

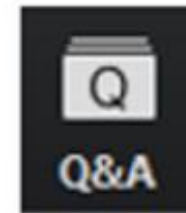
Back Porch Chat

May 2024

**Closed Captioning is available
for this webinar**
Participants can access real-time
captioning by clicking **“Show
Captions”** within Zoom.

Logistics for Today's Webinar

Question during the live webinar



Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

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Tailored Plan Launch Updates

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2023 PCP Experience Survey

03

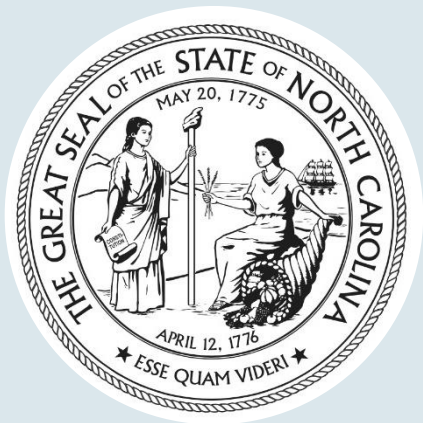
Pharmacy Updates

04

Hot Topics

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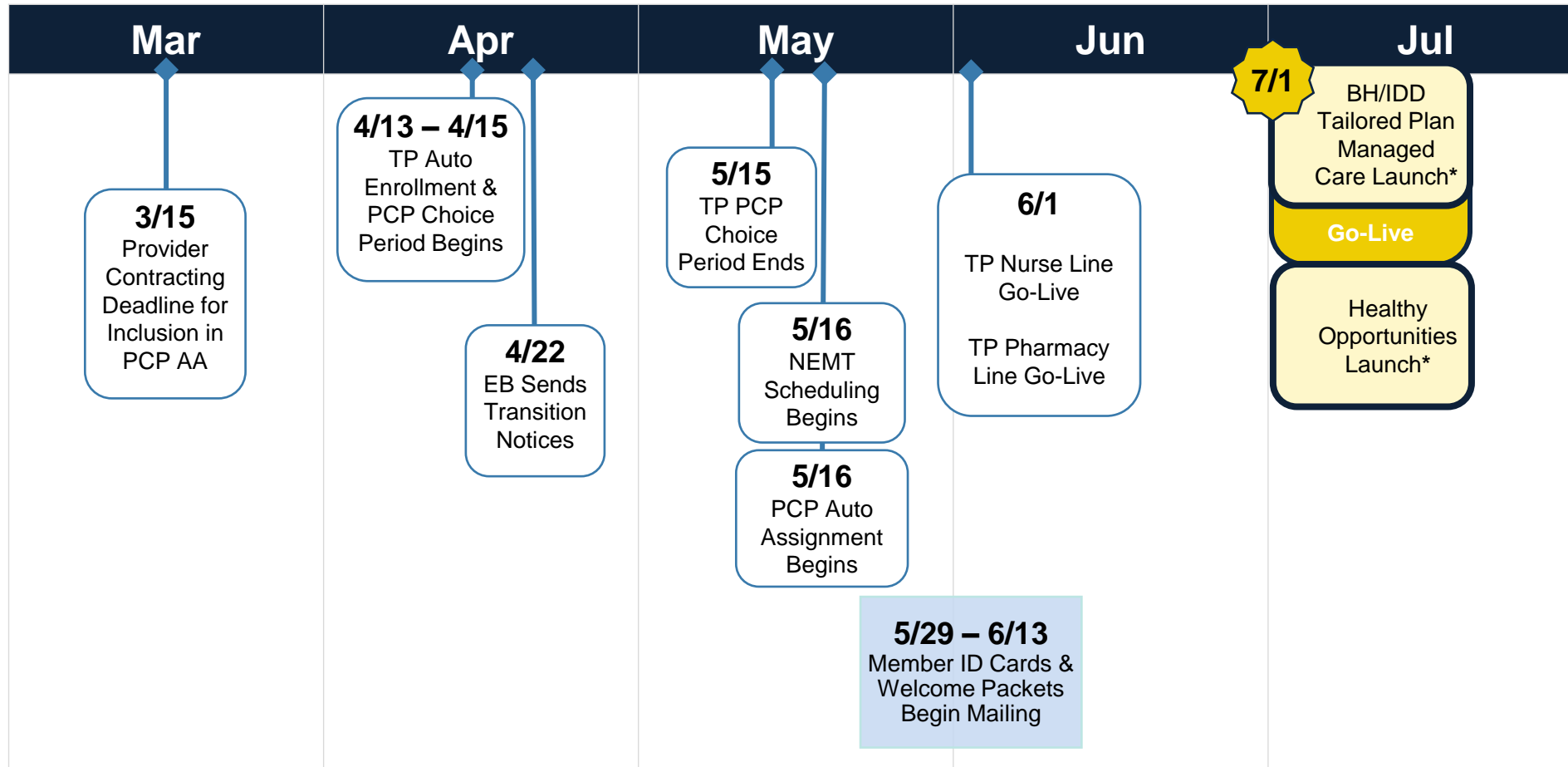
Q/A



Tailored Plan Launch Updates

Timeline for Tailored Plan Launch

The below timeline visualizes key milestones and activities associated with **Tailored Plan Go-Live**



Tailored Plan Choice Period

April 15, 2024

May 15, 2024

During this time, beneficiaries chose a primary care provider (PCP) or different health care option (if applicable).

Choice Period

- **Beneficiaries contacted their Tailored Plan to choose a PCP.**
- **Tailored Plan beneficiaries receiving Tailored Care Management (TCM) from their LME/MCO will continue to receive this service from their Tailored Plan.**
- **Beneficiaries contacted the NC Medicaid Enrollment Broker to choose a different health care option (if applicable).**
 - **Some Tailored Plan members will have the option to enroll in a Standard Plan. They cannot enroll in a Standard Plan via the website or mobile app – they must enroll by phone or enrollment form.**

Tailored Plan PCP Auto-Assignment

May 16, 2024

Tailored Plan beneficiaries will be auto-assigned an PCP if they did not select one during the choice period.

PCP Auto-assignment

- Members who did **not** choose a PCP with their Tailored Plan will be auto-assigned to one.
- On May 16, 2024, Tailored Plans will conduct PCP auto-assignment.
 - After auto-assignment, Tailored Plans will mail Welcome Packets (Welcome Letter, Medicaid ID Cards, Member Handbook) to their beneficiaries between May 29 – June 13.
 - Tailored Plan beneficiaries will use the NC Medicaid ID card from their Tailored Plan to receive services. Members do not have to have their card with them to receive services.
 - The NCTracks Provider Portal will continue to share a monthly Panel report for PCPs that includes members assigned to them by Plan (NC Medicaid Direct, each Standard Plan, each Tailored Plan). The NC Tracks provider portal can also be used to verify member eligibility.

Tailored Plan Launch

July 1, 2024

Tailored Plans begin providing services to beneficiaries.

Tailored Plan Launch

- Tailored Plan beneficiaries begin receiving health care services from their Tailored Plan.
 - Beneficiaries **will** use their NC Medicaid ID card sent to them by their Tailored Plan to receive services.
- Tailored Plan beneficiaries must be assigned an In-Network PCP and can access services from any In-Network Provider.
- Tailored Plan beneficiaries will continue to receive the same health care services NC Medicaid covers today. Medicaid eligibility rules and processes will not change with the Tailored Plan launch.

Policy Flexibilities

The Department will be enacting the following policy levers to ease beneficiary confusion and provider administrative burden during the transition period following Tailored Plan Launch. These flexibilities are applicable to both physical and behavioral health providers.

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.

Provider Playbook & Fact Sheet Updates

Provider Playbook is available

at: <https://medicaid.ncdhhs.gov/providers/provider-playbook-nc-medicaid-managed-care>

Key fact sheets available include:

- [NC Medicaid Managed Care Provider Playbook Site](#)
- [What Providers Need to Know Before Tailored Plan Launch](#)
- [Tailored Plan Provider Contracting Deadlines Questions and Answers](#)
- [Tailored Plan Auto-Enrollment & Opt-In Scenarios](#)
- [Medicaid and NC Health Choice Provider and Health Plan Lookup Tool](#)
- [NC Medicaid Managed Care: Provider Training](#)
- [Provider Payment and Reimbursement](#)



Day One Tailored Plan Provider Quick Reference Guide

Day 1 Resources:

- [Day One Provider Quick Reference Guide](#)

NC Medicaid Managed Care Provider Ombudsman

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

- Tailored Plan Provider Portal & Provider Service Line

Contact Information for all health plans is available at: <https://medicaid.ncdhhs.gov/health-plan-contacts-and-resources>

- Alliance Health <https://alliancehealth.okta.com> Phone: 855-759-9700
- Partners partnersbhm.org/tailoredplan/providerconnect Phone: 877-398-4145
- Trillium <https://www.ncinno.org/> Phone: 855-250-1539
- Vaya providers.vayahealth.com/provider-portal Phone: 866-990-9712

Tailored Care Management

Tailored Care Management is built around the six core Health Home services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Individual & family support
- Referral to community & social support services

Tailored Care Management eligibility:

- All Tailored Plan-eligible members, including individuals enrolled in the 1915(c) Innovations and TBI waivers.
- Individuals enrolled in NC Medicaid Direct (e.g., dual eligibles) who would otherwise be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.

Note: Excluded beneficiary populations include those with these services: Assertive Community Treatment (ACT) or Critical Time Intervention (CTI); Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs) or Skilled Nursing Facilities; Care Management for At-Risk Children (CMARC); Beneficiaries participating in the High-Fidelity Wraparound (HFW) program or Child ACT; Community Alternatives Program for Children (CAP/C); Community Alternatives Program for Adults with Disabilities (CAP/DA); Program of All-Inclusive Care for the Elderly (PACE)

Tailored Care Management

Tailored Plans oversee Tailored Care Management.

Beneficiaries may elect, or are assigned to, care management from one of the following Tailored Care Management provider types:



Advanced Medical Home Plus (AMH+)

Primary care practices whose providers have experience delivering primary care services to the Tailored Plan-eligible population



Care Management Agency (CMA)

Organizations with experience delivering behavioral health, I/DD, and/or TBI services and whose primary purpose is the delivery of NC Medicaid, NC Health Choice, or State-funded services.



Tailored Plan Care Management Team

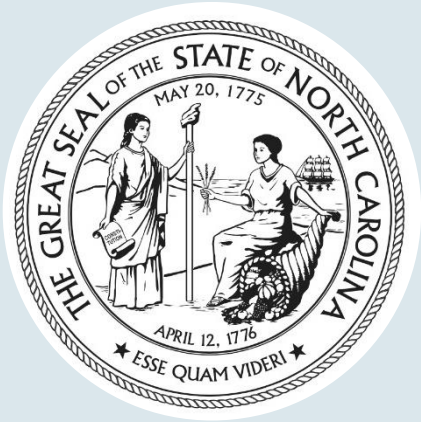
LME/MCOs and subsequent Tailored Plans also will provide care management with the same expectations as AMH+/CMA providers.

Tailored Care Management During Tailored Plan Launch

- The Department does not expect this transition will create any disruption for members engaged in Tailored Care Management services.
- Since LME/MCOs will operate the Tailored Plans, individuals will keep their same care managers at the LME/MCO, Care Management Agency, or Advanced Medical Home+ as they enroll in Tailored Plans.
- Individuals who remain in NC Medicaid Direct will also continue receiving Tailored Care Management from their current assigned care manager.
- Individuals who would like to request a new care manager may contact their Plan to make an active choice.

Finding Your Patient's Tailored Care Manager

- **Primary care providers can view the assigned Tailored Care Management entity for any of their qualifying beneficiaries on their Advanced Medical Home NC Medicaid Direct/Managed Care PCP Enrollee Report in NC Tracks.**
- **Other Providers should call the member's LME/MCO member support line.**

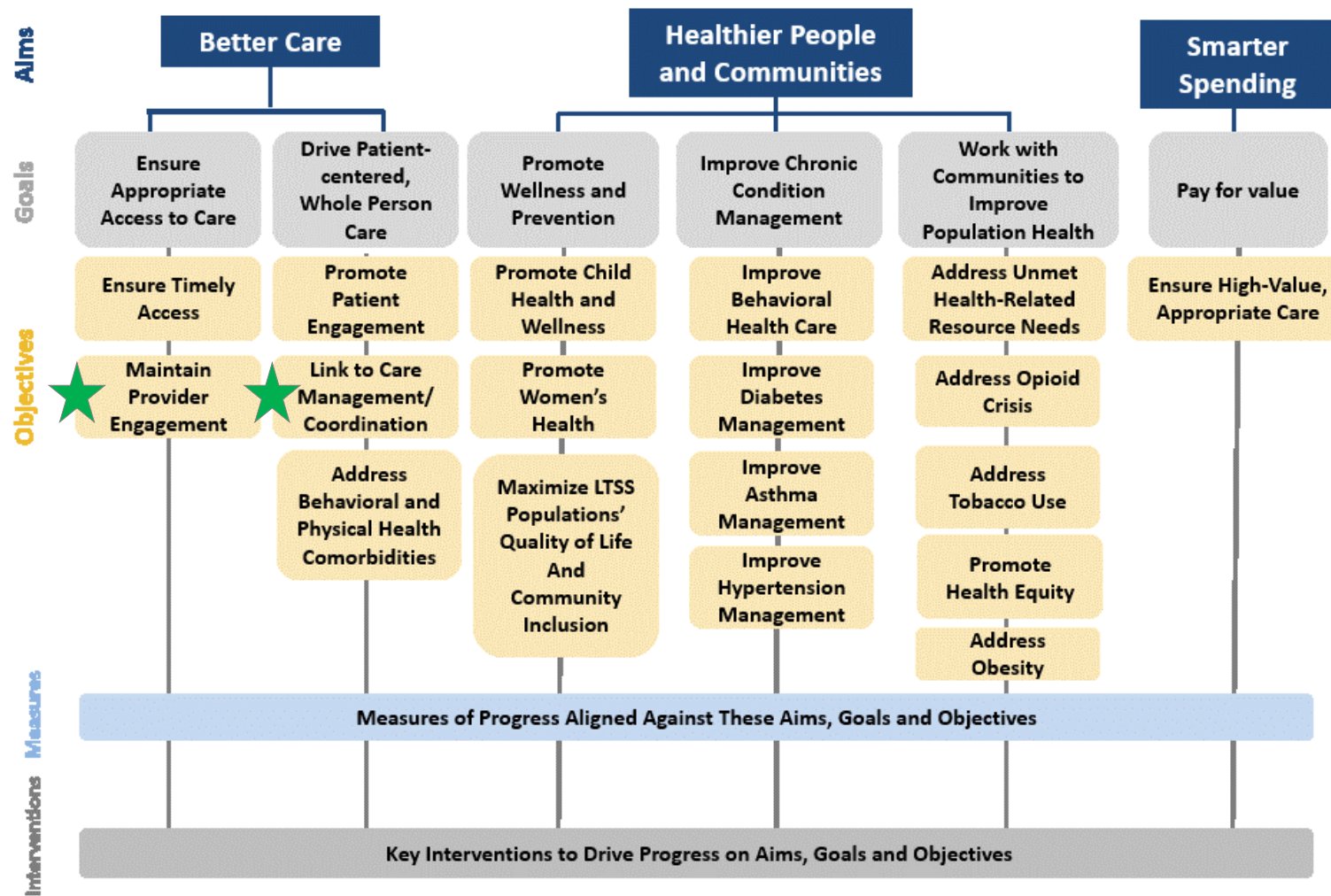


2023 PCP & ObGyn Provider Experience Survey Results

Arianna Keil, Chief Quality Officer

Hannah Fletcher, Survey Team Lead – Program Evaluation

DHB Quality Strategy



Overview

- DHB contracts with the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill for the survey administration and reporting of results annually
- Developed to evaluate the influence of NC Medicaid Transformation on primary care and obstetrics/gynecology (ObGyn) practices that contract with Medicaid.
- Administered across all North Carolina independent primary care practices, medical groups, and health care systems that provide primary care or ObGyn care.
- The 2023 results present provider experience at the end of the 2nd year of Managed Care in NC

2023 Provider Experience Survey (PCP & ObGyn) Administration

- Most recent survey was fielded from March 27 to July 12, 2023, representing experience with the SPs from the second year of Medicaid managed care
- The final response rate for 2023 was **60.8%** (total n=346 respondents)

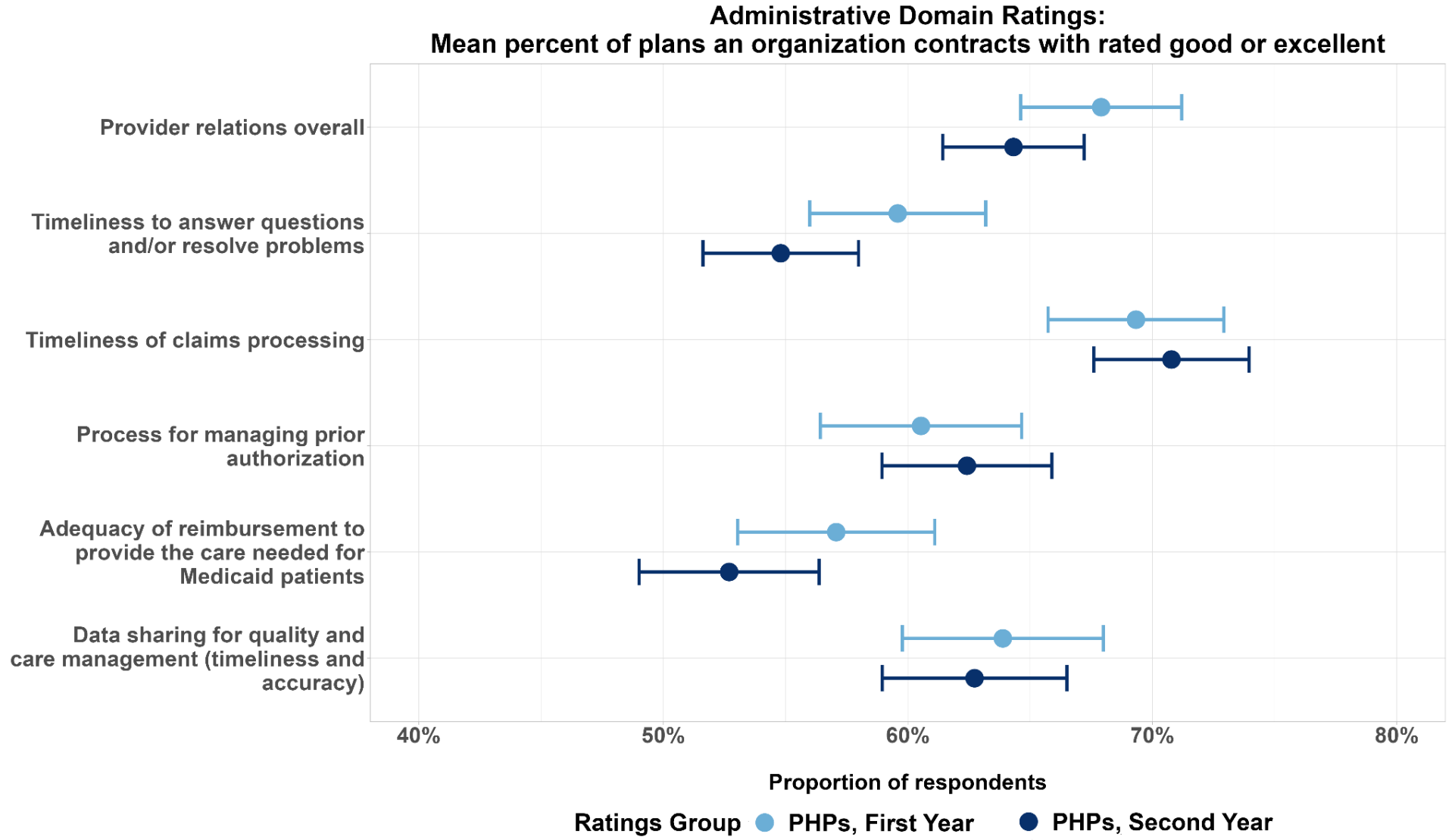
2023 Health System and Practice Characteristics	Self-Identified Health Systems (N = 16)	Self-Identified Medical Groups and Independent Practices (N = 330)
Services Provided for Patients with Medicaid		
Primary Care	15 (93.8%)	323 (97.9%)
Prenatal/Postnatal Care	14 (87.5%)	37 (11.2%)
Inpatient Obstetrics Care	15 (93.8%)	15 (4.5%)
Number of Providers (IQVIA-sourced)		
1-2 providers	0 (0.0%)	136 (41.2%)
3-9 providers	0 (0.0%)	148 (44.8%)
10 or more providers	16 (100.0%)	46 (13.9%)
Geography		
No Rural Practice Sites	2 (12.5%)	152 (46.1%)
Any Rural Practice Sites	14 (87.5%)	178 (53.9%)

2023 Provider Experience Survey (PCP & ObGyn) Measures

Domain Description	Category
Provider relations overall	Administrative
Timeliness to answer questions and/or resolve problems	Administrative
Timeliness of claims processing	Administrative
Process for managing prior authorizations	Administrative
Adequacy of reimbursement to provide the care needed for Medicaid patients	Administrative
Data sharing for quality and care management (timeliness and accuracy)	Administrative
Access to medical specialists for Medicaid patients	Clinical
Access to behavioral health prescribers for Medicaid patients	Clinical
Access to behavioral health therapists for Medicaid patients	Clinical
Access to needed drugs for Medicaid patients (formulary)	Clinical
Care/Case management for patients	Clinical
Customer/Member support services for patients	Clinical
Support for addressing social determinants of health	Clinical

Respondents answered questions in these domains using a scale from “poor” (equivalent to 1 numerically) to “excellent” (equivalent to 4)

Experience With Administrative Domains: First Year of SPs vs. Second Year of SPs



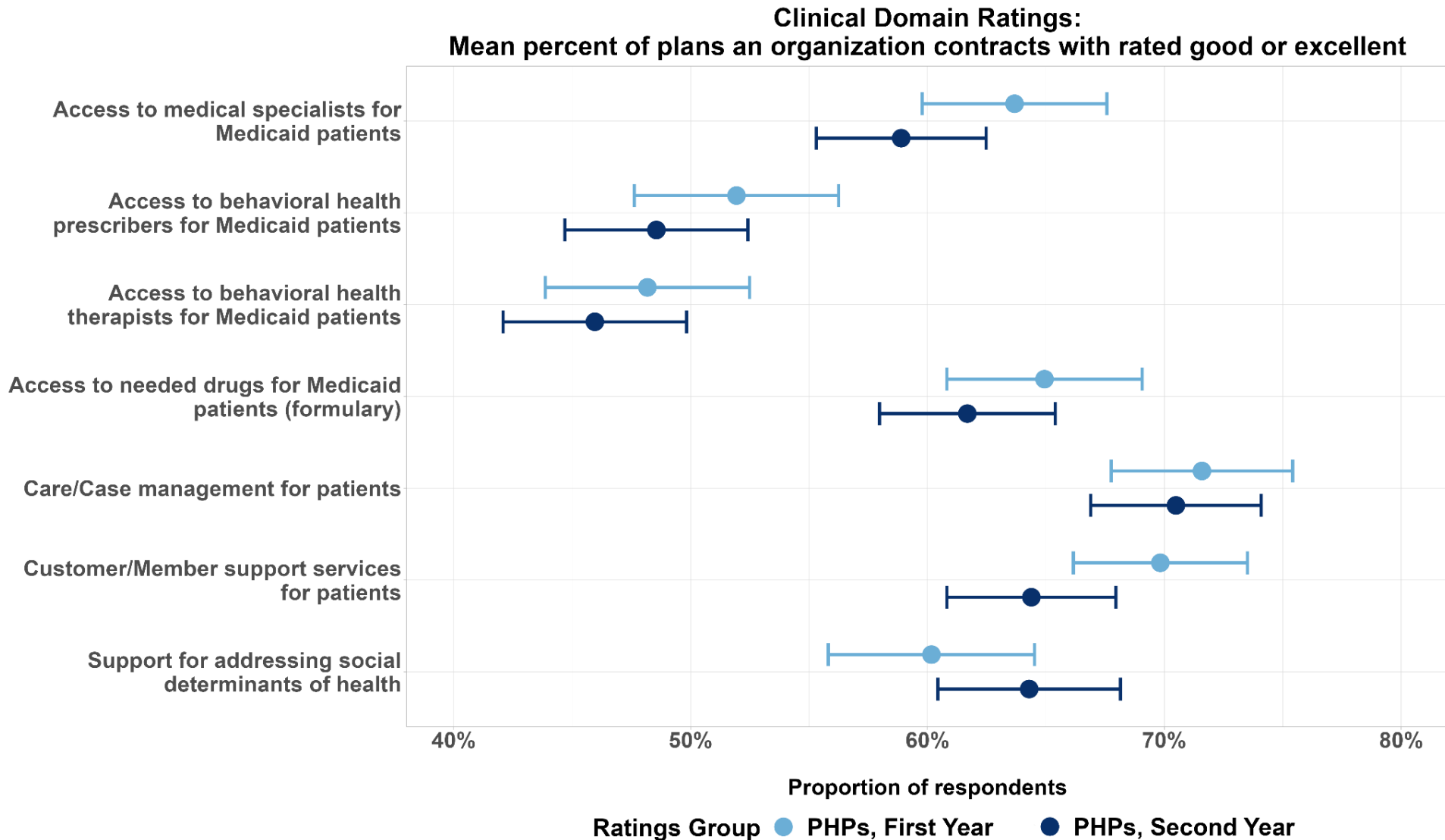
Administrative Domain Performance Rating Change Between Year 2 SPs and Year 1 SPs

	Ameri Health Caritas	BCBSNC Healthy Blue	United Healthcare	WellCare	Carolina Complete Health
Provider relations overall	↓	↓	↓	↓	↑
Timeliness to answer questions and/or resolve problems	↓	↓	↓	↓	↓
Timeliness of claims processing	↓	↑	↑	↓	↑
Process for managing prior authorizations	↑	↑	↑	↑	↑
Adequacy of reimbursement to provide the care needed for Medicaid patients	↓	↓	↓	↓	↓
Data sharing for quality and care management (timeliness and accuracy)	↓	↓	↑	↓	↑

Legend

↓	: Significant worsening	↓	: Marginal worsening
↑	: Significant improvement	↑	: Marginal improvement

Experience With Clinical Domains: First Year of SPs vs. Second Year of SPs



Clinical Domain Performance Rating Change Between Year 2 SPs and Year 1 SPs

	Ameri Health Caritas	BCBSNC Healthy Blue	United Healthcare	WellCare	Carolina Complete Health
Access to medical specialists for Medicaid patients	↓	↓	↓	↓	↓
Access to behavioral health prescribers for Medicaid patients	↓	↓	↓	↓	↓
Access to behavioral health therapists for Medicaid patients	↓	↓	↓	↓	↓
Access to needed drugs for Medicaid patients (formulary)	↓	↓	↓	↓	↓
Care/Case management for patients	↓	↑	↑	↑	↑
Customer/Member support services for patients	↓	↓	↓	↓	↓
Support for addressing social determinants of health	↑	↑	↑	↑	↑

Legend

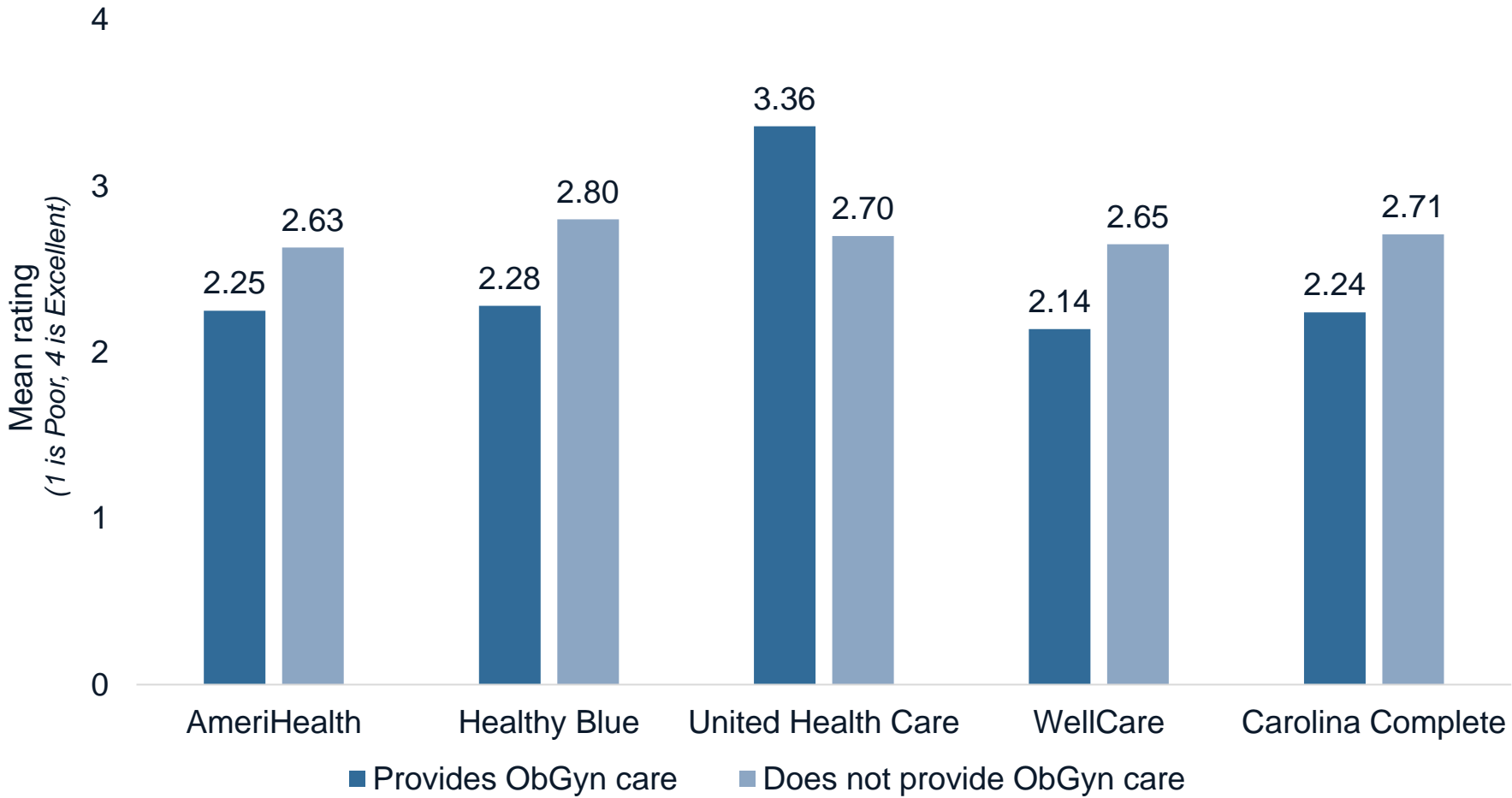
- ↓ : Significant worsening
- ↓ : Marginal worsening
- ↑ : Significant improvement
- ↑ : Marginal improvement

2023 Provider Experience Survey (PCP & ObGyn) Results

Provider's feelings on how SPs have affected various aspects of health care delivery in North Carolina.

Item	Strongly Improve N (%)	Improve N (%)	No Change N (%)	Worsen N (%)	Strongly Worsen N (%)
Overall health and well-being	13 (3.8%)	84 (24.5%)	189 (55.3%)	43 (12.6%)	13 (3.8%)
Overall quality of health care delivery	11 (3.1%)	80 (23.3%)	189 (55.0%)	43 (12.6%)	20 (6.0%)
Overall patient experience	13 (3.7%)	81 (23.6%)	159 (46.5%)	69 (20.0%)	21 (6.2%)
Overall financial health of your medical group or practice	9 (2.6%)	69 (20.1%)	144 (42.2%)	79 (23.3%)	40 (11.9%)
Overall provider experience	11 (3.2%)	62 (18.0%)	141 (41.2%)	86 (25.2%)	43 (12.5%)
Ability to access care	12 (3.4%)	74 (21.5%)	168 (49.0%)	60 (17.6%)	29 (8.6%)

Overall (Clinical and Administrative) Ratings of SPs by Provision of ObGyn Care



All clinical domains showed lower mean ratings however, the **largest disparities** in mean ratings were seen across all **administrative domains**.

Major Themes: Experiences Working with SPs

- **Patient Attribution**

- Many provider organizations report incorrect patient attribution and the process to correct attribution lists is difficult and an administrative burden. Reportedly, issues with attribution are impacting providers' ability to process claims and to report on required quality measures.

- **Claims denials and processes for resolution**

- Many provider organizations report overall dissatisfaction with the claims process. A commonly reported issue is resolving denied claims.
 - Quote: *“We have had a terrible time with denials with all plans except for [PHP name redacted]. We are trying to assist us and other practices in coming up with a spreadsheet showing if you have a certain denial, this is how you have to fix it. It shouldn't be this difficult to get paid for patient care. Additionally, we should not be held to a 180 day window for payment, yet the PHPs have a year to "take back" payments.”*

- **Administrative burden of working with many PHPs**

- Provider organizations cited issues with different billing processes, incentive programs, and quality measures across PHPs.

2023 Provider Experience Survey (PCP & ObGyn) Key Findings

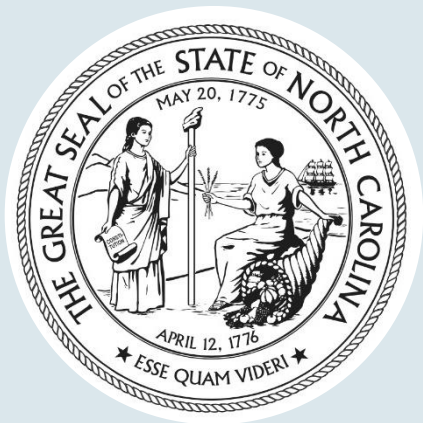
- Rates of contracting with each of the five available SPs ranged from **73.3%** to **97.2%**, and the organizations contracted with an **average of 4.3 plans**.
- **91.1%** of respondents report they **do not anticipate dropping any standard plan contracts** in the coming year.
 - Despite this, open-ended comments revealed notable **administrative burden** in sustaining multiple PHP relationships
- **Small but meaningful differences** were found in provider experience with SPs overall compared with the first year of managed care.
 - PHPs in the second year had higher experience ratings than the first year on the timeliness of claims processing domain, an important factor considered when contracting with PHPs.
 - PHPs in the second year performed worse than in the first year on timeliness to answer questions and/or resolve problems, and customer/member support services for patients.

2023 Provider Experience Survey (PCP & ObGyn) Key Findings (cont.)

- Overall, providers rated their experience with plans on clinical domains (e.g., access to specialists) **slightly worse** than on administrative domains (e.g., claims processing).
- **Key patterns** across plans emerged:
 - SPs worsened in more domains than they improved.
 - On two domains some plans improved, and others worsened: case/care management for patients and process for managing prior authorization.
- Large provider organizations rated their experience with the health plans **worse** than smaller provider organizations.
- **No differences** in experience were found when comparing **rural** versus **non-rural** provider organizations.
- **ObGyn** provider organizations rated their experience with the health plans **worse** than provider organizations that do not provide ObGyn care.

Provider Experience Survey Activity Status

- Recent published report: [2023 Medicaid Provider Experience Survey](#)
- The 2024 Survey launched in April of 2024
 - Updates to 2024 Survey Instrument:
 - Respondents will be asked to describe their overall experience with administrative and clinical domains for their largest commercial payor contract
 - New questions added:
 - Experience with the process and accuracy of patient assignment to practice
 - Experience thus far with Medicaid Expansion
 - Contracting with organizations to pursue an alternative payment model or ACO-like contract
- New Behavioral Health Provider Experience Survey to tentatively launch September 2024



Hot Topics

Pharmacist Enrollment as Providers

- Enrollment supports utilization of the NC Medical Board and Board of Pharmacy statewide protocols, which authorize immunizing pharmacists to dispense, deliver, or administer any of the five statewide protocols:
 - **Self-Administered Hormonal Contraceptives Protocol**
 - **Nicotine Replacement Therapy Protocol**
 - Prenatal Vitamins Protocol
 - Post-Exposure Prophylaxis (PEP) for HIV Protocol
 - Glucagon **Protocol**
 - Enrollment as a Medicaid provider allows the individual immunizing pharmacist to be the prescriber on protocol claims submitted for Medicaid beneficiaries.
 - **Enrollment is necessary for Medicaid to reimburse pharmacies for the drug dispensed under the statewide protocols.**
 - **Enrollment allows pharmacists to utilize statewide protocols within the state of NC.**
- *Enrollment allows for increased access for Medicaid members to drugs prescribed per statewide protocols.*

Reimbursement for Clinical Services provided by Pharmacists

- Effective January 8, 2024, NC Medicaid began reimbursing pharmacies for utilizing the State Protocols for Contraception
- Effective August 1, 2024, NC Medicaid will reimburse pharmacies for utilizing the State Protocol for Smoking Cessation
- **Utilization of the State Protocols requires:**
 - Pharmacist's time and expertise
 - Potential shifts in existing pharmacy workflows
 - Potential changes in staffing requirements
- Lack of reimbursement for clinical services has been a barrier to uptake of the State protocol for contraception by NC pharmacists and pharmacies.



**Reimbursement
will improve access**

BILLING CODES

- **Four pharmacy taxonomies** may bill for reimbursement of clinical services:
 - 3336C0002X – Clinic Pharmacy
 - 3336C0003X – Community/Retail Pharmacy
 - 3336C0004X – Compounding Pharmacy
 - 3336L0003X – Long Term Care Pharmacy
- **Applicable CPT Codes:**
 - 99202: Office/outpatient new
 - 99212: Office/outpatient visit established
- **Applicable Diagnosis Codes:**
 - Z30.011: Encounter for initial prescription of contraceptive pills
 - Z30.016: Encounter for initial prescription of transdermal patch hormonal contraceptive device
 - Z30.41: Encounter for surveillance of contraceptive therapy pills
 - Z30.45: Encounter for surveillance of transdermal patch hormonal contraceptive therapy
- **Applicable Modifier Code for Contraception:**
 - FP: Family Planning
 - Note: The FP modifier is required on the claim.
- **No Modifier required for Smoking Cessation**

***NEW:* Pharmacy Copay Exemptions – August 1**

- **Naloxone**
- **Nalmefene**
- **Nicotine replacement therapy**
- **Drugs used to treat Opioid Use Disorder**

Reminder: NC Medicaid Pharmacy Co-payment Requirements

A provider cannot refuse to provide services if a beneficiary cannot pay a copay at the time of service.

Pharmacy Policy 9, Section 5.5.1 Medicaid Co-payment Requirements

An eligible Medicaid beneficiary, who receives prescribed drugs, is required to make a co-payment of \$4.00 for each prescription received unless they are exempt for one of the reasons listed below in Subsection 5.5.2. **A provider may not deny services to any Medicaid beneficiary because of the individual's inability to pay a deductible, coinsurance or co-payment amount.** A provider may not willfully discount copays for a Medicaid beneficiary, and an individual's inability to pay does not eliminate his or her liability for the cost sharing charge. The provider shall open an account for the beneficiary, collect the amount owed at a later date, and document all attempts to collect the copay. If the account has not been paid, the pharmacy may in the course of normal accounting principles, write-off the charges and stop monitoring the claim.

Healthy Opportunities Pilot: Interim Evaluation Report

<https://www.ncdhhs.gov/documents/healthy-opportunities-pilots-interim-evaluation-report-summary/open>

- Healthy Opportunities Pilot services eligibility was extended to individuals eligible for Tailored Care Management starting yesterday, on May 15, 2024.
- The Department is tracking that HOP services will become available for Tailored Plan eligible members beginning on July 1, 2024.

Making Care Primary Request for Information

In 2023, CMS selected North Carolina as one of eight states to launch the Making Care Primary model – a voluntary primary care model focused on:

- (1) ensuring integrated, coordinated, person-centered, and accountable care;
- (2) creating a pathway for primary care organizations to enter higher level value-based payment (VBP) arrangements;
- (3) improving quality of care while reducing expenditures.

MCP will launch for participating Medicare providers in July. The model aims to create multi-payer alignment across several priority areas including payment reform, quality measures and incentives, data sharing, and learning systems. NC Medicaid's Advanced Medical Home (AMH) program is already well-aligned with Medicare MCP. NC Medicaid has flexibility in how it may further adapt elements of MCP to the Medicaid landscape.

NC Medicaid is planning to release a public update soon with more details on a proposed approach to further aligning elements of NC Medicaid's primary care work with the MCP model. We will be requesting written stakeholder feedback on our proposal via the public update.

Back Porch Chats:

- Quarterly webinars hosted by the Chief Medical Officer of NC DHHS's Division of Health Benefits.
- These webinars are designed to provide the latest updates and guidance on NC Medicaid's transition to Managed Care, as well as other relevant clinical updates.
- The target audience includes providers, practice managers, and quality managers.
- Starting this spring the cadence of these webinars will move to quarterly (used to be monthly/every other month for the past few years).
- Registration link [here](#)

Community Partners Webinars:

- Webinar series designed to provide updates on NC Medicaid and key Medicaid initiatives.
- Next webinar: May 30, 2:00 PM.

Become a Medicaid Ambassador:

- Walk people through the online Medicaid application ([ePASS](#) or [HealthCare.gov](#)) and answer application-related questions.
- Help people understand what information may be needed to complete an application.
- Refer someone to a NC Navigator or their local Department of Social Services (DSS) when needed.

Medicaid Advisory Committee (formerly Medical Care Advisory Committee):

- Purpose is to advise about health and medical care services that may be covered by their local Medicaid programs.
- In North Carolina, the MAC will advise the state about issues such as revisions to existing policies, policy development and methods of assessing the quality of care for NC Medicaid.
- MAC meetings are held quarterly, in person in Raleigh or online, for up to three hours. Meetings are normally scheduled on the third Friday of the month.

Beneficiary Advisory Committee:

- A new group to be comprised of NC Medicaid beneficiaries, their families, and/or caregivers.
- The purpose of this group is to create a “comfortable, supporting, and trusting environment” where Medicaid beneficiaries can share input freely.

HMP Connections Network:

- A statewide network of community-based organizations, state-level partners, and health equity champions representing and/or serving populations that are historically marginalized.
- Priority areas: increase awareness on public health topics, disseminate health education and messaging, address social and behavioral drivers of health, co-create resource linkages that encourage solutions.
- Meets the first Tuesday of every month; 12:00 – 1:00 PM.
- Reach out to Lauren Benson (healthequityoffice@dhhs.nc.gov) for more information.

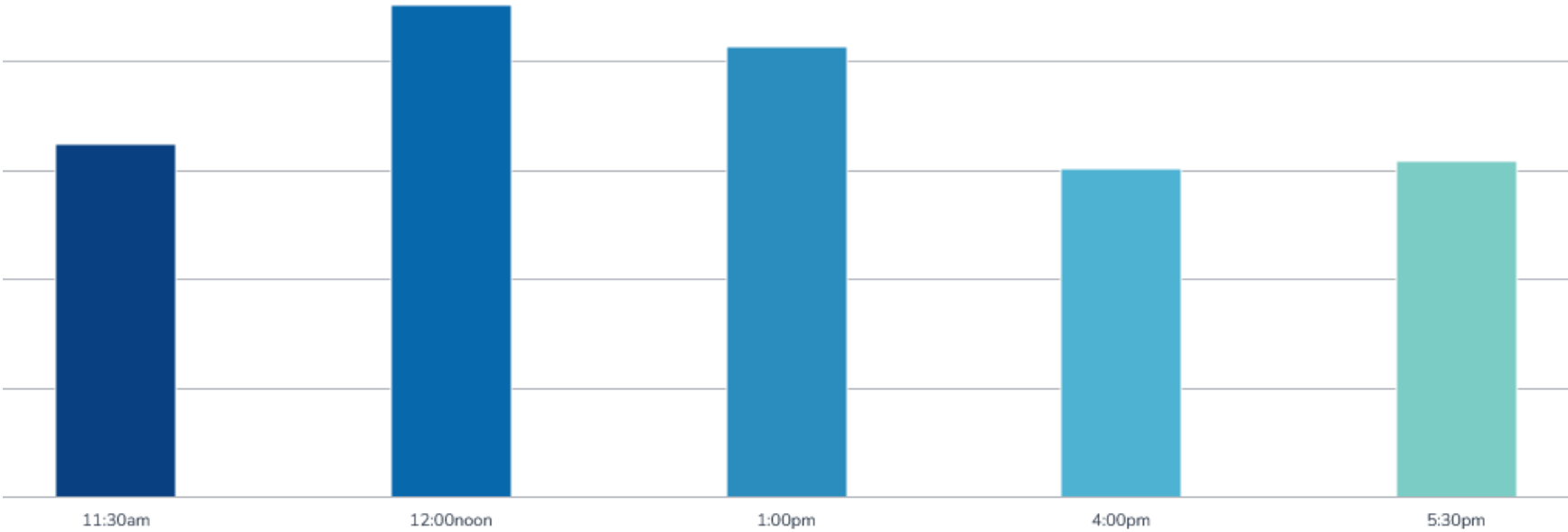
BPC Webinar Engagement Survey Results

What future Back Porch Chat webinar topics would be most helpful to you over the next 6 months?

Tailored Plan Launch	67.5%
Standard Health Plan simplification	51.3%
Panel Management	28.3%
QI health measure performance	36.2%
Claims denial management	49.8%
Other topics (click to view)	12.8%

BPC Webinar Engagement Survey Results

What time(s) would you prefer for these webinars to be available? Please click all times that would be convenient for your schedule.



BPC Webinar Engagement Survey Results

How frequently should DHHS offer webinars for Providers and Practice Managers?

Monthly	53.2%
Bi-monthly	26.8%
Quarterly	20.0%



QUESTIONS?