ across plans. A single PDL will be maintained across the 5 health plans and Medicaid Direct.

Q: What will change with mobile crisis and assessment services with managed care?

A: Mobile Crisis will be a behavioral health (behavioral health (BH)) benefit provided under the Standard Plans. There will also be an increase in the Mobile Crisis rate effective 7/1/21 to ensure provider stability and continued access.

Q: How will the State ensure the health plans are following appropriate utilization management (UM) standards/guidelines?

A: The health plans are required to document their UM policies and procedures and submit to the state for review and approval. Those policies must contain specific elements and be posted on their website for members and providers to access.

Q: How will the Innovations Waiver program work with Standard Plan and Tailored Plan? It seems that patients may qualify for a Community Alternatives Programs (CAP) waiver and Tailored Plan at the same time.

A: Innovations waiver will be administered under the Tailored Plans, not the Standard Plans. The Community Alternatives Programs (CAP)-DA and Community Alternatives Programs (CAP)-C Waivers will be covered in Medicaid Direct.

Q: What If a member qualifies for Tailored Plan based on the severity of their behavioral health issue; will they still be able to see the provider that was providing their opioid use disorder treatment if it is different from their behavioral health provider?

A: Standard Plans have open networks for both physical and behavioral health. Tailored Plans have a closed network for behavioral health but may not have a closed network for physical health.

Q: Do patients have the right to refuse certain Tailored Plan labels and diagnoses, but still receive the treatments (e.g., a parent with a 2-year-old with a positive M-CHAT that is evaluating options and perhaps seeking 2nd and 3rd opinions)? Can providers provide Tailored Plan services to patients who are not in Tailored Plan?

A: The Standard Plans will have an array of behavioral health services including Research Based Treatment for Autism Spectrum Disorder.

The Health Plans- Standard Plans or Tailored Plan do not provide diagnoses. A licensed practitioner is responsible for assessing and providing a diagnosis based on the presenting issues and treatment recommendations are based off of the licensed practitioner's assessment.

Q: What happens when a child presents with a mental health emergency (e.g., suicide crisis) and I am out of network? Will I still get paid?

A: In an emergency situation, out of network emergency providers will get paid at 100%. Non-emergency providers will be reimbursed at 90% of the health plan's fee schedule for non-emergency services performed in non-emergent locations.

Q: Will providers still be able to bill to the same collaborative care codes that we currently bill to?

A: Medicaid Direct allows reimbursement for behavioral health integration in primary care settings and covers the collaborative care codes. The codes and professionals that bill for outpatient behavioral health therapy should remain the same. The health plans will also cover the collaborative care codes starting July 1, 2021. You can refer to the Medicaid Bulletin on Coverage for Psychiatric Collaborative Care Management for more information.

Q: What If a standard plan does not approve request for peer supports? Will this be a covered service? What are my rights to contest or appeal a health plan decision?

A: The criteria is outlined in the clinical coverage policy and the plan's policy for peer supports cannot be more restrictive than the state. If a plan denies any service, the beneficiary may appeal that decision.

Q: Will compliance with mental health parity regulations be enforced by the State and if so, what are the mechanisms to enforce?

A: Each health plan must submit reports about how their benefits and processes meet parity requirements and have those reports reviewed by Department of Health and Human Services (DHHS).

Q: Many behavioral health providers support delivery of primary care and care provided by community health centers through telehealth. Will telehealth remain after the public health emergency?

A: Many Telehealth flexibilities have been made permanent - please see the updated Community Care Physician (CCP) (e.g. 1-H) for permanent changes.

Q: How is network adequacy going to get enforced and at what level of granularity?

A: There are several network adequacy standards specifically applicable to behavioral health services, some of which use a time/distance adequacy standard and some which dictate that the health plans have a certain number of providers of certain services in a region. In both cases, the Department's enforcement focuses on confirming that a health plan's network meets these standards. For the time/distance standard, we would check to assure that in every county in the health plan's regions, the at least 95% of the members live within the time or miles distance of the specified number of providers of the specific service. For the standards based on number of providers within a region, the Department will require the health plans to identify the providers for each region, and then will audit to assure that information is consistent with the health plan's submitted network and in some cases if the information is consistent with NCTracks. Additionally, the Department has emphasized the importance of contracting with historical providers in order to best ensure members have a smooth transition to managed care. The Department is reviewing the appearance of historical Medicaid/NC Health Choice crisis services and behavioral health (BH) outpatient services providers in the health plans networks and sharing that information with the health plans in order that the health plans can identify target providers for contracting.

Q: If a special type of service is needed and the health plan doesn't have an in-network provider that can provide the service (network adequacy), how will the child get the service?

A: A Standard Plan shall adequately and timely cover services out-of-network for a beneficiary if the Standard Plan's network is unable to provide the covered services from a network provider on a timely basis. And the plan shall continue to cover the service out-of-network until the gap is addressed. Note that out-of-network services generally require prior approval and the plan will likely try to get the individual to a participating provider.

Q: What services aren't measured in network adequacy?

A: There are specific network adequacy standards applicable to outpatient behavioral health (BH) services, specialty access to a psychiatrist, location-based services, crisis services, inpatient behavioral health (BH) services, and partial hospitalization services. Any other covered behavioral health (BH) specific services would be subject to the general network adequacy provision which requires that the health plans have a network of providers sufficient to ensure that all members have timely access to a provider for all covered services.

Q: What effort will the state make to assure oversight of "ghost networks" or when a plan list provider that are not actual in-network providers or one specialist contracts with all the plans? What does adequacy really mean?

A: The Department agrees that "ghost networks" would pose a problem in networks of health plans. The Department's oversight plan for networks will incorporate review and consideration of complaints filed with the health plans, the Department, and the Member Ombudsman relating to access problems, including the listing of providers in a network who are not actually participating in the network. Complaints relating to being unable to get an appointment with a provider could lead to the discovery of providers who are not actually "participating" in the network.

In addition to the time and distance standards, health plans must also have enough providers to ensure compliance with the appointment wait time standards that are based on the type of service (primary care, prenatal care, specialty care, and behavioral health (BH) services) and the urgency of the situation (emergency, urgent, routine, etc.) The health plans are responsible for monitoring their providers' compliance with those standards and reporting the results of that monitoring to the Department. The Department will analyze that information and work with health plans to assure members have timely access to care.

Q: For licensed independent practitioners, there is no rate floor. What if there is not enough licensed practitioners that have contracted with the health plans to provide services such as individual psychotherapy to children and adults?

A: There is no rate floor for behavioral health services (other than for psychiatrists who fall under the physician rate floor). Each Standard Plan will develop their own fee schedule for behavioral health. Providers should work with the Standard Plans during contracting to negotiate their behavioral health rates. Plans would be encouraged to raise rates to incentivize providers should they find they do not have enough providers.

Q: How will health plans find a provider (therapist) for beneficiaries if no one is taking new patients?

A: Health Plans are required to ensure that members have services that they need. If a member feels they are not being adequately connected to care, then can contact the Medicaid Ombudsman for support.

Q: Are there metrics that the State is tracking around integrated care that providers need to know about?

A: The health Plan measures are found here in the Medicaid Technical Specifications.
<https://files.nc.gov/ncdma/Technical-Specifications-Manual-20210401.pdf>

Q: Does the Advanced Medical Health model support collaborative care teams that include psychiatrists and mental health professionals?

A: Advanced Medical Health Tier 3s are required to have multidisciplinary care teams and have behavioral health (BH) specialists available for care management consultation. In addition, medical providers are able to bill Standard Plans for embedded behavioral health (BH) providers.

Q: Do we have the behavioral health metrics that primary care providers will need to follow in standard plan? What are the metrics and how will they be tracked?

A: All Health Plan measures are found here in the Medicaid Technical Specifications.

<https://files.nc.gov/ncdma/Technical-Specifications-Manual-20210401.pdf>

Q: Will current peer supports authorizations cross over at managed care launch?

A: Under the scope of 42 CFR Part 2, Local Management Entities – Managed Care Organizations (LME/MCOs) will transfer all open and recently closed authorizations (in previous 60 days) to the transitioning member's new Standard Plan Health Plan. The Member's Health Plan will honor the transferred authorization for at least 90 days unless the authorization expires sooner.

Q: How do we transition kids without seriously persistent mental illness between Local Management Entities – Managed Care Organizations (LME-MCO) and Standard Plan/Tailored Plan?

A: When a member has a need for an Local Management Entities – Managed Care Organizations (LME-MCO) only, or future behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plan only, service they may make a request to transition through the Enrollment Broker (Medicaid Direct Transition Process).

Standard Plans and behavioral health (BH) Intellectual/Developmental Disability (I/DD) Tailored Plans will be required to facilitate warm hand-offs between plans, so individuals are supported, and pertinent clinical information is exchanged between the plans.

Q: Are plans going to be required to reinstate or expedite coverage for people in the prison system?

A: The health plans do not reinstate Medicaid Eligibility. That is still the role of local Divisions of Social Services and that process is subject to the same rules as always. The prison population is not carved into managed care. Upon release, the beneficiary's eligibility will be determined in the normal timelines and the individual will be auto enrolled in a health plan if they are eligible for managed care. If the individual only had their eligibility suspended while in prison, it will be reinstated, and they will be auto enrolled.

Q: Is there a safety net for beneficiaries to get services while they figure out the plan/primary care physician they want or have been assigned to?

A: Beneficiaries will either choose a plan or be auto enrolled in a plan. There is no time of non-enrollment. They have the opportunity to change plans and primary care physicians within 90 days of enrollment

Q: Are the number of visits providers currently have per year under Medicaid going to stay the same under the different health plans?

A: The health plans are required to have at least the same amount, scope, and duration for Medicaid services. They do have the flexibility to go above and beyond our policy and visit limits in FFS.

Q: Are documentation standards different between Tailored Plans vs Standard Plans?

A: The Department is working to streamline requirements between provider types, including creating a single prior approval templates for Standard Plans and Tailored Plans to use. The Department is open to other ways to streamline documentation requirements if providers have specific areas of concern

Q: How are commercial insurance companies different than Medicaid? What is the difference between their Medicaid product/services and their commercial services?

A: Medicaid provides services with different amount, scope, and duration requirements than commercial plans. Medicaid also covers enhanced behavioral health services, extended long term services and support services, and covers any medically necessary service to address or ameliorate a medical condition for children under the age of 21 through our Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) federal requirements.

Q: As July 1 approaches, practices are hiring and onboarding new staff and getting them credentialed. How often will your health plan update provider credentials and staff list on your website?

A: The provider directory is updated daily with information consolidated from health plans and NCTracks. So, you will need to make sure the health plans have your providers so they can send that to NCTracks to update the provider directory.

Q: Providers like the current system of Medicaid and the ability to talk to someone who will listen to you. What if there is a problem, how do we escalate to a higher power after we attempt to work through the issue with the plan and they cannot help?

A: Contact the Medicaid Provider Ombudsman. Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or providers may utilize the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information will also be published in each health plan provider manual.

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Questions

Q: If someone needs to move to the Tailored plan, do we start services while waiting for the member to transition? If we have provided services while waiting what will the mechanism be for us to be paid for services and would it be the Standard or Tailored Plans responsibility?

A: Questions regarding transitions can be answered in the What to do After Launch Fact Sheet: <https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Need-to-Know-After-Launch-20210331.pdf>

Q: I tried to create a login with HMS provider portal - is this something all providers need to do going forward? In trying to create the login for the HMS provider portal I was told I could not create a login due to errors - I did not have any errors on the screen regarding our practice - could this have been a system error? Is this a problem other provider have had?

A: Per the bulletin <https://medicaid.ncdhhs.gov/blog/2021/05/04/new-health-management-system-provider-portal>, there will be demo training available this week :

May 12, 2021 - 10:30 a.m.

May 12, 2021 - 2 p.m.

May 13, 2021 - 10 a.m.

Links are attached to bulletin. Provider could also reach out by calling HMS at: 855-554-6748

Q: Will the 5% provider rate enhancement currently scheduled to end June 30th be extended past that date?

A: Legislation is still pending, and the State is waiting on the final decision. Once a decision is made, the State will update providers via a Special Bulletin.

Q: Will telephonic services also be covered after June 30th?

A: Telephonic E/M services will continue to be covered throughout the PHE and after under Attachment A in Community Care Physician (CCP) 1-H: https://files.nc.gov/ncdma/documents/files/1H_4.pdf

These changes will be in effect until the end of the public health emergency, at that time any changes will be published.

Q: Prior authorization isn't currently required for CPT code 90837, but a health plan is requiring it. Is this allowed?

A: 90837 is a code that is covered under Community Care Physician (CCP) 8C - Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Prior approval is required beyond the unmanaged visit limit. health plans are required to follow Community Care Physician (CCP) 8C except that they may be less restrictive than DHB's policy.

Q: Where do 0 - 3-year-old fall with Community Based Rehabilitative Services - standard or tailored?

A: Community Based Rehabilitative Services will be under the Standard Plan

Q: Do hospitals have a deadline to contract? What happens if they haven't contracted in time for July 1?

A: NC Medicaid established two "deadlines" for provider contracting that were intended to give providers timeframes to complete contracting in order to assure the inclusion of information for open enrollment and auto-enrollment. However, those timeframes have passed, and now no other deadlines have been established by NC Medicaid. However, the Prepaid Health Plans (health plans) may establish their own deadlines in order to assure providers are contracted with and loaded into their systems before Managed Care Launch to assure a smooth transition. Otherwise, NC Medicaid expects that provider contracting will be ongoing through and after Managed Care Launch.

While NC Medicaid Managed Care is designed as a program that utilizes provider networks and that out-of-network services will be limited, during a transition period following Managed Care Launch prior authorizations and ongoing courses of treatment, even with out-of-network providers, will be honored and allowed. Health plans will work to move members to participating providers at the end of the transition of care period. Generally, out-of-network care will require prior approval from the health plan.

If a health plan's network is unable to provide access to an in-network provider for a particular service without undue delay, the health plan must cover the service from an out-of-network provider until such time as there is a participating provider available to provide the service on a timely basis.

As mentioned above, since provider contracting is expected to be ongoing, providers are encouraged to continue to work with the health plans to complete contracting before Managed Care Launch in order to best be able to continue to serve Medicaid beneficiaries in the managed care mandatory population.

Q: Are the extended COVID rate increases for primary care medical home PMPMs extended through June 30, 2021?

A: Legislation is still pending, and the State is waiting on the final decision. Once a decision is made, the State will update providers via a Special Bulletin.

Q: We bill for Community Based Rehabilitative Services under our local CDSA (children's developmental service agency). We were told that we were going to be exempt from Managed care. Do you have any info on this?

A: Services provided and billed by Children's Development Services Agency (CDSA) are covered by NC Medicaid Direct for Medicaid-enrolled children and billed to the State. Please reference the following for more information: Session Law 2017-57, Senate Bill 257, which states, "Services provided and billed by Children's Development Services Agency (CDSA) that are included on the child's Individualized Family Service Plan" are not covered by NC Medicaid Managed Care.

Important: As the legislation is written, only services provided and billed by a CDSA are exempt from managed care and therefore covered by NC Medicaid Direct.

*Session Law 2017-57, Senate Bill 257:

<https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2017-57.html>

Q: Foster care kids who have gone into guardianship - and thus not adoption - are they are also staying in NC Medicaid Direct for now?

A: When a child is placed in foster care, the caseworker does a redetermination. Importantly, the state Transition of Care team, in partnership with eligibility and foster care subject matter experts, is establishing disenrollment protocols to ensure effective care management coordination at the time of disenrollment, including transition file (not medical records) transfer. Foster Care kids who have gone into guardianship will continue to receive services through NC Medicaid Direct for now.

Q: When will we be able to see on NCTracks which plan our clients have been assigned to?

A: NC Department of Health and Human Services (DHHS) generated a new Advanced Medical Home (AMH) NC Medicaid Direct/NC Medicaid Managed Care Primary Care Provider (primary care physician) Enrollee Report for distribution to CCNC/CA participating providers. The report contains a list of all NC Medicaid beneficiaries assigned to an identified National Provider Identifier (NPI) at any time during the past 12 months. The report contains several fields and can be filtered to display only those actively assigned to the identified National Provider Identifier (NPI). (Note: This is not verification of eligibility or primary care physician assignment through the listed End Date).

The report is being modified to begin displaying the beneficiary's health plan 30 days prior to the enrollment effective date. This means the June 2021 Enrollee Report, available June 14th, will contain health plan assignment information as of the date of the report.

For more information on the (Advanced Medical Health) NC Medicaid Direct/NC Medicaid Managed Care (primary care physician) Enrollee Report please go to this webpage

<https://medicaid.ncdhhs.gov/blog/2021/04/23/amh-nc-medicaid-directmanaged-care-pcp-enrollee-report-%E2%80%93-how-read-use-your-enrollee>

Q: How many intellectual/developmental disabilities Tailored Plan members do you estimate at this time?

A: The department is currently working on a document that will address your question regarding the number of intellectual/developmental disabilities tailored plan members, guidance on accessing the document is forthcoming.

Q: When will you be talking about Specialized Therapies?

A: Our specialized therapy back porch chat will take place on Thursday, May 20. For more information and how to sign up and view the webinar, please access the link below.

<https://www.ncahec.net/medicaid-managed-care/>