Transcript for Virtual Office Hours for Providers

August 26, 2021

4:00 – 5:00 p.m.

Presenters:

Trish Farnham

Chris Weathington

Chris Weathington

It's four o'clock. Let's get started. Thank you for participating in today's virtual office hour session with North Carolina Medicaid. Today's topic is supporting members transitioning to Medicaid direct North Carolina Medicaid in North Carolina AHEC of partner to ensure that health care providers across all 100 North Carolina counties have the information and support they need to adapt to and thrive under Medicaid managed care. This collaboration produces educational program and AHEC Practice Support coaches to provide one to one assistance directly to practices. I'm Chris Weathington and I will moderate today's session. Before I turn it over to the panelists Let me run through some logistics, everyone other than our presenters, is muted and the chat function is turned off, you can ask questions or make comments by using the q&a feature on the black bar at the bottom of your screen, we've learned in past sessions that the presenters will often address your questions during their presentations, I encourage you to wait until the presenters are through with their brief presentations before submitting a question, if we have questions that are not related to today's topic. These will still be accepted but forwarded to the correct internal area at North Carolina Medicaid, but will not be addressed during today's session. We will record this session, and we'll add that recording, along with these slides onto our NC AHEC Medicaid Managed Care website no later than tomorrow. We will also post the answers to your questions on our website as soon as possible. Now, I will introduce today's presenter. We have Trish Farnham, who is the Senior Health Policy Analyst at the North Carolina Department of Health and Human Services, Trish, I will now turn it over to you and your team.

Trish Farnham

Thank you Chris, and hello everyone. My name is Trish Farnham and I am with the North Carolina Medicaid program, and I have the humble privilege of helping coordinate some of our dynamics related to transition of care, and so I have had the honor of presenting on Dr Dowler's back porch chat, and you may have heard about the transition of care protections that we have established as part of Medicaid transformation in earlier presentations. Today, I am very humbled to be joined by such a number of really, really talented colleagues who are also listening in to potentially weigh in on questions you may have or to assist in the presentation. And our focus today is on a dimension of transformation that frankly doesn't get as much airtime as, obviously, the launch of the standard plans did. And today we are

really focusing on what happens when a member who is in a standard plan disenrolls from the standard plan and returns to Medicaid direct for a number of reasons. So Nevin you can go to the next slide.

As you all may have seen this slide before we just say think it's really important to establish what our vision is for transition of care as it serves as the foundation for all of the transition of care architecture that we as a state have established through the Medicaid transformation endeavor. And our vision is that as beneficiaries move between delivery systems, the department intends to maintain continuity of care for each beneficiary and minimize the prover the burden on providers during the transition. So as you all can appreciate the lodge of managed care was an enormous endeavor and at times of very, very complex one. And we have really worked to maintain this vision as our Northstar. So as we implement safeguards and architecture that works towards these goals. We certainly want to, hopefully, the things that we're talking about today also reflect this vision. Next slide.

So in North Carolina, we have a very, I think state specific brand of managed care and some of the dynamics that we have to think about as we have built this service delivery model. And as you can appreciate now that we are officially live and the standard plans have launched on July 1 We have members who made a mass transition on July 1 which we typically referred to as crossover, and we're now into the stage of what is typically referred to as our ongoing transition of care dynamics. And through these from July 1 forward members can transition between health plans, as you can appreciate and as they are actively doing right now. And because of various legislative carve outs and exclusions. We also have members who will be, Who will reach status that will exclude them from continued managed care enrollment. And so it's that population that we're focused on today, again, are those beneficiaries who started out in managed care and may potentially be in a state of plan right now, but at some point, hit a status, a status and eligibility status that requires them to disenroll from the managed care program, and return to what we call Medicaid direct. Next slide.

So we have three areas that we're hoping to focus on today in this time we have together. The first one is to very at a very high level briefly confirm the key populations who will disenroll from a standard plan back to Medicaid direct, just so that everybody has a very basic foundational understanding of the populations, we're talking about. The second thing we want to talk about are some of the short term and long term approaches that we are taking as a state, toward managing the prior authorizations for these dis enrolling members, as you all can appreciate prior authorizations are the backbone of service continuity, and we want to do everything we can to ensure that there is other safeguards in place to ensure members retained services that may have started through the managed care organization. Importantly, as we'll talk about here in a minute, as you all can appreciate we are having to pivot and make some accommodations for some other flexibilities that exist right now, and we'll talk about some of those short term accommodations we've had to make to our vision in order to honor some of the other flexibilities that are within our state.

And finally, because we know that the dynamic of members dis enrolling back to the LME NCOs, because of what are called tailored plan eligible status is a very very hot topic right now, we want to make sure to provide you all some updated information about the request to move process which you may have heard of at this point. So those are our three key topic areas for today. and you can go to the next slide. So just to level set on when we talk about members who are disenrolled from a standard plan into Medicaid direct we want to highlight some of the key populations, we're talking about importantly the list on your screen is not comprehensive, it's not exhaustive. There are additional eligibility categories that also fall into this population. And those fuller list is provided in your reference materials, but we do want to make sure you're aware of some of the really high level key groups. First of all, as you probably appreciate when a member who is Medicaid only hits dual status because of Medicare eligibility that member will disenroll from the standard plan and return to Medicaid direct. This is exactly the same dynamic that will occur if a member is enrolled in a waiver service, so like the cap da program or the cap C program, or in pace, any of those long term services and support programs, if a member enrolls in one of those programs that enrollment will activate a disenrollment from the standard plan back to Medicaid direct. Similarly for children who enroll in foster care, beneficiaries who have extended nursing facility stays and beneficiaries who require a service that's only available in our LME MCOs, and those folks are often referred to as tailored plan eligible folks. Like I mentioned before, this list is not exhaustive. And so we encourage you to take a look at some of the reference materials we've provided for additional populations that are impacted by this. And finally, as you can, as you can appreciate, there's always fine print, and we did want to acknowledge that there will be circumstances when a beneficiary is new status renders the current pa route because perhaps they become Medicare eligible and Medicaid is no longer the primary payer, so it's important that you have an appreciation for how prior authorizations are managed. Even if Medicaid is not the primary payer, so we just want to make sure we we give that caveat as we move forward with the rest of the presentation.

Next slide. So, like I said, the prior authorization process is really one of the backbones of ensuring service continuity, and over the next several slides, we're going to talk both about our long range direction, and our long range, architecture, and also some of the short term accommodations that we have had to make to the process, and then to talk about some of the short term flexibilities we are allowing because of those design tweaks we've had to make in the interim. Next slide. So this slide essentially summarizes what we'll be talking about over the next several slides. And like I've said before, again, prior authorizations are a key component of insurance service continuity, and it may be helpful to start by looking at the long range design, the design that is currently in place, is that unless the prior authorization is expressly excluded from transferring Medicaid prior authorizations that are authorized by the standard plan will transfer back to the Medicaid direct program for those dis enrolling beneficiaries. So it's really important to know that that is, again, advancing our goal of ensuring service continuity and also minimizing provider burden. We've communicated this in detail in a series of bulletins and the link for the primary bulletin is provided here. So some of the Long Range design discussion that we will have today has been outlined in this bulletin and we encourage people to go take a look at it at it if you haven't already.

As you can appreciate every day. After launch has been an exciting adventure, and as we appreciate new dynamics and unforeseen dynamics or dynamics that have had to pivot, because of additional information. We have established a short term we've identified a short term need related to prior authorization transfer, and we'll talk about this in more detail. But essentially, it's important to know that for covering services that require a PA with effective date on or after the beneficiary's transition date, a provider may need to resubmit a PA, if it did not otherwise transfer from the health plan, and we'll talk a little bit about some of the dynamics about why that may happen, but we really want to make sure people are very clear that it is possible that here in the first few months of managed care launch a provider may need to resubmit a prior authorization request for a member who has disenrolled from a standard plan option back to Medicaid direct in order to accommodate what we know is an extra step on the providers part, we have established, additional short term flexibilities to assist providers through this time limited, short term requirement. And we'll talk more about those here in just a minute. Next slide.

So now that we've kind of given you an overview of both the long term flexibilities, but also the need for some short term workarounds, we're going to talk about those short term needs, and some of the short term processes that we have established. Next slide. So you may be asking, So why the heck would a provider need to submit a prior authorization for a transitioning member back to Medicaid direct when you're saying that that long term architecture is in place. It's important to understand that in order to really accommodate providers and to make the process as smooth as possible health plans often provided additional flexibilities to their provider networks for members who are digit who are enrolling in a standard plan on July 1. And as providers you are probably familiar with some of these flexibilities in that a prior authorization may have been waived for a certain period of time, or an authorization may not be required for a certain period of time. And due to those time limited pa flexibilities that have been established to support providers who have transitioned into the standard plan. There are going to be potentially circumstances where a beneficiary Standard Plan waives these prior authorizations. And as a result, there may not be a prior authorization to come back to Medicaid direct if that member dis enrolls back to Medicaid direct. And so we want to make sure everybody's very clear that it is very possible that if a member is enrolled in a health plan where pa requirement has been temporarily waived, that it's possible that if that member dis enrolls back to Medicaid direct during these time limited flexibilities, they may not have a prior authorization that comes with them, and that is what necessitates the possibility of a resubmission of a prior authorization.

Next slide. So, again, in our effort to try to accommodate this this flexibility the Standard Plan flexibility we have established these additional flexibilities for providers who may have to resubmit a prior authorization, if their member disenrolls back to Medicaid direct and leveraging state federal flexibilities, we have established an allowance that will enable clinical coverage policies that do not currently allow for retro review. To do so for beneficiaries dis enrolling back to Medicaid direct. So let me say that again, if a member requires a PA. Once the member is disenrolled back to Medicaid direct, there will be a retro review flexibility allowed that enables providers to submit that pa request, even if the clinical coverage policy does not currently allow retroactive review. So to move to the second bullet, the Medicaid direct staff, and you have vendors are now authorized to retro actively review

authorization requests, the provider submits up to the last day of the month following the month of the beneficiaries transition date for dates of service, in which the beneficiary is enrolled in Medicaid direct. Now there was a lot of twists and turns in that statement and we're going to go through a scenario here in just a minute that will better illustrate this point.

Importantly, this flexibility right now only applies to beneficiaries who have recently transitioned to Medicaid direct. So again we're looking for members who have been in the standard plan but have to disenroll back to Medicaid direct because they've hit one of those eligibility groups that we talked about at the beginning of the presentation. Importantly, you and vendors and State team could only review for dates of service when the beneficiary is covered by Medicaid direct, so we're not necessarily going back and retro making retro authorizations or reviews of dates that the member was still covered by the standard plan. This is only covering dates of service, where the member is now back in Medicaid direct. And this flexibility while we anticipate it might be time limited. At this point it will remain in place until we communicate otherwise. And when we do communicate otherwise, if we communicate, otherwise we will do so with 30 days advance notice. I should have put this in the bullets but this will be formalized in an upcoming special bulletin but we just wanted to make sure that you all had the information as quickly as possible. Next slide.

So like I mentioned here is a timeline and a scenario that may help illustrate what we're talking about here. So, let's say, on July 1 2021 a beneficiary transitions to the standard plan as 1.6 million of them did, and the standard plan has established a PA flexibility that supports members and providers at crossover. On September 1 2021 This beneficiary hits one of those excluded Category status and transitions back to Medicaid direct. As a reminder, most disenrollment now though not all most disenrollments will occur on the first of the upcoming month once that evidence is in effect. Due to PHP flexibility, there's no PA for the needed service, and that be paid, there's no pa that has transfer for the service that that beneficiary needs. And let's say that the provider doesn't realize that the beneficiary has transitioned to Medicaid direct and doesn't realize that he or she needs to resubmit the prior authorization for service for services for dates of service while the beneficiaries in Medicaid direct and does so, on September 15. So let's say on September 15 The provider realizes, oh my goodness this number disenrolled back to Medicaid direct effective September 1, I need to submit an authorization. The provider may submit that pa request with an effective date back to September 1 if it's otherwise appropriate to do so, meaning that the service was provided or it's otherwise appropriate that the authorization request be submitted. And technically, under the allowance that we've provided the provider would be authorized to submit that for retro review up through October 2021. So again, this is to help providers, as they underprint understand both managed care and appreciate the dynamics of members who will disenroll back to Medicaid direct, and to provide some flexibility and frankly some breathing room to ensure that services can be authorized and maintained without any disruption to the member or the provider.

Next slide. We're now going to outline the our long range design, which again is technically in effect, and we want to reiterate what we have communicated in earlier bulletins to make sure that you can

appreciate what is the ultimate goal of our transition of care prior authorization, data transfer, design, just as a preview after we go through this, we're going to give you a couple of really important tips and our colleagues from NC tracks have joined us, and we're going to talk about how providers can really appreciate and anticipate when a member is going to disenroll so we'll talk about that after this long range Design Overview. Next slide. So again, let's have a different scenario where we talk about a member who has transitioned to a standard plan. And let's say, in the member is in the standard plan on in November 2021 and let's say that member has a current authorization that is slated to transfer back to Medicaid direct with an end date of January 5 2022. Currently, excuse me, standard plans, transfer, open prior authorizations back to Medicaid direct at the end of the month prior to their disenrollment. So on November 30 having received notice on an eligibility file that the beneficiary is about to disenrolled the Standard Plan sends the open prior authorization back to nctracks. And on December 1 the members dis enrollment date in this scenario, the beneficiary's new status results in disenrollment from the standard plan, and return to met and she returns to Medicaid direct, the Standard Plan PA is now available for the beneficiary, and the provider through nctracks. Through no resubmission requirements that prior authorization that was initially authorized by the standard plan continues, and is available to providers. Once that member disenrolls back to Medicaid direct, if the beneficiary requires services that extend beyond the initial authorization timespan, the provider would then resubmit an authorization request to the Medicaid direct appropriate vendor. Next slide.

Like, there we go. Thanks. So this next slide is probably the busiest slide in the whole deck and it's an important one. We want to make sure people are really clear on what prior authorizations, under this long term design will transfer back to nctracks, and there are a few exceptions, of ones that will not, or that have additional requirements related to the process. So, and again on the call is a wonderful representation of our colleagues within the Medicaid program, who manage these programs directly. And this entire effort has been an incredibly intensive and and collaborative effort to make sure that wherever possible we support providers in making sure that those prior authorizations transfer back to nctracks at the top of the screen, you have a table of those prior authorizations, which will transfer back to nctracks, or if the, if the prior authorization is managed by the LME MCO, the behavioral health prior authorization managed by the lnbf CEO, this similar architecture exists for those PAs to transfer back to the LMC Oh, assuming they are not otherwise covered by 42 CFR part Two. So if you are providing a service to any of the any of those services that are listed in the yes table, those, those prior authorizations will this transition back to Medicaid direct, in most cases, we do want to make sure that you are aware of a couple of exemptions from that. And that's reflected in the no table. So if you're providing a service that is outlined in the no table. Those are required to be resubmitted, and I believe it's, it's a eyeglasses, which are carved out. So, if you are if you are providing a service that's in the no table. It is, it is important to know that a prior authorization will need to be resubmitted.

We also want to make sure that there's a note that there are, there's a particular set of expectations for PCS services and we encourage you to review the bulletin which was published on July 17. Next slide. So we wanted to highlight a few special scenarios and again these are pulled largely from that special bulletin that I mentioned earlier. So, we're going to outline a few scenarios, again related to our long range design. If a standard plan transfers an authorization for a service that does not require a prior

authorization in NC Medicaid direct what happens as you all can appreciate, there are there are services. With that the PA, that the standard plans may require prior authorization for that Medicaid direct does not require prior authorization for examples include radiology as of July 1 and transplants. In this scenario, the transferred Health Standard Plan generated pa will be irrelevant and not required in order for applicable claims to pay the provider will not be required to submit an authorization. In the second scenario, if a standard plan has authorized the service for more units than allowed under applicable clinical coverage policy, as you all could appreciate PHPs have additional flexibilities for authorizing units and services at higher limit that is available in the clinical coverage policies. It's important to know that in those cases, the nctracks claims that it will only allow payment up to the limit, under the applicable clinical coverage policy when that member disenroll is back to Medicaid direct. And finally, if a standard plan transfers a prior authorization for a service that's not covered by Medicaid direct, we know that that in some cases that may happen. It's important to understand that when the member transfers back to Medicaid direct, they are entering a different service delivery model with a different set of allowable services, and a beneficiary will not receive the service in Medicaid direct unless the non covered service has been approved for beneficiary under EPSDT or under the Home Health final rule. So it's really important to know that there may be services that the plan offers that will not be available if that member does enrolls back to Medicaid direct. We do expect this to be a fairly exceptional situation as as the plans are largely adhering to our current clinical coverage policy benefits. Next slide.

So, I'm about to hand over the mic to my colleague and our colleague at nctracks Audra Troy, and we want to make sure that we as before we get into the details of these particular screenshots that we want to establish and reinforce the importance of good habits when supporting prior authorization submissions for members. It is always and this is old news we know this is old news, but we want to make sure to reinforce it. First of all, as you all well though. It's always important to check the beneficiary's current eligibility and managed care status before submitting a PA, the member may have disenrolled the member may have changed plans. It's important to know what the Members Current status is, before submitting a prior authorization, and we're going to talk about what, how to identify this in the provider portal in an upcoming screenshot. The second detail that we want to really underscore that is more route that is now relevant and more relevant. Since managed care launch is the importance of checking tracks to confirm if the PA is already available. So if you know that a member has disenrolled back to Medicaid direct, it's important to add as a matter of course to confirm whether the PA is already available, it may already be waiting for that member and for you as a provider and a prior authorization, another pa submission will be both unnecessary and just cause additional work. So at this point we're going to go through some screenshots of how to how to exercise, each of these good habits and I'm going to ask Nevin to change to the next slide and I'm going to hand the mic over to my colleague and our colleague Audra Troy.

Audra Troy

Thanks Trish. Um, so probably many of you are, if not all of you who currently have recipients enrolled in Medicaid or submit PPAs are familiar with the functionality to check the recipients current eligibility, or for future or previous months, through the nctracks Provider Portal. What the, what's being displayed in the slide is a screenshot of a single month and I know I provided these screenshots but it's I don't have a

big enough on my screen to see yet so this is looks like it is for the recipients. A recipient who has eligibility for the month of June in fee for service. So just so I can orient orient myself there to first check this if you're not familiar, in the Provider Portal under the eligibility tab, which is the first one in the multiple tabs that a user may have you'd select the inquiry option. Then on that page, you would enter the recipient ID, or if you don't have the ID you can do you can do name, you can do, date of birth, you can do social security number, and then you would enter the date range. But you know range of dates for the eligibility that you'd like to check the eligibility that then is returned, is the month covered by the first enter date, through the next month for the end date. So if doing a search for dates of service say June 1 through today, August, the 26th, the eligibility that will be returned will cover the month of June, July and August for the dates that were entered, plus the next month, which would be September. So in doing an inquiry and then seeing the results, what we've got in the slide currently is for a recipient who is enrolled in fee for service for the month of June. So you can see that that period selection has the month display. And then in the. The second section that is highlighted in the red box shows that, that for Medicaid for that recipient, they are enrolled in Medicaid FFS or fee for service, their benefit plan or category of eligibility, the months that it's associated with. And then it has the recipients county code below that which is collapsed because it's a large chunk of the stream, are the different service types that the recipient is eligible for under their category of eligibility, as well as if there is a copay. So that's in that next section service types and copay, but we have a collapse for in the screenshot. And then there are you know continues to list if under Medicaid, there are any other programs that the recipient is enrolled in for this recipient, they're also in a behavioral health services program, which also then lists the services, the service types and copay. And what then is lastly not screen shown is the last part, it also has for that recipient who they're associated are enrolled PCP primary care provider is.

So what is not shown in the screenshot that is, if for the eligibility that you're checking if the recipient is role is enrolled in managed care, the difference will be that under the Medicaid section. The benefit plan will state Medicaid managed care Standard Plan. It might also say, Medicaid managed care carve out plan. It will then list under managing entity, the column which is directly to the right of that red block under the Medicaid eligibility, it will list the name of the managed care entity, like a Blue Cross Blue Shield of North Carolina, or AmeriHealth are united, whichever of the five plans that the recipient is enrolled in for managed care, and then it will also list for that managed care entity, phone numbers under the daytime phone so if you go over a few more columns, it will list the numbers for the managed care group. Again it will have even under for for recipients enrolled in managed care. If what services are available and the copays, and then you know the same information available, as if, or if they that you would see when they were enrolled for fee for service. And then you would just be able to go through the drop down of the dates they're listed in period selection based off of the date range that was selected for the eligibility search and you can go through each month of the return results to see the details of the recipients eligibility. Trish, anything else I can maybe cover on that topic based off of the screenshots.

Trish Farnham

No, thank you, Audrey, I will give us a kind of an advertisement that our intention is to do a separate tour recorded tour of these screens in using, using an actual screen tour of the of the of the logic. So if

you would like additional information, just be sure to stay tuned for additional additional recordings on this but Audra thanks so much, I think you'd go to the next slide.

Audra Troy

So the second piece of kind of housekeeping and due diligence that Trish mentioned beyond checking the recipients eligibility is then checking to see, is there a PA for the recipient for the services in NC tracks, and whether that is a PA that has been submitted by the provider or one that has been sent to NC tracks from the PHP, when the recipient transitioned from managed care back to fee for fee for service. So in the provider portal there under, under the Prior Approval tab, there's the PA entry, I'm sorry pa inquiry option, and that is what this screenshot is of it's just the initial page, and this allows the provider to search for PAs for recipients that, that that provider is associated with. You can search. If you have the prior approval number or the confirmation number that's all you need to enter one of those and you'll get a single pa record returned if there's a match. You can also search for recipient ID and get all PAs for that recipient. There's some other play with some of the different search criteria like dates or if it's for DHB or DPH and specific procedure code if you're looking to narrow it down, but based off of the entered search criteria under the approval request list all the, all the PA records that match the criteria will be returned to get results through the PA inquiry. The NPI, or a typical ID that's selected in the top base information for the user. Only PAs that have that only pa records that have that provider ID as the requesting billing or rendering provider on the record will be returned so it may be that you are rendering services for recipient Jane Doe. And she's getting services from a different couple different providers.

Audra Troy

If you search for that recipient. Only the PAs, in which the NPI that's selected as part of the base information, and the inquiry will be returned. If that at that provider ID is exists on the PA record. And then so we'll list all, you can select the confirmation number the blue link and it will take you to the details of that record. Now, in NC tracks providers can search for and view pa records regardless of how they got into NC track so records, sent to NC tracks from the PHPs will be available and return in the inquirer inquire results, same as if PAs are done from one of the states us vendors such as CCME for specialized therapies. Those are all available and can be accessed and results viewed through the PA inquiry. There is no identifying information on the record that indicates how it got to NC track so a PA that originated in NC track submitted by the provider directly to NC tracks, compared to a PA that cut into NC tracks because it was received from the PHP on that record when you view it, there is no indicator, or you know no difference between those two. So, but that is how you can then view and confirm if you know that one of your beneficiaries has transitioned from managed care to fee for service that the PA is have transferred over and are available. You will then be able to see those as you know before you maybe bill or decide that, oh I need to submit or maybe beneficial to submit a new PA to nctracks after the recipient has transitioned. Trish anything else I can add or elaborate on that topic?

Trish Farnham

No thank you order this was really great and again we'll, we'll flesh this out with additional recordings soon so thank you all so much. Thank you. You're welcome. All right. So, we are now going to pivot to the last segment of this presentation. And this is moving away from the concept of the discussion of prior authorizations, but is still aligned with our transition of care principles of service continuity and supporting folks through these dis enrollments. We wanted to make sure that we use this opportunity to talk about a concept that is becoming increasingly known, certainly in our behavioral health communities called the request to move process, and we wanted to provide a bit of a refresher overview and some minor updates. And so, I'm going to kick us off and then invite our wonderful behavioral health colleagues who are on the line to supplement, or add anything, or correct anything that I say so. You can go to the next slide. So, just and you've probably seen some of these slides before, but just to again kind of ground ourselves and what we're even talking about. We know that there are going to be scenarios where a member who has enrolled in the standard plan requires behavioral health or IDD services that are not covered under the standard plans benefit. And that those services are only available through our LME MCOs. Our member ops team and our behind behavioral health team have worked really hard over the last many years to establish a process that was expeditious in supporting people to get where they needed to be in order to receive the services they needed. And from that process is where the whole concept of the request to move process was formed. And so, if after July 1 which is clearly where we now are a member needs a behavioral health service that is not covered by the standard plan, there is a process again called the request to move process where providers, and beneficiaries themselves can activate a request that assist them to potentially transition to the ellaby to and disenroll back to Medicaid direct. We're gonna go through the two different types of processes here over the next few slides. Next slide.

So, again, for folks who are in the know. This is probably a refresher, but for those folks who may not be familiar with it. We wanted to make sure people were aware of the different channels that a beneficiary could be identified as requesting to move back to the LME MCO because of needing a service that was only available in the LME MCO. And the process comes down to two different types of requests. We have one category of requests that is called service associated. And we have another category called nonservice associated, and the service associated request is the when a provider submits a request to move form with the service authorization, a PA request, and the supporting documentation needed to identify the specific service that a member really requires and necessitates transitioning back to the elements, yo, in order to receive. So for these service associated requests. These are typically are these will be submitted by the provider who intends or is anticipated to provide the service after the anticipated disenrollment. All of these requests have to be submitted with the beneficiary's permission. And with the beneficiary signed consent. Upon submitting a service associated request, the beneficiary will disenroll back to the medic from the standard plan back to Medicaid direct, and that disenrollment date will be retroactively applied back to the date of the request. So in some cases, it may be in the middle of the month,

Just to round out the process, it's important to know that those service authors are the service authorizations the service authorizations and the supporting documentation that are accompanying the request are reviewed by the LME MCO, in which that member will transfer to which that member will

transfer. The second process is the nonservice associate request, and this can be submitted directly by our provider or directly submitted by a beneficiary. And then there's non service associated requests the submitting provider, submitting doesn't have to be the provider who will provide the ongoing service, it may be, for example a hospital staff, who has identified that this member has a behavioral health need and wants to activate the process of examining this members potential disenrollment from the standard plan, and returning back to Medicaid direct a non service associated request does not include a service authorization request, and again can be either submitted directly by the beneficiary or by the provider with the members consent, non service associated requests are reviewed on a more extended timeframe, and if approved, take effect the first of the following month. Next slide.

We know it's really important for people to know where to get these forms and how to submit these requests, and the enrollment brokers website manages the serves as the front door for the request to move process and the related forms, and the links for providing the ID for accessing these forms are or the online option, online submission options are available here. Go to or anybody else want to say anything about the last two slides in case I missed something or you would like to clarify anything.

Kenneth

I think, and then I'll just go depth so this is Kenneth of so one thing just to kind of recap what Trish was saying is that the service associated requests that the provider bills out that, that request is an actual request for services that they intend to provide so that goes through that prior authorization process, even though the providers submitting that form they still need to have the beneficiary signature and consent. And then for the nonservice associated requests for those individuals who believe that they need to be in the LME MCO and Medicaid direct but do not have a provider who is going to start providing services right away. And it's really based on their eligibility criteria where their needs. If the provider submits that form the beneficiary has to sign it and consent to that as well. Both of the forms are actually the same form, so both of the processes are actually the same form. One is just completed by the provider, and they attach either a service authorization request or treatment authorization request, and then do you want to add anything additional.

Deb Goda

No, I think you've covered what I was going to cover I just don't, I would just encourage providers to, if you have a beneficiary who has submitted a form or view it's a tentative form and you receive a call, and they're looking for additional information, please get back to them. If they can't get the additional information, Then, they won't be able to approve the request.

Trish Farnham

Thanks fine colleagues. There's one more slide on this particular topic that we'll go through and again invite, go to ... to weigh in. But as you all can appreciate this process is now live, and there have been

important factors are important considerations that we want to reiterate here. Based on the information and the process to date. Importantly, the request to move process is only available and appropriate to support beneficiaries who require services provided by the LME MCO. It is not a vehicle for a member to return to Medicaid direct, if that member is not otherwise tailor plan eligible. So it's not simply a request that anyone who's in the standard plan can use to return to Medicaid direct, it has to be clinically appropriate for that member to disenroll from the plan, because of their behavioral health or IDD support needs. Importantly, the provider submitting a service associated request to move form should provide the necessary service authorization request and supporting documentation. So it's really important to know as, as, as has been alluded to that if the proper information is not received it is not it's going to slow the process down of either authorizing the disenrollment itself, or certainly authorizing the the service that the member requires. And importantly standard plans have been are having the expectation has been set that standard plans will assist in covering the expense of assessment costs that may be incurred prior to the disenrollment and are necessary in order to fulfill the requirements of the service associated request, and the underlying service authorization request. So we just want to make sure that that's very clear and that's well known Goda and Kenneth anything you want to say before we conclude this section and turn it over to Chris.

All right, you all thank you so much, and Chris. Thank you. At this point we are finished with our presentation, we have provided quite a few slides in the reference materials part of slide deck so if you would like additional information on something that we didn't fully cover, and that is provided in the reference materials you may find that useful to review it. So thank you so much.

Chris Weathington

Thank you, Tricia, we just have a few questions before we sign off this afternoon and I enjoyed the presentation I think it was, should be very helpful for everyone involved. But a question we got in here is we have some patients that we believe are to be carved out, but are covered by the standard plans. An example would be foster children or those with IDD support needs etc. How do we help them get moved to be for service. We've been directing them to their Medicaid caseworker, but they appear to not have any concern about it.

Deb Goda

So I will. Yeah, go ahead, please. So I would wonder Is it their Medicaid caseworker that has no concern with the beneficiary has no concern. The DSS worker is not the person out to the job was trying to transition back, both forms need to go to the enrollment broker. Now, not everybody may want to transition back to Medicaid direct which is by the beneficiary or, or the legally responsible person has to sign off to consent to move back to Medicaid direct, so not everybody with IDD is going to meet the tailored plan and foster care kids, if, if they come into foster care while they're with the PHP their Medicaid will be moved back to Medicaid Direct. But if that they've chosen to be in that PHP, and don't want the LME MCO services, if they're eligible to choose a PHP they can

Chris Weathington

This was clarification from the person who put that question and it was the DSS worker

Deb Goda

The DSS worker is not the person who's doing the choice counseling, that would be Maximus the enrollment broker does the choice counseling. So that's, that's where we need to, to get the beneficiary to if they would like to. To request to change plans. Okay.

Trish Farnham

Do any of our, do any of our eligibility colleagues want to provide any additional detail for the foster foster care scenario.

Sandy

Hey Trish, this is Sandy. So for the foster care. The DSS worker when the DSS Medicaid worker moves that foster child as dead back to, or to foster care, that Medicaid direct is going to retro back to the month of entry into foster care. Thank you.

Trish Farnham

The other thing I would, I would encourage is that if you have members that do fall into either of these categories, your health plan should all the members health plan should also be a resource, and, and, in both cases, there are higher. These both these populations would qualify for priority care management, and it's really important that if you have members who are identified as those that you inform the plan have that to also help activate the necessary processes for supporting these members to get where they need to go.

Chris Weathington

There is another question for the members who should not have transferred, you know, we were already providing them services that were not covered under the standard plan. We are seeing gaps in coverage for their services due to the start date of the Medicaid direct coverage, once they are transferred, how can we address the issue you may have brought this up earlier but you want to reiterate, anything related to that question.

Trish Farnham

Well, I'll start and then my colleagues can jump in. We, we know of some circumstances where members transition to the standard plan, who potentially were otherwise appropriate to remain with the LME MCO, and we're working those particular scenarios, directly in our Member ops team and our behavioral health colleagues are leading the effort to work on those cases. In order to make sure that the member is is dis enrolled and returning with her to the elevated to the LME MCO. It is important to know that if, if a member was enrolled in a standard plan, and the member is a child that many of the services that are available in the LME MCO benefit plan can be provided under EPSDT under the EPSDT benefit, while the child remains in the standard plan until that child is enrolled back to Medicaid direct Kenneth, Goda, Sandra, Sandy.

Kenneth

I think you got it Trish I think it's just really important to, like you said, just to reiterate that EPSDT criteria applies to the standard plans as well and many of the services can be covered through EPSDT criteria.

Chris Weathington

Okay, we're going to try to squeeze in a few more here on our

Ronda Owen

Chris This is Rhonda Owen, and I hate to interrupt you. I'm the program manager for optical and for hearing aid for those of you who are outside of Medicaid who are attending, and quits I wanted to ask if you could just for a quick second go back to slide 14 I just need to learn a little clarification, not only to that slide but to the bulletin article that it references. So, I did not see this until the presentation so slide 14

There we go and I'll talk quickly. If you look at the bottom if you're an optical provider on this call, and you provide contact lenses or eyeglasses, contact lenses, those are approved through the health plans, the approval occurs with the health plans and if the member transitions back to Medicaid direct, You would need to resubmit the prior approval request for contact lenses. However, with glasses. They were a little unique. And I think we said during the presentation that you would have to resubmit a retroactive prior approval request, and this bulletin article the link here also says that, but that's not correct, and I take full responsibility for that, but without eyeglasses, many of you know that the fabrication and the frame and lenses were carved out. So, all of your prior approval request for every Medicaid beneficiary whether they were Medicaid direct or fief Medicaid direct or a member of a managed care company of PHP, you're still going to obtain your prior approval through nctracks so that already exist in C tracks, and if we have a Medicaid beneficiary with a health plan, who transfers back to Medicaid direct your prior approval still exists in NC trap tracks and you won't need to do anything except for Bill NC tracks, if that member is back in Medicaid direct at the time, the dispensing occurs. So

I wanted to clarify that if there are optical providers on the call so you didn't leave with misinformation and I will also address that bulletin article so when you go to that it'll have the correct guidance, too. Thank you Chris.

Chris Weathington

Yes, thank you. Was there anyone else who wanted to comment. Okay, well we it is now in five o'clock. There are just a few more questions that are in the q&a box but we will get to those for you and post the answers onto our NC AHEC webpage under the Medicaid managed care section So Trish any closing words that she would like to share.

Trish Farnham

Chris, can I just, yeah, I do want to answer one question because it implicates service continuity for members. There's a question in the chat about are we supposed to stop PCS services for our clients until we become a provider for the new managed care. So it's important to know that the state actually just extended the flexibilities that are available for out of network providers, so please do not stop services. If you are not yet contracted with the, the, the members, health plan. It is important to know that you should be engaged in discussions with them in order to maintain or to start the contracting process, but even if you are currently out of network, you will be, have you will be able to provide services to their members, and you will be able to be compensated at 100% fee for service rate for those for services that you provide to those members, so please do not stop services while you're in the contract negotiation process, you will be reimbursed at 100% rate.

Chris Weathington

And Trish has through the end of November, right. Yep. Okay. We have to go ahead and sign off now but we appreciate everybody's time, we again we will answer these questions, you can find the slide deck the audio recording and the q&a transcript on our NC AHEC Medicaid Managed Care website in the section that says virtual office hours so we thank all of you for your time and appreciate all that you're doing, especially taking care of patients during the COVID 19 pandemic. Thank you again and we look forward to seeing you all very soon.