Trillium HEALTH RESOURCES
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Network Communication Bulletin #150

To: All Providers

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Subject: Important Medicaid Transformation Information

SPECIAL BULLETIN MEDICAID TRANSFORMATION

COMMUNITY INCLUSION ADDENDUM ADDED TO TAILORED CARE MANAGEMENT PROVIDER MANUAL

In June 2020, the North Carolina Department of Health and Human Services (DHHS) released the Tailored Care Management Provider Manual to serve as a resource for provider organizations that are interested in playing a central role in Tailored Care Management and are considering becoming certified as an Advanced Medical Home Plus (AMH+) practice or a Care Management Agency (CMA).

DHHS is releasing an addendum to the Tailored Care Management Provider Manual on community inclusion that addresses the in-reach and transition requirements for AMH+ practices and CMAs delivering Tailored Care Management.

DHHS will identify additional opportunities for providers to share feedback and engage with the department around these requirements. Providers also can send questions and comments to Medicaid.TailoredCareMgmt@dhhs.nc.gov.

The Tailored Care Management Provider Manual and Community Inclusion Addendum are available on the Tailored Care Management webpage under the Resources section.

Contact: NC Medicaid Contact Center, 888-245-0179

Tailored CM Provider Manual In Reach Transition Addendum FINAL

MEDICAID TRANSFORMATION RESOURCES

During Medicaid Transformation, with the launch of the Standard Plans in 2021 and Tailored Plans in 2022, Trillium will continue sharing information with our provider network. Trillium will host trainings, pass along updates from NC DHHS, and help answer questions from providers.

The Trillium Regional Directors are giving presentations on the Medicaid changes that will be occurring July 1, 2021 at each of the Community Collaboratives. We encourage Community Stakeholders to join these meetings learn the impact that it might have on your agency and community.

Visit the Collaboratives Community Meetings Schedule on our website.

Please see below for current resources:

- NCDHHS Facts Sheets
- My Learning Campus for Providers - Medicaid Transformation Training available
- Learn more about Medicaid Transformation
- NCDHHS Health Plan Contacts & Resources
- North Carolina AHEC Managed Care Website

MEDICAID MANAGED CARE PROVIDER UPDATE

KEY DATES FOR TRANSITIONING TO MEDICAID MANAGED CARE

- **March 15, 2021** – Open Enrollment begins
- **May 14, 2021** – Open Enrollment ends
- **May 15, 2021** – Auto Enrollment for beneficiaries who have not selected a health plan
- **May 22, 2021** (approximate) – Transition of Care information is sent to each health plan for beneficiaries assigned to that health plan
- **July 1, 2021** – Medicaid Managed Care launch

PHP QUICK REFERENCE GUIDES CREATED

NC Medicaid's Managed Care Prepaid Health Plans (PHPs) have created quick reference guides to include the most current and comprehensive information for providers. Each quick reference guide covers:

- Provider Services Contacts;
- Provider Portal Information;
- Prior Authorization / Notifications Information;
- Member Services / Eligibility Information;
- Claims / EDI Information;
- Provider Grievances and Appeals Information;
- Non-Emergency Medical Transportation Information;
- Pharmacy Information;
- Nurse Line Information;

- Behavioral Health Crisis Information;
- Transportation Information;
- Interpreter Services Information;
- Vendor Information;
- Care Coordination Information; and
- Additional resources.

NEW PROVIDER "QUICK REFERENCE GUIDE" CREATED BY THE PLANS TO ASSIST PROVIDERS IN THEIR CONTRACTING PROCESSES (LINKS TO THE GUIDES FOR EACH PHP IS BELOW)

- AmeriHealth Caritas North Carolina
- Carolina Complete Health
- Healthy Blue (Blue Cross Blue Shield)
- United Healthcare Community Plan of North Carolina
- WellCare of North Carolina

The PHP quick reference guides are available on the Provider Playbook Fact Sheet webpage under the Health Plan Resources section. Links to the Health Plan training webpages have also been added on the Provider Playbook Training Courses webpage.

PROVIDER CONTRACTING REMINDERS

Although providers may contract with health plans at any time, the NC Department of Health and Human Services (DHHS) published two specific deadlines to increase the likelihood of inclusion in the Medicaid and NC Health Choice Provider and Health Plan Look-up Tool, as well as the Health Plan provider directories by certain milestone dates. The first deadline to ensure inclusion during open enrollment (begins March 15, 2021) has passed, but it should not deter uncontracted providers from quickly beginning that process to meet the next deadline and be included in the provider directories as soon as possible.

In order for a provider's information to be used in auto-enrollment (May 15, 2021), contracts should be executed with Health Plans by April 12, 2021. This allows sufficient time for signed contracts to be returned and for the Health Plan to process those contracts. Typically, Health Plan processing time is two to three weeks, but may take longer. Providers need to contract with health plans in a timely fashion to avoid losing patients when health plans assign beneficiaries to in-network providers. More information is available on the Medicaid website under Provider and Health Plan Contract Deadlines for Inclusion in Open Enrollment and Auto-Enrollment.

PROVIDER PLAYBOOK UPDATES

The Provider Playbook is where you can access the latest information, tools and other resources to help you and your patients smoothly transition to Medicaid Managed Care. New resources to the Fact Sheet page include:

- Transition of Care for beneficiaries receiving long-term services and supports (LTSS) – An overview of how NC Medicaid Managed Care impacts beneficiaries with disabilities and older adults who are receiving LTSS.
- Advanced Medical Home (AMH) Program – A detailed look at how the Advanced Medical Home (AMH) program will serve as the primary vehicle for delivering local care management as the state transitions to Medicaid Managed Care.
- Early Intervention Services in Medicaid Managed Care – An overview of how the transition to Managed Care impacts Medicaid services to infants and toddlers with disabilities and/or developmental delays provided by Children's Developmental Services Agencies (CDSAs).
- Telehealth – An overview of the different virtual health care services available across the state under the Telehealth Program. Telehealth allows patients to stay safely at home while still receiving the care that they need.
- Eastern Band of Cherokee Indians (EBCI) Tribal Option – a detailed look at the health plan managed by the Cherokee Indian Hospital Authority (CIHA) to meet the primary care coordination needs of federally-recognized tribal members and others eligible for services through Indian Health Service (IHS)
- Managed Care Claims Part 1 – An overview of claims guidelines and resources to inform both in-network and out-of-network providers about their claims submission process and their billing guidelines.
- Managed Care Claims Part 2 – An overview of frequently asked questions regarding providers and PHPs during the claims and submission process.
- Auto-enrollment use cases - Detailed look at the beneficiary enrollment and auto-enrollment process with scenarios.

MEDICAID CONTACTS REFERENCE GUIDE FOR BENEFICIARIES AVAILABLE

With Medicaid Transformation comes the introduction of new points of contact for beneficiaries, such as the Enrollment Broker and health plans. A long-term goal of NC Medicaid is to provide a single point of contact – one number – for beneficiaries to call for assistance. For now, please try to direct beneficiaries to the appropriate contact using the information provided in this guide, located on the Beneficiary Materials page of the Provider Playbook. **When in doubt, you may always refer the beneficiary to the Enrollment Broker for assistance at 833-870-5500. This guide is intended for internal use only and not meant to be used as a handout for beneficiaries.**

HELP CENTER NOW AVAILABLE FOR PROVIDERS TO FIND INFORMATION

The NC Medicaid Help Center is an online source of information about Managed Care, COVID-19 and Medicaid and behavioral health services, and is also used to view answers to questions from the NC Medicaid Help Center mailbox, webinars and other sources. Formerly referenced as the "SWAT Command Center," the NC Medicaid Help Center also includes resource documents such as standard and COVID-19 Medicaid Bulletins.

Find more information on NC Medicaid Help Center.

VIRTUAL OFFICE HOURS

NC Medicaid and NC AHEC are conducting a series of virtual office hours for providers beginning in March 2021. These sessions offer an interactive format for providers to have their questions answered.

Providers are encouraged to submit questions in advance. Virtual Office Hours will cover a range of Medicaid Managed Care topics. For the most up-to-date schedule, visit the AHEC Medicaid Managed Care webpage.

HEALTH PLAN VIRTUAL MEET AND GREET SESSIONS

NC Medicaid and NC AHEC are hosting virtual health plan meet and greet sessions beginning on March 24, 2021. NC Medicaid consultants and health plan representatives will be available to address your concerns and questions about the transition from Medicaid fee-for-service to Medicaid Managed Care.

Virtual meet and greet sessions are structured as conversations between providers and health plan staff with a question and answer session for participants. Sessions will be delivered live with a recording and transcript made available after each event. For the most up-to-date schedule and to register, visit the AHEC Medicaid Managed Care webpage.

ENSURE YOUR INFORMATION DISPLAYS CORRECTLY IN NC'S PROVIDER DIRECTORY – MEDICAID AND NC HEALTH CHOICE PROVIDER AND HEALTH PLAN LOOK-UP TOOL

Interim reports are temporarily available on the Managed Care Provider Playbook Resources page to assist providers in verifying their records. The Provider Directory Listing Report, as well as the Provider Affiliation Report, is available to all actively enrolled Medicaid and NC Health Choice providers. In combination, these reports allow all providers to confirm the information visible to NC Medicaid beneficiaries as each utilize the "Medicaid and NC Health Choice Provider and Health Plan Look-up Tool" to find participating provider information, and if applicable, enroll into Medicaid Managed Care.

- Providers may use the NCTracks MCR process, available in the Secure NCTracks Provider Portal, to modify any provider record or service location information as well as individual to organization affiliations.
- If the Provider Affiliation information is incorrect, the affiliated individual provider or the Office Administrator for the affiliated individual provider must update the group affiliation.
- Providers unable to find their practice associated with the correct Health Plans should reach out directly to the Health Plan to discuss contracting options. If contracting with health plans through a Clinically Integrated Network (CIN), providers should reach out to their CIN to resolve.

As NC Medicaid moves forward with the implementation of Medicaid Managed Care, it is important enrolled providers use these resources to thoroughly review their individual and organization provider enrollment information and submit changes as needed using the Manage Change Request process.

Find more information on Ensure Your Information Displays Correctly webpage.

PROVIDER OMBUDSMAN

NC Medicaid offers a Provider Ombudsman to assist providers transitioning to Managed Care by receiving and responding to inquiries, concerns, and complaints regarding Health Plans. This service is intended to represent the interests of the provider community, provide supportive resources, and assist with issues through resolution.

The Ombudsman will also investigate and address complaints of alleged maladministration or violations of rights against the Health Plans. Health Plans are expected to resolve complaints promptly and furnish a summary of final resolution to NC Medicaid. Inquiries may be submitted at Medicaid.ProviderOmbudsman@dhhs.nc.gov or by calling the Medicaid Managed Care Provider Ombudsman at 919-527-6666. Likewise, responses may also be delivered through either the email distribution listserv or by phone. The Provider Ombudsman contact information can be found in each Health Plan's Provider Manual linked on the Health Plan Contacts and Resources Page.

Additionally, the Ombudsman will assist providers with Health Information Exchange (HIE) inquiries related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process. The Ombudsman service is separate and apart from the Health Plans Provider Grievances and Appeals process. Each health plan has a grievance and appeal process for providers, separate from the process for beneficiaries, which can be found in each Health Plan's Provider Manual, linked on the Health Plan Contacts and Resources Page.

TAILORED CARE MANAGEMENT CERTIFICATION

To continue supporting providers interested in obtaining certification as an Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA), the Department extended the Round 1 application deadline from March 1, 2021 to June 1, 2021. Find the information you need on Tailored Care Management Certification.

INTERIM PROCESS FOR COMPREHENSIVE INDEPENDENT ASSESSMENT ENTITY REQUESTS

Due to the cancelation of the contract for the Comprehensive Independent Assessment Entity (CIAE), NC Medicaid implemented a temporary interim workaround project on Oct. 19, 2020, to manage requests to receive Community Alternatives Program (CAP) services from interested applicants. Two distinct functions outlined in the scope of the canceled contract will be carried out by NC Medicaid until a new CIAE vendor is awarded. These two functions are completing the service request form that determines the level of care (LOC) and reviewing the initial assessments to decide enrollment in the CAP waiver.

At the launch of this project, stakeholders were informed that from October 2020 - March 2021, NC Medicaid would be flexible in processing referral requests and not strictly apply the timelines for the receiving, processing and closing out referral requests to ensure full understanding of the new referral process. Beginning April 1, 2021, NC Medicaid will begin strictly applying its timeline business rules, described in the chart below, in the processing, reviewing and closing out referral requests.

To ensure all CAP stakeholders are notified of the timeline enforcement that begins April 1, 2021, referral requests missing the consent form or Physician LOC worksheet, a notice will be generated to inform the applicant of the status of the referral. Notices were mailed on March 8, 2021. If no response is received by April 2, 2021, action will be taken on April 5, 2021 to close the referral. The applicant is encouraged to follow the instructions in the notice.

IMPORTANT THINGS TO CONSIDER WHEN COMPLETING A REFERRAL

1. Collect as much information as possible from the applicant to provide future assistance in obtaining CAP services, including:
   - No informal support system available
   - Non-English speaker
   - Needs assistance with reading
2. Check in with the applicant after five (5) business days to see if the consent packet was received and offer support.
3. Closely monitor the e-CAP referral tracker and reach out when an applicant appears non-responsive in returning the required forms.
4. Inform all applicants of the timeline from the date a referral is made to the date that a decision can be reached. The total timeline can take up to 105 days once all required documents are received. The timeline includes:
   - 45 calendar days to complete the service request
   - 30 calendar days for an initial assessment to be completed
   - 30 calendar days for the assessment to be reviewed to determine the final decision.

IMPORTANT TIMELINES THAT WILL BE ENFORCED DURING THIS INTERIM PROJECT

Business Workflow	Timeline
Processing a referral – The prompting of a disclosure packet that includes the consent, the physician's LOC recommendation and the selection of a case management entity	3 business days from the date the referral was received in CAP business systems
Tracking the receipt of required documents included in the disclosure notice – The uploading of a signed/dated consent form, a completed physician's LOC worksheet to the applicant's file to begin the processing of the service request to determine the LOC.	7 business days from the date the disclosure packet is received by the applicant
Voiding out a referral – The closeout of a referral due to the non-receipt of the consent form and the Physician's LOC worksheet after the mailing of a notice.	15 calendar days from the date of the non-receipt notice letter
Completing the Service Request – The LOC's determination from the review and analysis of data from the Physician's LOC worksheet paid claims and other supporting documentation based on the CAP clinical coverage policies (3K-1 and 3K-2), outlined in Section 3.0. This process also includes requesting additional information and the closeout of the workflow for requests that cannot be processed because of missing information.	45 calendar days from the date the consent form or the Physician's LOC worksheet is received.
Issuing a technical denial for a service request that can't be processed – The closeout of a service request due to missing information.	On or after the 46th calendar day from the receipt of the consent form or the physician LOC worksheet
Reviewing initial assessments - The conducting of a reasonable indication of need review to determine risk, determinants of health, impact on the l family and the need for at least one waiver service. This process may include the request for additional information. The review process includes a multidisciplinary engagement to confirm findings in the assessment to complete a review summary and close out.	30 calendar days from the date the case is assigned to assessment/assignment in the CAP business system
Reviewing and Approving CAP/C Service Plans – The review of the service plan to ensure services in the POC align with the needs of the waiver participant based on assessed risk, determinants of health, and stress on the family.	30 calendar days from the date of the received service plan.

Any questions about this Communication Bulletin that does not already have an email listed for questions from that specific section, may be sent to the following email: NetworkManagement@TrilliumNC.org. These questions will be answered in a Q&A format and published on Trillium's website.