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

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May 24, 2021 and June 7, 2021
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.

<table>
<thead>
<tr>
<th>NC Medicaid Beneficiaries Who Will Enroll in NC Medicaid Managed Care on July 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitioning beneficiaries will be able to choose from 5 Health Plans (aka “Standard Plans”)</td>
</tr>
<tr>
<td>• AmeriHealth Caritas</td>
</tr>
<tr>
<td>• Healthy Blue</td>
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<tr>
<td>• United HealthCare Community Plan</td>
</tr>
<tr>
<td>• WellCare</td>
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<tr>
<td>• Carolina Complete Health: Serving regions 3, 4, and 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key NC Medicaid Beneficiary Groups who Will Remain in NC Medicaid Direct on July 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Beneficiaries who are Dually Eligible for Medicare/Medicaid.</td>
</tr>
<tr>
<td>• Beneficiaries who receive waiver services or PACE.</td>
</tr>
<tr>
<td>• Beneficiaries who are enrolled in Foster Care.</td>
</tr>
<tr>
<td>• List is not exhaustive, for full list, please see NC Medicaid Managed Care Enrollment Table in Resources section.</td>
</tr>
</tbody>
</table>

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.
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

<table>
<thead>
<tr>
<th>Available In Both Standard Plan and BH I/DD Tailored Plan</th>
<th>Available Only in BH I/DD Tailored Plan (or LME-MCOs Prior To Launch)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Plan Services</strong></td>
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</tr>
<tr>
<td>• Inpatient behavioral health services</td>
<td>• Residential treatment facility services</td>
</tr>
<tr>
<td>• Outpatient behavioral health emergency room services</td>
<td>• Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)</td>
</tr>
<tr>
<td>• Outpatient behavioral health services provided by direct-enrolled providers</td>
<td>• Child and adolescent day treatment services</td>
</tr>
<tr>
<td>• Psychological services in health departments and school-based health centers sponsored by health departments</td>
<td>• Intensive in-home services</td>
</tr>
<tr>
<td>• Peer supports</td>
<td>• Multi-systemic therapy services</td>
</tr>
<tr>
<td>• Research-based intensive BH treatment for Autism Spectrum Disorder</td>
<td>• Psychiatric residential treatment facilities (PRTFs)</td>
</tr>
<tr>
<td>• Diagnostic assessment</td>
<td>• Assertive community treatment (ACT)</td>
</tr>
<tr>
<td>• EPSDT</td>
<td>• Community support team (CST)</td>
</tr>
<tr>
<td>• Partial hospitalization</td>
<td>• Psychosocial rehabilitation</td>
</tr>
<tr>
<td>• Mobile crisis management</td>
<td>• Substance abuse non-medical community residential treatment</td>
</tr>
<tr>
<td>• Facility-based crisis services for children and adolescents</td>
<td>• Substance abuse medically monitored residential treatment</td>
</tr>
<tr>
<td>• Professional treatment services in facility-based crisis program</td>
<td>• Substance abuse intensive outpatient program (SAIOP)</td>
</tr>
<tr>
<td>• Outpatient opioid treatment</td>
<td>• Substance abuse comprehensive outpatient treatment program (SACOT)</td>
</tr>
<tr>
<td>• Ambulatory detoxification</td>
<td><strong>Waiver Services</strong></td>
</tr>
<tr>
<td>• Non-hospital medical detoxification</td>
<td>• Innovations waiver services</td>
</tr>
<tr>
<td>• Medically supervised detoxification crisis stabilization</td>
<td>• TBI waiver services</td>
</tr>
<tr>
<td></td>
<td>• 1915(b)(3) services</td>
</tr>
</tbody>
</table>

**State-Funded behavioral health, I/DD and TBI Services**

*Enhanced Behavioral Health Services are Italicized
EPSDT Protections continue to apply*
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.

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**Ongoing Transition of Care**

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.

- Legal requirements
- Sensitivity to beneficiary needs and circumstances.
- Ensure providers have access to Crossover protections
- Ensure Health Plans have as much data as possible to ensure provider payment
• 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.
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.


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

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

<table>
<thead>
<tr>
<th>How can I determine which services require prior authorization for a health plan?</th>
<th>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: <a href="https://www.wellcare.com/North-Carolina/Providers/Authorization-Lookup">https://www.wellcare.com/North-Carolina/Providers/Authorization-Lookup</a></th>
<th>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: <a href="http://www.amerihc.org">www.amerihc.org</a></th>
<th>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: <a href="https://provider.healthbluenc.com/north-carolina-provider/prior-authorization-lookup">https://provider.healthbluenc.com/north-carolina-provider/prior-authorization-lookup</a></th>
<th>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.</th>
<th>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: <a href="https://unhprovider.com/priorauth">https://unhprovider.com/priorauth</a></th>
</tr>
</thead>
</table>
| How can I submit a prior authorization to a health plan? | WCHP submission methods:  
- **Standard:**  
  - Online via Provider Portal: [https://provider.wellcare.com/](https://provider.wellcare.com/)  
  - Via fax to the numbers listed on the associated forms: [https://www.wellcare.com/North-Carolina/Providers/medicaid/forms](https://www.wellcare.com/North-Carolina/Providers/medicaid/forms)  
  - **Urgent:**  
    - Call 866-799-5318 and follow the prompts.  
    - **Pharmacy:**  
      - Call 866-799-5318 and follow the prompts. | AMHC submission methods:  
- **Standard:**  
  - Online via Provider Portal: [www.navinet.navimedix.com](http://www.navinet.navimedix.com)  
  - Via Fax to 833-893-2262  
  - Call 833-900-2262  
- **Pharmacy:**  
  - Via fax to 877-234-4274  
  - Call: 855-375-8811 | Healthy Blue submission methods:  
- **Standard:**  
- **Urgent:**  
  - Call 800-964-3627 (Inpatient)  
  - 844-445-6649 (Outpatient)  
  - Call: 844-594-5072 | CCH submission methods:  
- **Standard:**  
  - 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.  
  - Call 833-552-3876  
  - Via Fax to 919-670-4948 | UNHC submission methods:  
- **Standard:**  
  - Online via Prior Authorization and Notification Tool on Link: [https://unhprovider.com/priorauth](https://unhprovider.com/priorauth)  
- **Urgent:**  
  - Call Provider Services at 877-842-3210 and follow the prompts.  
- **Pharmacy:**  
  - Call Provider Services at 877-842-3210 and follow the prompts.
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?

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


Next Training will occur on

- Monday, June 7, 2021: noon-1:00pm
- [https://register.gotowebinar.com/register/8020572701079118093](https://register.gotowebinar.com/register/8020572701079118093)
## NC Medicaid Managed Care Enrollment Table

<table>
<thead>
<tr>
<th>Status of Medicaid Managed Care Enrollment, Per Legislation</th>
<th>Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory (Must enroll)</td>
<td>• Most family &amp; children’s Medicaid, NC Health Choice, pregnant women, non-Medicare aged, blind, disabled</td>
</tr>
</tbody>
</table>
| Excluded (Cannot enroll, stays in NC Medicaid Direct)     | • Family Planning program, medically needy, health insurance premium payment (HIPP), 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)         | • 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

Notice of Authorized Services

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: [Redacted]

Consumer Address: [Redacted]

Consumer Phone #: (315) 555-5555

Consumer DOB: XX/XX/XX

Consumer SS #: [Redacted]

The following services are included in this treatment authorization

Service Codes: H003B/4 U4 Peer Support

Authorization Effective Date: 03/20/2019

Authorization End Date: 04/20/2019

Weekly Max: 29

Monthly Max: 347

Total Units Approved: 312

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Total Units Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>H003B/4 U4 Peer Support</td>
<td>312</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization Effective Date</th>
<th>Daily Max</th>
<th>Weekly Max</th>
<th>Monthly Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/20/2019</td>
<td>29</td>
<td>24</td>
<td>347</td>
</tr>
<tr>
<td>04/21/2019</td>
<td>29</td>
<td>16</td>
<td>347</td>
</tr>
</tbody>
</table>

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

[Redacted]

CROSSOVER May 24, 2021 and June 7, 2021