All Provider Meeting
September 18, 2019
1-3:30 pm
Welcome and Introductions: Cathy Estes Downs
Alliance Updates
Disaster Preparation Overview- Carlyle Johnson
Webinar- NC Department of Health and Human Services
  Crossover to NC Medicaid Managed Care: LME-MCO Provider Education-Trish Farnham
  NC DHHS Sr. Health Policy Analyst
Legislative and Medicaid Transformation Updates and Discussion(Sara Wilson)
HCBS Update- Tracylee Cicero
Questions

Powerpoint will be posted on the Alliance Website by September 27
https://www.alliancebhc.org/providers/provider-resources/all-provider-meetings/

Next meeting: December date TBD
Disaster Preparedness

Carlyle Johnson
## Today's Session

### What's Covered
- Summary Overview of NC’s Transition to Managed Care
- Transition of Care Concept
- Overview Activities Underway to Support Members and Providers through Crossover.
- Guidance on:
  - Identifying member’s PHP
  - Submitting authorization requests
- Additional Resources

### What's Not Covered
- Overview of Tailored Plan
- Specific guidance on how to enroll in PHP network
- Specific guidance on PHP benefits.
- Please see resource links for all items not covered.
- Ongoing Transition of Care, including linkages of Standard Plan Members into LME-MCOs

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INFORMATION PROVIDED IS CURRENT AS OF THIS PRESENTATION. TRAINING MAY BE AMENDED TO PROVIDE ADDITIONAL INFORMATION OR CLARIFICATION.
OVERVIEW OF NC’S TRANSITION TO STANDARD PLANS UNDER NC MEDICAID MANAGED CARE
Introduction

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service (FFS) to managed care.

Since then, the North Carolina Department of Health and Human Services (DHHS) has collaborated extensively with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:

- Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden
Medicaid Transformation Vision

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health.”
### What do some of the terms mean?

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>NC Medicaid Direct</strong></td>
<td>• New name for our current Medicaid program.</td>
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<td></td>
<td>• Fee-for-service + LME-MCOs (or PACE)</td>
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<td></td>
<td>• What everyone on Medicaid has now</td>
</tr>
<tr>
<td><strong>NC Medicaid Managed Care</strong></td>
<td>• The term used reference the five “prepaid health plans” or “PHPs” or “health plan”</td>
</tr>
<tr>
<td></td>
<td>• Also called “Standard Plan” or “Standard Plan Option.”</td>
</tr>
<tr>
<td></td>
<td>• Launch date (2/1/2020) is referenced as “Managed Care Launch (MCL),” “Managed Care Effective Date” or “Standard Plan Effective Date”</td>
</tr>
<tr>
<td><strong>Tailored Plan</strong></td>
<td>• Specialized plans for members with significant behavioral health needs and intellectual/developmental disabilities</td>
</tr>
<tr>
<td></td>
<td>• What the LME-MCOs will become in a few years</td>
</tr>
<tr>
<td></td>
<td>• <strong>NOT the focus of today’s training session.</strong></td>
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</tbody>
</table>
PHPs for NC Medicaid Managed Care

Statewide Contracts

• AmeriHealth Caritas North Carolina, Inc.
• Blue Cross and Blue Shield of North Carolina, Inc.
• UnitedHealthcare of North Carolina, Inc.
• WellCare of North Carolina, Inc.

Regional Contract – Regions 3 & 5

• Carolina Complete Health, Inc.
NC Medicaid Managed Care Regions

**Region 1**
- Avery
- Buncombe
- Burke
- Caldwell
- Cherokee
- Clay
- Graham
- Haywood
- Henderson
- Jackson
- Macon
- Madison
- McDowell
- Mitchell
- Polk
- Rutherford
- Swain
- Transylvania
- Yancey

**Region 2**
- Alleghany
- Ashe
- Davidson
- Davie
- Forsyth
- Guilford
- Randolph
- Rockingham
- Stokes
- Surry
- Watauga
- Wilkes
- Yadkin

**Region 3**
- Alexander
- Anson
- Cabarrus
- Catawba
- Cleveland
- Gaston
- Iredell
- Lincoln
- Mecklenburg
- Rowan
- Stanly
- Union

**Region 4**
- Alamance
- Caswell
- Chatham
- Durham
- Franklin
- Granville
- Johnston
- Nash
- Orange
- Person
- Vance
- Wake
- Warren
- Wilson

**Region 5**
- Bladen
- Brunswick
- Columbus
- Cumberland
- Harnett
- Hoke
- Lee
- Montgomery
- Moore
- New Hanover
- Pender
- Richmond
- Robeson
- Sampson
- Scotland

**Region 6**
- Beaufort
- Bertie
- Camden
- Carteret
- Chowan
- Craven
- Currituck
- Dare
- Duplin
- Edgecombe
- Gates
- Greene
- Halifax
- Hertford
- Hyde
- Jones
- Lenoir
- Martin
- Northampton
- Onslow
- Pamlico
- Pasquotank
- Perquimans
- Pitt
- Tyrrell
- Washington
- Wayne
NOTICE: NC Medicaid Managed Care will now Launch Statewide on February 1, 2020

Managed care will now launch in one phase. Open enrollment will be extended for the 27 counties in Regions 2 and 4 until December 13, 2019. Nothing changes for the remaining 73 counties. As planned, open enrollment will begin for those 73 counties on October 14, 2019 and run through December 13, 2019.

All stakeholders should continue to work towards the February 1, 2020 implementation date. It is critical that the managed care companies (PHPs) and doctors and health systems continue to work together on contracting.

The 27 counties where open enrollment will be extended include: Alamance, Alleghany, Ashe, Caswell, Chatham, Durham, Davidson, Davie, Forsyth, Franklin, Granville, Guilford, Johnston, Nash, Orange, Person, Randolph, Rockingham, Stokes, Surry, Vance, Wake, Warren, Watauga, Wilkes, Wilson and Yadkin counties

-From NC DHHS Communication about Open Enrollment Extension

Note: Resource materials may still contain earlier launch date information
Revised Enrollment and Launch Timeframe

- **SEPT. 2, 2019**
  - Mailings Start

- **NOV. 13, 2019**
  - Reminder Postcard

- **OCT. 14 – DEC. 13, 2019**
  - Open Enrollment

- **DEC. 16, 2019**
  - Auto-Assignment

- **FEB. 1, 2020**
  - Health Plan Coverage Starts

- **FEB. 1, 2020 – APRIL 30, 2020**
  - 90 Day Choice Period

- **MAY 1, 2020**
  - Lock-in Period Starts

Note: LTSS members may change plans at any time.
BH/IDD/SA/TBI Service Comparison Table

<table>
<thead>
<tr>
<th>Covered by BOTH Standard Plan and LME-MCO</th>
<th>Covered by ONLY LME-MCO (Tailored Plan at a later date)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Plan BH and I/DD Services</strong></td>
<td><strong>State Plan BH and I/DD Services</strong></td>
</tr>
<tr>
<td>• Inpatient behavioral health services</td>
<td>• Residential treatment facility services</td>
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<tr>
<td>• Outpatient behavioral health emergency room services</td>
<td>• Child and adolescent day treatment services</td>
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<tr>
<td>• Outpatient behavioral health services provided by direct-enrolled providers</td>
<td>• Intensive in-home services</td>
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<tr>
<td>• Partial Hospitalization</td>
<td>• Multi-systemic therapy services</td>
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<tr>
<td>• Mobile crisis management</td>
<td>• Psychiatric residential treatment facilities (PRTFs)</td>
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<tr>
<td>• Facility-based crisis services for children and adolescents</td>
<td>• Assertive community treatment (ACT)</td>
</tr>
<tr>
<td>• Professional treatment services in facility-based crisis program</td>
<td>• Community support team (CST)</td>
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<tr>
<td>• Outpatient opioid treatment</td>
<td>• Psychosocial rehabilitation</td>
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<tr>
<td>• Ambulatory detoxification</td>
<td>• Substance abuse intensive outpatient program (SAIOP)</td>
</tr>
<tr>
<td>• Research-Based Behavioral Health Treatment</td>
<td>• Substance abuse comprehensive outpatient treatment program (SACOT)</td>
</tr>
<tr>
<td>• Diagnostic assessments</td>
<td>• Substance use non-medical community residential treatment</td>
</tr>
<tr>
<td>• Non-hospital medical detoxification</td>
<td>• Substance abuse medically monitored residential treatment</td>
</tr>
<tr>
<td>• Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization</td>
<td>• Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)</td>
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<tr>
<td><strong>Waiver Services</strong></td>
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<tr>
<td>• Innovations waiver services</td>
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<tr>
<td>• TBI waiver services</td>
<td></td>
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<tr>
<td>• 1915(b)(3) services</td>
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<tr>
<td><strong>State-Funded BH and I/DD Services</strong></td>
<td></td>
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<tr>
<td><strong>State-Funded TBI Services</strong></td>
<td></td>
</tr>
</tbody>
</table>

State-Funded BH and I/DD Services

- Residential treatment facility services
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services
- Psychiatric residential treatment facilities (PRTFs)
- Assertive community treatment (ACT)
- Community support team (CST)
- Psychosocial rehabilitation
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment program (SACOT)
- Substance use non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)

State-Funded TBI Services
DHHS Vision for Transition of Care

As beneficiaries move between delivery systems, the Department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

-NC Department of Health and Human Services (NC DHHS)
Transition of Care: Two Distinct Phases

**Crossover to MCL Transition of Care**

One time crossover of beneficiaries eligible for NC Medicaid Managed Care on February, 1 2020 (“Managed Care Implementation” or “MCL”)

**Ongoing Transition of Care**

Ongoing transition of care for beneficiaries moving between PHPs, between PHPs and FFS, between FFS/LME-MCOs and PHPs

**NOTE:** TRANSITIONS BETWEEN SETTINGS ARE RELATED BUT IDENTIFIED IN SEPARATE PROTOCOLS AND NOT FOCUS OF THIS PRESENTATION
<table>
<thead>
<tr>
<th>Date Range</th>
<th>Key Activities</th>
</tr>
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<tbody>
<tr>
<td>September 2019</td>
<td>Open Enrollment Continues</td>
</tr>
<tr>
<td>October-December 2019</td>
<td>Auto Assignment Mid-December (12/16/2019)</td>
</tr>
<tr>
<td>February 2020</td>
<td>PHPs conduct follow along to high need members. PHP responsible for NEMT services for Enrolled Members. New PAs submitted to Member’s PHP. PHP must honor open FFS PAs for no less than 90 days. Non participating provider requirements in effect.</td>
</tr>
<tr>
<td>March-May, 2020</td>
<td>Managed Care Launch (MCL) Phase I: 2/1/2020. Enrolled Member May Change PHP without cause for 90 days after MCL. LTSS Members May Change Any Time</td>
</tr>
</tbody>
</table>
NC’s TRANSITION TO MANAGED CARE: THE CROSSOVER DESIGN
As beneficiaries move between delivery systems, the Department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

PHPs have the necessary data to ensure effective service continuity for transitioning beneficiaries.

PHPs maintain service continuity by implementing DHHS requirements related to prior authorizations, non-participating providers, appeal rights, and identified services.

High-need beneficiaries have additional “high touch” support to ensure service continuity and reassurance through the transition.

Providers facilitate service continuity by being effectively informed on Crossover-specific requirements such as PA submissions.

PHPs, LME-MCOs, and FFS vendors establish mechanisms that facilitate the effective data and knowledge transfer.

The Department ensures effective oversight through quality communication, reporting, and other oversight mechanisms.

The Department’s Crossover direction is enhanced by the insight and contribution of stakeholders.
Key Components of NC DHHS Crossover Design

- Supporting Continuity of Care Through Data Transfer
- Facilitating Uninterrupted Service Coverage
- Establishing Additional Safeguards for High Need Members
- Member and Provider Education
- Clear and Organized Communication Between Entities
Data Transfer at Crossover: Key Data

**Claims and Encounter**
- 24 months of paid and denied claims/encounter history for all services

**Open and Recently Closed Prior Authorizations (PAs)**
- Open and recently closed PAs (60 days).

**Identified Care Plans**
- Care Plans from CCNC and identified LME-MCO members receiving care coordination.
- PCS Care Plans/Assessments from PCS Vendor.
- All other treatment plans accessed from providers as needed.
Data Transfer at Crossover: Provider Impact

**Claims and Encounter**
- **Provider Impact:** None anticipated.
- **Provider Impact:** Data will be transferred by NC TRACKS

**Open and Recently Closed Prior Authorizations (PAs)**
- **Provider Impact:** Identified SUD “Part 2” providers will be asked to assist in requesting consent for identified members.

**Identified Care Plans**
- **Provider Impact:** PHPs may seek care/service plans for transitioning members if not otherwise included in LME-MCO transfer.
- **Provider Impact:** Identified SUD providers will be asked to assist in requesting consent for identified members.
Data Impacted by 42 CFR Part 2

- Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was promulgated… address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings… Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders can disclose such records. For more information: https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf

- Part 2 provider/member data, such as prior authorizations and care plans can only be transferred from the LME-MCO to the PHPs with express consent from the member; otherwise the data must be removed.

- As part of LME-MCOs’ and NC DHHS’ efforts to ensure PHPs have information necessary to support member needs, LME-MCOs are engaging in an effort to secure member consent from applicable members, prior to transferring the record.

- Any record where consent is not secured will be omitted from the transfer.
Data Transfer at Crossover: Provider Impact
42 CFR Part 2 Trainings

- **NC's Transition to Medicaid Managed Care: Navigating 42 CFR Part 2 Requirements**

- **Same training, 2 options:**
  - Friday, 9/27/2019, 1:00p-2:00p
  - Friday, 10/11/2019, 1:00p-2:00p

- **To register:**
  [https://attendee.gotowebinar.com/rt/7163570444590312705](https://attendee.gotowebinar.com/rt/7163570444590312705)

- **Description:** NC DHHS will host two identical trainings to orient applicable providers on how NC DHHS, LME-MCOs and providers will navigate 42 CFR Part 2 requirements related to the transfer of a member's substance use disorder (SUD) data during the NC's transition to NC Medicaid Managed Care. This training will supplement additional guidance provided by the NC LME-MCO network to applicable providers.

- **Target audience:** "Part 2" providers providing services to members who will be transitioning into the Standard Plan option on 2/1/2020 under NC Medicaid Managed Care.

After registering you will receive a confirmation email containing information about joining the training.
• LME-MCOs will continue to process Service Authorization requests for members enrolled at 11:59 prior to MCL.

• Open and recently closed service authorizations will be transferred to Member’s PHP to help ensure continuity of care.

• PHPs are required to honor open PAs for services covered by Standard Plan/PHP up to 90 days after launch.

• If PHP ends open PA after 90 days, it must provide appeal rights.
• PHPs required to honor open PAs for 90 days post MCL
• Outpatient Behavioral Health Services Provided by Directly-Enrolled Providers: Units will reset to zero.

| Unmanaged Visits for Outpatient Behavioral Health Services | As referenced in the Revised and Restated RFP, PHPs are required to adhere to Department’s Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-enrolled Providers. This policy states in relevant part: Outpatient behavioral health services coverage is limited to eight unmanaged outpatient visits for adults and 16 unmanaged outpatient visits for children per state fiscal year (inclusive of assessment and Psychological Testing codes). For members who are authorized for services under this Clinical Coverage Policy at Managed Care Launch (MCL), the unmanaged visit count shall reset to zero. PHPs are otherwise required to adhere to Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. |
### Member Covered by LME-MCO

**Scenario 1:** Provider submits Auth request prior to Managed Care Effective Date for member transitioning to PHP for service covered by both LME-MCO and PHP. LME-MCO authorizes services as clinically indicated. Authorization will be transferred to PHPs as part of daily PA transfer file.

**Scenario 2:** Provider submits Auth request prior to Managed Care Effective Date for member transitioning to PHP for service ONLY covered by LME-MCO. LME-MCO may process but benefit may not be available in Standard Plan.

**Scenario 3:** Provider submits retroactive Auth request for pre MC effective DOS for a member formerly enrolled in LME-MCO, now enrolled in PHP. LME-MCO may only authorize for pre MC effective dates of service (DOS).

### Member Covered by PHP

**Scenario 1:** PHP honors LME-MCO authorization for first 90 days. If Authorization extends beyond 90 days and the PHP ends, it must issue appeal rights.

**Scenario 2:** Benefit not available. PHP has no capacity or responsibility to provide. *EPSDT rules apply

**Scenario 3:** Provider may submit separate Auth request directly to PHP.
PA Requests at Crossover: What Providers Need to Know

• Confirm that a Member is Transitioning to a Standard Plan
  − Many members currently served by the LME-MCO will remain with the LME-MCO.

• Know Member’s Transition Date/Managed Care Effective Date
  − For members transitioning to Standard Plan, this date will be 2/1/2020.

• Be Clear on What and When You are Submitting:
  − Service Auth submitted before Managed Care (MC) Effective Date?
    • Send to LME-MCO
    • LME-MCO specific benefits may be authorized but may not be available in Standard Plan after MC Effective Date.
  − Service Auth submitted after MC Effective Date?
    • Will need to be submitted to PHP.
    • If retroactive request includes date of service (DOS) prior to MC Effective Date may submit to LME-MCO for only pre-MC Effective Date dates.

• Identify Member’s Managed Care Information
  − For Provider Portal Guidance: See Job Aid PHP Eligibility/Enrollment for Providers in NC Tracks Provider Portal

• To submit Service Auth/ Request on or after MCL
  − Follow instructions provided directly by the PHP
    • Coming Soon! All PHP instructions in one place: https://medicaid.ncdhhs.gov/providers
Information from Alliance Health

Providers are encouraged to monitor Provider News and the Alliance website for information regarding the Crossover and Transition to the Standard Plans

https://www.alliancehealthplan.org/

Please ensure your agency provides up to date contact information – Alliance will be reaching out to providers to assist in this process

Alliance has developed a Medicaid Transformation page on our website to assist Providers in having access to information on transformation.

https://www.alliancehealthplan.org/providers/medicaid-transformation/

Questions regarding this webinar can be sent to MedicaidTransformation@AllianceHealthPlan.org

Answers will be posted on the Alliance Medicaid Transformation page
Stop Lights for Attempted PA Requests to LME-MCO after Managed Care Effective Date

### Intensive Provider Education
- Ensure providers know about PA submission requirements.
- Ensure providers have information needed to resubmit PA request to proper PHP

### Notification: Auto-Information Message
- If a provider attempts to enter information for a member who is now enrolled in Managed Care, it *may* not find member in PA portal and will see banner message instructing where to get additional information.

### Informed Call Center Staff
- LME-MCO center staff will be informed on how to guide both members and providers.
• Generally, adverse determination process and appeal rights will be processed as typical.

• Members appealing initial service request denials will be instructed on option to submit new request to PHP.

• PHPs will be required to honor Continuation of Benefits/Maintenance of Service on covered benefits until can reassess and either approve ongoing services or issue appeal rights.

• EPSDT still requirements apply.
What Providers Need to Know: Processing Payment at Crossover

a. Claims for dates of service prior to the member’s Standard Plan Effective Date should continue to be submitted to the LME-MCO.

b. Claims for dates of service after the member’s Standard Plan Effective Date should be submitted to the member’s PHP following applicable PHP protocol as provided in provider enrollment materials.

c. Note: PHPs are required to treat claims for non-participating providers with dates of service on or after Standard Plan Effective Date equal to that of enrolled providers until the completion of the episode of care or 60 days, whichever is less.*

Transition-Related Safeguards for High-Need Members

Data File Transfer at Crossover
Claims/Encounter Data
PA Extract
Care Plans (As Applicable)

Targeted Follow Up For High-Need Members
PHPs perform time-sensitive follow up to High Need Members

Warm Handoff
Individualized knowledge transfer sessions for members identified by DHHS, LME-MCOs, CCNC. PHPs may also initiate.

Complex Treatment/Service Circumstances

Applies to All Transitioning Beneficiaries
See High Need Member Definition

Transition-Related Safeguards for High-Need Members

Complex Treatment/Service Circumstances
“High Need” Members include:

- High need subset of members receiving in-home long-term services and supports or select behavioral health services.
- High need subset of members receiving behavioral health services.
- Exempt members who elect to enroll in PHP.
- Members identified by CCNC, an LME-MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a “warm handoff.”
- NEMT users with repeated or multiple appointments.

Follow Up Prioritized based on Need, but must occur within 3 weeks of MCL (reported weekly to DHHS):

- Direct contact between PHP and member (in-person or phone)
- Are services in place?
- Any confusion about processes?
- Ongoing status of pre-MCL authorized services.

Pre MCL, PHP identify and prioritize “High Need” members based on criteria and information provided.
High Need Populations

• High need subset of members receiving behavioral health services
  - Member who has utilized Mobile Crisis, Behavioral Health Urgent Care or Facility-based crisis with DOS within 365 days of MCL.
• Exempt members who elect to enroll in PHP.
• Members identified by CCNC, an LME-MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a “warm handoff.”

Guidance for Providers

• A member’s PHP may be calling or visiting. A provider can help explain this.
• Providers are not responsible for arranging but may be invited to participate.
• LME-MCOs will be identifying members who necessitate a knowledge transfer between care coordination staff and PHP staff.

• LME-MCOs may determine own criteria but likely to include:
  – Time sensitive dynamics such as
    • Imminent facility discharge
  – Precarious clinical or social dynamics such as:
    • Imminent risk of homelessness

• Providers may be asked to participate.
Member Education

Member Guide to explaining enrollment pathways for beneficiaries with disabilities and older adults.

Member Education: Non Emergency Medical Transportation (NEMT)

• At launch, PHPs will assume responsibility for NEMT for enrolled members.

• Currently, DSSs are working with the PHPs to inform of member appointment schedules and additional considerations for high need members.

• Enrolled members will be able to reserve post MCL appointments 31 days **PRIOR** to their effective date.
  - Sara selects ABC Health Plan on December 10th, 2019. Her managed care effective date will be February 1, 2020.
  - Sara has an appointment on February 2, 2020.
  - Sara can reserve her 2/2/2020 appointment directly from ABC in January, 2020.

In Development: Additional Educational Materials to Help Members Understand this Option

Provider Note: Providers can help educate members about this option.
Preparing for Managed Care: Helping Members through Crossover Process

My health plan is:

My primary care provider is:

When I will start getting care through my health plan:

Number to call if I need to schedule a ride to an appointment after I start getting care through my health plan.

Number to call if I have issues getting care after my start date.

Number to call if I have questions about my supplies.

We want to ensure Members have simple, clear, “pocket reference” answers to these questions.
• **Ways Providers Can Help:**
  - Help members understand their options by providing them with the Enrollment Broker contact information.
  - Finalize outstanding contracting activity with PHPs so that members are clear on which PHPs.
Options for Beneficiaries

1. Direct them to ncmedicaidplans.gov to learn more.
2. Direct them to ncmedicaidplans.gov to chat with an Enrollment Specialist.
3. Direct them to download and use the NC Medicaid Managed Care mobile app.
4. Tell them to call 1-833-870-5500 to speak with an Enrollment Specialist. The call is free.
5. Individuals with hearing impairments may contact an Enrollment Specialist via the TTY line at 1-833-870-5588.
6. Beneficiaries can also enroll by mailing or faxing their completed enrollment form.
NC Medicaid Managed Care Education Resources for Members

- Enrollment Broker: [www.ncmedicaidplans.gov](http://www.ncmedicaidplans.gov)
- General Overview: [https://files.nc.gov/ncdhhs/Medicaid-ManagedCare-OpenEnrollment-Webcast-FINAL-20190714.pdf](https://files.nc.gov/ncdhhs/Medicaid-ManagedCare-OpenEnrollment-Webcast-FINAL-20190714.pdf)
- DSS Playbook

NC Medicaid Reference Guide

Educational Video
[https://www.youtube.com/watch?v=9xJyeXkypI8&t=](https://www.youtube.com/watch?v=9xJyeXkypI8&t=)
RESOURCES
Need More Information Right Now?

General information from State: Medicaid.Transformation@dhhs.nc.gov

Member is Confused about What to Do?

• Support the Member to Call:
  – Enrollment Broker (see earlier slide)
  – LME-MCO Call Center

Time-Sensitive Inquiries:

• Providers: NCTracks: 800-688-6696

• Beneficiaries: Enrollment Broker, LME-MCO Call Center or Medicaid Contact Center: 833-870-5500

• For urgent member or provider-specific issues: 919-527-7460 or MedicaidSWAT@dhhs.nc.gov
• Bookmark this page: https://medicaid.ncdhhs.gov/providers

Providers

Open Enrollment Extended for ALL Medicaid Beneficiaries

All beneficiaries will transition to Medicaid Managed Care on Feb. 1, 2020. DHHS held a webcast on Wednesday, Sept. 4, 2019, from 4-5 p.m. To provide additional details and answers to questions.
Provider Education: General Resources

- **General Overview of Provider Transition to Managed Care**
  - [MCT 101 Provider Transition to Managed Care](https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses)

- **Information about Provider Rates and Contracting**

- **Information about Provider Network Adequacy Requirements, Grievances and Appeals and Other Policies**
  - [MCT 104 Key Policies for Providers in Managed Care](https://files.nc.gov/ncdma/Provider-Policies-Webinar-5.9.19-Final.pdf)

- **Information about Standard Plan and Tailored Plans**

- **Information on Benefits under Managed Care**
  - [MCT 108 Clinical Policies under Managed Care](https://files.nc.gov/ncdma/documents/Clinical-Policies-Webinar-FINAL20190613.pdf)

- **To Contact the PHPs about Contracting**
  - Please visit the NC DHHS Medicaid Provider webpage
    - [https://medicaid.ncdhhs.gov/providers](https://medicaid.ncdhhs.gov/providers)
Provider Education: Crossover-Specific Resources

- Additional materials available at: https://medicaid.ncdhhs.gov/providers
  - General Crossover Webinar Scheduled for Thursday, September 19, 2019 from 1:00-2:00p
    - To Register: Go to https://medicaid.ncdhhs.gov/provider-playbook-training-courses
    - https://manatt.webex.com/manatt/onstage/g.php?MTID=eee7f23a0a1c9132a1f3f6dc6d9dddd74e
  - Crossover Resource Web Page Coming Soon!
    - Guidance on Finding Members’ Managed Care Status
    - Resources to Support Members through Transition through Managed Care
    - Guidance on Submitting Prior Authorizations
    - Contacting the PHPs
    - Overview of PHP Crossover Requirements

* Also note Crossover-Specific Medicaid Bulletin Articles beginning with August’s Bulletin.
Legislative Updates

Presentation to Alliance All Provider Meeting
September 18, 2019
Sara Wilson
Continuing Standoff Over FY19-21 State Budget

• March 6: Governor Cooper released his budget proposal
• May 3: NC House passed its budget
• May 31: NC Senate passed its budget
• June 27: General Assembly passes conference budget
• June 28: Governor Cooper vetoes conference budget
• September 11: Veto overridden in the House
(H555) Medicaid Transformation ‘mini-budget’ Bill

• Would provide funding for the operation of the Medicaid program and transition to managed care during 2019-2021
  • August 27: Passed the Senate
  • August 29: Passed the House
  • August 30: Governor vetoed
  • September 11: Veto overridden in the House
Impact of State Budget Standoff

• September 3: Standard Plan Phase 1 open enrollment extended to February 1, 2020
• Tailored Plan Go-Live – still on track for July, 2021
• Potential Medicaid expansion populations remain undetermined

• State spending generally running at FY19 levels
  o DHHS running on 2018-19 recurring spending levels
  o Nonrecurring spending did not continue
Open Enrollment Extended through 12/13/19 Statewide

Open Enrollment Began in July

Open Enrollment Will Begin in October
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Regions 2, 4</th>
<th>Regions 1, 3, 5, 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Packets Mailed</td>
<td>6/28/2019</td>
<td>10/1/2019</td>
</tr>
<tr>
<td>Open Enrollment Begins</td>
<td>7/15/2019</td>
<td>10/14/2019</td>
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<tr>
<td>Open Enrollment Ends</td>
<td></td>
<td>12/13/19</td>
</tr>
<tr>
<td>Auto-Assignment</td>
<td></td>
<td>12/16/19</td>
</tr>
<tr>
<td>Health Plan Effective Date</td>
<td></td>
<td>2/1/2020</td>
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</tbody>
</table>

Dates are approximate and subject to change.
HCBS PROVIDER SELF ASSESSMENT
HCBS Applies to…

• This rule applies to all 1915(c) waiver programs, which include both NC Innovations and TBI.
• Innovations, (b) (3) and TBI Waiver – Day Support
• Innovations, (b) (3) and TBI Waiver – Supported Employment
• Innovations, (b) (3) and TBI Waiver – Residential Support
• CAP/DA and TBI Waiver – Adult Day Health
HCBS

• For any applicable service sites yet to complete the HCBS provider self-assessment 2016 or later, the following applies:

• Prior to service provision, all sites providing Residential Supports (including AFLs) and Day Supports are required to complete a provider HCBS self-assessment and have it reviewed by the applicable MCO as “Fully Integrated.”
Address Change

• Providers are required to submit a Notice of Change at least 30 days prior to the address change. A determination will be made regarding Network need before any contract changes can be considered.

• A new self-assessment for the future address must be submitted.

• All new sites must be HCBS compliant prior to receiving a contract to provide any HCBS services at the site.
Provider Acquisitions/Mergers

• Provider’s are required to submit advanced notice to Alliance Health of plans to acquire an existing provider. Please contact your Provider Network Development Specialist or submit a Notice of Change to discuss any changes or possible changes. A determination will be made regarding Network need before any contract changes will be considered.

• A new self-assessment for acquired site location(s) must be submitted prior to any updates to credentialing or contracts can occur.
HCBS Validation

• The site validation process starts **April 1, 2019** and ends **March 31, 2020**.

• ALL sites within the transition period MUST be fully integrated/fully compliant AND validated by March 31, 2020.

• All new sites outside of the transition period must be fully integrated/fully compliant PRIOR to providing services.
“Key Issues”

• For licensed facilities individuals must have the opportunity to have a key to the home and their individual bedroom.

• For unlicensed AFL homes individuals must have the opportunity to have a key to the home. Keyed bedroom door locks are not required unless requested by the individual.

• If it is not appropriate for an individual to have their own key this must be documented in the ISP.
Resources

• Provider Self Assessment: https://www.hcbs.ncdhhs.gov/assessment.html


• You may address any questions regarding HCBS to Alliance at HCBS@AllianceHealthPlan.org