Transcript for NC Medicaid Managed Care Hot Topics Webinar Series: Hot Topics with Health Plan Chief Medical Officers

Presenters:

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Hugh Tilson

Good evening everyone and thank you for participating in this evenings back porch chat for Medicaid providers. Look at those beautiful back porches that'll get you fired up for a great webinar. As a reminder, our webinars part of a series of informational sessions that Medicaid may have put on to support providers during the transition to Medicaid managed care with these on the first and third Thursdays we're focusing on hot and timely topics, but we got a lot of those coming your way, I'll turn it over to Dr Dowler and our fabulous panelists quickly. Let me first run through some logistics. You can adjust the slides portion of the slides. By clicking on that gray bar just to the right of the slide and dragging it to the slide. So you can see more speakers and more slide. You can also get your video setting. If people aren't speaking to do so, click on the View button on the top of your screen, and select side by side colon speaker, so you'll get the speaker. Put that those instructions in the q&a for your convenience, we hope to have plenty of time for questions at the end. Two ways to submit questions. One is using the q&a feature on the back bar in the bottom of your screen. The second is to send an email to questionscovid19webinar@gmail.com. And since everybody's muted, that's the only way you can send in a question if you're dialed in by phone, get lots of questions and just encourage you to wait till the presenters have presented. Often they will in fact dress your question during the presentation, but regardless, All questions will be sent to Medicaid, making you respond directly to you or incorporate those into our upcoming webinars. There's been technical glitches in the past we think we've resolved those but if for some reason you can't hear any of our speakers, dial into these numbers. And we'll put that into the q&a For your convenience, again, we hope you won't need that but just an abundance of caution there there. These slides are going to be on the website there's a link in the q&a so, we just posted that we'll record the webinar and add the recording and a transcript of it, and add that to the slides. Tomorrow, on the website. So enough of me talking, let me turn it over to the experts, starting with Dr Dowler

Dr. Shannon Dowler

All right, thank you. Thanks Nevin for the great intro music and always gets me fired up. Excited to be here today with everybody we've got about 400 participants on so far which is awesome. And we have a really great agenda tonight. We've got a lot of content that we're going to give you around launch and everything you need to know and then we're really gonna focus on two areas, paying claims and utilization management because we feel like these are two areas where we felt a lot of anxiety from the field, and we want you to feel better about it, and who is we, I've got the CMOS from all the plans here joining me tonight, and some of their guests from their teams partners that they work with as well as some of the amazing DHB staff to make sure that we get questions answered for you as quickly as possible and as well as possible tonight. So if you go on to the next slide. Before we jump into the managed care transition I wanted to give you a heads up about a brand new code, hot off the press, it will be live starting next week. And this is a code to help with practices who are providing COVID vaccines, or hopefully help practices decide to provide COVID vaccines in your office we recognize that the burden is big, it's a significant lift to bring the vaccine into your offices. And while we're meeting the Medicare reimbursement rate, it's really not enough it's a lot, it's a whole different documentation system, you got to keep people in the room afterwards. So it's a lot that we're asking of you so we have created a new code 99401 We didn't actually create the code, it was a code we didn't pay for before but we are going to pay for. Right now it's a time limited, we're going to see how well it works that people are using it. It has a generous reimbursement rate for doing counseling around the COVID vaccine. The nice thing about this is you're going to be able to use it more than once for a beneficiary, we understand that people sometimes need counseling three or four or five times before they're ready to get the vaccine. We want to make sure that your time that you spend on that is paid for each and every time one of the other cool things about it is that if you're seeing a child and Medicaid beneficiary and you're doing the counseling with their parent or guardian who's at the office with them, we will actually pay for that, just like we do now with the postpartum counseling, except for won't have those age restrictions for postpartum depression so we're gonna use that same model so if you're seeing a child who doesn't qualify for the vaccine but you want to do that education with the parents and especially if you're willing to give the parents that vaccine. We want you to get that extra billing service so more details to come a special thanks to Beth Dano and her team for getting this across the finish line really quickly. All right, next slide.

So I don't know about you guys but my first days on the ward. As a young medical student, I was nervous, scared to death, and the Maxwell guide was what kept me going was this little cardstock multicolored bright colored spiral bound thing that fit into my top left pocket. This was back in the day I know I'm old school when people actually carried paper around in their pockets and we'd have our pockets loaded down with books and that technology, but the maxwell guide is what kept me feeling safe as a hospital as a medical student in the hospital. And then many of you are very familiar with the Cliff's Notes and I think Nevin if you'll click once my cliff notes should come up. So if you're not a physician that cured that Maxwell guide in your pocket. Most people can relate to the cliff notes. So if you had a big test coming on a book that you hadn't read yet, you would get into the Cliff Notes. Well we are less than two weeks from launch, and some of you guys have not read the website, some of you have not actually been to all of these backwards and fireside chats and what you need tonight is a tip notes and that's what we're going to give you at the end of this session, you should be able to print out this PowerPoint, or put it on your desktop or electronically, link to it so that you have everything you

need to have at launch, and without any doubt at all so lots of content for you tonight, most of it we're not going into in detail because we've covered in prior sessions, but we want you to have it at your fingertips all in one place. Next slide.

So probably the one of the most useful things we have is the day one quick reference guide that the amazing provider team put together at Medicaid working with the plans to get you the bottom line of if you need to reach the different plans, who to reach out how to reach them. So if you go on to the next slide, these two slides are pictures of that is also available on our website as is everything I'm sharing with you tonight. If you go on to the next slide, probably a really important place that you need to have bookmarked on your browser is the provider playbook and that provider playbook, we've got all the fact sheets to answer really every question you can think of as a matter of fact, if we haven't answered it yet, as things come through our provider ombudsman we're keeping track of the questions that people are asking, and we'll create new content frequently asked questions and other things to make sure we're responding to the questions that everybody has out there in the field. Next slide.

This is another way we looked at it, we looked at how to put the content together from a few different viewpoints because we all learn a little differently. And these are specific links to some of those fact sheets. So if you're looking for really specific things we think that looking at it this way might help you maybe you want to know more about the social determinants of health supports. We, we tell you where to find those things, maybe you want to understand more about care management transitions so this is just one other view of how you can look for resources. Next slide. The two sheets that there's nothing else, I think these two are the ones that you want to have printed out and available I know That's old school printing on paper, some of y'all aren't gonna do it, but I think there's still a time for printing things out these two fact sheets are really important, it's got that those that two pager I showed you at the beginning, and then the really key things about launch that I think will make you feel much more comfortable moving forward. Again, you know, props to the provider team who put together, just an unbelievable amount of resources to make this easier. Next slide. This is the transition of care quick reference we went over this in our last back porch chat but this is around people, what's gonna happen at crossover and ongoing transitions of care. So we kept it in this deck for you so you have it all in one place. Next slide. And these are the sort of bottom line things you need to think about. Really 60 days everybody's in network for the first 60 days. So July 1 isn't actually really magical date 60 days everybody's in network. 90 days, beneficiaries have a chance to change their plan for any reason at all. Which means we got lots of time to get stuff straight. So just want you to feel reassured with those two dates the 60 and 90 days. Next slide.

I wanted to touch base real fast on patient panel lists at the practice level. So if you're an AMH tier three, and you're in a CIN your CINS got your list. Back on the fourth June 4 And they've been taking that information and understanding it breaking it down and sending it out to practices, if you're an AMH tier three and you aren't part of a CIN, then those files went directly to you on June 4. But if you're a primary care provider who's in a different tier that you can see who your beneficiaries are assigned to by looking into tracks were after July 1 We'll be able to go through the portal for the plans. We are also doing a

special report that's going to come out next week, so that you will be able to see who your beneficiaries are, who your patients were assigned to prior to launch. And then it'll be updated in the second check write each month so starting in July after launch, it will be a routine thing, and this will come to you in your inbox, through NC tracks, so that should we think by the beginning of next week, there were some when we did the assignments we found an area where there was an opportunity to make an improvement, which is actually a great testament to the oversight process and how well it's worked already so far. And so those corrections are being made or have been made already, and we want to make sure that the report we get to you in your inbox is as accurate as possible, so look for that early next week. All right, next slide. This is one of those things I'm going to tell you to print again, I would print this out and put it by the station of your nurses your front desk staff, this is really what to do for members if they have questions. The first thing we want to do is make sure they know what plan they're enrolled in and they should call their plan if they have questions, but if they can't get their questions answered, they should use our ombudsman to help them on the provider side. You want to make sure you understand how to check in tracks, who were beneficiaries enrolled with, and when you're trying to work through a problem you want to call the health plan that they're enrolled with, but if you don't get solutions and you don't get what you need, then that provider ombudsman is there for you so this is a really important one pager the half. Next slide.

We covered this at the last back porch chat but again wanted you to see it here, this is really important our contracts with the plans are pretty strict, and there's a lot of ways that they have to they have to reimburse providers if they fail to have prompt payments. So they're very motivated to follow the deadlines and not have to pay interest rates of 18%, and so they're working really hard to make sure that the texts go out the way we want them to, which takes us to the next section, which is claims so we're going to the next slide Nevin. This is my very simplistic version of how I think about what happens when you see a patient and the claims go through. I am not a finance person, and this was actually hard for me to make I'm going to acknowledge it, but it's a really basic process that you submit a claim that's either right or it's wrong, I yeah it has all the things it needs to have or it doesn't. And then it's paid or it's not. And if it's not paid you have the chance to resubmit or appeal that decision. And if it's got errors, then we give you a chance to fix the errors and resubmit the claim, that's the way we do it now. That's the way it's going to be in the future as well and what we did is the CMOS and I got together and started working through, everybody's claims process for tonight because we wanted to make sure that the field was really ready to go through this process, our processes are identical, they're really really very similar, so we did something else to try to make that break it down for you and make this feel as simple as possible, knowing that instead of one entity, You now have multiple entities that you're working with. So we're going to start with I'm going to have all of our PHP CMOS, turn on their cameras and we're going to start with some level setting definitions, because not all of you are necessarily finance geeky people, I am not one of them. We wanted to make sure that we had some common definitions that we shared with you So now even if you'll go to the next slide, I think Michael is going to kick us off.

Dr. Michael Ogden

Absolutely, so you know some of these, are very jargony sounding official sounding elements and they're, they're really very simple when it comes to their definitions, you know, the first one we've got

here is was heard as 837 file, which sounds really strange, you know, when you're submitting a claim you submit an 837, all an 837 is, is a HIPAA compliant form that allows for an electronic submission of elements that are necessary for processing a claim. I'm going off script here a little bit. There's also another one that's mentioned in some of our materials called a 227CA. And the purpose of a 227 CA it's a claims acknowledgement report that provides a claim level acknowledgement of all claims received in the front end processing system before claims are sent to the adjudication system. We'll get into some of that later. But these are just forms that are HIPAA compliant, that transfer information one way and then another transfers it the other way.

Dr. Shannon Dowler

All right, with that Genie, do you want to take us through clean and unclean claims

Dr. Eugenie Komives

Sure, yeah, we had a phone conversation, making sure that all of us understood the definition of a clean and unclean claim, but the simple part of the clean claim is it's a claim that comes in with all the information that we need in order to process the claim, without having to ask for any additional information. And so then that gets to well what's an unclean claim right so an unclean claim is incomplete. Perhaps it's missing some of the required information like the patient's name or ID or provider NPI, or it can be a claim that we have to suspend in order to get more information from the provider.

Dr. Shannon Dowler

All right, Michelle, let's talk about timeframes.

Dr. Michelle Bucknor

Timeframes, and I think I have the easy definition is a period of time during which something has taken place or will take place and you know when we talk about UM, it really is a timeframe that outlines how much time providers have to complete an action, but I think one thing that's also important you'll hear a lot of time frames presented tonight and I think Shannon you have some on the previous slide and what was notice there's a lot of consistency, and that's because those are states defined -- that we all have to be compliant with the same time. So that makes it a little easier for you to know what the expectations are for us.

Dr. Shannon Dowler

Awesome, thanks Michelle. And that's really true, the state and the contract with the PHP is really clear timeframes and they're the same across the plans. So for many of the timeframes, you'll see that they're identical. Alright, William, you want to talk about disputes.

Dr. William Lawrence Jr

Yep, good evening. A claims dispute is pretty simply stated, is the process by which a PHP handles any complaint concerning the process of a specific providers claim. So the state is actually set it so that each of our plans is required to have a process in place to receive and resolve complaints and disputes, you know of this nature, and each PHP should have a method that allows those to be submitted through their provider portals, I think you'll see on one of our next slide so list of where we all make that access available and also please do recognize the quick reference scribes in each of the power plants, put together that also is a very very good tool for some of that weight readily needed information.

Dr. Shannon Dowler

Awesome George you want to take it home with appeals.

Dr. George Cheely

Yep, glad to and so we wanted to just articulate a little bit of a distinction in the term appeal compared to what it means in the fee for service program today, and how it will change slightly in, in managed care and so today appeal refers to the process where a beneficiary can request a State Fair Hearing if they disagree with a notice of adverse benefit determination, and then Managed care there are a few more steps in kind of that general process and so appeal from a PHPs perspective really refers to the process where a member or a provider on the member of staff can dispute a clinical utilization review decision and we'll go into a little bit more detail in the UM section of the talk, to give you a better flavor for what that means.

Dr. Shannon Dowler

Awesome. Thanks George and if you go on to the next slide. So one of the things you'll find in the appendix of the slide deck is very complex drawings that each of the plans did to show what their claims processes. So for those of you that are sort of detailed, um, you want to get into the nitty gritty of it all, it is there for you. But what we didn't want to do was make everybody's eyes glaze over and have everybody look at it so it is going to be in the appendix of the slide deck and you might really like it. You might not, but meanwhile we're gonna have each plan tell you just touch base on the really important things that we put in this spreadsheet for you to have at your fingertips. So take it away.

Dr. George Cheely

Oh yeah, George Cheely I'm at AmeriHealth Caritas CMO. So I just want to share a few details behind the process Shannon described so well so we receive claims via electronic submission through a change healthcare clearing house, if your practice happens to use a different clearinghouse. We've got our payer ID here we can also accept claims by mail to our claims processing department. I think you'll see consistency that if there are errors in the form that you submitted, you'll receive notification of those errors within 18 days, and that that notification will be mailed and you can also access the status of a claim in our provider portal which for us is, is Navinet. If we wind up denying the claim we will issue a denial within 30 days of receipt of the claim. In both, both the rejection with errors and the denial, will list the reasons for, for those determinations. And so that will give you a point of reference to know what to resubmit the claim claim will wind up paying. And once you get the claim, paying, then we will wind up paying, either through electronic funds transfer and some of the enrollment information is in the hyperlink in that section on our slides, we'll also pay by paper check which would come in the mail, and so the electronic funds, or all of our payments will really begin on July 7. And then this is going to be a point of difference for for the PHP is that we will make payments every Monday and Wednesday. And those payments are required to be made within 30 days of clean claim submission. I suspect I'm joined by my colleagues and saying we will make every effort to pay much more timely than that but at least from the standpoint of being able to predict when the fund should should hit the account for your clinic that 30 day timeline is really what to look for. And then, as Dr. Lawrence mentioned about the dispute kind of definition the process to submitted a dispute. Can Happen electronically through our Provider Portal Navinet or you can mail a dispute to us as well. And our timeframe similar to others for resolving those disputes, is really we need to receive the dispute dispute within 30 days of the denial and then we will commit to resolving the dispute within 30 days of receiving the dispute, and then I'll hand it over to Dr. William Lawrence, to share some of the details for Carolina complete Health.

Dr. William Lawrence Jr

It even again. You know, I think, as Shannon has already pointed out, you know our processes are really the same. I mean it's really just the details of where things go, and how you get them back that's different, but the process, the framework of the processes are really the same. For Carolina complete Health I think we actually I think except three of those clearing houses so in addition to change healthcare. I believe we also have connections with availity and ability. I believe on the others. I do know that you know the 18 day timeline for providing written notice of errors is set by the state no requirement across our plans that actually is a little tighter than we find in some other markets, and actually shows the commitment that I think DHHS is made to try and to make sure that we have a smooth, consistent and efficient process, you know, We will also process our disputes and denials, within that 30 day period have been one of the difference in terms of what George said all of us will pay in a similar fashion, but probably pay on different timelines that they will Carolina complete health or medical claims will pay primarily on Tuesdays and Fridays, pharmacy claims I think your process online service. But other than that I think our processes and our timelines are essentially the same. So I'll pass it on the healthy blue for any additions.

Dr. Michael Ogden

Great, Michael Ogden from healthy blue. So this is, I get the follow on with, with some of what Dr. Lawrence and Dr Cheely mentioned in that the, the timelines are essentially the same The platforms are going to be a little different, we use the availity platform, which is our electronic submission platform. But we also take paper claims, as was mentioned by my colleagues, we were sent back notice of errors within 18 days. As I mentioned at the outset, the way we notify our providers electronically, is to that 277 ca process as well. For our check writing for the first six months were actually going to do a daily check right after that, we'll end up going to weekly on Wednesdays. But to start with a full six months a daily check your check rights. These can be paper checks or they can be electronic transfers, and then the claims disputes are also easily dealt with through our availity portal, and same with the dispute timing 30 days and 30 days. So I'll pass it on to my colleague, Dr Buckner.

Dr. Michelle Bucknor

Thank you Michael. So Michelle Buckner from United and I think the consistency that we have across plans so we do accept paper them as a side, as well, electronic claims submission at uhcprovider.com our claims are protected with errors within 18 days of receipt. I do want to point out that the offset is limited to 77 report and we did provide a link for providers to be able to learn more about that report, I would highly suggest that where you do have access to that report. Once the claim is submitted, and then you'd have notification is a way to check the status of the claim and so just waiting to hear this system sometimes you want to know in advance and I would say, especially at launch, to understand claim payment that. Okay. Now, am I working now. Yeah. Oh, I'm so sorry, I don't know when I cut out, so I was saying, the 277 report we've provided a resource there. So I think that would be great for everyone to look into so that you can track the status of your claims, we do check right or electronic payment, we have daily check runs within 30 days of the claim claim submission, check right or electronic notification of pay, and then you submit the claims dispute, just like everybody else, you have the option for electronic or mail, and then we accept claims within 30 days. Claim dispute within 30 days and resolve them within 30 days.

Dr. Eugenie Komives

So, again, very similar to the other health plans here we accept paper and electronic checks will accept the electronic checks, either using -- or change healthcare. We will notify providers of any claims rejected because of errors within 18 days of receipt by mail letter. We do electronic check notifications by electronic or by paper within 30 days of clean claim submission. The check rates come out through a span or paper and, again, within 30 days of a clean claim submission we do check runs I believe six days a week, and then claims disputes can be submitted electronically or by mail, and same dispute timeframe 30 days from the denial and 30 days resolution.

Dr. Shannon Dowler

All right. So that was a really quick look at the claims process across the plans this cheat sheet we think is gonna be really helpful for you, so I'm going back to the printer you can keep an electronic copy or if

you're old school like me, you can print it out. Next slide. Here's the part that this this is the part I think I am most worried about because it feels like the biggest change for a lot of folks in Medicaid. It's, I don't think it's a bad thing, I think in many ways is going to refine our program, the claims is going to work where you're going to get paid, you're not, we're not I'm not worried about you not getting paid, I really believe that process is going to work well, and I think that utilization management process is going to work really well. And what we want to make sure that you in the field understand is that utilization management isn't a bug. It's a feature. It's what managed care is, and it is a feature of how you make sure that you are getting the right care of the right person at the right time. So and when you have a feature often you apply design to it, and North Carolina has been really aggressive in designing a managed care program that's different than most other states. We have a ton of things in our managed care plan that really create beneficiary and provider protections that is different. A great example is one prior authorization form that all the plans are using the same one in the fact that they helped us streamline it the one we gave them, had more fields than they wanted and they were able to slash out a whole bunch of fields to keep you from having to fill them out. So we have designed, utilization management to make sure that we're doing the best evidence based care we can for our Medicaid beneficiaries. We do have a floor policy so if you go to the next slide. Nevin.

There are things across the board that we're all the same about they're the same as we are today in Medicaid. The plans are the same. What I will say is, sometimes gonna feel a little different is the way that they go through their utilization management for some services, other services might feel actually easier to do than they did before. But there are certain things that we're all follow and that's listed on this slide and it'll be there for you to see, but what we wanted tonight was for you to really understand the utilization management process and the thoughts that the plans are going through, so that this doesn't feel different or too much like a surprise for you when we launch, but the most important thing that everybody has to remember is that the plans have to follow the Northland Medicaid clinical policies as the floor and not be more restrictive than our floor. That is absolutely true, but also in their contracts, they actually have to have utilization management, to manage the care. So there's a difference between providing the service as a floor, and then making sure it's being utilized in the right way possible. And so that is a feature of managed care and not a bug, but it is a place where we felt like when we talked about what the field really needed to understand that there was more opportunity. So each plan is going to take just a couple minutes and we're running a little low on time I talked too much. So, if each play on take about two minutes maybe three minutes and we'll go through these and then we're gonna open it up to questions that we haven't covered yet, so if you go on to the next slide.

Dr. Eugenie Komives

All right, Shannon, I'll take it away so the utilization management process is really probably not surprising. We'll get a case. Then we talked about how we can get cases. Phone, web or fax. We prefer web and then fax but the phone works too. And then what we do is we check to see whether or not that's versus a covered benefit. If it's not a covered benefit. And it's a child that's eligible under EPSDT, or if the request is something outside of their normal benefit limits so let's say it's additional PT beyond the 27 limit, then it's going to go to any EPSDT review for those children under 21 in Medicaid who are eligible for EPSDT. I'm gonna come back to that in a minute. If it's a covered benefit, then we look to see

whether or not we require an authorization, and I think all the plans your going to hear from tonight have some kind of a tool on the website. It allows the providers to check and see whether we require an authorization for that particular CPT or -- code. There's no PA, no problem, you just go ahead and do the service claim and as you pay. There is a PA required, then what's going to happen is that we are going to ask for clinical information, and we're going to apply clinical criteria based on the hierarchy that Shannon had on the previous slide. And if it meets criteria again that's the easy button, we get an approval and you go ahead and provide the service, but it doesn't meet the medical necessity criteria then there are a number of other steps that are going to happen. And the first one is it's going to go to a medical director for review. And then the medical director is going to look at that clinical information compared to the clinical policy, and they may feel like it meets criteria and go ahead and approve it. If they feel that it does not. And it's a child eligible under EPSDT then it's going to go through that EPSDT pathway. If it's not an EPSDT eligible number, and they are going to go ahead and issue an initial denial, all of the health plans offer an opportunity for the provider to do a period of care in welfare what we do is we send out something called an intent to deny. And it's a heads up that if you want to do if you're here, you can reach back out to us and we'll schedule a time to speak with one of our medical directors and this is the time my dog is probably going to bark at the truck coming down the street and I apologize, but that allows you to have a conversation directly with the medical director who's reviewing the case. At the end of that if the medical director still feels like the criteria is not met, then it's gonna go down that denial pathway, that's the same common pathway as if it doesn't meet under EPSDT. And at that point then it's eligible for an appeal. Next slide.

So, never gets to request an appeal, the provider can also request an appeal on the member of staff. The appeal does have to be requested within 60 days of what we call fondly the NABD or the notice of adverse determination, aka denial letter, we process the appeal the provider can submit additional new clinical information, and we apply the same criteria that we applied in the initial review, but it has to be done by a different medical director that at the end of the initial review and also has to be a same or similar specialty Medical Director, Then that's during that review timeframes are standard across all appointments 30 days for standard expedited 72 hours, and we're allowed to offer a 14 day extension, if it is in the best interest of the member. Typically that's when we try to get additional clinical information and for some reason that informations, not available and we're bumping up against the end of the timeframe and rather than issue a denial, we're going to continue to try to get additional clinical information. If the appeal is upheld, then the member still has the right to appeal to the office of administrative hearings. The so called state your hearing, and that includes the mediation process, And it's also outlined in detail in the nav letter that the members going to receive. If the services were ongoing and reduced or denied in that whole appeal process, the member can request that they get continuation of benefits. And that means that the services will continue until the appeal. And the secret hearing is complete. And now I'm going to turn it over to Michelle.

Dr. Michelle Bucknor

Thank you Genie and so what you'll notice is even though our slides may look a little different, the process is the same and so we will receive a new, new request for services we tend to call those cases I'd like to think of as requests for services. And so the first test for us is, is that a covered benefit. And so we

do receive those requests by phone or through portal, I will recommend that if you can get portal access you're gonna find that that's a much more efficient and effective experience for you. And so if the service is not a covered benefit just like Genie and well care, then it goes through a process and so the other thing is whether or not it's outside of the standard benefits so above limits that may be available. And then we also do the EPSDT review if it's not an EPSDT review it still routes to medical director for review and denial if it would be covered, and then we'll I'll talk about EPSDT a little further down the other track so if it is a covered service again, it's going to come through this portal. And what that does is determine whether or not pre certification or prior authorization is required. If it's not been, you can provide the service if it is, then we'll apply the criteria just as Genie mentioned through the hierarchy and that is, you know the state guidelines for federal guidelines first the state guidelines, and then our United policies and we do use and. And so if it meets medical necessity, it'll be approved if it doesn't meet those specific criteria, then it goes to that medical director for review. And I think really important is the opportunity before you know as a primary care pediatrician. I didn't really know about a peer to peer process and the opportunity to really have that conversation with a medical director, because sometimes what's been presented and what's in a medical record doesn't tell the whole picture. And so I would definitely use that opportunity to have that discussion and advocate on behalf of your patients to make sure they're getting the services. It also can be very educational for you to understand why the service is not being approved if that's the final decision. Next slide please. And like Genie saying sort of appeal process that comes in through our call centers through mail, email portal or fax and then we do have staff that will assist the member and preparing the appeal and acknowledgement letter will be sent the cases reviewed and if a specialty review is necessary, it'll be reviewed by a specialist, same sort of timeframe so the 30 days for standard appeal 72 hours for expedited and adjustments made if the appeal. If the decision is returned. If it's not overturned and the member is not satisfied with the decision, then they can request a state fair hearing.

Dr. Michael Ogden

Excellent well Dr Comives and Dr Buckner has made my job again very easy because all I have to say is, our, our processes are almost identical. I will highlight just a few areas that I didn't hear mentioned earlier or heard mentioned but wanted to point out the, you know, something in addition to that, and that is when you go in through a new case received and then we review the fee schedule which is kind of our source of truth. You know, we also do a code lookup the tool we'll use when we're doing that code lookup is this same exact tool that's available to our providers who can look up the same basic information, including, you know whether or not that particular item requires pre certification or not. And the policy that would be governing that the review of that particular service. Just like my colleagues had mentioned, you know, even if it's not a covered service, or if it doesn't, you know, meet the requirements that are covered by our policies. If it's a child who's, you know, under 21 and eligible for EPSDT we'll do an EPSDT review, um, you know, and then, if you know if it again doesn't meet medical necessity according to your policy or if it's a child under 21 always makes it to a medical director before denial and, and a medical director will review the specific information compared against both the policy and EPSDT way before issuing an NABD denial. There is, as my colleagues had mentioned opportunity for a peer to peer if you go to the next slide please. And you know that peer to peer option is we did I'll echo what Dr Buckner said, it's a, it's a great opportunity for for really a couple things. Number one, so that we can fill in the gaps that may not have been documented. You know, sometimes they're, you know, maybe an MRI that was done out of state not submitted with the original information and we can

get that information help approve that particular request. But there are also other benefits including you know if that member doesn't meet the criteria for the service being requested your medical directors can, you know help that physician understand what services may be available what may actually be also beneficial they remember that they would qualify for. And, you know, as every time I do these when I, when I get off the phone, I always say you know what the, even if we disagree, and, and I, I'd like to uphold the you know the decision, even after hearing the whole story. You know my word is never the last word at that stage. There's so many other options that a member would have to be able to challenge that decision, you know, including an appeal, which can go all the way down to mediation or you know even if that is something that, you know, the medical director that reviews that case on appeal. Also disagrees with number can also request a state peer hearing after that point as well so several steps beyond the initial decision where we're we'll have a dialogue with with the requesting provider and the plan. Now I'll pass it over to the great Dr. Lawrence for the, for the next portion as.

Dr. William Lawrence Jr

All right. So I think as you see as we get towards the end here. The processes, really do mirror each other, and there's not much I can say about the process that hasn't been walked through by my colleagues, I think we all follow a fairly similar path to how we look at, and you know review cases from relation utilization management standpoint, probably the only benefits I had at this point, having seen a walkthrough everybody's points, there's really maybe just to talk about, well, where are the differences, if there are differences there aren't really differences so much in the core process to us. We may have different approaches to policy. So all of us have our clinical policies, transparently presented, you know, on each of our respective websites that provides the guidance of what is utilized to help make some of those decisions about what leads to a denial, or what leads to approval as it goes through this process. And, you know, some of us may use inequal were one that uses and recall some of us may use MCG which is another form of evidence based guidance, but these are tools that are commercially available to simply help support, consistency, and accurate use of information in review of our cases. Next slide there. Similarly, in terms of process, there's really nothing different from the appeals standpoint, we can receive appeals, you know, verbally from members all the way through to fax or mail, we approach it in the same way in terms of how we take in that information, utilizing data different positions than the original review or someone who's not subordinate to that original review or to make another independent determination and accept any new information that might guide, a different decision from that original decision, we utilize the same timelines. So I think the reassurance there is, you know, we may have slightly different policies, or processes are going to be the same. We may in some situations use vendors, our use our own staff so whom you interact with may be slightly different, but still the core fundamental processes of how we handle utilization management should be very familiar to you. Now past to George.

Dr. George Cheely

Thank you. Sorry about that. Well I really didn't have much to add my colleagues in that instance. But ya know, our process, I think you'll recognize looks remarkably similar to those who have spoken before me and so maybe I'll, I'll build on. Dr. Lawrence his talking points and just say that, you know, I think the

department has been very deliberate about promoting transparency for providers, and from permit from my standpoint, that's a huge benefit to everyone on the line we were required to post our policies in a transparent way so that you all can see the criteria that we would be using to make the decisions on particular services. we use inequalities. Well, we actually have enabled a functionality called leader called transparency. I know many systems have access to the proprietor un guidelines but many providers do not so you'll actually be able to log in and look at the Interpol criteria so that you can see what what our reviewers would be using to make a determination. And in the interest of time, maybe I'll just jump to my next slide which is also a member appeals slide. And similarly, our member appeals process is consistent with with what those have shared before me we have multiple ways a member can request an appeal, needs to be filed within 60 days of the member receiving the adverse benefit determination or that denial letter. We may request additional clinical information, our physician reviewer team will be different than the team that made the initial determination, We will have a same or similar specialty physician reviewer, reviewing the appeal request. And we'll issue a decision that decision will happen within 30 days of the appeal request from the member under standard timeframe, a member or a provider can request an expedited repeal which results in a decision within 72 hours. That decision comes in the form of a letter called a Notice of decision in many have described the process, where a member can request a state fair hearing. There's even actually a due process step beyond the State Fair Hearing where a member can appeal through superior court if they disagree with the decision from the State Fair Hearing and I'm taking a little time to describe the length of that process because what probably is, I think, especially important for all of us who want to make sure that a member gets their services throughout what can be a very lengthy timeframe, the member can request continuation of benefits that would carry through the appeals process, and that request needs to come in. Within 10 days of of the member receiving the notice of adverse benefit determination so I think if you have the chance to advocate on behalf of members, or patients really emphasize that point, if, if the process might be a long one.

Dr. Shannon Dowler

All right, thanks everybody thanks for going through the utilization management and just so you all know, We're going to be doing a lot of oversight at, we're going to be doing a lot of oversight at Medicaid still so we're not going away. So we're going to be doing looking at claims looking at what's coming through. Are there major differences is one plan, not paying for something that other plans are, we're gonna be doing a lot of analysis and we're also going to be getting feedback from your specialty societies and from the field, and this is just a visual of art, we have our own process by which we're going to make sure that the plans are being held accountable to the floor requirements that's in legislation and in their contracts. And just so you know if, If we find that the plans are not meeting the floor, they actually have financial penalties that are not insignificant and so there's a real motivation on everybody's part one we want to make sure everybody gets cared for, I think everybody on this call feels really strongly about making sure the right services get to the right person at the right time. So there's no question about that. But then, things might happen and advertently we might accidentally find something's more restrictive that it doesn't mean to be, we're going to work immediately with the plans to make sure that these things are fixed and I feel competent that they're going to be responsive. So I just want you to know that that's going to be happening and Medicaid, we're going to be working around the clock to make sure that it's working for you. So if you go on to the next slide, I did want to

speak really briefly about this idea around contracting broadly. This is something actually the Secretary asked us to talk about, because we're noticing that some practices are really limiting how many people they're contracting with and we feel like there's really a lot of positives around greater choice for Medicaid beneficiaries, it creates better access. It's going to keep beneficiaries from having to choose between their medical home and maybe a critical specialist. Those are going to be really unfortunate circumstances so the more broadly you contract, the better it's going to be for the beneficiaries, but ultimately it will actually have less administrative burden. When you see someone out of network you're still gonna have to submit claims to that plan and authorization requests have to have single case agreements and those things that have more administrative time. I will say that in the last year the department's worked really closely with the PHPs and I am confident that PHP is really understand Medicaid in a different way now than they did even a year ago. And so what I would say is if your early experiences with contracting wasn't if it wasn't great, I would encourage you to try again and see if it's working better for you this time. Many providers are contracting with all five plans. They recognize that this is probably in the best interests of their beneficiaries and simplifies things at their front desk, and we're grateful for that and we hope that everyone will will lean towards that strategy. All right, next slide we have some questions we wanted to get through in the background. I will say that we have this team of people from the plans that are on the call and from DHB and 93 of your questions have been answered in the background, and we're still working through those, I think some of these questions we might hit here, and this. So what is the utilization management criteria for behavioral health hospitalization and admissions under Standard Plan, and we'll be consistent across plans or will each plan that gets us our own criteria, who's got that one.

Dr. Eugenie Komives

Shannon that would be me. And the answer to the question briefly is yes. The state has a mandated clinical policy for inpatient behavioral health care and all of health plans are required to use it. In addition, there are other specific behavioral health criteria like workers, -- XC and ACM and things that are the family doc I don't know a lot about right and true that we will all be using them according to the requirements in our contract with the state.

Dr. Shannon Dowler

All right, and how will will behavioral health services vary across the health plans.

Dr. William Lawrence Jr

So I'll jump in and answer that one, you know, generally, the array of behavioural services that you guys are familiar with the 88 B and 8 G services policy coverage that you're familiar with is required for all the five standard plans, So, the array of behavioral health services doesn't really change or vary, there may be some in lieu of services which are alternatives that a plan can choose to provide there might be different, but the core behavioral health coverage will stay the same.

Dr. Shannon Dowler

Awesome. How will health plans, find a provider, let's say a therapist for beneficiaries if no one's taking new patients.

Dr. George Cheely

So we have care management teams part of these responsibility is to make outreach to the member to identify potential options of in network providers that might meet their needs, even to help them members schedule an appointment and transportation is needed. If there's not a provider in network, to meet the members needs, then we'll look to NC tracks to identify if there are Medicaid enrolled providers that might serve that might be able to serve the member and we'll make outreach to try to contract with the provider we really want a relationship for that immediate member but also for future members as well. And if the provider is not willing to contract formally we'll seek a single case agreement of just for the care of that particular member. I'll also add, you know who we're talking about therapy in the behavioral health realm. Telehealth would be another option in this circumstance, if the member really prefers a face to face visit we'll support and figure out how to get them face to face but but telehealth is, I know a great modality that, that's really kind of washed over the state, by necessity.

Dr. Shannon Dowler

Alright, well providers, then these next two kind of go together so I'm gonna ask them as one will providers still be able to build the same collaborative care codes, and will PHPs offer training to providers on performing basic mental health assessments and more complex mental health assessments.

Dr. Michael Ogden

So I'll jump in on that one. Um, so, so, good gracious that's a, that's a, that's a big yes with respect to collaborative care, um, you know, it's a covered benefit under North Carolina Medicaid. And so all standard plans will be covering that. Um, you know, and I think I can speak for for certain could speak for healthy blue but will speak for, You know, all the other plans as well. This is something that we would support. And, you know for how we blue in particular, we're always looking for folks that are interested in beginning that process in their own practice. And, and Shannon, as you mentioned, you know the, that kind of segues nicely into the next question of offering training. So, certainly healthy blue will will will support training, such as, you know expert training for primary care providers, We support Project ECHO, which is a great resource that will, will help practices understand how best to do things that they typically haven't done in the past such as collaborative care. But there's also an interesting and I think a hugely beneficial forum. That will all have our quality forums, and even our Administrative Simplification workgroup will review the needs for the community and work on, you know, providing, you know, whatever, you know, elements may, you know may be necessary to improve the health of North Carolinians and this, this would be one that I would think would be intuitive for that forum as well.

Dr. Shannon Dowler

All right, so what if a patient needs help after July 1 but they don't speak English, what kind of support and advocates for the PHP provide to help them get the services they need or appeal a decision.

Dr. Michelle Bucknor

I'll take that one Shannon so I think it's really important to know that we as plans looked at all these questions and responded and our responses were really similar. So I can say with confidence while United might have a little bit of a different system that all of us have pretty much the same answer. So, any patient that needs help right we have the care management services to support them. We all have language lines I know United our language line is over 200 languages that are supported, and we definitely all advocate, or advocate and support the members as they need support to appeal a decision about services that they can obtain. So the bottom line is we want folks to get the necessary services that they need, but we also want to ensure that they're safe and effective services so we're here to support the Members we're here to support you and supporting the members and I think that's the biggest take home message from me tonight.

Dr. Shannon Dowler

Nevin. Next slide. So what if a child needs specialized care that they can only get at a state such as like, chop. Will the process recovering those services be the same for all the plans.

Dr. Michael Ogden

So, I'll take that one, I think it's going to be very, very much the same. All of us have methods by which we can take all of the information that would support, you know care outside of North Carolina if there's, you know, a procedure or a certain type of specialized care that's necessary. We all have ways to do a medical necessity review work with our providers work with books within the state. And then even, you know, in some cases even arrange transportation, and you know all the, all the other accoutrements that would be entailed and, and getting that patient, the care they need.

Dr. Shannon Dowler

Awesome. Clinical policies are they publicly posted and kept up to date for all the plans.

Dr. Eugenie Komives

Yes, they are so for WellCare policies are actually on our external WellCare website for the writers and members to view and all policies are reviewed at least annually and that's actually an NCQA

requirement for all of us. So, and then also policies get updated if the evidence changes or there's a new guideline that impacts the policy, then of course if the state changes their policy and it's a mandatory policy then we'll update ours accordingly.

Dr. Shannon Dowler

Prompt pay interest penalty does account for it, North Carolina Health Choice vaccine products.

Dr. George Cheely

There are no exclusions to the prompt pay interest penalty so that's really an important mechanism I think to drive accountability for all of us to keep those timely payment standards we talked about at the beginning.

Dr. Shannon Dowler

Awesome, and we're gonna pull Kelly in our AMH Queen, AMH tier threes, don't currently receive information on hospital admissions and discharges when we transition to managed care with a PHPs or CINS provide the infrastructure that allows these data to be shared with the medical home in an efficient way and who is responsible for ensuring the transfer of data and what systems will be used.

Kelly Crosbie

Yeah, so advanced medical home tier threes are actually required themselves to get ADT feeds. So they need to get this admission, discharge and transfer feeds themselves. Now they may contract with a CIN who could get those feeds for them. But in that case that contract should talk about how the CIN is actually going to ensure that the data gets to the practice. So that's just a requirement of a tier three mistakes you're doing it through the CIN, there's lots of ADT feeds available.

Dr. Shannon Dowler

All right. Next slide. I believe takes us to our questions and we are out of time I'm comfortable staying over a few minutes, if everybody else doesn't mind giving it a few minutes. We had a few frequently asked ones. We did see 105 of the questions get answered during the chat, which is pretty awesome. There are 76 open and remaining any patterns or things you wanted to pull out Hugh?

Hugh Tilson

So one of the underlying themes has to do with the administrative burden and payment delays for practices, especially smaller practices. What can y'all tell these smaller practices to assure them that they're going to be okay, that this process is gonna work.

Dr. Michael Ogden

So, I'll, I'll take a stab and we'd look for my colleagues to follow on. First of all, you know, as we mentioned the claims processing slide. You know one of the things that we're doing a healthy blue is we're doing a daily check right. We certainly understand this is going to be, you know, something that is a new process for a lot of folks and, you know, currently it's a weekly check right move into daily, you know, we hope it's going to ensure the right cash flow to ensure that these, these smaller practices, you know, we're really dependent upon that cash flow to keep the lights on and have it squared away. The second thing I'll mention is we do have an administrative burden and simplification workgroup. And I want to need still too much thunder from my colleague Dr. Lawrence who's done a lot of great work and in identifying some of the elements that need to be addressed to simplify. And I'll actually toss it to him real quick for for commentary there.

Dr. William Lawrence Jr

I'll jump in there thanks Michael and I just want to make it known, you know, we collectively as PHPs, not just the CMOS but many members of our teams have had ongoing and consistent effort looking at what can we do we recognize that as opposed to one, there's no way to make that more simple one, but we can look at what are the things we can align on to make processes more simple and we have done that, and we'll continue to do that as time goes on. I think one of the other things about what will make this work for all is all of our teams are very very well positioned in terms of staff to do support for individual practices. So going to our quick reference guides go on to our websites. If you want to Carolina complete Health website up on the right hand corner there's something that says, Help stat on our network website that will allow you to get questions answered immediately, and all of our great staff members that are ready and poised to support all of our practices students transition.

Dr. Eugenie Komives

I just want to shout out to the provider relations teams that I know that all the health plans have all across the state really ready to answer questions from any provider, I think all of us probably have mailboxes, they have phone numbers, lots of ways that I can gauge to try to assist if problems arise, And we all handle a lot of processes for providers so.

Dr. Shannon Dowler

Alright here you got any others you want to hit.

Hugh Tilson

Well, kind of a corollary to that we got this question which is most of our all of our patients are not aware of this change therefore we do not, they do not know that new insurance so, like, you've answered it from the provider side, can you talk a little bit about how we should all be comforted that our patients are going to be okay with this.

Dr. Eugenie Komives

So, I'll jump in real quick and then look for others but it's really been fairly recently I think within the last week and a half or two weeks are the ID cards have gone out. And so the patients are member, probably know more now than they did about three weeks ago, about being enrolled in a managed care plan, and the ID cards came with member handbooks and all kinds of useful information for the members so that they're aware of their new health insurance and how they use it. So, hopefully awareness will increase.

Dr. George Cheely

Yeah, I would also add, I, I know, me and my colleagues as well have been out at community events, trying to raise awareness for managed care in general to move to manage Medicaid. And also, you know, I think what how each of our programs, offers a slightly different set of benefits. So there's been a lot of activity to get in communities and get out there and I think to put friendly faces and to help understand company reputations and some of the people in personalities that that members we get to interact with moving forward as well.

Dr. Michelle Bucknor

Yeah, and if I could just say, well, the plans do outreach to new members for health risk assessments, and that's a key opportunity to start to engage with our members and make them aware of their new plan, and then we are receiving information from the state about high needs members, and so that's who we're really, we're concerned about everyone, but we really want to make sure that no one is doesn't have access to services they need. And so I think I could probably speak for my colleagues that will be doing outreach to all of those members and identifying more just to make sure they don't give flu service.

Dr. Michael Ogden

Absolutely. I'll, I'll, pile on here. The, we've been doing outreach since since June 1 on the on the patients we've we've, you know, has been have been assigned to healthy blue, you know that that is a rolling assignment process. And we've been also you know, we've been doing phone calls, we've been doing emails we've been doing community events, and, and reaching out and letting these folks know that you know we're here. You know, we're, we're, we're ready to help partner with the right providers to take care of them.

Dr. Shannon Dowler

Do you have any others you want to throw out there before we let folks go to dinner.

Hugh Tilson

Those are the kind of the bigger themes are a lot of kind of more technical ones it relates telehealth and we could talk about are you going to continue telehealth we could talk mean, But I think those are kind of the bigger ones at this point. So, I'll turn it back over to you unless you see any in here that you particularly want to focus on

Dr. Shannon Dowler

So many great questions in here and I hate that we don't have time to answer every single one of them 113 are now answered in the chat. 86 are left open. We always make a commitment to answer all the questions. At some point, but we don't usually do it within, you know immediately like we're able to do for the 113 that got answered. So maybe we need to look at longer times for these webinars for the future, I hate to take people past the time I've asked them to commit in the evening already but there are a lot of questions out there I just would encourage you to go to the website, the Medicaid website we have so many resources that answer, I mean every question I see in here is answered in one of our fact sheets or other resources that the team has put out there, go to the PHPs directly with your questions, and again encourage folks to contract as broadly as you can, especially in this initial year to minimize the impact on our beneficiaries as far as access and having to make tough choices. Thank you to all the CMOS thank you to your teams for being here. Thank you for the amazing Medicaid team and a heck, who helped make these webinars possible, we are not having one the first Thursday in July, we're going to take a week off, but we will be back the third Thursday in July and our CMOS will be back again with their teams to help answer lots of questions, and we might consider making that a longer session to make sure that we can really entertain more questions and answers. So thanks, everybody. Have a great night, and we'll see you on the back porch next month.