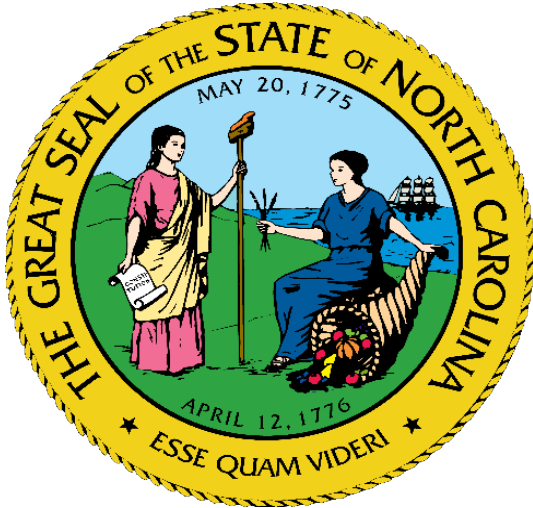


# Fireside Chat: Hot Topics in Medicaid Transformation

March 18, 2021



## RCC (Relay Conference Captioning)

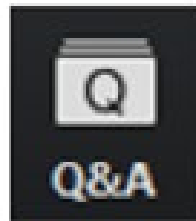
Participants can access real-time captioning for this webinar here:

<https://www.captionedtext.com/client/event.aspx?EventID=4743751&CustomerID=324>



# Logistics for today's COVID-19 Forum

**Question during the live webinar**



**Technical assistance**

[technicalassistanceCOVID19@gmail.com](mailto:technicalassistanceCOVID19@gmail.com)

# AGENDA

01

AMH, Panel, HOSAR, Glidepath, Quality Updates

02

Other Updates

03

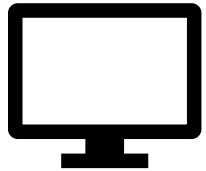
What Ifs

04

Questions

# Statewide Open Enrollment

NCDHHS [announced on Monday 3/15](#) the launch of statewide open enrollment for NC Medicaid Managed Care. Beneficiaries can enroll through one of **four channels**:



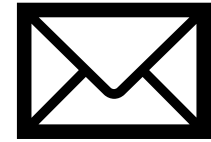
[Online](#)



Calling the NC  
Medicaid Managed  
Care Call Center at  
833-870-5500  
(TTY: 833-870-  
5588)



The free NC  
Medicaid Managed  
Care mobile app  
available on Google  
Play or the App  
Store



Using the mail-  
in forms sent  
to them in an  
enrollment  
packet

# Panel Management—New Functionality in NCTracks

Office Administrators will get a monthly message in NC Tracks Provider Message Center with a link to a report with their Medicaid Direct (FFS) and Health Plan panels.

REPORT: PM02429-R0010  
PAYER: XXXXX

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
NCTRACKS

PROCESS DATE: MM/DD/YYYY  
PROCESS TIME: HH:MM:SS  
PAGE: XXX,XXX

AMH MEDICAID DIRECT/MANAGED CARE PCP ENROLLEE REPORT  
AS OF MM/DD/YYYY

NPI/ATYPICAL ID: XXXXXXXXXXXX  
PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
ADDRESS LINE 1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
ADDRESS LINE 2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
CITY, STATE ZIP: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

- Program
- Start/End Dates of Assignment
- Date of Last Visit\*
- Total Visits\*

MID	RECIPIENT NAME	DOB	ACTIVE	ASSIGNMENT		EFF DATE	END DATE	LAST OFFICE VISIT	TOTAL VISITS
				PROGRAM					
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	Y	MED-DIR		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	XXX
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-MGD		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-MGD		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/YYYY	N	MED-DIR		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	BLANK

# PCP Reassignment

- DHB will do primary care reassignment in late March for **some** members
- Member Selection Criteria:
  - Managed Care Eligible
  - Enrolled in Medicaid before 09/01/2020 (enrolled for 6 months)
  - Currently assigned to a PCP practice
  - Does not have any primary care claims with their assigned PCP between 01/01/19 AND 02/28/21
  - Has primary care claims with another PCP practice who is active CA 2/AMH 2 or 3
  - At least one of the PCP practices the member saw is in the same county or an adjacent county to the beneficiary
  - At least one of the PCP practices the member saw for primary care was not an urgent care
- **~175,000 members meet these criteria**
- Each PCP practice the member saw for primary care is assigned a score that factors in the following:
  - The number of visits the member had with the respective PCP
  - The number of days since the member's most recent visit with the PCP
  - Whether the beneficiary lives in the same county as the PCP
- **Member is assigned to the PCP practice with the highest score (best fit)**
- DHB will distribute new Medicaid ID cards to affected members in April 2021

# Healthy Opportunities Screening, Assessment and Referral Payment (HOSAR)

~1000  
claims billed  
to date.

Effective January 1, 2021, NC Medicaid and NC Health Choice is temporarily covering **Healthy Opportunities screenings** to encourage providers to gain capacity for screening Medicaid beneficiaries for unmet health-related resource needs and referring them to appropriate community-based resources, prior to the launch of Medicaid managed care.

**Current Carolina Access (CAI) providers** are eligible to bill code **G9919** for positive healthy opportunities screenings conducted using the Department's standardized screening questions or equivalent questions. Coverage of this code will continue through June 30, 2021; continued coverage after managed care launch will be at the discretion of the Health Plans.

HOSAR Payment Issue has been identified. NCTracks issue will be fixed by 3/28. Look for Medicaid Bulletin on re-billing instructions.



# AMH Glidepath Attestation Is LIVE: AMH 3s can Receive \$8.51 PMPM for 3 Months After Contracting with 2 PHPs and Completing Data Integration Testing

Attest by March 30 for the April Payment. Providers only need to Attest once (by site).

## To Attest:

The AMH Tier 3 Glidepath Attestation is part of an updated set of AMH functionalities within the provider portal in NCTRACKS.

408 AMHs  
have attested  
(as of 3/15)

1. Input NPI and location for the practice attesting to glidepath requirements

2. Select "Attest to AMH Tier 3 Glidepath Payments Requirements"

**Provider Portal**

Welcome, Vijay Saxena. (Log out) | NCTracks Help

Eligibility | Prior Approval | Claims | Referral | Code Search | Enrollment | Administration | Trading Partner | Payment | Consent Forms | Training | PORTAL DEV

Home > Advanced Medical Home Tier Attestation

### Advanced Medical Home Tier Attestation

\* indicates a required field

Select Provider and Service Location

\* NPI/Atypical ID: 1437552015

\* Service Location: 7100 SIX FORKS RD, STE 101, RALEIGH, NC

This location is a certified Tier 3 Advanced Medical Home (AMH) provider.

Select Appropriate Action

☐ Downgrade to AMH tier Level 2

☐ View/Update AMH Tier 3 Supplemental Data

☒ Attest to AMH Tier 3 Glidepath Prepayments Requirements

Pre-Payment Glidepath Model Attestation

\* 1. The AMH Tier 3 has completed contracting with two or more of the following Health Plans at the AMH Tier 3 Level (Check all that apply and provide completion date):

<input type="checkbox"/> AmeriHealth Caritas	Complete Date	
<input type="checkbox"/> United Healthcare	Complete Date	
<input type="checkbox"/> Carolina Complete Health	Complete Date	
<input type="checkbox"/> WellCare of North Carolina	Complete Date	
<input type="checkbox"/> HealthyBlue	Complete Date	

\* 2. The AMH Tier 3 or its CIN/other partner has completed the following: 1.) necessary technology work based on the mandatory AMH data interfaces (LINK); 2.) has successfully completed testing of the data interfaces with at least two or more Health Plans 3.) has completed defect resolution with two or more Health Plans (Check all that apply and provide completion date):

<input type="checkbox"/> AmeriHealth Caritas	Complete Date	
<input type="checkbox"/> United Healthcare	Complete Date	
<input type="checkbox"/> Carolina Complete Health	Complete Date	
<input type="checkbox"/> WellCare of North Carolina	Complete Date	
<input type="checkbox"/> HealthyBlue	Complete Date	

\* Attestation

☐ I attest and verify that all information provided in this Attestation Form is accurate and complete in all respects. I understand that material misrepresentations in the Form may affect the eligibility for Advanced Medical Home Certification, and that North Carolina Department of Health and Human Services may further review such misrepresentations.

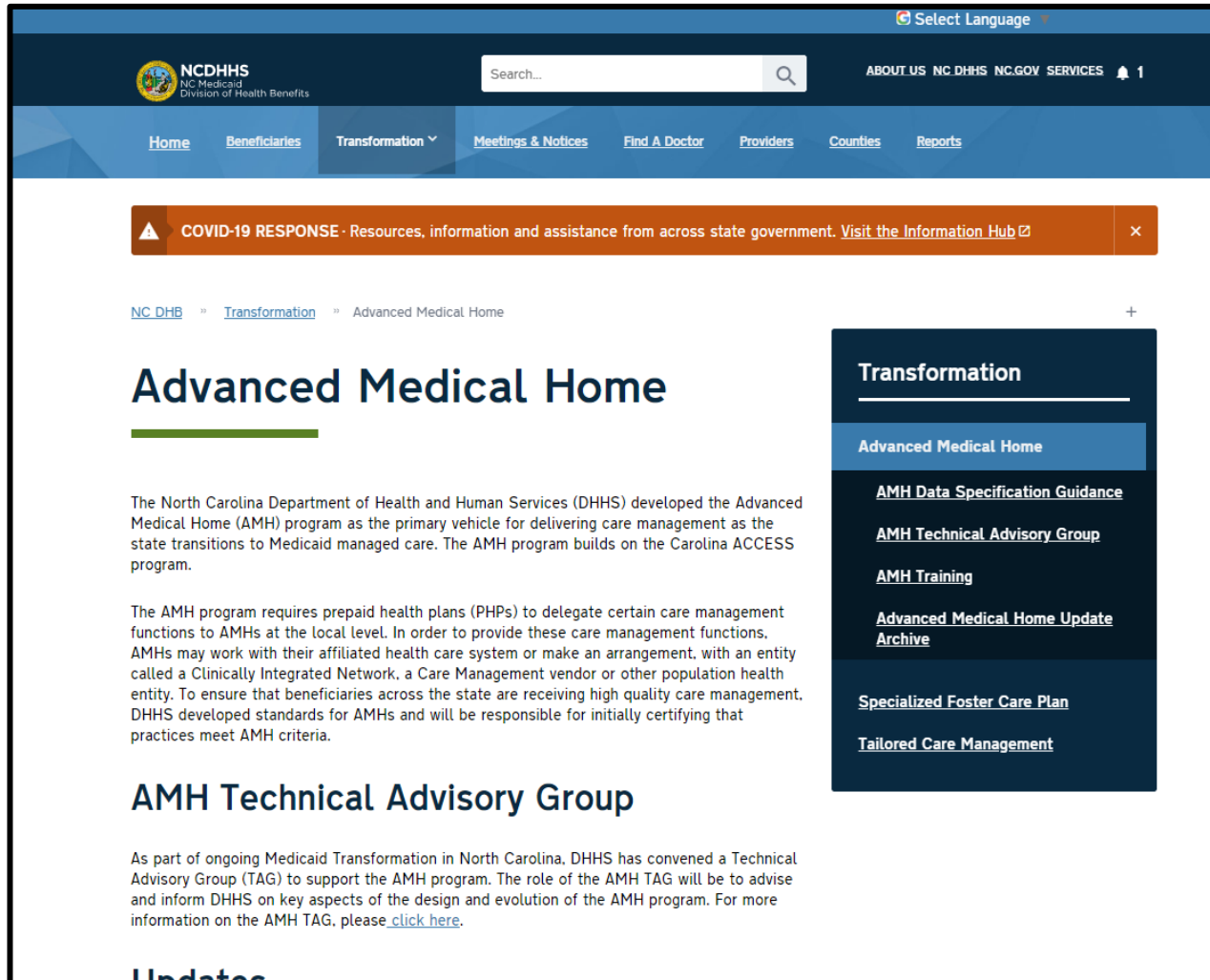
Submit

3. Practices should select the PHPs they are contracted with at the Tier 3 Level and date contracts were completed

4. Practices should select the PHPs they have tested with and testing completion date



# AMH Implementations

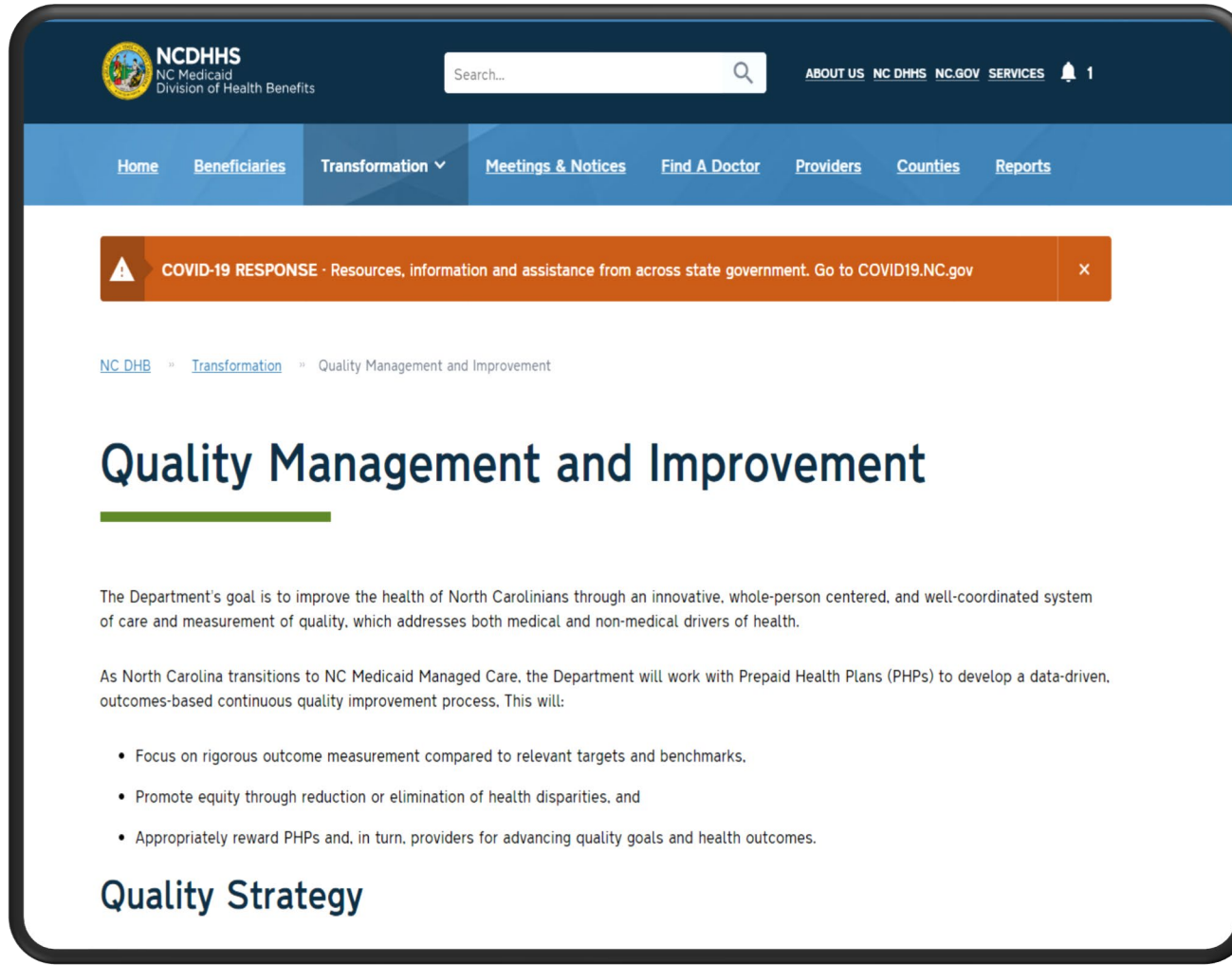


The screenshot shows the NCDHHS website with the following elements:

- Header:** NCDHHS logo, search bar, and navigation links (ABOUT US, NC DHHS, NC.GOV, SERVICES).
- Navigation Bar:** Home, Beneficiaries, Transformation (selected), Meetings & Notices, Find A Doctor, Providers, Counties, Reports.
- Banner:** COVID-19 RESPONSE - Resources, information and assistance from across state government. Visit the Information Hub.
- Breadcrumbs:** NC DHHS » Transformation » Advanced Medical Home.
- ## Advanced Medical Home
- The North Carolina Department of Health and Human Services (DHHS) developed the Advanced Medical Home (AMH) program as the primary vehicle for delivering care management as the state transitions to Medicaid managed care. The AMH program builds on the Carolina ACCESS program.
- The AMH program requires prepaid health plans (PHPs) to delegate certain care management functions to AMHs at the local level. In order to provide these care management functions, AMHs may work with their affiliated health care system or make an arrangement, with an entity called a Clinically Integrated Network, a Care Management vendor or other population health entity. To ensure that beneficiaries across the state are receiving high quality care management, DHHS developed standards for AMHs and will be responsible for initially certifying that practices meet AMH criteria.
- ## AMH Technical Advisory Group
- As part of ongoing Medicaid Transformation in North Carolina, DHHS has convened a Technical Advisory Group (TAG) to support the AMH program. The role of the AMH TAG will be to advise and inform DHHS on key aspects of the design and evolution of the AMH program. For more information on the AMH TAG, please [click here](#).
- ## Updates
- Sidebar:**
  - Transformation
  - Advanced Medical Home
  - [AMH Data Specification Guidance](#)
  - [AMH Technical Advisory Group](#)
  - [AMH Training](#)
  - [Advanced Medical Home Update Archive](#)
  - [Specialized Foster Care Plan](#)
  - [Tailored Care Management](#)

- AMH Provider Manual 2.0 posted All AMH Tier 3 requirements
- Advanced Medical Home Data Specification Page

# Quality Management and Improvement

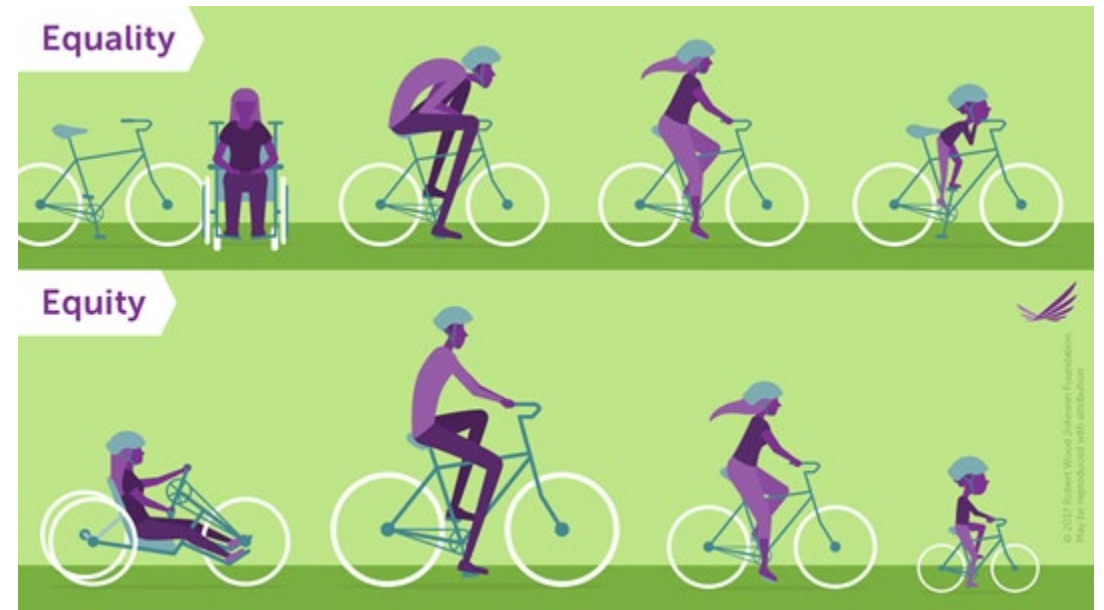


The screenshot shows the NCDHHS NC Medicaid Division of Health Benefits website. The header includes the NCDHHS logo, a search bar, and navigation links: ABOUT US, NC DHHS, NC.GOV, SERVICES, and a notification bell. The main navigation bar has links for Home, Beneficiaries, Transformation (selected), Meetings & Notices, Find A Doctor, Providers, Counties, and Reports. A COVID-19 RESPONSE banner is visible. The breadcrumb trail reads: NC DHHS » Transformation » Quality Management and Improvement. The main heading is "Quality Management and Improvement". The text states: "The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health." It also mentions: "As North Carolina transitions to NC Medicaid Managed Care, the Department will work with Prepaid Health Plans (PHPs) to develop a data-driven, outcomes-based continuous quality improvement process. This will:" followed by a bulleted list: "• Focus on rigorous outcome measurement compared to relevant targets and benchmarks.", "• Promote equity through reduction or elimination of health disparities, and", "• Appropriately reward PHPs and, in turn, providers for advancing quality goals and health outcomes." The section "Quality Strategy" is partially visible at the bottom.

- ✓ **Medicaid Quality Strategy**—outlines aims, goals, objectives and interventions to assure, monitor, and improve quality
- ✓ ***Annual Quality Report***—4 years of data on Medicaid quality
- ✓ ***Quality Measure Technical Specifications:*** Standard Plan and Tailored Plan measure sets with technical specifications and targets

# Proposed Carolina Access Temporary Health Equity Payments

- Available: April – June 2021
- Eligible providers: Carolina Access I and II providers serving beneficiaries from high needs areas.
- Increased PMPM based on practice's mix of beneficiaries (measured by poverty rate at beneficiary's census tract).

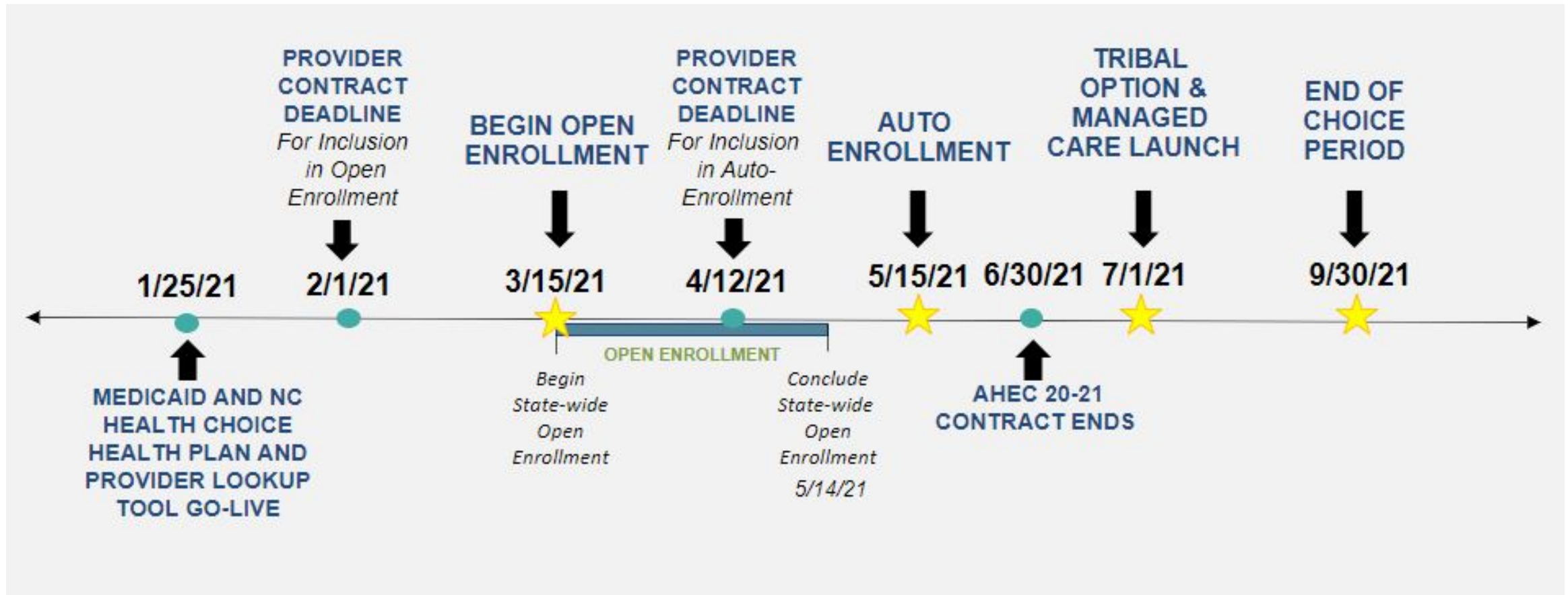


Source: Robert Wood Johnson Foundation:

<https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html#/download>

# Provider Contracting

Providers are encouraged to contract with all PHPs. Contact information each PHP to engage in contracting is available [here](#).



# Network Adequacy Oversight

## What are the network adequacy standards based upon?

- Network adequacy standards are established as either:
  - A maximum travel time or distance from a member's residence to one or more providers of a certain type or
  - A minimum number of providers of a certain type within a geographic boundary (county or region)
- Network accessibility standards are established as the maximum amount of time a member should have to wait to obtain an appointment with a participating provider based on the type and urgency of the service being requested.

## What does the Department measure?

- For the time/distance standards, the Department uses software to calculate the distance in travel time and miles from a member's residence to providers.
  - A PHP's network must demonstrate that at least 95% of members in a county live within the adequacy standard in order to be compliant in that county for that standard.
  - A PHP must request an exception from any standard with which they cannot comply.
- For the standards based on a minimum number of providers within a geographic boundary, PHPs' must demonstrate that their networks have the correct number of providers of the correct type in the specific area in order to be compliant.
- Appointment wait time standards will be monitored through secret-shopper analysis, provider surveys, and analysis of member complaints after managed care launch.

## When will the Department release network adequacy status publicly?

- The Department expects to release Standard Plan network adequacy information in April 2021.

# Newborn Coverage Changes

To ensure the best health outcomes for newborns, and to support adherence to the Bright Future Guidelines on newborn visits and immunizations, PHPs shall treat all out-of-network providers the SAME as in-network providers for purposes of Prior Authorization and shall be paid in alignment Medicaid fee-for-service for services rendered through the earlier of:

- 90 days from the newborn's birth date

OR

- Date the PHP is engaged and has transitioned the child to an in-network PCP or other provider.



# Newborn Coverage Changes

The Department recommends 90 days to ensure completion of all well-child visits through the 2nd month when critical vaccines are administered, while providing leeway for visits that may be scheduled a few days or weeks past 60 days. Prior Authorization is NOT required for well-child visits and will be reimbursed in alignment with Medicaid fee-for-service. Visits beyond well-child visits will be subject to in-network prior authorization requirements and paid in alignment with Medicaid fee-for-service for services rendered. PHP Transition of Care (TOC) policies should be updated for review and approval to include the transition of care of newborns to in-network providers during the first 90 days of life.

Bright Future Guidelines which align with HEDIS W-30 require:

- Newborn Visit
- First Week Visit (3 to 5 days)
- 1 Month Visit
- 2 Month Visit
- Immunizations 0-2 months: RV, DTaP, Hib, PCV13, IPV



# What Ifs



# Managed Care What Ifs: General Scenarios

I have a small practice and many of my patients have Medicaid. If I don't get paid in a normal speed, I won't make payroll. How can I make sure I get paid right away?

What if I can't get the Provider Ombudsman to change my information in the provider directory tool to correctly reflect the PHPs that I am contracted with?

What if I see someone who is on a plan I don't accept? Will I still get paid?

What if a clinic has smaller satellite sites that don't meet Tier 3 after hours coverage?

What if a patient is dismissed from a practice, will the patient still be assigned to that practice?

What if I do all the right things and see the right patients and I still don't get paid?

# Managed Care What Ifs: Newborn & Technology Dependent Children

What if a newborn needs to be transferred to a higher level of care emergently?  
How do I know if the hospital will take the plan the child will have?

How will the hospital/practice bills be paid when a newborn is aligned to a health plan that is not part of the hospital/practice network?

What if I have a technology-dependent child and the managed care plan denies request for durable medical equipment (DME) they currently have? What if the home care agency has not contracted with their plan?

# Managed Care What-Ifs: Transition of Care

What if a patient on a standard plan moves into Foster Care? What if they move to a new county overnight and are moved without their medicines?

What if kids/families move to another county/region, how quickly will health plan and PCP transition happen?

What if my patient enrolled in a plan I don't contract with? How long will it take after they call to change their plan to one I am enrolled with?

# Managed Care What Ifs: Provider Contracting/Network Adequacy

I am an employed physician in a health system, and no one seems to know what plans we are accepting. What do I do?

When will I know what plans the hospital and specialists in my community will take so I can start to understand my network options?

What if the behavioral health providers I am used to working with don't accept Medicaid anymore? Who will see the patient?

How many times can a person change their plan in the first 60 days? How about their PCP?

What if there is not a pediatric specialist in my community that my patient needs, and the plan wants to send my patient to an adult provider?

What if my patient sees a specialist, and has for a long time, that does not take their new plan? Do I have to find them a new specialist? Can they see them out of network?

# Managed Care What-Ifs: Quality Measurement

What if a patient switches plan but has continuous enrollment? How do I manage quality performance?

What if a patient is not continuously enrolled in a Medicaid plan? What happens to their quality data when they are on and off Medicaid?

What if a patient's PCP is not in network, will it take a long time for the patient to switch PCPs or plans?

When will it start costing my practice money if our withhold metrics are not good?

# Virtual Meet & Greets with Health Plans

- NC AHEC will host virtual sessions with NC Medicaid and each of the health plans to answer questions from providers across the state. The topics and their dates are as follows:

Primary Care & Specialty Care	March 23 & April 6
Long Term Services & Supports	March 24 & April 7
Behavioral Health	March 25 & April 8

## VIRTUAL OFFICE HOURS

- Offered monthly on the fourth Thursday at 4-5pm by NC Medicaid & NC AHEC.
- Next topic is Carolina Access Health Equity Payments on March 25<sup>th</sup>.
- [More information & registration](#)

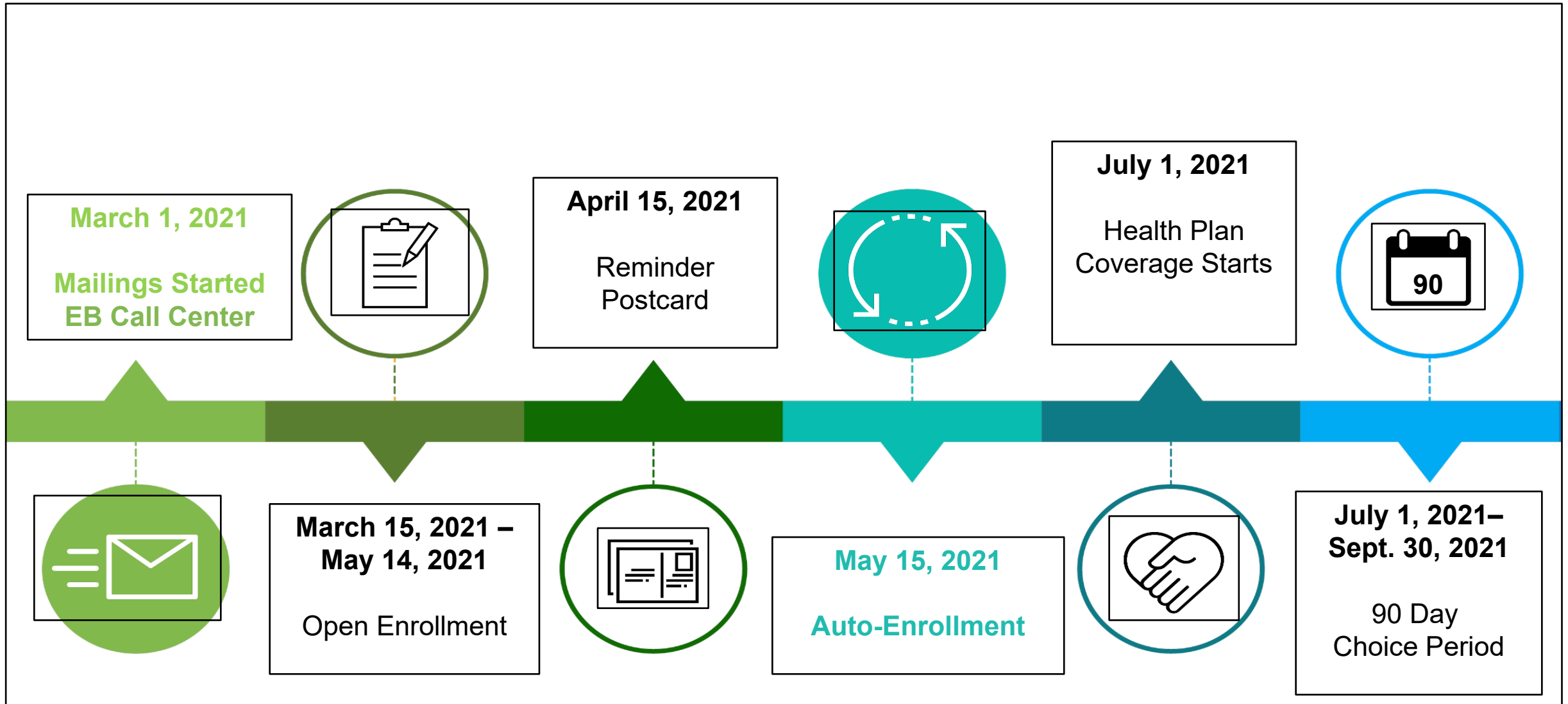




# QUESTIONS?

# APPENDIX

# NC Medicaid Managed Care Timeline



# Managed Care Populations

While most Medicaid beneficiaries will enroll in NC Medicaid Managed Care, some people will not. The table below outlines who must enroll, who may enroll, and who cannot enroll.

MANDATORY	EXEMPT	EXCLUDED <sup>1,2</sup>
<b>Must enroll</b> in a health plan	<b>May enroll</b> in a health plan or stay in NC Medicaid Direct	<b>Cannot enroll</b> in a health plan; stay in NC Medicaid Direct
Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled	Federally recognized tribal members/IHS eligible beneficiaries, beneficiaries eligible for behavioral health Tailored Plans	Family Planning Program, Medically Needy, Health Insurance Premium Payment (HIPP), Program of All-Inclusive Care for the Elderly (PACE), Refugee Medicaid

<sup>1</sup>Some individuals are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, Community Alternatives Program for Children (CAP-C), and Community Alternatives Program for Disabled Adults (CAP-DA).

<sup>2</sup>Some federally recognized tribal members/IHS eligible beneficiaries are excluded and may enroll in the EBCI Tribal Option.

# Enrollment Broker Call Center is LIVE!



**ALL OTHER TIMES:**  
Monday – Saturday  
**7 a.m. – 5 p.m.**

## Enrollment Call Center



Enrollment Specialists are available at the Call Center for support.

Beneficiaries can call toll free: 1-833-870-5500.

We are available to:

- Provide choice counseling
- Support search for preferred PCP
- Discuss health plan services
- Enroll beneficiaries in selected health plan
- Assist with some demographic changes
- Disenroll members as needed
- Process Enrollment Broker complaints and grievances
- Facilitate appeals process
- Provide support for the website and mobile app
- Aid with deaf and non-English speaking beneficiaries