



Fireside Chat

NC Medicaid Updates

Part of the Ready, Set, Launch! Series

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here: https://www.captionedtext.com/client/event.aspx?EventID=5349555&CustomerID=290

January 19, 2023

Logistics for Today's Webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

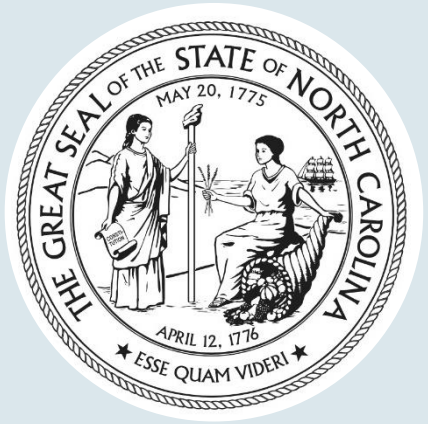
01 Tailored Plan Refresh

02 Standard Plan Updates

03 Legislative Updates

04 Clinical Updates

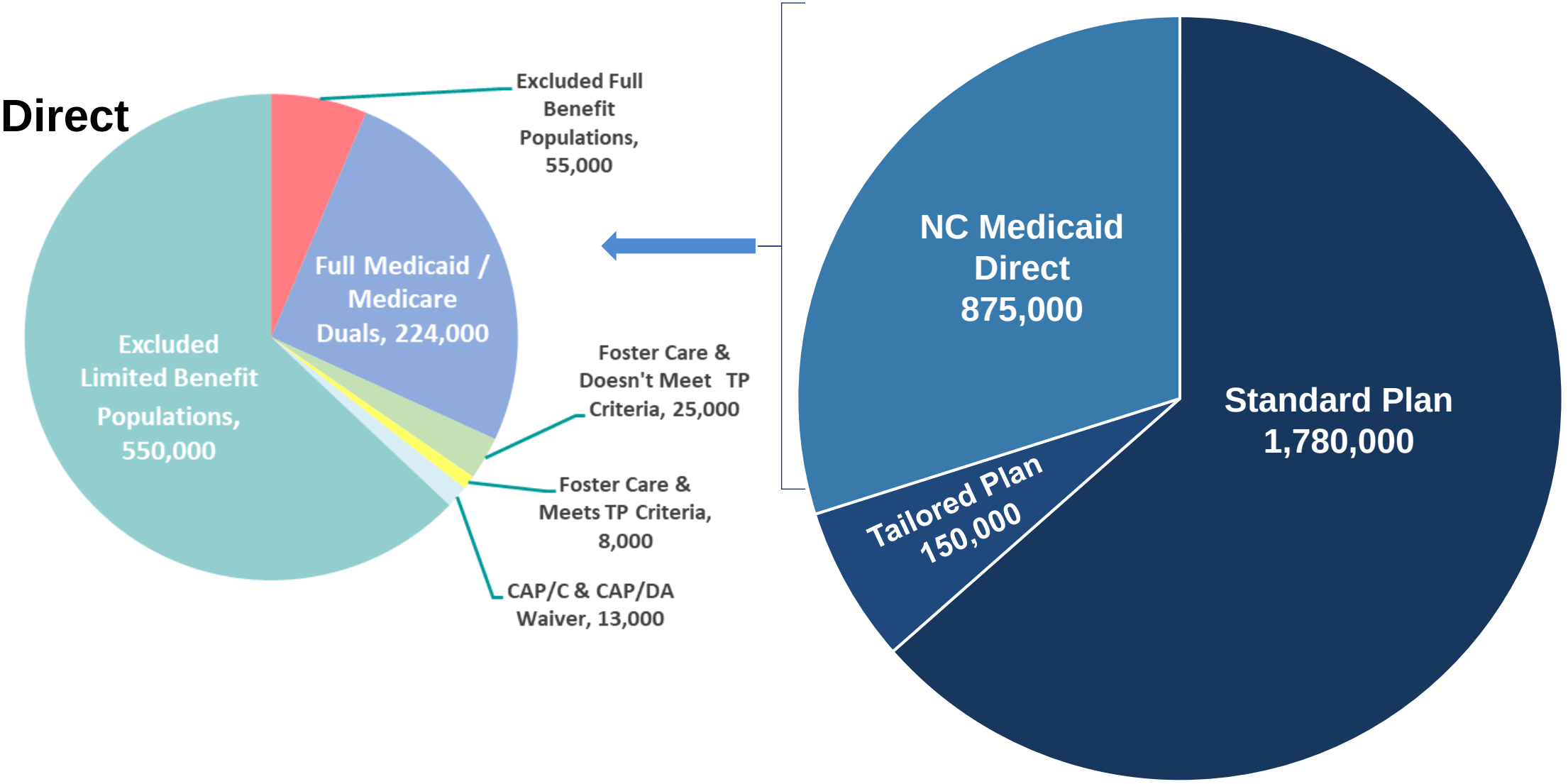
05 Q&A



Tailored Plan Refresh

Medicaid Expected Enrollment Numbers in December 2022

Medicaid Direct



Tailored Plan Launch Update

Tailored Plans are now scheduled to go live on April 1, 2023.

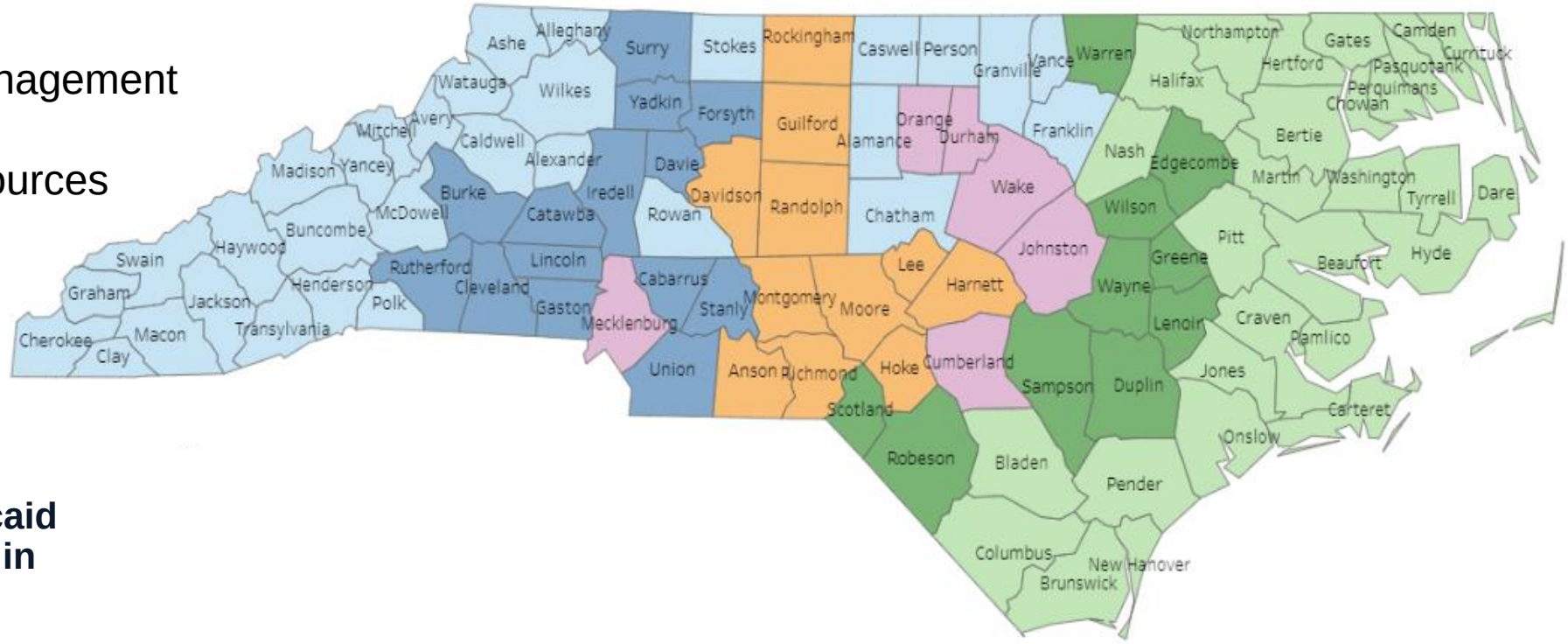
- The delayed start **will allow Tailored Plans more time to contract with additional providers to support member choice** and to validate that data systems are working appropriately.
  - 1915(i) option (requested April 1, 2023 start date from CMS)
- Some services began on Dec. 1, 2022:
  - Tailored Care Management (TCM)
- **Nothing changes for members today—except for adding TCM.**
  - Beneficiaries eligible for Tailored Plan received Notices about the delay at the end of October.
- Members still receive behavioral health services, I/DD and TBI supports through their LME/MCO and physical health and pharmacy services through NC Medicaid, just as they do today.

Which Health Plans Will Provide BH I/DD Tailored Plans Services?

There are 6 Tailored Plans:

- Alliance Health
- Eastpointe
- Partners Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

This map shows Tailored Plan service areas as of 2/1/22



Approximately 150,000 Medicaid beneficiaries will be enrolled in Tailored Plans.

Overview on Eligibility for Tailored Plans

- State law* outlines ***who is eligible*** to enroll in a Tailored Plan.
- Medicaid beneficiaries who are eligible for managed care and who are identified by the Department as having one of the following conditions are eligible to enroll in a Tailored Plan:
  - **intellectual/developmental disability (I/DD),**
  - **known traumatic brain injury (TBI),**
  - **serious mental illness,**
  - **serious emotional disturbance,**
  - **or severe substance use disorder (SUD)**
- **Tailored Plan eligibility criteria is identified via data review:**
  - The Department conducts reviews regularly to identify eligible beneficiaries.
  - Beneficiaries are also able to self-identify via a "Raise your Hand" process, allowing the Department to evaluate if they meet Tailored Plan eligibility.

Additional populations include, but are not limited to, Medicaid beneficiaries identified as:

- Eligible to participate in Transitions to Community Living
- Having 2+ psychiatric admissions in the past 18 months
- Having 2+ BH crisis events or ED visits for psychiatric reasons in the past 18 months
- Having an IVC treatment episode
- Receiving or needing services only available through LME/MCOs
- Children with complex needs

In Oct 2022, North Carolina's Department of Health and Human Services released updated guidance on **Tailored Plan Eligibility and Enrollment** which can be found here**.**

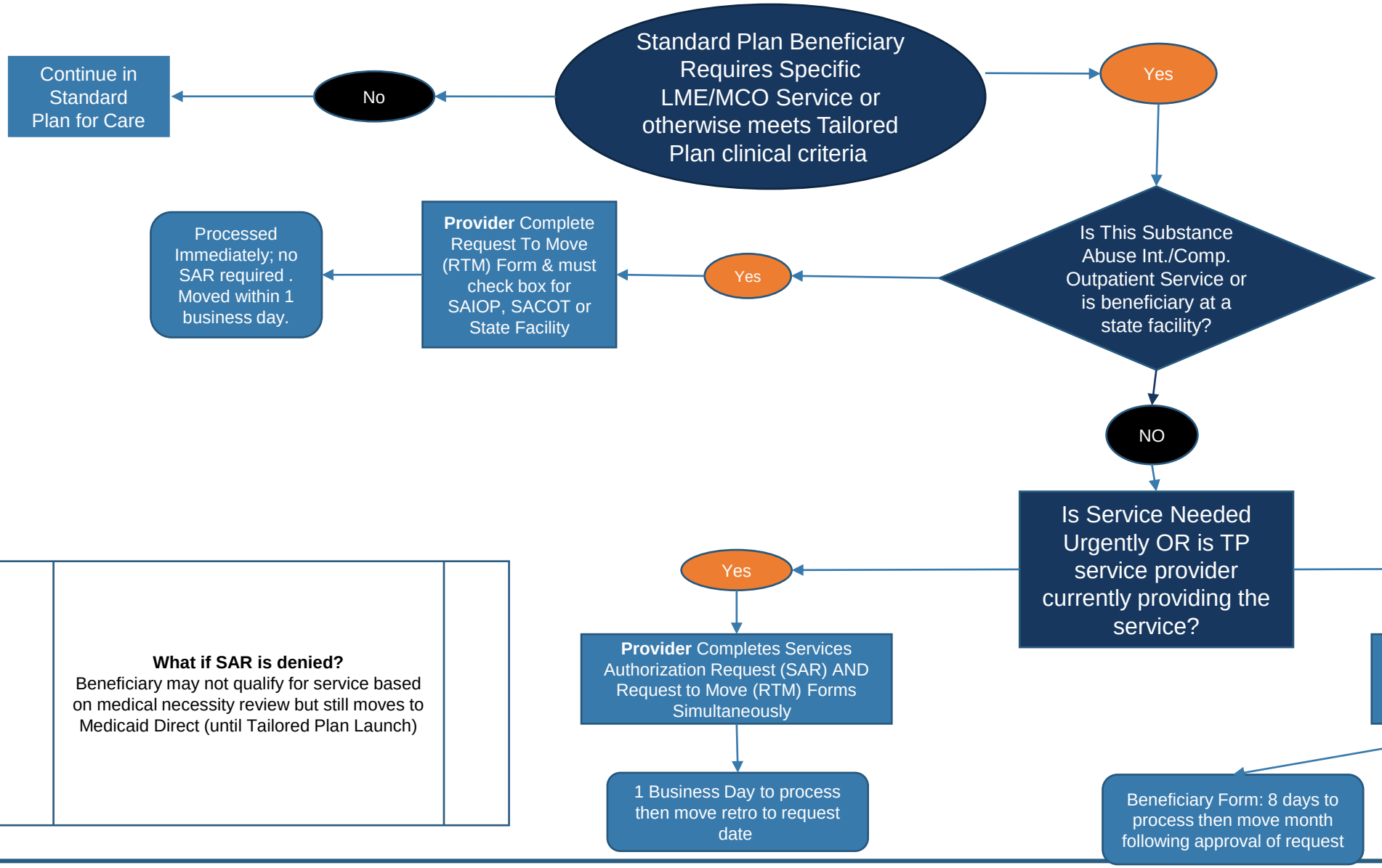
*** N.C. Gen. Stat. § 108D-40(a)(12) describes who is eligible for BH I/DD Tailored Plans**

Transition of Care – Automatic Move to Medicaid Direct (Current)

- **Innovations/TBI waiver**
- **Transitions to Community Living (TCL)**
- **Children with Complex Needs**
- **IDD Diagnosis**
- **TP only service use (including ICF-IID)**
- **Enhanced service use with specific mental health and SUD diagnoses**
- **Two Psychiatric Hospitalizations in 18 months**
- **One State Psychiatric Hospitalization or ADATC admission**
- **Two Psychiatric ED visits in 18 months**
- **Two Behavioral Health Crisis services in 18 months**
- **Certain SMI/SED Diagnoses**
- **Clozapine or long-acting injectable antipsychotic use**
- **ECT use**

Standard Plan to Medicaid Direct: The Flow

Request to Move Form can be found here. Please review Oct 21, 2021, Fireside chat for additional information on RTM process.

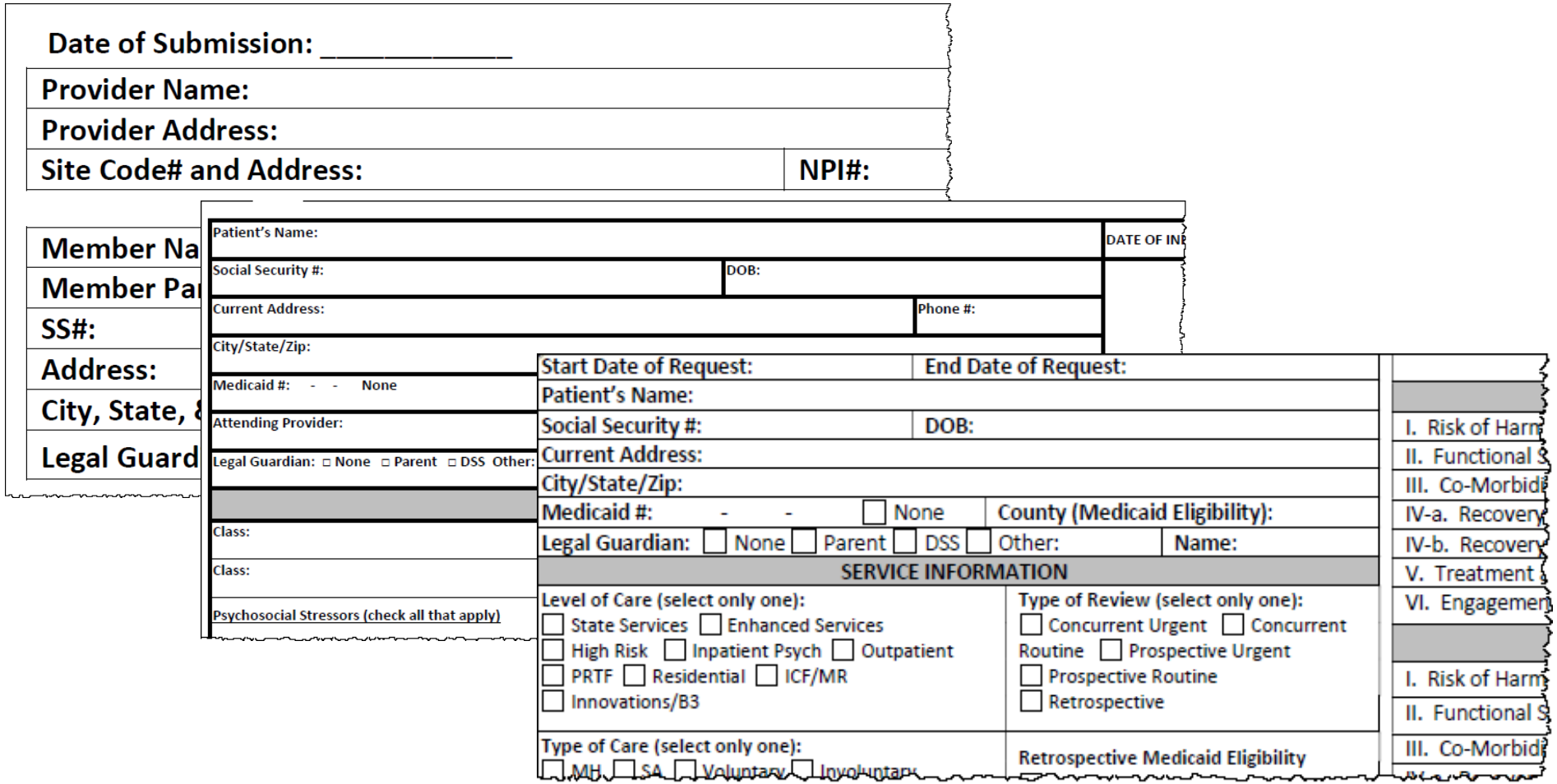


What if SAR is denied?
Beneficiary may not qualify for service based on medical necessity review but still moves to Medicaid Direct (until Tailored Plan Launch)

Service Authorization Requests

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

- Alliance
- Eastpointe
- Partners
- Sandhills
- Trillium
- Vaya



Top Reasons to Contract

By contracting with Tailored Plans:

- it creates greater choice for Medicaid Beneficiaries.
- it creates better access to care for Medicaid Beneficiaries.
- beneficiaries will not have to choose between their medical home and critical specialty care.

In-Network Providers will be paid a higher rate compared to out of network providers (Tailored Plans must cap OON payments at 90% of fee schedule – typically the FFS fee schedule).

- NOTE: By contracting, providers avoid or eliminate the risk of getting paid less than the full Medicaid rate.

In-network PCPs will receive additional AMH payments.

- NOTE: These payments are not available for OON providers.

Over the past year DHB has worked closely with the Tailored Plans; Tailored Plans understand NC Medicaid better and have improved on early contracting issues.

  - NOTE: If your early experience was not great, consider trying again.
- Some providers are contracting with all 6 plans, recognizing it is in the best interest of the beneficiaries.

Tailored Plan-Standard Plan Partnering

Tailored Plans are partnering with a Standard Plan to provide an integrated plan with behavioral health and physical health services.

Tailored Plan	Standard Plan Partner*	Leveraging Standard Plan Partner's PH Network
Alliance	WellCare Health Plan	Not at this time
Eastpointe	WellCare Health Plan	Yes, at least partially
Partners	Carolina Complete Health	Yes, at least partially
Sandhills	AmeriHealth Caritas of NC	Yes, at least partially
Trillium	Carolina Complete Health	Yes, at least partially
Vaya	WellCare Health Plan	Not at this time

More information on the Tailored Plan-Standard Plan partnering can be found in the Contracting with Tailored Plans fact sheet

*Tailored Plans are leveraging their Standard Plan partner for a variety of different functions and additional details can be found here in the ***Contracting with Tailored Plans*** Fact Sheet.

NC Medicaid Began Tailored Care Management 12/1/2022

As an integral component of the Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans, Tailored Care Management (TCM) is a new care management model that reflects the goal of whole-person care management in NC Medicaid Managed Care.

While the start of Tailored Plans was delayed until April 1, 2023, Local Management Entity/Managed Care Organizations along with TCM providers began providing TCM Dec. 1, 2022.

Beneficiaries receiving TCM have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all their needs, including physical health, behavioral health, I/DD, traumatic brain injury (TBI), pharmacy, long-term services and supports, and unmet health-related resource needs.

Letters were mailed beginning Nov. 14, 2022, to TCM-eligible beneficiaries and authorized representatives with the name and contact information of their TCM provider. The letter also explains TCM services and provides information on how beneficiaries can change their TCM provider or opt out of the service. A sample notice is available in the NC Medicaid Managed Care County Playbook under Other Beneficiary Notices. Beneficiaries can change their TCM provider at any time, without limits, prior to April 1, 2023, by calling their LME/MCO.

For more information on TCM, refer to the TCM Provider Fact Sheet, the TCM Beneficiary Fact Sheet (available in English and Spanish) or visit the TCM webpage on the NC Medicaid website.

NC Medicaid has published a list of certified TCM providers. The list is available on the Medicaid website and will be updated as new providers are added https://medicaid.ncdhhs.gov/media/11975/download?attachment

Who Can Provide Tailored Care Management?

Tailored Care Management

Tailored Care Management is provided by 3 types of entities.

Approach 1:
Certified "AMH+" Primary Care Practice

Approach 2:
Certified Care Management Agency (CMA)

Approach 3:
LME-Based Care Manager

What Does TCM Mean for Members & Providers?

Each member in a Tailored Plan will have an assigned care manager to help them navigate all care and connect them to community resources.

- **Members will have support to connect to their primary care providers (PCPs) and specialists.**
- **PCPs will have a resource (the care manager) if they need support meeting a member's need.**

Care Managers will help with:

- Coordination of all services and supports
- Crisis Support
- Transitional care management (from hospital to home)
- Diversion from institutional settings
- In-reach and transitions from institutional settings (for certain populations)
- Addressing unmet health-related resource needs
- Medication monitoring

Who is Eligible for Tailored Care Management on 12/1

- Individuals age 3+ in Medicaid Direct who will go into a Tailored Plan on 4/1/2023 including:
  - Innovations Waiver participants (including duals)
  - Traumatic Brain Injury (TBI) Waiver participants (including duals)
  - Children and Adolescents with Serious Emotion Disorder (SED)
  - Adolescents with Severe Substance Use Disorder (SUD)
  - Adults with Serious Mental Illness (SMI) or Severe SUD
  - Children and adults with intellectual/developmental disability (I/DD) or known TBI

We often describe this criteria as "clinically eligible for a Tailored Plan"

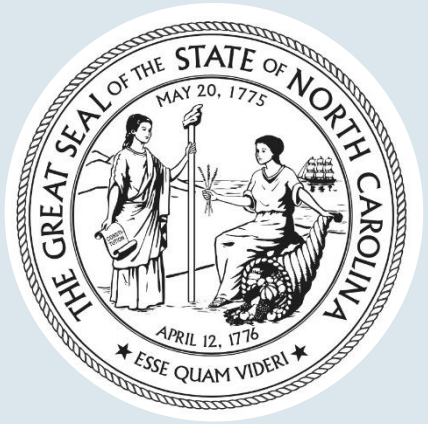
- Individuals age 3+ in Medicaid Direct who will stay in Medicaid Direct on 4/1/2023 including:
  - Children and Adolescents in Foster Care with SED or Severe SUD
  - Dual- Eligible Adults with SMI or Severe SUD
  - Dual-Eligible Children and Adults with I/DD or TBI who are NOT on the Innovations or TBI waivers

Children in NC Health Choice and Children (0-3) who meet the above criteria will be eligible for TCM on 4/1/23.

Tailored Care Management

Tailored Care Management (TCM) launched on Dec. 1, 2022.

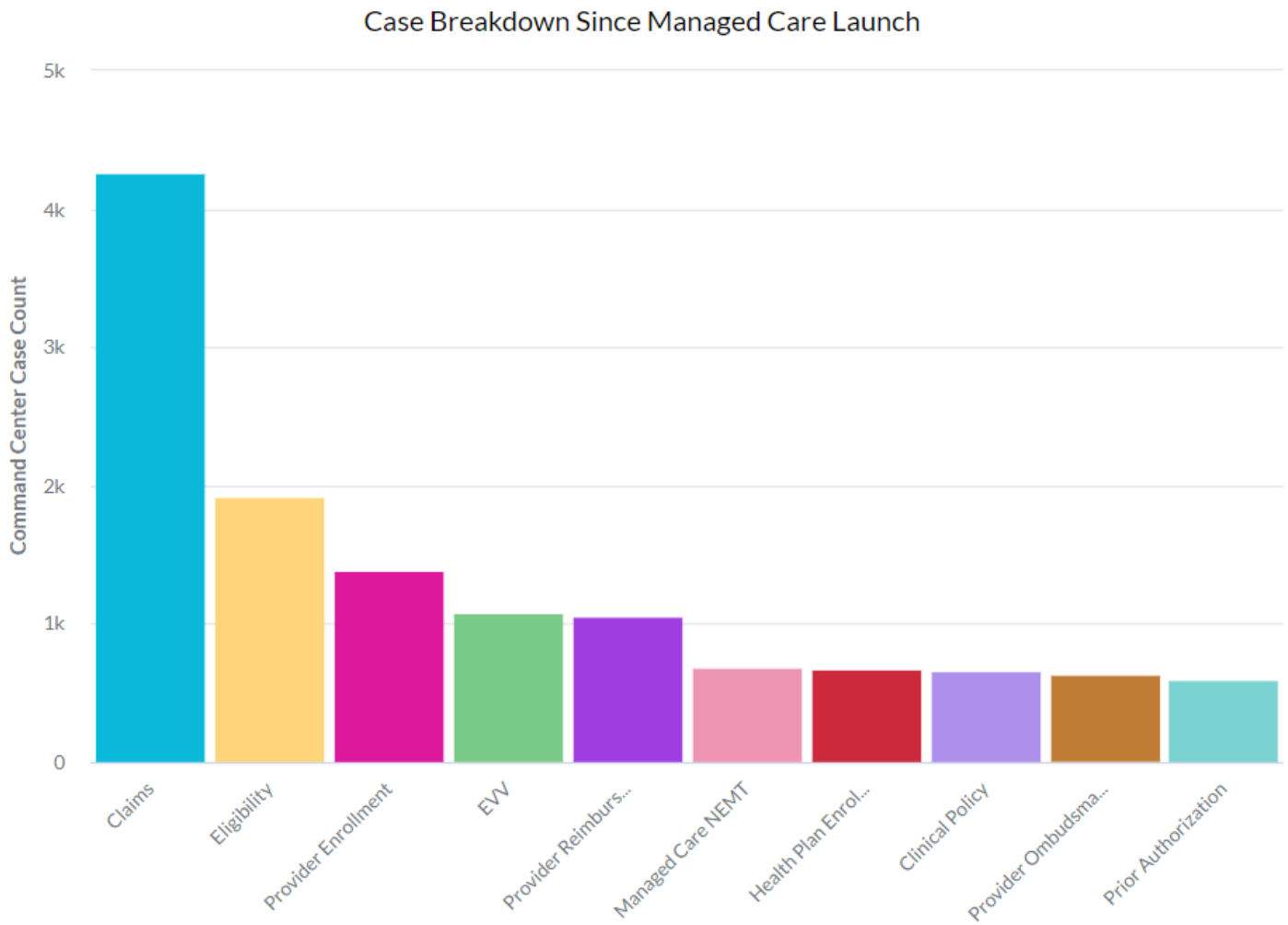
- NC Medicaid and LME/MCOs are working closely with TCM providers to ensure a successful start of the service.
- AHEC coaches are continuing to provide support to TCM providers.
- NC Medicaid has published a list of certified TCM providers. The list is available on the Medicaid website and will be updated as new providers are added https://medicaid.ncdhhs.gov/media/11975/download?attachment
- LMEs are currently contracting with Tailored Care Management providers (CMAs and AMH+s)
  - Next month we hope to show a network map of TCM agencies in each LME region.
- **You can find out if your beneficiary is eligible for TCM by checking in NCTracks**.



Standard Plan Updates

Medicaid Help Center/Provider Ombudsman

Weeks of July 1, 2021 - Present



Inquiry Sub-category	Command Center Case Count	Percentage of Count
Claims	4,257	32.82%
Eligibility	1,922	14.82%
Provider Enrollment	1,387	10.69%
EVV	1,086	8.37%
Provider Reimbursement, Including fee schedules	1,058	8.16%
Managed Care NEMT	690	5.32%
Health Plan Enrollment	676	5.21%
Clinical Policy	666	5.13%
Provider Ombudsman Duties- Complaints Against PHPs.	638	4.92%
Prior Authorization	592	4.56%
Total	**12,972**	**100%**

What Our Call Centers are Hearing from Members

November 2022

Call Center	Calls Handled	% Calls Answered in 30s	Abandonment Rate
AmeriHealth	7,777	98.11%	1.35%
Healthy Blue	11,039	97.06%	1.78%
Carolina Complete	6,764	99.44%	0.34%
United	13,618	96.70%	0.30%
Wellcare	14,060	99.75%	0.47%
Alliance	4,963	100.00%	0.80%
Eastpointe	1,792	97.70%	1.24%
Partners	2,623	99.96%	0.04%
Sandhills	2,023	99.00%	2.00%
Trillium	1,072	98.70%	0.65%
Vaya	1,571	98.25%	0.19%
EB	14,710	99.68%	0.20%
MCC	12,644	76.98%	2.19%

Top Call Center Reasons		
EB	1	Changing Enrollments
	2	Health Plan Questions
	3	Medicaid Questions
Health Plans	1	PCP Changes
	2	Benefits Questions
	3	Demographics Changes
	4	Find a Provider
	5	ID Card Requests

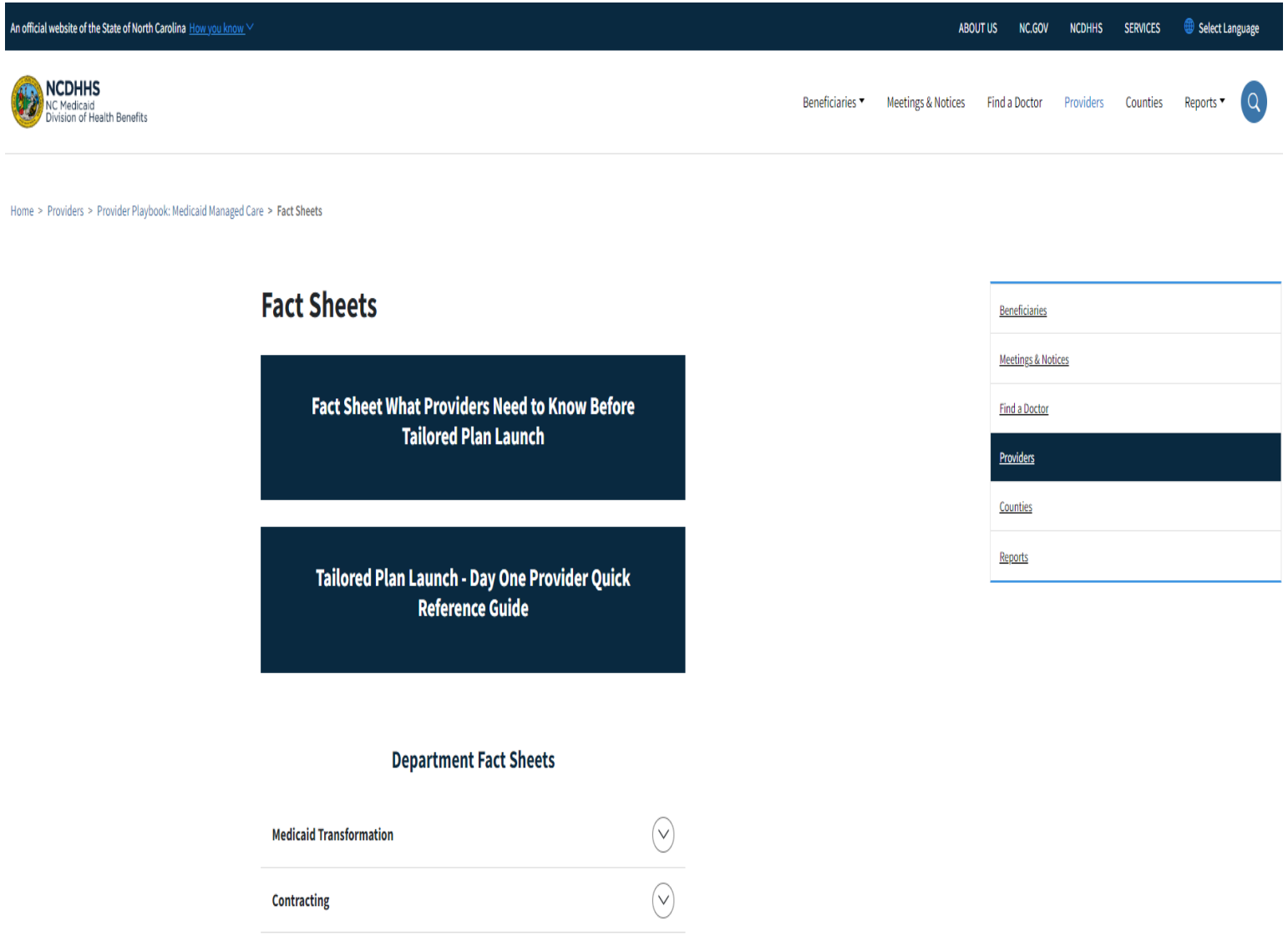
What Our Call Centers are Hearing from Providers

November 2022

Call Center	Calls Handled	% Calls Answered in 30s	Abandonment Rate
AmeriHealth	11,858	68.25%	4.99%
Healthy Blue	15,399	77.26%	2.27%
Carolina Complete	8,432	86.77%	0.37%
United	11,458	90.40%	0.81%
Wellcare	12,245	95.36%	0.42%
Alliance	2,823	100.00%	0.20%
Eastpointe	314	98.73%	1.53%
Partners	211	100.00%	0.00%
Sandhills	524	99.00%	3.30%
Trillium	713	99.86%	0.14%
Vaya	1,185	98.67%	0.17%

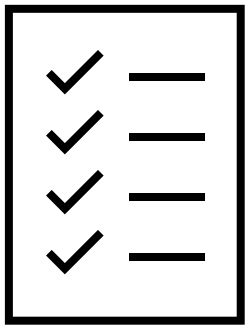
Top Call Center Reasons		
Health Plans	1	Claims/ Reimbursement
	2	Benefits and Eligibility
	3	Authorization Status
	4	Demographics Changes
	5	Provider Network Status
	6	Provider Enrollments

Provider Playbook



- Medicaid and NC Health Choice Provider and Health Plan Lookup Tool
- Day one Provider Quick Reference Guide for Tailored Plans (New)
- What Providers Need to know Before Tailored Plan Launch
- Tailored Care Management
- Bulletins & Fact Sheets are posted monthly
- Visit the Provider Playbook on a regular basis to view updated materials

How to Check Eligibility/ PHP Enrollment Prior to Launch?



Recipient Eligibility Verification function of NCTracks

- includes beneficiary's benefit program
- includes managed care assignment information
- allows providers to verify eligibility for the following month, if the beneficiary's eligibility segment extends into the following month

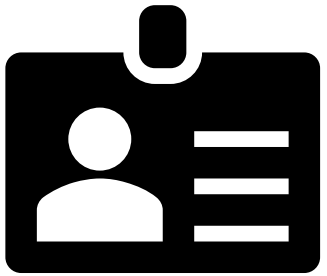
Please always verify coverage and managed care assignment prior to rendering services.

Panel Management for Primary Care Providers

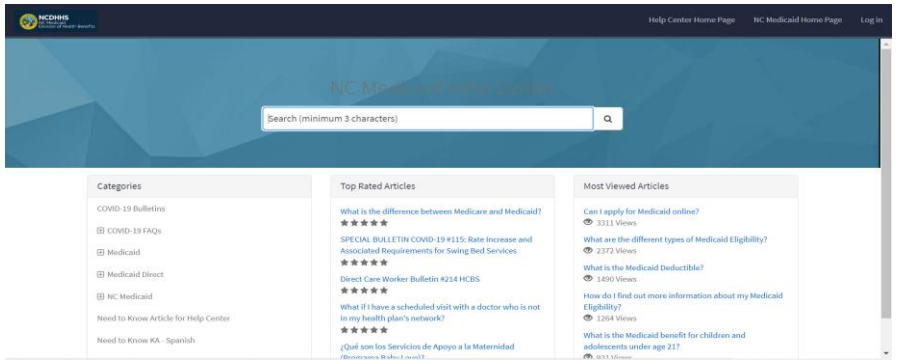
Member Eligibility Reminder

- Health plans are required to generate an identification card for each Member enrolled in their health plan that contains the Member's North Carolina Medicaid or NC Health Choice Identification number. Some health plans also include their health plan member ID as well.

- However, member ID cards are **NOT** required to provide service, and this includes pharmacies as well. Members should **NOT** be turned away due to the lack of a Member ID card in their possession.

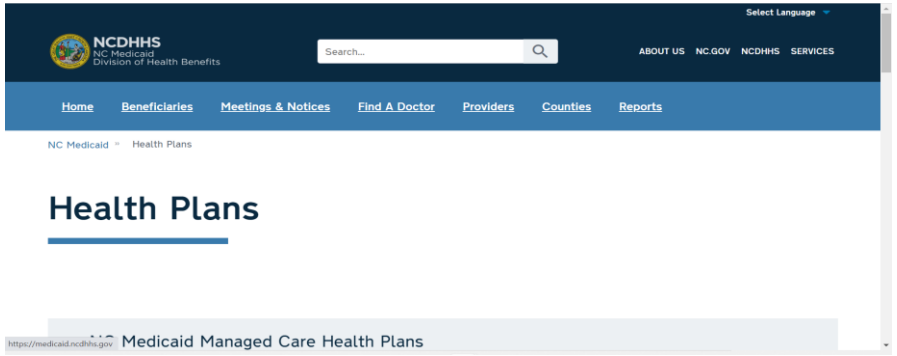


Reminder: Key Provider Information Resources



- NC Medicaid Help Center

- NCDHHS Transformation website (Including County & Provider Playbooks)



- Health Plan websites

Claims Dashboard Overview

- NC Medicaid Managed Care claims dashboards are available on the NC Medicaid Website for public viewing
- These dashboards include data on claim payments and denials, as well as a list of top denial reasons for each prepaid health plan
- The dashboards are updated monthly

Dashboards | NC Medicaid

Claims Dashboard Content: Sample View

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Click tabs above to view other PHP Claims dashboards.

PHP Top 3 Claims Denial Reasons
Nov 2022

Purpose: The PHP Top 3 Claim Denial Reasons chart shows the most common denial reasons for each PHP and claim type for the most recent month.
Navigation: Select Count to the right to see the highest volume claim denial reasons for each PHP and claim type. Select Amount to the right to see the highest dollar claim denial reasons for each PHP and claim type.

Select Claim Count or Dollar Amount: Count

Professional - Header

PHP	Denied Reason	
AmeriHealth	EXPLANATION OF BENEFITS FROM PRIMARY CARRIER REQUIRED	20.6%
	SUBMITTED AFTER PLAN FILING LIMIT	19.9%
	NO MEDICAID NUMBER ON FILE	14.3%
Carolina Complete	DNOCONTRACT - NON - CONTRACTED PROVIDER. CONTACT NETWORK MANAGEMENT ..	22.7%
CCH Note	DCLMAGE - CLAIM WAS NOT RECEIVED WITHIN THE TIMELY FILING OR RE - FILING PERI..	10.0%
	NO SIGNATURE PROVIDED	8.6%
Healthy Blue	SUBMITTED AFTER PLAN FILING LIMIT	23.2%
	DENY PREAUTH NOT OBTAINED	19.4%
	DEFINITE DUPLICATE CLAIM	12.2%
United	MISSING TAXONOMY BILLING	21.8%
	SEND PRIMARY CARRIERS EOB	16.9%
	NO AUTHORIZATION ON FILE	10.1%
WellCare	DENIED: MUST SUBMIT AN EOB FROM THE PRIMARY INSURANCE CARRIER	22.9%
	DENIED: EXACT DUPLICATE OF ANOTHER CLAIM OR SERVICE	21.0%
	DENIED: PRIOR AUTHORIZATION REQUIRED BUT NOT OBTAINED	17.9%

Professional - Line

PHP	Denied Reason	
AmeriHealth	SUBMITTED AFTER PLAN FILING LIMIT	18.2%
	EXPLANATION OF BENEFITS FROM PRIMARY CARRIER REQUIRED	15.6%
	NO ALLOWABLE ON FEE SCHEDULE OR CONTRACT	14.0%
Carolina Complete	ADJUST : CLAIM TO BE RE - PROCESSED CORRECTED UNDER NEW CLAIM NUMBER	25.5%
	SERVICE OR SERVICE/MODIFIER COMBO NOT FOUND ON FEE SCHEDULE	18.2%
	DENY : DUPLICATE CLAIM SERVICE	11.2%
Healthy Blue	SUBMITTED AFTER PLAN FILING LIMIT	27.6%
	DENY PREAUTH NOT OBTAINED	16.1%
	DEFINITE DUPLICATE CLAIM	12.7%
United	MISSING TAXONOMY BILLING	16.9%
	SEND PRIMARY CARRIERS EOB	12.9%
	INCL IN ANOTHER PROCEDURE	9.6%
WellCare	DENIED: MUST SUBMIT AN EOB FROM THE PRIMARY INSURANCE CARRIER	21.1%
	DENIED: EXACT DUPLICATE OF ANOTHER CLAIM OR SERVICE	20.6%
	DENIED: PRIOR AUTHORIZATION REQUIRED BUT NOT OBTAINED	17.5%

Member Resources

- NC Medicaid Enrollment Broker
  - Website ncmedicaidplans.gov
  - Call Center 1-833–870–5500 TTY: 711 or RelayNC.com
    (Monday–Friday, 7 a.m. to 8 p.m., Saturday, 7 a.m. to 5 p.m.)
  - Tailored Plan webpage ncmedicaidplans.gov/learn/get-answers/tailored-plan-services
- NC Medicaid Behavioral Health I/DD Tailored Plan webpage
  medicaid.ncdhhs.gov/Behavioral-Health-IDD-Tailored-Plans
- NC Medicaid Ombudsman
  - Website ncmedicaidombudsman.org
  - Phone 877-201-3750 (Monday–Friday, 8 a.m. to 5 p.m.)

Provider Ombudsman

- For provider inquiries, concerns, complaints regarding health plans, please contact the Provider Ombudsman

- The Ombudsman will provide resources and assist providers with issues through resolution

Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Phone: 866-304-7062

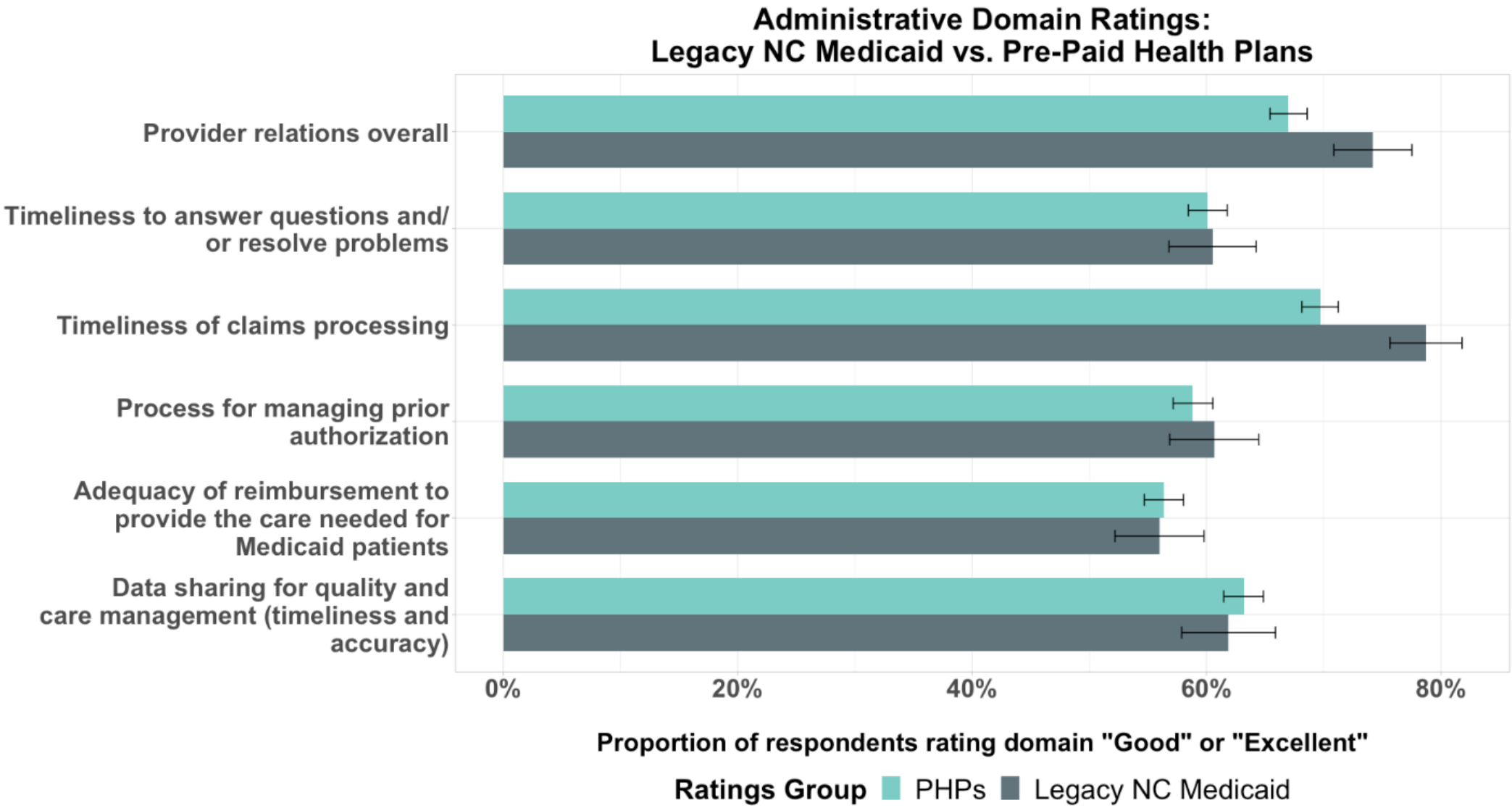
Provider Satisfaction Survey

- 2023 survey to **open early March**
- Goal: Understand experiences of primary care and obstetrics/gynecology providers with transition to Prepaid Health Plans
  - Survey of organizations (practices, medical groups, health care systems)
- Fielded in Spring 2021 and again in Spring 2022
  - We had excellent participation
  - Insights informed policy and discussions between DHHS and PHPs

We hope you will use this mechanism to help us improve the Medicaid Transformation!

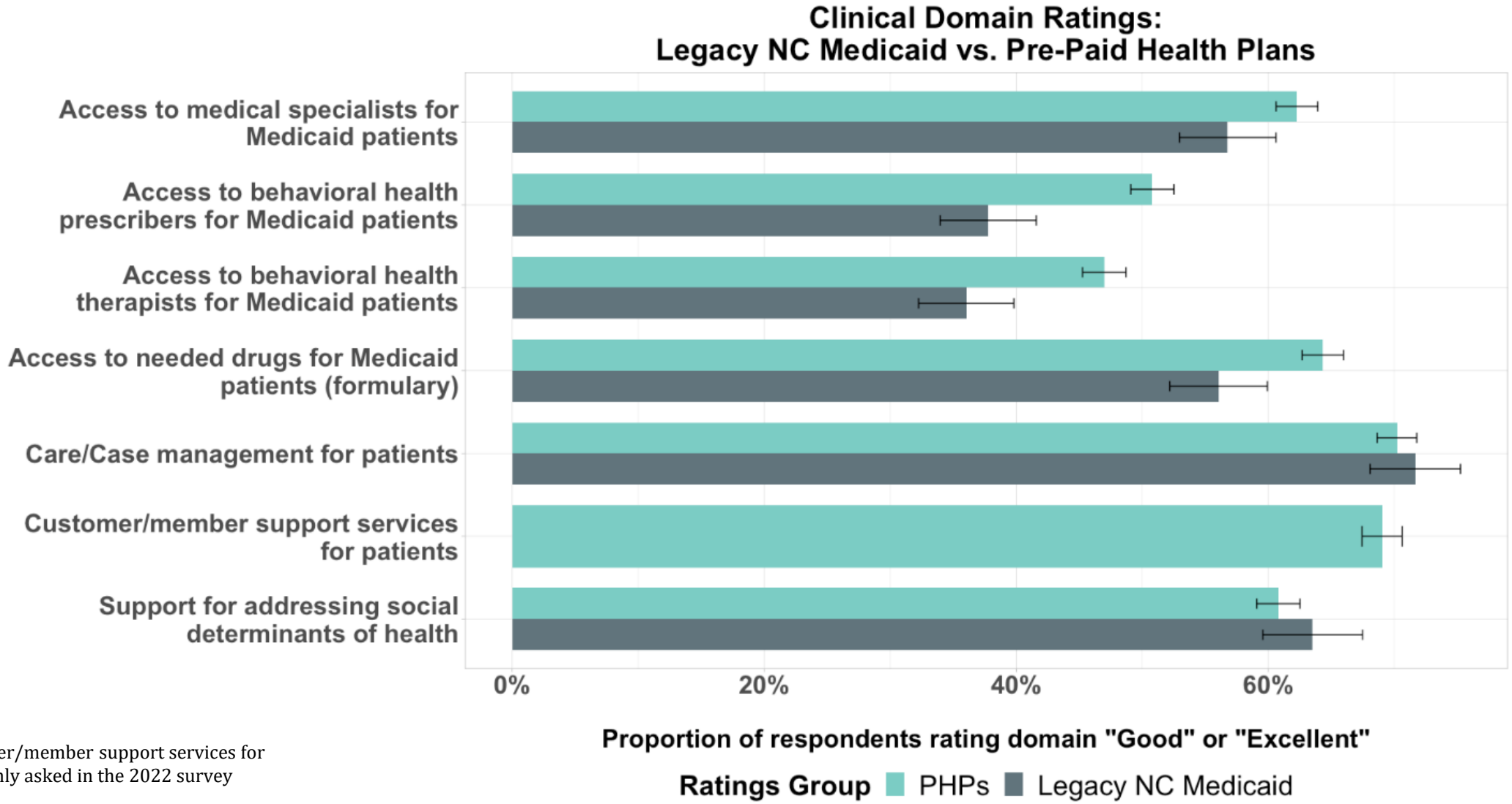
2022 Provider Satisfaction Survey

Experience and satisfaction with ADMINISTRATIVE domains, Legacy NC Medicaid vs. Pre-Paid Health Plans

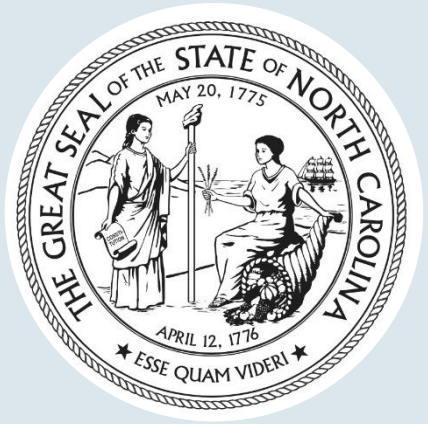


2022 Provider Satisfaction Survey

*Experience and satisfaction with **CLINICAL** domains, Legacy NC Medicaid vs. Pre-Paid Health Plans*



*__Note__: Customer/member support services for patients was only asked in the 2022 survey



Legislative Updates

Public Health Emergency (PHE) & Continuous Coverage Unwinding

- The 2023 Consolidated Appropriations Act (Omnibus Bill) delinked the continuous coverage requirement from the Federal Public Health Emergency.
- The PHE is expected to be renewed on January 11, 2023, for an additional 90 days extending clinical and other flexibilities.
- CMS has provided additional guidance on eligibility implications and requirements.

- DHB priorities:
  - Beneficiary communications focus on 2 key messages
    - Update your address via county DSS or create an enhanced ePASS account
    - Check your mail
  - CMS reporting due in February 2023

NC Health Choice Move to Medicaid - Overview

Per Session Law 2022-74 (HB 103), **effective April 1, 2023**

~55,000 children (aged 6 – 18) enrolled in NC Health Choice will move to Medicaid

Provides access to more services for NC Health Choice beneficiaries, including:

- Enhanced behavioral health services
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) services and well-child visits
- Non-emergency transportation
- No copayments or enrollment fees

Beneficiaries will be mailed a notice by March 2023 informing them of the change

Beneficiaries' Medicaid ID (Recipient ID) will NOT change

The move will NOT impact beneficiaries' health plan enrollment

NC Health Choice Move to Medicaid – Provider Impacts

Providers currently enrolled only with NC Health Choice will update to terminated status in NC Tracks as of 4/1/2023, unless they choose to enroll with Medicaid

Communications from NC Medicaid and Health Plans forthcoming with information on claims processing timeline and Prior Authorizations related to NC Health Choice move to Medicaid

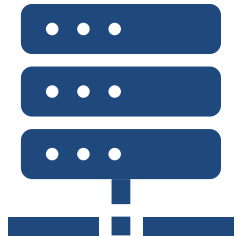
As of April 1, 2023, no beneficiaries will be enrolled with NC Health Choice but may present with an NC Health Choice ID card while they await their replacement Medicaid ID card

Providers must confirm Medicaid eligibility via the **Recipient Eligibility Verification function of NCTracks.**

PDM/CVO - Coming Early 2024

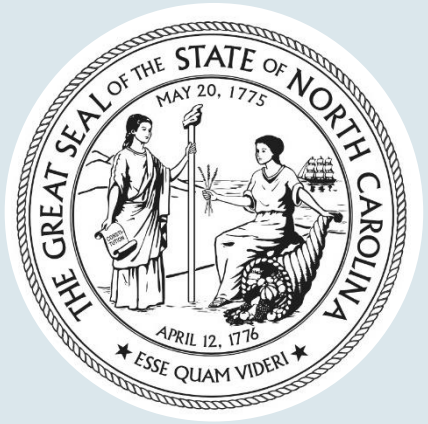
Session Law 2017-57 authorized the replacement of current Medicaid Management Information System (MMIS)

Provider enrollment, credentialing, and data management components of NCTracks will transition to a new Provider Data Management/Credentialing Verification Organization (PDM/CVO) solution



The new PDM/CVO solution will:

- Improve the user experience
- Reduce provider administrative burden
- Streamline data intake and maintenance throughout provider lifecycle
- Align CMS requirements to NCDHHS provider enrollment and credentialing processes



Clinical Updates

Did We Miss The Mark?

- Providers/external stakeholders may formally submit a request for coverage of any procedure(s), product(s) and/or service(s) through the NC Medicaid website
  - Evidence based guidelines must exist for consideration
  - Medicaid cannot cover experimental and investigational care
- Email completed form (PDF) to: medicaid.coverage.request@dhhs.nc.gov
  - Include any supporting documentation embedded within PDF or as attachments. Submissions will only be processed when all required information is completed.*

Request for Coverage Form

*Timeline varies for requests accepted for coverage but must follow a complex process

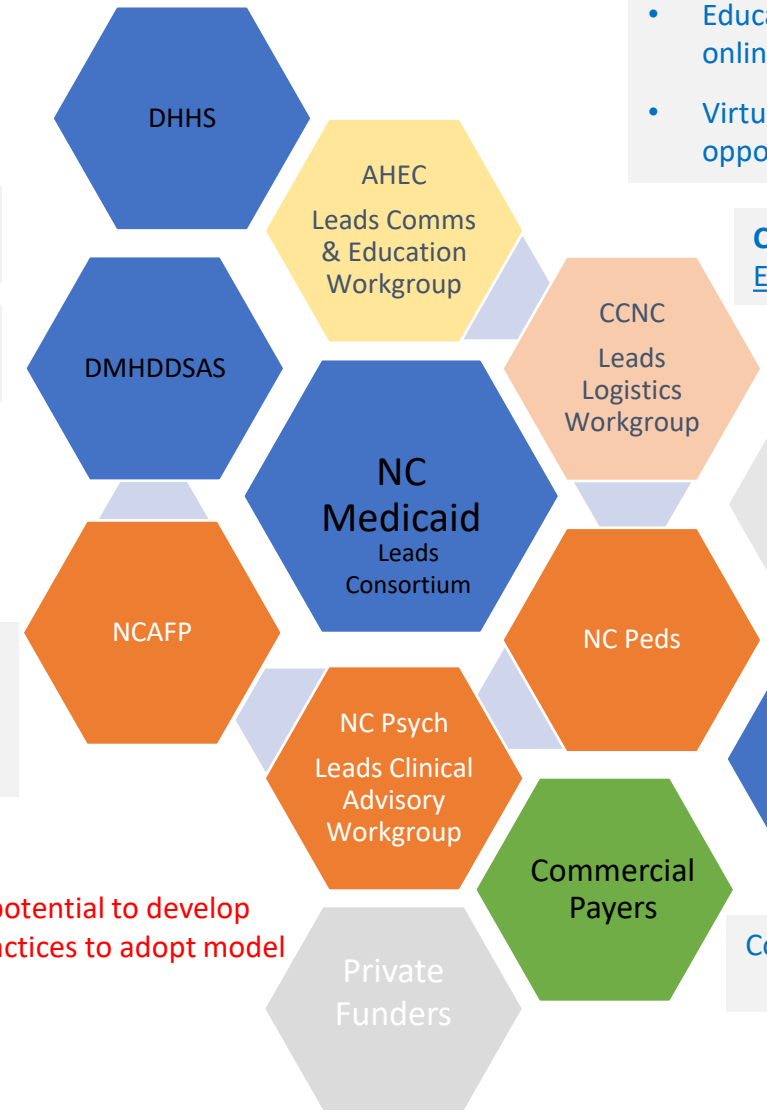
Collaborative Care Consortium

DHHS Strategic BH Priorities include advancement of the model

DMHDDSAS Coordination with NCPAL, Supporting Work Groups, Advising Consortium

NC Medicaid Alignment of clinical coverage policies to Medicare
12/1/22:Reimbursement increased to 120% of Medicare(previously 70%, primary care 100%)

Provider Associations (Family Medicine, Pediatrics, Psychiatry) creating "matches" between PCPs and Psychiatrists
Hosting Kick Off and Training at Annual Meetings
Promoting CME and Best Practice Models



NC AHEC Learning Collaborative(supported with Medicaid funding):

- Practice Support: coaches with expertise in primary care and behavioral health work w/practices to implement the model w/best practice standards.
- Educational Courses: important Collaborative Care topics are provided online to any provider or practice; continuing education credits offered.
- Virtual Peer Collaboratives: provide both a learning and networking opportunity with Subject Matter Experts presenting and facilitating.

CCNC Hosting Custom, State-of-the-Art Registry for all Medicaid Enrolled Providers(supported with Medicaid funding)

Opportunity for ACO/CINs to build hub and spoke models to engage more medical homes in this model.

Opportunity to develop financial incentives in value based care.

Medicaid PHP CMOs and BH Directors supporting workgroups and coverage.

Commercial Payers aligning coverage
BCBS NC Announced Coverage Effective 7/22

Opportunity for Private Funders potential to develop Capacity Building incentive for practices to adopt model

Link to NC Medicaid Bulletin on Updated Clinical Coverage for Psychiatric Collaborative Care Management

Healthy Opportunities Pilots Update

The Healthy Opportunities Pilot has delivered over 26,000 non-medical services to over 3,000 enrollees since March 2022.

Who's involved?

- DHHS, PHPs, CMs, NLs, HSOs, NCCARE360, and you!

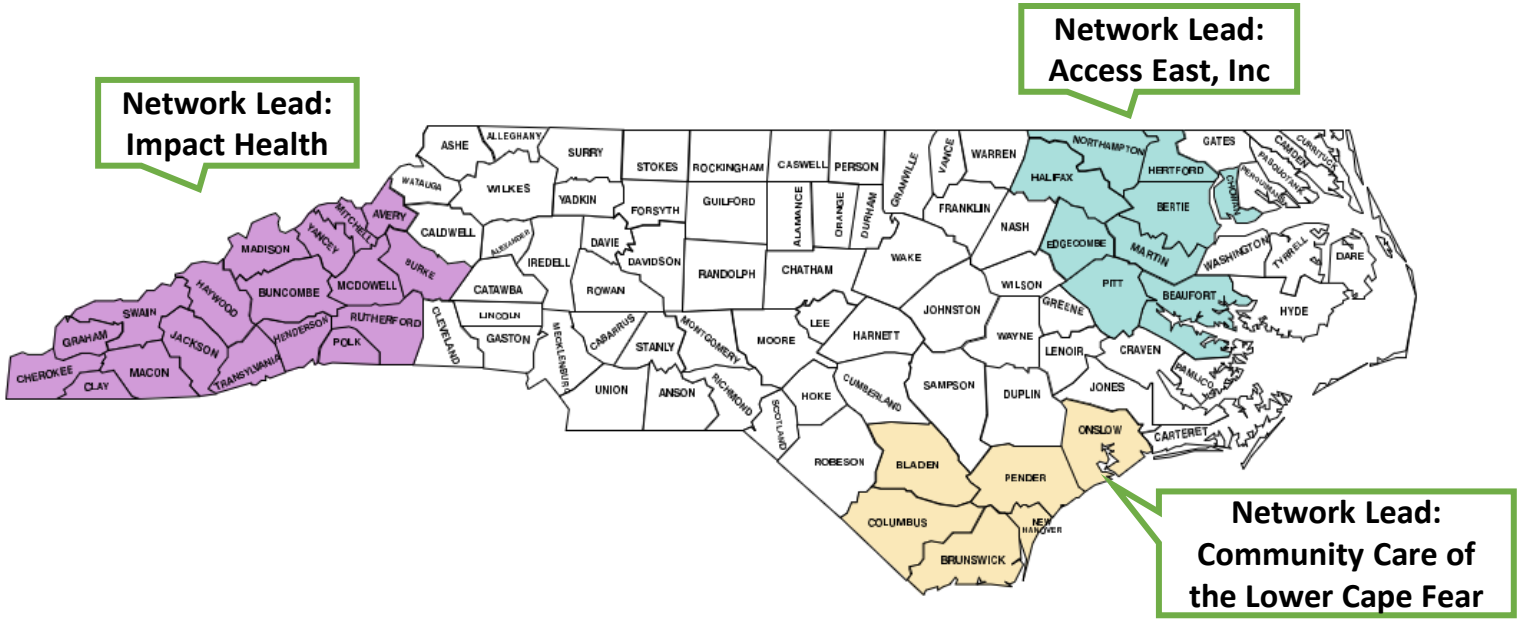
Service Domains

- **Food** (Ex. Food/Nutrition Case Management, Healthy Food Boxes/Meals)
- **Housing** (ex. Housing Navigation, Home Remediation Services, Move-In Support)
- **Transportation** (Ex. Reimbursement for Health-Related Private Transportation)
- **Toxic Stress** (Ex. Evidence-Based Parenting Curriculum and Home Visiting)
- **Cross-Domain** (Ex. Medical Respite)

Eligibility Criteria

- Enrolled in Medicaid Managed Care
- Live in a Pilot Region
- Have at least one qualifying physical/behavioral condition and one qualifying social risk factor
- Note: There are no age restrictions for eligibility!

Remember: A whole family can access HOP services through one Medicaid member!



- **No Wrong Door referral pathway in NCCARE360:** Create a "Benefits Eligibility Screening" referral in NCCARE360 to refer a member you think may be eligible for HOP to their health plan. The health plan will assess the member's eligibility and enroll them in HOP, if eligible.
- **Upcoming AHEC Webinar on 2/15 from 5:30-6:30 on HOP and No Wrong Door referral pathway**

Source: UniteUs Insights Dashboard, Payments Activity Overview, Data as of Jan. 12, 2023. For Additional Information Visit: Healthy Opportunities Pilots | NCDHHS


QUESTIONS?

APPENDIX

How Will I Know if Someone is Eligible for TCM?

- TCM Provider: Will receive a monthly member file (BA File)
  - That BA file will also list the member's PCP

- Member: Received a letter notifying them of their TCM agency and choice options

- Primary Care Physician (PCP): NCTracks Enrollee Report (List member's plan & TCM provider)
  - The Enrollee Report is delivered via a NCTracks Secure Provider Portal Private Message the Monday before the second checkwrite of each Month.
  - Additional Guidance for Report Access and Use

- Other Providers: The TCM provider should contact you (as needed) or you can call the LME-MCO for assistance.

REMEMBER: LME-MCOs still provide care coordination for members in Medicaid Direct who are not eligible for TCM or who opt-out of the service. Providers/members should still call the LME-MCO for support for members with BH/IDD/SUD.

How are Members Assigned to a Care Management Entity

Members who do not choose an organization for Tailored Care Management will receive an assignment based on the following factors:

- Member's **existing primary care provider (PCP) assignment to an AMH+ practice or an existing treatment relationship with a CMA**
- Member's **existing relationship with an LME/MCO Innovations waiver care coordinator**
- Member's **exceptional physical health and/or behavioral health needs** – examples include**:**
  - Members receiving cancer treatment or with end stage organ failure/organ transplant will be prioritized for AMH+ or LME
  - Members in child behavioral health residential services will be prioritized for CMA or LME
  - Members with both exceptional physical and exceptional behavioral health needs, or those in certain institutional settings will be prioritized for the LME
- Member's **geographic location**
- AMH+ practices or CMA's care management **panel size capacity**
- Federal **conflict-free** case management requirements for people using home and community-based services (HCBS), which prohibit a provider organization from delivering HCBS and care management to one individual

2022 Provider Satisfaction Survey

Health System and Practice Characteristics	Self-Identified Health Systems (N = 14)	Self-Identified Medical Groups and Independent Practices (N = 380)
	N (%)	N (%)
Respondent		
Role of Respondent		
Practice Manager	2 (14.3%)	255 (67.1%)
Medical Director	1 (7.1%)	25 (6.6%)
Other	11 (78.6%)	99 (26.1%)
Practice Composition		
Services Provided for Patients with Medicaid		
Primary Care	14 (100.0%)	371 (97.6%)
Prenatal/Postnatal Care	10 (71.4%)	32 (8.4%)
Inpatient Obstetrics Care	11 (78.6%)	12 (3.2%)
Number of Providers (IQVIA-sourced)		
1-2 providers	0 (0.0%)	261 (68.7%)
3-9 providers	1 (7.1%)	95 (25.0%)
10 or more providers	13 (92.9%)	24 (6.3%)
Geography		
No Rural Practice Sites (NCRC)	2 (14.3%)	192 (50.5%)
Any Rural Practice Sites (NCRC)	12 (85.7%)	188 (49.5%)

PDM/CVO - Coming Early 2024

North Carolina has matured its vision for the PDM/CVO as a core part of Transformation since Aug 2017.

Improves User Experience

- Mitigates administrative burden of completing data entry across multiple plans
- Collects data using common accreditation standards
- Allows providers to delegate access within their organization allowing multiple users to complete an application
- Offers an interactive enrollment process, automatically guided step-by-step and real- time online assistance
- Improves the notification process to streamline collaboration
- Simplifies registration for multi-payer providers
- Offers enhanced security controls and protocols

Meets State Program Needs

- Addresses administrative burden of multiple credentialing standards across programs and health plans.
- Utilizes nationally-recognized credentialing and accreditation standards
- Supports a multi-payer, multi-health plan program
- Matures data architecture and interfaces
- Establishes a representative, centralized credentialing committee with multi-payers

PDM/CVO website for updates:
https://medicaid.ncdhhs.gov/PDM-CVO

Meets CMS Requirements

- Provides more efficient, economical, and effective administration of State plan
- Supports seamless coordination and integration and allows interoperability
- Ensures HIPAA privacy, security, transaction and section 508 standards
- Increases flexibility to modify individual services efficiently and effectively to address the changing local and national health and human services environment
- Aligns with Centers for Medicare & Medicaid Services (CMS) requirements