NC Medicaid Managed Care Pharmacy Summit
Re. Medicaid Tailored Plan Rollout
October 12, 2022
8:00-9:30 am

Frequently Asked Questions

1. Will there be specialty pharmacy accreditation through URAC, ACHC, etc required through any plan to dispense specialty drugs.

    a. North Carolina Medicaid allows any willing pharmacy to dispense "specialty" medications. Tailored Plans, like Standard Plans, are not allowed to restrict the dispensing of any medication to a narrow network. Notably, NC Medicaid and the Tailored Plans acknowledge that some medications may be restricted by REMS or the other limited distribution restriction by the manufacturer or FDA.

2. Which benefits will stay with PHP plans on and after 4/1/2023?

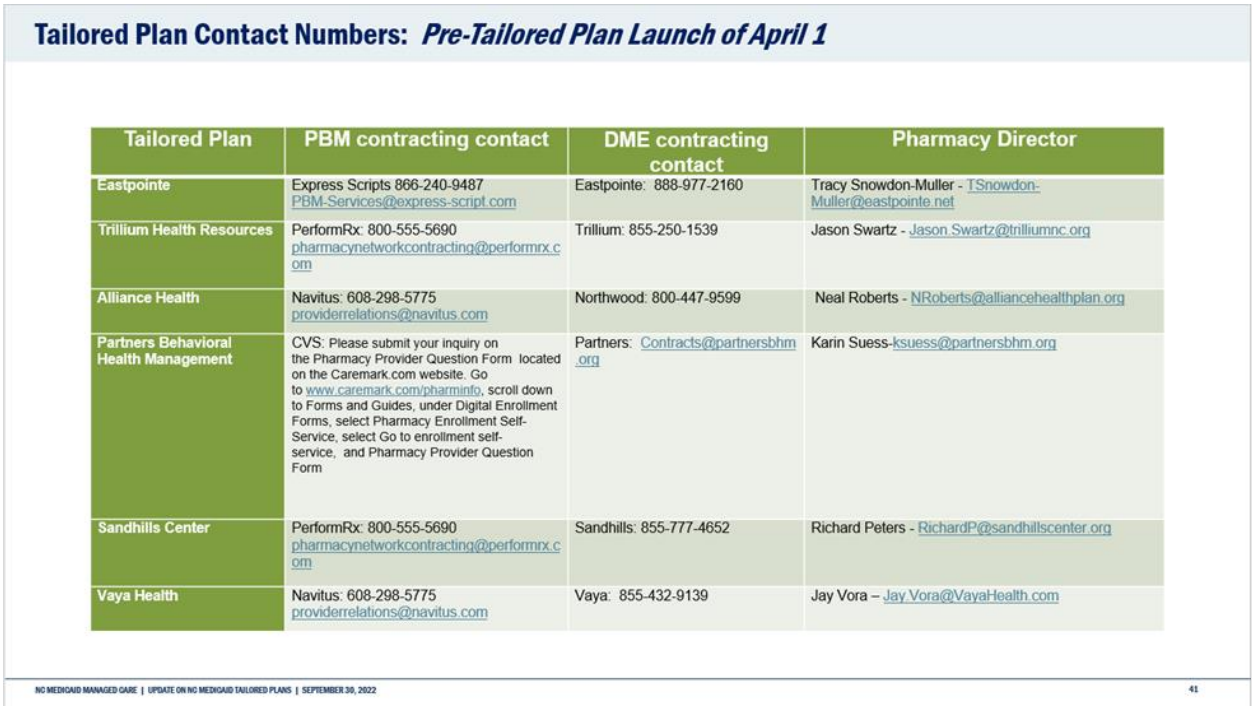
    a. All PHP "Standard Plans" will provide the same benefits after 4/1/23 as they did before 4/1/23. Tailored Plan PHPs will provide those same whole health benefits with the addition of services for people who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI). For more information, see https://ncmedicaidplans.gov/learn/benefits-and-services

3. Does the 72-hour emergency fill apply to eye drops and other unbreakable packages?

    a. 72-hour supplies may be dispensed by a pharmacy while a beneficiary is waiting for submission and review of a Prior Authorization Request. This 72-hour supply is limited to those medications for which there are prior authorization criteria. As of 10/13/2022, no eye drops require Prior Authorization. All plans, including NC Tracks, do allow extended days' supply on claims for medications with an unbreakable package such as eye drops or insulin.

4. Is there a list of the PBMs that go with each health plan so we know who to reach out to? Who specifically does a pharmacy need to contact to enroll as a DME provider for Tailored Plan members?

The Tailored Plan or the standard plan partner of the Tailored Plan or someone else?



Tailored Plan Contact Numbers: *Pre-Tailored Plan Launch of April 1*

Tailored Plan	PBM contracting contact	DME contracting contact	Pharmacy Director
Eastpointe	Express Scripts 866-240-9487 PBM-Services@express-script.com	Eastpointe: 888-977-2160	Tracy Snowdon-Muller - TSnowdon-Muller@eastpointe.net
Trillium Health Resources	PerformRx: 800-555-5690 pharmacynetworkcontracting@performrx.com	Trillium: 855-250-1539	Jason Swartz - Jason.Swartz@trilliumnc.org
Alliance Health	Navitus: 608-298-5775 providerrelations@navitus.com	Northwood: 800-447-9599	Neal Roberts - NRoberts@alliancehealthplan.org
Partners Behavioral Health Management	CVS: Please submit your inquiry on the Pharmacy Provider Question Form located on the Caremark.com website. Go to www.caremark.com/pharminfo, scroll down to Forms and Guides, under Digital Enrollment Forms, select Pharmacy Enrollment Self-Service, select Go to enrollment self-service, and Pharmacy Provider Question Form	Partners: Contracts@partnersbhm.org	Karin Suess-ksuess@partnersbhm.org
Sandhills Center	PerformRx: 800-555-5690 pharmacynetworkcontracting@performrx.com	Sandhills: 855-777-4652	Richard Peters - RichardP@sandhillscenter.org
Vaya Health	Navitus: 608-298-5775 providerrelations@navitus.com	Vaya: 855-432-9139	Jay Vora – Jay.Vora@VayaHealth.com

NC MEDICAID MANAGED CARE | UPDATE ON NC MEDICAID TAILORED PLANS | SEPTEMBER 30, 2022 41

5. Will the Tailored Plans act to expand who will be eligible for Medicaid, specifically those who have behavioral health issues and are currently not eligible for prescription benefits?

   a. No, Tailored Plan does not expand Medicaid eligibility. Tailored Plan allows for whole person, coordinated care for people who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI).

6. Did pharmacies need to contract to all plans to get enrolled or will this process be on the portal for enrollment to all the plans?

   a. Pharmacies must first enroll with North Carolina Medicaid through NCTracks to be eligible to provide services to NC Medicaid Members. After that, pharmacies must contract with Standard and Tailored Plans in order to submit and receive reimbursement for claims. Tailored Plans are using the full list of pharmacies enrolled in NCTracks to perform outreach for contracting.

7. What are the qualifications for the various managed care options? How is it decided what the patient chooses and/or receive?

   a. Only select NC Medicaid beneficiaries are eligible to enroll in a Tailored Plan. This includes people who get Innovations Waiver services, Traumatic Brain Injury (TBI) Waiver services, and People who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or TBI. Members who are eligible to enroll in a Tailored Plan may choose to remain in a Standard Plan but may lose access to services that are

offered exclusively in a Tailored Plan. Members who are eligible to enroll in a Tailored Plan may also choose to remain in Medicaid Direct. Those Members will continue to receive services for their mental health disorder, substance use disorder, I/DD, or TBI. Tailored Plans are assigned by administrative county. Only one Tailored Plan is available per county. See https://ncmedicaidplans.gov/learn/nc-medicaid-managed-care-health-plans for more details.

8. For behavioral health providers, are Standard Plans, Prepaid Health Plans, and Medicaid Direct the same?

a. NC Medicaid's managed care program have several plan types. The term Prepaid Health Plan (PHP) refers to a managed care plan that covers whole person care. PHPs include Standard Plans and Tailored Plans. The term "prepaid" is used because the PHP's are paid a flat rate, per member per month, to cover all of the care needs for that beneficiary. Medicaid Direct, the fee for service program managed directly through NCDHHS is not considered a PHP. Medicaid Direct has contracted with each of the LME/MCOs to continue to provide behavioral health services in their catchment area. This carve out is referred to as a Prepaid Inpatient Health Plan or PIHP. For behavioral health providers, you may hold a contract with all of the standard plans and potentially two contracts with each LME/MCO (one for Tailored Plan members, one for Medicaid Direct/PIHP members). Notably, the PIHP contract for Medicaid Direct beneficiaries only applies to behavioral health providers. Pharmacies should only consider the 5 Standard Plans, 6 Tailored Plans and 1 Medicaid Direct plan for business operations purposes.

9. How does enrollment change for out of state pharmacies that service facilities?

a. Enrollment should not change for out of state pharmacies. Pharmacies must first enroll with North Carolina Medicaid through NCTracks to be eligible to provide services to NC Medicaid Members. After that, pharmacies must contract with Standard and Tailored Plans in order to submit and receive reimbursement for claims. Tailored Plans are using the full list of pharmacies enrolled in NCTracks to perform outreach for contracting.

10. How many times per year can a patient change their plan?

a. Members may change health plans for up to 90 days after the start date shown on their health plan enrollment letter. After those 90 days, the member must wait until their next recertification date to change health plans unless they have a special reason. Members may change at any time for several reasons including but not limited to if they move, do not have access to necessary services, or are member of a federally recognized tribe. See the enrollment broker for additional details https://ncmedicaidplans.gov/

11. Do you anticipate any changes with 340b?

a. No changes are anticipated with regards to 340b related to Tailored Plan launch. Pharmacies should still submit their actual purchased drug price in the usual and customary (U&C) charge field and will be paid at the lower of NADAC, U&C, and State Maximum Allowable Cost (SMAC). Pharmacies must submit POS claims with an '8' in the basis of cost determination field (NCPDP D.0 field 423-DN) and a '20' in the submission clarification code field (NCPDP D.0 field 420-DK) to indicate they are dispensing a 340B product. For hemophilia drugs, pharmacies may submit the state upper limit established for a 340B purchased hemophilia drug.

Additional changes are coming for 340b providers across the entire North Carolina Medicaid program effective 10/23/22. See NCTracks for additional details.

https://www.nctracks.nc.gov/content/public/providers/provider-communications/2022-Announcements0/Further-Clarification-of-the-New-Edits-and-Automatic-Status-Updates-for-340B-Pharmacies-Coming-Soon-to-NCTracks.html

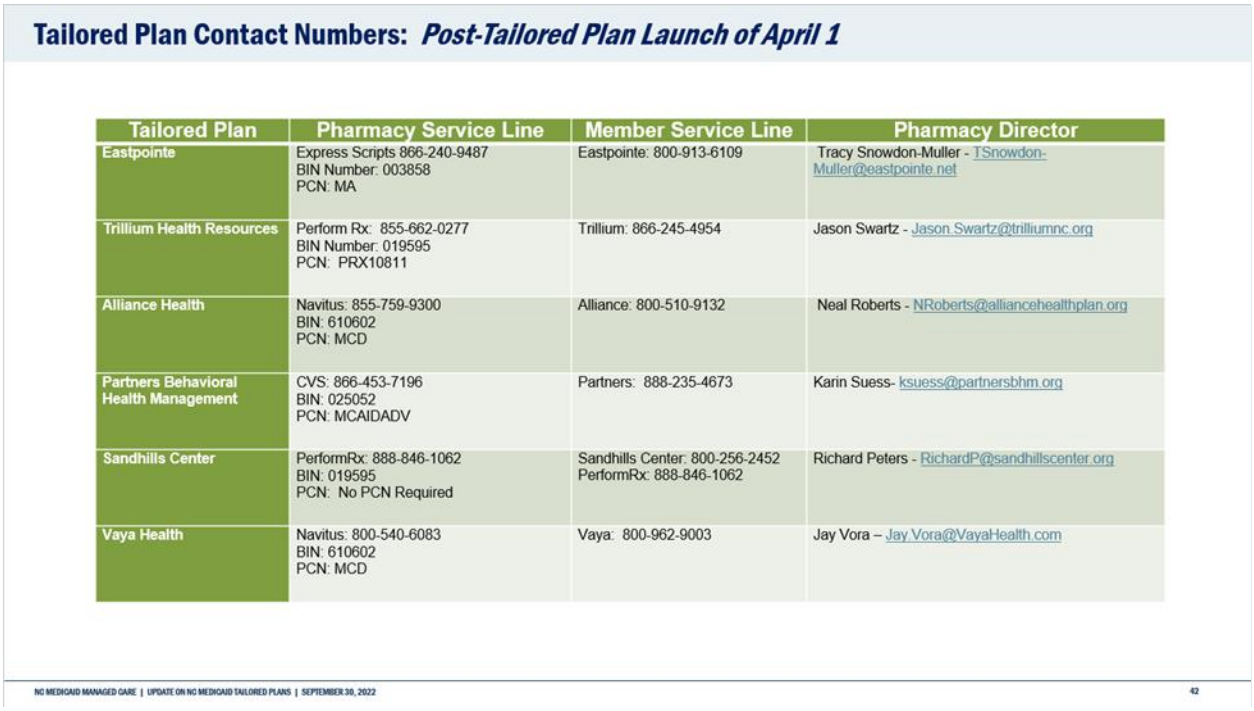
12. Often, when issues arose at Standard Plan Launch, resolution required highly time-consuming telephone calls. Will this be the same at Tailored Plan launch?

a. Tailored plans are working diligently to be as prepared as possible for a smooth go-live. As with any major change, we understand that there are bound to be issues that come up along the way. Each tailored plan has built a command structure team to ensure problems are addressed quickly if/when they do come up. For outpatient pharmacy, Tailored Plans all met with the Standard Plans to cover lessons learned to ensure we are better prepared for go-live. Tailored Plans will be monitoring PBM call centers including time to answer, hold time, call time, etc. to ensure issues are handled appropriately.

Tailored Plans will be receiving active prior authorizations for any Member transitioning to our plan from a Standard Plan or Medicaid Direct; however, Tailored plans will not be receiving prior authorizations for substance use treatment medications due to federal law. Pharmacies should utilize the 72 hour emergency fill override, while awaiting PA. Tailored Plan PBMs have been instructed to allow overrides, when clinically appropriate, for any medication requiring prior authorization for continuation during the first 90 days to prevent gaps in care and to allow the TP time to either track down the previous authorization or get a new authorization request from the provider.

If issues are not being resolved in a timely manner, pharmacies are encouraged to reach out to the Pharmacy Directors. All providers, including pharmacies, have the right to file a formal grievance (Standard Plan or Tailored Plan) to report concerns about our plan. Plans are strictly prohibited from discrimination or retaliation against any network provider based on submission of a grievance.

13. Please provide the billing info and contact information for the Tailored Plans for after go-live.



Tailored Plan Contact Numbers: ***Post-Tailored Plan Launch of April 1***

Tailored Plan	Pharmacy Service Line	Member Service Line	Pharmacy Director
Eastpointe	Express Scripts 866-240-9487 BIN Number: 003858 PCN: MA	Eastpointe: 800-913-6109	Tracy Snowdon-Muller - TSnowdon-Muller@eastpointe.net
Trillium Health Resources	Perform Rx: 855-662-0277 BIN Number: 019595 PCN: PRX10811	Trillium: 866-245-4954	Jason Swartz - Jason.Swartz@trilliumnc.org
Alliance Health	Navitus: 855-759-9300 BIN: 610602 PCN: MCD	Alliance: 800-510-9132	Neal Roberts - NRoberts@alliancehealthplan.org
Partners Behavioral Health Management	CVS: 866-453-7196 BIN: 025052 PCN: MCAIDADV	Partners: 888-235-4673	Karin Suess- ksuess@partnersbhm.org
Sandhills Center	PerformRx: 888-846-1062 BIN: 019595 PCN: No PCN Required	Sandhills Center: 800-256-2452 PerformRx: 888-846-1062	Richard Peters - RichardP@sandhillscenter.org
Vaya Health	Navitus: 800-540-6083 BIN: 610602 PCN: MCD	Vaya: 800-962-9003	Jay Vora – Jay.Vora@VayaHealth.com

NC MEDICAID MANAGED CARE | UPDATE ON NC MEDICAID TAILORED PLANS | SEPTEMBER 30, 2022 42

14. How are pharmacies being contacted by the Tailored Plan PBM's for contracting?

    a. Express Scripts (Eastpointe) -Express Scripts has pulled in data from the NCPDP and The Department's PEF and is outreaching to pharmacies to contract with Express Scripts.

    b. PerformRx (Sandhills, Trillium) - Primarily through email. If no email is available then Perform will call the pharmacy in question.

    c. CVS Caremark (Partners) -Most of the time new pharmacies reach out to CVS Caremark and the process is listed in the chart in Question #4 above. However, CVS Caremark monitors network access and assesses for gaps; when gaps are noted, CVS Caremark pulls the data from NCPDP and then outreaches to pharmacies using contact information from the NCPDP.

    d. Navitus (Alliance, Vaya) - Primarily reaching out via email. If Navitus does not have an email on file, they will use contact information previously on file (if your pharmacy is or was previously contracted with Navitus for other health plans). If no internal contact information is available, Navitus will use contact information from NCPDP.

15. Are we able to enroll through our PSAOs?

    a. Yes. All of the Tailored Plan PBMs are expecting to contract with pharmacies through PSAOs.

Partners-Our PBM, CVS Caremark contracts with multiple PSAOs. CVS Caremark does however require each pharmacy to individually establish a base contract and complete credentialing with CVS Caremark directly regardless of whether they decide to use a PSAO.

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Town Hall Questions

1. What is the timeline for roll out of the managed care Tailored Plans for NC?

   Response: As of September 29, the Tailored Plans will go live on April 1, 2023. This includes both the medical and pharmacy benefit, to begin on April 1. The delayed start will allow Tailored Plans more time to contract with additional providers to support member choice and to validate that data systems are working appropriately.

   We had previously communicated that the pharmacy benefit would go live April 1, and the rest of the benefit (including medical claims, DME, and medical drug claims) would go live on December 1. The change is that the part that was to go live in December is now moved to align with the Pharmacy benefit going live on April 1.

   You may hear that some services still go live on Dec 1. Those services are not pharmacy related, and include Tailored Care Management (TCM) and the 1915(i) option.

2. With the delay of the Tailored Plan launch to April 1, will this change the pharmacy provider and Tailored plan contracting timeline?

   Response: No. The TPs are encouraged to proceed with enrolling pharmacies into their networks now.

   It would be best for pharmacies to contract with all TPs, not just the one in your county, in case members utilize a cross county pharmacy. Our PBM, Navitus Health Solutions hopes to contract with approximately 2,300 pharmacies statewide to ensure broad pharmacy network coverage for our members who may need a prescription filled while traveling or while seeing a specialist in another region.

We would recommend that pharmacies not wait to execute their contracts associated with the TP PBMs. In fact, please do not wait until March 2023 due to the processing time that it can take to setup a new contract. We all want all members to have a smooth transition to TP without any disruption in their current provider of services, which includes the pharmacies they use.
It's important to point out that payment will continue to be the same across all plans. There will not be differences in any of our contracts regarding reimbursement. We are contractually required to use the same reimbursement logic as Medicaid Direct.

3. What does it mean to be in a Standard Plan versus a Tailored Plan versus Medicaid Direct?

Response:
NC Medicaid Managed Care is the name for the new Medicaid program, overall. Managed Care is provided by what we refer to as "the health plans" or the "PHPs." Members have one plan for most of their health services, including physical health, behavioral health, and pharmacy and addressing unmet health related resource needs. We have now have four types of health plans, including:

- Medicaid Direct
- Standard Plans
- Tailored Plans
- Tribal Option

Medicaid Direct is our traditional Fee-for-service program. It provides many of the same services as the health plans. People who do not get their services through a health plan will continue to receive their coverage through Medicaid Direct.

Standard Plans, there are 5 of them, they provide integrated physical health, behavioral health, pharmacy, and long term services and support to most Medicaid beneficiaries, as well as programs and services that address other unmet health-related resource needs. You know them as Healthy Blue, Carolina Complete, WellCare, Amerihealth, and United Health Care.

Eastern Band of Cherokee Indians Tribal Option is available to tribal members and their families and is managed by the Cherokee Indian Hospital Authority (CIHA).

Lastly, the **Behavioral Health I/DD Tailored Plans** provide the same services as the Standard Plans, plus specialized services for individuals with significant behavioral health conditions, intellectual and developmental disabilities, traumatic brain injury, and people using state-funded and waiver services.

To focus in on the Tailored Plans, this is a map of NC, showing the TPs and which counties they serve. Members are assigned to the TP of the county in which they reside. *(show slide of the state map)*

There are six TPs, including EastPointe, Trillium, Vaya, Sandhills, Partners, and Alliance. Each TP has contracted with their own PBMs and a Standard Plan partner. Each TP uses their Standard Plan partner for different things. It is best to consider the TP as a totally separate entity from their Standard Plan partner. You might think of their SP partner as serving in more of a supportive role.
(*show slide of the TPs and their corresponding PBM and SP, BIN/PCN numbers)*

Each TP has their own member card, which will include the member's Medicaid ID number and also the TPs own distinct BIN/PCN number.

EastPointe – Express Scripts
Trillium – Perform Rx
Vaya - Navitus
Sandhills – Perform Rx
Partners – CVS Caremark
Alliance – Navitus

4. Please explain the roles of your Tailored Plan vs. your PBM when it comes to contracts and interactions with pharmacists/pharmacies?

Response: Sandhills is contracted by the Department to manage and ensure that Pharmacy Benefits follow all Medicaid rules and requirements. We administer the pharmacy benefits by subcontracting with PerformRx, a PBM, to provide adjudication for these benefits, in accordance with the guidelines. We have complete oversight to ensure compliance, and PerformRx will provide us with regular reports demonstrating the ongoing adherence of required standards. I believe most pharmacies are already processing under some or maybe all available contracts through PerformRx, especially if your pharmacy is a chain, or independent member of a PSAO, like Epic Pharmacy Network. Every pharmacy that is listed on Medicaid's Provider Enrollment File should have received an offer to contract with each Tailored Plan network. If you have any questions on your contracting status, you may call PerformRx directly, and pharmacies serving our 11 counties are welcome to reach out to me for specific Tailored Plan questions or PBM concerns.

Our Tailored Plans will operate very much like the other MCOs in the state, as well as Medicaid Direct with regards to pharmacists and pharmacies. Our PBMs have already contacted you with regards to contracts and you will interact with them directly. When you have an issue with a claim you will call the PBM for assistance, just as you would do for the other MCOs or the state when you contact NCTracks. The PBM is our

contractor. If you have an issue with a PBM you may contact the plan directly to address your concern.

Like the others mentioned, Vaya is conveying all of the Department's rules and requirements to Navitus and ensuring that they follow those rules and requirements exactly. Navitus will hold the contracts with individual pharmacies and support pharmacies and providers in accessing medication for their patients. Any outpatient pharmacy contracting questions should go to Navitus. If you are also a DME provider; however, your store would need to contract with Vaya directly.

My role is to watch over the PBM and ensure they are following all of NC Medicaid's rules and handle any issues that might arise. I will serve as the point of contact for any problems with the PBM and will help resolve any grievances.

The contact numbers for each TP are listed in the slide deck, which we will distribute after the meeting. We encourage you to please reach out to the PBMs or to the TP to verify your contract status, if you do not currently know whether you are contracted or not. Please don't wait, as this can be a timely process.

5. Who gets to transition to a Tailored Plan? Is it optional? Are members allowed to remain in a Standard Plan or Medicaid Direct if that is their preference?

Response: Tailored Plan eligibility can be based on either diagnosis or what services the person is receiving. Generally, a Tailored Plan eligible member has a significant mental health disorder, substance use disorder, intellectual/developmental disability (IDD), or traumatic brain injury. Approximately 5% of all NC Medicaid beneficiaries will be enrolled in Tailored Plans. Tailored Plan enrollment is based upon the member's county of residence therefore, members are not permitted to enroll in a different Tailored Plan unless they move to a county that is within that Plan's catchment area. Medicaid eligible members may choose to remain in a Standard Plan but should be aware that some specialty mental health and IDD services are not provided by these plans. Members remaining in Medicaid Direct who will not transition to a Tailored Plan or Standard Plan are those who are either dually eligible (Medicare/Medicaid), medically needy, or are enrolled in the Community Alternatives Program, the Health Insurance Premium Payment Program or in the Foster Care program.

6. Will NC DHHS still be serving some Medicaid recipients?

Response: Yes, Medicaid Direct will continue to serve members who are dually eligible for Medicare and Medicaid, foster care members, transitions to community living, CAP/C & CAP/DA waiver programs, and limited benefit populations such as family planning.

7. What happens if my patient comes without a card? How do you verify which plan the patient is on?

   Response: Pharmacies will be able to verify member enrollment in TP-MCO Medicaid through the NCTracks portal, similar as they do today. Also, when a claim is sent through to NC Tracks, a message will return indicating which plan the member is enrolled in, as well as the BIN number.

   In addition to leveraging the NCTracks portal to confirm TP enrollment, Providers may also search beneficiary information one month in the future so they can look in April to see what the status will be starting in May.

   https://www.nctracks.nc.gov/content/public/providers/provider-communications/2021-Announcements/Functionality-to-Display-Future-Eligibility-Status-to-Be-Added-to-NCTracks.html

8. This question is about Prior Authorizations for drugs. What if my patient is here for a refill, and now they are on a new plan, do they need a new prior authorization for the new plan?

   Response: The BH I/DD Tailored Plan must honor existing and active pharmacy prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans for the life of the PA, to ensure continuity of care for members and to minimize provider burden. A new PA for the new Tailored Plan is not required to replace existing, active PA for drugs. The one exception to this is for SUD drugs, which require PA. Remember those PA will not transfer from Medicaid Direct to the TPs.

9. Will the Tailored Plans utilize a 72-hour fill, same as Medicaid Direct would, in the event issues arise with PA at launch?

   Response: Pharmacies will also be able to utilize a 72-hour emergency fill if necessary, and all pharmacies are encouraged to do so should the need arise. We would never want to jeopardize a patient's access to medications or cause an interruption of therapy. If you have issues you cannot resolve, do not hesitate to contact the corresponding PBM. We have instructed PerformRx to do everything possible to ensure there are no gaps in care.

10. Will all the prior authorization processes be universal or vary among the Tailored Plans?

Response: All Prior Authorization rules and requirements will be the same across all of North Carolina Medicaid and each of its MCOs. Processes may differ between plans, but all will have call centers you can call to inquire about a particular prior authorization of if you have any questions, or for the provider to call in a PA. In addition, for faxed request, all PA Forms should be the same with regards to questions asked and required information needed. Each Tailored Plan website will have access to these forms and links to their PBM websites.

Navitus will be processing prior authorizations for Vaya. Providers and pharmacies will be able to access the forms via Vaya's website. The links to those forms will be available several weeks prior to go live. The Department has built in a requirement that TP's honor any authorization made by the department or another managed care plan, so prescribers should not need to get a new PA at TP launch.

Prescribers will need to use the plan's specific form to make sure it gets returned to the right place, although the questions and requirements will be the exact same between plans. Cover My Meds is always an option, however they do not always have the most up to date forms. The best option to avoid duplicate work is to always refer providers to the plan's website.

11. Will the new Tailored Plans follow the single-state preferred drug list? Will the same committee structure and approval process continue?

Response: Yes. All plans follow the NC Single PDL, in conjunction with an open formulary of covered drugs. All drugs enrolled in the Medicaid Drug Rebate Program are covered by Medicaid and some of those covered drugs are also managed through the PDL. The PDL is a tool used by Medicaid to drive utilization towards covered medications, which are most cost-effective to the State.

The PDL approval process remains the same. After year 1, the plans may suggest recommendations for change to the PDL, but all recommendations then go through the same consideration and approval process already established by the State, which includes review by the Pharmacy & Therapeutics Committee and the Physician Advisory Group, followed by a public comment period. Any changes that are approved by the State, will be made to the Single PDL and implemented across all plans.

12. Will the cardholder IDs be unique/different format than existing MCO cardholder IDs?

Response: The state Medicaid ID assigned to the individual is used for any and all cards. All cards, regardless of who is responsible for it (Medicaid Direct, TO, SP or TP) uses the

Medicaid ID# and is referred to as their Medicaid card. Each TP will have their own card. The format may appear a bit different than the Standard Plan cards.

13. Medicaid has been the payer with the best reimbursement in our state for many years, and we understand reimbursement will not change under any of the managed care plans. Is this also true for the Tailored Plans? What can pharmacists expect, regarding reimbursement, as we move forward with the new Tailored Plans?

    Response: The dispensing fee and pharmacy claim reimbursement logic is set by the Tailored Plan contract, Legislation, and the State Plan… and there will be no difference in how the TPs reimburse pharmacies for drug costs, nor the dispensing fee, as compared to Medicaid Direct. It is important that the dispensing fee and drug reimbursement logic continue unchanged not only to remain fair to pharmacies, but to encourage continued participation in the evolving NC Medicaid programs, preserving access to medications for our members across all pharmacy settings. As a result of continued dispensing fee discussions, a proposal to remove the limit of one dispensing fee per member per medication per month is being considered, with a high probability of success. This is especially positive, for example, with medications that are often dispensed weekly such as Suboxone or clozapine, where in the past pharmacies may have only received one dispensing fee in every four fills. Again, this is intended not only to be fair to pharmacies but encourage participation in these programs to benefit our members. Access is one of our highest priorities.

14. We have heard that managed care will be done differently here in NC versus in other states. Are Tailored Plans unique to NC? How will the Tailored Plans bring value?

    Response: Medicaid in any given state is unique to that state, thus managed care in a given state is unique to that state. North Carolina is unique in that it has created separate plans for the general Medicaid population, the Standard Plans, and our Severely Mental Ill population, which will be a part of our Tailored Plans. MCOs in general have more opportunities to bring value to the Medicaid program by being able to provide unique clinical programs and services to the Medicaid Population. Tailored Plans hope to do the same and for the first time be able to coordinate care for our SMI patients in a much more efficient manner, because we will be taking care of all of the healthcare needs of our patients. In the past, SMI patients had fragmented care between the LME/MCOs and the State. Now, all of their care will be under one plan.

15. We know that state Medicaid will continue to aggregate buying through their rebate vendor, which means the Tailored Plans will not receive any revenue from rebates. Pharmacists worry

that this will result in PBMs using different claw back practices. How can we prevent this non-transparent, retroactive fee assessment from happening in our state?

Response: This is a great question and an area where NC Medicaid has really attempted to protect pharmacies and adhere to industry best practices. The Department's contract with each Tailored Plan is explicit in requiring reimbursement and any recoupment to follow the processes currently in practice by Medicaid Direct. There are no DIR fees or other clawbacks allowed. Transaction fees are not allowed per our contracts.

16. Keeping independent community pharmacies viable obviously makes sense regarding access to medication; however, what are your thoughts on why community pharmacies must remain open.

Response: I think I may speak for all the DOPs - It is important to all of us that we are contacted with as many independent community pharmacies as possible in our counties. There are several reasons for that. We recognize that independent community pharmacies have high patient satisfaction because of the high level of service and development of strong patient relationships that are provided resulting in better outcomes for our members. We also recognize that independent community pharmacies often provide more services to their patients such as compliance packaging or offering LAI administration or DME supplies making more services available to the members.

17. What clinical services, public health initiatives or chronic disease states do you envision your Tailored Plan will be interested in paying pharmacists to help manage?

Response: There are many enhanced services some pharmacies already provide and there are additional services that can be provided

- I'll begin with those services Medicaid has recently begun paying pharmacist to do
  - For the SPMI population (Serious Persistent Mental Illness -Schizophrenia and Bipolar) long -acting injectable antipsychotics have demonstrated improved outcomes. Pharmacy administration of LAIs offers the convenience to the member and improves access and reduces waste. Medicaid reimburses pharmacies for administration of LAIs.
  - mailing and delivery of medications is also covered now
  - Most behavioral health patients who smoke do want to quit and can with the proper support. Medicaid instituted a standing order for pharmacists to prescribe nicotine replacement therapy, which supports Medicaid coverage of this OTC product. The next step which Tailored plans are advocating for is for Medicaid to cover pharmacists provided smoking cessation counseling along with pharmacist NRT prescribing already authorized. This would tie in nicely with referral to the NC Quitline for behavioral

support and advocate for patients to request varenicline or bupropion from their prescribers.

- Now I'd like to move to pharmacy services we think would provide value to our members. Payment for these additional services are contingent on Medicaid approval and funding.
  - **Adherence packaging** and **medication synchronization** are services some pharmacies already offer are very helpful. For our members with limited incomes, **90 day supplies** reduce copay burdens.
  - **Clozapine** is the only antipsychotic for treatment resistant (failed 2 adequate antipsychotic trials) .Pharmacy support through Clozapine REMS registration and stocking clozapine is essential. There is an ANC Point of Care (POC) test that can be done in the pharmacy.
  - Another **POC testing** opportunity is the annual metabolic monitoring (lipids and glucose) required with all 2nd generation antipsychotics. POC testing reimbursement is a future opportunity
  - Pharmacies can provide many services to support regarding **substance use disorders** (SUDs) prevention and treatment.
    - The North Carolina Association of Pharmacists (NCAP) has offered several trainings on pharmacist **SBIRT** (Screening Brief Intervention and Referral to Treatment).
    - In the realm of **opioid safety**, pharmacies counsel patients on safe opioid use, safe storage and disposal and recommend naloxone for those on higher morphine milligram equivalents and/or with significant risk factors and can create pain contracts.
    - For those patients with Opioid Use Disorder (OUD), medications for opioid use disorder (MOUD) is THE highest evidence-based treatment to prevent overdose deaths and help recovery. Pharmacy **access to buprenorphine**, both the sublingual and potentially the long acting injectable, is critical, as is having access in the pharmacy to injectable naltrexone administration.
    - **Harm reduction** can be entry point for those who are still in active use toward recovery; pharmacists being proactive in dispensing naloxone via the standing order is critical.
    - The pharmacy should a safe place for syringe purchases without a prescription and no questions asked (though a prescription is needed for Medicaid to cover syringes).
    - Making the entire pharmacy a no-judgment STIGMA free zone will support those with SUDs towards recovery.
    - With all the focus on OUDs, other SUDs continue to also be a concern.
      - Illicit substances are expected to be tainted with fentanyl so all illicit drug users should have naloxone.

- Alcohol and tobacco are also a huge concern in the TP population. Alcohol use disorder treatment includes medication assisted treatment with numerous oral medications as well as intramuscular naltrexone, which can now be administered in the pharmacy.

- While the tailored plan population needs help with their BH conditions, they also have physical health needs that the pharmacy can support such as diabetes, hypertension, asthma/COPD, and contraception.

18. At Standard Plan launch, we had some issues with PA not crossing over to the Standard Plan as it should have and members not showing as enrolled in a plan when the member thinks they were or when Medicaid Direct says they were. Having some of these data issues at launch are not unexpected. What have you done to learn from issues such as these and how will this implementation be different?

    Response: It is important to understand and recognize that any large program change, and implementation will have challenges. With that said, the Tailored Plans are committed to working with the State and providers to get any issues resolved efficiently. There have been lessons learned from the PHP Standard Plan launch.

    One topic discussed earlier, was around Prior Authorizations (PA) and making sure that PAs transfer to the new Tailored Plan at launch to prevent access issues for members and to require providers to have submit duplicate PA during the transition. PAs will be honored for the life of the PA, regardless of whether they were initiated before the member was transferred to a Tailored Plan. If issues do arise regarding a member's PA at launch, we will be ready and available to ensure members have access to their medications as clinically appropriate. Our priority is to ensure members have access to the care they need.

    The Standard Plans shared lessons learned with the TPs, and among their list was the importance of having well trained Call Center staff. Call Center Staff should be properly prepared to answer questions about eligibility, claim rejections, prior authorizations, and lock-in change requests – from Day 1. With this launch, we are expecting that call center scripts are prepared to address these issues and that staff are well trained on the NC Medicaid benefit.

19. The Standard Plans allow pharmacies to process POS vaccine claims, which is helpful; however, Medicaid Direct does not currently have this functionality. Will Tailored Plan member vaccines require submission as a Medical claim or will we be able to process them at POS, similar to how we do it for the Standard Plans?

Response: We agree that processing vaccines at POS is the easiest and most integrated solution for all involved, and as such Sandhills Center/PerformRx will be utilizing this method when pharmacy POS goes live on 4/1. Pharmacies will be able to utilize the POS system for vaccine processing through each Tailored Plan's PBM, or they may choose to send a medical claim directly to the Tailored Plan.

20. At Standard Plan launch there were some pharmacies who were DME providers who had not contracted with the plans as DME providers. It then took some time to get them enrolled. Jason, do you have any advice for pharmacies, who also supply DME?

    Response: Points to consider for those of you who are also DME providers:

    First, if you are an existing DME provider, you should all have been approached by the medical side of our Tailored Plans to be DME providers for us. If you have not been contacted and need to contract, please reach out to us soon.

    Two, the Tailored Plan managed care contract does *not* require that the 5 series of DME/POS policies be followed exactly; however, the health plans are 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 NC Medicaid Direct". The contract allows for health plans to employ different prior authorization (PA) and other criteria as part of their utilization management program so long as they are evidence-based and provide a reasonable pathway to coverage.
    Reimbursement for durable medical equipment, supplies, orthotics, and prosthetics shall be set at one hundred percent (100%) of the lesser of the supplier's usual and customary rate or the maximum allowable NC Medicaid Direct rates for durable medical equipment and supplies, orthotics, and prosthetics in accordance with Section 11 of Session Law 2020-88, as amended.

    Finally, billing for DME is on medical claims as it was when the state had all of DME. The only pharmacy point-of-sale DME exceptions are for glucose meters, strips, lancets and therapeutic CGMs (e.g.: Dexcom G5, G6, Freestyle Libre). Blood glucose testing supplies may be obtained on *both* the POS Pharmacy side or through the DME program. Only non-therapeutic CGMs may be provided on the DME side.

21. Part of how the Tailored Plans partner with pharmacies, is to provide Non-Emergency Medical Transportation (NEMT) for eligible members who need to pick up a prescription. It is our understanding that not all plans are providing this service, but some are, including Vaya, …. We should probably talk about this. Jay, would you tell us more about NEMT for pharmacies?

Response: The Tailored Plans are doing several things to help facilitate medication access. All TPs will be paying the $3 or $1.50 reimbursement for hand delivered or mailed prescriptions respectively. In addition, TPs will be rolling out a Non-Emergency Medical Transportation benefit. Non-Emergency Medical Transportation or NEMT will arrange and pay for rides for Members to doctor appointments. Many of the plans have extended that service and are allowing coverage for trips to the pharmacy as a value added service. Every plan will be a bit different but for the Vaya counties, trips must be scheduled two days in advance and will be covered up to 50 miles one way. Urgent trips may be available on the same day or one day notice if a transportation provider is available. Members should contact their plans' Member and Recipient Service line to be routed to the NEMT scheduler for more information. Vaya does require that the Member or their caregiver actually calls to arrange. We are doing this to make sure there isn't any miscommunication and to reduce the number of missed rides. Pharmacies can help a member call in to the Member and Recipient Service Line, but the member or caregiver needs to be on the line to finalize the transportation request.