Transcript for Back Porch Chat: NC Medicaid Managed Care Hot Topics

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5:30 – 6:30 pm

Presenters:

Dr. Dowler

Jean Holliday

Melanie Bush

Trish Farnham

Deb Goda

Hugh Tilson

Well, good evening everybody and thanks for participating in this evenings back porch chat for Medicaid providers, tonight's webinar is part of a series of informational sessions put on by North Carolina Medicaid and NC AHEC to support providers during the transition to Medicaid managed care to put on these back porch chats on the first and third Thursday of the month to focus on hot and timely topics. Dr. Dowler, we missed you last week. Before I turn it over to you. Let me run through some quick logistics. You can adjust the proportions of the slides in the speaker by clicking on the gray bar just to the right of the slide and dragging it to either side to adjust the side size side slot. Slide size, it's hard to say. You can also adjust your videos that is a high people aren't speaking. To do so click on the View button on the top of your screen, and select the side by side: speaker. We'll put these instructions in the q&a for your convenience, we'll have time at the end for questions, everybody, other than our presenters is muted. There are two ways you can ask questions or make comments. One is using the q&a feature on the black bar on the bottom of the screen, or if you're dialing in. Send an email to questionscovdi19webinar@gmail.com. As a reminder, oftentimes our presenters will respond to questions during their presentations, I encourage you to wait till the presenters are through their presentation before submitting a question, especially about something that's on the agenda which Dr Dowler will run through shortly. Regardless, we'll send all questions to DHB who can respond to them either directly or including them in upcoming webinars. We do believe that we've addressed certain technical issues with Zoom webinar but should you have any problems hearing any of our speakers tonight, please dial into the webinar using one of the two numbers that are on the slide. We'll post these in the q&a for your convenience. Lastly we post these slides on the AHEC website, there's a link that we posted in the q&a, we'll record this webinar and add the recording and a transcript of the webinar with the slides on the AHEC website tomorrow morning. Now let me turn it over to you Dr Dowler,

Dr. Shannon Dowler

Hey everybody, I'm glad to be back. I missed you the last time but I heard it was a great session, I was enjoying my son's high school graduation, that is the last little birdie out of the nest, which is exciting. So this is our last full DHB team back porch chat, don't worry, they're not going away. Starting the third Thursday of June we're going to share the hot seat with the PHP CMOS and their teams and that's pretty exciting for all of us. We have a full agenda tonight, but we are going to make every effort to leave time for questions at the end so hold on to those questions and we are going to try to get to them. You go to the next slide Nevin.

I just wanted to take a segment, just a moment of personal privilege to reflect on what we're doing in North Carolina right now, and this transition to managed care is really a unique one. The decision to move was a legislative decision that was made into law, several years ago. Since then, the department along with nationally acclaimed consultants, state partners have designed a unique patient centered, what I would describe as value forward version of managed Medicaid, and it feels really complex because it is by design we've created a novel program that values member choice provider experience and meaningful improvements in the health of North Carolina. So we didn't do this work in a vacuum. This is our program this is North Carolina's programs, PHP partners associations healthcare leaders on the ground providers beneficiaries, everyone in the state leaned in to develop what I think is going to be a leading model for the country. Much like community care of North Carolina led the country in the pregnancy medical home and physician led PCCM work, North Carolina's continuing to live up to a long, proud history of being collaborative and innovative and so I just think it's important for us to remember that, and reflect on that as we all get ready for the launch, which is only a few weeks away. If you go on to the next slide.

One of the great benefits of the move to managed care is the ability to be innovative and creative. And one of those is our healthy opportunities so we announced our pilots last week, we'll be investing $750 million in the communities in the Far East and the far west to learn how investments and non drivers of health can actually transform health care. This is another place where the whole country is watching North Carolina and eagerly hoping to learn from our experience to set standards for other states. So now I'm going to turn it over to the main agenda focus today which is a really important one and probably one of the hardest ones transitions of care. And so with that, our very own Trish, the transition magician Farnum.

Trish Farnham

I'm still laughing about that introduction. I appreciate it. Thank you so much Dr Dowler my name is Trish Farnham and I'm very honored and humbled to be presenting on transition to care. Tonight, along with a very impressive panel of colleagues, as everything is through with transition work, it is inherently interdisciplinary and we rely heavily on the subject matter expertise of colleagues across the division across the department, and frankly, throughout the stakeholder community to make sure that we get this right as we support folks to transition into the Medicaid managed care model. A couple of just level

setting notes really quickly we, when we talk about transitions, there are different ways that the term can be defined or interpreted and we just want to make sure we're real clear on what we're talking about tonight, when we say transition of care in the context of this presentation, we're talking about the time specific processes and safeguards that are established to support continuity of care, when a beneficiary transitions to a new health plan or to a different health care delivery system. So we're not talking about care transitioned out of district of care settings or transitions between facilities, we're talking about the transition that a member will experience as we transition on July 1 into the Medicaid managed care model, and then subsequently afterwards as members pick new plans or in some cases disenroll back to Medicaid direct. Next slide.

Just like we're all working under a collective vision of Medicaid transformation, we also have an executively established vision for transition of care and it is essentially, hopefully what makes sense from everybody's perspective which is to ensure beneficiary continuity of care through the transition, and to look for opportunities to minimize the transition burden on providers. Next slide. So, throughout our transition of care work, and communication we have really found that the metaphor of a bridge seems to work well in describing what the heck we're talking about. And so we have two bridges that are going to be very very relevant to tonight's conversation. The first one is the crossover bridge, the bridge that we will all experience many of our beneficiaries 1.6 million will experience on July 1. And on July 1 The majority of the Medicaid beneficiary population will transition into a Medicaid managed care model. I know that's old news for this very well informed group but that's the concept of crossover and that's the transition we're talking about when we say crossover. And on July 1 those 1.6 million Medicaid beneficiaries will be enrolled in one of five prepaid health plans also referred to as the standard plans. And importantly, when we walk through tonight slide deck, when we talk about crossover. These are the safeguards and architecture that are established specifically for this July 1 transition. Next slide.

Immediately starting after July 1 In fact, later on the same day of July 1 People will start transitioning between health plans, as they have their open opportunity to transition health plans for the first 90 days in most cases, and as they have to disenroll from the Medicaid Standard Plan back to Medicaid direct because they ultimately fall into one of the eligibility categories that are carved out so imagine a person who is Medicaid only on July 1 but then on July 7 becomes dually eligible. Imagine a child who is not in foster care when they roll enroll on July 1 but unfortunately becomes foster care eligible at a later date. These are the types of dynamics that we have to pay attention to when we're thinking about our transition architecture, and the best metaphor this visual metaphor I have found this is the tridge in Midland, Michigan, This is an actual tridge, and hopefully, it captures the sentiment that we've got to think about transitions in multiple directions as we're working through this transition of care architecture. Next slide. So, regardless of the phase, whether we're talking about crossover or ongoing transitions of care we have worked to work toward the north star of our vision by establishing an architecture that advances the design priorities that are listed on the left side of the slide. And just for time, I'm not not gonna, we're not going to go into the weeds on all of these design priorities and we're really going to under highlight some of the design priorities related to facilitating uninterrupted service coverage, and also discussing some of the additional safeguards that have been established for high

need members, but just know that with everything that we are working to advance in this transition of care design, we are working to advance these design priorities. Next slide.

So, what I mentioned at the very beginning of the presentation, all things transition of care are interdisciplinary and so this first hot off the press announcement this first hot off the press, safe gaurd that I had the privilege of communicating is very much an interdisciplinary initiative, and it's been largely led by our member operations team, our benefits team, and our DSSs so I just want to acknowledge the collaboration has come together to make this particular safeguard happen, and it's important for providers to understand that any NEMT is a pivotal piece of service continuity through this crossover period. And in order to facilitate easy member access to NEMT services for appointments that occurred after July 1, the health plans have opened their call lines to accept appointments, NEMT appointments for appointments that are required that a member may have after July 1. So this is hot off the press, this just opened up a couple of days ago and we want to make sure people are aware of this resource, again, the whole point is to make sure that providers and members have a clear, clean guide glide path into the managed care model on July, 1. It's important to know that we are not leaning on beneficiaries exclusively to set up their own NEMT appointments after July 1 Our DSS colleagues and our health plans are working very very hard to make sure that NEMT data are effectively transferred and that appointment detail are effectively transferred for members, but we want to make sure people are aware of this resource. Equally important is a beneficiary has an appointment need prior to July 1 it's important to continue to go to the DSS as they do now. And I'm going to assume that any of my colleagues that want to weigh in on any slide that I have will do so, so I will keep going if I don't, otherwise hear anybody. Next slide.

So just to orient you visually to these next couple of slides, as we talk about some really key safeguards that are in place for members and their providers. We have visually divided these slides into the protections under the topic that are applicable to crossover so that happened right on July 1 or around July 1. And then what protections will be in place, as members transition between health plans or disenroll from the Medicaid the Standard Plan option, starting on July 1 and moving forward. So on the left side of the slide, you'll see the crossover protections and on the right side of the slide, you'll see those protections that are in place as members transition between health plans, or just roll back to Medicaid direct, and we all know that in the in the Medicaid space prior authorizations are a key vehicles for service utilization, and therefore serve as a key priority in maintaining service continuity for any transition, and a crossover we have established the architecture that open medical pharmacy and behavioral health prior authorizations will transfer from Medicaid direct to the members health plan. There are a couple of exceptions that are specific to the federal requirements under 42 CFR part Two, but for the general practice the open, be open medical pharmacy and behavioral health prior authorizations will transfer from the Medicaid direct program to the members health plan. It's important to know that health plans are required to honor medical prior authorizations and behavioral health prior authorizations minimally for the first 90 days or until the authorization expires whichever occurs first. It's also important to know the distinction that health plans are required to honor pharmacy prior authorizations for the life of the authorization. As new prior authorizations are submitted directly to the members health plan after July 1 the protection is established that if a beneficiary then transfers

to another health plan that prior authorization will be authorized will strict scrutiny will transfer to the second health plan, and then will be authorized for the remainder of the authorization.

Next slide. So this is a pretty busy slide and I apologize for all of the detail, but we wanted to make sure to communicate this effectively. And we know that as we move to managed care, the concept of being part of a provider, or part of the plans network is a very is a driving question for a lot of providers. We want to make sure that you're aware of the protections that are in place to make sure that members can continue receiving services from their providers, regardless of network status on July 1. It's important to know that as a principal health plans will seek to build their networks, and will seek to contract with providers that's always going to be the driving priority. It's also important to know that health plans have the authority to extend these out of network provider transitional periods that we're talking about tonight, beyond what is required in law or in contract. So once again on the left side of the slide you'd had the crossover protections and on the right side of the slide you have the ongoing transition of care protections. It's important to know that on during the crossover period, health plans will treat out of network providers on par within network providers, minimally for the first 60 days after launch, or until the episode of care ends, whichever is sooner. Importantly, like I've said health plans may extend the timeframe voluntarily in some cases, and are also required to do so under certain statutory requirements that are referenced in the footnote.

We're also really excited to announce or to communicate, again our newborn out of network provider policy and then Melanie Bush can certainly chime in on any of this if she'd like but health plans will treat all out of network providers, the same as in network providers for the purposes of prior authorizations and will pay out of network providers the Medicaid fee for service rate for services rendered through the earlier of 90 days from the newborns birth date, or the date that the health plan is engaged, and has transitioned child into an in network primary PCP or another provider. As we move into ongoing transition of care. Many of the provider out of network provider protections, continue, and that health plans are required by contract to adhere to statutory transitional periods for out of network providers serving transitioning members who meet the criteria for what's known as an ongoing course of treatment, or an ongoing special condition, and both of these if you're interested are defined in the transition of care policy which is posted on our website.

It's also important to know that we know that as providers leave the network there are certain elements and protections that need to be established for members to be informed of that of that dynamic. And so plans are also require that if a provider is terminated from the health plans network and the beneficiary has received services within the previous six months, the health plan must issue a letter to the beneficiary and assist in securing a new provider as necessary. Just to reiterate carry over the newborn policy the newborn policy will continue to apply to newborns who were born after July 1. Next slide. As kind of an introduction to some of the high need of the high need safeguards that we have established and that we're going to talk about for the remainder of my presentation. We also want to make sure that folks are aware that in addition to the safeguards we've already talked about in addition to the safeguards that have been tailored to meet the needs of high need members, we are also having a very

robust data transfer exercise that has actually already started for crossover and will continue on after July 1. We recognize and certainly my predecessors recognized that the inherent value of ensuring quality data transfer between health plans and between Medicaid direct and the health plans, and so a lot of blood, sweat and tears has gone into designing and developing and implementing the architecture that's referenced on this page. So we're not going to go through a lot of this detail but it's important to know that health plans are getting really key information like prior authorization data, like I mentioned, claims history, pharmacy lock in detail, and then more members specific care manager oriented material to make sure that they have a fully informed picture of that member circumstance, as they assume their support. Also important we're going to introduce the concept which you've probably heard of at this point of the warm handoff. It's certainly not introducing a new concept and maybe a new term, but essentially that is an understanding that sometimes information can't be fully appreciated through claims or data transfer, and it really does require a good old fashioned conversation between entities. And so we've established a warm handoff of process and architecture to ensure particularly vulnerable folks who are transitioning, that there are opportunities for the different partners involved to actually talk to each other. At the time of transition. Next slide.

So if you've been to a trasition of care presentation before I know you've seen the slides I'm going to do this very quickly, but we want to make sure, again, as we think through these, the 1.6 million members who are going to be transitioning into the managed care model on July 1 that we recognize two key factors. One is that a lot of folks who are transitioning in fact I would say the majority of folks, the vast majority of folks really only depend on Medicaid for health, health care, primary health care, maybe think about Medicaid a few times a year as they're going into a well child visit. That's not to diminish the importance that Medicaid plays in their life but Medicaid isn't a day to day thing in their in their minds. We also recognize that while a lot of our highest or most vulnerable populations are carved out of the managed care model on July 1. There will still be an important subset of members who will transition, who rely on Medicaid for things like in homes, in home long term care services, or are on a list for transplantation, things that are really really critical, and that put a member in a particularly vulnerable clinical vulnerable position. And really, their additional oversight and, and, by both the plans and the state. Next slide.

So we know that sometimes scenarios are the best way to illustrate some of the concepts that we are working to communicate tonight and so we're going to go through a couple of scenarios that hopefully address some of the questions that you may have had. And in order to so that you don't have to hear me yammer on consistently, I'm going to lean on my wonderful colleague Goda, Deb Goda to tee up the scenario and then I'll respond with the interventions.

Deb Goda

So, Joe is a 45 year old Medicaid beneficiary she has not been determined to have qualified for Medicare, but has been determined to have a disability, and she was auto assigned with the health plan A, and like some of us has not opened her mail in weeks. I'm not judging. So she receives over 91 hours

of personal care services every month depending on her aides to assist her with activities of daily living, on, on a regular basis. She has been recently hospitalized for COVID-19. And then she's back home now. She is currently providing care management and closely engaging with her after her discharge so she's clinically stable. And what do we do have Trish.

Trish Farnham

So because of the level of PCS services that Joe requires Joe is identified as being a high need beneficiary of crossover. And because of that high need status, the health plans will be getting a particular data feed that highlights Joe on it in order to make sure that Joe's that Joe is identified as being a high need member and then that the health plan follows up with Joe quickly after launch. It's important to know that in this particular scenario while CCNC would have the prerogative to identify her as requiring a warm handoff. They have not identified her for a warm handoff in this scenario. So like I mentioned, after July 1. Joe's health plan, or if it's been delegated the AMH tier three will conduct a high needs follow up, and the health plan contacts show to make sure that the personal care service issue relies on, and other key services have remained in place upon transition, and then troubleshooting as necessary. The health plan has then going to report to us when effective contact has been made. Just as a as an aside, it's also important to know that the state is establishing a look back, surveying process but we will also be sampling high need members in order to make sure that these interventions and these, these, follow up processes have been working as intended, and to also supplement any of the troubleshooting that the health plans may already be aware of. Next slide.

We recognize that again there are going to be high need members who transition between health plans, and in many cases will be just rolling back to Medicaid direct after July 1 And so we want to recognize, especially in the context of those members who will be dis enrolling back to Medicaid direct the the precarious dynamic that that transition in that disenrollment potentially poses are moving back to a different type of service delivery system that is organized differently. At a time when in fact they may actually be reaching different levels, or higher level of vulnerability. So we have worked really hard to prioritize certain populations to make sure we're very clear on how they will be supported through their disenrollment back to Medicaid direct. And so some of the examples of the populations that we are paying very very close attention to include children disenrolling due to foster care eligibility. Members disenrolling due to dual eligibility so they become Medicare and Medicaid eligible, or if a member is transitioning due to tailor plan eligibility. So even after July 1 If a member who is otherwise in the Standard Plan merits or require services that are more appropriately provided by the LME MCO, we want to make sure that the transition back to the LME MCO and back to Medicaid direct is as smooth and as organized as possible.

So in order to safeguard these particular safeguard distance disenrollment dynamic we have established safeguards with all of the related partners, we like to pre transition activity, activity at the time of transition and follow up after the transition. So essentially it ensures that the health plan is aware of these transitioning members and does interventions to support these numbers to prepare for the

transition. At the transition, it's important that there will be a coordination and a warm handoff, a file transfer to what we've referred to as the receiving entity for that particular population. It's also important to know that our amazing LTSS colleagues have established a really robust structure for making sure that LTSS services remain uninterrupted upon the disenrollment. And then finally, It's also important to note that for post transition those prior authorizations that the PHP has honored, or that has established will transfer back to Medicaid direct and nearly every case will be honored as it has been authorized. Next slide.

We wanted to run through another scenario again we know there's a lot of important, very important questions being asked about our potential foster care population and again, these are children who are in the standard plan and have not yet been identified for foster care enrollment, but due to unfortunate circumstances are identified for foster care enrollment and are brought into foster care custody, and we want to make sure that there are safeguards in place to support those members as they disenroll from the Medicaid managed care program so Goda, can I ask you to tee up that scenario again.

Deb Goda

Certainly, Sam is a seven year old child who is currently served by a standard health plan is removed from his family home, there's confirmed physical abuse. This DSS worker doesn't have much information, but it was an urgent removal. He's placed with a relative three counties away. Once DSS is able to enter the foster care evidence into NC FAST Sam is going to be disenrolled from his health plan, and returned to NC Medicaid direct. Trish, what is that transition look like.

Trish Farnham

So, again, we've worked really hard to make sure that our disenrollment strategies are customized to the different populations. And so I want to give a huge thanks to our DSS colleagues, our CCNC colleagues, our fostering health colleagues, all of the folks who have helped inform some of these protections and interventions that have resulted in a disenrollment protocol specific for these foster these foster care kiddos. Importantly, the health plans are expected to assist that child welfare workers access after hours information about the child, assisting to secure an urgent clinical needs, including finding providers available to see the child in the child's region. So we've really worked to run through various scenarios where a DSS worker is literally looking for information at nine o'clock at night and may not have information to go much information to go on. So we've tried to work through that scenario to make sure that the protections and safeguards are available for supporting those DSS workers, as they work to ensure the safety of the child. We do want the health plans as we all do and as the health plans themselves want to be good partners and good collaborators through supporting this child during this very very traumatic experience. And it's important to know that there is an expectation that if the child has not otherwise been identified as a priority for care management, they will be become a priority for care management upon the health plan learning of the foster care, dynamic, and importantly, I want to give a big shout out to our colleagues with CCNC. CCNC will work with, in partnership with our health plans to ensure that there's a seamless transition for this child back into Medicaid direct, and so the

protocols have been established to enable that seamless transition as this child is enrolls back to the Medicaid direct program. Next slide.

So, the, the last scenario that we're going to run through is, is a little bit more at a higher level and not member specific, and this and for this one I'm going to tag team once again with the wonderful Deb Goda, but we know that there is a lot of interest in making sure that folks who are in the standard plan, but subsequently merit services that are only available in the LMC MCO have a smooth and organized transition back to the Medicaid direct program in order to access those services. So, this, this process has been a collaboration, again, among many teams within the DHB and certainly informed by our very insightful elements CEO health plan and stakeholder colleagues and Goda I'm gonna turn it over to you to walk through one of the key pathways to supporting members to transition back to Medicaid direct in this circumstance.

Deb Goda

Thank you, Trish. So we have two different processes one would be if a beneficiary feels they'd be better served in a tailored plan than a standard plan, but also if a member needs a service. So in this instance we're talking about members who need a service that is not available in the standard plan. It is only covered by tailored plans or Medicaid direct prior to tailored plan launch. So provider can request a transfer for the individual for this service that is not available under the standard plan. The forum is located on our enrollment broker website. They can work, they work with the member to complete the request the member needs to sign this, it's very important or their legally responsible person because it also serves as a release for the receiving entity to be able to talk to them. So once it's signed the provider submits the request to the enrollment broker. And once the service authorization request form and the request to transfer form are received by the enrollment broker, the individual would be transition to Medicaid direct or later the tailored plan within one business day. And it will be record retroactive to the date of the service. So for example, you have an adult who needs.... You can submit that form. And there's a checkbox because that has passed through, or if they need PSR psychosocial rehab, you can submit a service authorization request with the request to move form even remote broker notifies our eligibility section. The individual is transitioned back to Medicaid direct, And then the LME MCO will receive that authorization request to take action upon it. That's it, Trish, come back, and thanks go to.

Trish Farnham

We can go to the next slide Nevin. So as you can appreciate, we have a lot to say. And there's a lot of dimensions to transition of care that we're not having a chance to cover tonight just because of time, we did want to make you aware of the incredible resources that our provider engagement team, our member engagement team, all of us have helped contribute to making sure that members and providers are fully informed about the transition dynamics that we're all about to experience, and I just wanted to alert you to some of the resources that are available in the appendix, or links that are available in the appendix of this presentation, so that you can take a look at them, and circulate them as appropriate. So

just wanted to make sure you knew about that. I think now we're going to pivot to our. What if section of question and answer and I think I hand it back over to Dr. D at this point.

Dr. Shannon Dowler

Yeah, so those of you out there and listening land we had our stakeholder engagement sessions and our What if sessions, all throughout the spring, the last one was this transition of care what if so we tried to answer a lot of those questions in the content that Trish and Deb have gone over, but we had some other questions that have bubbled up kind of again and again and we wanted to hit them today. So we're going to do speed questions really quickly, and then hit a few more highlights and go to your questions. So first transition What if is where can providers find out which health plans their hospital or organization has contracted with?

Jean Holliday

This is Jean Holliday providers should first of all, seek that information from their coordinators within their practices or systems that we'll be handling the contracting with health plans, but if they don't find it there, they may can find information at the enrollment broker website at NCMediacidplans.gov to see which providers are in each of the different health plans networks also each of the health plans have their own provider directories on their own websites. And again, that's another place to check that information.

Dr. Shannon Dowler

So what if a patient signs up for the wrong plan and they need to change their plan during this period.

Trish Farnham

So beneficiaries have 90 days from July one managed care launch to change their plans for whatever reason whether they pick the wrong plan, or they were assigned to the wrong plan. And to do that, they would do the same thing that will go to NCMedicaidplans.gov, or call the 1 800 number listed on that website. There's also a mobile application where you could also change your health plan at NCMedicaidplans.gov.

Dr. Shannon Dowler

Awesome. And they can do that now as well. They don't have to wait till July 1 to do that?

Trish Farnham

That's correct. The 90 day clock for for transitions really starts on July one. But beneficiaries can do that now until September 30 of this year.

Dr. Shannon Dowler

Awesome. So what if a patient comes to the office for services at launch and the providers not in network with their plan?

Jean Holliday

The collective goal of the phps is to develop robust networks of providers and certainly will try to encourage members to be to seek care from in network providers. But if at managed care launch a members provider is not in the network. Then of course, for those first 60 days, the authorizations and payment will be on par with participating providers. As Trish has explained in the in the in her previous presentation. After that there will be additional out of network safeguards for beneficiaries experiencing special ongoing conditions, or ongoing courses of treatment.

Dr. Shannon Dowler

All right, so let's say I'm an AMH tier three, how do I get information on the behavioral health services that my patients are receiving?

Trish Farnham

So if your and AMH is tier three, you'll actually be getting all the claims information for the members that you serve. So when we next week, actually, if you're an advanced medical home, or you're using a CIN and you're about to hit two years worth of claims information, and that's all claims, dental claims, behavioral health claims, facility claims, physical health claims, pharmacy, everything, and every month, you'll get a new load of claims. So as an AMH you'll get all that claims information, your CIN gets that claims information. And the goal is so you can understand the services that you're a member maybe getting that you don't even know about. So all of that should be in your care management platform. And your care manager should be able to help you coordinate those services.

Dr. Shannon Dowler

Awesome. All right. So what if the patient chooses a standard plan but because of their behavioral health needs, I really think they need to be in an LME MCO tailored plan.

Trish Farnham

So if the individual has chosen a standard plan, you can speak to them about the services that you feel that they need. And they should be able to if they are already tailored plan eligible. And they've just chosen a standard plan, they can call the enrollment broker and switch or you can assist them by filling out the form to transition them to the tailored plan.

Dr. Shannon Dowler

Thank you. Next slide. Alright, so we got some children what if surround transitions of care? So what if a child with complex medical needs attaining care from multiple academic centers is not able to get care from one specialist or center because they're not networked with the other specialists?

Jean Holliday

Similar to the previous question. First of all, during those first 60 days after managed care launch, you'll be able to seek you know, if you're going to an out of network provider, then that provider will be treated on par with network providers in terms of authorizations and payment until those 60 days are up or until the episode of care completes. And of course, there'll be additional possible safeguards depending on if there are special ongoing conditions or undergoing special courses of treatment. If however, the standard plan is not able to provide in network benefits in general after the transition period, then because they don't have providers that are available on a timely basis, then the health plan itself must cover the out of network benefits as though they were in network and, and continue to do that until the provider until that gap in their network is billed. It should be noted that the phps will work toward moving a member to a participating provider in those circumstances if there is one that's available within a reasonable without, basically undue delay.

Dr. Shannon Dowler

All right, thank you. So how do parents manage children in different plans, let's say you've got one child on Medicaid and a sibling with health choice or one's on a standard plan, and the other's in Medicaid direct.

Trish Farnham

So it's important to know that first of all, a lot of the auto enrollment or the enrollment algorithms are going to make sure that children are enrolled in same health plan where the eligibility is are the same. But in the case of where a child is, say, still managed in the Medicaid direct program and another child is managed in the Medicaid standard plan option, it's going to be important to know that those services will be managed differently and that it's going to be important to know that the care managers if, if they are involved in both children's lives will need to work together to manage family dynamics, but those management supports will be managed independently.

Dr. Shannon Dowler

So what if a child needs specialized care that they can only get outside of state such as Children's Hospital Philadelphia? What's the process for covering these services? Will it be the same for all the plans?

Jean Holliday

That will not necessarily be the same for all the plans, but we'll know that certainly services out of state can be covered. There are circumstances which permits that but that would generally require utilization review and probably prior authorization from the health plan. certainly encourage providers to work with the with the members care management and health plan in order to identify appropriate providers whether in state or out of state.

Dr. Shannon Dowler

Okay. So this is a tough question around a child that needs an evaluation possibly for sexual assault. It says when a child is referred to the child medical examiner or CME by the DSS social worker, does the CME have to be the child's primary care provider? If the CME is not enrolled in the same plan as the child? Is the prior approval required? And what if the exam is scheduled by another provider or by law enforcement?

Trish Farnham

So I'm going to take this question, but I want to give a shout out to my amazing colleague, Beth Daniel, for her contribution to this answer, and I'm literally going to read it. So if there are follow up questions, we certainly can take it. So North Carolina Medicaid has established a process for child welfare to access to care for children with suspected maltreatment. North Carolina Medicaid clinical policy 1A5 child medical evaluation a medical team conference for child maltreatment defines the services and spells out the requirements for the examination. The examiner must be enrolled in North Carolina Medicaid, and the services requested by the DSS social worker and is completed according to policy, the health plan will pay the examiner 100% of the established fee whether or not the examiner is enrolled with the PHP. A CME exam requested by law enforcement follows a process like that described like that described in policy 1A5, but it's not billed to Medicaid, there's a separate funding for these particular exams. Any child maltreatment evaluation outside of these procedures by any provider would need to follow the guidelines of the child's PHP. If providers out of network with the child's PHP prior approval may be needed. providers who may be asked to do such an exam should be familiar with the requirements of each of the health plans.

Dr. Shannon Dowler

All right, thank you Trish. And this is a complex topic. We've tried really hard to preserve the program. We have a great program in North Carolina and we've tried really hard to preserve the integrity of that program. So last question here. What if a foster care child needs to switch plans will coverage under the new plan be retroactive to the beginning of the diagnosis or event that allows them to switch plans?

Jean Holliday

This is Jean again. And I'm going to basically read this answer because I'm not the eligibility expert but I'll invite Deb or Trish or any of the other experts here to weigh in if I don't get this right. So if a child enrolled in a standard plan enrolls in foster care, the foster care eligibility will be retroactive in nearly every case. The standard plan is responsible for coordinating the child's medical care until the disenrollment evidence is reflected. Providers may serve the child while under standard plan enrollment, but due to the retroactive eligibility may bill under Medicaid direct.

Dr. Shannon Dowler

Alright, and so this payment stuff is complicated. And we've got a slide coming up about payment and then at our next webinar, I just put a plug for our third Thursday one, we're going to have all the different PHPs share what their processes for billing and payments we hope to really demystify this prior to launch for everybody. So Nevin, let's go on to the next slide.

Melanie Bush

Okay, so Trish has already walked through all of the scenarios very eloquently and in depth, but we just wanted to sort of hammer again, on some key points that providers really need to be aware of. Health Plans will honor existing and active prior authorizations for Medicaid and health choice for the first 90 days after launch, or until September 29 2021, or till the end of the authorization period. If it goes longer than September 29, then that will continue until the end of the authorization period. For the first 60 days after launch health plan will pay claims and authorized services for out of network providers equal to that of in network providers until the end of the episode of care or for 60 days, whichever is less. And if a member transitions between health plans a prior authorization authorized by one health plan will be honored for the life of the authorization of their new health plan. As you can see, there is an entire link to the transition of care materials that that Trish has already covered. But these are the key points or some key dates that really begin starting July one that we wanted to just remind you of.

Trish Farnham

Can I just make one clarification to the first bullet? Or Well, yeah, so the the standing expectation for medical and behavioral health care PAs is that the plan will honor it for the first 90 days or until the end of the authorization period, whichever occurs first. And also that should have been carried over on this slide is that Pharmacy PAs are on for the life of the authorization when they come over from Medicaid direct. So thanks Melanie.

Melanie Bush

Terrific. Thank you, Trish, you are the expert. All right, next slide. So I'm actually here to talk about a couple of other different topics as we transition aha out of transition of care. We wanted to let folks know we have completed our auto enrollment process. As you may know, already, beneficiaries were given from March until May 21 to select a health plan for those beneficiaries that did not make an active selection, we then used an auto enrolment algorithm that we have talked about on on these webinars to assign beneficiaries to health plans based on where they live based on whether they're a special population or not based on their existing primary care provider, family connection to another PHP, and then it goes through that entire filter and ends up with an auto enrolment assignment. All of our Medicaid beneficiaries are eligible. All of our Medicaid beneficiaries that were auto enrolled, have been assigned to plans 97% include their current primary care provider. And we really did try to keep primary care provider existing relationship with the primary care provider as the driving force in their auto assignment algorithm. And we are pleased to report that people have been enrolled in plans that include the 97%. For those 3% that are not enrolled in the primary care provider either isn't rolled in Medicaid, or their primary care provider has chosen not to enroll with a health plan. So we're very pleased with those results, because we hope that it has it encourages continuity of care.

Basically, to the next slide, I'll walk through what we've had, they have until I've already mentioned, they have until September 30 to make any changes for their phps. The phps that did have an auto enrollment are also auto assigning beneficiaries to their PCPs. So starting to I will starting now until September 30. As I mentioned to Shannon earlier, beneficiaries can change fees for any reason, they can also change their primary care providers if they've been auto assigned. Alright, next one. So this is how the beneficiary member enrollment sort of shook out, you can see that we have active selection, these are the individuals that made a plan choice during open enrollment, auto enrollment are the folks that did not make an active choice. And then you can see how it sort of divided amongst the different health plans and the EBCI the Eastern band of of Cherokee Indians tribal option. You can also see the percentage of beneficiaries that do you have a piece of their current PCP within their network. We are a total of 1.45 million beneficiaries. There's another about 160,000 folks that are up for Medicaid redetermination and they will be auto enrolled once they are determined eligible for Medicaid or have the choice. Next slide.

So here's another couple of things that we want to remind providers about because we've gotten a lot of questions about we do have a very detailed fact sheet in our Medicaid provider playbook. That is linked here on the end of the slide that I encourage you all to reference. But key points are health plans are responsible for claims processing and timely payments within 180 days of the data service health plans must within 18 calendar days notify whether the claim is clean or request additional information. If it is clean, they must pay or deny within 30 days. They are all if they do not pay claims within that timeframe, they suffer a penalty with interest of at 18% and they also shall pay the provider a penalty equal to 1% of the claim per day. So we built in incentives and carrots and sticks for the health plans to pay promptly. Pharmacy claims have to pay within 14 days if it's a claim claim or they can deny it and

then appended claim shall be paid within 14 days of receipt of the additional payments, because we did finalize the payments. So what's really exciting is that a lot of tier threes representing a lot of practices, and a lot of members did receive glide path payments, and that means they completed contracting and they completed data integration testing. So it's very exciting. Remember, it was a three month payment, so April, May, and June. And by the end of June, we had paid. And these are these are discrete rates per month. So in April, we paid over 1000 providers and maybe close to 1200 providers. And in June, we paid a little more than 1200 providers. That represents about 75% of enrolled tier three at the state. We tracked to about 1650 threes at this date right now. In total payments across the three months, we paid $31.8 million in glide path payments, again, that represents 75% of the tier three is currently enrolled at this state. And that represents 80% of members to 80% of the members in managed care are enrolled in these tier threes who have demonstrated there, they're ready by contracting and completed data integration testing. And this funding we're very excited about this funding because we hope it is being used to build the infrastructure, hire staff, trained staff, get all the data ready and prepared. So AMH tier threes are ready to go. On July 1, we're ready to go right on day one. Hate to say though, that means that there are a group of about 400 tier threes who have not attested. And so we are working with the health plans to look into those 400 providers to find out if they really are going to be ready on July one and if not, that's okay. But they are better served in it maybe a tier two until they're really ready to be a tier three. So please know we are working to understand what's happening with the other 400 ish providers. Because we don't want anyone going live who's not fully ready to go live on July. Next slide.

And just a super quick update on our healthy opportunities screening assessment and referral. This was the last month to provide the HOSAR service and get paid for it. In Medicaid direct. Again we are collecting data and getting lots of feedback from folks on how the code is working and not working have been working with have plans to analyze ways to potentially continue to have a service like this in the future where it would best live, What's the benefit of it? And we're certainly looking at the data that we're getting so far. So again, as providers are rebilling the service for close to 3000 claims now we're very anxious to see any we end up with and this match shows them jority of where we are seeing claims build. The orange part of the circle is the paid claims. So those are getting bigger. The orange part are getting bigger and circles show us how many screens are being done. So we have some really interesting pockets where the majority of screens are being done. And again, vast majority of positivie screens, sort of emphasize that positive screenshots coming back with food and housing as the prime Primary places where people are screening positive for having unmet resource needs in those domains. So thank you again for doing screenings and for giving us feedback on how the code is and isn't working with the way that you normally do your office work flows. And I will turn this over to someone else.

Dr. Shannon Dowler

All right, we've got a few minutes left um for some of the questions that are in the chat team has been answering things as we've gone along. Probably half the questions I've got answered in the conversation but if folks wanted to turn on their cameras stand ready to answer questions. That would be great. Hugh, you want to pick a few?

Hugh Tilson

Happy to, there was one quick one that says can you share the payment claims link again, quickly or at the end so Nevin, if you can find that payment claims link again, that might be helpful as we run through some of the questions so, Where's the service authorization request that was mentioned as needing to be submitted for transition back to medicaid direct. ... to request transcript back for but not the service request form. So where's that? Where can they find that?

Trish Farnham

if you go to NCMedicaidplans.gov there is a link to the form from the FAQ. But we can post that link in If we we need to, I can't get any further down the that chain that's what I remember.

Hugh Tilson

How about this one. Thank you for these very detailed plans but they all assume the phps do what DMA is told them to. What happens when the phps do the wrong thing, ie they don't honor the prior approval, don't transition correctly there are fees paid claims when we were at a network by July 10.

Dr. Shannon Dowler

Yeah, so they're gonna be a couple of ways that providers are going to be able to waive the flat. The first thing is to work with the PHP, I don't think and you know, call me Pollyanna, but I really don't think He was going into this with an intention of making it difficult. So I think reach out to the PHP and try to get it right. If that doesn't work, we have the provider ombudsman and they are They're for these exact sort of issues. The other piece is making sure your specialty societies are aware of the issues you're having and particularly if you're having repeated issues we want to catch the glitches really early on we'd actually like to catch them before they even get raised up for us because we see ... things and claims, but but just in case if you find tou're seeing patterns, use your provider Association help advocate for you and help make sure the department knows so we can make fixes if they're global issues, but Melanie, do you have any thing else that you would offer go with PHP data provider ombudsman and then use your partner associations to help raise the flag. Absolutely.

Hugh Tilson

About this one, then Trillium has provided unmanaged care during COVID for Medicaid services. My concern is peer support. We need to submit an authorization request to the PHPs can we submit prior to 7/1 service definition says there are six unmanaged hours for peer support, can we utilize this?

Unknown Speaker

So I'm going to tag team with Goda on this one, but I'll kick it off because it raises a really important point. The question that was asked in the middle of those questions is the one I want to address. First is should you submit a prior authorization to the plan prior to July 1, the answer is absolutely no. The health plans are not in place. decision to ingest those prior authorization requests prior to July 1, it's important to know the prior authorizations like we've mentioned will by and large transfer from the different Medicaid direct you and vendors to the health plan, so it's important to recognize that open prior authorizations will transfer. I wanted to say one other point on this specific question because it's come up in a couple of Behavioral Health circumstances and I want to lean on Goda to help clarify. We have confirmed that COVID base prior authorizations and COVID based flexibilities that the department has established will transfer but LME MCOs specific authorizations or COVID flexibilities will not, so I just wanted to make sure to clarify that.

Hugh Tilson

Great. Got this comment that I just want to raise up so many thanks, team DHB for all these chats. So thank you. And AHEC especially Nevin. So I wanted to call out my colleague Nevin for the great job that he did. So we're just about out of time but there was one question that I thought might be kind of a nice way to kind of close out tonight which is, What do y'all most excited about and what are you almost nervous about? So And then we only have like a minute or two left but Shannon, like to me that's a great kind of tee up for what what, what keeps you up at night because you're excited you're because you're nervous about it.

Dr. Shannon Dowler

So I think that I'll start with the worry and I think one of the things worth counting is known for is how many providers pick Medicaid beneficiaries, no questions asked. And that's a really weren't part of the state and so my worry is that this becomes more difficult and providers will choose not to. I really truly hope that that doesn't happen. And the thing I'm excited about honestly has changed. Over time his beneficiary choice in North Carolina Medicaid, beneficiaries have not really had any choice in the matter and this is the first time where we're really creating choice for them and I think it's really important and and something that we should probably celebrate also the value added services there's some pretty cool value added services and the ability to do the Healthy opportunities, also many things. All right, Melanie why don't you hit a what's your worrying? What's your excitement?

Melanie Bush

My worry is probably this same as Trish's just making sure that the transition of care happens smoothly and then that everyone who receives the services that they need. I am excited about the opportunity to do the healthy opportunities, I'm excited about our ability Kelly and her team have developed an amazing quality shop. We we'll be able to measure the health outcomes and we can truly see what these health plans are bringing to the table in terms of quality and value and improved health outcomes. So those are those are tools that we haven't necessarily had in house and so I'm excited about that.

Dr. Shannon Dowler

Kelly, you want to hit it real fast?

Kelly Crosbie

Yeah, I'm probably worried about the same thing that other folks are on to make sure that we keep all the wonderful providers in our network. We have wonderful provider I just want to keep them on. I want to make sure that our beneficiaries have the smoothest transition they can um really excited about, it's not the AMH model itself so much as the idea that now we have a bunch of smaller kind of clinically integrated networks that have whole kinds of data and they have care management infrastructure, and so it just feel like we're going to be able to bring hopefully much more whole person care Management care coordination is data informed to our communities and that's very exciting.

Dr. Shannon Dowler

Thanks Hugh, for whoever asked that question thanks for asking that question and for giving a couple of us the chance to answer it and I notice we are over time. I do want To say that we got more questions in the q&a. We will answer all of them per usual and we will make sure that the slides are available with the questions and answers the what if questions and their answers will be available to you as well. Sounds great. Thanks. I will see you in a couple weeks. The next session, the third Thursday is with the PHP CMOS and we're going to be talking about utilization management and payment in a lot of detail. So I think you're going to find that to be a very valuable session. So um, thanks to the team for pulling together all this information tonight and thanks all of you out there for joining us. Have a great evening, everybody.