CLINICAL POLICIES WEBINAR

David Moran

Welcome everyone, and thank you for joining today's webinar. My name is David Moran, and I will be your producer for today's webinar presentation on North Carolina Medicaid Clinical Policies. Today's presentation is the eighth in a series of nine provider education modules that are planned on Medicaid transformation. Notification on additional provider education modules will be forthcoming and posted to the Medicaid Transformation website. Now there's just a few housekeeping rules before we get started. If you experience technical difficulty at any time during this Webex event, please submit your technical issue in the Q&A panel, and I will assist you. Also, please note that as an attendee, you're part of a larger audience today. However, due to privacy concerns, the attendee list is not displayed. All attendees will be in a listen-only mode for the duration of today's call. And as a reminder, this call is being recorded. We will also be holding a Q&A session at the conclusion of today's presentation, time permitting. You may ask a question at any time throughout the event by entering it into the Q&A panel at the lower right of your screen. With that, we invite you to sit back, relax and enjoy today's presentation. I will now turn it over to Mandy Ferguson, consultant at Manatt Health Strategies, to make opening remarks. Mandy, you now have the floor.

Mandy Ferguson

Thank you very much to everyone for joining. Today's Clinical Policy webinar is intended to provide an overview of those key clinical policies that providers will need to be familiar with during the transition to managed care. The webinar will review the managed care benefit package, the approach to utilization management, and how appeals and grievances will work under managed care. Time will be allotted for questions and answers. We have several team members from the Division of Health Benefits that will be on hand to present today's webinar and help answer the questions that we receive. These team members include Dr. Nancy Henley, the Chief Medical Officer at North Carolina Medicaid, Beth Daniels, an Associate Director with the Medical and Behavioral Health Division, Melissa Clayton, a Program Manager of Practitioners and Facilities, Betty Jones a Program Manager for Policy Development and Operations, Lovette Young, the Associate Director of Appeals, Crystal Hilton, Long-Term Services and Support Transition Manager, and Sabrina Lee, the Associate Director for Long-Term Services and Support. I would now like to introduce Dr. Nancy Henley, the Chief Medical Officer at North Carolina Medicaid, who will provide the content overview for today's presentation and briefly cover North Carolina Medicaid Transformation. Dr. Henley?

Dr. Nancy Henley

Thank you, Mandy. Good morning everyone, and thank you all for joining us today to learn about Clinical Policies in Medicaid managed care. Next slide, please.

We will begin with the North Carolina Medicaid managed care transformation vision, followed by a deeper dive into key clinical policies, and we'll end by discussing more opportunities for provider engagement and for answering your questions. Next slide.

This slide presents the vision of the Medicaid – for Medicaid managed care that we as an organization share during our stakeholder event. We do this so that we all will remain focused on division of NC managed care, Medicaid, which is to be innovative and whole-person centered by integrating both the

physical and behavioral health needs of members as we transition into a well-coordinated system of care that addresses both medical and non-medical drivers of health. Next slide.

So, how did we get here, and why are we making this change? In 2015, the General Assembly enacted a law that directed the transition of Medicaid and North Carolina Health Choice Beneficiaries from a predominantly fee-for-service program to a managed care system. Since that time, we have been collaborating with clinicians, hospitals, beneficiaries, other health plans, elected officials, advocates, and many other stakeholders to shape the new program. DHHS is committed to ensuring that managed – excuse me – managed care delivers whole person care, that they address the full set of factors that impact health, that they perform local care management services, and that plans maintain broad provider participation in the program by helping to mitigate provider administrative burden. Next slide.

So, here we have our timeline. In February of this year, DHHS awarded contracts to five pre-paid health plans. In alphabetical order, the four statewide plans are Amerihealth Caritas of North Carolina, Blue Cross Blue Shield of North Carolina, UnitedHealthcare of North Carolina, and WellCare of North Carolina. A fifth pre-paid health plan, Carolina Complete Health, is a regional provider-led entity operating in Regions 3 and 5. Coming in the next couple of months, the first beneficiary open enrollment period will begin as Maximus starts sending welcome packets to beneficiaries enrolling in managed care that will be effective on November 1st, 2019. Maximus is the enrollment broker contracted by North Carolina Medicaid to ensure that Medicaid and North Carolina Health Choice beneficiaries understand managed care benefits and that they receive choice counseling to select a prepaid health plan and primary provider.

Speaker

They're having a hard time hearing in the audience. I'm not sure why.

Mandy Ferguson

And I think – hi, this is Mandy. And, David --

David Moran

Yeah?

Mandy Ferguson

Most folks are doing okay, correct?

David Moran

Yes, it does look like there were some audio issues with people, but it was just individually. I certainly have checked the backup computers I have connected as attendees and can hear clearly with the presentation.

Mandy Ferguson

Great.

David Moran

So, we can get --

Mandy Ferguson

Okay. So, Dr. Henley, I'll give you the floor back. I think we're doin' okay. It's just a couple of individual issues, which we'll handle.

Dr. Nancy Henley

Thank you, Mandy. We'll, we'll carry on. Just wanted to be sure everyone could hear. So, I was just saying that our enrollment broker will ensure that our beneficiaries understand managed care benefits and receive choice counseling to select a pre-paid health plan and primary provider. During the summer, PHPs would be working to finalize contracts with provides so they can bill their provider networks to meet the network adequacy standards established by North Carolina Medicaid. You may have already been contacted by one or more PHPs, but if you have not been contacted, and you're interested in joining their networks, you may proactively reach out to the PHPs using the PHP contact information available on the NC Medicaid Provider Web page.

Now, November 1st will be a historic day for North Carolina Medicaid. Managed care will launch in Regions 2 and 4. These regions span across the northern part of the state from Watauga County in the west to Nash and Wilson County in the east. Also in November, the open enrollment period will begin for beneficiaries in the remaining managed care regions, which span from Cherokee County in the far west tip of our state, all the way along the southern border and up the coast of North Carolina. Managed care for these regions will launch in February 2020. A map of the managed care regions is available on the NC Medicaid Transformation website. At this time, I'd like to introduce Beth Daniels, Associate Director for Medical and Behavioral Health, to initiate the discussion on key clinical policies, and specifically, the benefit package under Medicaid managed care. Beth?

Beth Daniels

Thank you, Dr. Henley. We're going to go on into the deep dive into clinical policies, which involves not only the benefit package under a managed care, but the utilization management of those policies and the clinical appeals that are available to our beneficiaries under managed care. We'll go onto the next slide, please. Actually, the one to the – the next slide.

Under managed care, the PHPs must adhere to federal and state regulations about providing benefits under managed care. These services that they provide must be the same as beneficiaries are able to get now in North Carolina Medicaid and North Carolina Health Choice state plans, unless they're carved out or otherwise offered in Tailored Plans. North Carolina has established a medical necessity definition and those, the plans are required to use that when making coverage decisions. There are, services must be covered at least in the same amount, duration and scope as under fee-for-service, however the health plans can expand on those. But our coverage policies as we have established over the years on our Web page that's available to you is basically considered the floor for coverage under managed care, but that the plans can offer more than that, but they have to at least offer what is in our coverage policies today. These health plans must also ensure that the services offered by providers to beneficiaries are sufficient in the amount, duration and scope to achieve the purpose of the service, and the service cannot be changed because someone has a different diagnosis or condition. The service has to be offered the

same to all beneficiaries. Under Medicaid, we have EPSDT for beneficiaries who are under age 21, and the health plans are to ensure that the EPSDT statutory and regulatory requirements are adhered to, as we go forward in providing services to these children and young adults. The PHPs must also have a comprehensive utilization managed program, management program, which we'll go to in a few minutes. The next slide.

This is just a summary of the covered services that are offered under managed care because they are the same services and benefits that our beneficiaries have had under fee-for-service Medicaid. And these are outlined on the slide, that you're familiar with these, and these are all going to be offered to, under the managed care plans. There's a callout there for telemedicine. Telemedicine can be used as a means to access and provide services that are not otherwise available within a network and a region, and we have encouraged the PHPs to look into using telemedicine in innovative ways to provide services that are not necessarily going to be constrained by the policy as we have it today in North Carolina Medicaid. Next slide, please.

Under Pharmacy, PHPs must cover all of the outpatient drugs for which CMS has rebate agreements and that DHHS has decided to cover. They have to adhere to our preferred drug lists and provide pharmacy benefits. Same amount, duration and scope as fee-for-service Medicaid. The formulary must include all of the drugs of North Carolina Medicaid's and Health Choice formulary preferred drug list, and cover drugs and drug classes that are not listed in the PDL and other outpatient drugs not excluded state and federal policy. And the callout on this slide is specific for Providers. You will not, you will only need to track one preferred drug list. The PHPs will be required to adhere to. You will not have to track different formularies for each PHP. Next slide, please.

Now services are going – some services are carved out from managed care by legislation. And there's six service types that are outlined here. Examples here listed are the Program of All-Inclusive Care for the Elderly, or our PACE program. Any service that is documented in an individual education plan or individual family service plan and provided or billed by the local education agency is carved out. Services provided under someone – under a child's IFST by the Children's Developmental Service Agency. Those are carved out and not billed to the PHPs. Dental services are carved out. However, we will still be having the Into the Mouth of Babes program, which is offered by providers and pediatricians in the offices for children. And there's two dental codes that physicians will still be able to bill to provide the service to children. Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined. This is when there's been retroactive eligibility. The month in which the retroactive eligibility occurs is the month beginning of the primary, the primary care provider will be billing to the PHP, but for the retroactive period prior to that month, that will be covered under fee for service. And, finally, the fabrication of eye glasses, complete eye glasses, lenses and the frames are carved out of managed care. The patients still have access to these services, and we want to stress that. And if there's any question, Providers should contact DHHS if their patients need to receive these services and are having difficulty. And now I'd like to introduce Melissa Clayton, Program Manager of Practitioners and Facilities, to cover utilization management.

Melissa Clayton

Thank you, Beth. For the overview of utilization management program, next slide, please.

Under managed care, the benefits and services will largely remain the same across PHPs. They do have the discretion within certain parameters in how they perform utilization management or UM for most

services. They may develop a UM Program for medical, behavioral and pharmacy services. Please note that for long-term services and support needs that must -- they must include specific policies to individuals. Under Medicaid fee-for-service, DHHS has developed clinical coverage policies that outline UM guidelines for covered services. For a subset of services under managed care, PHPs must use existing DHHS fee-for-service clinical coverage policies to make coverage determinations. Please refer to the index for these services.

For remaining services PHPs may develop their own UM protocols or use the department's fee-for-service clinical coverage policies as a basis for their UM Program. If PHPs develop their own UM protocols, they must be based on nationally recognized evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization. Again please refer to the appendix.

Next slide please. For prior authorization and as part of its UM program PHPs must establish and maintain a referral and prior authorization or PA process with the advanced medical home AMH at its center. PA is allowed for all physical, behavioral and pharmacy services except the following: emergency services, family planning services, children screening services, and first mental health or substance dependence assessments completed in a 12-month period. For prior approval on certain drugs, prescribers must be notified of a PHP's decision within 24 hours of processing a PA request. PHPs must allow members access to a drug without PA if a physician certifies that a member previously used an alternative drug not requiring PA and/or the alternative drug was harmful or ineffective. PA reviews must be conducted using current clinical documentation and consider a member's individual clinical condition and health needs.

Please note, Providers will be able to use a standardized prior authorization form with all PHPs. Most PHPs will require electronic submission.

And now we're going to go back to Beth Daniels for more information on utilization management and EPSDT.

Beth Daniels

So if we could go to the next slide that spotlights utilization management and EPSDT. Federal law is very specific for services for children under the age of 21 enrolled in Medicaid. If that service is medically necessary, our early periodic screening diagnostic and treatment services or EPSDT are offered under managed care and they will be in the same amount, duration and scope as the same services under fee-for-service Medicaid. This, the PHPs must determine whether it is medically necessary on a case-by-case basis, using the federal EPSDT criteria and the specific needs of each child. You have to be individually reviewed every case for each child.

The services may not be limited for beneficiaries under 21 when those services are determined medically necessary, according to the criteria for EPSDT. Notice is required to visits, limiting visits to physicians, therapists, dentists or other licensed or enrolled clinicians. Any limits that are placed on these services for other beneficiaries must be let loose for children when it is determined that they need the services beyond any specific limits established. The PHP may not make an adverse benefit determination on a request that they've been requested for a service for a child until that child's individual case is reviewed under EPSDT criteria and once that's been determined, they are responsible for replying to the provider with the reason for denial after the review has been completed under EPSDT. They may not require any prior approval for preventative care, but they may have PA for other

EPSDT services to the beneficiaries under age 21. There will be training offered by each individual plan and by Medicaid for providers on EPSDT annually as an update to what these rules and federal regulations are on.

Next slide please. Under each plan, there will be a UM program policy that the plan has to submit to DHHS for review within 20 days of the contract award and there are written policies and procedures, including their policies for service authorizations, their timeframes for decisionmaking related to service authorizations, and evaluation of consistency, which UM criteria are applied. This is something the state is in the process of doing at this time. What we need providers to understand is that the, each PHP will have a website that includes their UM program policy as approved by the state, the PA request form, and the drug formulary. And each PHP will provide education to providers and prescribers to any change that may be anticipated in their UM program, and this must be done prior to the change taking effect.

At this time I would like to introduce Lavette Young, Associate Director of Appeals, who will be covering the clinical appeals process.

Lavette Young

Thank you, Beth. Good afternoon. So the, all members will have access to a PHP grievance process at the plan level and they also will have access to a State Fair Hearing if they're not satisfied with the plan level appeal. So the the grievance of an appeal starts at the lowest level, in other words, the plan level …

_____

Next slide.

Lavette Young

Next slide. Thank you. And members are being provided with information on the Ombudsman program as needed, and the Ombudsman will be responsible for helping patients navigate through issues with appeals and grievances and other topics. Providers are going to be given information about PHP's grievance and appeals and the State's fair hearing procedures at contracting. Members may request a continuation of benefits during the appeals process,. However, providers can't request continuations of benefits on behalf of their members. And I just want to note as an aside, if a member is a Health Choice recipient, they do not get continuation of benefits.

Next slide, please. Okay, so the overview of the appeals process is that the provider requests on behalf of service authorization from the PHP. The PHP, if the PHP denies the request, they have to send a notice of adverse benefit determination. If the member does not agree with that, they can appeal that decision with the plan and and they can request a standard appeal or an expedited appeal, with the internal plan, but there is no process. If it's approved, then it stops there. If it's denied, the pers --the member can request what's called a mediation, or they can skip over mediation and go straight to you're the state for a hearing. It's up to the member. If the appeal was granted, everything is great., If not, it's upheld and denied by the State Fair Hearings, which is done by the Office of Administrative Hearings here in North Carolina.

Next slide, please. So when there is a decision by a PHP to deny a service or an an author request -- authorization request, the notice has to have certain criteria that is set out by the federal regulations. So there has to be the action and reason for that decision determination, whether it's denial of service or decrease in service or whatever the issue is. The member's rights and the procedures to file an appeal including the PHP level of appeals and the right to request a State Fair Hearing and also the option of having an expedited appeal for resolution. Members have the right to continue their benefits pending the appeals of that resolution. Now members have to give, are supposed to give a written notice of a termination suspension or reduction in services at least for things that have already been previously covered within 10 or at least 10 calendar days before the date that the adverse benefit determination is to take effect. There are some circumstances in which the PHP can give five calendar days, or may provide notice of the date of determination to take effect. And just giving examples there.

Next slide, please. Members will be able to appeal adverse determinations via standard or expedited appeal process and the expedited appeal process, that's when the standards appeal timelines could jeopardize the health of the event member. So for the standard appeal process timing members have 60 calendar days from the date of that adverse benefit determination notice, to file the appeal with the PHP, and the PHP has to acknowledge that request within five calendar days. So the PHP has to provide written notice within 30 calendar days of the receipt of the appeal but can extend that timeline up to 14 days. For example, if they need more information or if the member requests it.

So also note that members have to have had the opportunity to present and give evidence and testimony as well as any supporting documentation to, or records that support their opposition to that adverse benefit determination notice. For the expedited appeal process, members still have that 50 days to file that for expedited appeal, but the PHPs have to acknowledge the request within 24 hours, and then they have to provide written or oral notice of the resolution of that expedited appeal within 72 hours and there's certain circumstances where there's a 14-day extensions for certain circumstances.

Again, a member can request that, and if the request for expedited appeal is denied then that appeal is going should be resolved using the standard appeal timeframe. And note also that all expedited appeals that are submitted by the provider or indicated by theprovider, those are actually going to be processed as an expedited appeal. .Next slide, please.

So if the, during the PHP appeals process, if the PHP upholds that adverse determination benefit, if they do that appeals process, standard has 120 calendar days to submit a request for State Fair Hearing with the Office Administrative Hearing, and they can also the request just like they could do at the client level, mediation with the mediation network of North Carolina, and they can seek assistance from the Ombudsman program in helping them following that request for a State Fair Hearing. Fair hearings occur before administrative law judge, they're the ones who hear these appeals, and they issue a decision within 90 calendar days of the initial fair hearing request.

Next. I would like now to introduce Betty Jones, the Program Manager for Clinical Policy Development and Operations, to cover more opportunities for engagement.

Betty Jones

Thank you, Lavette. DHHS remains committed to ensure that providers receive education and support toward and beyond the transition of Medicaid managed care. We will look now at the Providers' opportunity for further engagement. Next slide, please.

Providers should know that we value their input and feedback and are making every effort to provide opportunities to connect through a multitude of activities. We are in the midst of a series of top-based webinars that offer education to Providers on key topics effectively to serve Medicaid and North Carolina health choice beneficiaries and the transition to managed care and also offer factsheets and FAQ sheets to assist in the understanding on Medicaid changes. The North Carolina Medicaid website serves as a central hub for providers to assess resources about the transition to managed care.

In addition to the Medicaid transformation link that provides -- that is provided on our slide, the main Medicaid webpage address is www.Medicaid.NCDHHS.gov., that's www.Medicaid.NCDHHS.gov, offers a link to additional engagement opportunities from the main Medicaid website then., To go to the main Medicaid website, you will click on Providers, then click on Providers' transition to Medicaid managed care, In addition to the presentations for recorded a received series of webinar training courses, there is information for PHP meet-and-greet currently being held across the state.

The PHP's meet and greets offer providers and practice staff the opportunity to meet PHP representatives and to ask questions by joining, about joining their network. DHHS is also hosting a virtual office hour, which is the opportunity for providers to ask questions regarding transition to Medicaid managed care in real time format. Please review the websites frequently and stay abreast of all new information and opportunities for engagement because we value your feedback, we encourage you to continue to link questions or concerns to Medicaid transformation email address.

Next slide, please. Upcoming events. The next and final webinar in the Medicaid transformation series will be held on Healthy Opportunities in Medicaid Managed Care and will be broadcast on June the 27th. Future webinars that will be held and conducted will be in July and will be announced shortly. In addition there is a link to the PHP meet and greet and the virtual office hours scheduled on the right side of the slide that you are viewing now.

Providers are encouraged to visit the Medicaid website often and look for upcoming events and webinars to advertise the special bulletin and the NC track provider announcement. Thank you for joining us today for the North Carolina Medicaid Managed Care webinar and clinical policy presentation. Now I will hand the baton back to Mandy to open up the floor for questions and answers.

Next slide.

Thank you so much, Betty. I really appreciate it. So, we've been getting some great questions in over the duration of the webinar. And so I want to start here with one from Melissa. And that's

"will I need to use a different prior authorization format for each PHP that my practice contracts with?"

No, it will be the same prior authorization form.

Great. And as a follow up to that, is there … will providers be able to find that standard format in a central location like NC tracks or is it going to sit with each php?

It will be on … with each php.

Great. Thank you. The next question I have is directed to Lavette. And, it's just to get a little bit more granular about the difference between standard and expedited appeals timing and if we could talk for a minute about what kinds of conditions qualify someone for an expedited appeal.

Well, I'm going to start by saying I have a JD and not an MD degree, but those decisions are made based on medical determinations. As a medical decision. Just to give a little more detail of what is on the slide. In the Federal Regs, it defines expedited, what it means, is when the standard resolution can seriously jeopardize the enrollees life, physical or mental health, or the ability to attain, maintain or regain maximum function. So, it's not a question I can really answer on a case by case basis. A case is based on the specific need or situation of that member. But, that's unfortunately, the best that I can answer, based on my knowledge.

Great. Thank you very much. And I'm going to stick on the appeals train here for a minute. We have a couple of questions that came in on it. Would you be able to tell us a little bit more about the difference between a state fair hearing and mediation process?

The mediation process, my understanding [is that it is] more informal. The… and if anybody has more experience with that ….[illegible] but my understanding is that the member can have a mediation with I think currently don't people within the department _____ so they might participate in that and they might come to like an informal resolution that prevents a member from having to go all the way to an administrative hearing. Whereas if it goes all the way to the office administrative hearing for a state fair hearing that's a bit more formal in front of an administrative law judge. So, there's difference in the level of intensity, so to speak. Okay, if I might add, the beneficiary who does come through a mediation process, still can take the case to the state fair hearing level. They are not mandated if they choose to try mediation first. That doesn't prohibit them from gong further.

Thank you, _____. Great. And then the next question that came in that's in the same vein is, do we know how a member appoints a representative to act on their behalf?

Well, there's different types of representatives, for example, there have been hearings where they might be a family member or things like that. If you're talking about something a little more (I hate to say substantial) but help on the effort benefit termination notices, there is information about how they can contact legal aid, to see if they might be able to assist in appealing a decision in a fair hearing. Also, there's contact information for contacting disability rights of North Carolina. So, that information for mediation and how to contact the state hearing office, office of administrative hearings, is included on those adverse benefit determination notices. .

Great. Thanks Lavette The next question that I have is for Beth: We have someone asking if it's true that beneficiaries in managed care can still obtain "carved out services" like vision under fee-for-service Medicaid? Yes, that is correct. .

Okay. Then let's see what else we have here. Perfect. We have one other question about whether providers will be required to track different drug formularies for each php with which they contract.

We already answered that and they will not have to track different drug forumlaries--hey will be the same for each php.

Great. And then if I could direct a couple of questions to Melissa, I believe. We have a couple of questions on utilization management, and we have someone asking for an example of a utilization management aspect that could differ between PHPs with which a provider contracts.

Say your question again?

Sure. Could we get an example of a utilization management practice or a requirement that could differ between phps?

They are required to make the same utilization criteria but their utilization criteria could be less. Yes. Mm-hm.

This is Melissa. So, um, for an example, one php may require PA for a service and another may not. That would be a difference in UM practices.

Right. Okay. Yep, that makes a lot of sense. And I think that we have we can take one more question and I'll say that any questions that we did not get to or we did not answer, we will take back with us and develop a frequently asked questions document that will also be posted on the same provider tab of the Medicaid transformation website that answers any of the other questions that we received today. So, if we didn't get to you don't fret. We'll be sure to answer your question in a timely way.

Um, so I think either from Melissa or Beth, we have one last question about whether or not php's can require prior authorizations for school based health services.

School based health services can be defined – are we talking – it depends, are we talking about services that are being provided by the LEA's which are carved out and will not be under the auspices of a health plan…. There are school based health centers where their clinic is set up in the schools, they will be enrolled with phps to provide services there. Services related to … that are being provided under a beneficiaries IFSP or IEP, if they're being provided by a cbsa, they are not – they are carved out – cbsa services. Now, if providers are providing services for beneficiaries based on the requirements of their IFSP or IEP, but they're not doing it through a cpsa. We'll have to come back and provide additional information to answer that question.

Okay. Thanks. Well, thank you everyone who was able to participate in today's webinar and to our subject matter experts who were so wonderful in gong over this really detailed helpful information. As Betty said, we'll have one last webinar in this portion of the provider series and we'll have more webinars starting up in the Fall. But, we hope to see you on the 27th to talk about healthy opportunities in Medicaid Managed care. Thank you so much.