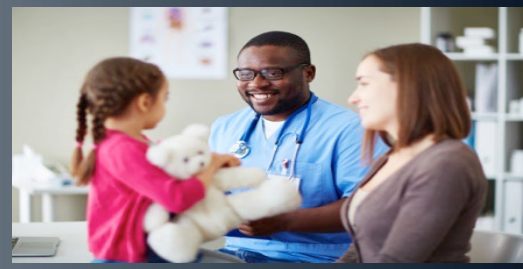






Back Porch Chat: Tailored Plan 101

Ready, Set, Launch! Series

August 18, 2022

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here:

<Enter Link Here>

Logistics for Today's Webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

01 Medicaid Enrollment Overview

02 Network Adequacy

03 AMH & Tailored Care Management Updates

04 Clinical Scenarios

05 Provider Readiness Resources

06 Hot Topics and Q&A

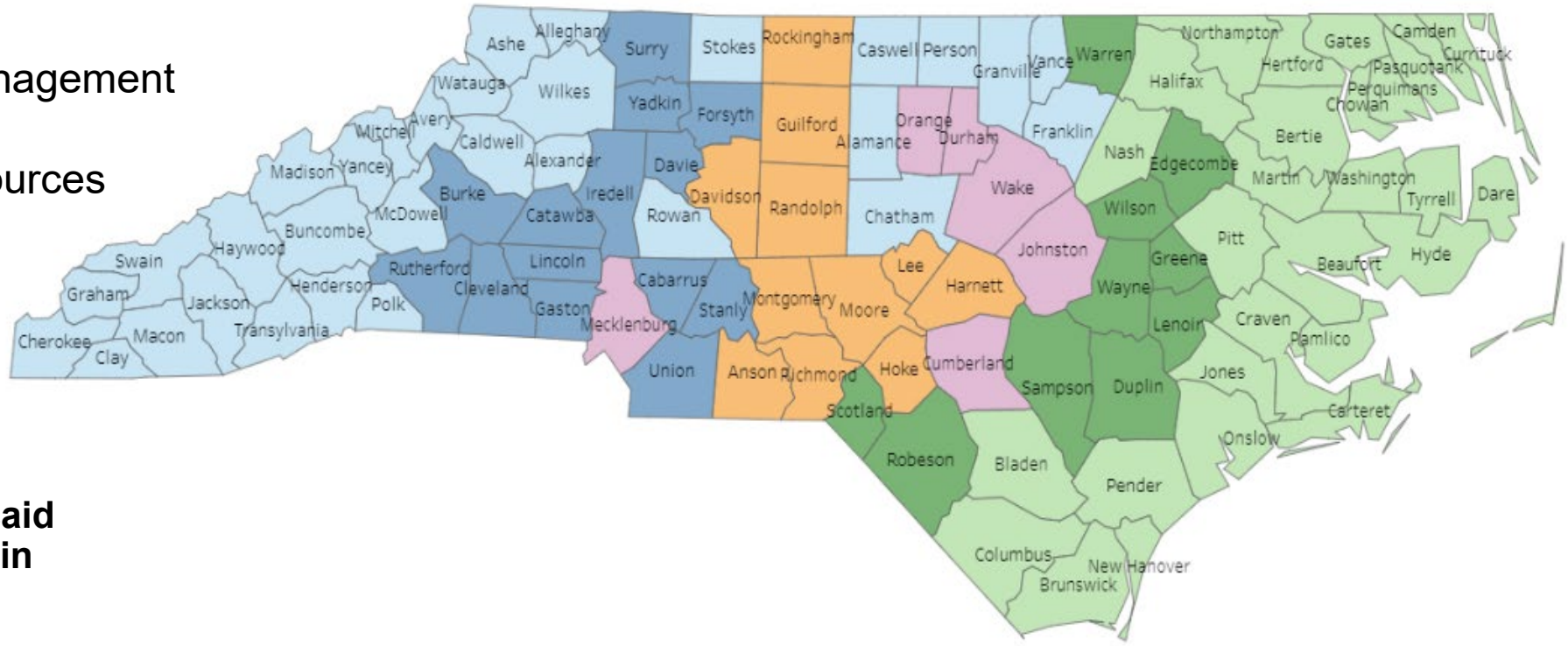
Medicaid Enrollment Overview

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

There are 6 Tailored Plans:

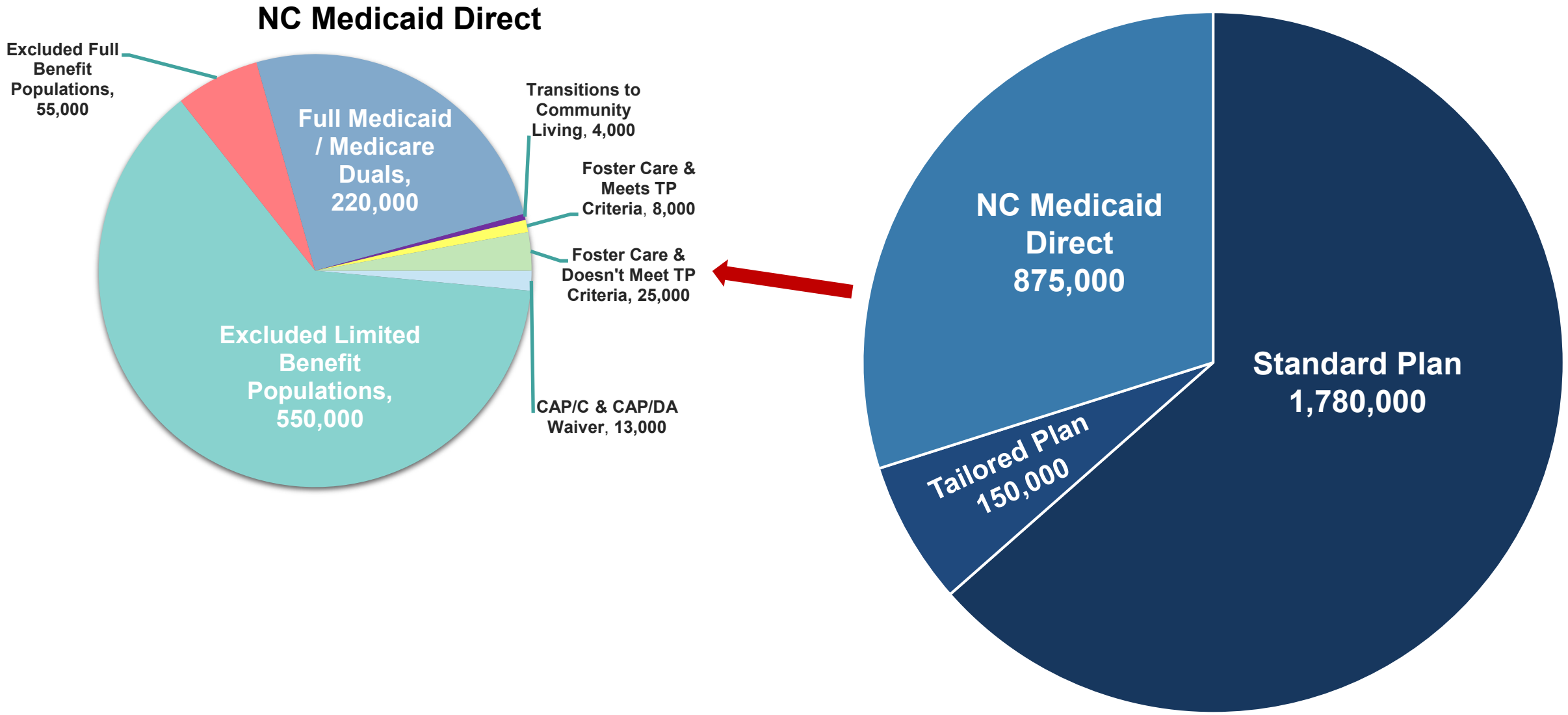
- Alliance Health
- Eastpointe
- Partners Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

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



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

Medicaid Expected Enrollment Numbers in December 2022



Auto-Enrolled vs. Opt-In Populations

Certain beneficiaries who meet Tailored Plan enrollment criteria will be auto-enrolled in Tailored Plans on **8/15/22.** Other beneficiaries who meet Tailored Plan enrollment criteria will not be auto-enrolled but can enroll **during the choice period (8/15/22 – 10/14/22)**.

Auto-enrolled Population Examples	Opt-in Population Examples
• Innovations Waiver participants (including duals) • TBI Waiver participants (including duals) • People who need certain services for a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI)	• Federally recognized tribal members • Individuals who qualify for services through Indian Health Service (IHS)

In both scenarios, beneficiaries will receive an Enrollment Packet in the mail.

Tailored Plan Enrollment Packet

Enrollment Packets will begin mailing August 22, 2022.

- Transition Notice
  - Explains Tailored Plan and the options available to the beneficiary
  - Includes information about how to choose a primary care provider (PCP) and Tailored Care Management provider
- Disenrollment Rights Notice
  - Explains how the beneficiary can leave their Tailored Plan
- Health Care Option Guide
  - Includes the health care options based on the choices available to the beneficiary
  - Highlights the top 10 added services for each health care option
  - Includes phone number, website, and sample ID card for each health care option
- Enrollment Form
  - Allows beneficiaries to choose or change their health care option and PCP

Sample beneficiary notices can be found on the County Playbook. Notices can also be found in the Provider Playbook: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/beneficiary-materials

Tailored Plan Transition Notice

Transition notices are specific to the beneficiary.

Auto-Enrollment Transition Notice		Opt-In Transition Notice
Tailored Plan	**Tailored Plan & Standard Plan**	**Tribal/IHS Tailored Plan**
• Tailored Plan description and services • Tailored Plan auto-enrollment and start date • How to choose a PCP • How to ask to leave the Tailored Plan • NC Medicaid Ombudsman	• Tailored Plan description and services • Tailored Plan auto-enrollment and start date • How to choose a PCP • How to choose a Standard Plan • NC Medicaid Ombudsman	• Tailored Plan description and services • Stay in current health plan • How to choose the Tailored Plan • NC Medicaid Ombudsman

*Only those individuals who are auto-enrolled in TP or who have the choice to opt in will receive notices

NC Medicaid Enrollment Broker – Roles & Services

- Choice Counseling
- Outreach and Education
- Communications & Notices
- Enrollment Assistance
- Website and Mobile Application
- County DSS Support

NC Medicaid Enrollment Broker – Contact

Beneficiaries can contact the NC Medicaid Enrollment Broker in various ways.

ONLINE

Online at ncmedicaidplans.gov
Chat feature is also available

MOBILE APP

Available on Android or iPhone

To get the free app, beneficiaries should search for NC Medicaid Managed Care in Google Play or the App Store

CALL

1-833-870-5500
(TTY: 711 or RelayNC.com)

The call is toll free

MAIL

NC Medicaid Enrollment Broker:
P.O. Box 613
Morrisville, NC 27560

Fax: 1-833-898-9655

Advanced Medical Home Updates

AMH Medical Home Fees for Members Eligible for Tailored Care Management

Effective Dec. 1, 2022, through June 30, 2023, Advanced Medical Homes (AMHs) 1, 2 and 3 that are serving as the assigned primary care provider for NC Medicaid beneficiaries eligible for Tailored Care Management **will receive an enhanced medical home payment of $20 per member per month**.

This enhanced medical home payment is meant to provide additional reimbursement to primary care providers as they are providing primary care and coordinating care with new Tailored Care Management providers for assigned members in the transition to Tailored Plans.

In the future the enhanced fee may be tied to additional performance expectations for primary care engagement.

REMINDER: AMH3 DO NOT RECEIVE CARE MANAGEMENT FEES IN TAILORED PLANS

The link to the full bulletin can be found here:

Enhanced Medical Home for AMHs Serving Members Eligible for Tailored Care Management

AMH Panels of Tailored Plan Members

To provide continuity of service to members and support the contracting efforts of Tailored Plans with primary care providers (PCPs), DHB is sharing a list of members by PCP/AMH practice (NPI + location code) who will be enrolled in the Tailored Plan as of 12/1/2022.

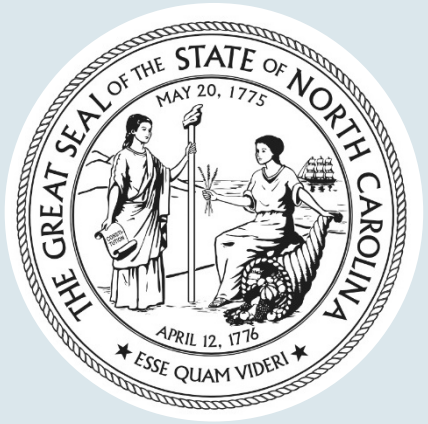
[This list should be posted shortly on the DBH website; we will alert providers via the Medicaid Bulletin.]

The table provides the following level of detail:

- NPI and Location Code and TIN
- Name of Provider, Address
- Tailored Plans of the members based on current member address
- Currently Assigned Panel of Members that might be enrolled with Tailored Plans*

*This number can change in future based on member eligibility at the time of actual enrollment with Tailored Plans.

Please Note: providers who have a panel size of 10 members or less were not included on this list



Tailored Care Management Updates

Tailored Care Management Phased Roll-Out

In order to ensure that providers certified as AMH+ practices and CMAs are ready to provide Tailored Care Management services to members both at Tailored Plan launch and ongoing, DHB is introducing a second readiness and contracting milestone as part of a Phased Assignment Approach.

The intent of the second milestone is to allow additional time for tailored care management (TCM) providers that have completed certification to prepare for launching their Tailored Care Management Program.

- **Providers that pass their NCQA readiness review and contract with Tailored Plans by September 30, 2022 will be included in TCM Auto Assignment for December 1, 2022 launch.**
- **Providers that pass their NCQA readiness review and contract with Tailored Plans by December 31, 2022 will be included in TCM Auto Assignment for February 1, 2023 launch.**

Tailored Care Management Staffing Flexibilities

DHB will allow increased flexibility in staffing requirements for tailored care management related to degrees required or licensure types.

Care Managers

- Care Managers for Tailored Care Management may now meet North Carolina's definition of Qualified Professional per 10A NCAC 27G .0104

Supervising care managers (BH/SDU) may now have the following licenses:

- A license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN).

IDD/TBI Supervising Care Managers

- The policy now allows for a broader range of degrees (to match QP degree language)

Extenders

- The policy has been clarified to allow flexibility in the supervisor of the extender and has removed FTE limits for care extenders assigned to each care manager

Updated policy guidance will be posted at Medicaid Tailored Care Management Webpages

Tailored Care Management FAQ

Question: How are members notified of their Tailored Care Management Provider? Will it be on the Medicaid Card?

Answer: Members receive a letter from the Tailored Plan describing the Tailored Care Management benefit and informing the members of their Tailored Care management provider AND how they can change their Tailored Care Management provider. The Tailored Care Management provider is NOT on the Medicaid card.

REMINDER: PCPs/AMHs can see the member's assigned tailored care management provider on their Panel Report in NCTracks

Network Adequacy

BH I/DD Tailored Plans Networks

BH I/DD Tailored Plans will be required to maintain a network of providers that is sufficient to ensure that all covered services are available and accessible to all members in a timely manner.

Purpose of Network Adequacy and Accessibility Standards

- To ensure that BH I/DD Tailored Plan members have access to providers and offer an important tool for DHHS to monitor that access

Types of Standards Utilized for Physical and Behavioral Health Services

- Standards include:
  - The maximum distance, measured in an amount of time or miles, a beneficiary must travel to a network provider
  - A minimum number of network providers within a specified region
  - Appointment wait times
- Standards are set by county and can vary according to whether the county is considered an urban or a rural county. Designation is based upon the population density of the county

BH I/DD Tailored Plans Networks

BH I/DD Tailored Plans will be required to maintain a network of providers that is sufficient to ensure that all covered services are available and accessible to all members in a timely manner.

BH I/DD Tailored Plan Network and Standard Plan Partner Network

- BH I/DD Tailored Plan must have a network for both physical and behavioral health services that complies with the network adequacy standards.
- While a BH I/DD Tailored Plan may utilize its Standard Plan partner's physical health network, DHHS's review of compliance is based upon the BH I/DD Tailored Plan's network (both physical and behavioral health providers) and all issues of compliance are the responsibility of the BH I/DD Tailored Plan.

DHHS BH I/DD Tailored Plans Network Oversight

DHHS has developed robust network adequacy standards to ensure BH I/DD Tailored Plan members' access to physical and behavioral health services and will monitor BH I/DD Tailored Plan for compliance before managed care launch and afterwards.

Network Oversight for BH I/DD Tailored Plans

- DHHS will collect network data detail information from plans and will:
  - Perform geo-mapping analysis on the data to confirm compliance with time/distance standards
  - Confirm the BH I/DD Tailored Plan has contracted with the minimum number of providers in a region and has proper coverage across the entire region

- Before managed care launch, DHHS will use criteria to monitor network adequacy progress on a regional and county basis for each BH I/DD Tailored Plan and will work with the health plans to understand and mitigate identified gaps and concerns

DHHS BH I/DD Tailored Plans Network Oversight

DHHS has developed robust network adequacy standards to ensure BH I/DD Tailored Plan members' access to physical and behavioral health services and will monitor BH I/DD Tailored Plan for compliance before managed care launch and afterwards.

Network Oversight for BH I/DD Tailored Plans (continued)

- DHHS will use network analysis:
  - To assist in decisions around auto-enrollment and managed care launch
  - To determine when/whether to require a BH I/DD Tailored Plan to submit a mitigation strategy submissions or a Corrective Action Plan (CAP)
  - To determine when to take other steps to mitigate deficiencies in a network, such as spot data submissions to demonstrate progress or evidence adequacy

- Shortly after managed care launch, BH I/DD Tailored Plans will make an official submission of their networks as part of a regulatory submission
  - For any county in which a BH I/DD Tailored Plan cannot meet the network adequacy standard, the plan must submit a request for approval of an exception
  - Exception requests are subject to DHHS approval and must demonstrate how the plan will ensure members are able to obtain the services covered under the exception.

BH I/DD Tailored Plans Network Adequacy Standards

DHHS has developed robust network adequacy standards to ensure B I/DD Tailored Plan beneficiaries' access to physical and behavioral health services. BH I/DD Tailored Plans will maintain an open network* for physical health and pharmacy services but are permitted to use a closed network for BH, I/DD, and TBI services.

Sample of Network Adequacy Standards from BH I/DD Tailored Plan Contract

*See appendix for full list

#	BH Service Type	Urban Standard	Rural Standard
1	Outpatient Behavioral Health Services	2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members
2	Location-Based Services (Behavioral Health)	2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
3	Crisis Services (Behavioral Health)	1 provider of each crisis service within each health plan region	
4	Inpatient Behavioral Health Services	1 provider of each inpatient BH crisis service within each health plan region	
5	Partial Hospitalization (Behavioral Health)	1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members

***Open Provider Network:** Any willing qualified provider that is enrolled in Medicaid and accepts the rates offered by the plan

BH I/DD Tailored Plan Appointment Wait Time Standards

DHHS has developed robust appointment wait time standards to ensure BH I/DD Tailored Plan members' access to physical and behavioral health services.

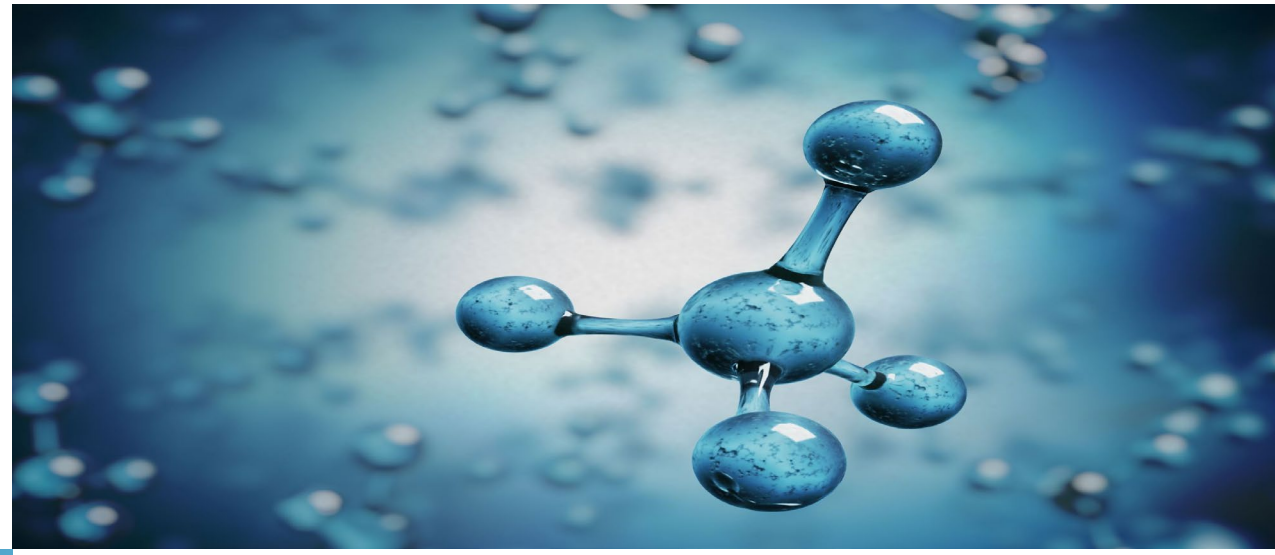
Sample Appointment Wait Time Standards From BH I/DD Tailored Plan Contract

*See appendix for full list

#	Service Type	Appointment Wait Time Standard
1	Mobile Crisis Management Services	Within 2 hours
2	Urgent Care Services for Mental Health	Within 24 hours
3	Urgent Care Services for SUDs	Within 24 hours
4	Routine Services for Mental Health	Within 14 calendar days
5	Routine Services for SUDs	Within 14 calendar days
6	Emergency Services for Mental Health	Immediately (available 24 hours a day, 365 days a year)
7	Emergency Services for SUDs	Immediately (available 24 hours a day, 365 days a year)

Network Adequacy – Pharmacy

State expects to see a broad pharmacy network across all plans.



Plans must contract with "**any willing provider**" that is a physical health or pharmacy services provider based on the State's fee schedule. Plans cannot choose to exclude independent pharmacies from participating.

Outpatient Specialized Therapies Managed Care Coverage Guardrails

Network Adequacy Standards for Occupational Therapy, Physical Therapy, & Speech Language Pathology:

"…Establish and maintain a Medicaid Managed Care Provider Network... sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner..."

Urban Standard:
≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

Rural Standard:
≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

Clinical Scenarios

Meet Mikayla. She is a 12-year-old with a developmental disability in a Tailored Plan. Mikayla broke her ankle and received a cast. She is now out of her cast but needs physical therapy. You are her primary care doctor.

How do you handle that referral?

What will be important for her physical therapist to understand about the TP?

Specialized Therapies at Tailored Plan Launch

What if Mikayla was already in physical therapy on Dec 1? What if her PT in not in network on day 1?

For beneficiaries enrolled in Tailored Plans on December 1, 2022:

- “The BH I/DD Tailored Plan must honor existing and active prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans for the first ninety (90) days after BH I/DD Tailored Plan implementation” or until the PA expires, if that is sooner.
- "For the first sixty (60) days after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of in network providers…“ or until the end of the episode of care, whichever is less. May extend longer if member meets criteria for Ongoing Special Condition or Ongoing Course of Treatment.

How Tailored Care Management Supports Coordination of Care

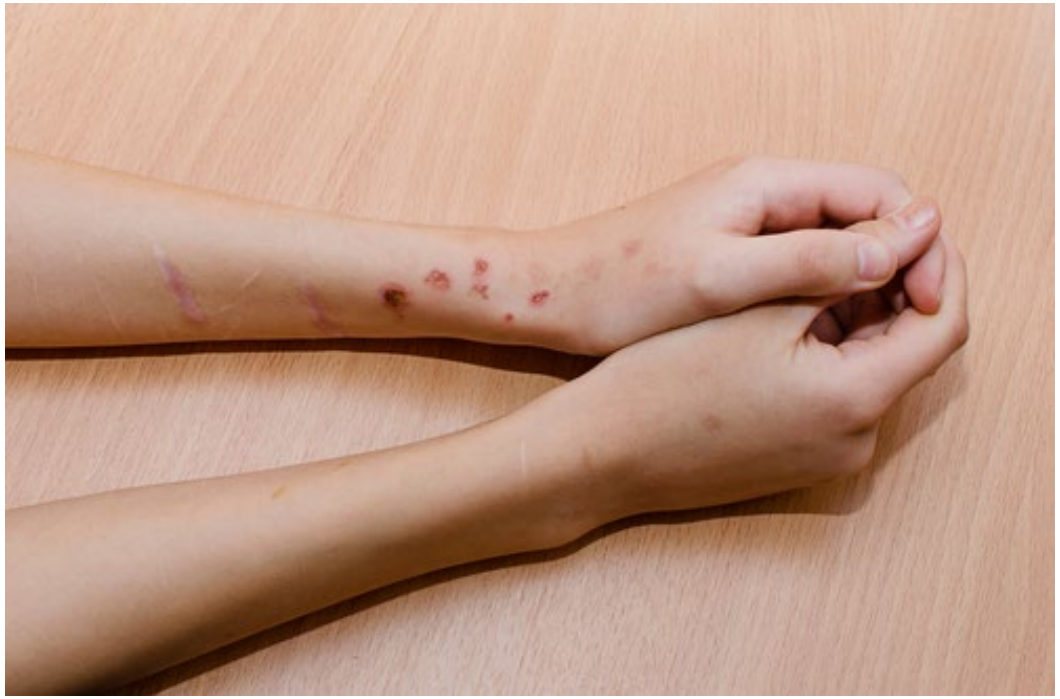
How might her Tailored Care Manager help?
What would be different if she was in the Innovations Waiver?

Her Tailored Care Manager might convene a care team of her providers (PCP, parent/guardian, school, HCBS providers) to help assess additional supports or service hours she might benefit from.

The Tailored Care Manager could help Mikayla and her family coordinate:

- Additional supports through the school
- Additional Community Living and Support services for home while she recovers (if needed)
- A physical therapist who has experience supporting people with I/DD
- Assistance with transportation and appointment coordination

Jane is a 26 year old with severe substance use disorder and was recently hospitalized with an abscess from IVDU. Her BH needs are being met in a recovery program, but she needs a primary care provider for family planning services and psoriasis. Her home is across the state, but since she will be away at the recovery program for 6-12 months, she is looking for new local providers. You are her behavioral health therapist and want to help her find a primary care provider—where would you start?



How Tailored Care Management Supports Coordination of Care

Jane will have an assigned **Tailored Care Manager** who should already be aware of her current substance use disorder treatment program and should be alerted to her hospitalization via ADT monitoring. The TCM should reach out to the discharge planner and to Jane to support aftercare recommendations. The TCM can set up a care team meeting with Jane and her care team (including her current assigned PCP and SUD provider) prior to discharge.

The TCM provider can support Jane with:

- Understanding her hospital discharge plan including any updates to meds
- Attending an aftercare appointment with a local in-network PCP and assuring her assigned PCP is part of the care team planning
- Supporting any follow-up appts from the PCP visit (like a GYN or dermatologist)
- Mitigating any issues with access to appointments (transportation, pharmacy coordination)

Once she gets to primary care, they decide to refer her to a dermatologist for her severe psoriasis that is not responding to aggressive treatment. **What do they need to know?**

Alonzo is a 34 year old with well controlled schizophrenia who is admitted with diabetic ketoacidosis, a new diagnosis. The discharge planner needs to make sure he receives solid hospital follow up. **What's the first step?**

How Tailored Care Management Supports Coordination of Care

Alonzo will have an assigned Tailored Care Management (TCM) provider. His TCM provider should be alerted (by daily ADT feeds) that Alonzo is hospitalized. The TCM provider should reach out to the hospital discharge planner to coordinate a care team meeting (PCP, treating psychiatrist, discharge planner, etc) to help Alonzo identify his choices associated with his medication and to help plan his course of aftercare treatment.

At/After discharge, the TCM provider can support Alonzo with:

- Understanding his hospital discharge plan including any updates to meds
- Attending his aftercare appointment with his PCP and psychiatrist
- Supporting any follow-up from the PCP visit (like getting an insulin pump)
- Attending his endocrinologist follow-up
- Connecting to any other BH providers for follow-up visits
- Finding diabetes education classes that meet his needs/schedule
- Mitigating any issues with access to appointments (transportation, pharmacy coordination)

Once Alonzo makes it to established care in hospital follow up with a new primary care provider, they identify that he is a great candidate for an insulin pump. However, because of his psychiatric history they want to consult with an endocrinologist before making the move. They make the referral to the endocrinologist who worked with him in the hospital, and they agree with this recommendation and refer him to diabetes education and prescribe a pump. **What's important to know here?**

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

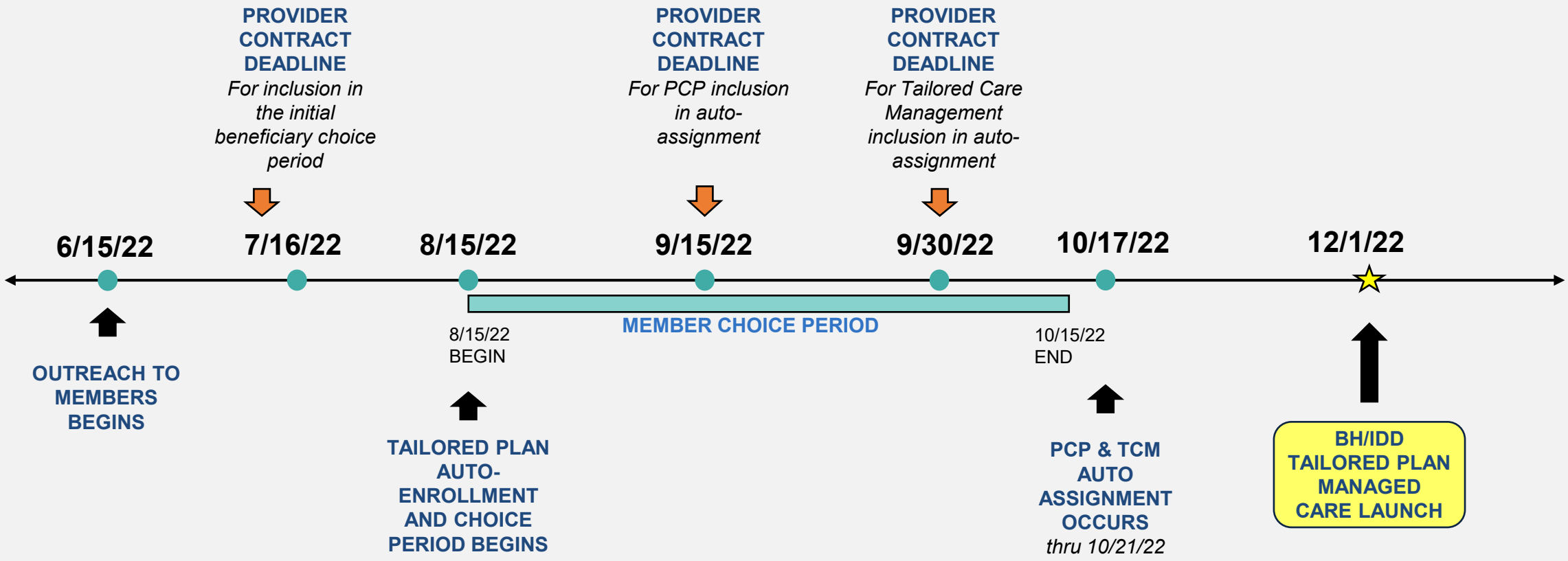
*Tailored Plans are leveraging their Standard Plan partner for a variety of different functions and additional details can be found here in the ***Contracting with Tailored Plans*** Fact Sheet.

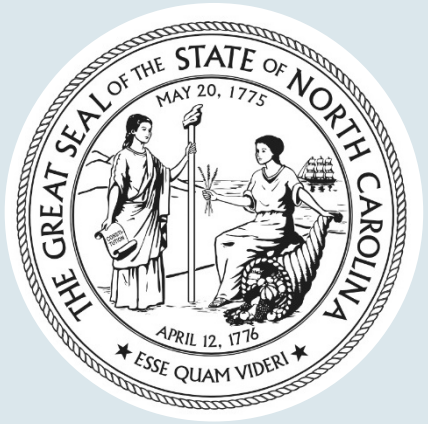
Tailored Plan-Standard Plan Partnering

Tailored Plan	Partners and Vendors as of 4/19/2022							
	Standard Plan Partner	**Primary Care Contracting Lead**	**Behavioral Health Contracting Lead**	**AMH+/CMA Contracting Lead**	**Hospital Contracting Lead**	**Pharmacy Benefit Manager (PBM)**	**Vision Administration**	**Specialties**
Alliance	Wellcare	Alliance	Alliance	Alliance	Alliance	Navitus	Avesis	**Northwood**: Durable Medical Equipment (DME); **WellCare**: Complex Labs, Cardiance Imaging, Radiation Oncology, Musculoskeletal, Orthopedics, Imaging Procedures
Eastpointe	WellCare	Wellcare	Eastpointe	Eastpointe	Eastpointe/ WellCare	Express Scripts	WellCare	WellCare (please reach out to Tailored Plan directly with questions
Partners	Carolina Complete Health	Carolina Complete Health	Partners	Partners	Carolina Complete Health for Physical Health; Partners for Behavioral Health	CVS Caremark	Envolve Vision	Carolina Complete Health
Sandhills	AmeriHealth	AmeriHealth	Sandhills	Sandhills	Sandhills Center/AmeriHealth	PerformRX	AmeriHealth	AmeriHealth
Trillium	Carolina Complete Health	Carolina Complete Health	Trillium	Trillium	Trillium / Carolina Health Complete Health	PerformRX	Envolve Vision	Carolina Complete Health
Vaya	WellCare	Vaya	Vaya	Vaya	Vaya	Navitus	Vaya	Vaya/ Utilization Management (UM) subcontractors TBD

Provider Contracting

Providers are encouraged to contract with all PHPs. Contact information each PHP to engage in contracting is available here.



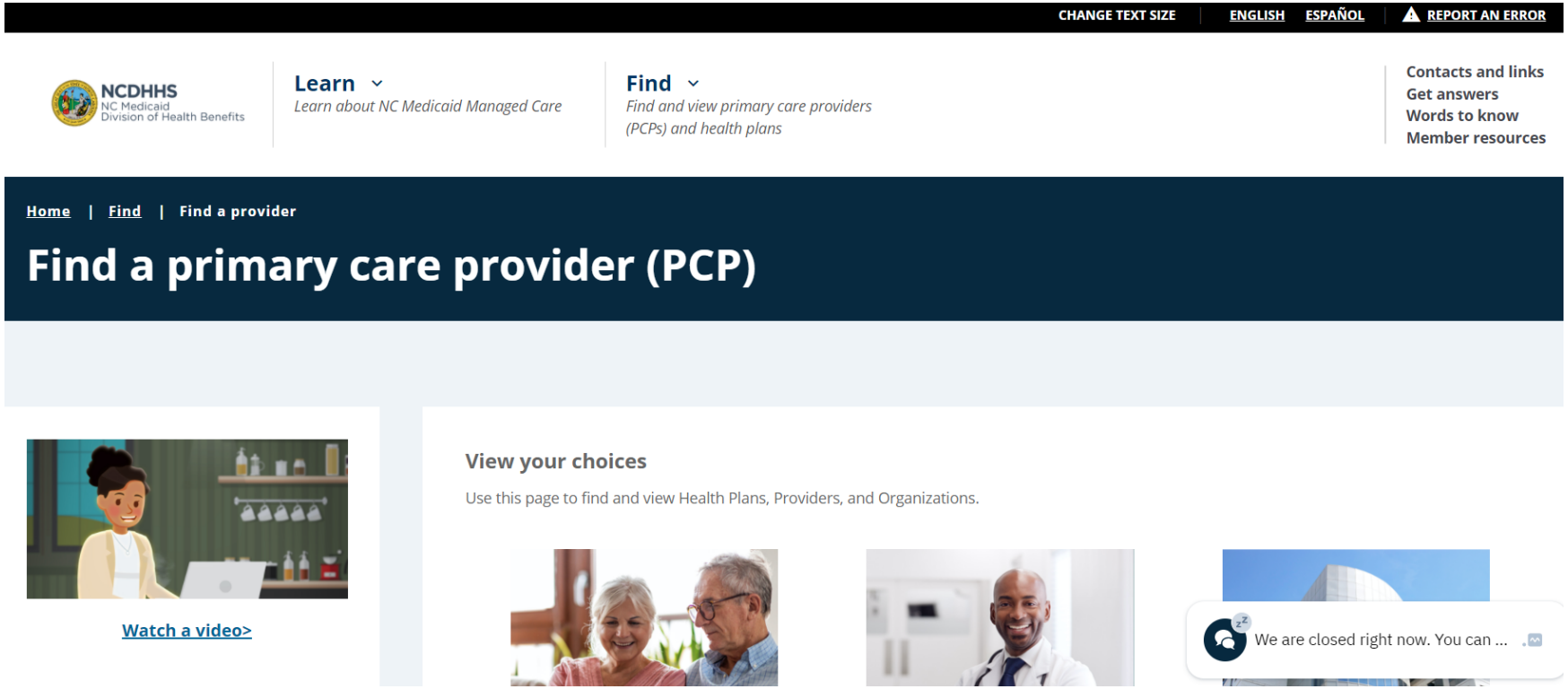


Provider Readiness Resources

Medicaid Managed Care Provider Directory and Health Plan Look Up Tool

The public version of the **Medicaid and NC Health Choice Provider and Health Plan Lookup Tool** is available at: https://ncmedicaidplans.gov/enroll/online/find/find-provider?lang=en. Providers are encouraged to use this tool to confirm the availability and accuracy of information contained in their NCTracks provider enrollment record.

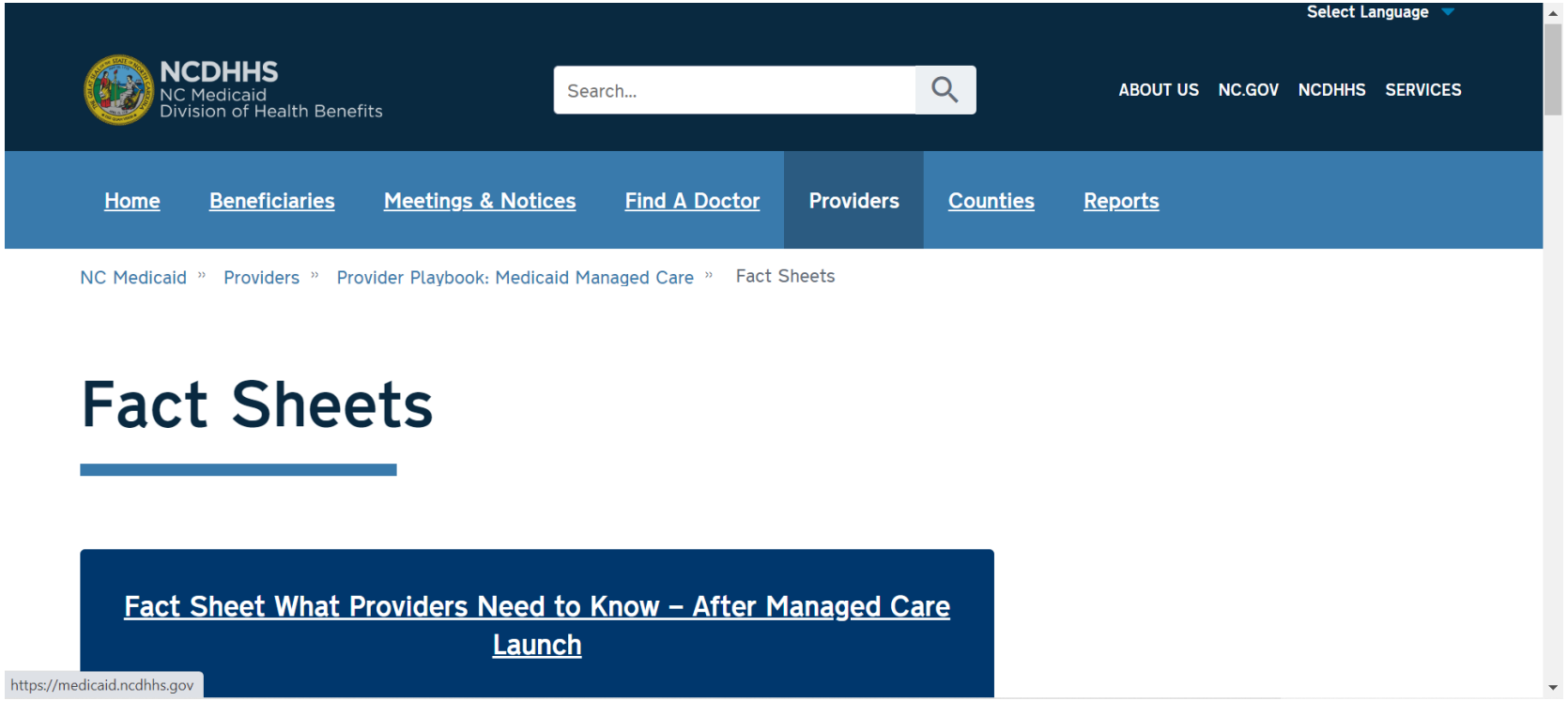
The provider directory contains all active Medicaid and NC Health Choice providers, including primary care providers, specialists, hospitals and organizations. The authenticated portal will be available to beneficiaries beginning **August 15, 2022**.



For more information, please visit the Provider Playbook for an updated NC Provider Directory fact sheet https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets#enrollment-broker

Provider and Health Plan Lookup Tool Fact Sheet

The Medicaid and NC Health Choice Provider and Health Plan Lookup Tool Fact Sheet is located on the Provider Playbook Fact Sheet page.

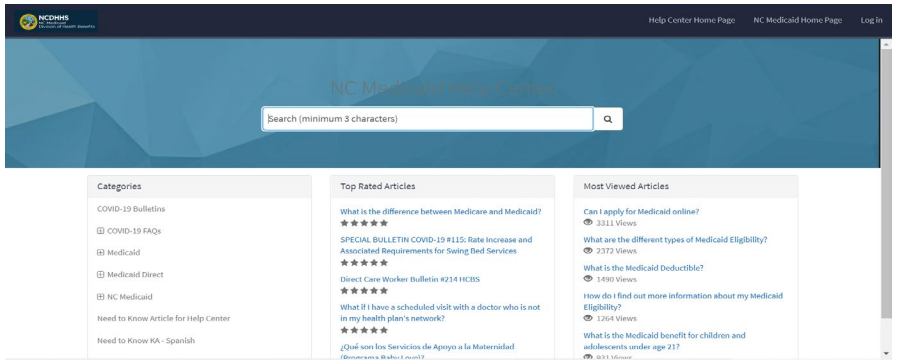


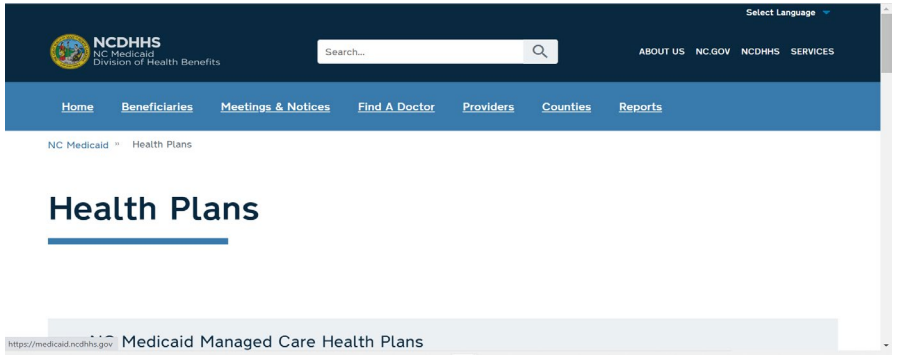
Tailored Plans

- Tailored Plan Enrollment and Timelines
- What Providers Need to know Before Tailored Plan Launch

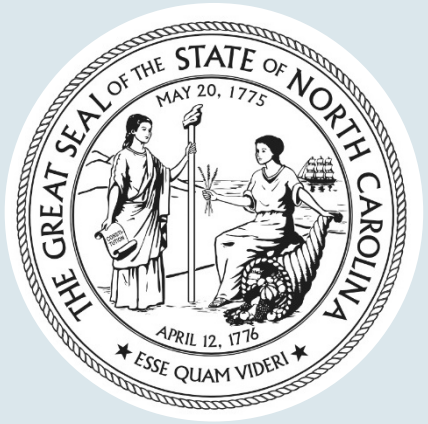
Bulletin & Fact Sheets are posted monthly. It Is vital to visit the Provider Playbook on a regular basis to continue viewing up to date materials.

Reminder: Key Provider Information Resources





- NC Medicaid Help Center
- NCDHHS Transformation website (Including County & Provider Playbooks)
- Health Plan websites



Medicaid Hot Topics

Integrating Community Health Workers into NC Medicaid

The North Carolina Department of Health and Human Services (NCDHHS) has long held a vision that Community Health Workers (CHWs), and other extenders, can play important roles in improving health. As the CHW workforce grows in North Carolina, NCDHHS seeks to emphasize the ways CHWs can be leveraged to improve health and health care for individuals enrolled in Medicaid.

DHB plans to release managed care guidance later this year describing our strategy to further integrate CHWs into NC Medicaid. This will include opportunities for stakeholder input and feedback to inform the strategy.

In the interim, the guidance document provides important overarching information on CHWs to encourage broader use of CHWs in Medicaid.

- It summarizes the definition of a CHW,
- Offers examples of how CHWs can serve Medicaid members, and
- Provides information on current CHW training and certification opportunities in North Carolina.

More information about Integrating Community Health Workers into NC Medicaid is available in the guidance document and Provider bulletin.

DHB Publishes PHP Rates & Targets for AMH Measure Set

DHB has set of quality metrics that are used to assess health plans' performance across their populations. DHB has identified a subset of these measures for health plans to use to monitor Advanced Medical Home (AMH) performance and calculate AMH performance incentive payments.

The first quality performance period for AMHs began in January 2022.

- The 2022 and 2023 AMH Measure Targets table provides baseline data and targets for health plans.
- NC Medicaid does NOT set targets for AMHs.

This data also identifies measures with disparities by race and ethnicity. As a reminder, where we have identified disparities, we have a MORE aggressive target aimed at closing the disparity gap over time.

These baseline data and targets are shared as a reference for AMHs. An AMH practice (NPI + location) will have its own rate that may be above or below the baseline state median rate. AMHs should negotiate target performance rates with health plans.

Additional information and resources for AMHs are available on the NC Medicaid Advanced Medical Home webpage. More information about quality strategy and metrics are available on the NC Medicaid Quality Management and Improvement webpage.

UPDATED: PHP COVID Vaccine Incentives

WellCare	United HealthCare	Healthy Blue	AmeriHealth Caritas NC	Carolina Complete Health
Who is Eligible? Members 5 years of age and up.	**Who is Eligible?** • Members 5 years of age and up who receive 1st or 2nd COVID Vaccine doses.	**No Member Incentive Program as of June 2022**	**Who is Eligible?** • Members 5 years of age and up.	**Who is Eligible?** • Members 5 years of age and up.
Incentive Dates/Timeline • Members who completed their vaccination (series) on or after 9/1/21 through 12/31/22 are eligible for a $50 Walmart gift card. Members may attest to their, or their dependent's vaccination status via web portal, and a gift card will be provided to them.	**Incentive Dates/Timeline** • Eligible members will be paid a $50 gift card upon UHC receipt of a claim between 4/1/22 and 12/31/22 for any of the following: ○ Pfizer/Moderna 1st dose ○ Pfizer/Moderna 2nd dose ○ Johnson & Johnson single dose • Limit 3 gift card incentives per member per fiscal year		**Incentive Dates/Timeline** • Eligible members will receive the following amounts for doses received 7/1/22-12/31/22: ○ Moderna and Pfizer: $75 for second dose (maximum of one $75 incentive) ○ Johnson and Johnson - $75 for single dose (maximum of one $75 incentive)	**Incentive Dates/Timeline** • The first 35,000 eligible members who receive a first, second, or booster COVID-19 vaccination between 11/15/21 and 12/31/22 will receive a $75 incentive, while rewards last.
Member Incentive • Members will receive a Wal-Mart gift card in the amount of $50.	**Member Incentive** • Incentive offering to all incentive-eligible members in the form of a $50 gift card with appropriate restrictions.		**Member Incentive** • Rewards are loaded onto the member's pre-paid CARE Card and can be used to purchase OTC health products, wellness products and healthy foods at participating retailers. Member is notified by mail when rewards are loaded to CARE Card.	**Member Incentive** • Members will receive $75 on their My Health Pays Rewards card when they receive a first, second, or booster vaccination. • Every member receives a My Health Pays card within two weeks of enrollment. If the member does not have a My Health Pays Rewards card, they should contact member services.

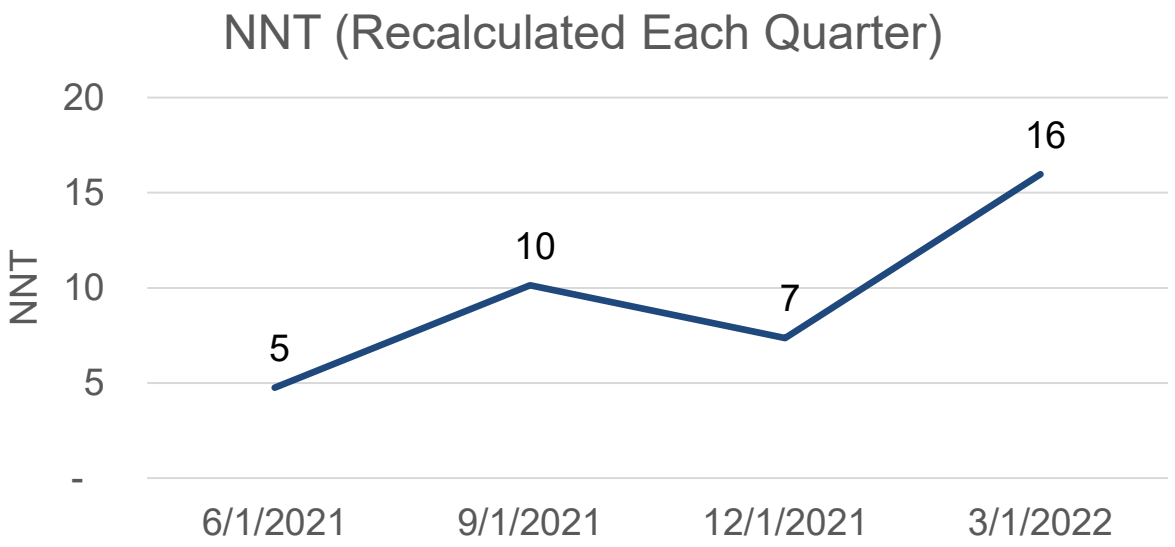
UPDATED: PHP COVID Vaccine Incentives

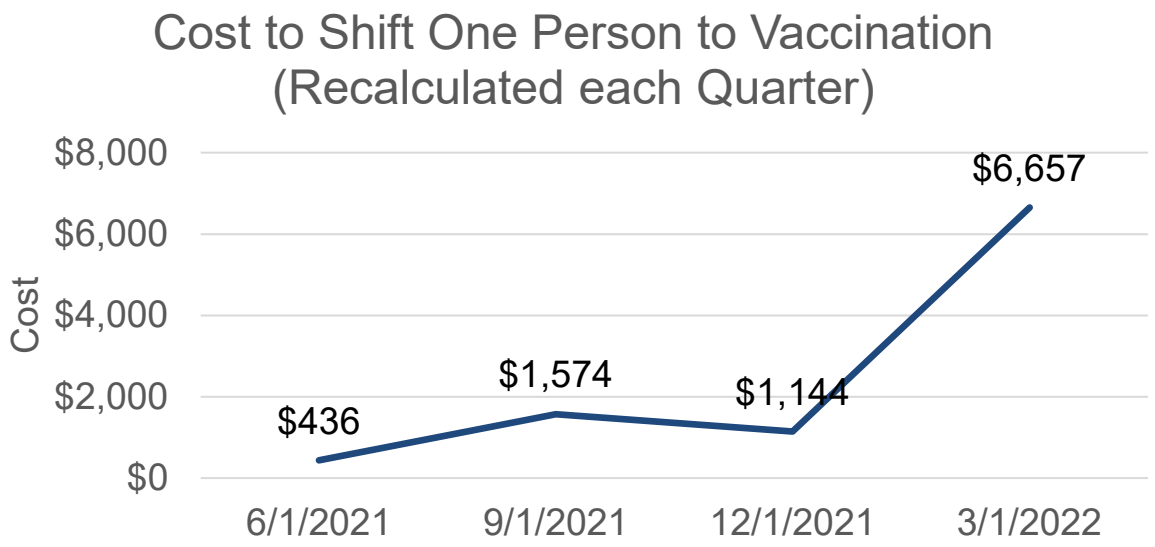
What should members do to receive the incentive? • Members must attest to their vaccination status or a minor under their care's vaccination status at: https://wellcarerewardspprd.inspireandperform.com/ - Enter identifier information - Enter vaccine information (vaccine brand, date of each shot depending on vaccine)	**What should members do to receive the incentive?** • Members will attest to their vaccine status by providing name of vaccine, date received and location by mail, online or by phone.		**What should members do to receive the incentive?** • Member should attest by calling Member Services or using the secure contact form at: www.amerihealthcaritasnc.com	**What should members do to receive the incentive?** • Members will receive the incentive based on a claim. Members can also provide proof of vaccination by uploading a copy of their vaccination card online or mailing a copy to Carolina Complete Health.
How is it verified? • WellCare of North Carolina members will attest to their vaccination status or a minor under their care's vaccination status by: • following a link to a microsite • https://wellcarerewards.inspireandperform.com entering identifier information • entering vaccine information (vaccine brand, date of each shot depending on vaccine) • The site will perform authentication by comparing identifier information to enrollment files.	**How is it verified?** • UnitedHealthcare Community Plan of North Carolina will monitor claims data to identify qualified members that receive a COVID 19 vaccination.		**How is it verified?** • ACNC tracks vaccine claims paid to pharmacies or providers • ACNC identifies a member in a data source from the State • Member attestation via Member Services or the secure contact form on our website www.amerihealthcaritasnc.com and validated by ACNC	**How is it verified?** • Carolina Complete Health will use claims data to determine when members receive the vaccination and are eligible for the incentive.** • If there was not a claim, the member can provide proof of vaccination by uploading a copy of their vaccination card online or mailing a copy to Carolina Complete Health.***
More information for members: https://www.wellcarenc.com/covid-19/count-on-me.html [wellcarenc.com]	**More information for members:** https://myuhc.com/CommunityPlan/HealthWellness [myuhc.com]		**More information for members:** https://amerihealthcaritasnc.com/covid-19/vaccine-carecard.aspx	**More information for members:** www.carolinacompletehealth.com/vaccine

Primary Series Complete Rate for the 12-17 Hesitant Population by Discrete Time Period

Through 5/31/2022

Month #	Date	Age Group	PSC With Counseling	PSC With No Counseling	Ratio	NNT	Claim Cost / Counseling Session	Cost to shift one person to vaccination
3	8/31/21	12-17	34.93%	13.93%	2.86	5	$32	$ 436
6	11/30/21	12-17	20.60%	10.73%	4.86	10	$32	$ 1,574
9	2/28/22	12-17	20.58%	6.99%	4.86	7	$32	$ 1,144
12	5/31/22	12-17	7.68%	1.41%	13.03	16	$32	$ 6,657





NC Medicaid Quality Survey Results

NC Medicaid has recently published results of two surveys. One measures patient experiences with their health care while the other describes findings from the baseline assessment (Year 1) of the provider experience and satisfaction with the traditional NC Medicaid Direct system, including the partnership with Community Care of North Carolina.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS)
This is a patient experience survey that serves as a national standard for measuring and reporting respondents' experiences with their health care. NC Medicaid administers the CAHPS surveys to adult and child Medicaid beneficiaries to understand the Medicaid beneficiary experience and inform improvements in care. CAHPS allows states to include supplemental questions that are fielded with the standard survey questions. For 2021, NC Medicaid decided to devote the supplemental questions to gaining insight into patient experiences with the telehealth services offered due to the COVID-19 pandemic. The full report and a two-page summary are available.

The North Carolina Provider Experience Survey
This was developed and administered across all North Carolina primary care practices or their corporate parent to evaluate the influence of the North Carolina Medicaid Transformation on primary care and obstetrics/gynecology (Ob/Gyn) practices that contract with NC Medicaid. This assessment also explored the experience of providers in early contracting with prepaid health plans (PHPs), as it overlapped with the launch of Standard Plans on July 1, 2021. The baseline assessment will serve as a comparison against PHP performance in future years. The full report and a two-page summary are available.

For more information, please visit the NC Medicaid Quality Management and Improvement webpage.

QUESTIONS

APPENDIX

Tailored Plans Network Adequacy Standards

DHHS has developed robust network adequacy standards to ensure B I/DD Tailored Plan beneficiaries' access to physical and behavioral health services. BH I/DD Tailored Plans will maintain an open network* for physical health and pharmacy services but are permitted to use a closed network for BH, I/DD, and TBI services.

BH I/DD Tailored Plan Time/Distance Standards for Medicaid

#	BH Service Type	Urban Standard	Rural Standard
1	Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
3	Hospitals	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4	Pharmacies	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5	Obstetrics	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

BH I/DD Tailored Plan Time/Distance Standards for Medicaid

#	BH Service Type	Urban Standard	Rural Standard
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard
8	Location-Based Services	• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard	• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

BH I/DD Tailored Plan Time/Distance Standards for Medicaid

#	BH Service Type	Urban Standard	Rural Standard

9	Crisis Services	• Professional treatment services in facility-based crisis program: The greater of:
		  • 2+ facilities within each BH I/DD Tailored Plan Region, OR
		  • 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates).
		• Facility-based crisis services for children and adolescents: ≥ 1 provider within each BH I/DD Tailored Plan Region
		• Non-Hospital Medical Detoxification: ≥ 2 provider within each BH I/DD Tailored Plan Region
		• Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal: ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region
		• Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard	

10	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12	Community/Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

BH I/DD Tailored Plan Time/Distance Standards for Medicaid

#	BH Service Type	Urban Standard	Rural Standard
13	All State Plan LTSS (except nursing facilities)	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14	Nursing Facilities	≥ 1 nursing facility accepting new patients in every county.	

15	Residential Treatment Services	• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region,
		• Substance Abuse Medically Monitored Residential Treatment: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to 10A NCAC 27G.3400)
		• Substance Abuse Non-Medical Community Residential Treatment:
		  • Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department)
		  • Adolescent: Contract with all designated CASPs within the BH I/DD Tailored Plan's Region
		  • Women & Children: Contract with all designated CASPs within the BH I/DD Tailored Plan's Region
		• Substance Abuse Halfway House:
		  • Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)2
		  • Adolescent: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)
		• Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard	

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

BH I/DD Tailored Plan Time/Distance Standards for Medicaid

#	BH Service Type	Urban Standard	Rural Standard
16	1915(c) HCBS Waiver Services: NC Innovations	• Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. • Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard	
17	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment: ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. • Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports: ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. • Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification: N/A	

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid

#	BH Service Type	Definition
1	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2	Location-Based Services (BH I/DD)	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4	Inpatient BH Services	Inpatient Hospital – Adult • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid

#	BH Service Type	Definition
4	Outpatient BH Services	Inpatient Hospital – Adolescent / Children • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
5	Partial Hospitalization	• Partial hospitalization (adults and children)
6	Residential Treatment Services	• Residential treatment facility services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID:
7	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid

#	BH Service Type	Definition
8	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications
9	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Tailored Plans Network Adequacy Standards

Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid

#	BH Service Type	Definition
9	1915(c) HCBS Waiver Services: NC TBI Waiver	• Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Residential Supports • Resource Facilitation • Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Vehicle Modifications

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

BH I/DD Tailored Plan Appointment Wait Time Standards

DHHS has developed robust appointment wait time standards to ensure BH I/DD Tailored Plan members' access to physical and behavioral health services.

Medicaid Appointment Wait Time Standards

#	Service Type	Appointment Wait Time Standard
Primary Care		
1	Preventive Care Service – adult, 21 years of age and older	Within thirty (30) calendar days
1a	Preventive Care Services – child, birth through 20 years of age	Within fourteen (14) calendar days for member less than six (6) months of age Within thirty (30) calendar days for members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Routine/Check-up without Symptoms

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

BH I/DD Tailored Plan Appointment Wait Time Standards

Medicaid Appointment Wait Time Standards

#	Service Type	Appointment Wait Time Standard
Prenatal Care		
5	Initial Appointment – 1st or 2nd Trimester	Within fourteen (14) calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester	Within five (5) calendar days
Specialty Care		
6	After-Hours Access – Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
7	Urgent Care Services	Within twenty-four (24) hours
8	Routine/Check-up without Symptoms	Within thirty (30) calendar days

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

BH I/DD Tailored Plan Appointment Wait Time Standards

Medicaid Appointment Wait Time Standards

#	Service Type	Appointment Wait Time Standard
Behavioral Health, I/DD, and TBI Services		
9	Mobile Crisis Management Services	Within two (2) hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
11	Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
12	Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
14	Urgent Care Services for Mental Health	Within twenty-four (24) hours
15	Urgent Care Services for SUDs	Within twenty-four (24) hours

Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

BH I/DD Tailored Plan Appointment Wait Time Standards

Medicaid Appointment Wait Time Standards

#	Service Type	Appointment Wait Time Standard
Behavioral Health, I/DD, and TBI Services		
16	Routine Services for Mental Health	Within fourteen (14) calendar days
17	Routine Services for SUDs	Within forty-eight (48) hours

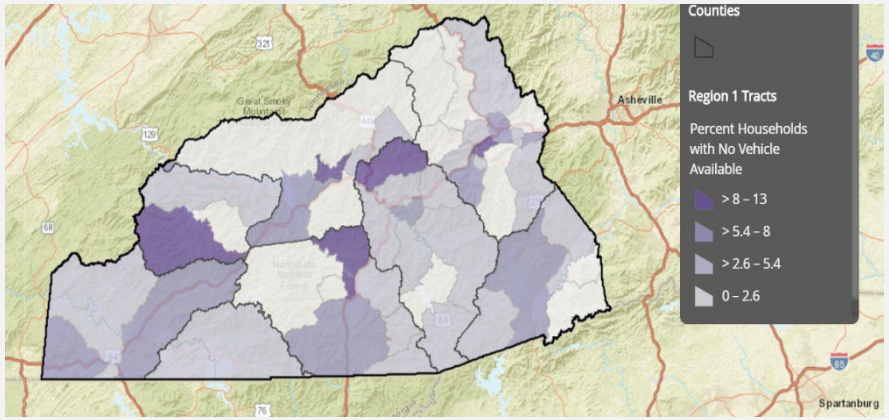
Source: Tailored Plan Request for Application: Addendum 3, Section VII, Attachments A-P

Unmet Health-Related Needs in North Carolina

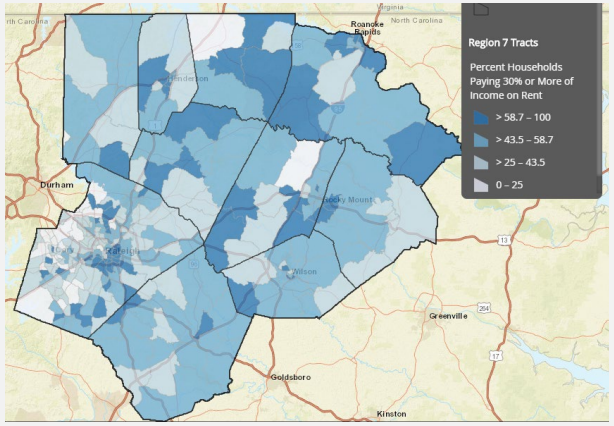
Citizens of North Carolina grapple with the impact of unmet health-related social needs every day.

- Over 1.2 million North Carolinians cannot find **affordable housing**, and one in 28 of the state's children under age six is homeless.
- NC has the 8th highest rate of **food insecurity** in the US, with more than one in five children living in food insecure households.
- 47% of NC women have experienced **intimate partner violence.**
- Nearly 25% of NC children have experienced **adverse childhood experiences** (ACEs),
- On average 7% of the state population do not have access to a vehicle and report that **lack of transportation** causes them to delay their medical care.

Percent of Households Without Access to a Vehicle*



Percent of Households Pay >30% Income on Rent



*NC Association of Local Health Department regions are represented in the maps above. For more information: North Carolina Social Determinants of Health by Regions (arcgis.com)

Healthy Opportunities Pilots Regions

The Department procured three (3) Network Leads (NLs) with deep roots in their community that will facilitate collaboration across the healthcare and human service providers. PHPs, Care Managers (CMs), NLs, and Human Service Organizations (HSOs) will work to implement the Pilots in three Pilot regions.

Who's involved?

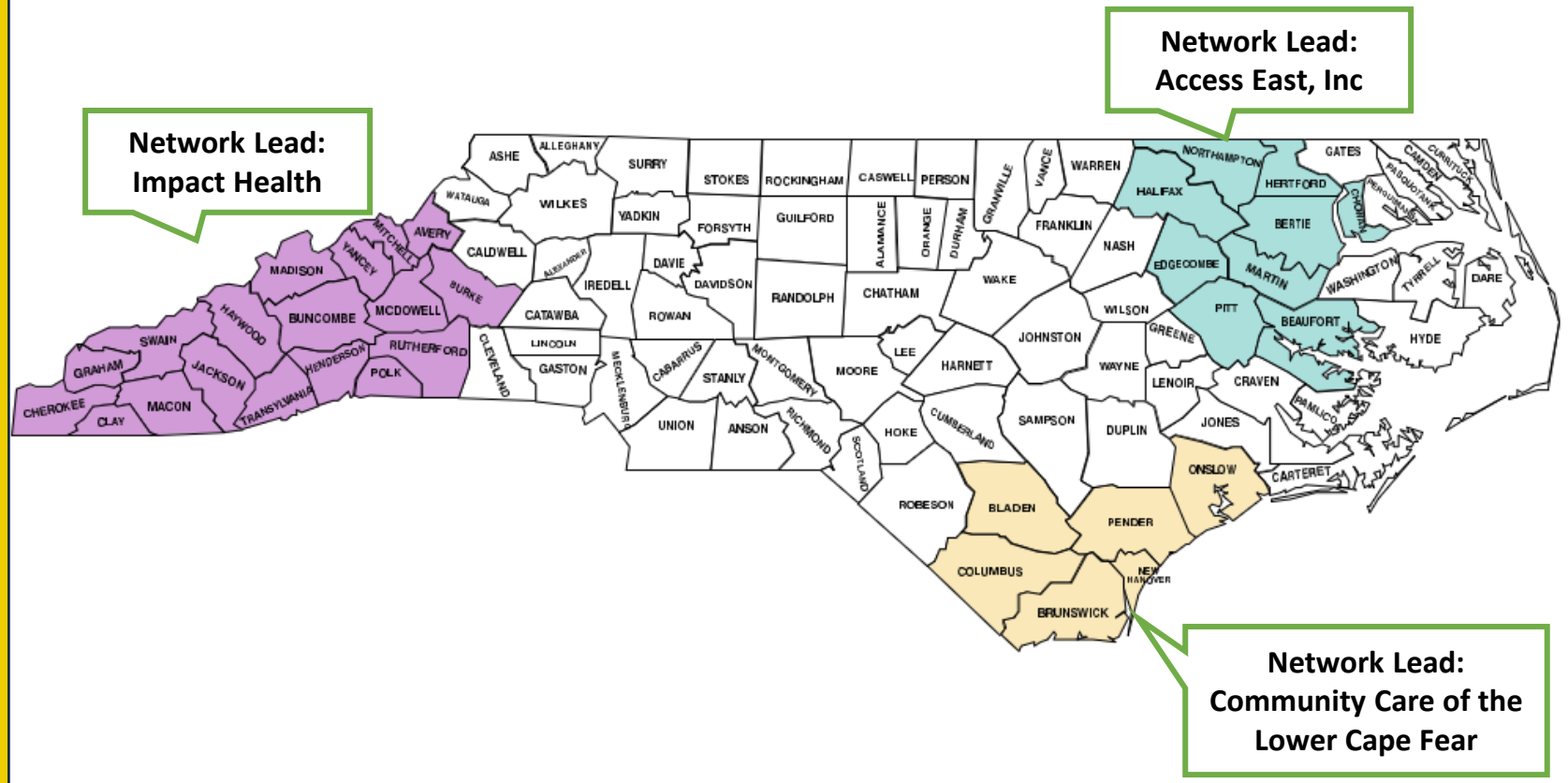
- DHHS, PHPs, CMs, NLs, HSOs, NCCARE360, and you!

Service Domains

- **Housing** (ex. Housing Navigation)
- **Transportation** (Ex. Reimbursement for Health-Related Public Transportation)
- **Food** (Ex. Food and Nutrition Access Case Management Services, Food Boxes/Meals)
- **IPV/Toxic Stress** (Ex. Evidence-Based Parenting Curriculum)
- **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!



For Additional Information Visit: [Healthy Opportunities Pilots | NCDHHS]

No Wrong Door: Entry Points into the Pilots

The Pilots is utilizing a "no wrong door" approach to identify and enroll individuals in the program, ensuring that individuals who first show up at various "entry points" can efficiently undergo the Pilot eligibility and service authorization process.

Provider Referral

Referral from Pilot Participating HSO

Referral from Non-Pilot Participating HSO

Self/Family Referral

PHP Identification

Care Manager Assessment

Members at all entry points will be connected to their care manager (at either their health plan or their primary care medical home)

Providers may refer members/families to the PHP. The PHPs will ensure that members are connected to their care manager for Pilot assessment.

Pharmacy Point of Sale at Tailored Plan Launch

Update regarding pharmacy claims processing under Behavioral Health and Intellectual/Developmental Disabilities (I/DDs) Tailored Plans

- Pharmacy Point of Sale (POS) claims for members enrolled in Tailored Plans will be temporarily managed by NCTracks when the plans launch on Dec. 1, 2022, through March 31, 2023. Beginning on April 1, 2023, these claims will be managed by the Tailored Plans. This change was made as a result of a key Pharmacy Benefit Manager (PBM) unexpectedly leaving the NC Medicaid market in late 2021, which required some Tailored Plans to procure another PBM.

- There will be no impact to members' pharmacy benefits during this transition period. From Dec. 1, 2022, through March 31, 2023, member ID cards will not include pharmacy information. A new card will be issued for April 1, 2023, indicating the new RxBin and PCN numbers for the Tailored Plans.

- NC Medicaid will reach out to members, pharmacists and providers in the coming months with additional information about this transition. For more information, please see Medicaid bulletin Pharmacy Point of Sale Process at Tailored Plan Launch.

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