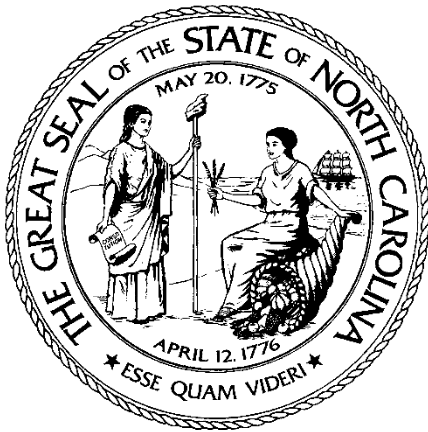

Medicaid Transformation: Transition of Care

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Transition of Care Agenda

- Overview of NC Transition to Managed Care
- Transition of Care Guiding Principle
- Transition of Care Summary of Activities
  - How We Got Here: Policy, Design, Process and Technology Requirements
- Summary of Crossover-Related Requirements and Processes Related to:
  - Data Transfer
  - Safeguards for High-Need Members
  - Reporting
  - Education
- Appendix

OVERVIEW OF NC'S TRANSITION TO STANDARD PLANS UNDER NC MEDICAID MANAGED CARE

Introduction

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:
  - 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 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.”

What do some of those terms mean?

NC Medicaid Direct

- New name for our current Medicaid program.
- Fee-for-service + LME-MCOs (or PACE)
- What everyone on Medicaid has now

NC Medicaid Managed Care

- The term used reference the five “prepaid health plans” or “PHPs” or “health plan”
- Also called “Standard Plan” or “Standard Plan Option.”

Tailored Plan

- Specialized plans for members with significant behavioral health needs and intellectual/developmental disabilities
- What the LME-MCOs will become in a few years
- **NOT the focus of today’s webinar**

PHPs for NC Medicaid Managed Care

Statewide Contracts

- **AmeriHealth Caritas North Carolina, Inc.**
- **Blue Cross and Blue Shield of North Carolina, Inc.**
- **UnitedHealthcare of North Carolina, Inc.**
- **WellCare of North Carolina, Inc.**

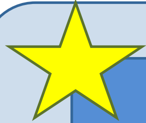
Regional Contract – Regions 3 & 5

- **Carolina Complete Health, Inc.**

Transition of Care: Our Guiding Principle

As beneficiaries move between delivery systems, the Department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

Transition of Care: Two Distinct Phases



Crossover to MCL Transition of Care

One time crossover of beneficiaries eligible for NC Medicaid Managed Care on or February, 1 2020 (“Managed Care Implementation” or “MCL”)

Ongoing Transition of Care

Ongoing transition of care for beneficiaries moving between PHPs, between PHPs and FFS, between FFS/LME-MCOs and PHPs

NOTE: TRANSITIONS BETWEEN *SETTINGS* ARE RELATED BUT IDENTIFIED IN SEPARATE PROTOCOLS AND NOT FOCUS OF THIS PRESENTATION

Transition of Care: Summary of Activities

Policy	• Established Transition of Care Policy Focused on Our Guiding Principle – Continuity of Care.
Design	• Collaborated Across the Business, Technology and External Stakeholders to Design the Transition of Care Model
Requirements	• Developed technology and process requirements for all stakeholders to support the Transition of Care Design including safeguards for High Need Beneficiaries
Governance	• Continuing to develop Governance structure to support oversight of Transition of Care Activities.
Communication and Education	• Defining Communication Requirements for all Transition of Care Entities and Education Strategy for Beneficiaries and Providers

Our Crossover Policy Direction

As beneficiaries move between delivery systems, the Department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

PHPs have the necessary data to ensure effective service continuity for transitioning beneficiaries..

PHPs maintain service continuity by implementing DHHS requirements related to prior authorizations, non participating providers, appeal rights and identified services.

High-need beneficiaries have additional "high touch" support to ensure service continuity and reassurance through the transition.

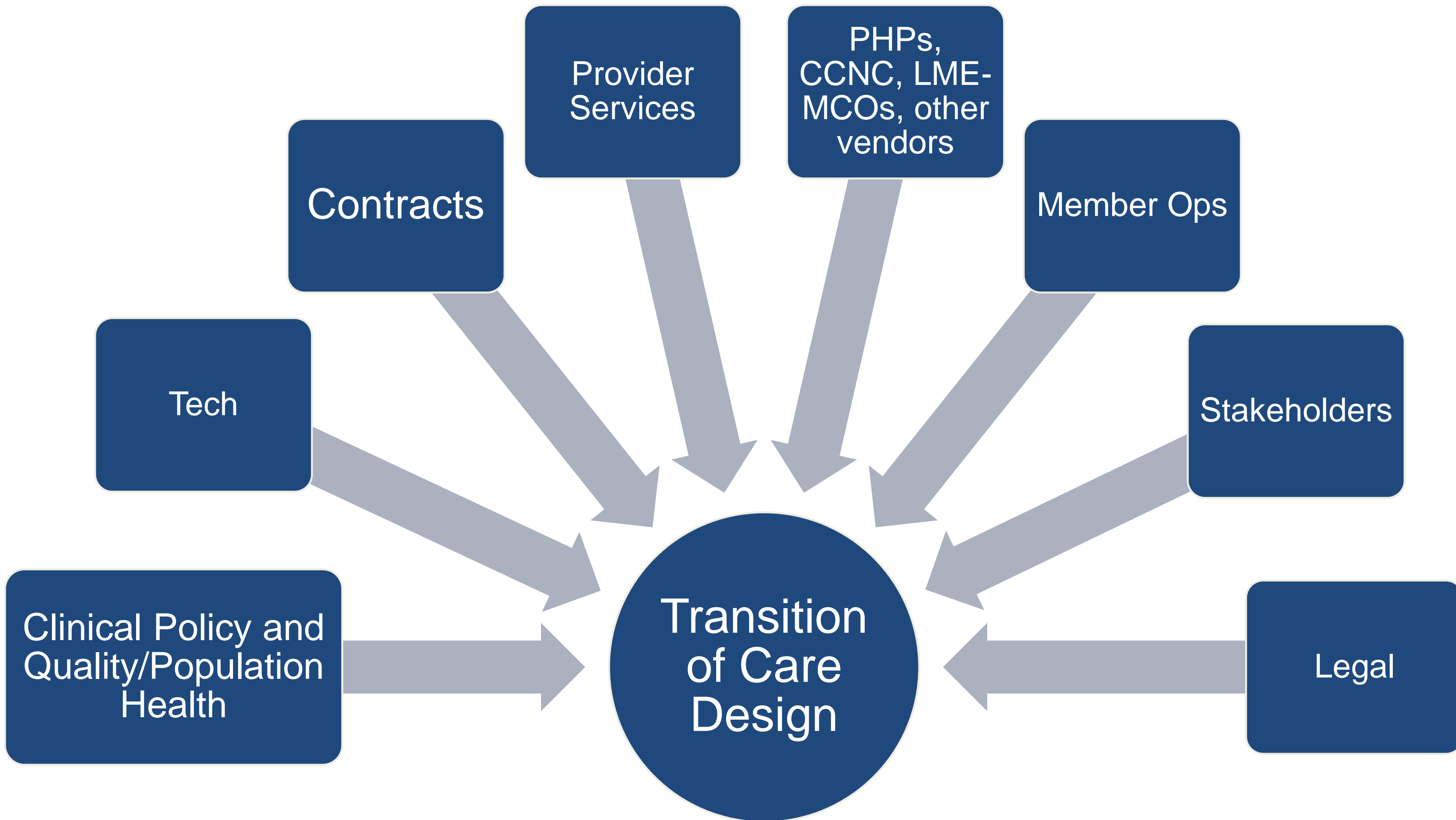
Providers facilitate service continuity by being effectively informed on Crossover-specific requirements such as PA submissions.

PHPs, LME-MCOs and FFS vendors establish mechanisms that facilitate the effective data and knowledge transfer.

The Department ensures effective oversight through quality communication, reporting and other oversight mechanisms.

The Department's Crossover direction is enhanced by the insight and contribution of stakeholders.

Transition of Care Design: An Interdisciplinary Effort



Crossover Data Transfer: Requirements and Processes

Requirements Developed to Address the Following Areas

- DHB Claims & LME-MCO Encounter History
- Open and Recently Closed Prior Authorizations
- Care Plans/Assessment
- NEMT
- Pharmacy Lock In
- Previous PCP Assignment

Requirements Cover the Following Process and Technology Capabilities

- Intensive Provider Education
- Data Transfers
- Informed Call Center Staff
- System Notifications
- Governance and Oversight
- Teamwork Across Stakeholders

Additional Crossover-Related Data Transfer Processes and Requirements

- Non Emergency Medical Transportation (NEMT)
  - PHPs will be required to accept NEMT appointments for post-MCL services one month prior to MCL.
  - PHPs will identify NEMT utilizers through claims detail.
  - In collaboration with Member Operations team, finalizing additional DSS-generated NEMT utilization data transfer and process requirements.
  - In collaboration with PHPs and Member Operations team, fortifying current outreach strategies to address Crossover-related NEMT processes.
- Substance Use Disorder (SUD)-related Requirements
  - 42 CFR Part 2 requires member consent be secured or SUD data be removed when transferring member detail from FFS vendors to PHPs.
- Appeals
  - In collaboration with legal and appeals staff, have established necessary crossover-specific appeals position statements and protocols.

PHP Requirements for Continuing Existing Authorizations

Honoring Prior Authorizations

- PHPs must honor open fee-for-service (FFS) PAs adjudicated by the State prior to MCL for at least the first 90 days after MCL
- The Department will track FFS PAs with open units that extend beyond 90 days and monitor PHPs post-90 day determinations.
- PHP must issue appeal rights for reduction/termination of FFS PAs.

Non Participating Providers

- For the first sixty (60) days after MCL, PHPs required to pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of in network providers until end of episode of care or the 60 days, whichever is less.*

*Note: N.C. Gen. Stat. § 58-67-88 also applies

Crossover-Related Safeguards for High Need Members: Requirements and Processes

Transition-Related Safeguards for High-Need Members

Data File Transfer at Crossover
Claims/Encounter Data
PA Extract
Care Plans (As Applicable)

Applies to All Transitioning Beneficiaries

Targeted Follow Up For High-Need Members
PHPs perform time-sensitive follow up to High Need Members

See High Need Member Definition

Warm Handoff
Individualized knowledge transfer sessions for members identified by DHHS, LME-MCOs, CCNC. PHPs may also initiate.

Complex Treatment/Service Circumstances

Crossover-Related Reporting

- Claims, PA and Care Plan Reconciliation
  - Claims: weekly reconciliation
  - PAs: daily reconciliation
  - Care Plan: reconciliation for one-time transfer
- High Need Member Reporting
  - Begins: Friday after MCL with a Weekly Frequency
  - Content:
    - Member specific
    - High Need designation
    - Date and type of follow up
    - Date of handoff session as applicable
    - Confirmation/Issues identified
    - Anticipated disposition of PA-ed services post 90 days
- NEMT Appointment Adherence
  - Method of Identifying Member Who Will Utilize NEMT during reporting period
  - Member Appointment Status
  - Begins: 10/25/2019 with a Weekly Frequency

Crossover-Specific Member and Provider Education

Educating Members about the Transition

- PHPs and LME-MCOs now have crossover-specific member education requirements.
  - Call Center competencies
  - Outreach
- Collaborating with Clinical Policy, Member Operations and others to identify needs and opportunities to supplement general member education efforts.
- Activities to date include:
  - Member-focused sessions on enrollment and transition of care, including to the MCAC Behavioral Health Subcommittee, the Council on Developmental Disabilities Cross-System Navigation Initiative and MFP Roundtable webinar series.
  - Development of LME-MCO call center toolkit to assist call centers in guiding members.

Thank You!

Appendices

Additional detail about identified process requirements.

How We Have Organized Our Crossover Design Work

SUPPORTING CONTINUITY OF CARE THROUGH DATA TRANSFER

ADDITIONAL SAFEGUARDS FOR HIGH-NEED MEMBERS

CLEAR AND ORGANIZED COMMUNICATION BETWEEN ENTITIES

MEMBER AND PROVIDER EDUCATION

Key Data Sources to Be Transferred at Crossover

Claims and Encounter

- 24 months of paid and denied claims/encounter history for all services
- Full file to begin 9/21/2019, weekly updates
- Transferred via GDIT Move It site

Open and Recently Closed Prior Authorizations (PAs)

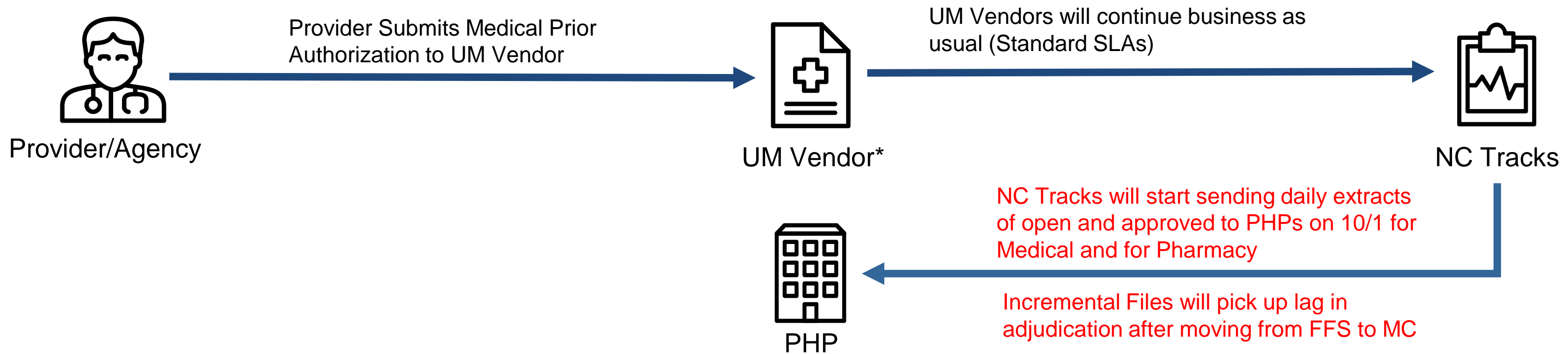
- Open and recently closed PAs (60 days)
- Full file to begin 10/1/2019, daily updates.
- Transferred via GDIT Move It and state ftp site.

Identified Care Plans

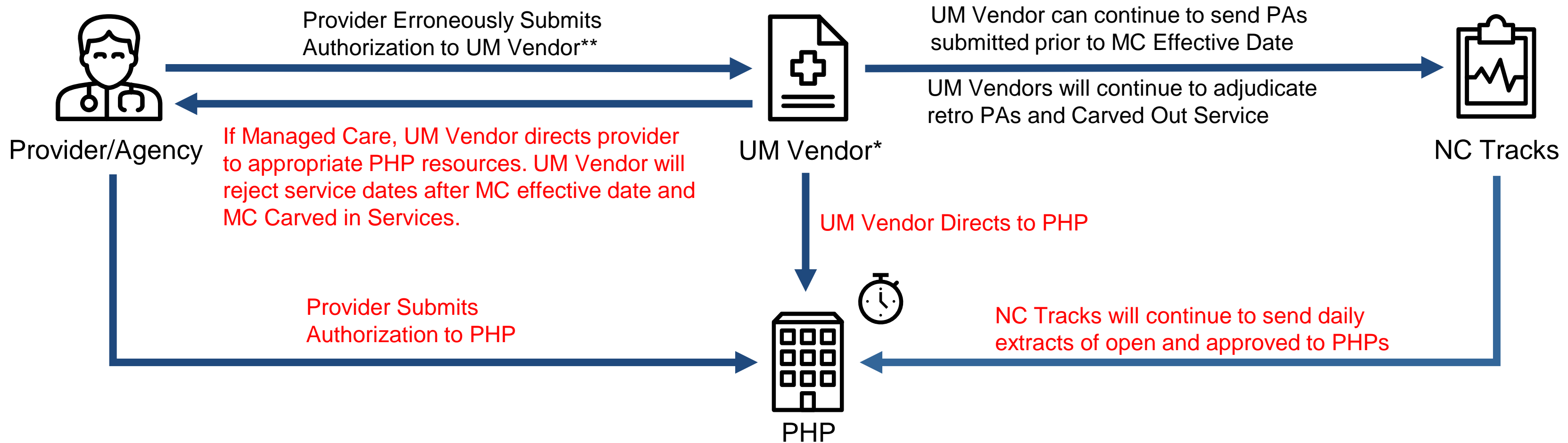
- Care Plans from CCNC and identified LME-MCO members receiving care coordination.
- PCS Care Plans/Assessments from PCS Vendor.
- All begin approximately 3 weeks prior to MCL
- All via state ftp site.
- All other treatment plans accessed from providers as needed.

Crossover: Prior Authorizations

- Up Until 11:59p on day prior to Managed Care Effective Date



- From First Day of Managed Care Effective Date Onward



*UM Vendors in this context can be any of Medicaid's PA Vendors, GDIT or LME-MCOs
** Erroneous Submission includes MC Carved In Service with effective dates after the Managed Care Effective Date

Data Transfer at Crossover: Summary Process for the Erroneously Routed PA Request

Intensive Provider Education

- UM vendor assists with pre-MCL provider education.
- DHHS-sponsored "PA Guidance" on DHHS Provider site providing specific information about each PHP's PA submission process.

Notification: Auto-Information Message

- After MCL, if a provider attempts to submit a PA request to UM vendor, the provider will see an error/banner message indicating a member is now enrolled in a PHP and guiding provider to DHHS PA guidance webpage.

Informed Call Center Staff

- UM Vendor call center staff will be informed on how to guide both members and providers.

Crossover: Safeguards for High Need Members

Pre MCL, PHP identify and prioritize "High Need" members based on criteria and information provided.

Managed Care Launch Date

"High Need" Members include:

- High need subset of members receiving in-home long-term services and supports or select behavioral health services.
- High need subset of members receiving behavioral health services
- Exempt members who elect to enroll in PHP.
- Members identified by CCNC, an LME-MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a "warm handoff."
- NEMT users with repeated or multiple appointments.

Follow Up (reported weekly to DHHS):

- Direct contact between PHP and member (in-person or phone)
- Are services in place?
- Any confusion about processes?
- Ongoing status of pre-MCL authorized services.

CLEAR AND ORGANIZED COMMUNICATION BETWEEN ENTITIES

Summary of Activities to Date

- PHPS, LME-MCO, CCNC and other vendors now under crossover-specific communications requirements
  - Member-specific
  - As part of DHHS Crossover governance design

- Establishing Crossover Specific Communication Protocols between PHPs and Other Entities Related to Data Testing and Data Transfer.