Webinar 102 - Provider Payments and Contracts, Medicaid Managed Care

Gerald

Welcome everyone. Thank you for joining today's webinar. My name is Gerald and I'm the producer at WebEx and I will be your organizer for today's webinar presentation on North Carolina Medicaid Transformation Provider Payment and Contracting. Today's presentation is the first in a series of eight provider education modules that are planned on Medicaid transformation. Notification of additional provider education modules will be forthcoming and posted to the Medicaid Transformation website.

Before we get started I have a few housekeeping items to cover. Now, if you do experience any technical difficulties during or joining this WebEx session, you can call WebEx technical support at 1-866-779-3239 or you can message me, the WebEx producer using the Q&A panel on the right hand side of your screen. 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 by using the Q&A panel at the bottom right of your screen. Please type your question into the text field and hit the send button. Please keep the drop down as all panelists. With that, we invite you to sit back, relax and enjoy today's presentation.

I would now like to turn the call over to your very first speaker and moderator for today's event. He is a manager at Manatt Health, Mr. Avi Herring. Sir, you have the floor.

Avi Herring

Thanks very much. Today's provider payment and contracting webinar is intended to help providers understand what and how they will be paid, understand changes and financing and implications for their net revenue and ensure continuity of payment and services during the managed care transition. I would like now to introduce Roger Barnes, chief financial officer at North Carolina Medicaid who will provide the content overview for the presentation, and then briefly cover North Carolina Medicaid transformation before moving into a deep dive on provider payment. Roger, I'll turn it over to you.

Roger Barnes

Thank you Avi. This is Roger Barnes, chief financial officer for the North Carolina Medicaid program. We do welcome everybody to today's session. If you advance the slide to our contents – thank you – we will take and go over the following on today's module. We will have a brief overview of the Medicaid transformation. Section 2 will be general payment provisions. Section 3 will be payments by provider type. Then, we'll move into operationalizing the provider payments. Have a Q&A session, and then end up the session with next steps.

So the next slide please. This will be part 1, this will be North Carolina Medicaid transformation and if you'll go to the next slide. As you all know, in 2015, the general assembly passed session law 2015 245 directing us to transform the traditional fee for service programs into the predominantly the health choice of Medicaid into a managed care program. To do that, we have spent several years in submitting an 1115 labor and working with CMS and we are avid approved labor and are ready to move forward. We have worked with collaboratively with the clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates and other stakeholders to shape the program and we are committed to ensuring a Medicaid managed care plan.

We plan on delivering whole-person care through a coordinated physical health, behavioral health and electrical developmental disability and pharmacy products and care models. Address the full set of addresses that impact health, uniting communities and health care systems, perform localized care management at the site of care in the home or community, maintain broad provider participation by mitigating provider administrative burden.

Next slide. The prepaid plans that we are working with and have awarded contracts are AmeriHealth Caritas North Carolina, Blue Cross and Blue Shield of North Carolina, UnitedHealthcare of North Carolina and WellCare of North Carolina. Those will be in four statewide and we will be rolling those out and go live on November 1, at least two regions of the state. There is one regional PLE that is Carolina Complete Healthcare in North Carolina, Inc. and they will be operating in regions 3 and 5 and they will be part of the phase 2 rollout.

Next slide. So you can see the six regions that we are planning on rolling out. We plan on November 1, 2019 rolling out regions 2 and 4. Those would be if you have color screen, those would be the yellow regions and the red regions. The other regions will be rolling out in February, 2020.

Next slide. So, in Slide 7, you will see the timeline that we propose on the rollout. As I said earlier, February ’19 we began contracting with the providers through managed care go live. In June to July, ’19, the enrollment broker will send out the phase 1 enrollment packages to the beneficiaries. Open enrollment begins. Summer of ’19, health plans must meet network adequacy requirements. On October ’19, phase 2 open enrollment will begin. On November, the managed care state plan launch will – in selected regions. And then in February of ’20, we will launch out phase 2. Now, key takeaways in the February, you’ll notice in the box over there is the time for PHP contracting is now and as I understand some of the providers have been contacted by the health plans and so we feel that that process is taking place. If a PHP has not reached out to you, please reach out to them as soon as possible. There will be a meet and greet events with PHP to discuss policies and procedures. The timing on that will be announced as to be determined. I will tell you that we are holding conference calls with health plans targeted on working on technical items.

So next slide. Okay, so part 2, we’ll go over some general payment provisions. In this section we will have further payment information in the later section when we get into a little more detail. So if we go to the next slide. All right, so we’re on slide 9, the PHPs will be required to contract with any willing and qualified provider. PHPs must offer these provider contracts with these payment terms. First payment term, PHP required, again, to contract with any willing provider. If you meet the quality standards, accept a PHP rate and PHP must contract with you, however you do not need to contract with every PHP. And part of that is you must enroll in the Medicaid program to be part of a willing and qualified provider. Payment to in-network hospitals, position extenders must be no less than 100% of the Medicaid fee schedule, unless the PHP and provider mutually agree to an alternative reimbursement method. We will go a little bit further into the detail on that later in this presentation. But to get 100% of the Medicaid fee schedule for those providers listed, you must contract with a health plan.

PHPs must offer these provider trust contracts with these payment terms. Providers can negotiate higher rates or alternative payment arrangements, but are not required to do so. Special payment providers apply to certain provider types and we will cover that in part 3 of this presentation. Provider types that do not have a rate floor must negotiate rates with a PHP.

Next slide please. So PHP payment levels for out-of-network providers depends on why the provider is out of network and the type of service provided. Situations where the PHPs must pay no more than 90% of the fee for service are as follows: PHP has made a good faith effort to contract with the provider but the provider has refused the contract. Please note the note at the bottom of this page and when we discuss good faith. The provider has excluded from PHP's network for failure to meet the objective quality standards. So, again, the provider must meet the quality of standards in order to be contracted and receive the full fee schedule.

Situations which a PHP must pay 100% of fee for service with providers. The provider must not have been offered a contract or still engaged in good faith negotiations. All family planning providers, all state providers that deliver emergency and post-stabilization services, in state providers that deliver emergency and post-stabilization services. Out of network services are generally subject to prior approval by the PHP. So, again, there are notes at the bottom of this slide. Please note those notes to help define some of the terms.

Next slide please. Network adequacy. The network adequacy standards help ensure the PHP build a robust provider network and beneficiaries must have access to care. Medicaid has set forth some guidelines on what is considered network adequacy. The standards vary by geographic area and include time and distance standards. And point and wait time standards. So for hospitals, there must be more than one hospital within 30 minutes or 15 miles for at least 95% of its members in an urban county. In a rural county, it must be one or more hospitals greater than 30 minutes or 30 miles or at least 95% of its members. Primary care for urban county must have at least 2 providers within 30 minutes or 10 miles for at least 95% members. For a rural county, 2 providers within 30 minutes or 30 miles for at least 95% of its members. Specialty care, urban county, at least 2 providers for a specialty type within 30 minutes or 15 miles for 95% of its membership. And for rural, it's two providers for a specialty type within 60 miles or 60 minutes of at least 95. Within patient behavioral health, there must be at least one provider for each in patient behavioral health service within each PHP region. The takeaway is PHPs need to meet the network adequacy standards by the summer of 2019 and are actively building provider networks. The time for contracting is now.

All right, so this will bring us on the next slide, part 3 which we'll start diving into the provider detail on payments. And I'm going to switch this over to Mr. Reggie Little who is the associate director of our provider reimbursement area. Reggie.

Reggie Little

Thank you Roger. The overview of payments by provider type that we're going to cover today are listed on slide 13, so if you advance the slide, we will be covering physician and physician extenders, advanced medical homes, federally qualified health centers, rural health clinics, local health departments, hospitals, pharmacy, public ambulance, Indian health care providers, nursing, state-owned and operated facilities and hospice.

Next slide please. For physician and physician extenders, PHPs must reimburse those providers at no less than 100% of the Medicaid fee for service rate, unless there is a mutually agreed upon alternative payment agreement. The department plans to increase the fee for service rates to the Medicare levels for a subset of primary care service providers, but that is contingent upon CMS approval. And once we receive that approval, those rates will be adjusted.

For primary care physicians, the PHPs must reimburse the primary care providers according to the following parameters for all E&M codes. And you will notice there is a note at the bottom of the slide that defines the range of codes as defined in section 1202 of the Affordable Care Act. For primary care physician extenders and OB/GYNs, PHPs must pay 100% of Medicare physician rates. For nurse practitioners and physician assistants, the PHPs must pay 85% of the Medicare physician rates. PHPs and providers can mutually agree to alternative payment agreements and the Medicaid fee for service codes serve as the rate floor for all remaining services.

For specialty care providers, PHPs must reimburse all in-network specialty care physicians and physician extenders at least 100% of the Medicaid fee for service rate for the service or the bundle. And they can also mutually agree upon alternative payment agreements in this instance. So I will now transition back to Roger Barnes to cover AMH.

Roger Barnes

Thank you Reggie. So, in this slide, we're going to talk about the advanced medical home practices will continue to receive medical home fees for assigned members and may earn additional care management fees and performance incentive payments depending upon the tier status. For the detail of this, I'm going to let Julia Lerche speak on the details of this slide.

Julia Lerche

Thank you Roger. For practices that qualify as advanced medical homes, as you can see on the slide, the service based payment clinicals will remain as described on the prior slide for physician payments and other provider payments that will go through in the remaining slides. In addition, the health plans or the PHPs will be required to continue payments similar to those today for the Carolina access program. So practices that meet the requirement for advanced medical home care 1, they'll receive a per member, per month payment of $1 for their assigned members. For tier 2 and tier 3 advanced medical homes, the payments will continue similar to how they are today for Carolina access to $2.50 for most of their enrollees and $5 for members who are aged, blind or disabled.

In terms of the care management fees, the advanced medical home practices are expected to take on additional care management functionality and those fees will be negotiated between the AMH practices and the PHP. Additionally, for the AMH tier 3 practices, the PHPs are required to offer performance based incentive payments for practices that meet certain quality standards. So, I'm going to now pass it on to Jim Flowers to talk about FQHC and RHC.

Jim Flowers

Thanks Julia. Currently, federally qualified health centers and rural health providers receive payment streams in the form of service payments from NC tracks and annual cost settlement or PPS wrap reconciliations from the division. These payment streams will transition under managed care. For service payments, providers will bill the health plans for managed care beneficiaries and the health plans must reimburse FQHCs and RHCs at not less than the Medicaid fee schedule for covered services. This includes the Medicaid unique provider specific T1015 rate as a rate floor for all core services and the Medicaid physician fee schedule for all non-core services.

Then for wrap-around payments, the federal rules permit DHHS to continue making additional wrap around payments to FQHCs over and above the health plan payments for services after transition to

managed care. How will this happen? DHHS will calculate a quarterly PPS reconciliation and make quarterly wrap around payments to FQHCs and RHCs in order to ensure that these providers receive aggregate payments equal to the PPS per-visit rate that is required by federal law. And then annually for those FQHC and RHC providers that are currently cost settled, DHHS will make an additional wrap-around payment representing the difference between Medicaid costs and payments received for those services.

Next slide. All right moving on to local health departments. Local health departments will receive three separate payment streams from the health plans under managed care. Service payments, care management payments and additional legalization based payments. For the service payments, the health plans shall negotiate base reimbursement amounts to in-network health departments that are no less than 100% of their respective Medicaid fee for service rate schedule as set by the department. For the care management payments, for years one through three, the health plans will pay health departments no less than the per member per month payment they receive today for the provision of care management or high risk pregnancy and for at risk children. The rates are set here on the slide listed below. In year four, the PHPs will then compensate health departments and other providers of care management services at net mutually agreed upon rates.

For additional utilization based payments or directed payments, DHHS is committed to ensuring health departments receive similar per-unit payments under managed care compared to what they currently receive under fee for service. Under federal rules governing managed care, the department cannot pay cost settlements to help LHDs directly, but we can direct health plans to make additional payments to the health departments that promote quality access and/or delivery system reform.

So, to ensure continued access to health department services for Medicaid beneficiaries, DHHS will make, through the PHPs, additional payments to cover the difference between each health department's PHP reimbursement rate and a rate set by the health department that approximates 100% of their cost, allowable cost, for using a calculated cost to charge ratio to make this calculation. To finance these additional utilization based payments, or directive payments, the health departments will make IGTs or intergovernmental transfers to the department in an amount equal to the non-federal share of the AUBPs the health department receives. I'll now turn it back over to Roger to discuss hospital reimbursements.

Roger Barnes

Thank you Jim. Next slide. We'll start with the hospital payments and as with the health departments, all supplemental payments that are made to providers such as hospitals and local health departments can no longer be made in the same manner as today. So, we are going to go through the method of which we have worked with the hospital industry on the payments. The base payments contain most of the supplemental payments, excluding the DSH and GME, folded into the base rates. So, hospitals will see an increased base rate going into managed care. The in-patient payment rates set to ensure that each hospital within a class receives the same percentage of Medicaid and unreimbursed cost covered on a per unit basis. And that is without on the per unit basis that does not include the utilization changes. Outpatient payments are set to approximately 100% of costs and enhanced inpatient and outpatient rates set to Medicaid fee for service and serves as a rate floor in the managed care arena. So the fee for service rates and the managed care rates for hospitals will be the same once we transition.

Rate floors, PHPs required to pay mandated rates for five contract years to all critical access hospitals and all hospitals located in economically distressed counties. Those are the counties known as tier counties 1 and 2 and that designation is provided by the North Carolina department of commerce. PHP is required to pay mandated rates for three contract tiers to all other hospitals not in tier 1 and tier 2 counties. To help in the transition, the department is going to pay life path payments. They will direct the PHPs to make directed or pass through payments, depending upon when the managed care proposed rule is finalized. The hospitals, to address approximately 40% of estimated hospital revenue declines, net of provider assessments and IGTs. DHHS is seeking general fund appropriations to finance the non-federal share of the glide path payments.

As we stated GME is not included in the base payments and so this is a payment that the state can make directly to our teaching facilities and they will be outside of the managed care arena. Directed payments will be calculated for GME will be based on statewide per-resident average, indirect medical education will be calculated based on the Medicare formula.

Hospitals will finance 100% of the non-federal share of GME payments, including assuming responsibility for the state's current annual contribution at $30 million. DHHS has proposed a parallel reduction of $30 million to the state retention from the provider assessment to account for the additional contribution to non-federal share of the GME payments.

Next slide. More to the same we want to reach out here is hospitals continue to finance a similar portion of the Medicaid payments under managed care. And to do that, they will do so by one of two methods, or both methods in some cases. Intergovernmental transfers, also known as IGTs, the hospitals will currently make – continue making those under the new methodology based on a 2018 IGT amounts. The annual adjustment based on the over year change in Medicaid payments to public hospitals. They will be adjusted, the 2018 amounts will be adjusted for those changes.

Assessments, the hospitals are currently paying assessments, we're going to establish under law changes to those assessments and there will be two, one will be the base assessments replaces the UPL assessment. Set based on the 2018 UPL assessment amount and adjusted to finance higher hospital payments related to crossover, NC Health Choice and GME. Assessments will be adjusted in subsequent years based on a change in Medicaid payments to all hospitals subject to the base assessment.

Second assessment is a supplemental assessment. This replaces the equity assessment that the hospitals currently pay. This set based on the 2018 equity assessment amount and adjusted based on the change in Medicaid payments to all hospitals subject to the supplemental assessments. Again, there are notes at the bottom of the page, please refer to those so that you take those into account as you read through this slide.

On the next slide, I'm going to transition to Reggie Little to talk about pharmacy.

Reggie Little

Thank you Roger. Pharmacy reimbursement. PHPs will implement a pharmacy benefit which ensures that members have access to therapeutically needed medications at the best overall value. PHP requirements, PHPs are required to cover all outpatient drugs for which the manufacturer has CMS rebate agreement and for which the DHHS provides coverage. PHPs are required to adhere to the DHHS defined preferred drug list and they're also required to furnish covered benefits in an amount, duration

and scope no less than the amount, duration and scope for the same services furnished to beneficiaries under the Medicaid fee for service program.

Rate floors in regards to pharmacy reimbursement for dispensing fees, PHPs will reimburse the same rates as Medicaid and North Carolina Health Choice fee for service, dispensing fees as determined by the methodology defined in the state plan attachments 4.19-B. Ingredient costs should be reimbursed at the same rate at the Medicaid and North Carolina Choice fee for service rate. Please note the asterisk on the slide that refers to a note at the bottom of the screen in regards to ingredient costs. For drug rebates, PHPs are not permitted to negotiate rebates for any drugs in the Medicaid and North Carolina Health Choice program.

I will now turn it over to Jim Flowers who will cover public ambulance payments.

Jim Flowers

Thank you Reggie. For public ambulance providers, this is similar in nature to the local health department reimbursement we covered earlier. Public ambulance providers will receive two separate payment streams from the health plans under managed care. Service payments and additional utilization based payments, which serve as a replacement for the cost settlement payments they receive now. For the service payments, the health plans will reimburse the public ambulance providers for services after managed care transition based on negotiated rates between the two parties. At no less than the amount private ambulance providers receive for similar services.

And then again, similar to health departments, ambulance providers will receive additional utilization based payments. For ambulance providers DHHS is committed to ensuring they receive a similar per trip leg payment under managed care compared to what they currently receive under fee for service. Under federal rules, DHHS cannot make cost settlements to the public ambulance providers directly, but instead we can direct a PHP to make additional payments to the ambulance providers that promote quality, access and/or delivery system reform.

So to ensure continued access to the public ambulance provider services for Medicaid beneficiaries, DHHS will pay through the PHPs an additional payment to cover the difference between their PHP reimbursement rate and a fully loaded per trip leg rate. This includes Medicaid fee for service base payments and gross cost settlement payments divided by tip legs. To finance these additional utilization based payment or directed payment, the public ambulance providers will make intergovernmental transfers to the department equal to the non-federal share of the AUBP payments they have received.

Next slide. And back to Reggie Little.

Reggie Little

Thank you Jim. Indian health care providers, PHPs will reimburse Indian health care providers, referred to as IHCPs within the side as follows. For those that are not enrolled as an FQHC, regardless of whether they participate in the PHP's network, they shall be reimbursed at the applicable encounter rate, also known as OMB rate, published annually in the federal register by the Indian Health Service, or they're reimbursed at the Medicaid fee for service rate for services that do not have an applicable encounter rate.

For those that are enrolled as FQHCs, but do not participate in the PHP's network, they're reimbursed at an amount equal to what the PHP would pay a network FQHC that is not an Indian health care provider. PHPs will permit tribal members to obtain services from out-of-network IHCPs. PHPs will permit the IHCPs to refer a tribal member to any provider within the IHCP purchase referred care network, or PRC, even if the provider is not a contracted provider without having to obtain prior authorization or referral from a contracted provider. PHPs may not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or a health care Indian health care provider through cost sharing or other similar charges levied on a Tribal member.

Next slide please. Additional providers, nursing facilities. For a period of time to be defined by DHHS, PHPs shall reimburse in-network nursing facilities, excluding the state owned and operated facilities, at a rate that is no less than the Medicaid fee for service rate in effect six months prior to the start of the capitation rating year. In this case, January 1 would be prior to the July 1 rating year that the department is heading towards. Unless the PHP and provider have mutually agreed to an alternative reimbursement agreement.

Now for state owned and operated facilities, PHPs will reimburse facilities that are state owned and operated according to the rates established by DHHS. PHPs will also reimburse veterans homes according to the rates established by DHHS in collaboration with DMVA. For hospice, PHPs will reimburse hospice services according to section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following: the rate shall be no less than the annual federal Medicaid hospice rates that are updated each federal fiscal year, for hospice services provided to members residing in nursing facilities. The PHP shall reimburse the hospice provider at the hospice rate and 95% of the Medicaid nursing home fee for service room and board rate in effect at the time of service.

Next slide and I will now turn it back over to Roger Barnes.

Roger Barnes

Thank you Reggie. So, on this section, we are going to talk about how we're operationalizing these provider payments. If you'll turn to the next slide, thank you. PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. The medical claims, we are requiring that within 18 days of receiving a claim, the health plans will notify the provider whether the claim is clean or hold, also known as pending, the claim and request additional information. Within 30 days of receiving a clean claim, the health plan will pay or deny the claim. Within 30 days of receipt of requested additional information, PHPs will pay or deny pending claim.

The pharmacy claims within 14 days of receiving the pharmacy claim, the health plan will pay or deny a clean claim or pend a claim and request additional information. Within 14 days of receiving the requested additional information, the PHPs will pay or deny the claim. And if the PHPs do not receive requested information within 90 days, the PHP shall process the claim based on what information is available and then pay or deny the claim accordingly. Please note that the asterisk at the bottom of this page that this is in accordance with general statute, North Carolina general statute.

The PHP may require that claims be submitted within 180 calendar days after the date of the provision of care to the patient by the health care provider, and in the case of a health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. Again, that is in accordance with the North Carolina general statute.

Next slide. PHPs will be held responsible for delayed payments to providers. The health plan will pay interest on late payments to providers at an annual interest rate of 18% beginning on the first day following the date that the claim should have been paid. PHPs will also pay the provider a penalty equal to 1% of the claim for each calendar day following the date that the claim should have been paid as specified in the PHP contract. And finally, PHPs will maintain written or electronic records of its activities. Again, this is in accordance with North Carolina general statute.

Next slide. So part five is a question and answer and so we will have some time for questions and try to provide answers during this session.

Female Speaker

Ave, we're going to turn this back over to you for the Q&A portion of today's webinar.

Avi Herring

Great, thanks very much, appreciate it. So, we have a number of questions coming in and we'll do our best to address as many as we can. So first question is what does it mean to be a qualified willing provider? Roger, I'll turn it over to you for that one.

Roger Barnes

All right. Thank you very much Ave. What we do here is I'm going to let our subject matter expert answer that.

Jean Holliday

This is Jean Holiday. Any willing qualified provider is a provider that meets the – first of all is a Medicaid enrolled provider. And second of all that meets the objective quality standards that each PHP will set up as the standards for their contracting. These might have to do with, for example, do they have an appropriate amount of liability insurance or no records of past history of malpractice or other criminal activity.

Roger Barnes

Okay, thank you Jean. Ave, do we have another question?

Avi Herring

Great. Yes we do, thank you. Next question is why are supplemental payments for local health departments and public ambulance providers transitioning to these additional utilization based payments? I'll turn that one over to Jim, or if there is someone else who wants to take that question.

Jim Flowers

No thank you Ave, I'll take it. Under federal rules, we cannot pay cost settlements to any providers, to local health departments or public ambulance providers directly. So, additional utilization based payments are a payment methodology permitted under the managed care final rule to promote quality access and delivery reform. And these are on a per unit basis. And so, it is a methodology that's

intended and designed to ensure local health departments and public ambulance providers receive a similar per unit payment under managed care that they're currently receiving today in cost settlement. It's a way to transition the cost settlement funding mechanism per unit into managed care.

Avi Herring

Great, thanks Jim. Okay, next question, can providers with guaranteed rate floors negotiate alternative arrangements with PHPs? Julia, I'll turn that one over to you.

Julia Lerche

Sure. The answer is yes. The PHPs must offer the fee for service rate floor to providers that have a rate floor subject to it. So, that includes physicians and hospitals and the other provider types that we have gone through today. Providers working with the PHPs can negotiate alternative arrangements if there is mutual agreements.

Avi Herring

Great, thanks a lot. Next question and this is a question that we've gotten from a number of folks on the line. How do you contact the PHPs as a provider? Folks are asking for addresses, phone numbers and other contact information.

Lynne Testa

Thanks Avi, it's Lynne Testa. I just wanted everyone that's participating in today's call to know that we did provide contact information for each of the PHP provider network folks and that information is live on our website under the provider tab.

Avi Herring

Great, thanks Lynn. Next question is about reimbursement for physical therapy, occupational therapy and speech therapy. Julia, would you take that one?

Julia Lerche

Sure. I believe the question is whether those provider types are also subject to a rate floor and the answer is no. There is no rate floor or other rate requirement in the contract with the PHPs for those provider types. So those provider types will need to negotiate rates with the PHPs. There's not a rate prescribed or a rate quote described by the department.

Avi Herring

Great, thank you. So, next question is about – going back to pharmacy. Are all plans required to have the same prescription formulary? Reggie, I'll turn that one back to you.

Reggie Little

That would be yes.

Avi Herring

Thank you. Okay, next question, we got several questions asking about payment requirements will be for ambulatory surgery centers? I'm happy to turn that one over to Julia or any others to answer that question.

Roger Barnes

So this is Roger. Ambulatory surgical centers, they were not listed within the group of having a rate floor and so therefore they will have the ability to negotiate the rates with each of the health plans that they contract with. Next question Ave.

Avi Herring

Great, thanks Roger. The next question is related to the payment methodology and whether there will be any type of rate floor for non-emergency medical transportation.

Roger Barnes

So, Ave, as the RFP has stated that non-emergency medical transportation is under the purview of the health plan. They will take and contract with those providers and will negotiate a rate for each transport.

Avi Herring

Great, thanks Roger. The next question is do providers need to contract with all PHPs?

Female Speaker

Ave, I think Jean and I will share this response. What we have been telling providers is that they need to make a business decision that best fits how they deliver care to their patients. There may be some practices that will determine it is in their best interest to contract with all PHPs because their members will now have choice and patients could be going to any one of those plans. So, again this really is a business decision that the practices need to make based on their business model. Jean, I don't know if you have anything you'd want to add to that.

Jean Holliday

The only thing I'd want to add is that providers should keep in mind if you don't participate and you don't contract with any PHP, then you'll be limited to being providing out of network services which as noted in the presentation are always subject to prior approval and the plan can refuse to allow an individual to see those services from an out of network provider.

Avi Herring

Great, thank you. The next question is, we've gotten a few questions on this whether there is any type of rate floor or requirements around payment for BME providers.

Julia Lerche

This is Julia Lerche. There are not rate floors for BME medical equipment providers. Those providers will need to negotiate their reimbursement arrangements with the PHPs.

Avi Herring

Thank you. The next question is around timing for submitting claims. So the question is currently under Medicaid providers have 360 days to submit claims. Will that change with the transition to managed care?

Roger Barnes

So Ave, thank you, this is Roger. Yes, that does change. As we point out on slides, the providers must provide the claims and I'm trying to find the slide, wait a moment here.

Female Speaker

It's 180 days.

Roger Barnes

Yeah, they have 180 days in which to provide a claim and it's 180 days from the date of service provided.

Jean Holliday

However, I will clarify just a little bit, this is Jean Holiday again, the statute this is based upon also provides that there can be an ability for a provider to submit a claim after the 180 days if there are reasons why it couldn't be submitted within the 180 days and that allows up to that year. So, the plan could give you up to 365 days with some kind of mutual agreement.

Roger Barnes

Right. But I think the important note is this is a change from current Medicaid practice and when they contract with the health plan, they need to lift the contract to make sure that they understand those claim submission standards.

Avi Herring

Great, thanks very much. The next question is whether PHPs will be required to use the same pre-authorization guidelines for approval of services or uniform set of preauthorization guidelines.

Roger Barnes

So Reggie – I don't think we have that subject matter expert in the room with us, so let's take that question back to provide an accurate answer.

Avi Herring

Sounds good, thanks Roger. Next question is whether providers will still use NC tracks under managed care and if not what the new process is?

Roger Barnes

Ave, this is Roger. For all fee for service claims, they will submit them to the NC tracks. For those claims that are paid by one of the health plans, they should follow the directions of the health plan as to where and how to submit those claims.

Avi Herring

Great, thanks very much. I think we have time for one or two more questions. So the next question is as a mental health provider who is providing basic out-patient therapy, where do our services fall under managed care? Will there be a rate floor for those services?

Julia Lerche

This is Julia Lurch. There is not a rate floor for behavioral health providers unless they are physicians. Those providers will be subject to negotiation with the health plan similar to how the current behavioral health system works with LME-NCOs where providers negotiate their rates with those LME-NCOs.

Avi Herring

Great, thank you. So, we've gotten a few additional questions as a follow up to an earlier questions about where to find the information on the department's website for PHP contact information. So, is that something that folks can either clarify or perhaps we could send out a follow up or a link after the presentation?

Female Speaker

I can absolutely do that Ave and we will include that information in the Q&A summary that will follow this webinar and will be posted probably within the next week.

Avi Herring

Great, thank you. So last question that we have time for, there is a question on whether there will be a rate floor on care management payments for AMH tier 3 providers.

Julia Lerche

So this is Julia Lerche, So, as we described on the slide, there will be a floor for the per member per month medical home payments which is similar to the current payment for Carolina access. So that $5 per member per month for members that are within the age, blind and disabled category of eligibility and $2.50 per member, per month for other beneficiaries that are enrolled within AMH tier 2 or 3 practice. There's the expectation that if the AMH is taking on the care management functions of the tier 3 that they are negotiating a care management payment component with the PHP for that function. There is no specific rate defined by the department for that care management function.

Avi Herring

Great, thanks very much. Okay, so let's go ahead and move to the final slide of the presentation.

Roger Barnes

Okay, so next steps. If you'll go to the next slide please. All right, so additional information for you, if you have further questions and want to contact us, here is our email address to send those questions or you can send them via US mail to the address listed on this slide. Again, our DHHS website for the managed care is listed below. This is slightly different than our main website, so please be sure that you go to the Medicaid-transformation. White papers, manuals and frequently asked questions are also on the websites and you can certainly have access to those by visiting our website, or looking at this electronically, you can click on the links that you see for each of those.

Next slide. And that's our last slide so I think Ave, I'll transition back to you and we appreciate everybody's listing and comments and questions.

Avi Herring

Great, thanks so much Roger. So, we wanted to thank you all for participating today and for asking such helpful questions. You should know that shortly, the presentation recording and Q&A summary will be posted to the department website. Thanks very much and have a wonderful afternoon.

End of Webinar