Back Porch Chat

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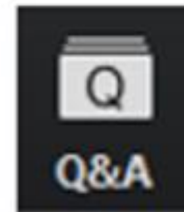
August 2024

Logistics for Today's Webinar

Question during the live webinar



Technical assistance

technicalassistanceCOVID19@gmail.com

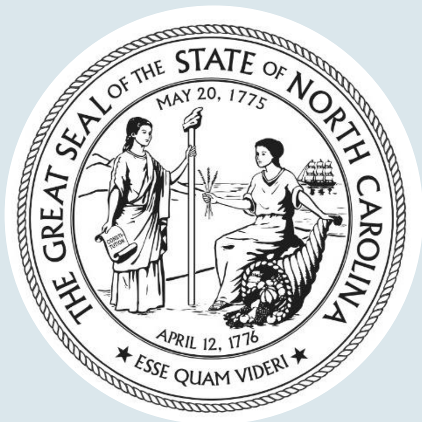
AGENDA

01 Tailored Plan Updates

02 Healthy Opportunities Pilot – Interim Report

03 Hot Topics

04 Q/A



Tailored Plan Updates

Tailored Plan Provider Resources

NC Medicaid has many resources to aid providers as they begin to serve patients covered by Tailored Plans and submit claims.

- **Fact Sheets**
  - General claims submission information: https://medicaid.ncdhhs.gov/managed-care-claims-submission-what-providers-need-know-part-1/download?attachment
  - FAQs on each Tailored Plan's submission process https://medicaid.ncdhhs.gov/tailored-plan-managed-care-claims-and-prior-authorizations-submission-frequently-asked-questions/download?attachment
- **Playbooks**
  - Provider Playbook: https://medicaid.ncdhhs.gov/providers/provider-playbook-nc-medicaid-managed-care
  - County Playbook: https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care/nc-medicaid-managed-care-overview

Tailored Plan Contact Information

First point of contact for all Tailored Plan questions

Plan	Website	Member Services Line	Provider Services Line
Alliance Health	https://www.alliancehealthplan.org/	1-800-510-9132, TTY: 711 1-800-735-2962	855-759-9700
Partners Health Management	https://www.partnersbhm.org/	1-888-235-4673 TTY/English: 1-800735-2962 TTY/Spanish: 1-888825-6570	877-398-4145
Trillium Health Resources	https://www.trilliumhealthresources.org/	1-877-685-2415, TTY: 711	855-250-1539
Vaya Health	https://www.vayahealth.com/	1-800-962-9003, TTY: 711	866-990-9712

Tailored Plan Contact Information

Second point of contact after the service lines

NC Medicaid Ombudsman (Member Initial Escalation Point)

- Website: https://ncmedicaidombudsman.org/tailored-plans
- Phone: 877-201-3750

Provider Ombudsman (Provider Initial Escalation Point)

- Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov
- Phone: 866-304-7062

NC Medicaid Contact Center (Secondary Escalation Point)

- Phone: 888-245-0179

Policy Levers to Ease Beneficiary Confusion & Provider Administrative Burden

Policy Lever	Duration	Time Frame
Relax Medical PA requirements	91 days	7/1/2024 – 9/30/2024
Relax Pharmacy PA requirements	91 days	7/1/2024 – 9/30/2024
Non-Par Providers Paid at Par Rates	91 days	7/1/2024 – 9/30/2024
Non-Par Providers Follow In-Network Prior Authorization Rules	122 additional days	10/1/2024 – 1/31/2025
Ability to Switch PCP	214 days	7/1/2024 – 1/31/2025
Continuity of Care for Ongoing Course of Treatment	7 months	7/1/2024 – 1/31/2025

Note: The Department may opt to extend any of these flexibilities after the designated timeframe above, based on Tailored Plan operations to ensure the stability of Medicaid operations for Tailored Plan beneficiaries.

Pharmacy PA POS Denials

Tailored Plans are taking additional actions to address Pharmacy PA POS denials in response to Medicaid Help Center trends identified in the initial weeks following launch.

- For all Pharmacy POS denials, the denial response message from Plans should include **verbiage that encourages Pharmacies/Members/Prescribers to call the Pharmacy Help Desk to discuss the denial.** The Pharmacy Help Desk number should be included in the denial message.
- In some cases, the Plan's denial response message may also state the expectation for **the pharmacy to dispense a 72-hour supply, if appropriate, while awaiting PA**.
- Plans are reviewing claim denials to confirm if sufficient historical evidence is available (e.g., historical diagnosis and/or historical drug utilization from claims data, Pharmacy/Prescriber attestation of previous drug use while on NC Medicaid, or refill status of the claim in NCPDP field 403-D3) to **allow a 30-day PA override for the member to get a 30-day supply of the drug**.
  - Plans are expected to **work in parallel with the provider to request a new PA** within the 30-day period to ensure continued access to the drug.
  - Plans are expected to **outreach to Pharmacies/Members/Prescribers when an override is needed** and subsequent PA approvals are needed, to ensure members have access to the medications.

Scenarios

Scenario 1

What should a Tailored Plan beneficiary do if their primary care provider or specialist is not in-network with the Tailored Plan?

Currently, there are a number of flexibilities that support those out-of-network providers in continuing to provide services for Tailored Plan members and get claims paid. Additionally, it is important for beneficiaries to contact their Health Plans to let them know about their concerns and lack of access to specific provider services, particularly where ongoing specialty care is an issue.

NC Medicaid will continue to monitor member and provider concerns related to transitions and may extend the flexibilities if needed

Scenario 2

What exactly is the patient opting out of if they choose to go with a Standard Plan versus a Tailored Plan so that they can still see their pediatrician or sub-specialist? What services will they not be able to receive?

By opting out of Tailored Plans, the patient is opting out of access to Tailored Plan-specific benefits, such as enhanced behavioral health services (e.g., specialized services provided in home/facility/residential settings/), home and community-based services for children with serious mental health conditions or intellectual / developmental disabilities (e.g., respite, community living and supports), and tailored care management.

In addition, the patient would be opting out of the specialized expertise the Tailored Plans have in providing care for individuals with mental health conditions and developmental disabilities. In fact, some individuals, such as those on the Innovations Waiver or receiving Transitions to Community Living Services, may not move to Standard Plans unless they first disenroll from services.

With this knowledge, if a member selects to move to a Standard Plan, and should the patient need Tailored Plan only services in the future, the patient (guardian or provider) can – at any time – request to move back to a Tailored Plan, including if a provider determines that one of these extra services is needed. The Enrollment Broker can assist the patient/guardian with understanding the differences between Plans and switching between Plans.

Scenario 3

If a patient opts out of Tailored Plan because a provider isn't contracting with their Tailored Plan, will they get automatically assigned a Standard Plan or do they have to directly do this?

When a beneficiary moves to a Standard Plan, the beneficiary or guardian first must select their preferred Standard Plan. Once the Standard Plan is selected, the beneficiary or guardian may select a primary care provider based on the primary care providers in the Standard Plan's network who are accepting new patients. The Enrollment Broker can assist with selecting a Standard Plan. If a choice of Standard Plan is not made, then the beneficiary will be assigned to one by DHHS. If a choice of PCP is not made, the Standard Plan will assign the patient a PCP.

When selecting a Standard Plan, it is important for beneficiaries and guardians to first check their preferred providers are in-network and accepting new patients.

Q & A

We encourage providers to refer to the **Medicaid Provider Playbook** for answers to Frequently Asked questions.

https://medicaid.ncdhhs.gov/tailored-plan-managed-care-claims-and-prior-authorizations-submission-frequently-asked-questions/download?attachment.

Question 1

Will children with existing prior authorizations for outpatient therapy (PT/OT/ST) be honored until the current end date or would the patient's therapy be interrupted until prior authorization (PA) is received through their new tailored plan?

Tailored Plans must also honor existing medical PAs for physical and behavioral health services for 91 days after Tailored Plan launch or until the expiration/completion of a PA, whichever occurs first.

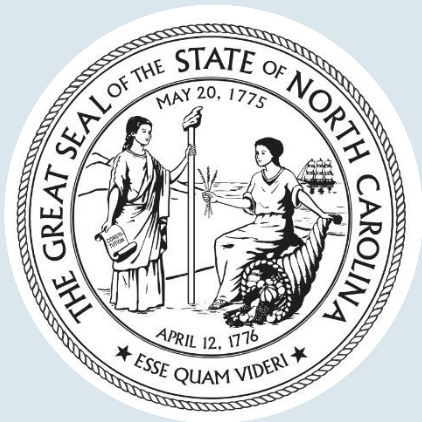
Flexibilities to Ease Provider Administrative Burden at Tailored Plan Launch | NC Medicaid (ncdhhs.gov)

Question 2

For Tailored Plan members accessing Tailored Care Management services, where will the providers and staff find care plans and the care manager's name and contact information?

Tailored Care Management (TCM) provider information was added to the Recipient Eligibility Verification page in NCTracks for applicable members. This includes health plan name, TCM provider information and contact information, as well as the health plan’s assignment for PCP/AMH.
Please contact the Tailored Care Manager for care plans.

For a list of all certified community-based Tailored Care Management providers, see:
https://medicaid.ncdhhs.gov/certified-tailored-care-management-providers/download?attachment



Healthy Opportunities Pilot – Interim Evaluation Report

Disclaimer: Results provided in this presentation are pending CMS approval and should not be distributed outside of DHHS

NC HEALTHY OPPORTUNITIES PILOTS INTERIM EVALUATION REPORT

NC Section 1115 Medicaid Demonstration Waiver
Enhanced Case Management and Other Services Pilot (ECM)

Prepared by: Cecil G. Sheps Center for Health Services Research
Commissioned for: North Carolina Department of Health and Human Services – Division of Health Benefits

AGENDA

- Background
- Results from Evaluation Questions 1-6
- Summary
- Limitations

BACKGROUND

IER Findings:

- **Includes:** screening and enrollment rates; connection to services; trends in needs; cost, utilization, and some clinical outcome findings
  - Data through November 2023
- **Not included**:
  - Clinical metrics for which data collection is on-going/not yet available
  - Next round of qualitative data collection (will begin Spring 2024)

Plans for Summative Eval:

- Comprehensive report of all evaluation findings, including aspects not covered in the RCA1 and IER

PURPOSES

The Pilots

To test evidence-based, non-medical interventions for their direct impact on NC Medicaid beneficiaries' health outcomes and healthcare costs, with the purpose of incorporating findings into the Medicaid program.

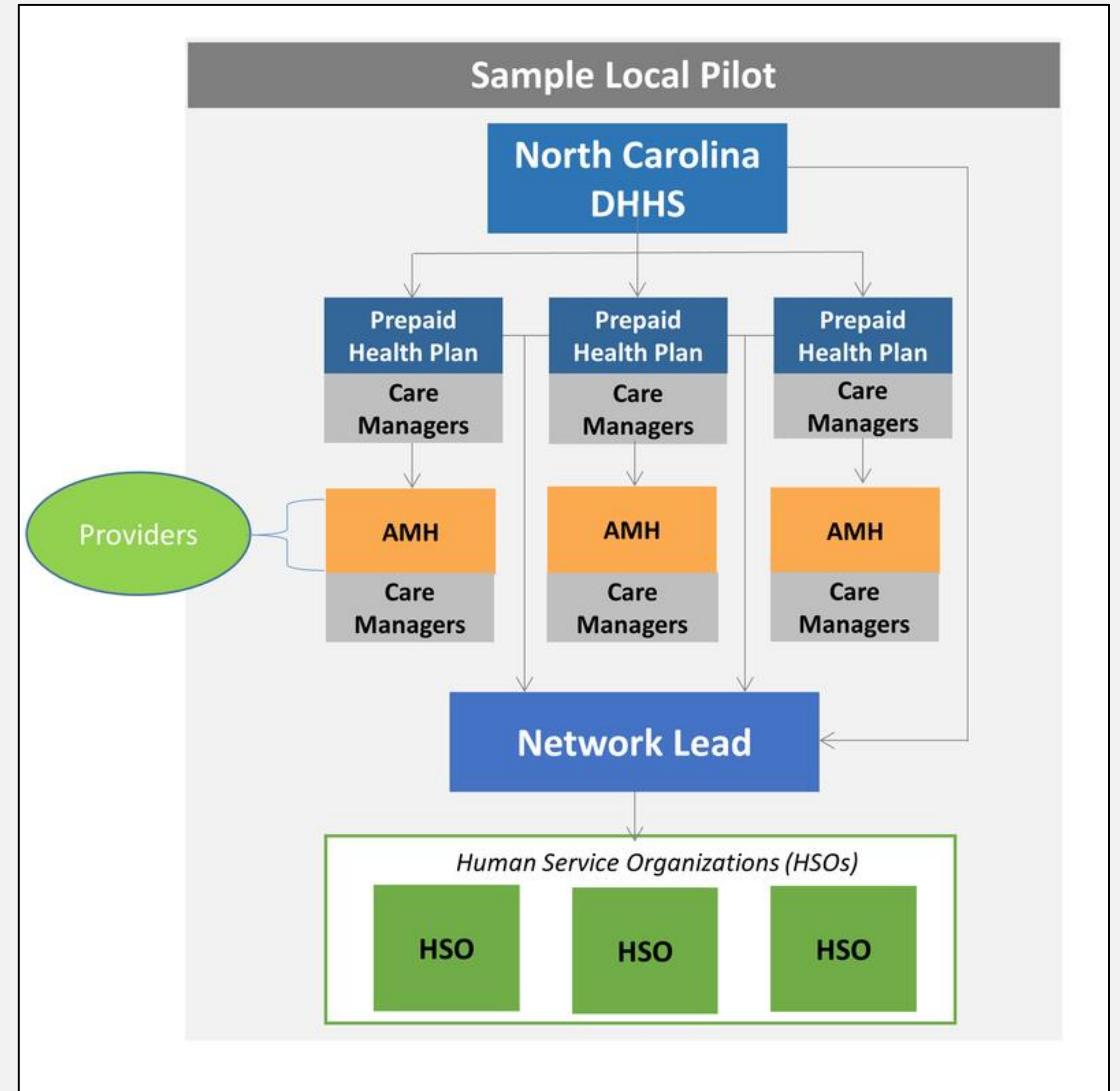
Interim Evaluation Report

Provide analytic information to guide continued service delivery and programmatic adjustments for the Pilots

PILOTS OVERVIEW

HOP Goal:

Promote health equity by building a well-coordinated system for qualifying Medicaid beneficiaries



OVERVIEW OF PILOT SERVICES

What Services Can Members Receive Through the Pilots?

North Carolina's Pilot Service Fee Schedule defines and prices 29 services that HSOs can offer as part of the Pilot. Examples include:

Food

- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals
- Medically tailored meal delivery

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Transportation

- Linkages to existing transportation resources
- Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits)

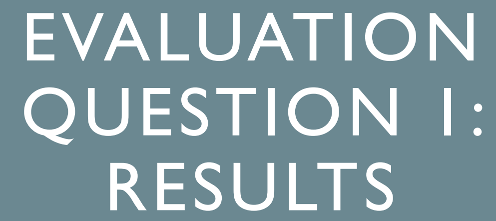
Interpersonal Violence

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

Cross-Domain

- Holistic high intensity enhanced case management
- Medical respite
- Linkages to health-related legal supports

Pilot service definitions and fee schedule: https://www.manatt.com/Manatt/media/Documents/Articles/NC-Pilot-Service-Fee-Schedule_Final-for-Webpage.pdf

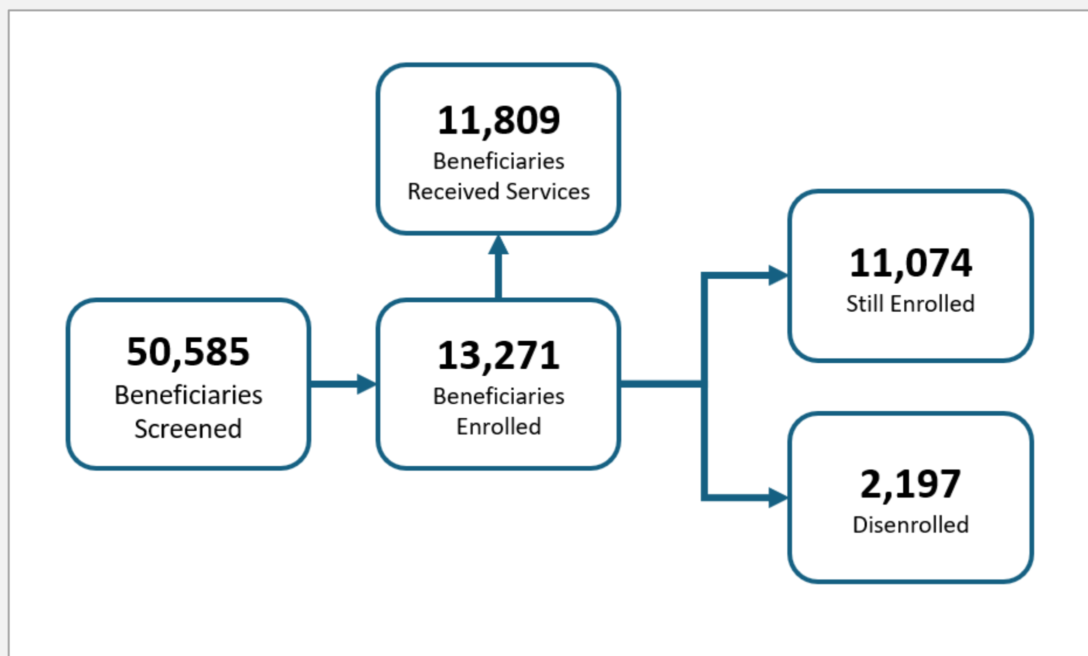


EFFECTIVE DELIVERY OF PILOT SERVICES

THE PRINCIPAL GOAL: Evaluate effectiveness of Pilot network in delivering HOP services

EVALUATION QUESTION 1: RESULTS

EFFECTIVE DELIVERY OF PILOT SERVICES



Key Points:

- 90% of beneficiaries received at least 1 service
  - Median time-to-service: 7 days
- 147 HSOs provided at least 1 service
- 75% of invoices paid within 45 days
- $36 million in service spending

INCREASED RATES OF SOCIAL RISK FACTOR SCREENING AND CONNECTION TO SERVICES

THE PRINCIPAL GOAL: determine whether there was a greater rate of screening for social risks in Pilot regions, as compared with non-Pilot regions.

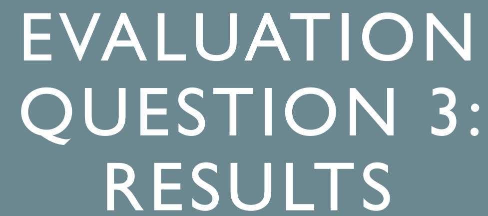
EVALUATION QUESTION 2: RESULTS

INCREASED RATES OF SOCIAL RISK FACTOR SCREENING AND CONNECTION TO SERVICES

Screening Rates are 13% higher in HOP, compared with non-HOP, regions (p< .001)

Region	Screened		Total	P-Value
	Yes	No		
HOP	50,585	506,551	**557,146**	<0.001
Non-HOP	182,186	2,088,204	**2,270,410**	
Total	**232,771**	**2,594,561**	**2,827,556**	

Note: Counts of Medicaid beneficiaries in HOP and non-HOP regions were based on March 2022 Medicaid beneficiaries plus any beneficiaries who completed screening but were not in the March 2022 file.

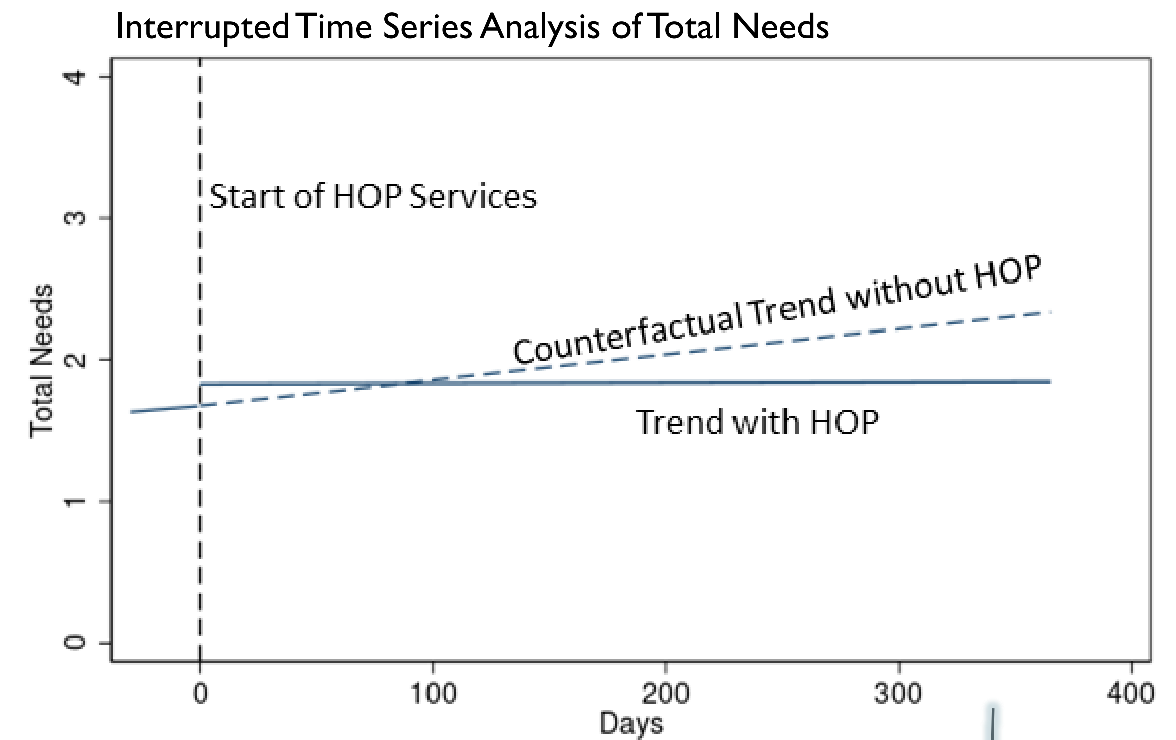


IMPROVED SOCIAL RISK FACTORS

THE PRINCIPAL GOAL: determine whether the overall burden of needs decreased with Pilot participation—among all participants and across different eligibility categories—along with determining whether the risk for specific needs decreased with Pilot enrollment.

EVALUATION QUESTION 3: RESULTS

IMPROVED SOCIAL RISK FACTORS



Changes in Level and Trend of Total Needs

Eligibility Category	Change In Level (95% CI)	Trend (95% CI)
Overall	-0.03 (-0.07 to 0.01)	-0.01 (-0.01 to -0.01)
Non-Pregnant Adults	-0.01 (-0.07 to 0.04)	-0.01 (-0.01 to -0.01)
Pregnant Individuals	-0.12 (-0.28 to 0.04)	-0.02 (-0.03 to -0.01)
Children 0 to 20 years of age	-0.03 (-0.08 to 0.02)	-0.01 (-0.01 to -0.01)
Children 0 to 3 years of age	0.04 (-0.09 to 0.18)	-0.008 (-0.014 to -0.002)

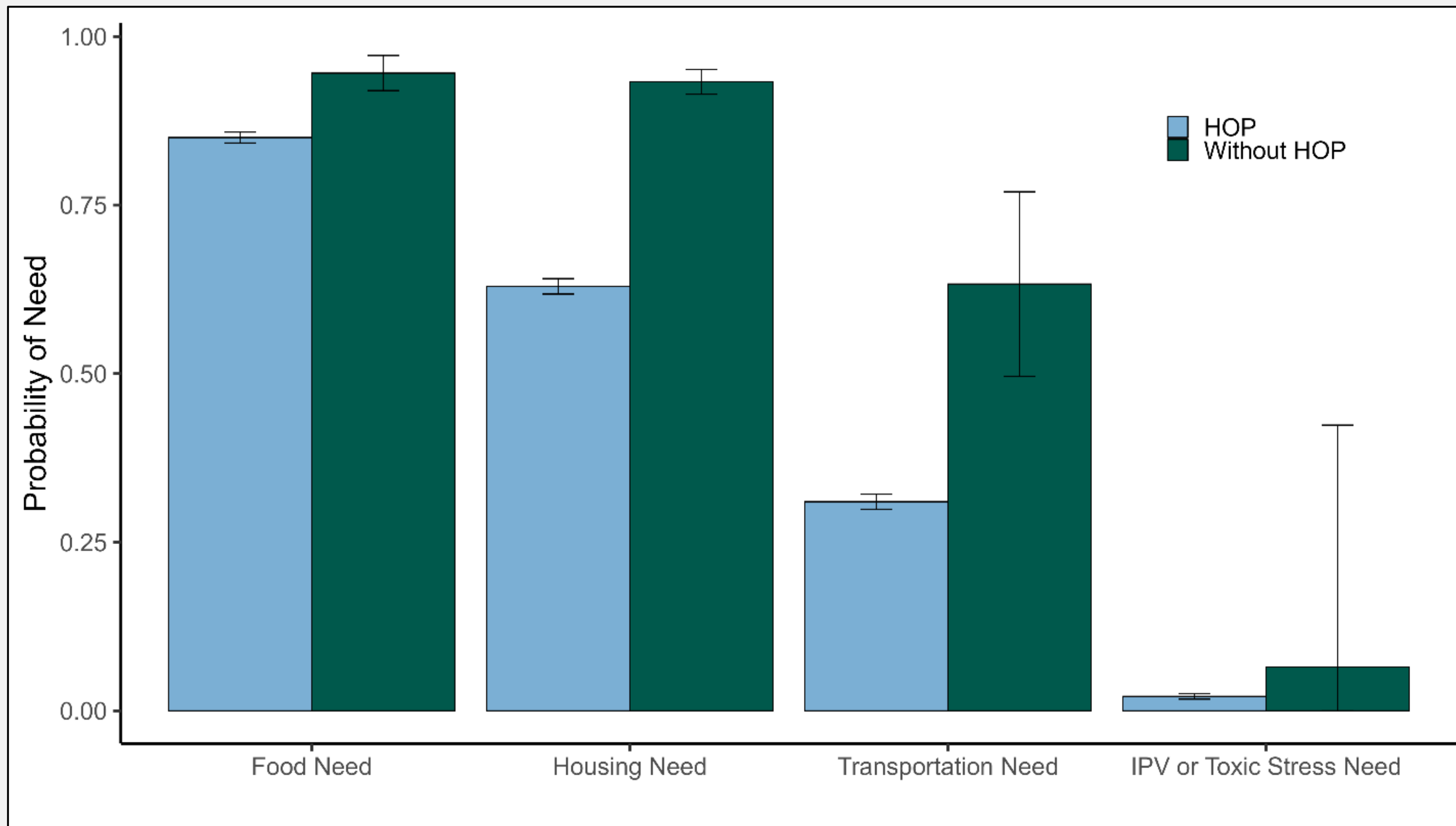
Note: Change in level indicates the change in number of needs immediately associated with Pilot services. A positive number indicates more needs being identified. Trend indicates the change in needs per day associated with Pilot services. A negative number indicates declining needs.

Increased duration is associated with greater **reduction in total needs**

EVALUATION QUESTION 3: RESULTS

IMPROVED SOCIAL RISK FACTORS

- HOP decreases the probability of all specific needs except IPV/Toxic Stress*



*NB:

- IPV services only available since April 2023 and low prevalence of IPV needs reduces power
- Positive signal for IPV needs in the subgroup of pregnant individuals

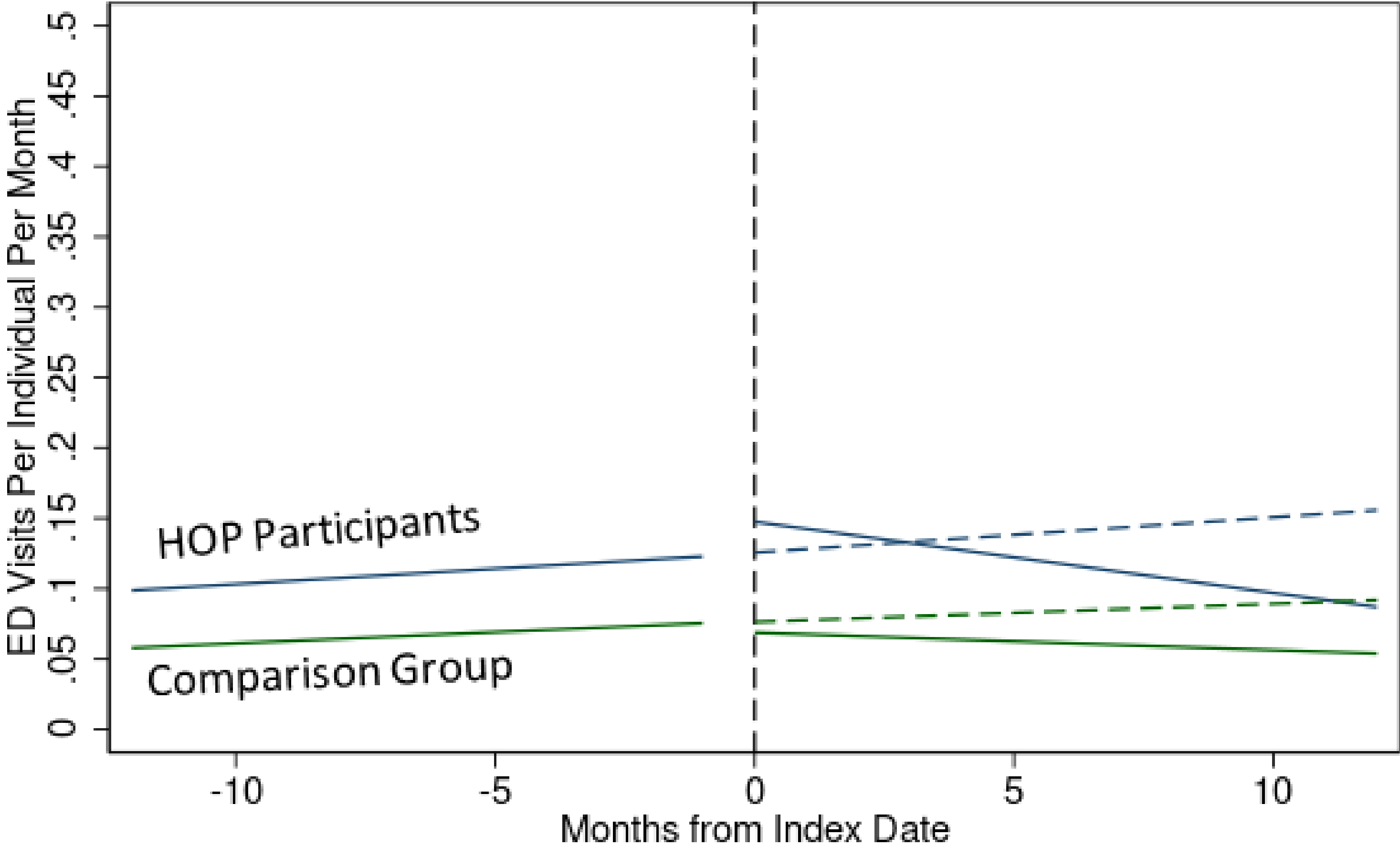
HEALTHCARE UTILIZATION

THE PRINCIPAL GOAL: determine how healthcare utilization changed with Pilot participation, among all participants and across different eligibility categories

EVALUATION QUESTION 5: RESULTS

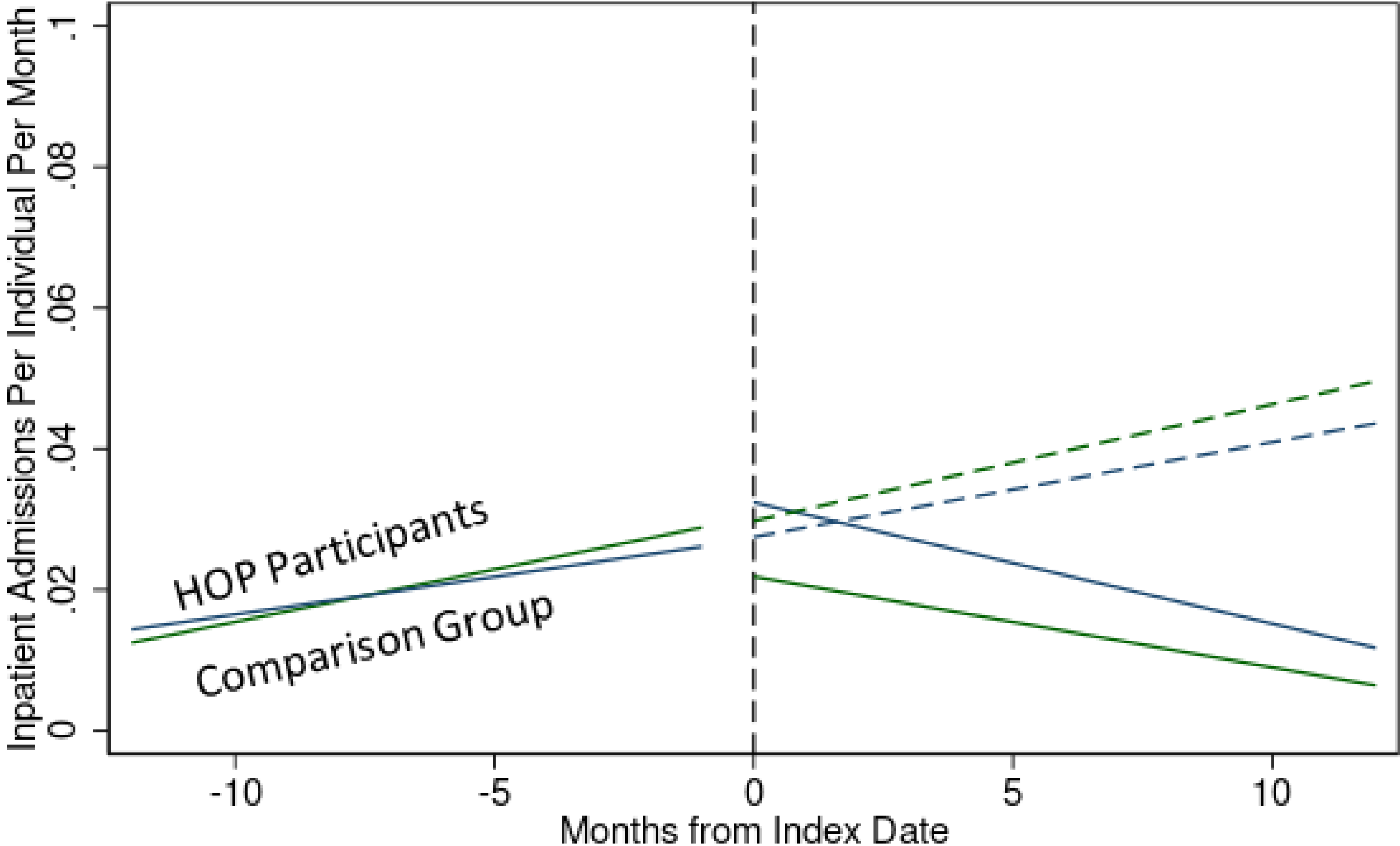
HEALTHCARE UTILIZATION

HOP significantly reduced ED Visits both overall and for all subgroups



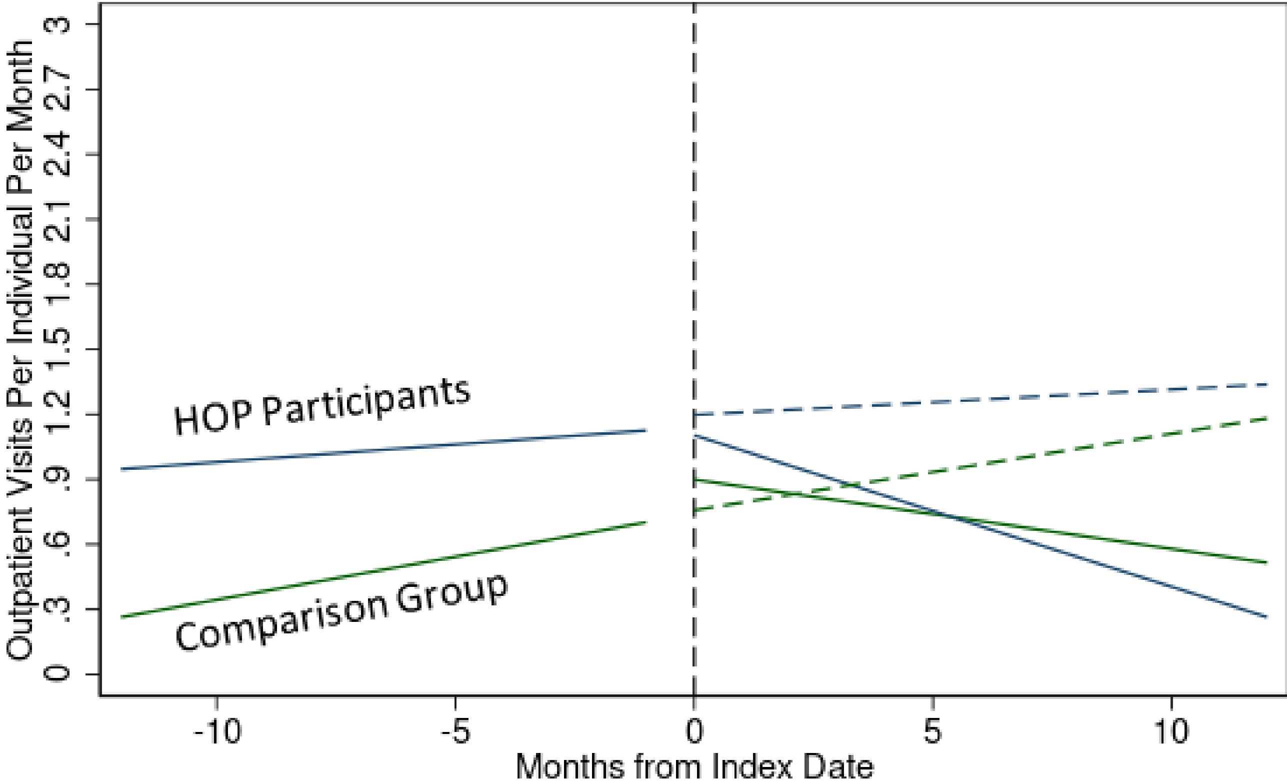
EVALUATION QUESTION 5: RESULTS
HEALTHCARE UTILIZATION

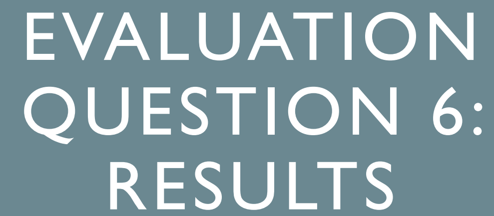
HOP impact on inpatient admissions was heterogenous



EVALUATION QUESTION 5: RESULTS
HEALTHCARE UTILIZATION

No clear HOP impact on outpatient visits





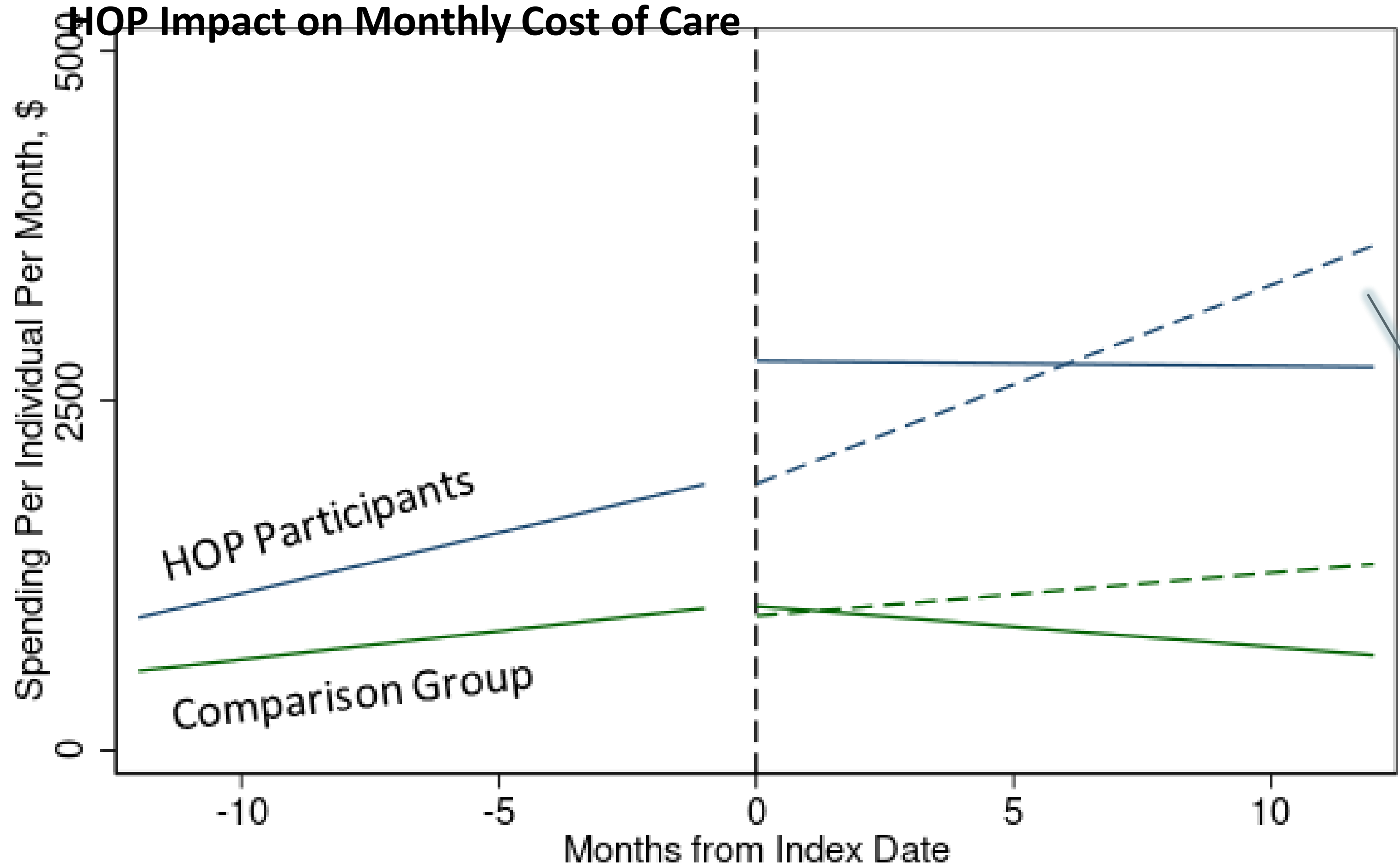
EVALUATION QUESTION 6: RESULTS

COST OF CARE

THE PRINCIPAL GOAL: determine how healthcare costs changed with Pilot participation, among all participants and across different eligibility categories

EVALUATION QUESTION 6: RESULTS

COST OF CARE



Overall, monthly costs decreased $85 per beneficiary, per month.

Approximately $1,000 less per beneficiary over a 12 month follow-up period

SUMMARY

Effective Delivery of Pilot Services

- 13,271 individuals enrolled
- 90% received at least 1 service
- 1 week to first service (median)
- Invoices paid within 60 days
- $36 million in spending on services

Increased Rates of Social Risk Factor Screening

- 13% increase in social risk factor screening (compared with non-HOP regions)

Improved Social Risk Factors

- HOP reduced total number of needs
- Larger impact as time goes on
- Pilot services reduced the food, housing, and transportation n eeds.
- IPV and/or toxic stress needs decreased with Pilot participation for pregnant individuals only.

Healthcare Utilization

- HOP reduced ED visits
- HOP may have reduced inpatient admissions (mixed evidence)
- No HOP effect on outpatient visits.

Cost of Care

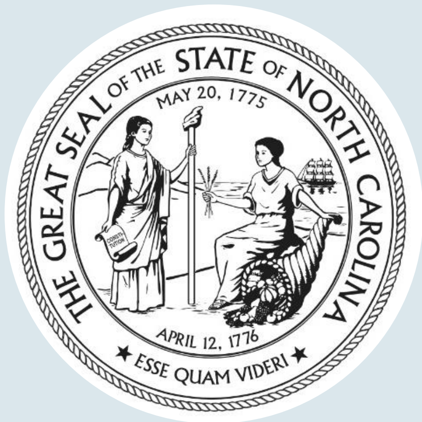
- HOP associated with $85 per beneficiary per month lower costs (inclusive of HOP service costs)

LIMITATIONS

Data lag or data entry errors could lead to erroneous estimates, but we have little reason to expect this to be differential across the groups being compared.

Receipt of services was not randomly assigned. Aspects of a participant's clinical or social situation could have influenced both what type of service they received for their need and the likelihood that such a need would resolve or utilization would improve.

Analyses in this report used several approaches to mitigate these potential biases



Hot Topics

Pharmacy Program Enhancements, SFY24

- Copay waivers for medications used to treat:
  - HIV
  - Opioid overdose (naloxone, nalmefene, naltrexone), effective August 1
  - Opioid use disorder (buprenorphine, Lycemyra), effective August 1
  - Nicotine replacement therapy, per the State Protocol (nicotine patch, gum, lozenge, oral inhaler, nasal inhaler), effective August 1
- Expansion of OTC Covered Drug Formulary
  - Coverage of OTC Narcan, with a prescription
  - Coverage of OTC Opill, without a prescription, effective August 1
- Coverage of imported Extencilline for Syphilis treatment
- Allow (highly encourage) pharmacists to enroll as Providers
- Pharmacy payment for clinical services
  - State Protocol for Contraception
  - State Protocol for Smoking Cessation, effective August 1
- Coverage of drugs used to treat obesity, effective August 1

New Coverage Policies

About NC Medicaid | Beneficiaries | Find a Doctor | Providers | Reports | Meetings & Notices | Counties

Home > Recent Blogs > NC Medicaid To Add Coverage For Obesity Management Medications

JULY 17, 2024

NC Medicaid to Add Coverage for Obesity Management Medications

Effective Aug. 1, 2024, NC Medicaid will cover obesity management medications for beneficiaries 12 years of age and older.

This bulletin applies to NC Medicaid Direct and NC Medicaid Managed Care.

Effective Aug. 1, 2024, NC Medicaid will add coverage for U.S. Food & Drug (FDA) - approved obesity management medications for beneficiaries 12 years of age and older.

Covered medications will include drugs from manufacturers enrolled in the Medicaid Drug Rebate Program, which are covered for the FDA-approved indication of treating obesity. The additional coverage applies to both NC Medicaid Direct and NC Medicaid Managed Care beneficiaries who are covered under the Outpatient Pharmacy benefit.

Medicaid Expansion Updates

To date, over 500,000 people are enrolled in Medicaid health coverage due to Medicaid expansion

Third Party Liability Pay and Chase

Pay and Chase, Medicaid pays as the primary payer but learns after the claim has been paid that another insurance carrier is liable for the services. We bill the liable insurance carrier to recovery Medicaid monies paid on the claim. The lines of business that include pay and chase activities is as follows;

- Casualty Recovery
- Estate Recovery
- Trust Recovery
- Commercial Insurance Direct Bill
- Commercial Insurance Disallowance
- Medicare Disallowance
- Credit Balance Audits

Health plan should not recoup provider payments due to other found insurance. The health plan shall bill the liable insurance carrier to pursue recovery for Medicaid primary provider payments.

Note: Health plans may recoup provider payments when Medicare coverage is discovered after the health plan paid as the primary Medicaid payer.

Third Party Liability Pay and Chase Cont.

Common Denial Reasons for Other Found Insurance

- The member cannot obtain medication due to other found insurance on the members record;
  - The health plan should verify the other found insurance on the member’s record
  - The health plan must contact the pharmacy to request TPL override at point of sale which would allow the member to obtain medication
- The member cannot obtain treatment due to other found insurance on the members record;
  - The health plan should verify the other found insurance on the member’s record
  - The health plan must contact the provider to ensure the member can obtain needed medical treatment

Third Party Liability Pay and Chase Cont.

Medicaid is always the payer of last resort

- When the member has other insurance or Medicare coverage, the provider must bill the primary payer first.

Exceptions to Medicaid being the payer of last resort

- Child Support Enforcement members
- Early Periodic Screening and Testing Diagnosis (Services included in our Health Check guide Ex. Immunizations)
- Federal Programs that require Medicaid to pay as the primary payer (ex. Ryan White Program)

External Parties Reporting Other Found Insurance

- The DHB-2057 Provider Referral Form
  - Should be used by providers, members or the county case workers to report Other Found Insurance to DHB
    - Link to the DHB-2057 Online submission for health information referrals
      - Health Insurance Referral Form (hms.com)

If you feel the Managed Care health plan has recouped funds in error, please reach out to us at Medicaid Provider Ombudsman. Inquiries, concerns or complaints can be directed to: Medicaid.ProviderOmbudsman@dhhs.nc.gov email or Provider Ombudsman line at 919-527-6666.

F Codes

What are these F Codes that everyone is talking about???

Updates to Clinical Coverage Policy 1E-5

You can access additional information on the Updates to Clinical Coverage Policy 1E-5 Obstetrical Services Webinar held August 6, 2024 at the following link:

https://public.3.basecamp.com/p/MnLoKFK6fdKUZZfdM51Q385w

Please join the next Back Porch Chat!

November 21, 2024

Noon – 1pm

QUESTIONS?