

North Carolina Medicaid Transformation: *Clinical Policies*

June 13, 2019

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Medicaid Transformation Vision

“ To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health. ”

Context for Medicaid Transformation

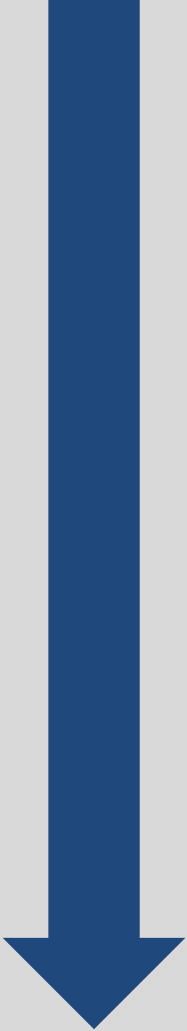
In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service (FFS) to managed care.

Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:

Focus for today's webinar


- Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden

Medicaid Transformation Timeline



Timeline	Milestone
October 2018	1115 waiver approved
February 2019	Standard Plan contracts awarded
June - July 2019	Enrollment Broker (EB) sends Phase 1 enrollment packages; open enrollment begins
Summer 2019	Standard Plans contract with providers and meet network adequacy
November 2019	Managed care Standard Plans launch in selected regions; Phase 2 open enrollment
February 2020	Managed care Standard Plans launch in remaining regions
Tentatively July 2021	Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans Launch

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***Benefit Package
under Managed Care***

Overview of Medical & Behavioral Health Benefits

PHPs must adhere to federal and state regulations in providing benefits under managed care

PHPs must:

- Cover all services in the NC Medicaid and NC Health Choice State Plans that are not carved out or otherwise offered only by Tailored Plans
- Use North Carolina's medical necessity definition to make coverage determinations
- Provide covered benefits in at least the same amount, duration and scope as provided under Medicaid FFS
- Ensure that services are sufficient in amount, duration and scope to achieve their purpose and not denied/reduced because of a member's diagnosis/condition
- Implement and adhere to EPSDT statutory and regulatory requirements
- Develop a comprehensive Utilization Management program

Covered Services under Managed Care

Patients will have access to the same services and benefits that they had under fee-for-service Medicaid

Summary of Covered Services

- Inpatient and outpatient hospital services
- Emergency room services
- Physician services
- Federally Qualified Health Center, Rural Health Clinic, Local Health Departments and other clinics
- Family Planning services
- Podiatry and chiropractic services
- Therapies (e.g., speech, occupational)
- Behavioral health services, including outpatient
- Long term services and supports
- Durable Medical Equipment
- Lab/X-Ray
- Optical
- Transportation, including non emergency transportation
- Prescription drugs

Telemedicine

- Telemedicine may be used to facilitate access to needed services that are not otherwise available within a PHP's network*
- PHPs are encouraged to develop innovative uses of telemedicine and are not restricted to use of telemedicine based on the State's FFS coverage policy**

*PHPs must establish a provider network that is sufficient to ensure that all covered services are available and accessible to all Members in a timely manner.

**Current FFS coverage policy is available [here](#); under the policy, telemedicine is covered only if certain criteria are met, including use of encrypted two-way real-time interactive audio and video telecommunications system for a consultation.

Deep Dive: Pharmacy Benefits

PHPs must:

- Cover all covered outpatient drugs for which the manufacturer has a CMS rebate agreement and for which DHHS provides coverage;
- Adhere to DHHS' defined preferred drug list (PDL); and
- Provide pharmacy benefits in at least the same amount, duration, and scope as provided under Medicaid FFS

PHP drug formulary must include:

- All drugs on NC's Medicaid and Health Choice PDL;
- All other covered drugs in drug classes not listed on the PDL; and
- Outpatient drugs not excluded by state or federal policy.

Similar to today, providers will only need to track one preferred drug list, which PHPs will be required to adhere to; providers will not have to track different formularies for each PHP.

Services Carved Out of Managed Care

Six service types are carved out of managed care and provided through Medicaid FFS:

1. Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
2. Services documented in an individualized service plan (e.g., Individualized Education Program (IEP), Individual Family Service Plan (IFSP) and provided or billed by Local Education Agencies (LEAs)
3. Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's IFSP
4. Dental services (with the exception of two CDT codes associated with the “Into the Mouths of Babes” (IMB)/Physician Fluoride Varnish Program)
5. Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved
6. Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

Patients still have access to these services. Providers should contact DHHS if their patients need to receive these services.

Utilization Management

Overview of Utilization Management Program

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

- PHPs must develop a utilization management (UM) program for medical, behavioral health, and pharmacy services
- Under Medicaid FFS, DHHS has developed clinical coverage policies that outline UM guidelines for each covered service
- For a subset of services under managed care, PHPs must use existing DHHS FFS clinical coverage policies to make coverage determinations (see Appendix)
- For remaining services, PHPs may develop their own UM protocols or use the Department's FFS clinical coverage policies as the basis for the 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 (see Appendix)

Must include specific policies to individuals with long term services and support needs

Prior Authorization

- As part of its UM Program, PHPs must establish and maintain a referral and prior authorization (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's screening services; and
 - First mental health or substance dependence assessment completed in a 12 month period
- For PA 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

Providers will be able to use a **standardized prior authorization format** with all PHPs. Most PHPs will require electronic submissions.

Spotlight: Utilization Management & EPSDT

Federal law requires states to cover all services for children under age 21 enrolled in Medicaid if that service is medically necessary

- Early & Periodic Screening Diagnostic & Treatment (EPSDT) services offered under managed care will be in the same amount, duration and scope as the same services under FFS
- PHPs must determine whether a service is medically necessary on a case by case basis, accounting for federal EPSDT criteria and the needs of the child
- Services may not be limited for children under 21 when those services are determined medically necessary according to federal EPSDT criteria; this applies to visits to physicians, therapists, dentists or other licensed, enrolled clinicians
- PHPs may not make an adverse benefit determination on a service authorization request for a child until the request is reviewed per federal EPSDT criteria
- There may not be any PA for preventive care for children under age 21 but PHPs may have PA requirements for other EPSDT services

Providers will receive training on EPSDT annually

Oversight of UM Program Policy

Overview

- UM program policy must be submitted to DHHS for review within 90 days of contract award and contain written policies and procedures topics including:
 - Service authorizations
 - Timeframes for decision-making relation to service authorizations
 - Evaluation of consistency with which UM criteria are applied

Key Takeaways for Providers

- Providers will have access to a PHP-developed website that includes the UM program policy, PA request form and drug formulary
- Providers and prescribers will receive training and education from PHPs ahead of any changes to UM program prior taking effect

Clinical Appeals

Overview of Member Grievances and Clinical Appeals

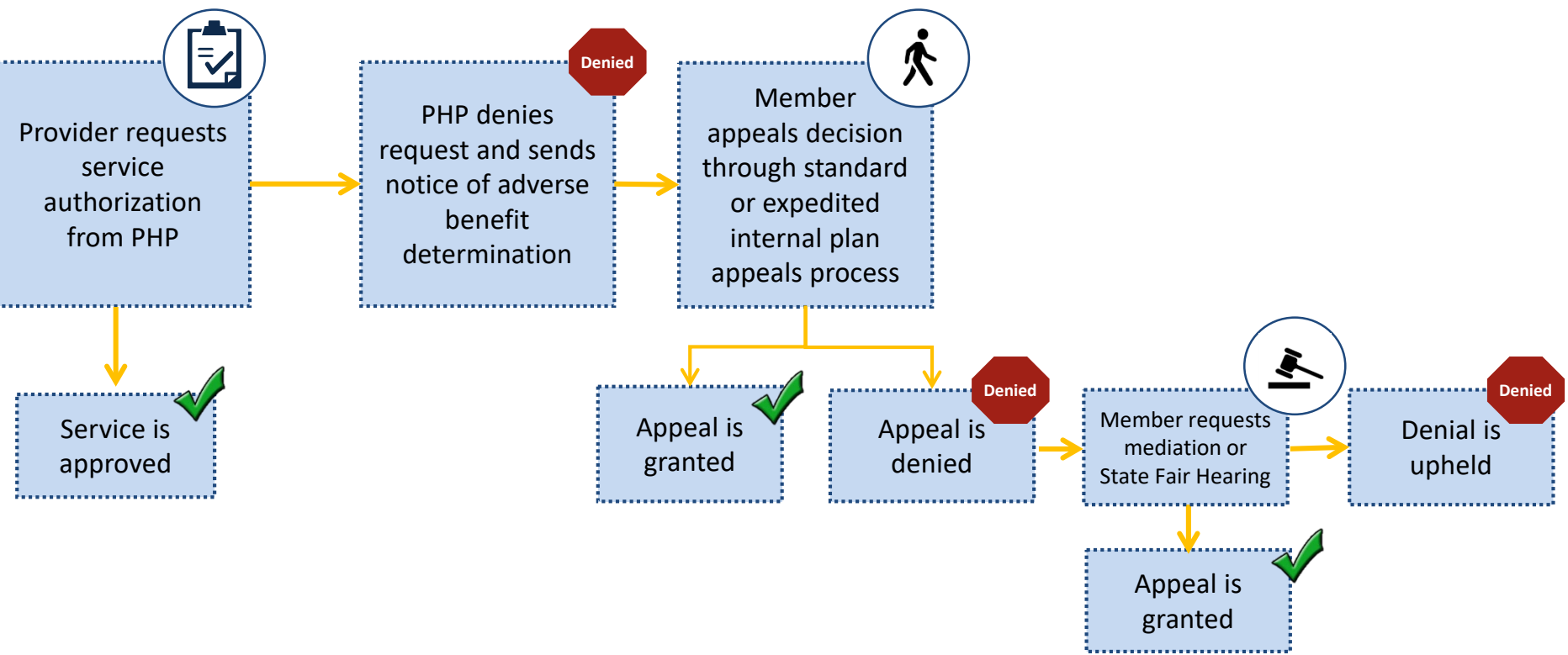
All members will have access to the PHP grievance process, plan level appeal process and access to a State Fair Hearing

- Member grievances and appeals must be resolved at the lowest level of escalation (i.e., at the plan level first)
- Members must be provided with information on the Ombudsman program and as needed, receive assistance undertaking the appeals process (e.g., interpreter services, form completion)*
- Providers will be given information about a PHP's grievance, appeals and State Fair Hearing procedures at contracting
- Members may request a continuation of benefits during the appeals process; however, providers may not request continuation of benefits on a member's behalf

Today's focus is the appeals process for when a patient is denied a clinical service

* Providers should be aware that there will be a Member Ombudsman responsible for helping patients navigate issues with managed care. More information regarding the Member Ombudsman is available in the provider training on Beneficiary Policies, available [here](#)

Overview of Appeals Process



Notice of Adverse Benefit Determination

Both providers and members will receive written notice of a PHP's decision to deny a service authorization request or to authorize a service in a lesser amount, duration or scope than what was requested

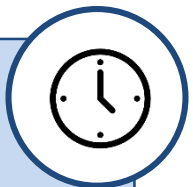
Notice must include

- PHP's action and reason for action
- Member's rights and procedures to file an appeal, including PHP level appeal and right to request State Fair Hearing
- Option, if available, to request expedited resolution
- Member's rights to have benefits continue pending appeal resolution



Timing

- Generally, members must be given written notice for termination, suspension, or reduction in previously authorized Medicaid covered services at least **10 calendar days** before date of adverse benefit determination is to take effect
- In limited circumstances, PHPs may give **5 calendar days** (e.g., if the PHP has evidence indicating member fraud) or may provide notice by the date the determination takes effect (e.g., member admitted to institution and is no longer eligible for services under the plan)



Internal Plan Appeals

Members will be able to appeal adverse determinations via a standard or expedited process (when standard appeal may jeopardize member's health)

Standard Appeals Process Timing	Expedited Appeals Process Timing
<ul style="list-style-type: none"> Members have 60 calendar days from date of Notice of Adverse Benefit Determination to file a standard appeal; PHP must acknowledge request within 5 calendar days PHP must provide written notice of appeal resolution within 30 calendar days of receipt of standard appeal request but may extend timeframe by up to 14 calendar days in certain instances 	<ul style="list-style-type: none"> Members have 60 calendar days from date of Notice of Adverse Benefit Determination to file an expedited appeal; PHP must acknowledge request within 24 hours PHPs must provide written or oral notice of expedited appeal resolution within 72 hours with a 14 day extension under certain circumstances If request for expedited appeal is denied, appeal will be resolved on standard appeal timeframe

Members must be given an opportunity to present evidence/testimony in support of the appeal and PHPs must consider all documents and other records submitted by the member

All expedited appeal requests made by providers will be processed as such

Mediation and State Fair Hearing Process

- If PHP upholds adverse determination benefit, member may submit a request for a State Fair Hearing within **120 calendar days**
- Members may request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing
- Fair Hearing occurs before an administrative law judge who issues a decision within **90 calendar days** of the initial fair hearing request



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More Opportunities for Engagement

DHHS values input and feedback and is making sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website:
<https://www.ncdhhs.gov/assistance/medicaid-transformation>
- Comments, questions, and feedback are all very welcome at
Medicaid.Transformation@dhhs.nc.gov

Providers will receive education and support during and after the transition to managed care.



Upcoming Events

Upcoming Managed Care Webinar Topics

- **Healthy Opportunities in Medicaid Managed Care (6/27)**

Other Upcoming Events

- **Virtual Office Hours (VOH):** Running bi-weekly, as of April 26th
- **Provider/PHP Meet and Greets:** Regularly hosted around the State

Schedule for VOH and Meet & Greets available on the [Provider Transition to Managed Care Website](#)

Look out for more information on upcoming events and webinars distributed regularly through special provider bulletins

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Q&A

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Required Clinical Coverage Policies

While PHPs have discretion to develop their own clinical coverage guidelines for many services, they must use existing DHHS FFS clinical coverage policies for making coverage determinations for these services

Clinical Subject	Scope
Behavioral Health and I/DD	<ul style="list-style-type: none"> • Enhanced Mental Health and Substance Abuse Services (limited to services listed): <ul style="list-style-type: none"> • Mobile Crisis Management • Diagnostic Assessment • Partial Hospitalization • Professional Treatment Services in Facility-based Crisis • Ambulatory Detoxification • Non-hospital Medical Detoxification • Medically Supervised or ADATC Detox Crisis Stabilization • Outpatient Opioid Treatment • Facility-based Crisis Services for Children and Adolescents • Inpatient Behavioral Health Services • Outpatient Behavioral Health Services Provided by Direct-enrolled Providers • Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder
Obstetrics & Gynecology	<ul style="list-style-type: none"> • Family Planning Services
Physician	<ul style="list-style-type: none"> • Child Medical Evaluation and Medical Team Conference for Child Maltreatment • Physician Fluoride Varnish Services • Implantable Bone Conduction Hearing Aids (BAHA) • Routine Costs in Clinical Trial Services for Life Threatening Conditions
Auditory Implant External Parts	<ul style="list-style-type: none"> • Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair • Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
Pharmacy	<ul style="list-style-type: none"> • Outpatient Pharmacy • Over-the-Counter products • Hemophilia Specialty Pharmacy Program • Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 • Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older • Physician Drug Program

Development of Utilization Management Guidelines

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

Guidelines must:

- Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
- Consider the needs of members;
- Be adopted in consultation with contracting health professionals;
- Be reviewed and updated periodically as appropriate; and
- Meet the clinical practice guidelines required for Health Plan Accreditation set forth by NCQA