

**Alliance Health
All Provider Meeting
3/17/2021
1 PM to 3 PM via Zoom**

Legislative Updates and Medicaid Transformation

Q: The letters my clients received stated that they have been auto enrolled into NC Medicaid direct - do they need to do anything? - do they need to respond to the letter they received if they want to remain in NC Medicaid direct?

A: Without seeing the actual letters, it sounds like the question is referring to the “exempt” notification letter that members who have been identified as Tailored Plan-eligible are receiving. These individuals do not need to do anything in order to remain with the LME-MCO for behavioral health services, and their physical health services will continue to be fee-for-service, or Medicaid Direct, until Tailored Plans go live. Should anyone who is Tailored Plan-eligible select a Standard Plan, they likely will lose their current behavioral health services once Standard Plans go-live if the services are not included, covered by a Standard Plan.

Q: Would kids in Therapeutic Foster Care (TFC) likely receive one of these “exempt” notification letters?

A: TFC is considered an enhanced service, and a youth in TFC would be considered Tailored Plan-eligible. In order to continue receiving TFC, a youth would need to remain with the LME-MCO.

Q: For TFC kids in DSS custody, would their letters have gone to the county DSS?

A: They are being sent to the address on file with DSS for Medicaid.

Q: Who can help explain all of this?

A: Members should be referred to speak with the Enrollment Broker about any questions they have around plan selection and Open Enrollment notices they may have received. It is important for providers as well as the LME/MCOs not to engage in activities that could be considered choice counseling as this is the responsibility of the Enrollment Broker. The link to Beneficiary materials is below
<https://medicaid.ncdhhs.gov/providers/provider-playbook-medicare-managed-care/beneficiary-materials>

Q: Will consumers in OMT remain in managed care?

A: **Please note this is a correction to the initial response to this question during the meeting:** OMT, service code H0020, is in the enhanced service category per Appendix B of the February 2, 2020 BH IDD Tailored Plan Memo on Eligibility and Enrollment Updates (<https://files.nc.gov/ncdhhs/BH-IDD-TP-EligibilityUpdate-AppendixB-0020221-Updates.pdf>) which also requires a qualifying diagnosis in order to meet Tailored Plan eligibility. Individuals receiving OMT would likely fall in the F11 diagnosis range which is now included in the list of TP eligible diagnoses with no enhanced service use required for TP qualification, therefore meeting Tailored Plan eligibility for having an eligible diagnosis.

Q: How do we know what portals to sign up for (for billing/enrollment purposes)?

A: Contact the PHP's(Standard Plans) to learn about their billing processes and how to access their portals. Each PHP will have its own billing system.

Q: If any of these contracts were done previously when this started rolling out last time, do those stand or are we starting from scratch and need to recontract?

A: We suggest you look at the online directories to see if you're listed for any of the PHPs (link is included in All Provider Presentation) and/or contact the PHP directly to inquire.

Providers can contact Health Plans to check on the status of a contract. Contracting contacts for Health Plans can be found at <https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources>

Q: What are the Standard Plans (PHPs)?

A: These plans are AmeriHealth Caritas, BCBS (referred to as Healthy Blue for their Medicaid plan), United Healthcare, Wellcare, and Carolina Complete Health.

<https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources> The latter will only operate in a portion of the state.

Q: If our contract is supposed to be renewed this year, is there any need to do this if we are only doing OPT and transitioning to one of the four Standard Plans?

A: Alliance is in the process of identifying those providers who have not served any Tailored Plan-eligible members. For those providers, Alliance plans to extend contracts through 9/30/2021 to help with the transition. If a provider has no concerns about the transition, they can ask Alliance not to extend their contract beyond 6/30/202, by submitting a Notice of Change.

Licensed Practitioner Search Tool update

Q: Please confirm this is where a TFC provider would check to make sure their therapeutic foster child's Therapist is still available to them? Now and after 7-1-21 when Standard Plan goes live?

A: The tool includes practitioners who are currently contracted and credentialed with Alliance. If a licensed practitioner chooses to leave the network AND informs Alliance, they will be removed from the directory. Please note that sometimes, practitioners choose to stop seeing Alliance's members (i.e., leave the network) without informing Alliance.

COVID Vaccine Distribution Update

Q: Group 4 includes TBI?

A: Group 4 includes neurological problems and dementia, so it's thought this would include those with TBIs.

Q: Can you speak to the rumors and/or facts that the vaccine will have to be re-administered after a period of time for those who have been fully vaccinated? Said differently, the need for a booster shot. Is there a variation in effectiveness between the vaccines when it comes to the variants?

A: We will see. Viruses mutate, and depending on any mutations, there might be a need for a booster. The current vaccines have been found to be effective with regard to the UK variant.

Q: Any ideas on the best way to help clients get a vaccine who are not technologically savvy or don't have transportation to get to another county?

A: It's suggested that you contact the local health department to inform them of individuals who are homebound.

Other Questions:

Q: Will there be IPRS funds available to providers after the transition? Will Alliance be adding providers for enhanced services before or after the transition?

A: State funding remains limited, and Alliance will not be adding state-funded providers unless a specific need is identified AND there is funding for it. Alliance continually reviews needs and gaps, and if an area of need is identified, there may be an RFP or a natural extension of an existing contract. However, there is no specific plan to open the network at this time. Providers are encouraged to monitor the website for current service needs: <https://www.alliancehealthplan.org/providers/current-service-needs/>.

Standard Plans will not cover State-funded services. Those services will continue to be managed by the LME/MCOs.

Q: Will the suspension of the auth process follow the same time lines as the COVID rates...trying to plan for when auths resume.

A: The State's COVID flexibilities address temporary changes to authorization requirements. The State has said they will give a 60 day notice for when the changes will end. This may not match the temporary COVID rate dates

Q: When will the next All Provider Meeting be?

A: Wednesday, June 16, 2021, at 1 PM