Sharon Woda

Welcome everyone and thank you for joining today's webinar. My name is Sharon Woda and I'm a managing director with Manatt Healthcare Strategies, a firm that is supporting NC AHS as it transitions to managed care. I will be your organizer for today's webinar presentation on North Carolina Medicaid Transformation, for providers. Today's presentation is the first of a series of seven provider education modules that are planned on Medicaid transformation. Notification of additional provider education modules will be forthcoming and posted on the website. Additionally, in the slides we will review today, we'll also post it to the website.

There are just a few housekeeping rules before we get started. All attendees should have received an audio pin upon registration. If you did not receive a pin, please raise a hand or send a chat to the organizer and a pin will be provided to you at the email that was used at registration. All calls are going to be muted for the duration of this event. However, questions can be entered at any time during the presentation and are very much encouraged. If you have a question, please use a raise a hand feature, which is located at your control panel. At the end of the presentation, I will read submitted questions and ask the NC Medicaid subject matter experts to respond to them. We will answer as many questions as time permits. And please note that a complete Q&A summary, even for the questions that we couldn't get to, will be made available within a few weeks following the conclusion of today's presentation. For now though, we will turn it over to Sarah Gregosky who is the deputy director of Standard Plans.

Sarah

Thank you Sharon. Thanks everyone for joining today and welcome to our first webinar on Medicaid transformation as providers transition to managed care. As Sharon mentioned, this will be the first in a series of meetings. We already have two others planned around provider reimbursement and quality and value that will be rolling out in a few weeks, but wanted to go ahead and go through a few slides with you today. We have a great team gathered in the room that's going to provide an overview of some of our key initiatives, future opportunities for engagement, as well as the vision that we have as the department around Medicaid transformation.

If we could go to the next slide. On page three, we've outlined the vision that we, as an organization have had and been communicating with all of our stakeholders over the past few years around our vision for managed care. I won't read the vision to you, but I'll reiterate some of the key points of it. We really focused on being innovative, making sure that we are purchasing health as we're thinking through Medicaid transformation. Being whole-person centered, so integrating the physical and behavioral health needs of that member as they transitioned to managed care. And addressing both the medical and non-medical drivers of health, really bringing together those opportunities for health that we talk about with most of you all in the field.

Can we go to the next slide? For a little bit of context on how we got here, in 2015 the general assembly enacted a law that directed the transition of Medicaid and North Carolina health choice members from a predominantly fee for service system to a managed care system. Since then, we've been collaborating with you all as well as hospitals, beneficiaries, counties, other health plans, elected officials, acts and other stakeholders help shape the brand and ensure that our Medicaid managed care plans deliver whole-person care, address the full set of factors that impact health, perform local care management

and maintain a broad provider participation in the program by helping to mitigate against provider administrative burden.

Can we go to the next slide? On this page, we just wanted to outline a few of our recent milestones around managed care. In October of 2018, we received federal approval from CMS, our federal partners around our 1115 demonstration waiver. And then earlier in this year in February, we awarded contracts to five pre-paid health plans that will lay the groundwork for implementing managed care later this year.

In June, we'll begin sending welcome packets through our enrollment broker to beneficiaries living in part of the state that will give the information about how to select a health plan. They'll have an open enrollment period and then they will select a health plan. The first two regions that will go live are regions 2 and 4 and we'll show a map a little bit later but those are regions really focused around the triable and the triad.

Later this summer, and as many of you know this is already happening, these prepaid health plans will begin to contract with providers in the market to build their network so that they can meet the detailed network adequacy standards that the state has already established for the health plans. Then in November, on November 1st, managed care PHPs will launch in two regions. At the same time, we'll start the open enrollment period for beneficiaries in the remaining regions of the state. Then in February, we will go live in those remaining regions. Again, we'll get to the math later, but that's really the far west part of the state, then along the southern border and up the coast of North Carolina.

Next page. We're going to review some of the key initiatives. We'll start with an overview of managed care on page 7. And then dive into some details around advance medical home, quality and value, behavioral health integration, opioids and then our healthy opportunities.

Next page. To provide an overview to you all of where we are, so we anticipate that the majority of our Medicaid and NC health choice beneficiaries will receive Medicaid coverage through pre-paid health plans. And when we say the majority, we anticipate that in the first year of standard plans that will be around 1.6 million individuals. As a part of this, you, as providers, will begin to contract with and be reimbursed by prepaid health plans rather than by the state directly.

There will be two types of PHP health plans, commercial plans and provider-led entities. They will be offering two distinct types of products, though we're going to focus mostly on standard plans today. Standard plans will be for most beneficiaries and are scheduled, as we mentioned on the prior page to launch later this year and into 2020. Throughout this process though, we'll remain focused on continuing to provide high quality and local care management.

Next page. To give you guys a little bit more details on who's actually eligible for managed care, we outline on page 8 those individuals that are excluded, as well as those that are delayed from going into managed care as well as those who are exempt, and we'll talk a little bit more about that in a minute. So on the left side of the page, we outline a group of populations that will be excluded from managed care indefinitely and remain in fee for service are the current delivery system. Most of these individuals have limited benefits like family planning, population or inmates of prisons, both participate in our health insurance premium payment program.

On the right side of the page, we get into three distinct groups. Those that will be delayed until behavioral health intellectual and developmental disability tailored plan launch in two years. And those individuals will be in more specialized plans. We're still finalizing the criteria around the eligibility for

those individuals, and we'll be rolling that out in the coming month. Additionally, we'll be temporarily excluding beneficiaries in long-term nursing facilities and those that are duly eligible. Finally as required under federal law, members of federally recognized tribes that reside in North Carolina and are part of the North Carolina Medicaid program will be exempt from managed care. This means that they can either opt into managed care or remain in the fee services model.

Next page. On page 9 we outline the contracts that we have awarded to the pre-paid health plans to provide standard plan benefit beginning later this year. We awarded four state-wide contracts, one to AmeriHealth Care Cartas North Carolina; Blue Cross/Blue Shield of North Carolina; UnitedHealthcare of North Carolina and WellCare of North Carolina. All of these plans will offer statewide coverage to those individuals that are eligible for standard plans. Additionally, we awarded one regional provider-led entity to Carolina Complete Health. That organization will operate in regions 3 and 5 of the state.

Next page. On page 10, as I mentioned, here's a map of how we'll do the roll out of regions of the managed care launch of standard later this year and into next year. Phase 1 will begin in November in regions 1 and 2 so those in yellow and red at the top of the slide. And then in February, 2020, it will begin in regions 1, 3, 5 and 6, for those regions that are in light green, orange, dark green and blue at the bottom of the page. I will note, however, that the contract here for all of those regions will run through the end of June 30, 2020 or the end of the states as clear. The contract with each of the PHPs will be for three years, with the option for the department at its discretion to renew for two additional one-year terms.

At this time, I'd like to introduce Jamika Wilkins, senior program manager of quality to provide an overview and information on the advanced medical homes.

Jamica Wilkins

Thank you Sarah. Next slide will review advanced medical homes. Ultimately, the AMH program is a pathway for providers to leverage and take on increasing accountability for the cost and outcomes of the populations they serve. Practices that are well positioned to do this will have opportunities to enter into value based contracts, that extend beyond traditional fee-for-service models.

The goals of the AMH programs are as follows: preserve broad access to primary care services for Medicaid enrollees. Access is strong today under the current Carolina access foundation and we desire to preserve it. Strengthen the role of primary care in care management, care coordination, and quality of the improvement. The AMH program aims to support practice teams and tend to leave wherever possible and being appropriately paid for doing so through the levels of AMH tiers. Allow practices to implement a unified approach to serving Medicaid beneficiaries, minimizing administrative burden. We recognized early on that managed care brings with it the possibility of fragmentation by PHP population. That's why we have a state certification program for practices to enter into tier 3 and stand up a unified approach to serving Medicaid members across all PHPs. Provide clear financial incentives for practices to become more focused on cost and quality outcomes for populations, increasing accountability over time.

Over time, the AMH program is desired to be a glide path for practices and systems for more responsibility for their Medicaid population and for managing total quality costs for those populations. Through the AMH program and our targets for value based payments, we will be measuring progress in this broader efforts.

Next slide please. Now we will discuss the overview of the advanced medical home program. The AMH programs will serve as the primary vehicle for delivery of local care management under Medicaid managed care. AMHs will have multiple tiers. In tiers 1 and 2, the prepaid health plans will retain primary responsibility for care management. Practice requirements for tier 1 and 2 AMHs are the same as those for Carolina access 1 and 2 providers. In tiers 1 and 2, providers will need to coordinate across multiple plans. Practices will interface multiple PHPs for the care management platforms that they've established.

PHP may employ different approaches to care management, which those providers will need to work with as AMH tiers 1 and 2. In these tiers, AMH payments paid by the pre-paid health plans to practices will be on a per member per month basis and they'll be the same as Carolina access. These medical home fees will meet minimum payment floors for $1 for Carolina access 1 and Carolina access 2, $2.50 for most beneficiaries or $5 per member per months for age, blind, disabled, beneficiary categories.

For those providers attested to tier 3 of the AMH program, prepaid health plans will delegate primary responsibilities for delivering care management to the practices. Practice requirements include in tier 1 and 2, some additional tier 3 care management responsibilities. Tier 3 AMHs enable and support and single, consistent care management platform that practices will be able to provide in house or contract with a CIN or other party. In terms of AMH payments, there will be a per member per month medical home payment made by PHPs to practices and they are the same as Carolina access tiers 1 and 2 PMPM payment.

Additional care management payment can be negotiated and should be negotiated between PHPs and practices. The tier 4 AMH program will be launched at a later date with more innovative advanced payment arrangement. There is more information to come about this tier.

Next slide please. Working with CINs and other partners in the AMH programs. So how can CINs and other partners help AMHs? There are a number of different ways that CINs can help, depending on the specific needs of the practice. A first key functional area that they can assist in is the actual provisions of local care management and care coordination. The second area is related to data analytics. CINs can help integrate and analyze the wide range of data that AMHs are going to receive from PHP. And they can also help pick that data and help to produce reports for other outputs that provide information that's useful and actionable for practices. Third, they can also assist in contracting by helping practices negotiate care management fees and VBP payments with PHPs in certain instances. One final thing to note here that applies throughout is the state anticipates the majority of AMH tier 3 practices will elect to contract with a CIN or other partner for support. So, we really want to stress that they're not required to do so. If a practice feels that it has the necessary in-house capacity to do AMH tier 3, they're not required to work with a CIN or other partner.

At this time I would like to introduce Amanda Van Fleet, senior program analyst who focuses on healthy opportunities and value based payments to cover the next two slides on value base payment and population health.

Amanda Van Vleet

Thanks Jamica. So as I'm sure many of you as providers are aware, the shift from fee-for-service to value-based payment is well underway nationally and in North Carolina. The healthcare community as a whole is shifting from _____ for the volume of services provided to paying for health outcomes and improved quality of care and improving the cost of care. So, nationally, the amount of value-based

healthcare payments has steadily increased in the past few years. In 2017, value-based arrangements were most common in Medicare but were widespread across care.

In Medicaid specifically, a quarter of all payments were value-based. And specifically value-based care is well underway in North Carolina. Major health systems are signing value-based arrangements across payers including commercial plans and Medicare. For example, five major health systems recently signed contracts with value-based arrangements like Blue Cross/Blue Shield of North Carolina. UNC Health Alliance signed a value-based arrangement with Blue Cross North Carolina in relation to their ACA plans. And Duke Connected Care is in care ACO as part of the Medicare shared savings program. So, North Carolina Medicaid shifted to a value-based payment is really part of a broader shift in payment models ranging across care.

Next slide please. So, on this slide I'll talk a little bit more about North Carolina Medicaid strategy to move to value based care. Our strategy is basically we are allowing somewhat of a glide path for providers and plans to form VBP arrangements in years one and two of managed care. However, both providers and plans should expect the department to raise the bar on value based payment requirements beginning in contract year 3. So, enter contracts with prepaid health plans, we stated that by the end of contract year 2, PHP's expenditures that are governed under VBP arrangements must either increase by 20 percentage points or represent at least 50% of total medical expenditures.

So I know that may sound somewhat aggressive, but we believe that we are allowing quite a bit of flexibility in these first two years for what counts as value based payments. And you can find more information on that in guidance that is listed on our website.

So again, providers and plans should anticipate that the state will have higher expectations related to value based payment arrangements beginning in contractor 3 will be releasing guidance on those expectations in the next few months. We expect the providers will take advantage of the ramp up period in the first two years to build the infrastructure that's needed to participate in higher level or higher risk VBP arrangements from where they currently are now.

So we do realize that providers in the state have a wide range of capabilities, infrastructure and experience with value based arrangements and that some providers have no experience. The department expects to meet providers where they are in their range of capabilities. So, we will have higher expectations of large hospital based health systems than we do for smaller and independent practices. However, we will be expecting that all providers will be moving towards value no matter where on this value scale they start.

And some points on quality. Value based arrangements must be linked to the department's quality measures. PHPs will be monitored on 33 priority quality measures against national benchmarks and state targets. And quality of care will, of course, be taken into great consideration when looking at VBP arrangements. The department is also requiring that PHPs implement annual quality improvement projects to ensure improvements in quality of care and health outcomes.

So now I would like to introduce Kelsey Knicks, senior program manager for population health to lead the presentation on behavioral health and for the implementation of tailored plans.

Kelsi Knicks

Thank you Amanda. One of the main components in driving principles of Medicaid managed care is the integration of physical and behavioral health benefits to provider holistic, well-coordinated whole person just in the care. As part of Medicaid managed care, we will have two types of products: standard plans which as Sarah mentioned will go live in November, 2019 and behavioral health intellectual and developmental disability plans, otherwise referred to as tailored plans, which are tentatively scheduled to go live in July, 2021. Both standard plans and tailored plans are fully integrated managed care products offering physical health, behavioral health, pharmacy and long-term services and support. The majority of Medicaid in North Carolina health choice enrollees including those children and adults with mild to moderate behavioral health needs will participate in the standard plan. Those enrollees with higher behavioral needs or who have an intellectual and developmental disability, or a traumatic brain injury will receive their comprehensive care through the tailored plan.

Next slide please. So, what are the high level differences between standard plans and tailored plans? As I previously mentioned, tailored plans will serve those enrollees with significant behavioral health needs. Those with intellectual and developmental disabilities and those with a traumatic brain injury. That does include those individuals participating in the TBI waiver, the innovations waiver and those who are on the wait list. But unlike standard plans, tailored plans will not be statewide, they will be regional plans. And per legislation for the first four years of managed care, Medicaid can only allow our current Local management entity, managed care organizations or LME-MCOs, to hold a contract as a tailored plan. After the four years, it will become a competitive procurement process that any non-profit prepaid health plan or PHP may bid for a contract to operate a tailored plan. Medicaid can also award no more than seven and no fewer than five tailored plan contracts. Tailored plans must contract with an entity that holds a PHP license.

There will also be differences in the behavioral health and intellectual developmental disability service array between the standard plan and the tailored plan. Tailored plans will offer the entire behavioral health I/DD and TBI North Carolina Medicaid service array as well as Medicaid's 1915 B3 services and manage the state fund services for the uninsured and the underinsured.

Next slide please. So, this slide is a nice visual representation of standard plan and tailored plan timelines. Again, as Sarah mentioned, we awarded our standard plan contracts just last month in February. With standard plan, the first phase launching in November, 2019. Simultaneously as we prepare for standard plans to go live, we are designing the components of our tailored plan. The department will issue a request for application or an RFA, tentatively in February, 2020 for those current LME-MCOs that want to become a tailored plan. And again, we have a July 2021 proposed start date for the tailored plan.

Next slide. Lastly, as part of our 1115 waiver and the department's commitment to fight the opioid epidemic, North Carolina's opioid strategy. North Carolina is driving toward improvement in care and quality outcomes for individuals with substance use disorders. Two of the main components of an opioid strategy is to increase access for in-patient and residential substance abuse services and expand our North Carolina substance use disorder service array. Amanda will now cover the next slide on healthy opportunities within Medicaid transformation. Amanda?

Amanda Van Vleet

Thanks Kelsey. So Sarah mentioned early on in the presentation the department is committed to improving the health of North Carolinians through the idea of whole person care, which includes addressing both medical and non-medical drivers of health. And we care so much about these non-medical drivers because they are really fundamental to an individual's health. Some estimates show that as much as 80% of a person's health is determined through social, environmental and behavioral factors alone. So, we see this as the real function in the opportunities for health we would like to address.

So to do all of this, we are embedding these opportunities for health into Medicaid managed care. All PHPs will have a role in addressing these non-medical drivers for all of their Medicaid members. For example, PHPs will be required to screen for social risk factors in their initial care need screening as new members, and are also required to connect members to community resources using NCCARE360, which is the state's new online and phone based resource center for all platforms.

And more fundamentally, we're really encouraging PHPs and providers to address social risk factors in their overall care and quality strategies in a similar way that they would address physical health and behavioral health. So, in addition, North Carolina has been granted the authority from CMS to test healthy opportunities pilots in 2-4 geographic areas of the state. These pilots are designed to fit into the managed care infrastructure but offer an enhanced case management and additional covered services to pilot enrollees. These pilots will test if evidence based interventions that are designed to both improve health and reduce costs by more intensely addressing social risk factors in four domains. And those are housing instabilities, transportation insecurities, food insecurity and interpersonal violence or toxic stress for eligible Medicaid beneficiaries. And more information about these healthy opportunities pilots can be found on our website.

So my colleague, Lynne Testa, senior program analyst, will now lead the presentation on the deep dive into managed care.

Lynne Testa

Thank you Amanda. During this segment of today's presentation, we'll be taking a deeper look at managed care, covering topics of health plan standardization, member selection of their plan and primary care physicians, credentialing, network advocacy, health and oversight and provider payment.

Next slide please. The department has worked hard to mitigate administrative burden for providers. As previously covered in earlier designed documents and policy papers, considerable effort was made to ease administrative burden to support provider transition to managed care. Administrative simplification efforts have included standardizing and simplifying administrative processes across PHPs wherever appropriate; incorporating a centralized and streamlined provider enrollment and credentialing process; ensuring transparent and fair payments for providers; establishing a single statewide drug formulary that all PHPs will be required to utilize; requiring PHPs to cover the same services as Medicaid fee for service, with the exception of services carved out of Medicaid managed care. We've also asked that the PHPs use the department's definition of medical necessity when making coverage decisions, and using standard prior authorization forms.

Next slide please. Regarding beneficiary plan selection and auto assignment process, it is important to note that the department will be conducting extensive outreach to encourage timely selection of their

health plan. Where circumstances exist but the member has not selected their health plan timely, they will be auto assigned. The state's enrollment broker (Maximus), will work with county departments to educate beneficiaries at the local level.

The key points to remember here are that beneficiaries will be able to select a plan at application, recertification and through choice counseling with the enrollment broker. Beneficiaries will be able to select a plan through any of those methods starting at soft launch. Beneficiaries who do not make a selection prior to the end of open enrollment will be assigned a health plan. For beneficiaries that do not make a plan selection, the following auto assignment criteria will be utilized. We will consider the beneficiaries geographic location, whether the beneficiary is a member of a special population. We will take a historic view of the provider-beneficiary relationship. We will make plan assignments for other family members. Previous PHP enrollment during the prior 12-month period and we will make equitable health plan distribution with enrollment subject to health plan enrollment ceilings and floors, increases in a PHP's based formula, intermediate sanctions or other considerations.

Beneficiaries will be able to change their plan assignments from soft launch through 90 days post launch. And a 12-month eligibility recertification interval, beneficiaries will receive a 90-day choice period. Beneficiaries also have the right to change plans through the enrollment broker for both with cause and without cause reasons.

Next slide please. In addition to beneficiaries and health plans, they also choose their advance medical home primary care provider or AMH-PCP. Or they will be auto-assigned. Here to the enrollment broker Maximus will be helping to provide beneficiaries with information and assistance to make these choices at the time of enrollment. It is important to remember that beneficiaries will be able to select a provider at application, recertification and through the choice counseling with the enrollment broker. They will be able to select a provider through the enrollment broker if the member is changing a plan. The beneficiary's primary point of contact to select or update their AMH-PCP assignments will be with the PHP. Beneficiaries can change their AMH-PCP without cause twice per year. Members shall be given 30 days from receipt of notification of their beneficiary to change their AMH-PCP without cause and shall be allowed to change their AMH-PCP without cause up to one time per year thereafter. That's the second instance.

Beneficiaries shall be allowed to change their AMH-PCP with cause at any time. Beneficiaries who do not select a provider will be assigned a provider by the PHP using the PCP-AMH auto assignment criteria. That means we'll look at the prior AMH-PCP assignment, the member claims history, the family member's AMH-PCP assignment, family member's claim history, geographic proximity, special medical needs and language and cultural preference.

Next slide please. Many of you are already aware that provider enrollment and credentialing is a critical part of the federally regulated screening and enrollment process. The centralized approach that has been designed or reduced administrative burden on providers as well as maximized efficiency among plans. Today, a provider must be enrolled through the North Carolina Medicaid provider enrollment process in order to be paid for treatment and services delivered to Medicaid beneficiaries.

Similarly in managed care, a provider must also be Medicaid enrolled to deliver services, whether those services are in-network or out of network. Under managed care, providers will enroll in North Carolina Medicaid just like the current enrollment process. The centralized credentialing and re-credentialing policies as signed are intended to be uniformly applied by all health plans. To minimize administrative

burden on providers as North Carolina Medicaid transitions to managed care, our provider data contractor, YPRO, will supplement the state's existing provider data to support the health plan's ability to make their objective quality determinations.

As we indicated in earlier policy papers, the department will be establishing a nationally recognized third-party credentials verification organization or CVO solution. The CVO will not be operational when Medicaid managed care launches. However, during this transition period, the department will ensure providers still experience a seamless and largely invisible credentialing process as they transition into managed care. Additional details surrounding provider credentialing will be forthcoming in a soon to be scheduled webinar on provider policies that is targeted for early May, 2019.

Next slide please. Network adequacy is the ability of a health plan to provide beneficiaries with timely access to all covered health care services through a sufficient number of in-network providers. Beneficiary access to care will be monitored under such measures as availability of services and assurances of adequate capacity and services. A snapshot of network adequacy standards that the department created appears on the right hand side of this slide. These standards are intended to establish a maximum time or distance a beneficiary must travel to a network provider. The standards vary by the type of provider or type of service and whether the county is designated as urban or rural. Appointment wait time standards are intended to ensure that beneficiaries may access in-network care without unreasonable delay. The standards vary by the urgency of the care needed and the type of service involved.

A network adequacy monitoring an oversight systems will be put in place that ensures health plans have adequate capacity to provide care to all beneficiaries in their service areas. Some key components of oversight and monitoring will include submission of regular documentation by the health plans including provider network data and report to demonstrate network adequacy, monitoring beneficiary complaints related to access to care and provider networks, and if necessary issuing corrective action plans and health plans are identified as non-compliant with network adequacy standards and access requirements.

Next slide please. I'd like to transition the presentation back to Sarah who will now cover the next few slides on oversight and payment.

Sarah Gregosky

Thank you Lynn. As Lynn referenced in her discussion of network adequacy, the state will be performing a variety of different types of oversight as a part of their ongoing relationship with the PHPs and implementation of managed care in North Carolina. The PHPs will be required to report on compliance in a number of contract areas as defined by the department, including network claims payments, contract provider enrollment and key turn around times related to provider payment. DHHS will monitor for compliance, identify tends and improve corrective actions if needed. Those actions could include penalties for non-compliance, a corrective action plan, retraining of the health plans, sanctions, liquidated damages and, if needed, contract termination.

Additionally, DHHS will approve each PHP's provider appeals and grievance policy and processes. The PHPs will share regular information with DHHS around appeals and grievances once that policy is implemented. Additionally, the state intends to implement a provider ombudsman program to assist when grievances cannot be resolved and the provider has exhausted all of the PHP's appeals processes.

Next slide please. The department also intends to closely monitor the utilization management program of each PHP to ensure that beneficiaries receive services and that providers are paid appropriately. The PHP is required to submit utilization management policies to the department for approval and additionally those policies will be subject to NCQA approval as a part of each health plan's accreditation. Once approved, the PHPs will be required to report on claims submitted and denied payments as a part of their encounter data where the state will then analyze those patterns around denied payments and suggestions around inappropriate denials. We will additionally monitor prior authorization on a regular basis and make sure that the utilization management policies are consistent with the fee for service policies as required under federal law that managed care can be no more restrictive in time, duration or scope than what is offered in the fee for service program. The department seeks ongoing feedback from you all and other providers when certain plans or work codes are seeing higher denial rates.

Next page please. We want to talk a little bit around provider payments. Underneath North Carolina managed care, the PHP will be required to contract with any willing provider. This means that a provider cannot be refused a contract if they accept the PHP's rate or unless they do not meet the PHP's objective quality standards. Additionally, payment to in-network hospitals, physicians and physician extenders must be no less than 100% of the Medicaid's fee for service rate, unless the PHP and the provider agree mutually to an alternative arrangement.

Special payment provisions apply to certain provider types and will be discussed at future webinars. Those providers include local health departments, public ambulance providers and FQHCs. For out of network payment, the PHPs are prohibited from paying out of network providers who refuse to accept the PHP's contract or fail to meet objective quality standards at more than 90% of the Medicaid fee for service rate. But we will note that this excludes emergency and post stabilization services which must be reimbursed at no more than 100% of the fee for service rate. Additionally, the PHP must reimburse out of network providers 100% of the Medicaid fee for service rate if the provider was excluded for reasons other than those listed in the slide.

Next page. Finally, we want to talk about the transition of hospital payments to value. The current system of supplemental payments allowed under Medicaid is not permitted in managed care and it's not aligned with our vision of paying for value. As a first step payments will be carved into base rates directly tying hospital payment utilization. The North Carolina hospitals have played a leading role in developing this new approach including the methodology to set higher base rates, the approach to graduate medical education payments and changes to the hospital assessments. Dollars previously paid through supplemental payments will be reinvested in higher hospital base payment rates to preserve payment levels.

Additionally, PHPs will be required to pay no less than this new higher base rate for at least the first three years of the contract. This period will extend longer for hospitals in economically distressed counties. Finally, hospitals will receive an additional amount in the form of directed or pass-through payments to offset projected utilization losses due to uncertainty during the transition to managed care. Similar to the phase out listed above, these payments will phase out in the first year of the contract.

Now I'll transition over to Lynn to talk about additional opportunities for provider engagement.

Lynne Testa

Thanks Sarah. The department remains committed to ensuring that providers receive education and support through the transition to Medicaid managed care and beyond. Let's take a closer look at how providers will have opportunities to engage with the department.

Next slide please. Providers should know that their input and feedback is really important. We want providers to have opportunities to connect with us through a number of venues and activities. The upcoming series of webinars will educate providers on key topics to effectively serve their patients in the transition to managed care. _____ and FAQs will accompany each webinar. The department's web page that is highlighted on the screen will serve as a central hub for providers to access resources about the transition to managed care.

In addition, very soon, we will be scheduling PHP meet and greets and virtual office hours. The PHP meet and greet will be held in each of the six regions and will be similar in style to an open house. Providers and practice managers can mingle with PHP representatives to ask specific questions about joining their networks. Virtual office hours will offer opportunity for providers to ask questions of the North Carolina Medicaid leadership team regarding the transition to Medicaid managed care in a real time format. Please look for an announcement soon on a calendar of coming events. And, we encourage providers to continue submitting questions or concerns to the Medicaid transformation email address provided on the slide.

Next slide please. Here is a quick snapshot of upcoming provider education opportunities. There are six webinars that will roll out in the coming weeks that will cover topics on provider payment and contracting; overview of quality and value; clinical policies; provider policies; beneficiary policies; behavioral health services regarding standard plans and the transition period. In addition, we will very soon be announcing a calendar of PHP meet and greets and virtual office hours.

Providers should continue to be watchful for upcoming opportunities that will be promoted on our website through special bulletins and articles and announcements that will be pushed through NC tracks. At this time, I would like to transition the presentation back to Sarah who will offer closing remarks for today's presentation.

Sarah Gregosky

Thank you Lynn. Again, we want to thank everyone for joining our first webinar around transitioning providers to managed care. We'll now transition to question and answer. Sharon, are you ready?

Sharon Woda

Yes, I am. Thank you for everyone that submitted their question. And just as a reminder, if we don't get to it during this time period, we will be taking all the questions and putting out a document on the website. The first question is for Amanda. And we got in a couple of questions on – you had mentioned that there's going to be higher expectations for VBP and something will be really soon coming up. Can you provide a timeline on that and can you provide any more context on what that looks like?

Amanda Van Vleet

Sure. We are releasing more items this summer. And it will –I got into an outline are longer term vision for value based payments. And we may set some more specific parameters around what counts as VBP or set more specific parameters around targets or types of arrangements. So, for example, right now we're counting value based payments as anything in land categories 2-4. We may set some additional parameters around expectations for different types of providers based on provider capabilities. So, keep an eye out for that coming this summer. And I will mention that we will also be taking stakeholder feedback on that guidance once we release it and we will be iterating it over time based on the feedback that we get.

Sharon Woda

Okay thank you. The next question I received is will practices be allowed to limit their enrollment by setting caps on enrollees or an age limit or any other factors? So basically where does the relationship between what a practice wants to do to put parameters on their enrollment? Where does DHHS setting up guidelines around that?

Female Speaker

Thank you for that question. At this time, the state is still having discussions about enrollment restrictions for their participation with the PHPs. As you know today with our CCNC program practices are allowed to limit and put caps on the number of enrollees, but please look forward to more communication on that. And also at the provider PHP's meet and greet, that would be a great question to ask the PHP as you would be in the same room.

Sharon Woda

Thanks so much. We have a few question that I think are alluding to the fact that some plans are protesting or some questions of if we can rely on the ones that have been chosen. Should we contract with them or should we be sort of tracking that process in any way and how does that process intersect with the rollout of managed care. Sarah, I think that one's for you.

Sarah

Thanks Sharon. Thanks for the question. The state has a well-defined protest process and ask folks know several of the non-awarded health plans have begun that process. That, however, does not stop the state from moving forward with implementing managed care with the awarded health plans. We will continue to move forward with the five PHPs that were selected until such point that we are told by the courts to stop. So, in other words, keep going, feel comfortable to meet and discuss with any of the PHPs that have been awarded because on our end we anticipate to continue to move forward unless told otherwise to stop.

Sharon Woda

Great, thanks Sarah. Question on network adequacy. The question is when is the state looking at what adequacies to the plan and will that be the same for region 1 as it is in the _____ versus the subsequent _____.

Jean Holiday

This is Jean Holiday. The plans will be showing us their adequacy of their networks in various points between now and managed care launch. We do expect that all the plans will demonstrate their adequacy prior to November 1st, even the PLE that is limited to regions 4 and 5 – no, 3 and 5, even though they're not going to be going live until February of next year. So, we will be getting that network adequacy demonstration a number of times between now and the managed care launch in November.

Sharon Woda

A couple questions regarding AMH. I think the main ones are really can you restate the tier fees that will happen as well as can you provide more information on where folks should go for more information on the AMH program? And I think that can go to Jamika or Melanie.

Jamika Wilkins

So, all the information around AMHs are out on the AMH webpage. If you go through Medicaid transformation there's an advanced medical home webpage that has all of our policy papers, as well as our provider manual, our FAQs, etc., listed on that page. There's a link from that AMH page to an AMH training page that has all of the AMH 101-108 webinars listed with the slide deck as well as the transcript for those presentations. So, all that information is out on the website. Now, what was the other question Sharon?

Sharon Woda

It was a clarification of the different fees that are paid, in particular of the distinguish between the AMH tier 2 and tier 3.

Jamika Wilkins

So, AMH tiers 1 and 2 receive their PMPM payment. They also receive any payments received for their services as normal for visits to office. Tier 3 receives additional care management payments and are also eligible for any incentive payment. So, the AMH tiers 1 and 2, 1 get their $1 PMPM, 2s get their $2.50 PMPM for most beneficiaries. $5 for the age, blind, disabled beneficiary category. And then tier 3 gets the $2.50/$5.00 plus a care management fee and are eligible also for incentive payments.

Sharon Woda

Great, thanks so much. We got a couple questions about how providers sign up for managed care. Is it just one application? Where do providers go and then a few questions on where providers should submit claims and if it's the same process that's in place today? So, I think that should probably go to Sarah or anyone else in the room that wants to take that one.

Jean Holiday

This is Jean Holiday again. Providers need to be aware that the plans are obviously building their networks and are seeking to contract with providers. So, providers need to consider whether or not they want to contract with any PHP or however many that they may wish to contract with. Keep in mind that in general services are only covered if they're provided by contracted providers, therefore out of

network services are not automatically covered. And providers should be reaching out to the PHPs if they have not already been contacted by those PHPs to start discussing contract conditions. Please be sure that you understand that all providers need to be actively enrolled in Medicaid before they contract with a PHP. And this also includes a provider who is providing out of network services. You also need to be an enrolled provider. Sarah, do you have anything you want to add?

Sarah

I'll just add one thing to Jean's comments. The question around will claims be submitted the same way? No, claims will not be submitted the same way. Today, your claim would be submitted in fee for service through NC tracks. Going forward, those claims would be submitted to the PHP in which that member was enrolled where they would process those claims and make reimbursements to you for providing those services.

Sharon Woda

Thanks Sarah, thanks Jean. This one's for Kelsi. A lot of questions about the benefits covered under behavioral health services, so I think the summary here is what behavioral health services are going to be covered by the standard plan?

Kelsi Knicks

So, the standard plan is going to have your basic outpatient therapy services, your med management, all your crisis services such as facility based crisis for adults and children. Certainly in patient care, acute in patient care, somebody needed to be psychiatrically hospitalized. And quite a few of our substance use services as well. We really want to make sure that somebody who needed a crisis service or a substance use service can get that treatment regardless of what plan they're in. And then your tailored plan is going to offer every single state plan service that Medicaid currently offers for behavioral health.

Sharon Woda

Thank you Kelsi. I know we're at the top of the hour, so I'll just have one last question here on provider training for Lynn. Can you just give us a quick explanation of the upcoming webinars that are coming in, specifically those where we stated that you'll have one on clinical policies, provider policies and beneficiary policies? Can you quickly summarize what's in those and then that will be our last?

Lynn Testa

Thanks Sharon. So, the upcoming webinars on clinical provider and beneficiary policies are really designed to help ensure that providers understand managed care requirements. So, with the clinical policies webinar, providers can expect to learn more about the benefit package, pharmacy, an appeals and grievances for UM related purposes. With the provider policies, providers are going to get additional understanding on where the state has simplified and streamlined administrative requirements across all the health plans, where they can go for extra support if it's needed. And they're also going to hear more about items that will be covered on provider credentialing, network adequacy, provider grievances and the new role for the provider ombudsman.

On the beneficiary policies, providers will have greater understanding on which populations are moving to managed care. The beneficiary eligibility and enrollment process. The beneficiary support

infrastructure. Patient attribution to practices and the role of PHP member services and over beneficiary related items. So, these next few webinars that are coming up really will get more into the details on each of these subject areas.

Sharon Woda

All right, thank you Lynn and thank you, I know we're a couple minutes over. Thank you everyone for participating and we look forward to seeing you in a forthcoming webinar.

End of Webinar