SUPPORTING THE LTSS COMMUNITY THROUGH THE TRANSITION TO MANAGED CARE

Moderator Tim

Hello, and welcome to today's webinar. My name is Tim, and I'll be in the background answering any Webex technical questions. We have a few housekeeping items before we get started. If you experience technical difficulties, please send a message to the WebEx producer using the Q&A panel. You may also dial 1-866-779-3239 and receive technical support systems. During the presentation, all participants will remain in listen-only mode, and as a reminder, this event is being recorded for rebroadcast. We will be holding a Q&A session at the conclusion of today's presentation. We encourage you to submit written questions at any time during the presentation using the Q&A panel at the bottom right of your screen. Please type your questions in the text field and hit Send. Please keep the drop-downs All Panelists. With that, we invite you to sit back, relax and enjoy today's presentation. I would now like to introduce your first speaker for today, Trish Farnham, Senior Health Policy Analyst. Trish, you have the floor.

Trish Farnham

Hi, Tim. Thank you so much, and welcome everyone who is joining today. My name is Trish Farnham, and I am a Senior Health Policy Analyst with the Division of Health Benefits and working in the Quality and Population Health Section. I'm very glad to be doing this session today, along with my colleague Garrick Prokos from the Project Management Team of the Accenture Group, who is also going to be assisting in the session today. And Mandy Ferguson is going to be helping emcee the session, so thanks to her and our support Charlene, as well. We have a pretty full agenda for you today, so we're going to jump ahead to the first slide.

And as we start today's session, we wanted to clarify kind of what we're talking about. Those of you who have attended the last two sessions on Long-Term Services and Supports in Managed Care were probably aware that this session is the third in a series related to LTSS support, and those of you who are attending because you're interested in transition of care may recognize that this is first in a series. So, we are working to use this webinar to bridge the LTSS presentations that we've been doing over the last few months, and to also launch our transition of care sessions that are starting today and will continue into September. So, we are going to be focusing on the transition of care dynamics, specifically, to the LTSS populations. And we'll certainly use this as kind of a soft launch to the sessions that are going to happen in September. We wanted to clarify what's going to be covered and what isn't.

So, importantly, we'll provide a very, very high-level overview of our transition to Managed Care. Most folks on the call probably know these slides well, so we'll do them fairly quickly. And then we're going to talk a little bit more about the concept of transition of care and what we mean about, what we mean by that concept. And specifically, the term cross-over and the concept of cross-

over, which is essentially the large transition that we will all be experiencing when the health plans go live either in November or in February.

We're going to talk a little bit about some of the activities and interventions that are being established to support members and providers through the cross-over experience. And then we're also going to give you a little bit of a preview to some of the resources that are in development that we expect to be established by the time we do our sessions in September. Just to clarify and to manage expectations, we wanted to also note what's not covered today. We are not going to be giving guidance on how to enroll in a PHP network. Our provider team here, our provider education team, has done a really great job of providing resources for months now, and so that resource and that guidance is available, and we'll point you in the right direction of it, but we're not going to be talking about that specifically today. We are also not going to be talking specifically about health plan benefits on this call. Again, there are other webinars that have gone through that, and additional information is likely forthcoming, but that will not be the focus of today's session. Again, we definitely suggest and direct you to resources that our provider education team have put together that are referenced at the end of the webinar.

If we don't cover something that you're really interested in, more specifically the transition of care, we want to acknowledge that the transition of care concept is very broad. And so, our priority today is very broad, and so, our priority today is to talk about the systemic transition that we'll be going through in November or in February. And we also want to recognize that there's lots of really important detail and content to provide related to how members will transition between plans after our initial launch date. Because that concept and because that content is so involved in itself, we are going to actually table that for today, and we'll regroup and have another session similar to this on an ongoing transition of care dynamics.

Okay, we can go to the next slide. We always try to start our presentations with acronyms to make sure that people are clear on which acronyms are being used, and so we have identified those acronyms used throughout the presentation here. FFS is Fee-for-service. MCL is Managed Care Launch, which is the day the health plans go live in that particular region. PHP stands for Pre-paid Health Plans. So, when we talk about health plans, and we refer to them as PHPs, that's what we're talking about. Important to this particular conversation is going to be the term Prior Authorization, or PA. And then finally when we talk about UM Vendors, we're talking about Utilization Management Vendors. So, just want to kind of give you a tour and a preview of the acronyms that we may be using in today's session.

Next slide. So, like I mentioned earlier, we're going to go through these next slides fairly quickly, because we want to always level set with any audience about why we are having these conversations, but we also recognize that this group is probably a very informed group at this point, so we'll go quickly through these next few slides, which really outline the foundation for our transition to managed care and provide some basic timelines and activities that are under way.

Next slide. So, as folks on this call well know, and if you've been in North Carolina for any length of time, you know that this move to managed care is the culmination of actually many years of activity both within the Department of Health and Human Services and within our General Assembly. We kind of count the 2015 General Assembly legislation as our starting point for when

Managed Care really, the wheels really got set in motion for bringing Medicaid Managed Care into North Carolina. And since then, we have been working very hard with stakeholders and vendors and other, other interested parties to develop and shape a Medicaid system that really ensures that as we move to Managed Care, the following goals are prioritized. We worked to develop a system that facilitates whole-person care, so this LTSS community can certainly appreciate the value and the importance of that integrated care model. We work to address the, what is, what is referenced here is the full set of factors that impact health, often called social determinants of health, so thinking through the social dynamics of a person's experience and the health impact of those social dynamics, such as housing instability, transportation instability, food insecurity, or living in toxic environment. One of the guiding priorities for our work was to ensure that care management was considered, was developed to be as local as possible. And finally, really working hard to engage providers and ensure, to minimize provider burden so as to ensure as robust provider participation in the program as possible. And so, hopefully, you'll see some of those goals reflected in the activities that we're looking at today.

Next slide. You all have seen this before. This continues to be our Medicaid transformation system.

You can go to the next slide. Just to confirm some of the terms that we may be using today, and just to distinguish and delineate between the different programs that are now at play in the North Carolina Medicaid program, the first term we wanted to clarify is when we say North Carolina Medicaid Direct, or if you hear that term, essentially that is the catch-all term for services, the Medicaid program as it exists today before launch. So, this is largely fee-for-service. But it also includes the Managed Care activities that are already under way in North Carolina and related to the LME-MCO work, or the Pace program. When we talk about North Carolina Medicaid Managed Care, we want to make sure that it be clear that we're talking about the pre-paid health plans that are going live in November or in February. So, when we say that in this context, we're talking about those health plans. And finally, we know that the LTSS community is particularly interested in the Tailored Plan concept that is being developed and established. We wanted to make sure to note that these are also going to be Managed Care integrated health plans, but those are not established yet, and that will not be the focus of today's webinar.

Next slide. So, again, just as level setting, I think everybody on the call probably knows this, but we have listed the health plans that were awarded a contract back in February to implement the North Carolina Medicaid Managed Care program. And we have four statewide contracts, and then we have one regional contract, and so our, our vendors are reflected here.

Next slide. The next couple of slides again you've also probably seen, but just to level set, our North Carolina Medicaid Managed Care program is divided into six regions, and the regional map is reflected at the bottom. And all of the counties reflected under each header are reflected in those particular regions.

Next slide. The next two slides go together, and it's essentially reflecting that we are launching Medicaid Managed Care in phases. So, Phase I begins November 1st, and it actually includes the smaller number of the two counties

in that launch. So, you have Region 2 and 4, which will launch on November 1st, and those counties are reflected here.

And then if you go to the next slide. You have the other regions, which are called, under Phase II, which will launch in February. And those counties are reflected here in green.

Next slide. We know that there is a lot of activity under way already to prepare for the transition to Managed Care in November. And we wanted to, again, recap a slide that's been shared several times at this point about what activities are happening right now, and this is, this slide is specific to Phase I, but it's important to know that, as you all probably well appreciate, our enrollment broker, Vendor Maximus, is very much operational and is assisting members, particularly in Regions 2 and 4, to understand what options exist, what health plan options exist, and how to best choose a health plan, based on whatever factors are most important to that member, including the member's current primary care physician. And so, this slide works to acknowledge the activities that are under way related to that enrollment process, and we will soon be entering the next stage, which is an exciting place to be, whereas those members who do not actively select a health plan will be assigned a health plan, again, based on various criteria that ensure the member retains continuity of care. And that will happen in mid-September. From mid-September on, the November is the next material timeframe related to the enrollment is that the health plan coverage starts. And then, as you all probably well appreciate, members have a choice period that continues 90 days after launch. So, they have the authorization to change plans within that 90-day period. It's important to know that specific to LTSS population, LTSS members may select different PHP without cause at any time, even if it goes beyond that 90-day choice period.

Next slide. So, we are now going to, pardon the pun, transition to the conversation about transition of care specifically. And we always want to start with our guiding vision of what we hope to accomplish as we support members and providers through this very involved and momentous transition into the Medicaid Managed Care phase. Our goal as has been long established by our secretary, is that, as beneficiaries move between service delivery systems, the department ___ maintain continuity of care for each beneficiary and minimize the burdens on providers during the transition. Next slide.

As I alluded to earlier, we have defined transition of care to be two distinct stages or phases. We're going to be talking about the first one that's listed here on the slide. And we reference that as crossover. So, when we talk about crossover we've talking about the activities that facilitate both member and provider transition into the managed care phase. And so, this is the activity's underway to ensure continuity of care at that launch date. So, at the November 1st date or at the February 1st date, depending on the region that the member is in.

Importantly, we also want to note that the ongoing transition of care concept is ___ is also very important and relevant here. And when we say ongoing transition of care, we're talking about the practices and the safeguards that are in place for members who is in transition between health plans, or in North Carolina's context, may transition back to the fee-for-service service delivery system. So, we want to be very mindful that we do have other safeguards and additional safeguards that mirror our crossover safeguards that we'll talk

about today but have a little bit more nuance to them. And we'll talk about those at a later date.

Importantly, in the LTSS space sometimes in can get confusing because when we think transitions we're often thinking about changing from one setting to another, whether that's a hospital discharge or nursing facility transition. In – just to clarify this concept, we refer to those as care transitions, and we're not talking about those today. So, we're not talking about hospital discharge protocols, we're not talking about long term care transition protocols. What we're talking about is when a member transfers between health plans or payment delivery systems in some way. And the safeguards that that member will experience through that process. Next slide.

So again, like I've mentioned, we're focused today on our crossover dynamic, and later in the slide deck we will show you a slide with the timelines and the related activities and summary. But the next two slides we're going to talk about what safeguards we have worked to establish and are finalizing to really ensure that the member experiences true continuity of care throughout the transition to managed care. The next slide.

So, as we have worked to operationalize our state of transition of care vision, we have worked toward addressing several goals that are listed here. We want to make sure that health plans have the necessary data to ensure effective service continuity for beneficiaries who are transitioning. We want to make sure that there are safe ___ place related to prior authorizations, and non-participating providers appeal rights and identified services to make sure that those, those concepts are fully addressed in the transition, and that the member dynamic is fully considered.

We want to recognize that all – the folks who are transitioning into managed care represent a spectrum of needs from Moms and kiddos who simply use Medicaid to access their primary care, to more involved and complex beneficiaries who really rely on Medicaid to meet most of their daily living activity support needs. So, we wanted to recognize that spectrum and put in additional safeguards for a group we refer to as high need beneficiaries. We also want to make sure that providers have the information they need to support this member continuity and doing so through robust education options and opportunities, including today's session. And we want to make sure that all of our fee-for-service vendors and our managed care vendors, and our LME-NCOs all have mechanisms that ensure that continuity of care kind of on both sides of the transition. So that, if we were to think of transition as a bridge over a river, we want to make sure that both banks of the river have the mechanisms in place for the bridge to be continuous over the process.

We also are working and finalizing our oversight of the transition of care dynamics, both at the crossover and in an ongoing dynamic. And we also want to make sure that all of our crossover and transition of care design work is informed by the insight and experiences of all of our stakeholder communities. So, you all were instrumental, both directly and indirectly, in identifying and establishing the requirements and the – the __ that we're talking about today. And we always welcome additional feedback as we're working to fine tune, fine tune the requirements.

Next slide. So just to highlight what we're going to be focusing on today, we have bucketed all of the work that we're doing related to transitional care into the five segments that we've outlined on this slide. So, we're going to talk a little bit about some of the data transfer activities underway. We're also going

to talk about how we are working to facilitate uninterrupted service coverage. And we're going to be focusing primarily on prior authorization. We're also willing to highlight the additional safeguards that we have established for high need members. And then also recognizing that member and provider education are foundational to the success of these transitions, we want to highlight some of the activities that are underway related to the member and provider education. One of the other dynamics that is not going to be fully discussed today but that we also recognize as being fundamental is ensuring that entities who are involved in a transition have clearly, clearly talked each other. And so, we certainly want to reflect that goal on this side as well.

Next slide. So, we're going to segue into our first set of activities that are related to the crossover experience. And just as one other final bit of a tour guiding here, we are going to give folks a sense of what the overarching plan is, and the design is, and then we're going to highlight those specific considerations for providers. So, just know that we'll start with the high-level overview and then we'll provide some details about how these particular design decisions can help providers. So, people can appreciate supporting the data transfer is a critical key for ensuring continuity of care. And just to put that in real terms, health plans rely on prior claims history or the LME-MCO dynamic encounter history. They rely on care plans, they rely on prior authorization data, to really have a sense of who their members are, and then to really work to prioritize and to quote "stratify" the needs of those members, so that they can be fully engaged with their membership and have a better sense of what their members are going to be prior to actually serving them. So, to that end, we are working, and Garrett, my colleague and co-presenter, is also going to help clarify any additional technical design pieces on this. But we are currently operational as being the transfer of claims—24 months of claims and encounter history for members who are transitioning into managed care. We are working to finalize the transition of openly and recently closed prior authorizations for members who are transitioning. And we are also working to transfer, where possible, identified care plans from various fee-for-service vendors to the, to the health plans. So, this includes care plans through our CCNC vendor, and also through our LME-MCOs to a limited extent. Importantly, PCS service plans in ___ will also be transferred to the appropriate health plan. We've outlined the timelines on this slide, about when that – that data transfer will begin. And it will continue, or it will certainly be finalized prior to the launch date. Just one other qualifier – some of these dates are referencing the Phase One launch that occurs in November. Right, next slide.

So, again, working to make sure providers have a clear sense of what's coming up and how they may be impacted so they can prepare appropriately. We wanted to outline some of the specific provider impact based on these particular date of transfer design decisions. Importantly, on the claims and encounter detail, we do not anticipate any provider impact of the claims and encounter transfer is largely operationalized through our UM vendors or throughout NCTracks vendor, and the working with the plants to develop the appropriate transfer technical architecture.

On the openly, and open and recently closed prior authorizations, again, we are anticipating very little ___ impact on this as this is largely the work of our UM vendors. And again, or NCTracks vendor and our health plan.

Finally, on the identified care plans, we do want to note that we know that there are lots of services that have service specific service plans that are managed at the provider level. In order to minimize the macro list providers,

we made the decision that we would focus on transferring care plans that could easily be collected from vendors and transfer those to the plans. It's important to know though that as the plan receives the information and receives the claims and encounter history, they may reach out to help, they may reach out to their provider network to inquire on certain service dynamics related to particular members. So, we just wanted to make sure you had noticed that that may happen. Next slide.

We're going to shift gears a little bit and talk about something that we know is really important to our provider community, and that's to talk about, provide an overview of how the prior authorizations request will be managed at the time of launch. As you all can well appreciate, life does not stop for members just because of a November start date for the managed care plan. And so, it's important for us to put in desi – the architecture and the safeguards necessary to ensure that prior authorizations are managed as seamlessly as possible so that there is no disruption in the members' care. So, this is one of the slides where I'm going to note that there is a bit of a soft launch dynamic, so we wanted to note that very clearly. We want to note that GDFP and forgive me I realize we didn't describe that acronym, that's the NCTracks vendor. NCTracks and other UM vendors will continue to process prior authorizations __ request very close to the launch date. So, in most cases, it's going to be up to October 31st at 11:59. We are fine tuning a couple of provider – excuse me, service specific dynamics, which we put an asterisk on this slide. But it's important to know that if a UN vendor receives a prior authorization request for a member, and that request is received in most cases up to 11:59 on October 31st, the UN vendor is under the instruction to process that prior authorization. Even if the dates go in to managed care. We'll provide additional information on in our September session, so just note that this not a one and done.

Importantly, like we mentioned earlier in the date of transfer, both open and recently closed prior authorizations will be transferred to the members' health plan to ensure continuity of care. So as those fee-for-service UM vendors approve the prior authorization requests that were submitted prior to the launch date, that data will be transferred through the data transfer architecture we talked about earlier to the appropriate health plan. And the health plan will become aware and informed of those prior authorization approvals. As you all may know, the health plans are required to honor open prior authorizations for up to 90 days after launch. And if a PHP ends an open authorization after 90 days, it must provide appeal rights.

Importantly, and I should have added this to the slide, we are monitoring the prior authorization disposition very closely, both through the appeals and __ grievances process, but also through direct reporting from the plan to have a sense of where their assessments are landing as far as continued services for members after 90 days. Next slide.

This slide intends to articulate two, or to visualize two of the dynamics that we anticipate you're interested in. So, in some ways it's restating what I said earlier. But we just wanted to put it in visual form. So, if you look at these two scenarios, on the left side you have under the red banner, that the member is covered by fee-for-service. The yellow line in the middle reflects the managed care launch date. And the green header on the right side reflects that time that the member is now covered by the health plan. So, we have two scenarios listed here. And under scenario A, this is where a fee-for-service UN vendor generated PA is received prior to MPL. So like what I just said, if providers submit the prior authorization through the regular channels,

the UN vendor will process those prior authorizations up to very close to the launch date. In most cases it's going to be 11:59 the night before. And so scenario A essentially outlines what I mentioned on the last slide.

We want to note about scenario B, which is related to retroactive prior authorizations, the important emphasis here is that we will not, first of all, be modifying any of the current retroactive processes that vendors are currently under, so this slide should not be construed to in any way modify the process that is currently established for the particular service or UN vendor structure related to prior author – retroactive PA. But we do want to make sure that everyone is very clear that if the provider – if the provider submits a retroactive P-ray request prior – for dates of service prior to the launch date – back to the UN vendor, it's going to be important that if that prior authorization cover -- _____ covers those pre-launch and post-launch days that the fee-for-service UN vendor will only be able to authorize the pre-launch fee-for-service days. And providers will need to submit a new prior authorization for any post-launch dates directly to the health plan. All right, you can go to the next slide.

And again, before we go to this next section, I wanted to reiterate that again, this is in some ways, even though it's the third in a series on LTSS, it is a first in a series on transition of care. So if you're curious, or want additional information, no worries, if we're not going to cover it today, there will be additional information coming in subsequent webinars.

So we want to highlight, we know that obviously, in order to ensure people are able to submit the prior authorizations appropriately, it requires to make sure that people have the support to understand the process. So we don't want providers to feel uninformed. We don't want providers to feel like they're wandering in the wilderness on this front. And so we are launching several interventions to hopefully assist the provider community in understanding the prior authorization crossover processes that we've highlighted today. The first one is that we recognize that the better informed our provider community is, the better off we will be all avoiding potential challenges or confusion later at launch. So this webinar is one part of a much broader educational effort to inform providers on the prior authorization practices that we've highlighted today, and that will also be highlighted in the September webinars.

In addition to the webinar series, we are launching guidance through the Medicaid Provider Bulletin. And we're also working with our UM vendors to provide education to – on their websites, and in some cases provide additional educational opportunity for providers to have a full appreciation of the dynamics at play.

We've also worked to establish the functionality that is for whatever reason a provider doesn't understand or doesn't perhaps, didn't, wasn't able to attend the training. That if the provider attempts to submit a prior authorization for, to the UM vendors, to the fee-for-service UM vendors, on a date that is otherwise covered in managed care. That there is an error message or a banner message on the provider portal that clearly reflects why that member may either not be showing up, or why that particular date of service cannot be processed. So again, really making sure that there are again error messages or banner messages clearly established on the PA portal, on the UN vendor's PA portal, to guide providers on next step. We'll talk about that in a second.

Finally, where call center staff in their UN vendor, in a UN vendor space, we are working with them to make sure that they have the appropriate

information and script to assist you and assist providers who may call to guide them through the process of accessing the health plan information, or in many cases doing a warm transfer to the health plan's UN vendor point of contact. Next slide.

So like I mentioned earlier, much of the safeguard that – one of the safeguards that we're establishing is to make sure that if a provider attempts to submit a prior authorization for – that is not appropriate to that UN vendor, that the UM vendors have, either again an error message or banner message that is similar to the one that's reflected here. This is the message, and this is I think going to be final language of the message that providers who submit a PA request through NCTracks will see if that request cannot be processed because of the crossover dynamic. So you can see here we've tried to be clear in providing notice about why the PA can't be processed, and then to provide clear instruction on next steps. So that members or providers can be directly, can be directed appropriately. Next slide.

We know that you all deserve additional information, and what's coming, that what's being here on this, and so we just wanted to recognize that. And anywhere you see this little tool icon is areas that we know you all need and deserve additional guidance on. And these are the areas we are also developing.

Importantly, I want to highlight that last bullet. So the web resource that will provide health plan specific PA submission contact information and instruction. So we are working with our communications team and our PHP partners to establish the resources in one place related to the prior authorization process by health plans. Additionally, we will also be providing additional guidance on how to identify a member's managed care status in the NCTracks provider portal. We are finalizing that guidance now, and our hope is to be able to share screenshots in September. Next slide.

So again this next slide is trying to, to synthesize everything I've just said and really highlight those things, the key takeaways for the provider community at this point. Again, we will talk more about this in September, so this is not a one and done. But just at a high level, as we are working to make sure that prior authorizations are submitted appropriately, it's going to be important for providers to have a clear sense of the member's Managed Care launch date. So it's going to be important to know which county your member is receiving services in. Most of the time, that's pretty common sensical, but it's going to be important to be mindful of that. That's also going to be part of the guidance that we're developing related to the provider portal and for our UM Vendors through the global eligibility file training. So just know that more information on that to come, but that's going to be an important key piece to know.

It's also going to be important to be mindful of dates of service that are covered under our prior authorization request, so that it can submitted to the appropriate channel. And identifying the member's Managed Care status and the selected provider. So, as I mentioned at the very beginning of this session, members, or beneficiaries, are currently in the process of picking their particular health plan for the Phase One launch, and that evidence as those selections are made, or if they're made at auto assignment in September, the evidence will be available both in the provider portal and the on the global eligibility file. And again, we are working to finalize the guidance

that we can share to make sure you all know exactly where to find that information.

And then, like I mentioned earlier, we are also wanting to make sure providers are clear on PA submission requests and the process related to that for each individual health plan. You know, the provider contracting with the health plans has been well underway, so in many ways, you probably have a lot of this information already if you're contracted with the health plan. But just as kind of a safety net, we are also going to be establishing a one-stop shop resource center where folks can access all of the health plans UM Vendor points of contact in one place.

Next slide. So we are going to actually make a pretty hard transition here in our slide deck, and we're going to move from talking about data transfer and prior authorization submissions to really some of the higher touch safeguards that we are establishing for members to support them through the transition process, particularly again at the crossover stage. So this slide reflects, on a summary level, those interventions that are being established. And the date of transfer is included on this slide for the reason I mentioned earlier. That health plans, as they receive data related to claims utilization encounter detail, prior authorization detail – they are making their own informed decisions about where those members' needs may be and kind of identifying additional members that may deserve priority, or may require priority follow-up. So it's important to know that that date of transfer is not just about a bunch of numbers and tech details – it really does inform continuity of care in an important way.

But we also know that it's important to establish additional safeguards that are also high-touch, and for the department to use its history to identify specific details on specific members who may also need high-touch interventions right at the crossover dynamic. And then within that, we know that sometimes the most effective way to ensure continuity of care is not through data or through form, but for a conversation, and so we want to make sure that our fee-for-service partners who know their membership very well identify those members who they really feel may need a warm transfer, a knowledge transfer, between themselves and the member's health plan care manager. So when we talk about warm handoffs that's what we're talking about. It's essentially the fancy name for a conversation.

Next slide. So this slide attempts to reflect kind of the process for those high touch interventions for identified members. And we wanted to try to summarize this on a page – it does not reflect all of the nuisances, but we're trying to make sure everybody has a basic sense of how the process is intended to work. So on the left side of the page, you have a summary listing of those members that the department has identified as being high need. And so it's important that we have identified members who receive in-home long-term services and support – particularly those related to private duty nursing and other services. We have identified a high needs subset of members who receive behavioral health services. It's important to note that any member who is considered tailored plan eligible but elects to transition to a standard plan is also considered in this cohort. We have also given our CCNC, our LME-MCO and our state partners the opportunity to identify individual situations that may also necessitate a warm handoff, and consider those a high need. So even if those members don't, for whatever reason, meet the other criteria, we know that there are situations where the behavioral complexities or the LTSS complexities may not be, may not rise to the level of requiring a high need touch. But we know that there may be social dynamics

at play related to housing or other dynamics that people need to make sure to have a conversation about. So those are all, those warm handoff folks are also considered in the high need category. And then NEMT users – if they're not emergency medical transportation users with repeated or multiple appointments – so we are working with our DSS colleagues to make sure that the health plans are aware of high need members who perhaps use NEMT for life sustaining services and making sure the plans have those specific members on their radar screen at launch. And then finally, members with inform errors of metabolism – it's a relatively small group, but a very vulnerable group – and this group is also considered a high need population.

So what does that actually mean? Importantly, after launch, what that means is that the health plans are going to be doing active follow-up with these individual members – direct contact with these members immediately following the launch date. Importantly, the plans will be prioritizing members based on guidance that is given to them by our vendor teams, and also based on their own algorithms and details that they also have. But they are required to do personal contact with these high need members in the first several weeks after launch.

Some of the questions that we are tracking and wanting them to track very closely are the services that we've outlined here. And it's an important note again as a provider note to note to providers who are probably on this call, that providers may be invited to participate in the follow-up session. So as the plans are getting know their membership it's going to be really important that providers who know their members very well are likely going to be part of those dialogues and plans maybe reaching out to providers to participate in this discussion. Next slide.

So we also want to __ segue and recognize that member education is critical throughout this process. We know that the transition to managed care is a big one, and even though managed care poses lots of opportunities for LTSS population that don't currently exist in fee for service, we know that any transition of this significance is a big deal and can be daunting at best.

We also know that in the long term services and support community, different members are going to be impacted by the transition in different ways. So as we talked about on earlier calls this summer, some members will be transitioning into a health plan. So those members who are Medicaid only, who do not have Medicare, those members who are not on – while other members will remain in the fee for service program. So members like members with the _____ program, or members in ___. So it's important to know that the long-term services support populations experienced with managed care is dependent on a lot of factors. And so one of the things that we have worked to do is to develop educational materials that help some of these – the long term services and support community or aging and disability community to understand what's going on and how they are potentially impacted by this transition. So we want to also recognize the – that education is a clear piece of this, and on this slide we've identified one of the pieces of, one of the guides that we've created for this, for this purpose. Next slide.

It's also important to know that as we, even though there are a lot of long-term services support members who are not transitioning into managed care, we also want to make sure that members who *are* transitioning into managed care of all types, are fully informed of some of the supports and the resource that are available to them at – to support them through the crossover experience. And we know in the LTSS space in particular providers become

critical sources of information for members. So we know that people may be coming directly to their providers, asking them questions, and that you all are in a unique position to help inform members about the options that exist. So one of the things we wanted to make very clear on, is that we know that non-emergency medical transportation is a critical need, and that getting it right is a priority, not just for the department at launch, but also the health plan. The health plan has experience in similar type launches in other states, and they've brought that guidance and insight into helping us create safeguards to support members, insuring that they don't experience disruption in any __ services at crossover.

So we want to highlight that members, enrolled members who enroll in a health plan, will be able to reserve post-launch appointments 31 days prior to their effective date. So I've given an example here in case it's helpful, that if you have a member, I've called her Jan, that Jan is in a Phase One county and selects a health plan on ___ 15th, her managed care effective date will be November 1st. Jan has an appointment on November 2nd. Jan can reserve her appointment directly from the health plan starting October 1st. So we want to make sure that there's plenty of lead time for members to get oriented to the health plan's NEMT structure and to make sure that they receive support through that structure. We know that just telling you all is not sufficient. We want to make sure members understand this is available directly. Our colleagues in our DSS engagement team have worked very hard with the DSS's to identify ___ get information to members and to the plans about NEMT. And so we also know that additional communication to members specifically is going to be really important, and those things, those educational materials are currently in development. Next slide.

We are also working with the health plans and our other colleagues and vendors to make sure that the members is empowered with the clear answers that that member deserved to have and be clear on prior to launch. Again, our priority is particularly those high aid, high risk members who really depend – not on Medicaid, not just for an annual primary care appointment, but really to live their daily lives. But we want to make sure that members have the information needed to answer the questions that are listed here on the left, so they are clear on who their health plan is, who their primary care provider is, when they will start getting health care through their health plans. The number to call is a scheduled ride if they need to schedule a ride. The number to call if the person has issues getting ___after the start date. And the number to call if I have questions about how to get my supplies.

So we want to make sure people have very clear information on these questions, and are currently working again with our partners, and the health plans directly to insure that they have access to this information. Next slide.

So this slide is a summary slide that hopefully outlines all of the details that I have referenced today, and also provides a bit of a time framing for how these activities will actually be launched and implemented. So you can see here again this is focused on Phase One. We consider that ___ the crossover education activities have really started this month. In some ways they started before this month. And I will continue in earnest through September and October. In November we have our Phase One launch, and we will continue providing follow-up and monitoring very closely with our Phase One experience. Certainly through December and frankly through January and likely even in to Phase Two launch. So candidly we are anticipating that we

will be in crossover mode, crossover oversight mode, minimally through next April. Next.

So I'm going to just highlight through these next few slides at a high level so we have a little time for questions. But we wanted to make sure that you have the resources that you need, and want to use whatever opportunity we can to provide them. We know that there is a lot of dialoguing already under way, with health plans and the provider community, so we know that a lot of this is probably already well understood by the people on this call. But just in case you wanted additional support, we want to make to provide. And so the first slide I wanted to highlight – next one, thanks.

-- is really a credit to our incredible work of our Provider Education team, who have since last spring launched a series of webinars, of which this is one of, that really highlights specific dynamics related to the Medicaid transformation process design, and the transition into the Medicaid Managed Care space. So if any of these topics on the left pique you interest, and you haven't already seen these materials, this is a really good starting place. Next slide.

So like I mentioned earlier, this is really – this webinar is really launching a much broader effort to inform providers about crossover dynamics. So this is largely a stay tuned slide. We are starting to post things in the monthly bulletin, provide these crossover trainings like we're doing today. And again, we will be posting the department, what we're formally calling the crossover resource page, and hope to have that live by the September training. Next slide.

Just to give you a preview on – you are probably well aware of this slide or this web page, that exists already. It is the Medicaid transformation provider page. And we've provided the link here. The crossover additional resources that we've talked about today will be links off of this particular page. And we've listed some of the content that we anticipate to have posted at this page on the slide here. Next slide.

So we're getting to the very end, we know you have additional questions, and we'll try to answer a few of them now. But just in case you have additional questions that aren't answered, we want to make sure you're aware of the Medicaid SWAT Team's email address. That is becoming increasingly circulated and is really good as a clearinghouse email. If you have questions, there is a really incredible team that fields those questions, directs them into appropriate to other subject matter experts, and then works to track them to make sure that questions get answered in a timely way. So that's a really good email to have in your contacts list. If a member, or if you have questions about the enrollment process that is currently underway, we've provider the enrollment contact information here. Again, this is, the enrollment workers work really hard to talk to members and their families or their supports directly, but we know that providers may also be assisting or facilitating that call so we want to make sure you have the information.

Like I mentioned earlier, if you're interested in any of the training sessions that were referenced a couple of slides ago, they're also at that provider link. That's going to be another good link to hyperlink, if it's not already, or to bookmark, if it's not already. And if you want to review any of the provider Medicaid bulletins that are, have been written – only one so far – but as more are written, they will be housed at the link that's provided here.

Mandy, I think we're getting close to the end and ready for questions. You want to go to the next slide, one more time, this last slide.

So as the final think I'll say is that I keep referencing other transition of care webinars that are scheduled and the dates are listed here. And again, we hope to provide additional detail and additional tours of the resources that we've highlighted today. So we invite you to put these both on your calendar and look forward to continuing this dialog.

Mandy, I think I'm finished and we're happy to take a few questions, if that's helpful.

Mandy — Great. Thanks, Trish. OK, so we do have a bunch of questions here – and thank you, this is super informative and I know we won't get to everyone's questions today, but just to say that we will be able to answer any questions that folks have other the next, over the coming weeks, and we'll post them to the same website that Trish referenced, on provider education.

So, since we just have a couple of minutes here, I'm just scanning to see what my, what my top ones are. I think that – Trish, if you wouldn't mind saying a little bit more about the data transfer at crossover. I think folks are interested in exactly how long it'll take or approximately how long it'll take. And I know that you said it won't affect providers and there's some questions no, you know, is it going to look different, are care plans going to look different for me on the back end, you know, are claims going to be different, and that kind of thing. So if you wouldn't just saying a couple of words about that.

Trish — Yeah. We can some description of the data transfer, but as far as the specific questions go, those are probably going to be best submitted through the SWAT, because it's largely going to be – there may be health plan nuance, and some of those questions are going to be outside the scope of our care and quality subject matter. So it's important to submit specific questions to the SWAT email, but Garrick, do you want to talk a little about the data transfer in general?

Garrick — Yeah, I can talk a little bit about the prior authorization data transfer and the timing around this. So for beneficiaries that are going to be moving from fee-for-service to Managed Care starting on November 1st, what's going to happen is if you an adjudicated PA in NCTracks system or through a UM Vendor, what will happen is, starting on October 1st, those open and approved prior authorizations will be sent to the PHPs and it will continue on a daily cadence from October 1st onward. So what will happen is, as we move toward Managed Care launch starting on October 1st, as newly adjudicated PAs come through the system, NCTracks will, and the UM Vendors will pick up those prior authorizations that get adjudicated and continue to send them on a daily basis through launch.

Trish — Mandy, hope that's helpful but we know that there may be specific questions that, again, can't be effectively answered on a global scale so feel free to, please folks, submit your question through the Medicaid SWAT email.

Mandy — Yeah, not that's really helpful. And I see that some folks are asking whether or not the slides will be posted from this webinar and from the webinars on September 5th and 19th, and all of the slides will be posted to the provider education website, and that goes for some of the presentations that Trish highlighted earlier that we've been doing throughout the spring and summer.

	So, I know that we're at the top of the hour here and thank you everyone for joining us this afternoon.
Trish	Thank you all.
Voice	Ladies and gentlemen, this concludes today's event. Thank you for attending. You may now disconnect your lines, and have a great day.

End of webinar.