NC Department of Health and Human Services
Division of Health Benefits

NC Medicaid Managed Care Update

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Medical Care Advisory Committee (MCAC) Meeting
June 11, 2021

Agenda

- Countdown to July 1
- Vision for Managed Care
- Day 1 Priorities
- Milestones
- Key Updates
  - Healthy Opportunities
  - Tailored Plan
  - Other Program Updates
  - Ombudsman
- Provider Resources

NC Medicaid Managed Care

20 days

North Carolina's Vision Remains the Same

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

Priorities for Day 1 Launch

- Individuals get the care they need
- Providers get paid

Auto-enrollment Complete

- Open Enrollment for Medicaid Managed Care concluded 5.21.21
  - ~15% individuals in mandatory category self selected a health plan
  - ~85% auto enrolled into a health plan
- Beneficiaries who had not selected a PHP by May 21 were automatically enrolled in one.
- As of May 22, all Medicaid beneficiaries currently eligible to transition to managed care had selected or been assigned a health plan
  - 97% of beneficiaries were enrolled in a plan that includes their current primary care provider (PCP) in-network

NC Medicaid Managed Care Enrollment Summary (As of 5/22/2021)

Total Members by Health Plan by Enrollment Method

All Regions	Active Selection	Auto-Enrollment	Total		Existing PCP in-network
Plan	Total Members	Total Members**	Members	% of Members	% of Members
AmeriHealth Caritas	12,120	264,048	276,168	19%	97%
HealthyBlue	104,870	251,578	356,448	25%	98%
Carolina Complete Health*	23,943	166,816	190,759	13%	98%
United Healthcare	37,824	283,815	321,639	22%	97%
WellCare	33,854	268,525	302,379	21%	97%
Tribal Option	76	3,630	3,706	0.3%	100%***
Total	212,687	1,238,412	1,451,099	100%	97%

*Carolina Complete Health is only available to members in Regions 3, 4 and 5.

**Totals include members temporarily living out of state that were auto-enrolled into plans.

***Members who have an existing PCP that is not in the Tribal Option network will remain in NC Medicaid Direct

Note: Total Members do not include the approximately 166,000 Medicaid beneficiaries who are due for Medicaid recertification between May 22 and July 1, 2021. After completing recertification, these members will be auto-enrolled into a health plan and will have a 90-day choice period to change plans like all other beneficiaries in Medicaid Managed Care.

Managed Care Milestones

June 12th - Member Information disseminated

Aug. 30th - Last date out of network claims paid at in-network rates

Sept. 29th - Last date health plan honors existing/prior authorizations

Sept. 30th - End of enrollment choice period*

* Without cause end date; Individuals can change plans with cause beyond this date; Individuals who are exempt may change plans at any time

Three Regions Selected for Healthy Opportunities Pilots

Healthy Opportunities is the nation's first comprehensive program to test evidence-based, non-medical interventions designed to reduce costs and improve the health of Medicaid beneficiaries.

- The program will test and evaluate the impact of providing interventions related to housing, food, transportation and interpersonal safety to high-needs Medicaid enrollees.

- The following organizations were selected and will reach three regions:

  - **Access East Inc.:** Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
  - **Community Care of the Lower Cape Fear:** Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
  - **Dogwood Health Trust:** Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

ncdhhs.gov/about/department-initiatives/healthy-opportunities

Tailored Plan Update

- Silent period remains in effect; cannot address items related to procurement
- Key Areas of Focus
  - Finalized requirements of Tailored Plan
  - Initiating work on notices to Tailored Plan individuals for post go live
  - Transition of Care Activities to maintain continuity of care
  - Tailored Plan AMH+, Tailored Care Management, and data strategy

Tailored Plan Update

- Well-being of beneficiaries continues to be the Department's top priority
- Close monitoring of active selections revealed an increased uptick in the number of Tailored Plan eligible individuals who enrolled in a Standard Plan
  - ~7,000 beneficiaries
  - Selection may make them ineligible for services they are currently receiving, have recently received, or may benefit from receiving

The Department stopped Standard Plan enrollments of all Tailored Plan-eligible beneficiaries who selected a Standard Plan will remain in NC Medicaid Direct and their LME-MCO through NC Medicaid Managed Care Go-Live on July 1, 2021.

- **Plan**
  - Provide additional information to ensure individuals are fully aware of the impact of their decision
  - In June, send notice informing individuals of the change back to NC Medicaid Direct with detailed list of services that are not available in a Standard Plan
  - By early August, implement a specific enrollment process for Tailored Plan-eligible individuals that will include enhanced choice counseling to help verify that beneficiaries have all the information they need
  - Continue to provide updates on this process

Additional Updates

- Beneficiary Assignment Files have gone live to communicate to AMH Tier 3s or their CIN which beneficiaries have been assigned to them by PHPs
- Health Plan Call Centers went live June 1:
  - Pharmacy
  - Nursing Line (available 24/7 for questions about non-emergency medical issues)
  - Behavioral Health Crisis Line (available 24/7 for Behavioral Health issues
- Ongoing engagement with CMS
  - EQRO contract approved

NC Medicaid Ombudsman

- The NC Medicaid Ombudsman Program is a resource for beneficiaries when they are not able to resolve issues with their health plan or PCP
- Has the ability to connect with members “personally”
- The program has trained staff available to assist beneficiaries with:
  - Information and education on Managed Care
  - Referrals
  - Issue resolution

Website ncmedicaidombudsman.org

Phone 877-201-3750

Monday – Friday, 8 a.m. to 5 p.m.

Provider Claims Payment & Timely Filing

- Within 18 calendar days of receiving the Medical claim Health Plans must notify the provider whether the claim is clean or request all additional information needed to timely process the claim.
- Pay clean claims within 30 days of receipt.
- Timely filing limits within 180 days of the date of service
- Claims not paid within the required timeframe bear interest at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid or was underpaid.
- Additionally, must pay the provider a penalty equal to one percent of the claim per day.
  - Providers do not have to make separate requests to the health plan for interest or penalty payments and are not required to submit another claim to collect the interest and penalty.

Question: Different timely filing requirements between LME-MCO and PHPs

Question: Given that LME-MCO have set 90 days as timely filing requirements and PHPs requirements are set at 180 days, how will a provider know which entity to bill. This could be a problem especially as members move back and forth between LME-MCOs.

Answer:

- Providers may access information on member plan assignments:
  - Through the NCTracks Provider Portal
  - By using the Recipient Eligibility function in NCTracks to verify plan assignment for a single beneficiary.
  - By using the NCTracks batch eligibility verification function
  - An AMH can review the beneficiary assignment file they will receive from the health plan
- DHHS has defined enrollment pathways for Standard Plan enrollees to better ensure that those who urgently need a service covered only by Behavioral Health I/DD Tailored Plans (or only by NC Medicaid Direct/LME-MCOs prior to Behavioral Health I/DD Tailored Plan launch) are transitioned as quickly and smoothly as possible.

Standard Plan Provider Claims Payment & Timely Filing

- Within 18 calendar days of receiving the Medical claim Health Plans must notify the provider whether the claim is clean or request all additional information needed to timely process the claim.
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- Claims not paid within the required timeframe bear interest at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid or was underpaid.
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  - Providers do not have to make separate requests to the health plan for interest or penalty payments and are not required to submit another claim to collect the interest and penalty.

Provider Resources

- NC Medicaid Enrollment Broker website ncmedicaidplans.gov
- NC Medicaid Transformation medicaid.ncdhhs.gov/transformation
  - Includes County and Provider Playbooks
  - Fact Sheets including:
    - Panel management
    - Managed care claims and prior authorizations
    - Day one provider quick reference guide
- NC Medicaid Help Center medicaid.ncdhhs.gov/helpcenter
- Practice Support ncahec.net/medicaid-managed-care
  - Back Porch Chat Webinar Series
    - Hosted by Dr. Dowler on the first and third Thursday of the month
  - Virtual Office Hours for Providers
- Regular Medicaid Bulletins medicaid.ncdhhs.gov/providers/medicaid-bulletin

Questions