WEBINAR TRANSCRIPTION: NC'S TRANSITION TO MANAGED CARE: CROSSOVER

Trish Farnham

Hi everyone. I hope everybody's having a good Thursday afternoon. My name is Trish Farnham and along with my colleague Garrick. We are pleased to provide the session today on the transition to managed care and focusing on the cross-over experience that we are all will be going through in a few months. I work as part of Kelly Crosbie's quality and population health team and I'm very honored to be the voice of an effort that represents the work of a lot of people. So thank you so much for taking time out of your day to be on the call today. And we hope we give you information that is both informative and useful. A couple of things to note. One, just to provide some context about this series, we are part of a larger provider education engagement series that is managed by our provider education team. And so we're very happy to be a part of this effort. And we'll be referencing trainings and other opportunities that have already been provided earlier through this series, but may be helpful for questions that we don't cover directly today. So I just wanted to kind of provide that context. Additionally, we know we have a pretty full slide deck today, and so at the end of the session we will be providing an email address for you all to submit the questions directly. We encourage that for a few reasons. One, we're able to give more thoughtful and comprehensive answers. And two, there will be a record of the questions and answers, so that other folks who aren't able to attend today will also benefit from the questions you ask. So we encourage you, instead of using the chat box to submit your questions through those emails, those emails are tracked and will receive responses. So thank you for your help in doing that.

I'm going to go to the next slide. So just as a point, an important note, just to kind of manage the scope and manage expectations for today's session. Our quality and population health program scope is really about ensuring that their systems are designed in a way that facilitates quality and continuity of care for members. And so, it's important to know that as we talk about our transition to Managed Care in February, that our focus will be on those design elements and the architecture that we've put in place in order to facilitate those goals. We know you'll probably have questions that are outside the scope of this session, and but that are still very relevant to the provider community at the crossover timeframe. So, just know that we're going to try to point you in the right direction of additional information. And again, if you submit questions through the email we'll provide at the end, those questions will also be directed and managed.

A couple of other notes about what we're going to cover and not cover today, importantly, as we'll talk about in a few minutes. When we talk about transition of care and the transition into Managed Care, we are going to be talking about that, the design elements that have been put in place for that transition on February 1st. We know that after launch, members will be transitioning between health plans and different service delivery systems on an ongoing

basis. We will not be talking about the architecture related to those transitions, although they will be very similar to what we talk about today. A couple of other things to note. We will not be talking about the tailored plan – I know a lot of folks are very , very interested, rightly so, on the tailored plan design work. Our transitions to tailored plan, which will occur after our Managed Care launch will not be the scope of today's session, as well. The final qualifier is that we are constantly working to refine and improve the system's design that we are establishing and are now implementing. And so, this deck is current as of today and it is accurate as of today – we certainly don't anticipate making corrections, but we may provide refinements or additional information in the future. So I just wanted to be, also acknowledge that this deck certainly represents a point in time resource for you.

OK. I think with all of those qualifiers we are now ready to actually get into the content of today's session. So we'll go to the next slide. Just as a level setting, we know that this is a provider-oriented webinar, and so we know that this is a very informed group, and very familiar with the terms, but just to do a dusting off, we provided some of the acronyms that we will be referencing today here on this slide. So, obviously FFS is going to be fee-for-service; MCL is going to be Managed Care Launch – we may also reference a Managed Care Effective Date. It's the date that the Managed Care program goes live, which as everybody on this call well knows, now is set for February 1st. We'll refer to PHPs, which refer to the prepaid health plans, those five prepaid health plans – Managed Care – companies who are implementing the Managed Care programs that we'll be discussing today. PAs obviously reference prior authorizations – in some context they're also known as service authorizations – the concept is the same. And then UM Vendors – obviously the Utilization Management Vendor – we know that there are a number of UM Vendors in our state that you all are probably working with and we want to make sure that when we say UM Vendor, everybody's clear on what we're talking about.

Next slide. So again, like I mentioned a minute ago, this is a very informed group, so we anticipate that these next few slides are probably old news for most folks. But just to level set the discussion and to make sure everybody is coming from the same, on the same page before we get into the details. We wanted to provide a few contextual slides for why we are here at this point in our systems development.

So, the next slide really is our kind of historical marker – as many of us who have been in the Medicaid program or worked with the Medicaid program in North Carolina for years knows that the effort to develop and expand Managed Care actually predates 2015, and there was lots of legwork prior to the enabling legislation that's referenced here, to establish the Managed Care program. But in 2015, really start, 2015, the enabling legislation referenced here really served as kind of our starting point for the work that we have now worked for nearly four years, or actually over four years to establish and to develop. Just as we have all recognized the legislation direct our work, we are also guided and directed by the goals, the aspirational goals, that are articulated here in bullet points on the slide. So, importantly, the design work we have all advanced hopes to deliver a whole person care system recognizing the importance of coordinated and multi-disciplinary – taking a coordinating and a multi-disciplinary approach to support really vulnerable people. It also works to address a full set of factors that impact health and uniting communities and healthcare systems. And that really is kind of a high level description of what is commonly referred to as social determinants of health. So really making sure that as we examine and as we build what is hopefully a much more effective healthcare delivery system, that we are also

recognizing and validating the non-medical drivers of health related to housing, food and securities, transportation, or even interpersonal violence. We also recognized through both this enabling legislation and through the design, that localized care management is a priority in our state – we certainly learned lessons along the way and really worked to develop a design that honors the importance and the recognition of localized care management. And then finally, a fundamental recognition that the provider network is essential to establishing a quality North Carolina Medicaid program and so working to make sure that the provider network is effectively supported both through this transition, but also in the ongoing operational design.

Next slide. So all of that to the end has resulted in a Medicaid Transformation Vision articulated and fully endorsed by our Secretary, Mandy Cohen, and it's to improve the health of North Carolinians through an innovative whole person-centered and well-coordinated system which addresses both medical and non-medical drivers of health.

Go to the Next slide. We know that even those of us who have been in this system a long time are probably still acclimating to the various new terms and concepts that are now being integrated into our day-to-day professional lexicon and we want to make sure that before we dive into the technical details that we're all clear on the terms that may have been introduced to all of us through this design work. So importantly, you all may have heard of a rebrand called Medicaid Direct, and when the term Medicaid Direct is used, it is simply a reference to our existing service delivery system as it exists prior to launch. And those service delivery systems that will remain related to the fee-for-service program or the LME/MCO network that will exist and continue to run after the launch of Managed Care. When we say North Carolina Medicaid Managed Care, it's important to recognize that we have actually had managed care in our state prior to the contracting of these five health plans. But when we say it, we typically are talking about those five health plans, and like I mentioned earlier, we also reference those health plans as prepaid health plans, or PHPs, sometimes in conversations related to the tailored plan, it's referenced as the standard plan or the standard plan option. All of those are referring to the five contracted entities which we will reference here in a minute. Finally, when we talk about the launch date, which is now February 1st, we also reference that as Managed Care Launch, or the Managed Care effective date, or the standard plan effective date. And finally, as I mentioned earlier, the tailored plan concept is a relatively new concept in our state, and it is really intended to be a holistic health plan available for folks who experience significant mental illness, developmental disability, traumatic brain injury, or substance use disorder. The tailored plan option is not live yet – in fact, it's still in its development stage. It is not the focus of today's session, but we want to make sure you know what we're taking about if it's referenced.

Next slide. So, again, this slide is probably really old news at this point, but just to reiterate, we have contracted, as of last February, with five prepaid health plans. Four of them are going to be working statewide in the now six regions that our state is divided into for purposes of Managed Care. And one will have a regional contract focusing on regions three and five.

Next slide. Again this slide is probably well-circulated at this point, but just to reiterate, again we are now divided as for the purposes of Medicaid Managed Care into six regions, which are listed here. They are obviously delineated by

counties. And as we have talked about, referenced before, and we will reference again, all six are now slated to launch on February 1st.

Next slide. So as I keep alluding to and again, probably old news to this very informed group, but just as a, just to restate – earlier this month, the department released a statement and made a strategic decision to extend the current open enrollment process that was slated for what was known as phase one – we may all remember that originally the regions were going to launch in phases, with phase one launching in November, and the remaining regions launching in February. Earlier in September, the department made the determination for a variety of reasons to extend open enrollment that is currently underway for phase one counties, and launch all regions at the same time on February 1, 2020. Again, probably old news to this group, but just wanted to confirm.

Next slide. So you've probably seen some version of this slide before – this is a timeline that was really intended to outline the enrollment process, the open enrollment process, and how members would be engaged through the open enrollment process. This slide now – used to represent the phase two timeline – it now is intended to reflect the timeline for both, for both phases – again those phases have now been merged for a launch of, a joint launch on February 1st. So as you can see, I'll just highlight a few things here on this slide. Open enrollment will continue through December 13th for all members, with auto assignment resulting on December 16th. And then on February 1st, the health plan coverage starts in all regions.

Next slide. So we are now getting ready to segue really into kind of the meat and potatoes of our, of our presentation today, which is really to talk about some of the crossover dynamics at play, and some of the architecture that we're establishing in order to ensure member continuity of care at crossover. This slide is really representing a lot of the detail we'll talk about today, and does, it has been updated to reflect the revised launch date. So just wanted to reference it – again, we will be going through each of this detail through the rest of this presentation.

Next slide. So aligned with our overarching vision for the Medicaid Managed Care program, we actually, within our transition of care work, have a driving vision that we consider our North Star for all of the design work that we're going to be discussing today. And it's that as beneficiaries move between service delivery systems, the department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition. We hope that as you see the details that we've outlined today, and that we will continue to update and provide additional information on, that you all feel that this vision is being honored in our design work.

Next slide. Again, we've already referenced the crossover terminology, but just to reiterate – when we talk about transition of care, we're talking about transitions of members between service delivery systems. And so, in order to delineate the work that we're doing to support everyone to transition in February, on February 1st, and to delineate that activity from the transitions that will happen on a much beneficiary specific basis after launch, we have kind of describe, we describe the two different components of transition of care here. So when we talk about the mass launch in February, we refer to that time period, that launch and the time period around it as crossover. So when we talk about crossover, which is our priority today, we are talking about how we are preparing the various aspects of our program for that transition in February. When members transition between health plans after launch, as

they will certainly have the prerogative to do, or when they disenroll from Managed Care back to the fee-for-service, as many of them will, we refer to those dynamics as ongoing transition of care. Importantly, those of us who have thinks, have thought about transitions for years, may also think of transitions as members transitioning from one type of facility to a different type of facility, or one type of facility to a home-based setting, it's important to know that we are not talking about those types of care transitions in this context. So, in case there's any confusion, we just want to clarify that up front.

Next slide. So we're getting ready to start really talking about some of the design pieces that we have established over the course of a year, in order to prepare members and, accordingly, providers for this transition. As we have worked to develop the architecture, we have worked to address, identify goals in our design work. These elements here, this policy direction really had served as kind of our goalpost, or guidepost, excuse me, as we developed this particular system and architecture. So they are referenced here and we're going to talk about how we've worked to address these throughout the rest of this presentation. In addressing those goals, we have identified some key elements for design work. So first of all, we have worked to develop design that supports continuity of care through effective date of transfer. As you all can appreciate, we devote the health plans and the very support systems related to supporting members to transition, are dependent on robust data from various sources to assist them in identifying members and effectively supporting members – in effect, providing effective follow up to members. And so, Garrick and our other members of our tech team have worked really to establish and to develop the architecture needed to accomplish this particular design aspect. We also recognize that it is critical to facilitate uninterrupted service coverage – so again, a lot of our design work is intended to create streamlined processes for maintaining continuity of care, maintain service continuity, and again, we hope you will see that reflected in the architecture. We also recognize that various Medicaid populations are going to be experiencing this transition in February. Many folks who will be transitioning are simply using Medicaid as their insurance, getting health care either for themselves or for their child, and really that Medicaid is an insurance that they think about occasionally, much like many of us do. However, we also recognize that there is a sub-population of members who really Medicaid is a lifeline for them, to receive the kinds of services they need, not just related to their health care but to their long-term care. And so we've worked really hard to identify those members and establish additional safeguards for them through this transition. We know that the last two lines on this slide are foundational, to making sure that all of the other things work as intended. And so we are working with our education partners – both our provider education partners here, and our member education partners – to make sure that members are clear on the crossover dynamic that is going to be happening, and also that providers have the in tools they need in order to support both their own business, but also members through the process. And then finally, we are working to establish clear lines of communication at every opportunity between all of the entities involved in the transition.

So we're getting ready to go into the weeds of some of the design elements and for the rest of the presentation, we've tried to give you an overview of what is being established, or has been established, and then put out this particular high level notations about how providers may be impacted or engaged in a particular design aspect. So just to give you a sense of how the rest of the format of this presentation will go.

As I mentioned earlier, the date of transfer to our partner health plan partners is critical in ensuring they have the information they need to support members effectively, to identify members and support them effectively. We have bucketed sev-, we have bucketed the date of transfer into three identified buckets here. This list is actually not complete, but it's important to, that this is our starting place list. So importantly, we are working very hard to establish and finalize the architecture necessary to provide 24 months of claims and encounter history to PHPs for their enrolled membership. Second, we are, secondly we are working with our vendors to establish processes to transfer open and recently closed prior authorizations to the appropriate health plan for their enroll members. And finally, where possible and viable, we are also building design elements that allow for the, for transition of care plans, by identified Medicaid Direct vendors, to the health plans for identified members.

Related to the provider impact of these data transfer efforts. Importantly, claims and encounter to date of transfer, we do not anticipate that there to be a provider impact of any kind. That design architecture is largely being managed by our NCTracks vendor, and the state and other vendors related to the claims, the claims details. So we do not anticipate this to have any impact on our provider network.

Related to openly, open, excuse me, open and recently closed prior authorizations, we do, again anticipate that to date of transfer to be minimal. Importantly, health plans may seek clarification on a detail related to a prior authorization, but our intention is to provide the information sufficient to review and to honor open prior authorizations at crossover.

And finally, for identified care plans, importantly, we are working really hard with those vendors who house care plans on a statewide level, to assist and facilitate in the transition of those care plans, or the transfer of those care plans. We know that we will not be transferring provider specific service plans in any sort of global way, so it's possible that the PHP may reach out to the provider network, or member's provider network, to access additional information on a member specific service plan or member specific detail.

So we know that this provider network on the call today is very, very interested in the prior authorization design work that is under way to really support providers and, as a result, members through the process and to achieve our goal of member continuity of care. Again, this may be clearly known at this point among this particular group of webinar attendees, but just to reiterate, the NCTrack vendor, GDIP and other UM Vendors will continue to process prior authorizations requests through January 31, 2020, as usual. So if you have a prior authorization that is, that requires to be submitted and that you are submitting it before January 31st or before, excuse me, February 1st, you should submit it through the proper channels that you do, use currently use now.

Openly and recently closed prior authorizations, like I mentioned, will be transferred to the member's PHP to help ensure continuity of care, so upon the UM Vendor receiving and reviewing those prior authorizations, the resulting prior authorization will be transferred to the health, the appropriate health plan.

Health plans are required to honor open prior authorizations up to 90 days after launch. So again, if there is an open prior authorization it goes over the fence to the appropriate PHP that has unused units and unused time spans on it, those, that time span is required to be honored for no less than 90 days.

It is a contractual requirement of the health plans to honor open units for the first 90 days after launch. Importantly, if the health plan ends a PA after 90 days, it must provide appeal rights.

So this next slide is probably the most involved slide that we'll go through today, so I'm going to go through it slowly, and I'm also going to invite my technical advisor, Garrick, to join at any point if he wants to add or clarify anything. But this slide attempts to reflect the various scenarios that providers might experience in submitting a prior authorization around the crossover, around the launch date of February 1st. So we're trying to reflect the different scenarios on a page. You all may identify a question, or have questions that help us clarify future slides, but we wanted to make sure you had a starting place with the scenarios identified here.

So just to orient you to how this slide is set up – if you look on the left side of the slide, under the red header Members covered by fee-for-service or Medicaid Direct. These are the dynamics that are at play prior to launch, and so this is obviously where you would start in reviewing this slide deck, or this, excuse me, this particular slide. The yellow line down the middle represents the launch date, so you could put a February 1st on that yellow line. And that's the point where the program crosses over into a managed care program. And then on the right side, you have under the green header, the member is now covered by the health plan. So just as a very basic overview of how the slide works before we get into the scenarios.

One final qualifier on this particular slide is it's important to know that we are doing LME/MCO providers specific trainings with our LME/MCO partners, and so this slide is not intended to reflect every prior authorization dynamic – in fact, we are again, like I said, doing tailored LME/MCO trainings for their provider networks that provide specifics on the LME/MCO prior authorization detail. So if for whatever reason, you are contracted with an LME/MCO, we encourage you to attend one of the upcoming sessions that your LME/MCO will be holding.

But in general, we are identifying two scenarios on this slide. So scenario A is the most applicable and the most straightforward. So in scenario A, a provider submits a prior authorization request prior to the Managed Care effective date, which is again February 1st, for a member transitioning to the health plan. The UM Vendor authorizes services as clinically indicated. They're following the exact same review standards – they will be reviewing all PAs. The authorization will be transferred to health plans as part of the incremental PA file transfer.

Once that launch date occurs on February 1st, we now move to the right side of the slide. And under scenario A, the health plan honors the open fee-for-service prior authorization for the first 90 days. If the authorization extends beyond 90 days, and the PHP terminates or reduces, it must appeal rights. This is a reiteration of what we said on the earlier slide, but this is how this would play out.

Scenario B is when providers submit a retroactive PA request for dates of service prior to the Managed Care effective date for a member formerly enrolled in Medicaid Direct, and is now enrolled in the health plan. So retroactively, the member is covered now by a health plan, but the prior authorization covers dates of service prior to the launch date.

In those cases, the vendor may only authorized for dates of service prior to the Managed Care effective date. If a provider needs to provide, to seek an authorization covering dates of service for the member who is now covered by the health plan, the provider may submit a separate PA request directly to the health plan. It's an important note here at the bottom for scenario B, that this is the general direction we are working with our UM Vendors and their technical, their technical operational team to ensure that this, in spirit, can be aligned with their practices at crossover; however, it's also important to know that each UM Vendor has some specific dynamics related to their system that might tweak how this looks in their particular context. And we encourage folks, as we get closer to the launch date, to review those UM Vendors websites for additional information on this particular dynamic.

Next slide.

So we recognize that in order to ensure member continuity of care it is critical that prior authorizations are clear and continue without disruption. We feel like the most important thing to ensure is that as PAs are submitted prior to launch, those are transferred over to the health plan, which is what we've articulated on the last few slides. But we know that there are other safeguards that are needed to ensure that people and providers don't erroneously submit a prior authorization to the wrong entity. And we know that obviously working currently in a fee-for-service context that vendors or providers are accustomed to submitting prior authorization to our existing Medicaid direct vendors. So importantly, we are also setting up safeguards to minimize incorrect submission to prior authorization so as not to disrupt or delay really important authorization for member care. We've established what we call a few stoplights or speedbumps to make sure that providers don't submit to the wrong entity. And first is intensive provider education. It's what we're doing now, it's what we're doing through various sessions, it's what we're trying to do in writing. It's what we will be doing on our website. But it's important to know that education is obviously going to be the key preventer of misdirected prior authorization requests. We also have been working with all of our vendors to establish what we're calling an auto-information message that the content will be largely aligned across UM vendors. It's important to know that in some context it will be a banner message, in another context it will be a pop-up message. But the intent is the same. That if the provider attempts to submit something to the wrong place, they get a note that indicates that they're doing so and that it won't be able to be [thus?] processed. And finally we are also setting up requirements with our UM vendor call center teams to be able to answer questions as providers have them related to their prior authorization.

This slide just simply reflects an example of one of the error messages that a provider may receive if the provider incorrectly submits a prior authorization request that should now be directed to the members' health plan. This one, I believe, comes from NCTracks. They will look a little different, depending on the UM vendor. But again, information will be [uploaded?] _____ aligned across UM vendors and its intended to direct providers to the appropriate resource for resubmission.

Importantly, and we'll mention this a couple of times, we are working very hard as quickly as we can if we can to establish the various communication and education _____ support staff _____ the providers network fully deserves through this process. And we are working with our health plan partners and working with our web managed here [at department ?] to establish a one-stop resource for providers who may, for whatever reason, not

be fully informed on the PHP specific PA submission process. So just be aware that more information will come on this. And again, many of you probably have this information through your provider orientation materials that you may have received from the health plan. But we are going to try to reinforce that information on a department-specific website.

So a couple of key takeaways for how prior authorizations will need to be managed at the crossover – during the crossover timeframe. Again, right at that launch date of February 1st. Importantly, it's going to be very important to know and be clear on when the PA is submitted, and on the dates covered. Again, that more involved slide with the two scenarios really kind of speaks to the different dynamics that are at play for this particular piece. So it's going to be really important to be mindful of those details as providers work to either submit prior authorization or insurers make sure that authorizations, existing authorizations are honored.

After February 1, 2020 it's going to be very important to be clear on if a member has transitioned to a health plan or the standard plan. As I mentioned, as I alluded to earlier in this presentation, there are a number of factors at play here during our transition to Medicaid Managed Care, including large swathes of the population being carved out. So it's important to know that many member may not transition to Managed Care. I gave a particular highlight here to be those who are duly eligible but there is an entire list of types of members who will not transition to Managed Care. A list to reference ___ and all this has been tweaked on the edges since this presentation, is on the provider education series, which we'll talk about here in a second. On the presentation 101 there's a list provided of those carved out and exempted members.

The next step on this will be to ensure that a member's, to identify a member's Managed Care status and specific health plan information. Again, the open enrollment period is going to be ending in December, on December 13th, and auto-assignment will occur on December 16th. After auto-assignment those members who will be transitioning to a health plan will have their health plan's entity status reflected in the NCTracks, NCTracks provider portal. So it's going to be important to be mindful of that information.

Instead of trying to duplicate effort, we have referenced here a current provider job aid that is not available through the provider portal that NCTracks has developed in order to orient providers ____ to access this particular information and where to look for it. So we've provided the name of the job aid here, and we encourage you to go to the provider portal and access it.

If for whatever reason you have questions or issues accessing it, please submit that question through the email that we'll provide at the end of the session just so that we can troubleshoot with or NCTracks partners, because we know how important this is.

And finally, in the prior authorization exercise at launch, it's going to be important to submit the service authorization or the PA request to the PHP on or after – after 2/1/2020. So if a prior authorization is covering dates of service that are on or after February 1st, it's going to be really important that those prior authorizations are submitted directly to the health plans. And again like I mentioned earlier, our – we are working hard with our webinar – excuse me, our website design team, to provide the information needed for accessing the health plans PA submission request process in one place.

We wanted to do a couple of high level notes about how appeals will be managed at crossover. This is again from very much member-specific perspective. Again, our goal here is to do what we can to ensure continuity of care. But we know that given that members are going to be transitioning from various types of fee-for-service delivery systems, both fee-for-service and in some, in some cases from LME/MCO Managed Services into Health Plan Managed Services. We wanted to provide kind of a collection of our high level appeals dynamics here.

So importantly, any PHP termination of an open PA after 90 days post the MC Managed Care effective date – which is again February 1st – triggers appeal rights. We've said that a couple of times, at this point, we just want to reiterate it here. Generally, an adverse determination process and appeal rights will be processed as usual. So it's important to know that if an appeal is initiated prior to launch, the correct paperwork and letters and notifications will still be submitted to the member.

Members appealing initial service denials prior to the launch date, will be instructed on the option for submitting a new request to the health plan. PHPs will be required to honor continuation of benefits or maintenance of service on covered benefits that are at play prior to launch until the can reassess and either approve ongoing services or issue appeal rights. Importantly through all of this, EPSDT requirements still apply. So this is going to be a slide, we can tell you now, where we anticipate providing additional detail and clarification, but we wanted to make sure everybody had a high level sense of how appeals will be managed during the crossover time frame.

So we know that provider claims and payments is outside of our immediate scope of within quality and population health – we know that a lot of our team members within the department and within the division of health benefits are far more capable of providing insight on this process than we are. But we also know that this is an important thing that you all want to know, and there are transition of care and crossover implications to the payment design. We just wanted to highlight them here. Claims for dates of service prior the member's Managed Care effective date should continue to be submitted to NCTracks or to the applicable entity. Claims for dates of service after the member's Managed Care effective date should be submitted to the member's health plan following the applicable PHP protocol, as provided in in provider enrollment materials. Importantly, number c or letter c is intended to be somewhat of an exceptional situation but we wanted to identify some of the crossover related safeguards that's been established related to provider payment. PHPs have been very, very consistent in telling us that their goal is to build the most robust provider network possible, and really, and proactively looking and seeking to contract with the Medicaid provider community as it exists now. So that is their overarching intent. However, it's important to know that an additional crossover related safeguard has been established, where PHPs are contractually required to treat claims from nonparticipating providers with dates of service on or after the Managed Care effective date in a way that is equal to that of enrolled providers until the completion of the episode of care, or 60 days, whichever is less. So it's important to know that nonparticipating providers will not be held to a different standard than participating providers in submitting claims for the first 60 days. There's a note that's an asterisk here – we're not going to get into the details of this – but it's an important note, that the general rule is to honor nonparticipating provider claims for the first 60 days. But there is a general statute that is referenced here related to ensuring continuity of care for members in ongoing courses of treatment. And so we want to note that that would also apply, and so 60 days

may be the minimum and, in fact, in some circumstances, that timespan may be longer.

We're now going to segue to a different part of our presentation today and really starting to talk about some of the expectations that have been established for the plan, and some of the architecture that we've established with all of our partners, to really safeguard some of those high-need members.

There we go – sorry for the technical glitch. So we're now transitioning away from prior authorizations and into more of the member-specific safeguards that are going to be established, or that have been established, and try to highlight those areas where providers may be very engaged or have a role to play in support.

So again, we know that one of the most overarching safeguards for all transitioning members, again, are the things we've already talked about: the data file transfer; and some of the prior authorization request detail that we've discussed earlier. But like I mentioned at the top of the presentation, we know that there are members who really are identified as higher need and frankly, need a higher touch during this transition to ensure member continuity of care, and to ensure, frankly, that they, everything is OK during this transition phase. So this is not, these higher need protocols are not going to apply to all transitioning members. As a reminder, most folks who are going to be transitioning are moms and kids. But we do know that there are a subset of the Medicaid transitioning population that do need and deserve a higher engagement level.

So we're going to talk a little bit about what we are calling follow-up to high-need members. And then we also want to, at a very high level, let folks know – it's called that for a very select group of people. Our fee-for-service, our Medicaid Direct vendors are identifying those individuals who may require a warm handoff, which is literally a clinically oriented conversation between entities about a member services or a member dynamic to ensure that the health plans have a full understanding of the member's circumstance and appreciate any particular complexities related to that member's dynamic.

Next slide. So this slide intends to reflect and summarize some of the activities that are required as part of supporting members who have, that have been identified as high-need members. So again, on the left side of the screen, you can note that there are a number of categories of high-need members that have been identified through our policy design work. We have worked very closely both with our internal state subject matter experts, and stakeholders to help develop and define this list, and then refine it. There is some latitude, both for the health plans and for some of our vendors to do some member-specific identification. So it's important to know this list is a little fungible for a reason, so that we can make sure to make it as inclusive as it needs to be. But broadly, high-need members are going to be including the highest need subset of members receiving in-home, long-term supports and services. So we've been working closely with our LTSS clinical policy team to identify what these subsets should be, and then working with the health plans to articulate this particular expectation. Similarly, there will be a high-need subset of members receiving behavioral health services that will be transitioning and we have also identified these as high-need members. Importantly, standard plan exempt members who elect to enroll in a PHP will also be considered high-need, so there is expected to be at least a reasonable size of the tailored-plan eligible population that actually elects to

enroll in a health plan, even though they are not required to by legislation. So we also have identified these members who are identified as tailored-plan eligible, but elect to enroll in a health plan as being high-need. And again, like I mentioned, our identified Medicaid Direct vendors have latitude in identifying other members that may not meet any of these specific criteria, but again require a bit more high-level, more personalized engagement.

And then the last two, we want to highlight here, is that we are working very closely with our NEMT colleagues to identify those members through the DSS of NEMT users who may also meet the criteria for high-need follow-up. So working with our DSS partners and our NEMT partners within the state program, to both develop systems for identifying those members and then informing the health plans on who those members are. And finally, the state team has identified members with Inborn Errors of Metabolism as being a particularly vulnerable subset of our transitioning population, and so those will also, those members will also be tracked very closely at crossover.

What does follow up actually mean? It is the PHPs are required to provide contact to members, either in person or the phone, or by phone. I have to say as an aside, we have been going through a very rigorous process, readiness review process with the health plans, and have been running through scenarios that are very specific to how this will look, and we have appreciated the level of thought and the level of intention that the plans have been put into their efforts to engage high-need members at crossover. And then essentially the follow up will be to really make sure that everything is OK. So importantly, we will be looking to make sure services have remained in place. If there are confusions in process, making sure that authorized services have continued as intended. Importantly, an important provider note, providers may be invited to participate in follow up sessions; in fact, we hope that you will be interested in doing so as it is applicable. Again, we anticipate that most of the providers engaged in this process will likely be LTSS and behavioral health providers, but we know that other providers may also be invited to participate.

Next slide. We wanted, we want to recognize, again knowing that education is a critical component of all of the work that we're doing, and to recognize that, we want to have as many opportunities and ways as possible to help members through the transition, and to prepare them for the transition. We have developed, and continue to develop, a number of materials to support those, the member process. We wanted to highlight one bit of member education that may be helpful for members who are potentially confused about their enrollment dynamics. The department and our enrollment broker vendor have done a really great job of providing educational materials, but we also wanted to highlight this one, which has been specifically developed for our aging and disability population, because there are so many service enrollment dynamics specific to their service experience. And so, we just wanted you to be aware that this also exists, and that you may find it useful.

Next slide. We are also working with our health plans and our NEMT subject matter teams to ensure that health plans are – or that members are aware of a policy design that is intended to ensure member continuity of care related to NEMT use. We know that transportation, non-emergency medical transportation is a critical component to ensuring members continue to receive the care that they need and continue to make the appointments that are scheduled. Importantly, the NEMT process and NEMT appointment scheduling for post-launch visits – those visits scheduled for on or after February 1st. Members will have the capacity to call the health plans directly and start those schedules, or start scheduling those appointments 31 days

prior to the launch date. So as we've allowed in the scenario here, if a member has an appointment scheduled for February 1st, she can start reserving her, she can start reserving NEMT for that appointment on January 2020. It's also important to note that we understand that many members may not actively and proactively use this option, so again, we are working with our NEMT teams and our health plans, to ensure that they have as much context and information about standing appointments that are already on the books, and those appointments can be uploaded into their own NEMT architecture to ensure continuity of care. But this is, again, an additional safeguard.

We know that a lot of information related to transition of care, and maybe this option in particular, will come from providers. We know that members look to providers for information, and they have questions about this. We appreciate any help that you all, any help you all provide in helping members this understand this option will be available. And it's also important to know that this information will be communicated in multiple ways, including inserts in the member packet, that will be released to the members after plan selection.

We're closing out on our slide deck and, but we really wanted to reiterate that through the transition and the crossover timeframe, our priority is member continuity of care. And again, we also often know that member education is a clear instrument for supporting continuity of care. So we are working with our health plans and our other partners to make sure that members are clear on these particular design elements, or these particular service dynamics. So we want to make, our goal is to make sure that members understand who their health plan is – we know that a lot of folks will be auto-signed. We also want to make sure that members understand who their primary care provider is. We want to make sure they're clear on when they will start getting care through their health plans. We want to make sure they're clear on who to call if they need to schedule an appointment, like we've talked about, or arrive for an appointment. We want to make sure they're clear on the number to call if they have issues getting care. So if somebody doesn't show up, or if somebody says, hey we don't serve, we don't work under this plan – we want to make super clear that they know what to do, and they feel like they have a simple, clear direction on what the next step is. And similarly, the last one here is making sure there's a number to call if I have questions about supplies. So again, we are working with our health plan partners to clarify and confirm exactly what the answers to these questions are, and then we are working with our member education team, and with our provider at our, excuse me, our health plan network to make sure members are very clear on these particular service dimensions.

So like I said, we are getting ready to close out our deck, but we wanted to spend a few minutes talking about additional resources that are either already available that may be helpful, or that are on their way. So, importantly, like I mentioned at the very top of the presentation, this particular presentation is part of a larger provider education and engagement series that is facilitated by our provider education team. And so, we wanted to acknowledge that there are likely topics that we did not cover today, that you're very interested in, and we wanted to point you in a direction that, in case you did not know about these resources, they do, in fact, exist, and we've provided hyperlinks to them here. They are all available on our, the provider playbook website, which we were actually going to show you next, but we just wanted to some specific information about what is available that may be helpful.

So this, one of our other intended design aspects is to work on the provider education page that exists now within the division of health benefits Medicaid

transformation web platform, to ensure that there are crossover specific, there is crossover specific information available to providers in one place. The link that is provided here if you are not already familiar with it, is probably a good one to bookmark, because not only will it include [sound cuts out for a few seconds] materials like the ones we referenced on the last slide.

Next slide. So importantly, if you need information – so we know that on this, in this deck, there was a lot of information presented and we know that you all will likely have follow-up questions that need either, that, where you require additional information or additional clarification. Like I mentioned at the top of the presentation, we are strongly encouraging you to submit those questions through the Medicaid SWAT email that is listed here – those questions are catalogued, tracked, and will be directed either to me or to the appropriate group, and we want to again benefit from the questions you all ask so that we can make sure that we provide clear and cogent answers, and also that other people who do not today can benefit from your questions. So thank you so much for using that direction instead of the comment box today to submit your questions.

Importantly, you all probably know this very well at this point, but if you have members who are confused about the process or what to do, we strongly encourage folks to call or have the member call the North Carolina Medicaid enrollment broker, and we've provided the toll free number and the website here. So we please, we hope that this number has been already well distributed and is well known, but in case it's not, it's provided here. Like I mentioned earlier, if you're interested in prior trainings, like the one we talked about today, or like the ones we talked about today, the link again is reiterated here. And finally, we are doing an episodic series on crossover activity through the Medicaid provider bulletin. So if you are interested in going back and seeing the provider bulletins that has been communicated related to crossover, you can go to that link and start, starting with the August, the August provider bulletin, you'll find crossover related announcements. The detail contained in those bulletins is anticipated to get more and more involved, so we look forward to having you use that as a future resource.

We are now at the top of the hour. I want to thank my colleagues, both who attended today's session, and also who helped contribute to the design within this deck, for their time and their attention and their effort in developing this. And to thank the provider network, not only for helping inform the design work that we talked about today, but more fundamentally, for supporting the Medicaid membership through this transition to managed care. We appreciate your engagement, we appreciate your partnership, and we wish you a very good afternoon.

I think we're finished. Thank you so much.