

Transition of Care Data Transfer: Processes Impacted by 42 CFR Part 2

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with support from NC Medicaid Legal Office

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Scope of Today's Presentation

In Scope

- Refresher on relevant Medicaid positions impacting the transfer of prior authorization data.
- How 42 CFR Part 2 will impact data transfer for beneficiaries transitioning to Medicaid Managed Care on July 1, 2021.
- Alternative process established for relevant prior authorizations and warm handoffs.
- Summary overview of processes established for transitions occurring after July 1, 2021.

Out of Scope

- Comprehensive training on Medicaid Managed Care or Transition of Care.
- Educational training and legal advice on 42 CFR Part 2.
- Tailored Plan design.
- LME/MCO or Health Plan-specific processes related to authorization submission.

Reminders about Related Transition of Care Policies and Positions

Reminder: NC Medicaid Will Launch NC Medicaid Managed Care on July 1, 2021, while also retaining its current service delivery models (“NC Medicaid Direct”)

On July 1, 2021, approximately 1.6 million of the current 2.5 million Medicaid beneficiaries will transition to NC Medicaid Managed Care.

This means 900,000 will not transition and will continue to receive services as they do today.

NC Medicaid Beneficiaries Who Will Enroll in NC Medicaid Managed Care on July 1, 2021

Transitioning beneficiaries will be able to choose from 5 Health Plans (aka “Standard Plans”)

- AmeriHealth Caritas
- Healthy Blue
- United HealthCare Community Plan
- WellCare
- Carolina Complete Health:
Serving regions 3, 4, and 5

Key NC Medicaid Beneficiary Groups who Will Remain in NC Medicaid Direct on July 1, 2021

- Beneficiaries who are Dually Eligible for Medicare/Medicaid.
- Beneficiaries who receive waiver services or PACE.
- Beneficiaries who are enrolled in Foster Care.
- List is not exhaustive, for full list, please see NC Medicaid Managed Care Enrollment Table in Resources section.



A Note about Tailored Plan Eligible/Standard Plan Exempt Population (*)

If a beneficiary qualifies for a service that is only available in LME/MCO (“Tailored Plan eligible”), they will be exempt from enrolling in NC Medicaid Managed Care but may choose to enroll in NC Medicaid Managed Care. It may impact the services they currently receive.

(*) 6/7/2021: More information coming

Reminders from 5/6/2021 Back Porch Chat

Key Takeaways: For Providers of BH and I/DD Services

- Behavioral health providers will need to contract with both Standard Plans and LME/MCOs until BH I/DD Tailored Plan launch to be in-network for both types of plans. When BH I/DD Tailored Plans launch, providers will need to contract with both Standard Plans and BH I/DD Tailored Plans. Contracting with both types of plans will better ensure continuity of care, as well as appropriate payment for the services you are providing.
- A subset of high-intensity behavioral health, I/DD, and TBI benefits will only be offered in BH I/DD Tailored Plans (LME/MCOs prior to BH I/DD Tailored Plan launch). It will be important for providers to understand which benefits are offered in which type of plan to provide guidance to their patients.
- Standard Plans will have open provider networks for both physical and behavioral Health. Tailored Plans will have closed provider networks for Behavioral Health and an open provider network for Physical Health.
- Once managed care launches, providers will bill the appropriate plan (Medicaid Direct, LME/-MCO, or Standard Plan) for services.

Reminder: Comparing Plan BH/IDD/TBI Benefits

Available In <u>Both</u> Standard Plan and BH /DD Tailored Plan	Available <u>Only</u> in BH /DD Tailored Plan (or LME-MCOs Prior To Launch)
<p>State Plan Services</p> <ul style="list-style-type: none"> • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • Research-based intensive BH treatment for Autism Spectrum Disorder • Diagnostic assessment • EPSDT • <i>Partial hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment</i> • <i>Ambulatory detoxification</i> • <i>Non-hospital medical detoxification</i> • <i>Medically supervised detoxification crisis stabilization</i> <p style="text-align: right;"><i>*Enhanced Behavioral Health Services are Italicized</i> EPSDT Protections continue to apply</p>	<p>State Plan Services</p> <ul style="list-style-type: none"> • Residential treatment facility services • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • <i>Psychiatric residential treatment facilities (PRTFs)</i> • <i>Assertive community treatment (ACT)</i> • <i>Community support team (CST)</i> • <i>Psychosocial rehabilitation</i> • <i>Substance abuse non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • <i>Substance abuse intensive outpatient program (SAIOP)</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> <p>Waiver Services</p> <ul style="list-style-type: none"> • Innovations waiver services • TBI waiver services • 1915(b)(3) services <p>State-Funded behavioral health, /DD and TBI Services</p>

Reminder: There are Two Distinct Phases of Transition of Care (TOC)

Crossover to NC Medicaid Managed Care Transition of Care

One time transition of eligible beneficiaries into NC Medicaid Managed Care on July 1, 2021.

Ongoing Transition of Care

Ongoing transition of care for beneficiaries moving between Standard Plans, between Standard Plans and Medicaid Direct.

Reminder: Managing Prior Authorizations at Crossover

- Standard Plans will not accept prior authorization requests before July 1, 2021.
- Providers should continue to submit prior authorization requests to the appropriate UM vendor (i.e. LME/MCOs, NCTracks, CCME, etc.) up through 11:59 pm on June 30, 2021.
- Authorizations not impacted by 42 CFR Part 2 will transfer to Beneficiary's new Standard Plan.
- Standard Plans are required to honor the open authorizations for 90 days or until the authorization expires, whichever occurs first.
- If the Standard Plan reassesses an open authorization at 90 days and reduces or terminates, it must issue appeal rights.

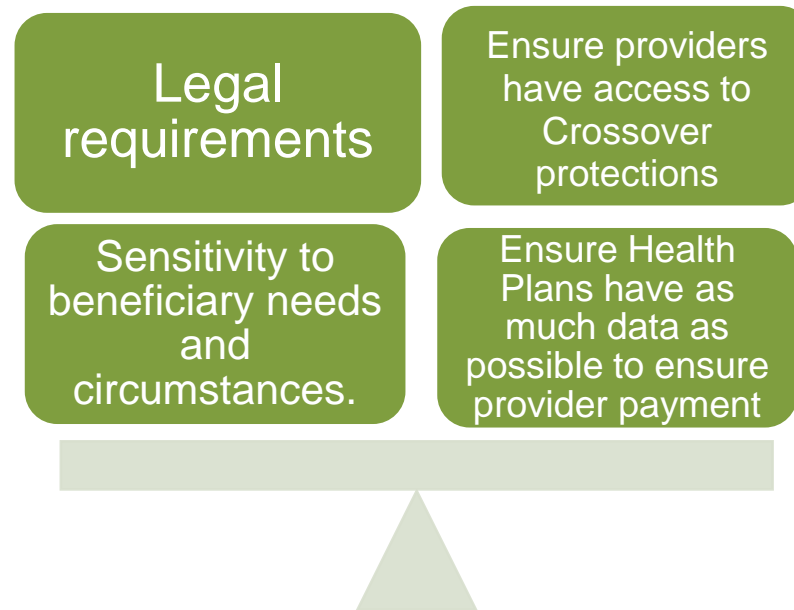
Reminder: 42 CFR Part 2 Impacts How Data Can Be Transferred

- *Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was promulgated... address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings... Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders can disclose such records.*
- For more information:
<https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf>

NC DHHS Positions and Protocols related to Transferring Data under 42 CFR Part 2 during Crossover

Crossover Data Transfer and Consent Strategy: Balancing the Interests

Consistent with the TOC goals of ensuring beneficiary continuity of care and minimizing administrative burden on providers, the State has established an alternative transfer process for Prior Authorizations covered by 42 CFR Part 2



42 CFR Part 2-related Prior Authorizations Will Not Transfer from the LME/MCO at Crossover

- Data covered by 42 CFR Part 2 can only be transferred from the LME/MCO to the Health Plans with express consent from the beneficiary. Otherwise the data must be removed.
- Untenable and unrealistic that LME/MCOs could secure timely consent for every applicable Prior Authorization transferred.
- If Prior Authorization is for service under the scope of 42 CFR Part 2, the Prior Authorization will not transfer.
- The targeted list includes authorizations for the following services:
 - Outpatient opioid treatment
 - Ambulatory detoxification
 - Non-hospital medical detoxification
 - Medically supervised or alcohol drug abuse treatment center (ADATC)
 - Detoxification crisis stabilization.
- While the services listed above are anticipated to represent the vast majority of impacted authorizations, LME/MCOs have the authority to exclude other Prior Authorizations in order to comply with 42 CFR Part 2.

Crossover PA Submission impacted by 42 CFR Part 2 and Timelines

- Know if your client (beneficiary) is transitioning to NC Medicaid Managed Care.
 - NC Tracks Provider Portal will allow providers to see a Beneficiary's managed care status and Standard Plan in Recipient record starting June 2, 2021 (30 days in advance).
- If applicable, secure consent to submit information to the Beneficiary's Standard Plan.
- Submit prior authorization in effect on July 1, 2021 and notice of authorized service issued by the Beneficiary's former LME/MCO to Beneficiary's new Standard Plan.
 - Provider should submit on or after July 1, 2021 but no later than 5:00pm Friday July 16, 2021.
 - The Standard Plans may accept but are not required to accept evidence of current authorizations after this date.
- Standard Plans will honor the authorization as if it had been transferred as part of the LME/MCO PA File transfer (and therefore honored for a minimum of 90 days or until the end of the authorization, whichever occurs first).
- Please contact Standard Plans for additional Plan-specific authorization flexibilities that may be in place.
- New authorization requests submitted after July 1, 2021 must be directed to the beneficiary's Standard Plan (or to LME/MCO if beneficiary remaining in Medicaid Direct).

42 CFR Part 2 Impact on Warm Handoffs at Crossover

Reminder: Safeguarding Beneficiary Services Through Crossover

Crossover Activities Customized Based on Service History, Vulnerability



All Transitioning Members:

Data Transfer:

- Claims
- Prior Authorization
- Pharmacy Lock In Data
- Care Plans or Assessments, if relevant

"High Need" Members:

- High Need Members are transitioning Members whose service history indicates vulnerability to service disruption
- **This group is identified on DHHS "High Need Member List"**

"Warm Handoff" Members (<2000 Members):

- High Need Members who have been identified by Medicaid Direct "transition entities" (CCNC/LME-MCOs) or by the Health Plan as warranting a verbal briefing between transition entity and Health Plan
- This group is identified on the DHHS "High Need Member List" and through a specific warm handoff/summary sheet process.

Securing Consent for Crossover Warm Handoff Activity

- LME/MCOs will identify transitioning members meeting the Warm Handoff criteria,
- For Beneficiaries identified for a Warm Handoff, the LME/MCO will conduct a clinical briefing with the Beneficiary's new Standard Plan and provide a Warm Handoff Transition Summary to the Standard Plan.
- If a transitioning Beneficiary's circumstance is under the scope of 42 CFR Part 2 protection (i.e. services or clinical dynamics related to 42 CFR Part 2 will be disclosed through the warm handoff process), the LME/MCO will be required to secure the Beneficiary consent prior to disclosing related information.
- LME/MCOs will have the authority to omit information covered by 42 CFR Part 2 in order to otherwise communicate other material issues without additional consent.
- The LME/MCO may seek provider's assistance in securing the Beneficiary's consent for impacted Beneficiaries using a consent form developed by the Department.

Looking Forward: 42 CFR Part 2 and Ongoing Transition of Care

Reminder: Starting July 1, 2021, beneficiaries enrolled with the Standard Plans may transition to a new Plan or in some cases back to Medicaid Direct.

Health Plan 1



Health Plan 2

“Tridge” in Midland, Michigan:

<https://www.kuriositas.com/2012/01/tridge-michigans-three-way-bridge.html>

Medicaid Direct/Tribal/LME/MCO

- Enrolling
- Disenrolling
- Tailored Plan eligible

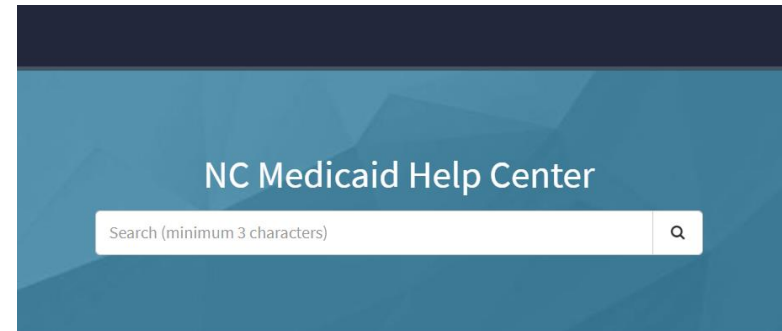
Ongoing Transitions: Preview of Intended Process

- Standard Plans and LME/MCOs will transfer information for transitioning beneficiaries.
- Both Standard Plans and LME/MCOs required to make “good faith” effort to secure consent prior to transferring prior authorizations or Transition File or holding warm handoff session.
 - LME/MCOs have the authority to omit information covered by 42 CFR Part 2 in order to otherwise communicate other material issues without additional consent.
- Anticipated use of consent template comparable to template created for Crossover.
 - May request provider assistance in securing .
 - If cannot transfer PA due to lack of consent, provider instructed to resubmit to member’s new entity.
- Request to Move forms are currently being updated to include 42 CFR Part 2 consent requirements.

Key Resources for Additional Information

Reminder: Key Provider Information Resources

- [NC Medicaid Help Center](#)
- [NCDHHS Transformation website \(Including County & Provider Playbooks\)](#)
- **Standard Plan websites**



Accessing Information about the Health Plans' Prior Authorization Process

Home Benefits Transformation Meetings & Notices Find A Doctor Providers Counties Reports

COVID-19 RESPONSE: Resources, information and assistance from across state government. [Visit the information hub!](#)

NC.DHS > Transformation

Transformation

North Carolina's Transformation to Medicaid Managed Care

Go to Provider Playbook's Fact Sheets Section:

Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2

<https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets>

<p>How can I determine which services require prior authorization for a health plan?</p>	<p>WCHP provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. WCHP's Provider Look-up tool can be found at: https://www.wellcare.com/North-Carolina/Providers/Authorization-Lookup</p>	<p>AMHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. AMHC's Provider Look-up tool can be found at: www.amerhealthcaritasnc.com</p>	<p>Healthy Blue provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. Healthy Blue's Provider Look-up tool can be found at: https://provider.healthyluenc.com/north-carolina-provider/prior-authorization-lookup</p>	<p>CCH provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. This tool will go live later this summer, before the launch of NC Medicaid Managed Care.</p>	<p>UNHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. UNHC's Provider Look-up tool can be found at: https://UHCprovider.com/priorauth</p>
<p>How can I submit a prior authorization to a health plan?</p>	<p>WCHP submission methods:</p> <p>Standard: Online via Provider Portal: https://provider.wellcare.com/</p> <p>Via fax to the numbers listed on the associated forms: https://www.wellcare.com/North-Carolina/Providers/Medicaid/Form</p> <p>Urgent: Call 866-799-5318 and follow the prompts.</p> <p>Pharmacy:</p>	<p>AMHC submission methods:</p> <p>Standard: Online via Provider Portal: www.navinet.navimedix.com</p> <p>Via Fax to 833-893-2262</p> <p>Call 833-900-2262</p> <p>Pharmacy: Via fax to 877-234-4274</p> <p>Call: 855-375-8811</p>	<p>Healthy Blue submission methods:</p> <p>Standard: Online via Provider Portal: https://provider.healthyluenc.com/north-carolina-provider/prior-authorization</p> <p>Via Fax to:</p> <p>800-964-3627 (Inpatient)</p> <p>844-445-6649 (Outpatient)</p> <p>Urgent: Call 844-594-5072</p>	<p>CCH submission methods:</p> <p>Standard: Online via Secure Provider Portal: http://carolinacompletehealth.com/</p> <p>Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization. This tool will go live later this summer, before the launch of NC Medicaid Managed care.</p> <p>Call 833-552-3876</p> <p>Via Fax to 919-670-4948</p>	<p>UNHC submission methods:</p> <p>Standard:</p> <p>Online via Prior Authorization and Notification Tool on Link: https://UHCprovider.com/priorauth</p> <p>If you're unable to use Link, call Provider Services at 877-842-3210.</p> <p>Urgent: Call Provider Services at 877-842-3210 and follow the prompts.</p> <p>Pharmacy:</p>

Screenshot excerpt from referenced document to provide example. Links not active.

42 CFR Part 2 at Crossover May 24, 2021 and June 7, 2021

Questions?

Questions about this process or whether Prior Authorization will Transfer at Crossover?



Contact Beneficiary's LME/MCO.

Questions on how to submit a Prior Authorization or Authorization Request?



Review materials on Provider Playbook and Contact Beneficiary's Standard Plan

Need to Review this Presentation Again?

NCDHHS
NC Medicaid
Division of Health Benefits

Search...

Home Beneficiaries Transformation Meetings & Notices Find A Doctor

COVID-19 RESPONSE - Resources, information and assistance from across state government

NC DHB » Transformation » Care Management » Transition of Care

Transition of Care

The North Carolina Department of Health and Human Services (DHHS) developed policies and procedures for Transition of Care to support beneficiaries who transition between Medicaid Direct (fee-for-service) and Medicaid Managed Care delivery systems. The Transition of Care design intends to maintain continuity of care for each beneficiary and minimize the burden on providers during transition.

Presentation will be posted on NC DHHS Transition of Care Website.

- <https://medicaid.ncdhhs.gov/transformation/care-management/transition-care>

Referenced Materials

NC Medicaid Managed Care Enrollment Table

Status of Medicaid Managed Care Enrollment, Per Legislation	Populations
Mandatory (Must enroll)	<ul style="list-style-type: none"> • Most family & children’s Medicaid, NC Health Choice, pregnant women, non-Medicare aged, blind, disabled
Excluded (Cannot enroll, stays in NC Medicaid Direct)	<ul style="list-style-type: none"> • Family Planning program, medically needy, health insurance premium payment (HIPPP), Program of All-inclusive Care for the Elderly (PACE), refugee Medicaid • Some beneficiaries are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, foster care/adoption, & Community Alternatives Programs for Children (CAP/C) and Disabled Adults (CAP/DA).
Exempt (May enroll or stay in NC Medicaid Direct)	<ul style="list-style-type: none"> • Federally recognized tribal members, beneficiaries who would be eligible for behavioral health tailored plans (until they become available). Target launch date for Tailored Plans is July 1, 2022.

Sample Documents

Sample of Notice of Authorized Services

Cardinal Insurance

Notice of Authorized Services

11/6/2019 9:46:11 AM

Provider ID: [REDACTED]

TREATMENT AUTHORIZATION NUMBER: [REDACTED]
TAR REFERENCE NUMBER: [REDACTED]

Processed Date: 2/2/2019 10:03:01 PM
Insurance: Medicaid B Waiver
Consumer ID: [REDACTED]
Consumer Name: DOE, JOHN
Consumer Address: [REDACTED]
Consumer Phone #: (252) 555-5555
Consumer DOB: XX/XX/XX
Consumer SS #: XXX-XX-XXXX

The following services are included in this treatment authorization

Service Definition: B3 SERVICES

Service Codes	Total Units Approved
H0038:U4 Peer Support	312
Authorization Effective Date	Daily Max Weekly Max Monthly Max
01/20/2019	20 24 347
Authorization End Date	
04/20/2019	
Service Codes	Total Units Approved
H0038:U4 Peer Support	208
Authorization Effective Date	Daily Max Weekly Max Monthly Max
04/21/2019	20 16 347
Authorization End Date	

Weekly Maximums will be applied for all services from Sunday to Saturday.
 Monthly Maximums will be applied for all services from the 1st day of the month to the last.
 Notwithstanding this authorization, failure to comply with the terms and conditions of your contract with

Screenshot of Consent Form

[LME/MCO LETTERHEAD]

CONSENT TO SHARE CONFIDENTIAL HEALTH INFORMATION

Name of Member (printed):

Member's Date of Birth (printed):

Clinician/Provider Representative (print):

An Explanation of this Form
 You will soon have a different health plan to manage your Medicaid healthcare benefits. To help make sure your new health plan has the information it needs to continue to provide access to and payment for your health care, we need your consent to share records about your treatment with your new health plan. You can take back your consent any time you want by signing the revocation section on this form and giving it to name of LME/MCO contract here. You can tell us how long you want this consent to be valid, or you can tell us an event or condition upon which it will expire. If you don't give us a different time frame your consent is good for one year. You will be given a copy of this form to keep.

Giving Your Permission to Share Your Records

To ensure that my current services are not interrupted and so that my new health plan can support me effectively, I name of member/patient or legally responsible person hereby authorize name of LME/MCO to transfer and share information related to my prior authorizations, treatment received and care plans with:

Name of Prepaid Health Plan ("PHP")	Initials next to applicable PHP. If Member does not know PHP, provider may reflect PHP assignment with X and secure member's initial to confirm consent.
AmeriHealth Caritas	
Carolina Complete Health	
Healthy Blue	
United Healthcare	
WellCare	

By signing this form, I authorize name of LME/MCO to share the following specific information with the health plan identified above, which may include information relating to my substance use disorder diagnosis, condition and treatment:
 Transition of Care: Crossover Consent under 42 CFR Part 2
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