Back Porch Chat: Medicaid Updates and Focus on Collaborative Care

November 18, 2021

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here:

<Enter Link Here>

Logistics for today's webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

01 Quick Updates on Hot Topics

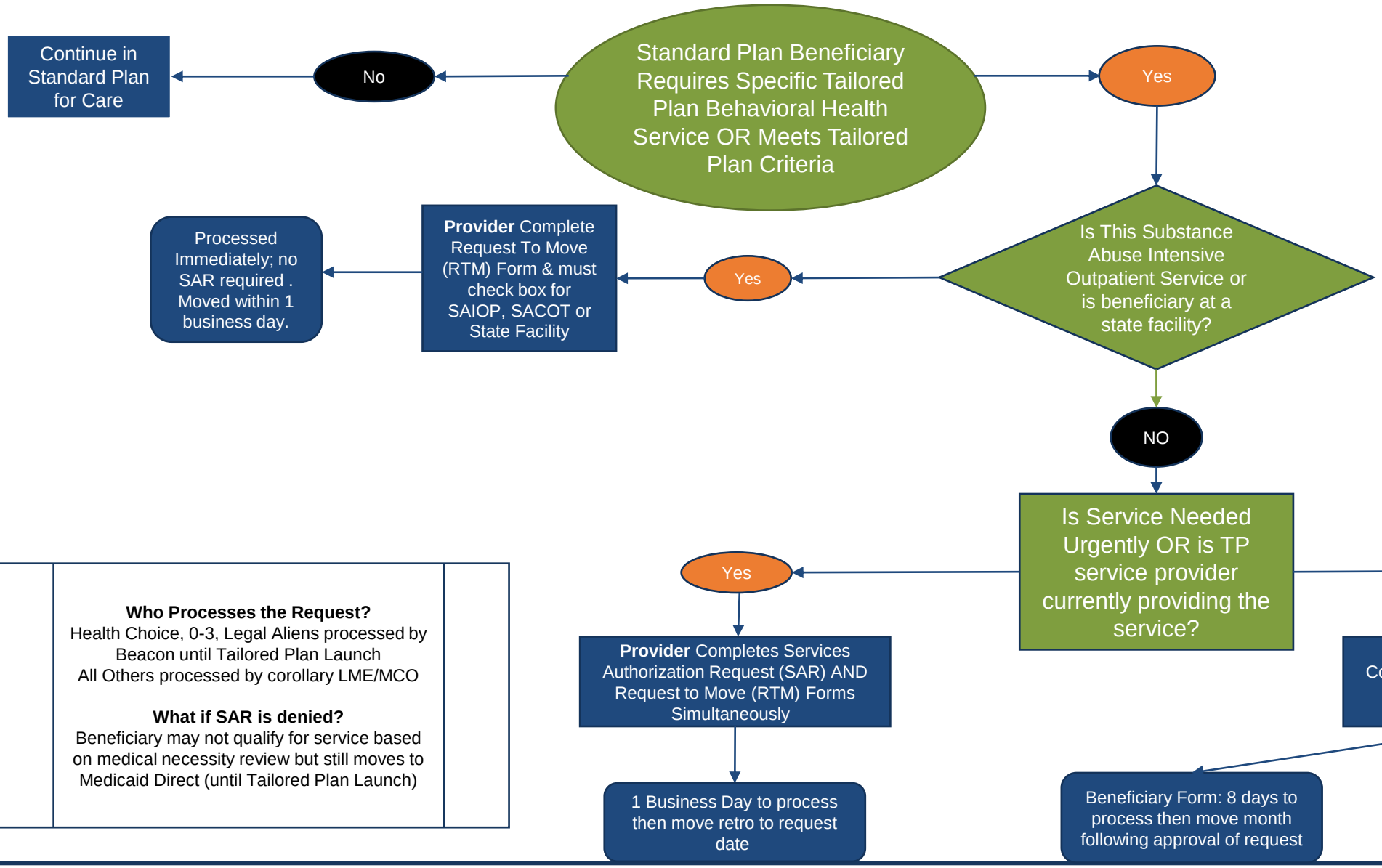
02 Managed Care Provider Survey Results

03 Utilization Data on Collaborative Codes

04 Collaborative Care Codes

05 Q&A

Standard Plan to Medicaid Direct: The Flow



TP Criteria:

A beneficiary who has:

- a serious mental illness (SMI)
- a serious emotional disturbance (SED)
- a severe substance use disorder (SUD) an Intellectual or developmental disability
- survived a traumatic brain injury (TBI) and who are receiving TBI services, who are on the waiting list for the TBI waiver, or whose TBI otherwise is a knowable fact

For more information:

- https://www.ncdhhs.gov/media/10968/download
- https://www.ncdhhs.gov/media/10969/download

Who Processes the Request?
Health Choice, 0-3, Legal Aliens processed by Beacon until Tailored Plan Launch
All Others processed by corollary LME/MCO

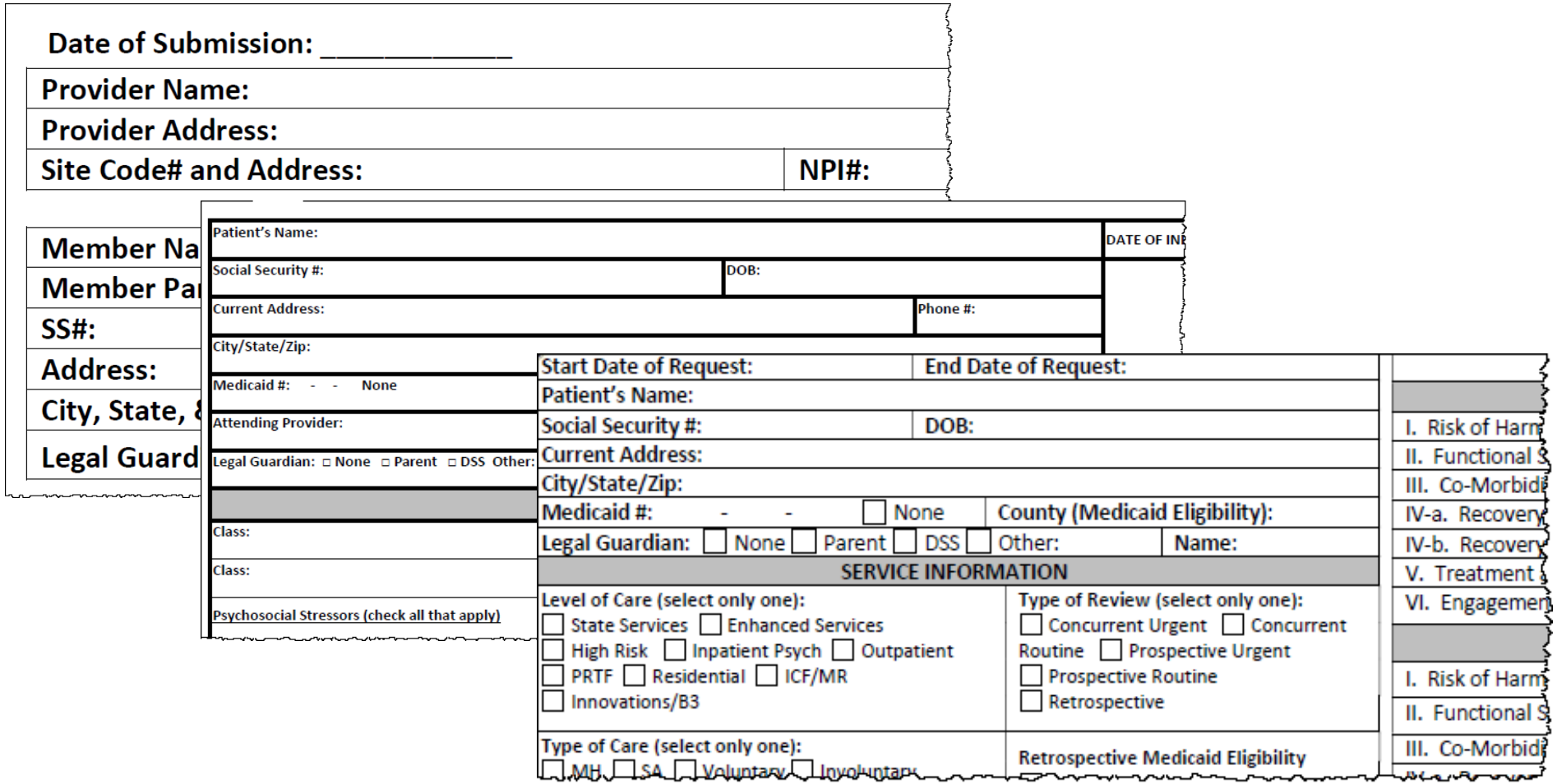
What if SAR is denied?
Beneficiary may not qualify for service based on medical necessity review but still moves to Medicaid Direct (until Tailored Plan Launch)

For more information, please reference the October BPC.

Service Authorization Requests

The LME-MCO Service Authorization Request (SAR) or Treatment Authorization Request (TAR) forms can be found at the following links.

- Alliance
- Cardinal
- Eastpointe
- Partners
- Sandhills
- Trillium
- Vaya
- Beacon



The RTM form can be found here

When Will it Ever End???

For more information, please refer to the NC Medicaid Bulletin

Key Budget Impacts on NC Medicaid

- Extension of Pregnancy Medicaid to 12 months postpartum for women who qualify based on financial need
- Continued Medicaid coverage when a parent loses custody while child is in foster care
- Additional slots for our waiver programs
  - 1000 Innovations waiver
  - 114 CAP-DA program
- Major investments for Home and Community Based Services to support workforce
- Capacity Funding for Tailored Care Management

Provider Contracting Reminders

Although NC Medicaid beneficiaries have transitioned to managed care, providers are reminded that contracting is an ongoing process. Uncontracted providers may begin the process at any time, understanding that health plans need sufficient processing time to complete the process and add the provider to their network.

Nov. 30, 2021, is the last day NC Medicaid will require that health plans pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers. If a contract is not in place by Dec. 1, 2021, and the provider has not engaged in good faith negotiations as defined in the PHP's Good Faith Contract Policy, Medicaid-enrolled out-of-network providers are at risk for being reimbursed at 90% of the current Medicaid fee-for-service rate and subject to additional prior authorizations. For more information on contracting with the health plan, contact the health plan.

Information for each health plan is available here.

Beneficiaries are able to change their assigned PCP/AMH until Nov. 30, 2021 "without cause". After their initial PCP/AMH assignment, beneficiaries can change their PCP/AMH only one time each year or "with cause." Beneficiaries must contact their assigned health plan to request a change of their PCP.

See the Member Enrollment fact sheets for more information

Except for out of network emergency services, post-stabilization services and services provided during transitions in coverage, the PHP shall be prohibited from reimbursing an out of network provider more than ninety (90%) of the Medicaid Fee-for-Service rate if the PHP has made a good faith effort to contract with a provider, but the provider has refused that contract.

PHPs may apply PA on all services provided by out of network providers.

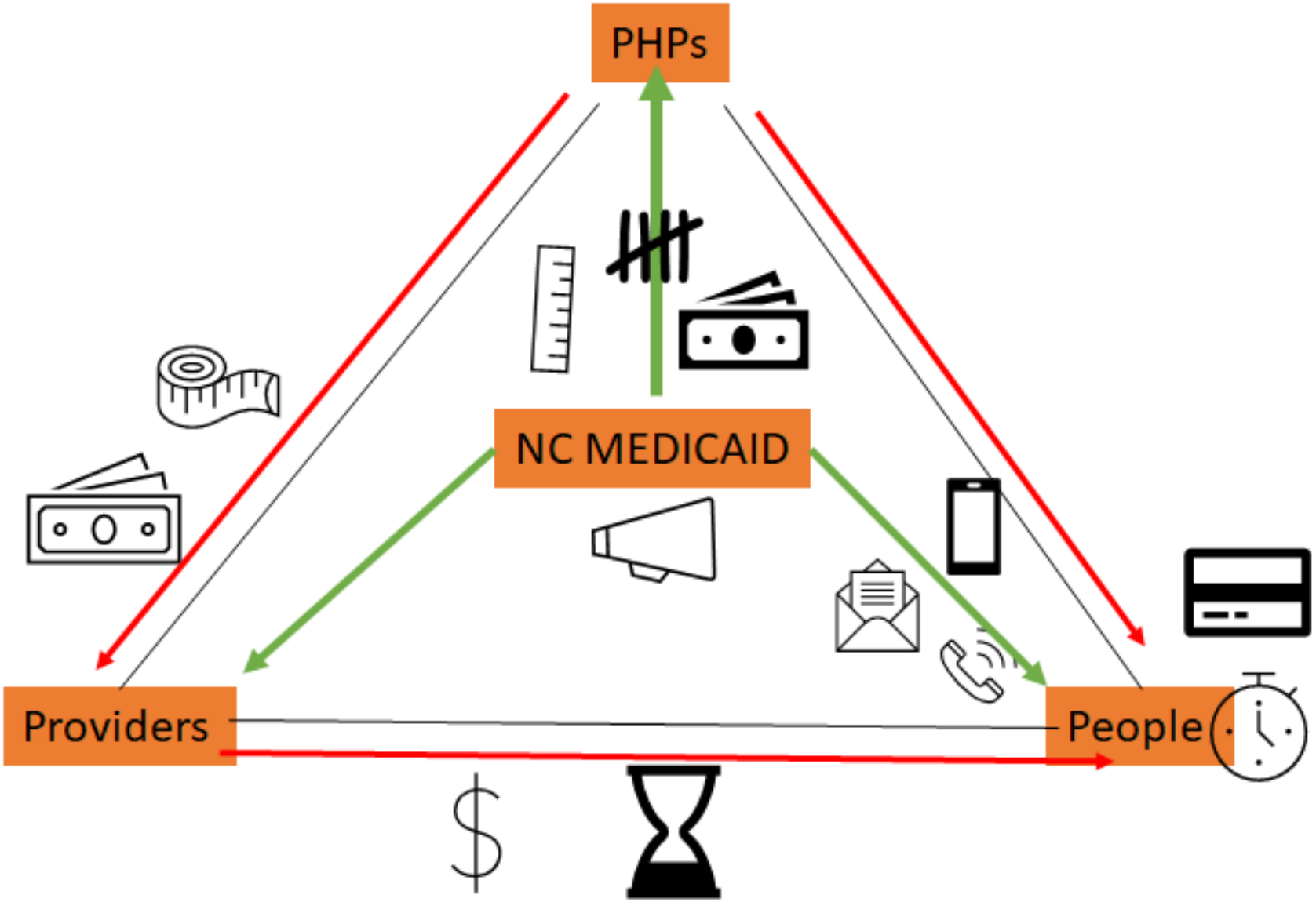
Organizational Provider Records Without the Required Individual Provider Affiliation Risk Suspension/Termination

Forthcoming modifications to NCTracks will allow the system to identify organizational providers enrolled in taxonomies (provider type, classification, specialization) without the required affiliation of at least one active individual provider.

Beginning Nov. 21, 2021, organizational providers with certain taxonomies are required to have *at least one active affiliated individual provider with at least one active taxonomy* related to their credentialed status as a taxonomy level 1 provider.

- This modification will verify providers meet the enrollment criteria for each taxonomy and supports efforts to keep provider enrollment files current.
- Once implemented, this will become an ongoing requirement, obligating providers to maintain and update affiliations in order to avoid potential claims suspension and/or provider enrollment termination.

For more information, please see the Medicaid bulletin article Organizational Provider Records Without the Required Individual Provider Affiliation Risk Suspension/Termination


PHPs
NC MEDICAID
Providers
People

Vaccine Counseling Impact

- The vaccination rate for the counseled population is **25.5% greater** compared to the non-counseled population(all 18+) and **49.9% greater** (12+).
- Early data suggests:
  - 18+, **100** people need to receive counseling for **three** beneficiaries to be vaccinated beyond what would have occurred without counseling. With an average of 1.25 counseling sessions per beneficiary at a cost of $32 per claim, this correlates to **$1,333 to shift one person to vaccination**.
  - 12+, 100 people need to receive counseling for seven beneficiaries to be vaccinated beyond what would have occurred without counseling. With an average of 1.25 counseling sessions per beneficiary at a cost of $32 per claim, this correlates to **$571 to shift one person to vaccination**.
- Initial evidence indicates that vaccine counseling by trusted providers increases the likelihood that beneficiaries will make the decision to get vaccinated.
- Being vaccinated in NC means a person is 5X less likely to get COVID infection and 20X less likely to die from COVID-19.

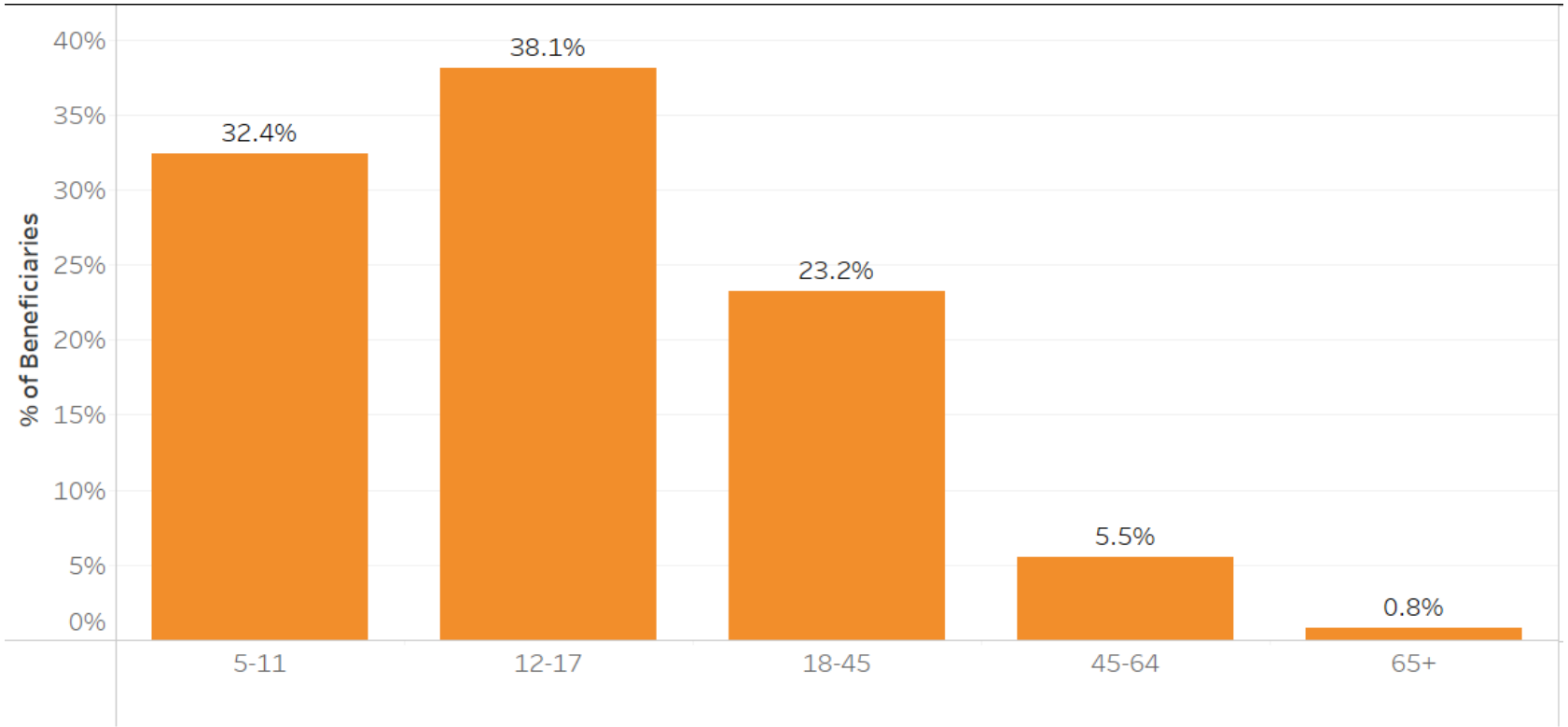
Vaccine Counseling & Outreach Guidelines

	Counseling	**Outreach**
Who Can Bill It?	MD, DO, PA, CNM, NP	Office staff of the previously listed providers
Quantity Limits	One time in 24 hours	One time in 24 hours
How to Bill It?	99401, CR If with E&M: 25 modifier If with telehealth: GT modifier If telephonic: KX modifier	99401, CR, HM
Goal of the Code	• Increase vaccine uptake • Can be billed the same day the vaccine is provided • Parent counseling can be billed under the child	• Identify unvaccinated medical home members to encourage counseling & vaccination appointments

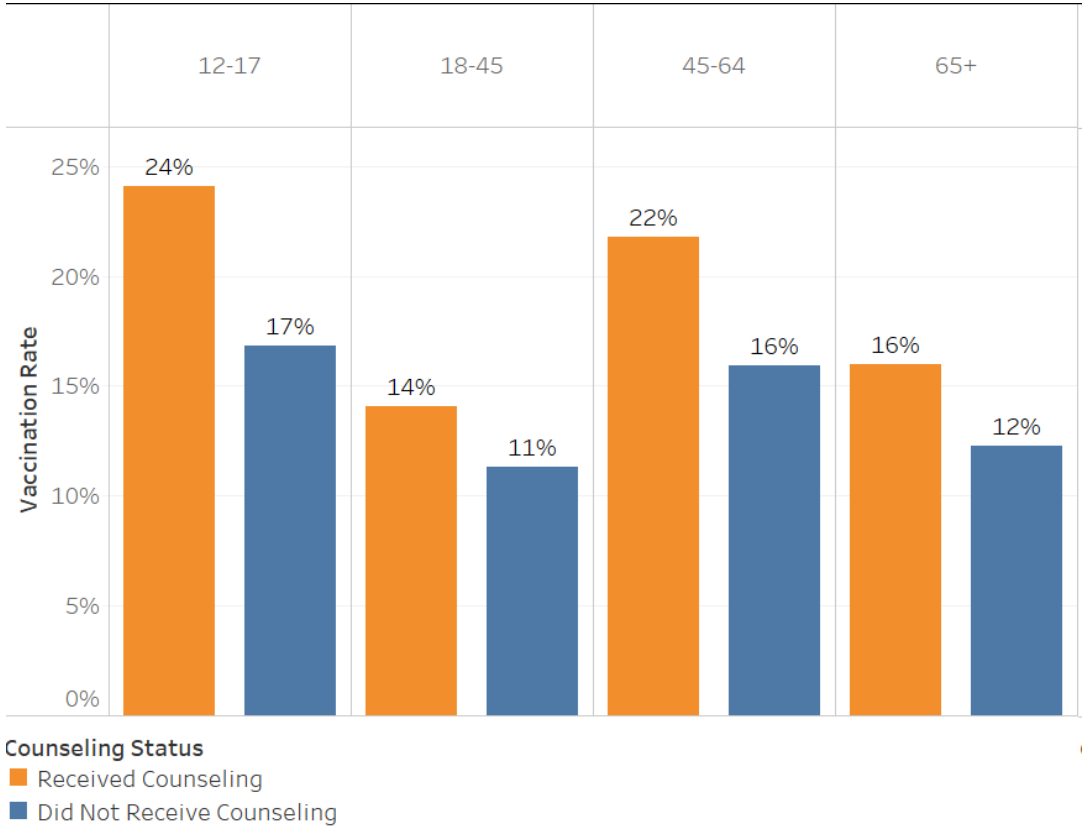
More Information can be found in NC Medicaid Bulletin.

Age Distribution of Counseling Population (99401)

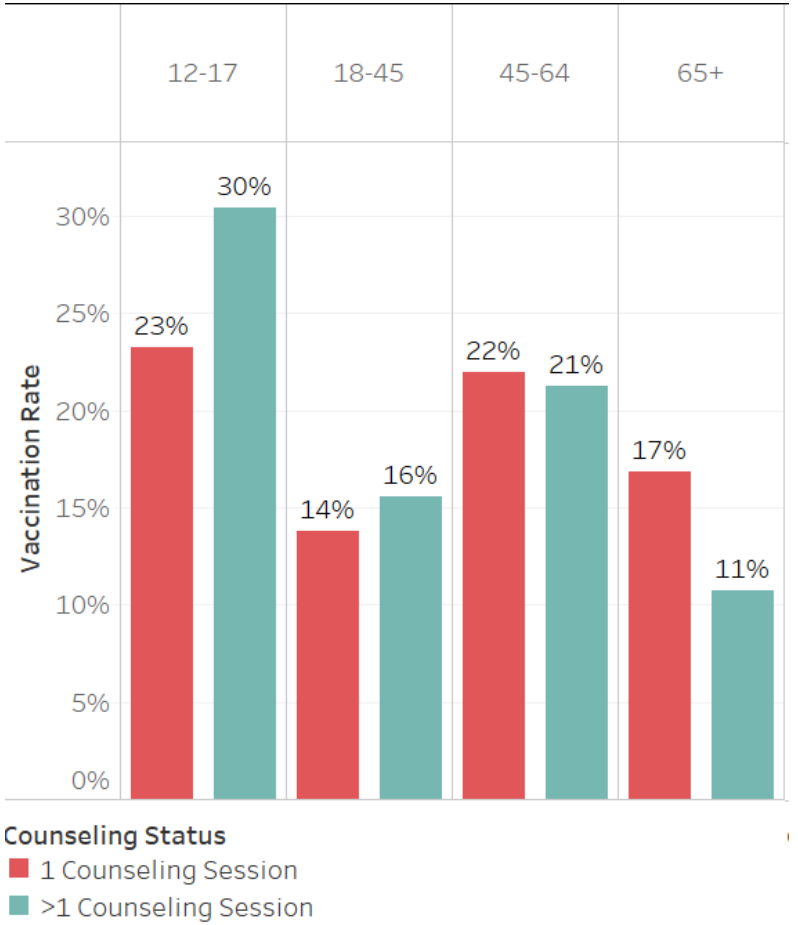
- **Counseling recipients consists of more vaccine hesitant populations (71% are 17 or younger, compared to 39% of overall Medicaid population)**



Vaccination Rate by Age Group by Counseling Status



Vaccination Rate by Age Group by Volume of Counseling



COVID Member Incentives

WellCare	United HealthCare	Healthy Blue	AmeriHealth Caritas NC	Carolina Complete Health
Who is Eligible? • All members 5 years of age and up.	**Who is Eligible?** • Members 5 years of age and up.	**Who is Eligible?** • All members 5 years of age and up.	**Who is Eligible?** • Members age 5 years and older who receive 1st or 2nd COVID Vaccine Doses during the campaign.	**Who is Eligible?** • Current eligible members for the vaccination incentive are age 5 years and older.
Incentive Dates/Timeline • Members who completed their vaccination (series) on or after 9/1/21 through 6/30/22 are eligible for a $50 Walmart gift card. Members may attest to their (or their dependent's) vaccination status via web portal, and gift card will be provided to them.	**Incentive Dates/Timeline** • Eligible members will receive an email or direct mail with an invitation to participate • Members who receive their first COVID vaccine dose between 11/1/21 and 1/31/22 will receive a $50 gift card. • Program may be extended.	**Incentive Dates/Timeline** • 2021 pilot program dates: October 1st through January 30th	**Incentive Dates/Timeline** • First campaign from 11/1/21-1/31/22 *may be extended through 6/30/22 and adapted based on campaign results and in consultation with NC DHHS.	**Incentive Dates/Timeline** • Eligible members who receive a first, second, or booster COVID-19 vaccination between 11/15/21 and 3/31/22 will receive a $75 incentive, while rewards last.*
Member Incentive • Members will receive a Wal-Mart gift card in the amount of $50.	**Member Incentive** • Incentive offering to all vaccine-eligible members in the form of a $50 gift card with appropriate restrictions.	**Member Incentive** • Members who receive a series of 2 Moderna, 2 Pfizer, or 1 Johnson & Johnson vaccine(s) choose from a digital or physical gift card received via U.S. postal service. Multiple card selections from retailers, restaurants, Amazon. • Reward value: - November $100 - December $100 - January $50	**Member Incentive** • Pfizer or Moderna 1st Shot: $60 • Pfizer or Moderna 2nd Shot: $100 • Johnson & Johnson Single Shot: $100 Rewards are loaded onto the member's pre-paid CARE Card and can be used to purchase OTC health products, wellness products and healthy foods at participating retailers. Member is notified by mail when rewards are loaded to CARE Card.	**Member Incentive** • Members will receive $75 on their My Health Pays Rewards card when they receive a first, second, or booster vaccination.* • Every member receives a My Health Pays card within two weeks of enrollment. If the member does not have a My Health Pays Rewards card, they should contact member services.

COVID Member Incentives

WellCare	United HealthCare	Healthy Blue	AmeriHealth Caritas NC	Carolina Complete Health
How is it verified? • WellCare of North Carolina members will attest to their vaccination status or a minor under their care's vaccination status by: - following a link to a microsite - https://wellcarerewardspprd.inspireandperform.com/ [wellcarerewardspprd.inspireandperform.com] - entering identifier information - entering vaccine information (vaccine brand, date of each shot depending on vaccine) • The site will perform authentication by comparing identifier information to enrollment files.	**How is it verified?** • Members will attest to their vaccine status by providing name of vaccine, date received and location • Incentive fulfillment available by mail, online or by phone • Monitoring of vaccination rates of those receiving the incentive will be performed by comparison to state data	**How is it verified?** • Proof of vaccination provided by member: - Submit a photo of CDC vaccination card via the HealthyBlueNC.com member portal - Call Healthy Blue Member Services to verbally provide vaccination information.	**How is it verified?** • ACNC tracks vaccine claims paid to pharmacies or providers • ACNC identifies a member in a data source from the State • Member attestation via Member Services or the secure contact form on our website www.amerihealthcaritasnc.com and validated by ACNC	**How is it verified?** • Carolina Complete Health will use claims data to determine when members receive the vaccination and are eligible for the incentive.** • If there was not a claim, the member can provide proof of vaccination by uploading a copy of their vaccination card online or mailing a copy to Carolina Complete Health.***
More information for members:	**More information for members:** https://myuhc.com/CommunityPlan/HealthWellness [myuhc.com]	**More information for members:** https://member.healthybluenc.com/public/login	**More information for members:** https://amerihealthcaritasnc.com/covid-19/vaccine-carecard	**More information for members:** www.carolinacompletehealth.com/vaccine

Managed Care Provider Survey Results Background

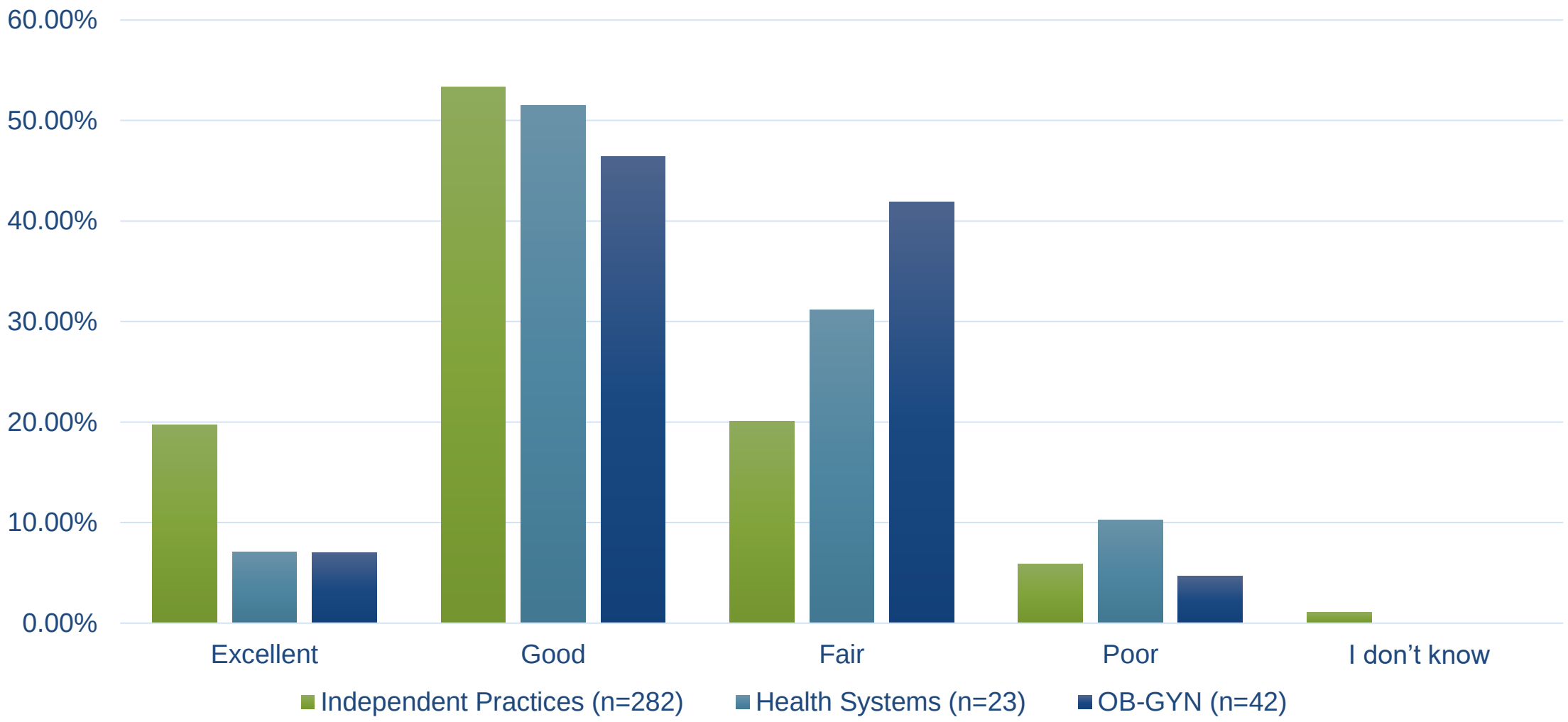
Background: DHB worked with The Sheps Center for Health Services Research at UNC-CH to develop a provider experience survey for practice managers, medical directors, or other leaders of systems and practices that deliver primary care and OB-GYN care to Medicaid beneficiaries in the current system.

- Historical experience with Medicaid support for healthcare quality
- Historical experience with Medicaid administrative process
- Experience with PHPs during the contracting phase

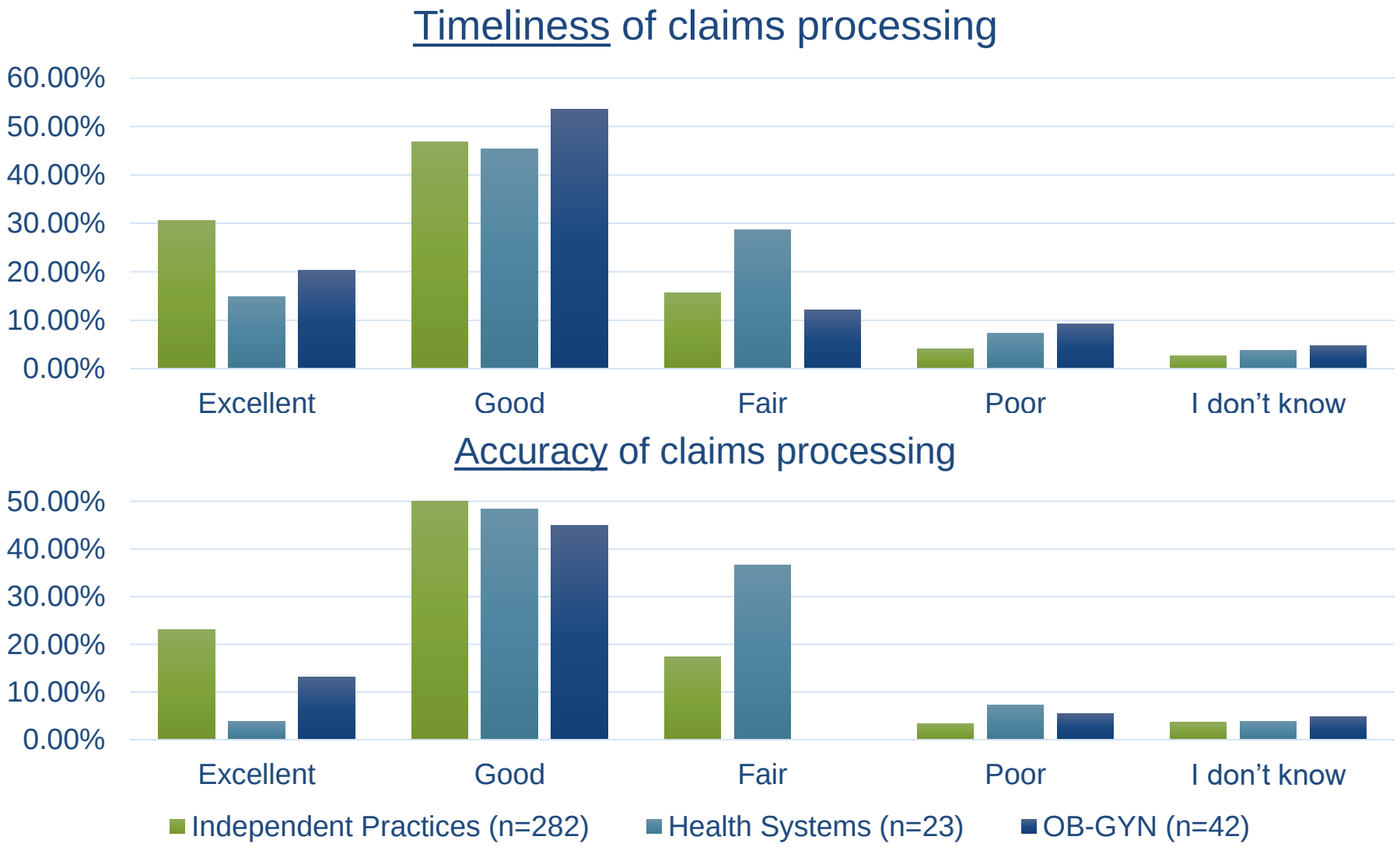
- **Future Iterations of the Provider Survey**
  - Add other provider types
  - We will use survey findings as a leading indicator for PHP quality improvement.
  - We will do more specific/detailed investigation of issues and opportunities for improvement via other data collection (e.g., focus groups, interviews, claims analyses)

- **Response Rate 58.8%**

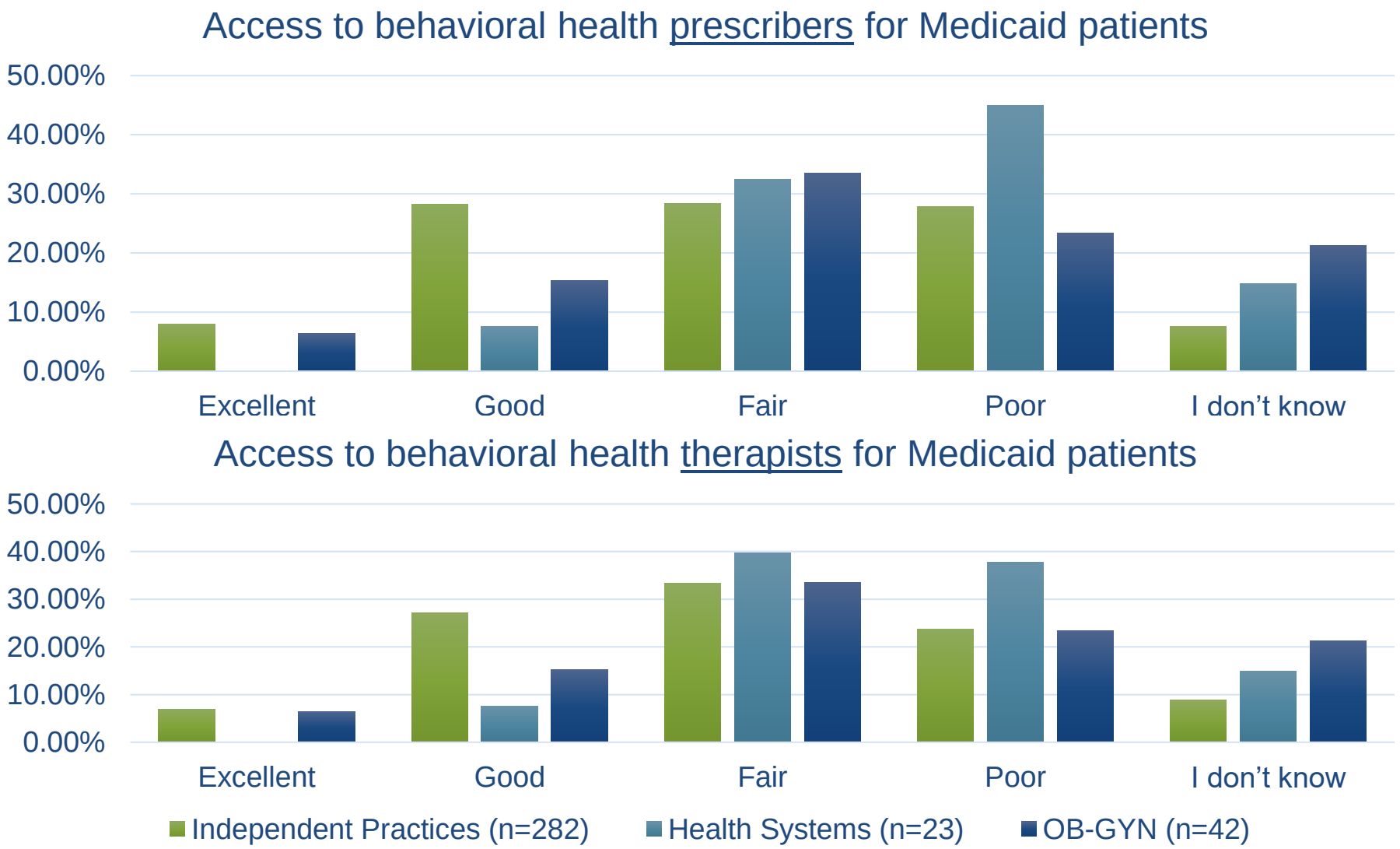
Overall Experience with NC Medicaid



NC Medicaid – Claims processing



NC Medicaid - Access to Behavioral Health



Coverage for Psychiatric Collaborative Care Management Throwback to 10/18:

In response to provider requests and to allow reimbursement for behavioral health integration in primary care settings, North Carolina Medicaid added coverage for the following evaluation and management codes effective October 1, 2018:

- 99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- 99493 – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
- 99494 – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

Psychiatric collaborative care management services must be rendered under the direction of a treating physician or non-physician practitioner (NPP), typically in a primary care setting. These services are rendered when a beneficiary has a diagnosed psychiatric disorder and requires assessment, care planning, and provision of brief interventions. These beneficiaries may require assistance engaging in treatment or further assessment prior to being referred to a psychiatric care setting.

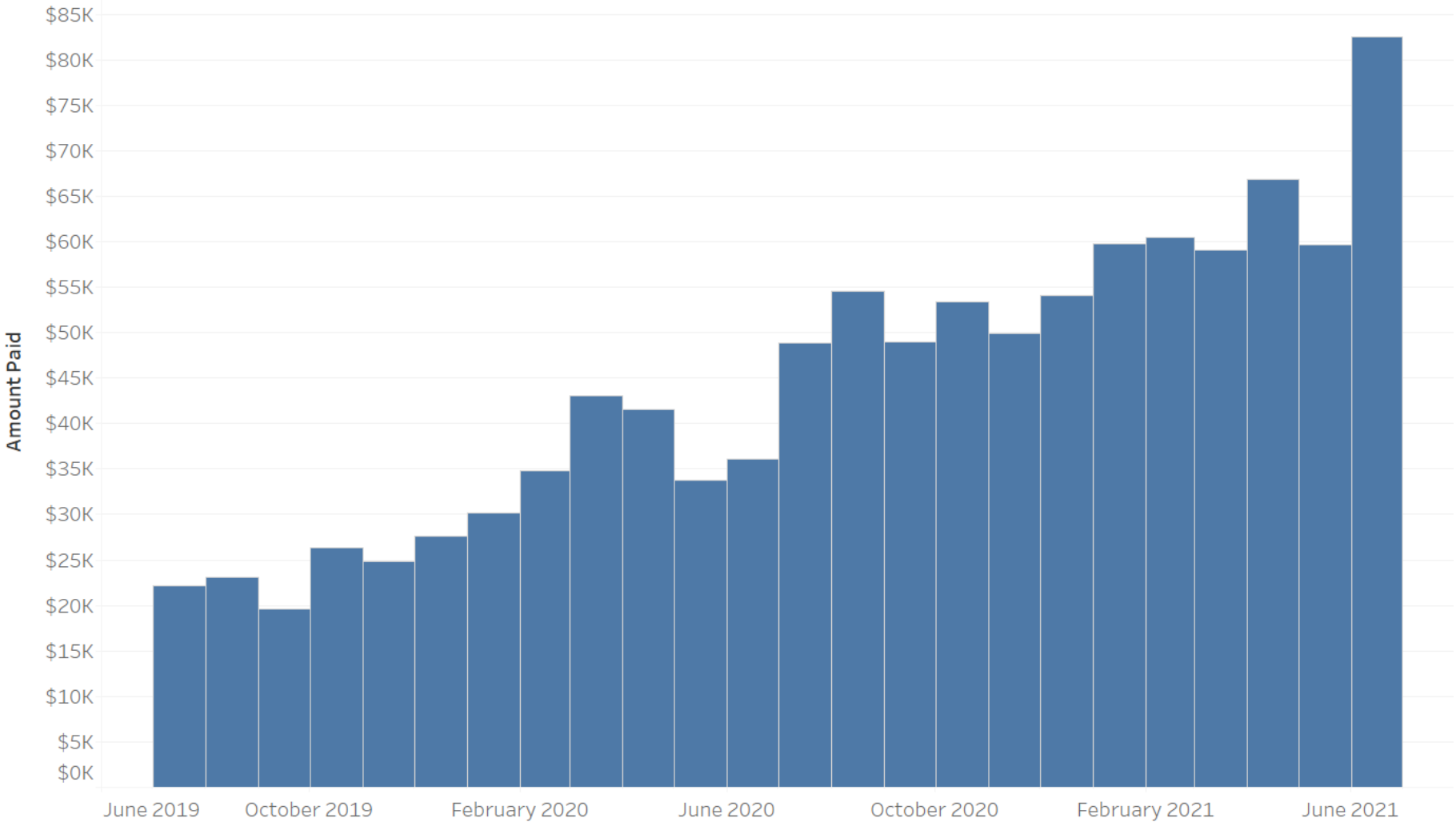
For more information, please visit the Coverage for Psychiatric Collaborative Care Management Bulletin

Collaborative Care Claims Summary (July 2019-June 2021)

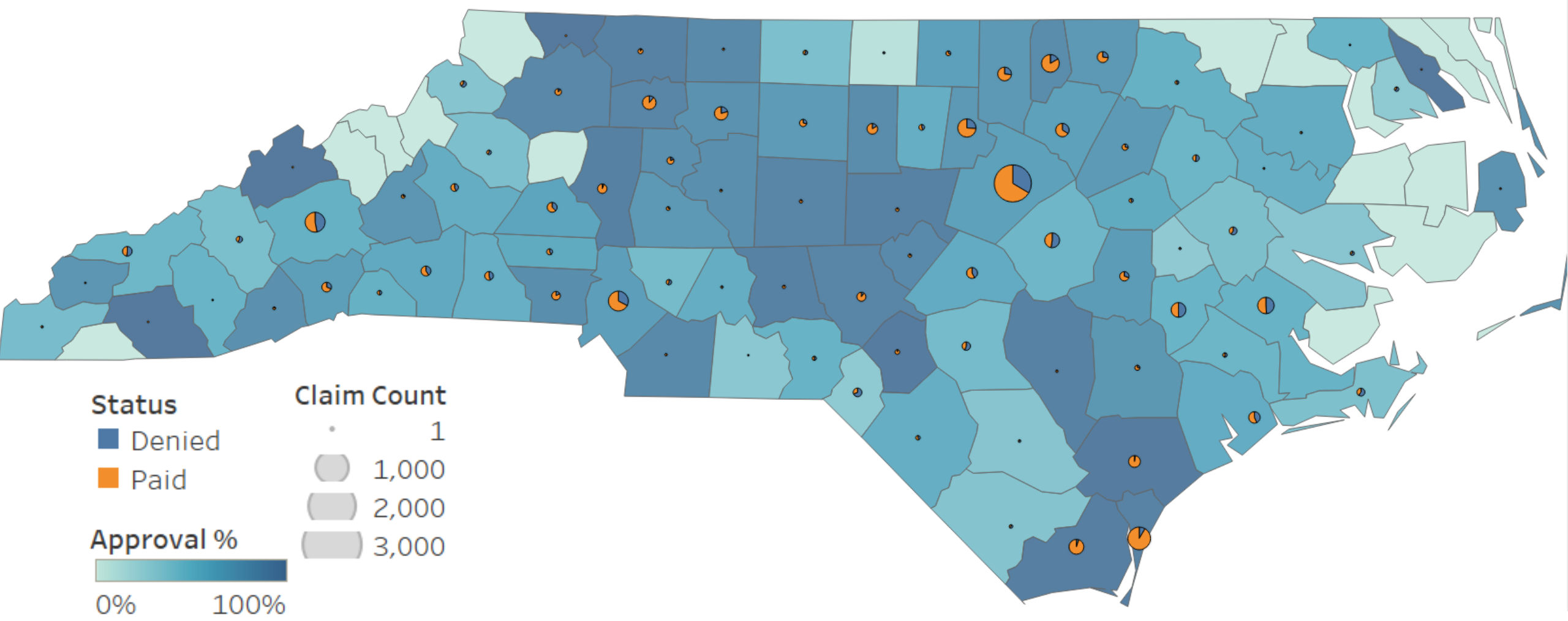
- 2,480 beneficiaries have at least 1 paid claim
- $1,061,300 paid out over 2-year period
- 11,712 paid claims
- Average payment of $90.62 per claim

99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
99493 – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
99494 – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

Monthly Collaborative Care Payments (July 2019-June 2021)



Collaborative Care Claims by County (July 2019-June 2021)



Collaborative Care Claims Overview (July 2019-June 2021)

- **Utilization by Plan:** 43% SP members; 35% TP members; 22% Medicaid Direct.
- **Utilization by race:** 47% White/Caucasian; 42% Black/AA (who represent 35% of our population)
- **Utilization by ethnicity:** 91% Non-Hispanic/Latinx; 9% Hispanic/Latinx (members trend younger)
- **Utilization by age:** 29% (under age 18) and 71% (over 18); compared to general Medicaid population: 47% (under age 18) and 53% (over 18)
- Majority of utilization **clusters around major hospitals/cities.**

Why Aren't Practices Providing CoC?

Barriers We Have Heard About:

Medicare Rules aren't the same as Medicaid Rules

- Who can do BH coordination

Lack of connection or access to a psychiatry partner

- Complexity to contract or find a partner

Administrative burden to manage population

- Standing up a registry is difficult

Too much going on

- Need support to set up, understand, and implement

Troubleshooting all alone is hard

- No clear place to learn from others

Making the Case for Collaborative Care

Problem

- One in five Americans experienced mental illness in the past year. [1]
- Mental health and substance use disorders (MH/SUD) are often chronic conditions that people experience with other health conditions, such as heart disease and diabetes.
- Yet only 25 percent of patients receive effective mental health care, including in primary care settings, where the majority of patients with MH/SUD receive their usual care.[2]

Solution

- Better care coordination via integration of mental health and primary care has been shown to improve patient access, outcomes, and reduce costs.
- Three decades of research and over 80 randomized controlled trials (RCT) have identified one model in particular — the Collaborative Care Model — as being effective and efficient in delivering integrated care.[3]
- In the Collaborative Care Model, a primary care physician treating patients' behavioral health problems leads a team that consists of a behavioral health care manager and psychiatric consultant.
- It is estimated that $26 – $48 billion could be saved annually through effective integration of mental health and other medical care.[4]

Team-based	**Systematic**	**Cost-effective**	**Patient-Centered**	**Evidence Based**

Making the Case for Collaborative Care

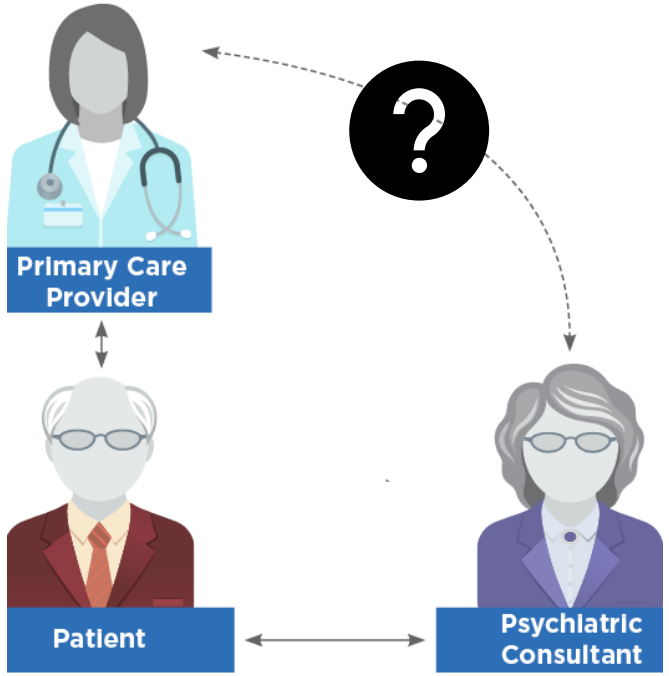
- Shown to be affective in a variety of settings, safety net and FQHCs, OB/GYN and rural care settings
- Disparities in access to quality treatment for mild to moderate BH conditions experienced by racial and/or ethnic minority groups can be alleviated with CoCM.
- CoCM can enhance treatment for patients with cancer, diabetes, cardiovascular disease and other physical conditions.
- Observational studies and clinical trials show how CoCM improves screening, referral and treatment for SUD in primary care.

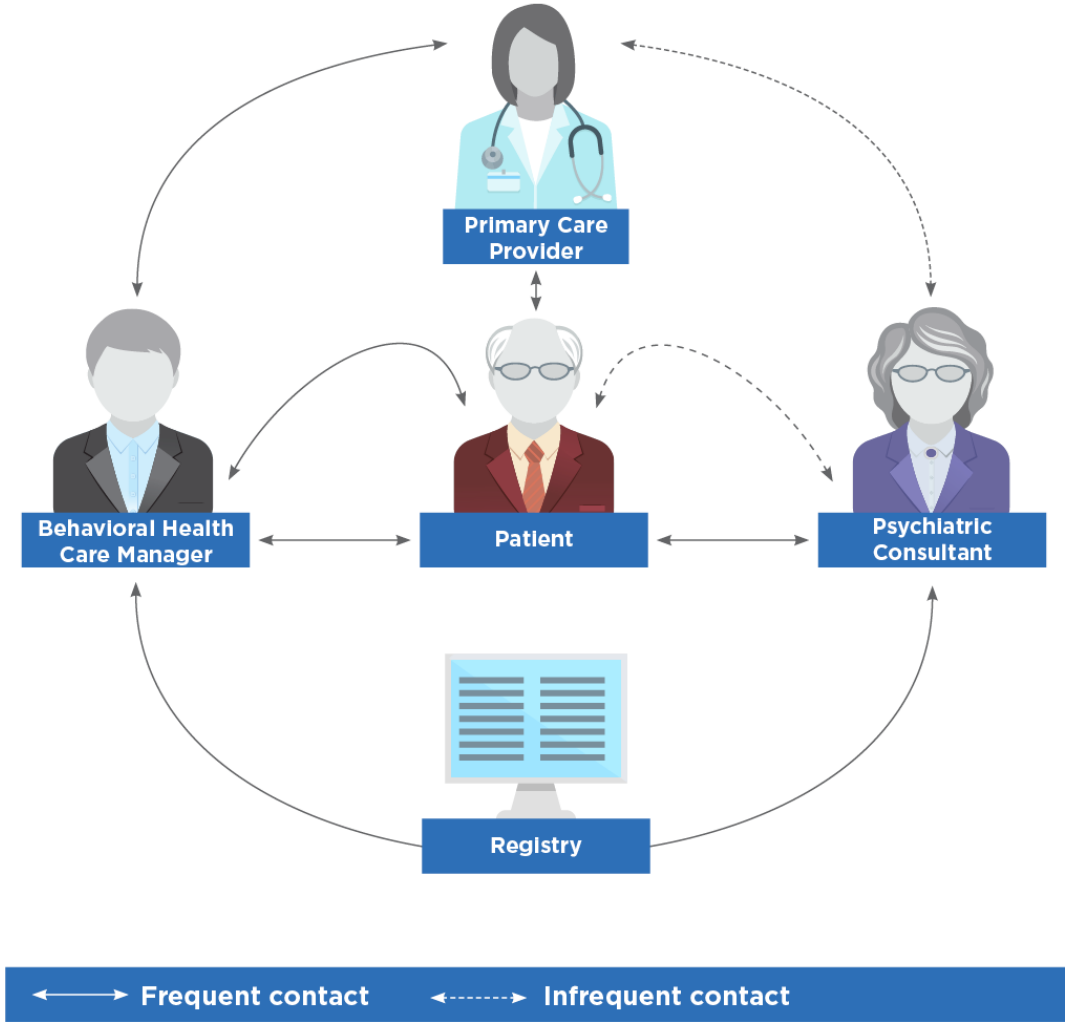
References

1. Department of Health and Human Services. "Mental Health Myths and Facts." http://www.mentalhealth.gov/basics/myths-facts/
2. Unützer J et al. "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes." Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013.
3. Advancing Integrated Mental Health Solutions (AIMS) Center. "Evidence Base." https://aims.uw.edu/collaborative-care/evidence-base
4. Milliman, Inc. "Economic Impact of Integrated Medical-Behavioral Healthcare. Implications for Psychiatry." April 2014.

The Collaborative Care Model in Primary Care

From This to This





Case Studies: Adult Behavioral Health

- “Anna” is a 56yo F with history of depression and fibromyalgia presenting to PCP with worsening symptoms in the context of caring for her ill father and increased work stress.
- Recent symptoms include worsening sleep difficulty, anhedonia, fatigue, difficulty concentrating at work, and social withdrawal for the past 6 weeks. Rx Duloxetine 90 mg daily x 5 years for depression and fibromyalgia, but feels not as helpful as in the past.
- Anna’s PHQ-9 score was 16/27 (moderately severe depression) and PCP referred patient to Care Manager who obtained a more detailed assessment and provided brief psychotherapy.

Case Studies: Adult Behavioral Health

- CM contacted consultant Psychiatrist who verified the diagnosis and worked with CM to formulate a formal treatment plan, including short-term evidence-based psychotherapy (CBT and grief therapy in this case) to be performed by CM weekly for the next 3 months and recommended the PCP increase Duloxetine to 120mg daily while considering augmentation strategies if no improvement by next PCP visit in 3 mos.
- Anna added to registry in PCP's EMR in order to track clinical outcomes at every visit.

Case Studies: Adult Behavioral Health

- During Anna's third visit with CM, she mentions some improvement in mood, but continues to have trouble with concentration, and has noticed side effect of restless legs since increase in medication.
- CM documents and reports this to consultant Psychiatrist, who communicates with CM and PCP to discuss alternatives, in this case lowering Duloxetine back to previous dose of 90mg daily and adding low dose Bupropion to her regimen.
- By next FU PCP visit, Anna reports improvement in all symptoms including better concentration and no RLS.

Case Studies: Adult Behavioral Health

Improved patient access, outcomes, and satisfaction	Anna received BH care quickly with feedback in between PCP appointments
Better allocation of healthcare resources	Allowing Psychiatrists to impact patient care on population level and allows more time in their schedule to see patients with requiring more intensive or complex psychiatric care

Case Studies: Pediatric Care

- Jorge is a 13 year-old struggling with school. Pre-pandemic, he was a good student, easygoing around his peers. However, after 18 months at home with remote schooling, he is having a difficult time learning and focusing, and his parents have noted that he seems incredibly uncomfortable around peers, isolative.
- Due to Jorge scoring positively on the PHQ-2, a PHQ-9 was completed, and with Jorge's elevated score, he and his family were invited to meet with the BH care manager for brief 4 session CBT with the CM. Medication was discussed with Jorge and his parents, but they wanted to hold off.

Case Studies: Pediatric Care

- Jorge's symptoms and response to treatment was tracked and discussed in consultation with the pediatrician and consulting psychiatrist
- Jorge is continuing to have some isolation and low mood, but the bigger issue has become his academics. His PHQ-9 score had only dropped a few points, and so the consulting psychiatrist recommended addition of an SSRI medication and provided guidance to his pediatrician on dosing and managing side effects.
- With the combination of brief CBT, phone contact and care management with the parents and the SSRI, Jorge is doing better in school and his PHQ-9 score is improving.
- He remains on the registry and his treatment, and scores are continuing to be tracked by the BHCM, PCP and consulting psychiatrist with ability to step him up back up to CBT or transition to specialty MH care if needed.

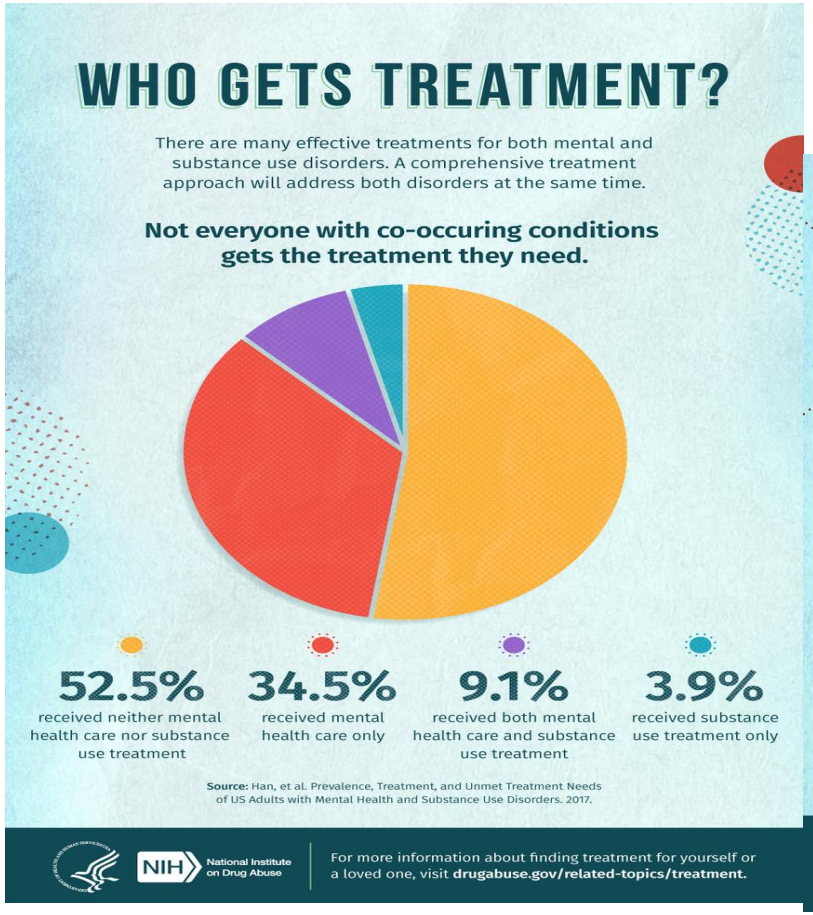
Collaborative Care Outcomes in Pediatrics

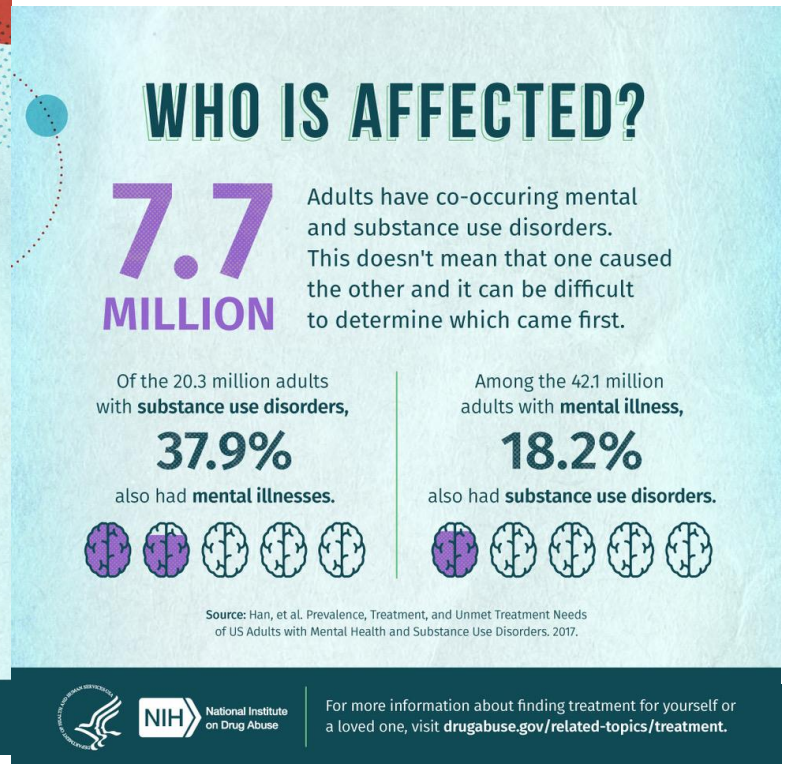
- Greater access to care, less stigmatizing through stepped collaborative care
  - More likely to initiate referred treatment
  - Longer duration of treatment
  - Increased likelihood of receipt of treatment
  - Greater uptake in psychotherapy vs. solely medication
  - Increased odds of engagement
- Symptom improvement
  - Decrease in externalizing/internalizing problems, gains in social behaviors
  - Improvement in depressive symptoms
  - Decreased hyperactivity
  - Decreased parental stress
- Pediatricians participating perceived change, efficacy and skills in treating MH disorders

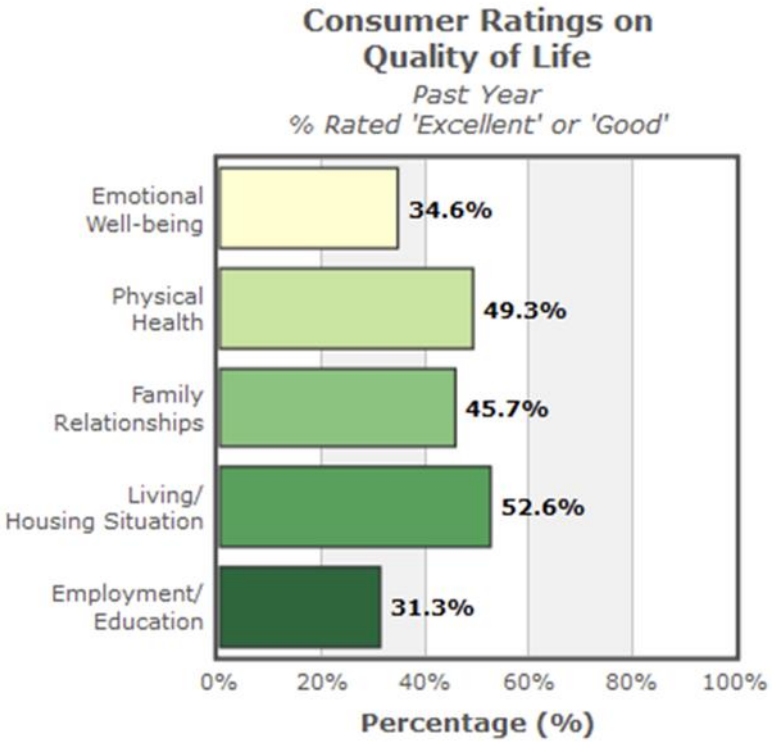
Pediatric Integrated Care Models: A Systematic Review. Burkhart et al. Clinical Pediatrics 59 (2): 148-153

Collaborative Care

- MAT for Opioid **and** alcohol conditions







NC Topps data – All SUD members, initial interview

Major identified barriers for PCP MAT prescribing addressed in Collaborative Care

BARRIERS

- Lack of BH and psychosocial support
- Limited time
- Stigma - difficult patients
- Lack of specialty backup
- Lack of confidence
- Funding

SOLUTIONS Within Collaborative Care

- CM/ addiction specialist., weekly review caseload, discuss medication and therapy issue, review needed BH/SUD services, written recommendations, level of care connections
- BH care manager screens for conditions, frequent contact, psychosocial support, adherence, monitors, maintains registry
- Specialist can provide direct consultation services outside of collaborative care, telehealth changes for SUD may remain post Covid
- Collaborative care codes support oversight

SUD Model Challenges

PHQ –9 does not measure SUD outcomes.

- Retention major measure-treatment adherence, drug screens
- Brief Addiction Monitor- Assesses past 7-30 day use, risk and protective factors.

Limited availability of BH/SUD expert

- CM development of linkages to SUD provider system, knowledge of brief interventions, motivational interviewing, brief action planning, FRAMES, etc.
- monitor outcomes to outside provider with initial induction, possible transfer to PCP for maintenance treatment

CM knowledge to monitor treatment phases.

- CM or RN with ability to screen/assess for appropriateness office-based treatment and induction, stabilization, maintenance phase.

SUD Model Challenges

OUTCOMES

SUMMIT
Randomized Trial

39% received treatment in collaborative care vs. 16% control

33% abstinence vs 22% control


QUESTIONS?

APPENDIX

Collaborative Care Claims by Program (July 2019-June 2021)

	Beneficiaries with Approved Claim	Subgroup Population (% of Medicaid)
Tailored Plan	869 (35%)	221,024 (35%)
Tribal Option	1 (0%)	5,522 (0%)
Standard Plan	**1059 (43%)**	**1,666,308 (40%)**
Medicaid Direct	**551 (22%)**	**800,359 (25%)**

***DARK BLUE text denotes a difference in % of total Medicaid population that the group represents.**

Collaborative Care Claims by Race (July 2019-June 2021)

	Beneficiaries with Paid Claim	Subgroup Population (% of Medicaid)
American Indian	7 (0%)	36,709 (1%)
Asian	2 (0%)	46,605 (1%)
Black	**967 (42%)**	**954,788 (35%)**
Hawaiian or Pacific Islander	1 (0%)	2,639 (0%)
Multiracial	257 (11%)	290,575 (11%)
White	**1,085 (47%)**	**1,339,175 (50%)**
Unreported	5 (0%)	22,722 (1%)
Not Known	156 *(excluded from % calculation)*	-

***DARK BLUE text denotes a difference in % of total Medicaid population that the group represents.**

Collaborative Care Claims by Ethnicity (July 2019-June 2021)

	Beneficiaries with Paid Claim	Subgroup Population (% of Medicaid)
Hispanic	232 (9%)	405,400 (15%)
Non-Hispanic	2,483 (91%)	2,287,813 (85%)

*DARK BLUE text denotes a difference in % of total Medicaid population that the group represents.

Collaborative Care Claims by Age (July 2019-June 2021)

The average age for beneficiaries with a paid claim is 36.1.
The average age for the Medicaid population is 26.3

Age Group	Beneficiaries with Paid Claim	Subgroup Population (% of Medicaid)
0-17	673 (29%)	1,257,430 (47%)
18-45	859 (37%)	888,190 (33%)
46-64	514 (22%)	327,233 (12%)
65+	278 (12%)	220,360 (8%)

*DARK BLUE text denotes a difference in % of total Medicaid population that the group represents.

Collaborative Care Use by Advanced Medical Homes (AMH) (July 2019-June 2021)

	Beneficiaries with Approved Claim	Subgroup Population (% of Medicaid)
Tier 3	**1,640 (66%)**	**1,649,843 (61%)**
Tier 2	382 (15%)	355,201 (13%)
Tier 1	21 (1%)	27,895 (1%)
No Tier	**437 (18%)**	**660,274 (25%)**

***DARK BLUE text denotes a difference in % of total Medicaid population that the group represents.**

Expanding Opportunities for Competitive Integrated Employment and Other Meaningful Day Options for Individuals with Disabilities

The NC Department of Health and Human Services (DHHS) is committed to transforming its services and systems to support individuals with disabilities as fully included members of their communities. To achieve this vision, the Department intends to maximize opportunities for individuals with disabilities to explore, seek, and maintain Competitive Integrated Employment and benefit from other meaningful day options.

This initiative builds upon historical efforts by DHHS to expand opportunities for North Carolinians with disabilities to achieve their goals for employment and community inclusion and furthers the Department's mission to improve the health, safety and well-being of all North Carolinians. It aligns closely with the Department's 2021 – 2023 Strategic Plan, its ongoing work to update the state's Olmstead Plan, and the integration mandate of the Americans with Disabilities Act.

The Department's commitment to maximize Competitive Integrated Employment and meaningful day options for individuals with disabilities (e.g., Community Living and Supports, Day Supports, Supported Employment) is a comprehensive effort that continues to evolve and improve. The Department will enhance service delivery for individuals with Intellectual and Developmental Disabilities (I/DD) and Traumatic Brain Injury (TBI) by taking key steps over the next five years to align employment services with evidence-informed, current best practices.

Specifically, the Department will undertake the following:

- Update and align state and Medicaid-funded Supported Employment (SE), Community Living and Supports (CLS), and Day Supports services to incorporate current best practices in the service delivery system for individuals with IDD and TBI. DHHS remains committed to consistent evaluation regarding the services provided to individuals with mental illness as well.
- Engage stakeholders in disability communities to ensure understanding of new services and pathways available to them.
- Conduct informed choice awareness campaign with focus on career pathways and related support services that lead to Competitive Integrated Employment and meaningful day options.
- Offer trainings for providers, families, and advocates regarding changes in service definitions and best practices.
- Develop and promote a comprehensive Transition to Competitive Integrated Employment guide for stakeholders that clearly explains defines the new service array and how to access inclusive educational and employment opportunities for individuals with disabilities.
- Offer enhanced provider training to help inform and enrich employment service delivery.

For more information, please see Expanding Opportunities for Competitive Integrated Employment and Other Meaningful Day Options.

Kidney Health Toolkit

November is National Diabetes Month, a time when people across the nation team up to bring awareness to diabetes. The focus this year is on prediabetes and preventing diabetes. The National Committee for Quality Assurance (NCQA) has developed a Kidney Health Toolkit to assist with this effort. Materials in the toolkit support providers and agencies in educating patients on the link between Chronic Kidney Disease and related conditions including diabetes and cardiovascular disease. The toolkit is available on the *NCQA webpage*.

Chronic Kidney Disease (CKD) is common but under-recognized. Over 37 million adults in the US have CKD and as many as 90% don't know it, because it often has no symptoms. Many people are also unaware of CKD causes and risk factors, including diabetes.

Early diagnosis, regular monitoring and ongoing management of CKD are crucial to preventing or delaying its progression and health complications. Health plans and primary care teams play a critical role in identifying and managing CKD.

The Kidney Health Toolkit includes the following tools to help patients and care teams navigate CKD diagnosis, monitoring and management:

Let's Talk About Diabetes and Kidney Health: Ready-Set- Provider guide on diabetes and CKD testing.

Learn more about best practices in promoting kidney health and CKD care.

Access the Kidney Health Toolkit

Name *

FIRST LAST

Title

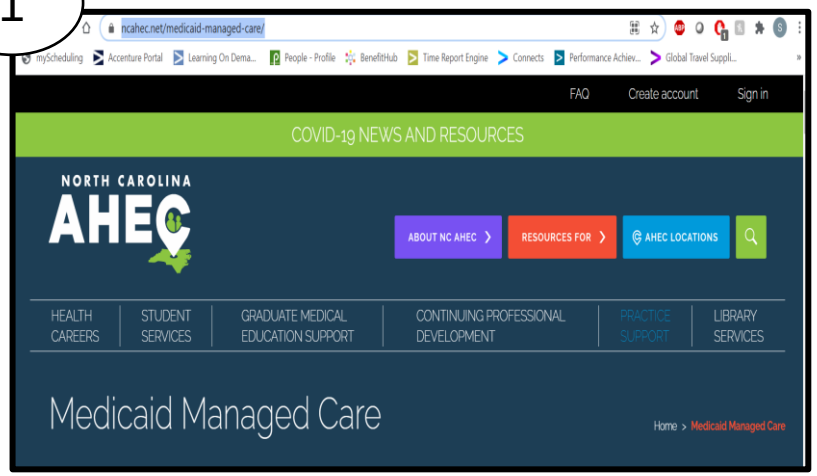
Organization *

Email *

Submit

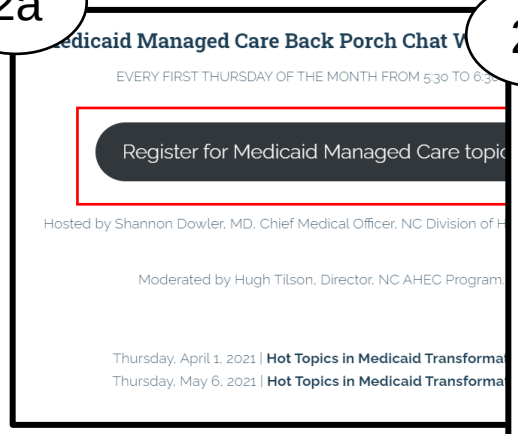
How To Sign up for the Back Porch Chat Webinar Series

1



1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



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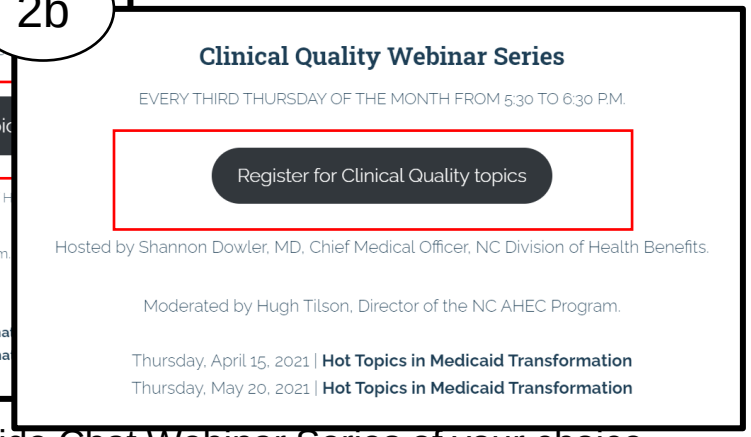
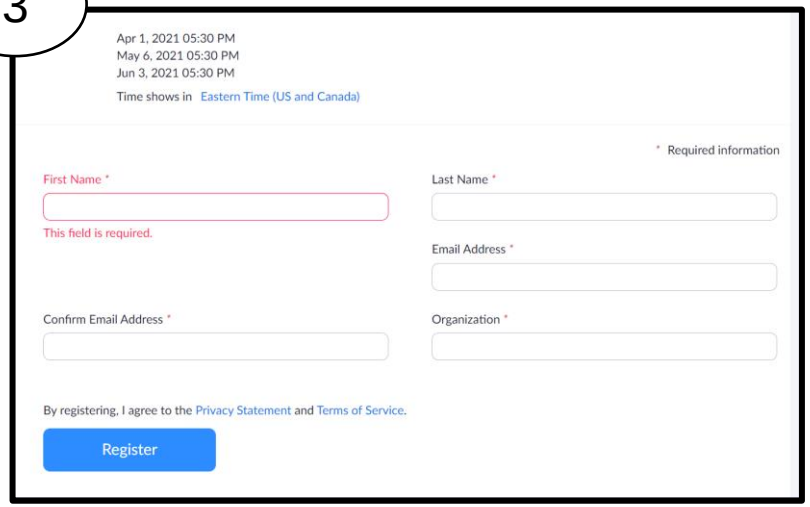


2. Scroll down to the Fireside Chat Webinar Series of your choice

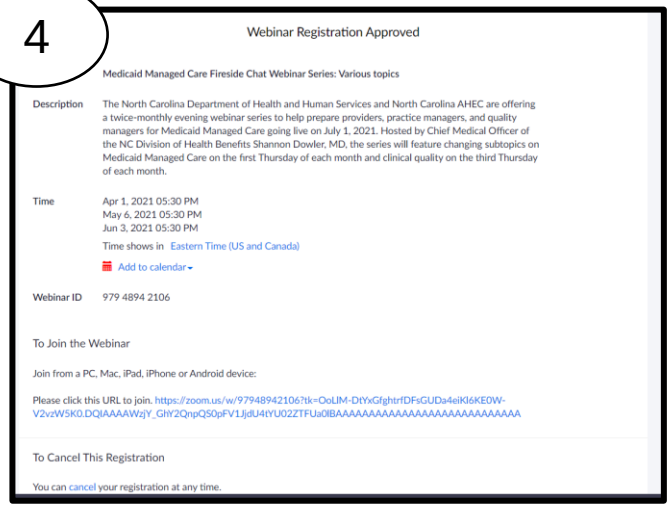
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.

Provider Resources

- NC Medicaid Managed Care Website
  - medicaid.ncdhhs.gov
  - Includes County and Provider Playbooks
  - Fact Sheets
  - Day One Quick Reference Guide
- NC Medicaid Help Center
  - medicaid.ncdhhs.gov/helpcenter
- Practice Support
  - ncahec.net/medicaid-managed-care
  - NC Managed Care Hot Topics Webinar Series, hosted by Dr. Dowler on the first and third Thursday of the month
- Regular Medicaid Bulletins
  - medicaid.ncdhhs.gov/providers/medicaid-bulletin

What should Providers do if they have issues?

1

Check in NCTracks for the Beneficiary's enrollment (Standard Plan or Medicaid Direct) and Health Plan

If you still have questions, call the NCTracks Call Center: 800-688-6696

2

Connect with the Health Plan (PHP) for coverage, benefits, and payment questions.

You can find a list of health plan contact information at health-plan-contacts-and-resources
Also, please refer to the Day One Provider Quick Reference Guide for more information on how to contact PHPs

3

Consult with the Provider Ombudsman on unresolved problems or concerns.

Call 866-304-7062 or email Medicaid.ProviderOmbudsman@dhhs.nc.gov

Day 1 Quick Reference Guide

VERIFICATION OF ELIGIBILITY AND PLAN

- **NCTracks:** Providers will be able to verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal
- **Real Time Eligibility Verification Method**
  a. Log into the NCTracks Provider Portal: https://www.nctracks.nc.gov/ncmmisPortal/loginAction?flow=PP
  b. Follow the Eligibility > Inquiry navigation
  c. Populate the requested provider, recipient and time period information
- **NCTracks Call Center:** 800-688-6696

PROVIDER PORTAL / PROVIDER SERVICES

- **AmeriHealth Caritas**: https://navinet.navimedix.com / Provider Services: 888-738-0004
- **Carolina Complete**: https://network.carolinacompletehealth.com / Provider Services: 833-552-3876
- **Healthy Blue**: https://provider.healthybluenc.com or https://www.availity.com / Provider Services: 844-594-5072
- **United Healthcare**: https://www.uhcprovider.com / Provider Services: 800-638-3302
- **WellCare**: https://provider.wellcare.com / Provider Services: 866-799-5318
- **NC Medicaid Provider Playbook**: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

PRIOR AUTHORIZATIONS

- **AmeriHealth Caritas: Online**: Provider Portal / **Phone**: 833-900-2262 / **Pharmacy**: 866-885-1406
- **Carolina Complete: Online**: Provider Portal / **Phone:** 833-552-3876 / **Pharmacy:** 833-585-4309
- **Healthy Blue: Online**: Provider Portal / **Phone:** 844-594-5072 / **Pharmacy**: 844-594-5072
- **United Healthcare: Online:** UHCProvider.com / **Pharmacy: Phone:**855-258-1593 **Online**: CoverMyMeds: https://www.covermymeds.com/main/prior-authorization-forms/optumrx/; SureScripts: https://providerportal.surescripts.net/ProviderPortal/optum/login; Pharmacy Resources and Physician Administered Drugs: UHCprovider.com
- **WellCare: Online**: Provider Portal / **Phone:** 866-799-5318 / **Pharmacy**: Fax: 800-678-3189 **or** SureScripts: https://providerportal.surescripts.net/providerportal/

Day 1 Quick Reference Guide

CLAIMS

- **AmeriHealth Caritas: Online**: https://navinet.navimedix.com / **Phone**: 888-738-0004
- **Healthy Blue: Online:** www.availity.com / **Phone**: 844-594-5072
- **Carolina Complete: Online**: https://network.carolinacompletehealth.com
- **United Healthcare: Online**: https://www.uhcprovider.com / **Phone**: 800-638-3302
- **WellCare: Online**: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims / **Phone:** 866-799-5318

Two Claims Submission Fact Sheets are available on the Provider Playbook at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care that address filing managed care claims.

NON-EMERGENCY MEDICAL TRANSPORTATION & NON-EMERGENCY AMBULANCE TRANSPORTATION

- **AmeriHealth Caritas, Carolina Complete, Healthy Blue, United Healthcare:**

ModivCare Health Care Provider Line: 855-397-3606 / ModivCare Transportation Provider Line: 855-397-3604

- **WellCare**: One Call Health Care Provider Line: 877-598-7602 / One Call Transportation Provider Line: 877-598-7640

If you are helping a member arrange transportation, call the PHP Member Services line on the member's Medicaid ID card.

PROVIDER OMBUDSMAN

Medicaid Managed Care Provider Ombudsman: **Phone:** 866-304-7062 / **Online:** Medicaid.ProviderOmbudsman@dhhs.nc.gov

HEALTH PLAN QUICK REFERENCE GUIDE LOCATION

- AmeriHealth Caritas: https://www.amerihealthcaritasnc.com/assets/pdf/provider/provider-reference-guide.pdf
- Carolina Complete: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHNCurrent-PDF-QRG-Form.pdf
- Healthy Blue: https://provider.healthybluenc.com/docs/gpp/NC_CAID_QuickReferenceGuide.pdf
- United Healthcare: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/NC-Medicaid-QRG.pdf
- WellCare: https://www.wellcare.com/North-Carolina/Providers/Medicaid