Transcript for NC Medicaid Managed Care Hot Topics Webinar Series

May 20, 2021

5:30 - 6:30 pm

Presenters:

Dr. Abby DeVries

Ronda Owen

Melanie Bush

John Vitiello

Jean Holliday

Hugh Tilson

Well good evening everybody. Thank you for participating in this evening's webinar for Medicaid providers. As reminder, tonight's webinar is part of a series of informational sessions put on by North Carolina Medicaid in North Carolina export providers during the transition to Medicaid managed care. But on these back, back porch chat webinars on the first and third Thursday of the month to discuss hot topics in managed care, Dr. dollars on vacation could for her and turn over to Dr. Avery shortly but let me run through some brief 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 on the top of your screen and select side by side colon speaker. But these instructions in the q&a for your convenience will have time for questions at the end. Everybody other than our presenters is muted. You can ask questions two ways actually ask questions or make comments. One is using the q&a feature on the black bar on the bottom of the screen. You can only do that if you're participating by the webinar if you're dialing in. You can only do that by sending an email to questions COVID-19 webinar@gmail.com. before in the past, the presenters will often address your questions during their presentations. So I encourage you to see if your question gets answered. Before you submit it. Please know that we'll send all questions we receive, including we may not any we may not get through tonight to Medicaid so they can respond directly to you, or incorporate your question into future webinars. I will observe that we've recently encountered some technical difficulties with zoom webinar, but we're pretty sure we've resolved them at an abundance of caution. Should you have any problems hearing any of our speakers, please dial into the webinar using one of the two numbers that are on this slide, or posted these numbers in the q&a for your convenience. Lastly, we posted these slides on the NC AHEC website. A link is in the q&a or record this webinar and had the recording and a written transcript of it along with the slides on the NC AHEC website as soon as possible. Probably first thing tomorrow morning. Now let me turn it over to Dr. Drew Brees.

Dr. Abby DeVries

Thank you. Good evening, everybody. Thank you for joining us. You can see here the agenda for this evening. We're talking about optical and Hearing Services, as well as specialized therapies in the transition to standard plan Medicaid managed care. We have a couple of other hot topics to discuss and then some what if questions that have been posed by members of the community around the managed care transition. And hopefully have some time at the end for additional questions. Get to the next slide. So just as a level set reminder of who will be transitioning to Medicaid managed care in July one versus who is not enrolling and then some people who have some choices so, mandatory enrollment is most children and families with Medicaid and SSI house choice, pregnant women, and Medicare, non Medicare aged, blind and disabled folks are those who are excluded, meaning that they cannot enroll are the family planning program for medically needed. folks in the hip are PACE programs and those with refugee Medicaid. Some people are temporarily excluded that may become eligible later. And then in the exempt category, but do have choice includes individuals who are members of recognized tribes, as well as beneficiaries who would become eligible for the tailored plans, which start July 120 22 as a target date. Next, I'm going to turn it over to Rhonda Owen, who's going to talk through our

Hugh Tilson

optical and Hearing Services. Rhonda.

Ronda Owen

Oh, how's that? There you go. Very good. Thank you. I'll start over. Welcome everybody, again to this back porch chat. This evening, we're going to look at auditory implant parts, hearing aid and optical services under managed care. So let's get started first with auditory implant parts that's on the next slide. Here you can see that North Carolina Medicaid covers external parts for cochlear implants, auditory brainstem implants and implantable bone conduction hearing aids. And any beneficiary who is implanted is eligible for these services. And the device manufacturers or the I'm sorry, the qualified providers are the device manufacturers. This just means that clinicians will continue to work through the manufacturers who will do all of the legwork of getting prior approval and filing claims for this small population, which is generally under 300 beneficiaries each year. So on the next slide, we'll look at what will change and what will not change in managed care. Because these policies policy 13 A and 13 B. They're in a group of policies for which the plans are required to follow them exactly. So nothing is going to change except that the plans will be responsible for managing the services. What that means for the qualified providers the device manufacturers is that since these services are fully carved into managed care, they'll get prior approval and Bill claims through the health plans instead of fu NC tracks. The next slide we'll look at hearing aid services you can see on the left all of the things that are covered under the hearing aid services currently, and any beneficiary under 21, who meets the criteria for hearing aids is eligible for these services. The qualified providers in North Carolina are doctors of Audiology with a North Carolina audiology license and individuals with North Carolina hearing a dealer and fitters license. That can be an audiologist who does not have a doctrine and can also be an individual whose license but

is not an audiologist. And the next thing we'll look at is what things will look like under managed care. What will not change is that primarily the cover population is children under 21. And it's not on this slide. But that number of kids served generally averages about 1300 children a year. And although this clinical coverage policy isn't in the list of required policies, health plans are required to not be more restrictive than the current clinical coverage policies. So providers and members can expect health plans at a minimum, we'll cover the same services they're being covered today. What will change is since hearing aid services are fully carved into managed care, the health plans will manage these services also, and providers can expect to obtain power approval and they'll claims through the health plans instead of NC tracks. Another thing that will change that I'm excited about Medicaid is excited about is that well cares offering one hearing aid every two years for adults who qualify. So it's exciting that adults will receive at least one hearing aid as we move forward in managed care. So we'll move on to optical services. I want to say two things before we dive in here. First is, I want to put this benefit into context. This benefit is to our Medicaid beneficiaries, what your private vision insurances such as Superior Vision or BSP is to you. So that kind of gives you a scope of what what this covers. I also want to point out before we get started that unlike the other two benefits that we've looked at optical isn't fully carved into managed care. So there are some nuances for this benefits I just wanted to give you that heads up before we dive in. On this slide, you can see that routine eye exams, eyeglasses and medically necessary contact lenses are covered, and every beneficiary enrolled in traditional Medicaid is eligible for these services. The frequencies frequencies vary based on age, children are eligible once a year adults every two years with the caveat that exceptions to these frequencies can be made based on the medical necessity. The qualified providers are North Carolina licensed ophthalmologist, optometrist, and opticians.

Let's look at what will not change on the next slide versus what will change under managed care. And just a heads up I'm going to say eyeglasses until the very end. So we'll look at what will not change. The important thing is that access to care will stay the same. providers who provide that eye exams and glasses to non Medicaid patients will continue to provide both of those for members in the health plans. And just like with hearing aids, optical is not a required policy. But providers in numbers can expect the health plans to at a minimum cover the same services that are being covered today. What will change is that the carved in services carved into managed care, there'll be managed by the health plans. Those are routine exams, medically necessary contact lenses, and the dispensing phase for both glasses and for medically necessary contacts. So providers will obtain prior approval and Bill claims through the health plans instead of nctracks with an exception regarding eyeglasses, and we're going to cover that in the next slot. We also have optical value added services to America health care costs and Carolina complete health. Both are offering an additional exam and eyeglass benefit for adult members. So there's an extra benefit with these two health plans. And with the glasses everything will stay the same except for billing the dispensing fee. So on the net this slide, here are the details of what that will look like for providers. Because eyeglasses are a single benefit that's been split down the middle with the frame and lenses and fabrication being carved out and the dispensing fee being carved in eyeglasses have been dubbed the hybrid service and managed care. So if you're an optical provider in the blue box, you'll see that you'll continue to follow clinical coverage policy six, A and D all of the sections that relate to eyeglasses, and you'll continue to get prior approval to nctracks and you'll receive will receive the eyeglasses from Nash optical plan. And once you dispense the glasses to the member, that's when you'll shift and do

something new. Instead of billing the dispensing fee through nctracks. You'll build the health plan or the health plans third party vision vendor for the dispensing fee. So I hope that these slides lend some clarity as we transition to managed care. I think the next slide may have some questions that came in earlier that will we'll try to answer here. Exactly Rhonda. So

Dr. Abby DeVries

during our listening sessions, some things have come up some what ifs and so I'll pose these to you. Will all health plans reimburse both medical and routine diagnosis on the same visit? Well, with current

Ronda Owen

Medicaid policy, billing, medical and routine on the same day with the same doctor is not covered. It's not allowed. So the PHP ones will not be required to do that either. That doesn't prohibit them from doing it. But they're not required to do it.

Dr. Abby DeVries

Thank you. And so then for hearing aids, some managed care companies are using third party companies that usually deal with adult hearing aid services. So the question is Will adult audiologist be able to get pediatric friendly devices and be reimbursed for ongoing maintenance and animals.

Ronda Owen

So the state's contract with the phps require that all PhDs and third party vendors meet the floor of the current coverage policy, because they may not be more restricted than current policy. Providers and members can expect to have access to at least the same services that are provided. Added currently under the current Medicaid clinical coverage policy, regardless of who that third party vendor is. Excellent. And here's another question. I've

Dr. Abby DeVries

seen some variations in the chat as well on this. So if a patient is seen in June, and gets glasses ordered, but they arrive after July one after go live, how does the provider build a dispensing fee? Who do they build that to?

Ronda Owen

So the receiving PHP, which is the health plan that the beneficiary will move to, as of July one is responsible for the dispensing thing covered under the original prior approval. This is true when a

beneficiary moves from a Medicaid direct, which is traditional Medicaid fee for service to a PHP or from one PHP to another. So if the provider doesn't enroll with the new PHP, the PHP will honor the prior approval and pay the dispensing paid. I think that's during the first 60 days after launch. After that first 60 days, the provider wouldn't be reimbursed more than 90% of that fee for service. Right.

Dr. Abby DeVries

Thank you very much. And thank you for the presentation. We'll turn now to specialized therapies with John Vitiello.

John Vitiello

Thank you. So first we'll start out with some definitions. So what we mean when we talk about outpatient specialized therapies is outpatient physical rehab. These services include physical and occupational therapy, speech therapy and audiology as well as respiratory therapy. Medicaid covers these services for all ages when provided by home health agencies, hospital outpatient clinics, and physician offices that employ therapists. Medicaid also covers the services been provided to public school students through local education agencies or LEA's and to preschool kids through the children's developmental services agencies or CESAs and to the entire under 21 population through the independent practitioner program. And this last bullet, outpatient Respiratory Therapy is only covered for beneficiaries under 21 through the independent practitioner program. Next slide please.

Okay, so what is what is coverage for this area look like at Medicaid direct today. As it stands today, prior authorization is required for all treatment services, except those provided to public school students through the LEA's. There are generally no visit limits applied to beneficiaries under 21, except based on the dates of service and visits that are approved through the PA process. We do have some soft visit limits for speech therapy, audiology and respiratory therapy based on severity of deficit for this population or under 21, but those are routinely overridden by EPSDT guidelines. And just a quick reminder here that EPSDT guidelines only apply to Medicaid recipients and not to health choice recipients. In this third bullet for adults 21 and older we do have a hard limit of 27 visits per calendar year combined across OT, PT and speech therapy disciplines. And in the last bullet PA requests are currently submitted to CCMEs choice pa portal, and claims are submitted to nctracks.

So now a little bit about what specialized therapies will look like in managed care. The first thing to recognize is that specialized therapy services will be included in the managed care plans for members who cross over into standard plans on July one. Even though the vast majority of Medicaid beneficiaries will crossover on July 1 of this year, there is a small population of beneficiaries who are either temporarily exempt or excluded from the standard plans, and they will remain in Medicaid fee for service after July 1. There are some some of you may be aware that there are some mandatory policies that must be followed exactly by the health plans and it's actually 18 of those. But those are mostly in the behavioral health area and pharmacy and a couple of Ronda's policies and optical hearing like you

heard about, but none of the specialized therapies policies, the 10 series, none of those policies are mandated to be followed exactly by the phps. But there are guardrails in the managed care contract for all non mandated policies, and we'll talk about that in a little bit. And please remember after July one for beneficiaries who cross over into managed care, the requests are going to be submitted to the beneficiaries health plan and not to CCME. Next slide, please.

Okay, so other things to keep in mind are that in managed care, the health plans are permitted to employ different PA criteria as part of their required utilization management program. We'll talk about this a little more in a minute. We'll also talk about the second bullet more in a later slide. But for now, just know that there are network adequacy standards in the contract for OT, PT and speech therapy. But there is not rate floor language applied directly to specialized therapy services, which means specialized therapy providers contracted with the health plans must negotiate the best rates they can. Now let's talk a little bit more about managed care exemptions or carve outs. There are two such carve outs in legislation that apply to specialized therapies. One applies to the public schools or LEA's and the other one applies to CDSAs. In summary, for the LEA is the legislative language states that services provided by LEA's or billed by LEA's are carved out of managed care, or services provided by CDSAs and build by CDSAs are also carved out. And there's a little bit of a difference in the language there. And we'll talk about that.

But before we get to that, let's first take a minute in this next slide to describe LEA and CDSA services as currently defined in Medicaid fee for service. On this slide, we'll talk about local education agencies which are roughly the equivalent of the county and public schools throughout the state. I believe we have 100 County districts and another 15 City districts in North Carolina. Medicaid coverage for services provided by the LEA's include the usual specialized therapy services that we've already mentioned. Law School Psychology, school counseling, school nursing and school nursing services for Medicaid recipients from age 3 through 20. Currently, we do not require the LEA's to submit for PA for CCMA's choice pa portal. Next slide please. For the CDSAs, these are considered the local lead agencies for the NC infant toddler program, and there are 16 of them operating in regions across the state. Medicaid coverage for services provided by the CDSAs foods all the usual specialized therapy services, plus medical, nutritional, psychological and clinical social work services for beneficiaries under three. For specialized therapy services there are no magic unmanaged visits available. And the cbsa is and their contractors are required to submit PA through CCMEs choice pa portal. The non specialized therapy services provided by the CDSAs I believe, at least for the behavioral health services, there are unmanned visits that can be utilized without PA. But once those are used, services need to continue then PA is required. Next slide please.

Okay, so now that we're oriented to how Medicaid covered LEA and CDSA services work and Medicaid direct pay for service, let's talk a little bit about what LEA and CDSA services might look like in managed care. And we'll do this by comparing the managed care exemption or carve out language as they exist in current legislation. So on the left side of the slide, I have the LEA carve out language pulled from from general statutes. So this is out of context, but I think it gets the point across showing the differences

between these two carve outs. So what it says is, the capitated contracts required by this section shall not cover services documented in an IEP or other documented or other document described in the Medicaid state plan and provided or billed by a local education agency. So that means services provided by LEA's or billed by LEA's are carved out of managed care. So for example, if an LEA staff speech therapist provides a covered service and the LEA bills for that service, then that service would be considered carved out of managed care and claims would be paid directly to the LEA by medicaid. This language also gives the liaise flexibility to use contractors and have those services carved out of managed care as well. So long as the LEA does the billing however, LEA contractors who do their own billing must submit PA requests and claims to the beneficiary's health plan if their clients are in managed care. For the CDSA is the carve out language is a little different. Their language says the capitated contracts required by the section shall not cover services provided any bill by a CDSA that are included in a child's IFSP. This means that only services provided by CDSA staff and billed by the CDSA would be carved out. So cdsa contractors must submit pa requests and claims to the beneficiary's health plan if their clients are managed care. There is currently not an option for CDSA contractors be carved out like the risk for LEA. However, the CSA carve out language could be changing. Look at that on the next slide.

So on this slide, you'll see at the top the same language I had on the last slide. For the current CDSA carve out language that talks about services provided and billed by the CDSAs being carved out. There is a proposal in Senate Bill 594, that that might that you know is proposed to change this language. The new language is underlined. And the old language that will be removed, if it's passed, is is is lined out and struck. So if it passes in its current, it would read the capitated contracts required by the section shall not cover services documented in an IFSP under the IDEA that are provided and built by a CDSA or by a provider contracted with the CDSA to provide their services. So you see the difference there. This new language, if it's if it's approved and passes would add the CDSA contractors to the CDSA managed care carve out.

Next slide please. Okay, so we're going to move on now from the LEA's and the CDSAs. Earlier, we mentioned that the specialized therapies policies were not among the 18 mandatory policies that plans must follow exactly. So now we're going to talk a little bit about what guardrails do exist in contract for programs like this one. On the left side, hold a quote from the managed care contract demonstrating that we expect the plans to furnish covered benefits in an amount, duration and scope no less than the amount duration and scope, the same services furnished to beneficiaries under Medicaid fee for service. So as an example of this, if a plan chose not to cover occupational therapy for adults, this would be considered a more restrictive scope than in fee for service because we do cover occupational therapy for adults. Another example might be if a plan only covered 10 visits per year for adults. While we allow 27 up for service, we consider this to be a more risk, we'd consider this to be more restrictive and amount. And in both of these situations, we would pursue some kind of corrective action to help the plan aligned with our policy floor. In the middle of box, it says the PHP may place appropriate limits on a service based on medical necessity, or for utilization control, provided the service furnished can be reasonably expected to achieve their purpose. An example of this might be that a health plan may require the actual order that initiated therapy services to be uploaded in their pa portal. Whereas in fee for service, we only require the ordering practitioners NPI to be included on a claim for the initial

evaluation. Since this would not be a violation of scope, amount or duration, it would be permitted by a contract. And on the right hand side, it says the PHP shall develop a utilization management program based on nationally recognized evidence based clinical practice guidelines to support UM and prior authorization or services not otherwise defined mandated clinical coverage policies. So yeah, that's a lot of legal jargon. But if you're familiar with our specialized therapies policies, you'll know that we have specific criteria documented for speech and audiology, as well as for respiratory therapy. While for OT and PT, the policies are much more general. So this passage in the contract would allow a health plan to employ more specific pa criteria for OT and PT, so long as those guidelines are evidence based and not arbitrary in nature. Next slide please.

Here we have two more managed care contract quotes that are important to be aware of. The first one states that the plans must honor existing inactive pas on file with Medicaid until they end, or for up to 90 days after managed care launches, whichever is less. This means that if you already have an existing pa with ccme, that goes past July 1, when your client crosses over into managed care, this pa should follow them into their new plan, and the plan must honor it until it ends or for 90 days, whichever is less. Of course, if continued therapy is necessary. After that pa expires or the 90 days passes, the next pa request would have to be submitted to the client's health plan. On a related note for beneficiaries who cross over into managed care on July 1 of this year, claims for dates of service before July one should be submitted to nctracks for payment. While claims for dates of service after July one would be submitted to the members health plan. So claims routing will depend on the beneficiary's enrollment at the time of service.

Bullet two says for the first 60 days after Medicaid managed care launch, the PHP shall pay claims and authorized services for Medicaid eligible out of network providers equal to that in network providers. So this means that if for some reason you as a provider, are not contracted with your clients health plan, in order to reduce continuity of care issues the health plans are required to work with out of network providers as if they are in network for the first 60 days after managed care launches, or until the end of the episode of care, whichever is less. Now there are a couple of exceptions to this. In special circumstances, the period could be extended longer than 60 days. But that's beyond the scope of tonight's presentation. But in general, it's probably good practice for providers to contract with as many health plans as possible to prevent continuity of care issues. Next slide please.

So once your clients are crossed over into managed care and you're working directly with the health plans, you'll want to be aware of the PA managed care pa timelines. The contract requires standard pa requests to be reviewed by the plans as expeditiously as the members condition requires and no later than 14 calendar days after receipt of the request. There will also be an option for expedited PA review, which requires health plans to provide notice within three days after receipt of the request. But health plans are permitted to extend pa timeframes for up to an additional 14 days if a member requests an extension, or if the plan justifies the need for additional information. Another thing to note here is that there is not a mandate in the contract that these pa reviews must be performed by therapist peer reviewers like how it's done in fee for service now. But all the health plans have indicated that they'll

either be using therapist peer reviewers, or that therapist peer reviewers will be available as consultants for non routine cases. As for pa forms, if the health plan requires a PA form be submitted with a PA request. That must be the standard form developed by the state. Next slide, please.

Okay, so now here we have a little bit about network adequacy as it applies to specialized therapies providers, here on the left side is is contract language, which generally requires each plan to establish and maintain a provider network sufficient to ensure that all services covered under the contract are available and accessible for all members in a timely manner. And the way that's operationalized for specialized therapies is in the middle and to the right of the slide. In the middle it says the middle of the slide are the urban adequacy, standard urban and rural adequacy, standard network adequacy standards for OT, PT and speech therapy. These standards apply separately to each discipline. So for example, the urban standard means at least two OTs two PTs and two speech therapists must be available within 30 minutes or 10 miles at least 95% of the members, of course, on the right hand side on the rural standards are a little bit more lenient because of lower population density. I think that's my last slide. I think next, we'll cover some questions that we received back on April 26. That's Thank you, john.

Dr. Abby DeVries

So a couple of questions here. When will we know which agencies and therapists are signed up with which health plans?

Jean Holliday

This is Jean holiday, you can check the enrollment brokers website, too search on each, you know, specific providers or specific provider types to identify providers and with whom they have contracted. You can also go to each health plans individual website and also do a similar search.

Dr. Abby DeVries

Thank you, Jane. Does the patients assigned PCP or practice have to make the referral for therapy or can any in network provider make a referral?

Jean Holliday

So the managed care contract doesn't require that outpatient specialized therapy services only be ordered by a PCP. And so the best direction would be to consult with the individual health plan.

Dr. Abby DeVries

And thank you. Well, the process for referring patients to specialized therapists be the same across the different plans.

Unknown Speaker

So just based on our experience, at this point, the plans will often work together to ensure that processes are harmonized to minimize and reduce provider burden. However, it's really important to understand that plans do have the flexibility to establish plans specific processes and referral requirements. And as John mentioned earlier, plans are not allowed to change the amount duration and scope of services as establishing the clinical coverage policy. So again, the best direction would be back to that your individual health. Thank you.

Dr. Abby DeVries

One Health Plan has implemented speech therapists rate cuts statewide for their commercial plans. Will there be pay cuts for therapists in for men who provide Medicaid services?

Unknown Speaker

So there is no current plan to cut medicaid rates or Medicaid fee for service but of course, it's done mentioned earlier, there is no rate floor for this service. And so it's subject to the negotiations between the health plans and the providers. Thank you. Next slide.

Dr. Abby DeVries

Next question standard plans do not cover occupational therapy and behavioral health services for beneficiaries over age 21. Is there a plan to cover these services for this age group through the PHPs.

John Vitiello

This is John I'll take that one. That's actually not true. We would expect the health plans to cover the same services like I said earlier in amount duration and scope, as in fee for service so we would expect them to cover ot services for members 21 or older. If we found that this turned out to be the case for a particular plan we would work with that plan to help them align with our policy floor.

Dr. Abby DeVries

Thank you. And then here's another network question How do we know which therapy providers are in a health plan's network?

Melanie Bush

I think Jean spoke to this earlier about we would encourage you to go to NC Medicaid plans.gov and search for providers there, that information is updated, and on a daily basis as providers contract with the health plans, so continue to search there also you can go to the individual PHPs website and conduct that search. Thank you Melanie.

Dr. Abby DeVries

And then last question here, around, authorization, will the health plans have access to the records that have already been submitted and approved by CCME.

Melanie Bush

So, as we outlined a bit earlier. Open authorizations will transfer at launch so authorizations authorized by CCME that are open. On July, 1 will transfer to the members new health plan, where the health plan will be expected to honor it for 90 days or until the authorization ends, whichever is sooner. However, there's no contractual expectation of CCME to transfer the underlying records that were used to evaluate and determine approval for the authorization. Thank you very much.

Dr. Abby DeVries

I will move on to the next slide, and I'll turn it over to Jean Holliday to talk about network adequacy oversight.

Jean Holliday

Okay. Hi. Um, So, we get some regular questions across all of these sessions about network adequacy and what is the department's approach to it, first of all want to talk about that, there are two different types of network adequacy standards that we use. One is what we call a, you know, measuring the maximum travel time in miles or time from a members residence to one or more providers of a certain type we call those time and distance standards. And then we also have some standards that for certain categories of benefits, where we just say that there needs to be a certain number of providers of a certain type within a geographic boundaries such as one, a county or a PHP region. So those staff those standards are established, as, as we said, as a maximum amount of time that the members should have to. We also I'm sorry have network adequacy standards about how long a member should have to wait to access an appointment. Based on the urgency for that particular type of appointment that they're seeking. So, all of those different types of standards together, you know, kind of mix together to determine whether or not a network is adequate. In terms of our oversight for those time and distance standards we will actually be taking the PHPs networks, and confirming that they do meet those standards through some geo mapping analysis where a members address is mapped against the providers of a certain type and and then it's determined how far and how long it takes them to get there using the roads, not a, you know, not some sort of circular radius type analysis.

They also have to demonstrate that at least 95% of the members in that county meet that standard. And so, you know it is, it's not just that one member has it, it should be it has to be at least 95% of the members. If a health plan is unable to meet that standard and that could be because there aren't providers in that particular areas that that can meet those, you know the can meet those specific time and distance standards, then the PHP must request an exception from us and in requesting the exception they have to tell us why they can't meet the standard. What is their plan to make sure people get access to those services because regardless of the fact that there may not be providers in that area those members still have those still must be able to access those covered services in some fashion. And the department is certainly not obligated to approve any of those if we don't approve them, then we'll be putting the PHP on what we call corrective action plans or other types of actions that we can take when a PHP is not, you know, living up to the expectations. And we would be monitoring that to make sure that they are following whatever corrective action plan, they design and we've approved. And would you know we've been continually monitoring that. As far as some of the other standards like the appointment wait time standards, we'll be looking at secret servers, excuse me secret shopper surveys, complaints that we get from members who say they can't access benefits, as well as perhaps, you know, other analysis like from provider surveys and things of that sort. And we were also asked when will we be releasing network activity standards publicly and we expect to do that later this spring. And so we certainly expect that we'll be doing that in the not too distant future. Thank you. I think I hand off to Melanie.

Melanie Bush

So we've hit on this topic a couple of different web backs porch chats. But I did want to clarify something based on stakeholder feedback. So our newborn coverage policy has changed in the last couple of months based on provider feedback, and we have changed it to state that you know in order to get best health outcomes for newborns and make sure that they go to all the visits and get all the immunizations that they need, the health plans will treat all out of network providers, the same as in network providers for the purposes of prior authorization, and they'll be paid 100% of Medicaid fee for service for services rendered through the earlier 90 days from the newborns birth date, or the date that the health plan is engaged in has transitioned the child into an in network PCP. And so our clarification is What does engage mean and engage means, Yes, the child has been assigned to a health plan, the child has been assigned to PCP, but if that child is continuing to get to see another PCP then the child has not engaged in the health plan and it is to come up with PHPs to make that engagement. Um, so an engagement leads, there's actually visit within network provider. And then at that point the, the coverage and the general application of the policy will change, you can look into NC tracks and see on beneficiaries information, it will list the health plan that is associated with them, and then you can build that health plan, and then if you do receive a denial, you can try to resubmit with extenuating circumstances. And then if that is not. And then we've spoken with the chief medical officers and they have assured us that they do take that into account, especially during this 90 day transition period. Okay, next slide.

So, this is the current enrollment and plan selections during open enrollment as many of you may have heard we extended our open enrollment period by one week until Friday, May 21 to allow beneficiaries to have more time to select. So far we've had about 200,000 beneficiaries select a plan out of 1.6 million. And of those about 54% have selected a primary care physician, for those that are not selecting a health plan, they will be auto enrolled in a health plan, this weekend. And for those who do not select a PCP their PHPs will auto assign them a PCP, when they are enrolled in that. I think I'll hand it off to Krystal.

Krystal Hilton

Thanks Melanie. Good afternoon everyone. I'd like to share a little information on the Tailored care management model for the Tailored plan population. We, the department has been working with stakeholders to design a Tailored care management model for behavioral health in intellectual developmental disabilities within the Tailored plan population. This care management plan will launch in July of 2022, and we want it to. We've done some recent several program updates, and we'd like to share a few of those updates. We have published some updated guidance on the tailor care management program itself, and this includes updates on the certification for providers that are able to provide the services or capacity building to help prepare the provider field for service provision, as well as service rates within the application process, there has been an optional supplemental documentation, added to the application for historically underutilized providers. This is a voluntary supplement, and it allows providers to share the opportunity of self identifying as a historically underutilized provider. The last update with the program that has been recently released, is that there is a non binding, statement of interest for potential clinically integrated networks or other partners. The design is that these other partners or clinically integrated networks would denote their interest in partnering with the tailored care management providers being a AMH plus, or a CMA, and they would share that responsibility for certain functions and capabilities for the AMH for CMH provide a practice to function as care management service provider. Please note the submission of this statement of interest is voluntary and non binding. Someone's also share that here we have a website for Taylor care management where additional information can be obtained related to the tailor care management model, and these latest updates. Next slide please.

I'd also like to move into a discussion with the advanced medical home to three glide path attestestation there with the glide path attestation just as a quick reminder that the timeframe to attest to meeting the glide path payments for the last cycle, which is the June payment cycle was on Friday, May the 14th. Any providers that had successfully attested prior to this timeframe. I'm sorry. I had attested prior to earlier cycles such as the march in the April cycle did not have to reattest. For the glide path. In light of the fact that the attestation period has has ended, we do. The department has developed a reconsideration process. And with this reconsideration process. Initially the AMH tier three providers had to attest to being leading the glide path eligibility within nctracks, then the department will go on to validate that the practice is enrolled with Northland Medicaid and attested as an AMH tier three provider. With that attestations in place, the department would then confirm with information from the prepaid health plans in order to validate that the practice had indeed completed the contracting and testing criteria. With this reconsideration that we now have in place, that if a provider for whatever

reason being, having missed the deadline due to hardships for due to the COVID pandemic, or the public health emergency, or they disagree with the outcome of the initial validation determination, they're able to submit a request for reconsideration, through the Medicaid transformation, email address, all right, and that deadline for reconsideration is May the 23rd. Here we've also included a link to the webpage that gave more details about the adaptation, the glide path adaptation payments in general.

The last note in regards to the glide path is just a little update on our numbers so far as to what information has been coming in from providers on providers that have attested. We've had 1186 providers, having been paid for glide path, during the April and May cycles, and this is resulting in $9.3 million in payments to providers to help in preparation for launch. So far we've had just about 25 providers submitting reconsideration requests, and of those reconsideration request 100% have been approved for reconsideration. With the providers attesting to date. They account for 84% of all amh tier three providers within the system, just want to reiterate as a reminder that that final date for reconsideration of glide path attestation is May the 23rd. Here we will have an additional link to get information on the glide path reconsideration, if that will be helpful. And I will turn it back over to Dr DoVries. you

Dr. Abby DeVries

So now we're going to move to some additional questions that we'll try to go through quickly and hopefully have time to answer a few questions from the chat as well. So the first question is how is third party liability determined for children with commercial and Medicaid insurance does pay and che supply,

Melanie Bush

So children can have, or anyone on Medicaid can have commercial insurance and Medicaid at the same time. All the premiums, and prior authorization policies of the commercial insurance should be followed by the provider first Medicaid is the payer of last resort, Medicaid should also the commercial insurance should actually also be filled first, because they are the primary and Medicaid is payer of last resort. After the initial billing then you would bill the PHP, to see whether or not is within the allowable Medicaid rates allowance, so that is how that works.

Dr. Abby DeVries

Here's a question about EPSDT will those services be different across plans, Or will things remain the same across plans.

Frank

Good evening. Well for services provided through EPSDT of course services supported by the federal benefit are accessible regardless of plan, the rules for implementing EPSDT really won't be different, managed care implementation at the benefit is consistent across NCO contracts with uniform across the state. As a reminder, now that EPSDT benefit guarantees are federal in their origin, the federal requirements allow any service the federal Medicaid program covers to be available to kids under 21, when they're found medically necessary to correct or ameliorate a health condition services requested are available in tailored plans, only the PHP may provide those services until the child transitions to the challenge plans, Medicaid direct it's going to support those services until Tailored plan launch. There was a question that was tacked on to the end of it, that I thought was a good one because its come up on several occasions, vitamins, would vitamins, who are now covered for kids with nutritional deficiency remains the same across plans and the answer is a yes. Remember that Medicaid can only reimburse for drugs including over the counter medications, and vitamins for which Medicaid federal receives a rebate from manufacturers so this is, there's a limiter there, it's federal in origin for kids with specialized medical needs. However, these products may be covered when they're found again medically necessary to correct or ameliorate a health condition by a professional review applies EPSDT standards. Also, just a tagline, some of y'all have heard this before in managed care it's possible that some over the counter drugs or vitamins might be covered differently as a value added benefit, for that particular plan. Thanks.

Dr. Abby DeVries

Thank you Frank. Well, any services, not be available to beneficiaries receiving the innovation waiver services who stay on Medicaid direct, and how does it beneficiary know if they should be in standard plan, tailored plan or Medicaid direct.

Melanie Bush

So individuals who remain on the innovations waiver, and receive their physical health care services through Medicaid direct until tailored plan launch will not lose any services. The individual who wants to know which plan, they're on can contact the enrollment broker for that information. Those folks who were qualified to stay in Medicaid direct pending launch of the tailored plans should have received a letter, letting them know that they were eligible to remain a Medicaid direct or they had a choice of choosing the standard plan. I just want to note though that innovations waiver members cannot enroll in a standard plan unless they withdraw from the innovations waiver first.

Dr. Abby DeVries

Thank you. Will Medicaid directs medically medically fragile children have the same benefits when they transition.

Melanie Bush

So if you're speaking of the medically fragile children who are participating in the community Alternatives program for children, Cap C. They are temporarily excluded from managed care, So they will not be transitioning to Medicaid direct, they will stay on Medicaid direct and not transition to the standard plans. If you're talking about children who are not on the waiver who are medically fragile maybe receiving credit union nursing care benefits will be at a minimum.

Dr. Abby DeVries

Thank you, if we could go to the next slide, I try to make sure we make it to these questions. This may have already been answered, is there a website where families can learn about upcoming changes to the Medicaid program.

Melanie Bush

Yes, NCMedicaidplans.gov would be your first stop and then the second stuff would be medicaid.nc dhhs.gov. There's an entire beneficiaries portal where you can learn more information about Medicaid.

Dr. Abby DeVries

Great, I'm going to skip the next question and go to the one after that which is how families learn about changes in accessing non emergency transportation for their treatement.

Melanie Bush

So, beneficiaries will receive welcome packets from their health plan that will include information about how to schedule an EMT. In addition we have been working behind the behind the scenes for with our counties who currently manage any EMT process, and we are sending the high utilization high utilizers of an EMT to the PHP, so that they can do outreach ahead of time before July 1 to make sure that their services are scheduled.

Dr. Abby DeVries

Excellent. And I'm gonna skip the next one too because I think we sort of covered that if we could get to the last slide. Are provider minimum rates, or rate floors expected to be honored for the first four years of managed care, and then will rate and reimbursement policy changes in year five.

John Vitiello

Yeah, this is John. So the master contract does not include rate floor specific to specialized therapies providers. And there are currently no plans to change the Medicaid direct fee schedule for specialized therapy providers.

Dr. Abby DeVries

Great, thank you. And I think we've sort of covered the last question too, so I'm gonna move I know there's a lot of questions in the chat. I'm hoping we have time to answer address a few of those. And if there's anybody on the Medicaid team that thought there was one that we really need to answer I think you could go ahead and chime in as well.

Hugh Tilson

We look like you had flagged a couple that you might want to answer. Did you already answer those.

Melanie Bush

No, I think they were all kind of around the same theme, folks wanted to know whether or not we'd be able to see the health plan that a beneficiary selects or is auto enrolled with in NC tracks and the answer is yes. Currently you can look up beneficiaries and you should every time they come into your office to confirm eligibility. And then beside that it will list the health plan if they are remaining in NC Medicaid direct which is our Medicaid fee for service program, there will not be a health plan listed but if they have selected a health plan and then after this weekend, if they're enrolled in the health plan, you will see that helps them listed there. I phoned a friend during this chat to confirm that you are able to see the information now for beneficiaries that have already selected a health plan and then of course, it will change. Next week, you should be able to see the health plan but of course you cannot bill those health plans until July 1. Thank you.

Hugh Tilson

Anybody else have any specific questions that they saw or themes that wanted to respond to.

Frank

I think it's really important to remind people is that this was a decision made by the general assembly back in 2000 and, I guess it was 2015 decision originally was made to go live with managed care. I've been a lot of starts and stops because that was the, the emphasis with this and that's why we're making this change.

Hugh Tilson

There were also lots of questions about the complexity of having to deal with five different plans. And what that means and there's not a good answer for that, but maybe if you guys could provide some context about that as well, that might be helpful to the people who are having to figure out how to do that.

Unknown

I think to add on to what Dave said, managed care for Medicaid, gives a lot of opportunities that we don't have under regular fee for service Medicaid. The plans can individualize the rates, they can be more or less restrictive or less restrictive as they need to be. They can, they can offer value added services. And in lieu of services that are not things that we can do under regular Medicaid. As far as having a number of plans. Most of us have a choice of different insurance plans on the open market. And it's a matter of choice, and CMS really does believe in offering people a choice of their plan their PCP. So while it may it may be confusing, it, it brings a richness and creates innovation, which results in better outcomes.

Hugh Tilson

Just about at a time, Dr. DeVries, do you see any other questions, kind of as a jumping off point, or?

Dr. Abby DeVries

I don't think I saw any other, I mean lots of great questions and we'll follow up with with everybody to make sure people get the answers because I know we didn't have time to answer some of the more detailed ones, so I appreciate everybody being on tonight, and we will get back to these questions and thank you to all the presenters for, for clarity of information presented that event.

Hugh Tilson

Thanks, everybody and we will talk to you I guess our next Fireside Chat is great thing about transitions of care. In the meantime, everybody. Take care. Thank you. Goodnight. Bye bye.