MEDICAID

# Provider Orientation

BlueCross BlueShield of North Carolina | HealthyBlue

# Agenda

- About Us
- Who We Serve
- Members
- Joining our Network
- Tools and Resources
- Billing
- Vendor Services Partners
- Compliance
- Quality Management

# About Us

- Introducing the Healthy Blue plan
- How We Work with Providers

# Introduction

## Who We Are

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) has established an alliance with Amerigroup Partnership Plan, LLC (Amerigroup), combining more than 85 years of deep local expertise with best-in-class Medicaid managed care capabilities and experience to create our Healthy Blue plan.

The Healthy Blue plan aligns with the North Carolina Department of Health and Human Services' (NCDHHS) goals for Medicaid. Through Healthy Blue providers, Blue Cross NC will help coordinate physical and behavioral healthcare for enrolled Medicaid members to offer education and the Disease Management program.

**We are dedicated to offering real solutions that lower costs and improve healthcare access and quality care for our members.**

# Our Goals

- Offer members access to an integrated, whole-person care model
- Streamline the member experience for members of a prepaid health plan (PHP)
- Support the overall vision of creating a healthier North Carolina

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# Provider Pledge

We will approach provider engagement and collaboration with what we call our ***Provider Promise***: To simplify healthcare so providers can focus on health.


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# Provider Support and Assistance

| | | |
|---|---|---|
| We support you through many different departments as you provide care to our members, including: | • Our Provider Relations Team<br>• Our Medical Management staff<br>• Specialized teams to help you with your claim questions<br>• Provider Services | Call Provider Services for assistance with claim issues, member enrollment and general inquiries at **1-844-594-5072**. |
| Provider Relations serves the following functions: | • Provider ongoing education and training<br>• Engaging providers in quality initiatives<br>• Building and maintaining the provider network<br>• Offering support for claims and billing questions and issues | You can always contact your local Provider Relations representative with questions. |

# Who We Serve

- What is Medicaid Managed Care?
- Population

# What is Medicaid Managed Care?

Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between the North Carolina Department of Health and Human Services (NCDHHS) and the prepaid health plans (PHP) that will accept a set per member per month (PMPM) payment for services delivered to enrolled members.

# Medicaid Population

Beneficiaries who do not qualify for Medicaid managed care will remain on NC Medicaid Direct.

| Must enroll: Currently in Medicaid Direct — Must enroll in Medicaid managed care | Excluded:* Currently enrolled in Medicaid Direct and excluded from enrollment in Medicaid managed care | May enroll: Currently in Medicaid Direct — May enroll in Medicaid managed care |
|---|---|---|
| • Most family and children's Medicaid<br>• NC Health Choice<br>• Pregnant women<br>• Non-Medicare aged<br>• Blind, disabled | • Family planning program<br>• Medically needy<br>• Health insurance premium payment (HIPP)<br>• Program of All-Inclusive Care for the Elderly (PACE)<br>• Refugee Medicaid | • Federally recognized tribal members<br>• Beneficiaries who would be eligible for behavioral health<br>• Tailored plans (until they become available)** |
| Standard Plans — Members will benefit from integrated physical and behavioral health services.<br>Tailored Plans — Refers to specialized plans that offer integrated services for members with significant behavioral health needs and intellectual/developmental disabilities. | | |

Notes:
*Traditional Medicaid Program — does not include Duals or Medicare. Some beneficiaries are temporarily excluded and become mandatory later. This includes dually eligible Medicaid/Medicare, Foster Care/Adoption, and Community Alternatives Program for Children (CAP-C).
**Target launch date for Tailored Plans is mid-2021.

## Serving our Members

- Eligibility and Benefits
- PCP Access and Availability
- Benefits
- Preventive Programs/Services
- Cultural Competency
- *Medical Policies* and *Clinical Utilization Management Guidelines*

# Member Eligibility

- NCDHHS will continue to determine a member's eligibility for Medicaid.
- Medicaid members will now choose their own healthcare plan. The enrollment broker (Maximus®)* will provide choice counseling to assist the member in selecting the PHP that aligns with the member's needs.
- If the member does not select a PHP, one will be auto-assigned to them.
- The enrollment broker will work with the member to select their Advanced Medical Home (AMH) or PCP.
- Copays, if applicable, will stay the same.

# Member Eligibility (cont.)

- The same health services/treatments/supplies will be covered.
- Members will continue to report enrollment changes to the local Department of Social Services.
  - This enrollment includes newborn members, who will need a permanent Medicaid ID before claims can be processed.
- Be sure to use the member eligibility and benefits inquiry tool to verify member enrollment status.
- Only claims for Healthy Blue members will qualify for claims reimbursement.

# Verifying Eligibility and Benefits

Prior to rendering services, providers are responsible for verifying member eligibility.

Member eligibility can be checked by:

- Submitting a batch 270/271 transaction using your electronic data interchange (EDI) software vendor or your clearinghouse.
  - For more information, register for one of the Availity® Getting Started with EDI webinars.
- Submit a request on Availity Secure Provider Portal
  - Go to https://www.availity.com.
  - Select **Patient Registration** > **Eligibility and Benefits**.
  - Select **Healthy Blue** from the drop-down list.
  - Complete any required fields and submit the request.
    - For more information, register for one of Availity's new user trainings.
- Log in to NC Tracks

# Member ID Cards

# Access and Availability

It's our responsibility to make sure our members have access to primary care services for:

- Routine care services.
- Urgent and emergency services.
- Specialty care services for chronic and complex care.

We make sure our providers respond to members' needs in a timely manner by conducting telephonic surveys to confirm providers are meeting these standards. Availability and access standards are specifically outlined in the provider manual.

# Access and Availability (cont.)

**Appointment standards:** You must arrange to provide care as expeditiously as the member's health condition requires and according to each of the following appointment standards:

| Appointment Purpose | Time Frame |
|---|---|
| Emergency services | Immediately |
| Urgent medical condition | Within 24 hours |
| Nonurgent sick care* | Within 24 hours |
| Routine or preventive care* | Within 30 calendar days |

This standard does not apply to appointments for:

- Routine physical examinations.
- Regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days.
- Routine specialty services (for example, dermatology, allergy care).



Note:
* Please review the provider manual for more information.

# PCP Selection

A member must select a PCP.

- During enrollment, a member can choose their PCP.
- When a member does not choose a PCP at the time of enrollment or during auto-assignment, we will auto-assign a PCP within one business day from the date we process the daily eligibility file from the state.
- Pregnant members should select a PCP for the child prior to the birth. If we receive notification of birth prior to discharge, we will auto-assign a PCP before discharge from the hospital or birthing center.
- If a member requests a change in their PCP, the change will be made within 24 hours from the time the request was made.
- Members can select a PCP from the directory or call Member Services at **1-844-594-5070**.
- A member can see a specialist without a referral from their PCP.

# Covered Benefits and Services

Some covered member benefits and services:

- Behavioral health
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Well-child visits
- Family planning services
- Personal care services
- Pharmacy services
- Preventive medicine
- Telemedicine
- Nursing facility services

# Carved-Out Services

When a covered service is not provided through managed care, it is considered *carved out*. Carved-out services will continue to be delivered through Medicaid fee-for-service. NCDHHS will continue to administer and manage prior authorization and providers will continue to submit their claims through fee-for-service platforms when services fall under carved-out services.

Some of these services are:

- Dental services
- Services provided through the Program of All-Inclusive Care for the Elderly (PACE)

Please see the provider manual for more information about covered benefits and carved-out services.

# Value-Added Services

Value-added services are new extra benefits* that eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added services. Examples of value-added services offered by Healthy Blue include:

- Expanded chiropractic care.
- Nonemergency Medical Transportation (NEMT) for NC Health Choice (NCHC) Members.
- Community Transportation Benefit.
- Substance Use Disorder Recovery Support Program.
- Youth Club Memberships.
- Traditional Healing Benefits.
- Sensory Solutions.

Note:
* Some benefits have eligibility requirements.

# Early and Periodic Screening, Diagnostic, and Treatment

- Blue Cross NC will continue to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Healthy Blue members.
- EPSDT service is a complete and preventive child health program for Medicaid members under age 21.
- We encourage members to stay within the Healthy Blue network. However, EPSDT services will still be provided, regardless of network. EPSDT training materials/toolkit are located on the provider website at https://provider.healthybluenc.com.
- Covered EPSDT services include complete medical screens with a complete health and development history, with assessment for both physical and mental health development.
- Services include screening for child maltreatment risk factors, trauma and adverse childhood experiences.
- Services include screening for developmental, behavioral and social delays.

# Vaccines for Children

- The Vaccines For Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to pay.

- The Centers for Disease Control and Prevention buys vaccines at a discount and distributes them to grantees (in other words, state health departments and certain local and territorial public health agencies), which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers.

# Vaccines for Children (cont.)

To participate, providers need to contact the North Carolina Department of Public Health Immunization Branch for NC Registry enrollment requests.

- Blue Cross NC pays only for the vaccine administration for VFC-eligible children. Vaccines provided to children enrolled in Medicaid outside of VFC are not a covered benefit.
- Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. We reimburse PCPs for both the vaccine and administration fee for NC Health Choice members.

# Into the Mouths of Babes Program

**Into the Mouths of Babes (IMB) program**:

- NCDHHS trains medical providers to deliver preventive oral health services to young children insured by Medicaid.
- Allows previously trained medical providers and staff to train others in their practice using the IMB online oral health toolkit.

**Training:**

- The oral health section offers a live one-hour session in which continuing medical education credit is awarded.

**Visit the website for more information:**
https://publichealth.nc.gov/oralhealth/partners/IMB.htm

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# Into the Mouths of Babes Program (cont.)

**Oral prevention procured:**

- Oral evaluation and risk assessment
- Counseling with primary caregivers
- Application of topical fluoride varnish

**Reimbursement:**

- Blue Cross NC reimburses medical providers for the procedure given to Healthy Blue members.
- Medical professionals can provide the preventive oral procedure to a child a total of six times from tooth eruption until 3.5 years of age (42 months).

# Into the Mouths of Babes Program (cont.)

**Evaluation and outcomes[1]**

- Ongoing evaluation conducted by the UNC Gillings School of Global Public Health
- Reduction of 21% in hospitalizations for dental treatment for children receiving four or more IMB visits before 3 years of age
- Reduction of 17.7% in caries on average for children receiving four or more IMB visits before 3 years of age
- Statewide decline in dental caries rates since 2004
- Helped reduce gap in tooth decay for children from low-income families at the community level



Footnote:
1 https://publichealth.nc.gov/oralhealth/partners/IMB.htm

# Maternal Child Services — The New Baby, New Life Program

New Baby, New Life℠ is a proactive care management program for mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, pregnancy and delivery notification forms, and self-referrals.

Once pregnant members are identified, we act quickly to access obstetrical risk and ensure appropriate levels of care and care management services to mitigate risk.

The program offers:

- Individualized, one-on-one care management support for women at high risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

# Maternal Child Services — The New Baby, New Life Program (cont.)

Forms:

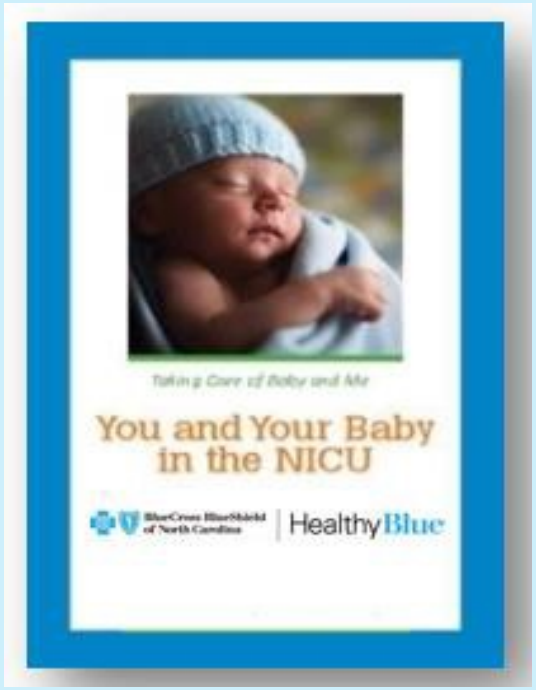
- For newly identified pregnant women, complete the *Maternity Notification Form* and fax it to **800-964-3627**.
- For pregnant women that have delivered, complete the *Newborn Notification of Delivery Form* and fax it to **800-964-3627**.

**As part of the New Baby, New Life program, members may receive the My Advocate® program as well**.* This program provides pregnant women proactive, culturally appropriate outreach and education though interactive voice response (IVR), text messaging, web or smartphone application. For more information on My Advocate, visit www.myadvocatehelps.com.

# Maternal Child Services — The New Baby, New Life Program (cont.)

## Neonatal intensive care unit (NICU) support

- We offer the You and Your Baby in the NICU program and NICU Post-Traumatic Stress Disorder (NICU PTSD) program.
- Parents receive education and support about how to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge.
- Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.
- The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents.
- This program will support mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

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# Disease Management Program

The Disease Management program is based on a system of coordinated care management interventions and communications designed to help physicians and other healthcare professionals manage members with chronic conditions. The Disease Management program includes but is not limited to:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)

In addition to our condition-specific Disease Management programs, our member-centric, holistic approach also allows us to assist members with managing their weight. Disease management *Clinical Practice Guidelines* are located at https://provider.healthybluenc.com.

- Coronary artery disease (CAD)
- Hypertension
- Major depressive disorder — adult and child/adolescent
- Schizophrenia
- Substance use disorder (SUD)
- Diabetes

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# Cultural Competency

We are committed to fostering cultural competency within our company and provider networks.

Cultural competency can enable you to:

- Acknowledge the importance of culture and linguistic differences.
- Recognize the cultural factors that shape personal and professional behavior.
- Enhance support of all patients by incorporating cultural insights into practice, where appropriate.
- Strive to expand cultural knowledge.

Cultural barriers between provider and patient can:

- Impact the patient's level of comfort and fear of receiving medical care.
- Result in differences in understanding of our healthcare system.
- Cause a fear of rejection of the patient's personal health beliefs.
- Impact your patient's expectation of you and of treatment.

# Cultural Competency (cont.)

- Like you, Blue Cross NC provides quality, effective and compassionate care to all patients. Delivering healthcare to a diverse patient population may present challenges. We are here to help.
- We offer translation and interpreter services, cultural competency tips, training, guides and resources based on the culturally and linguistically appropriate service standards.
- Refer to our cultural competency training located on the Healthy Blue provider website at https://provider.healthybluenc.com.
- Complete the course evaluation at the end of the training in order to reflect that you have completed the training in the directory.

# Cultural Competency (cont.)

The website MyDiversePatients.com features robust educational resources to help support providers address disparities. On the site you will find:

- Continuing medical education learning experiences about disparities, potential contributing factors and opportunities for you to enhance care.
- Real life stories about patients and the unique challenges they face.
- Tips and techniques for working with all patients to promote improvement in health outcomes.

While there's no single, easy answer to the issue of healthcare disparities, the vision of MyDiversePatients.com is to start reversing this trend one patient at a time.

**Accelerate your journey to becoming your patients' trusted health care partner by visiting the site today.**

# *Medical Policies* and *Clinical Utilization Management Guidelines*

*NC Clinical Coverage Polices* are the primary guidelines and *Medical Policies* and *Clinical Utilization Management Guidelines* are the secondary guidelines used to determine whether services are considered:

- Investigational/experimental.
- Medically necessary.
- Cosmetic or reconstructive.

*MCG Care Guidelines* will be used to determine medical necessity for acute inpatient care. A list of the specific *Medical Policies* and *Clinical Utilization Management Guidelines* will be posted and maintained on the Healthy Blue provider website and can be obtained in hard copy by written request. To request a copy of the criteria on which a medical decision was based, call Provider Services at **1-844-594-5072**.

## Joining Our Network

- Enrollment
- Credentialing and Contracting
- Provider Roles and Responsibilities

# Provider Enrollment

- Enrollment qualifications vary, but all providers must complete an application with NCDHHS. Providers are responsible for maintaining the required licensure, endorsement and accreditation specific to their provider type to remain qualified. Providers are required to notify NCDHHS immediately if a change in status occurs.
- For detailed information about specific requirements for each provider type, refer to the Provider Permission Matrix on the NCTracks website (https://www.nctracks.nc.gov/content/public/providers.html) or call the NCDHHS Provider Enrollment Team at **1-800-688-6696**.
- All provider enrollment, data management, recredentialing and verification must be completed by the provider through NCTracks.
- Providers who wish to contract with Blue Cross NC **must** be enrolled with NCTracks to participate in our Healthy Blue network. Information about enrollment in NCTracks can also be found at the NCTracks website.

# Credentialing and Contracting

- Providers will continue to use NCTracks (https://www.nctracks.nc.gov/content/public/providers.html) to complete the enrollment process, which includes credentialing and recredentialing.
- If you are interested in participating in the Healthy Blue network and are registered with NC Tracks, contact our Provider Services at 1-844-594-5072 choose prompt 4 or via email at ncproviderquestions@nchealthyblue.com.
- If you are not registered with NC Medicaid, visit https://www.nctracks.nc.gov to get started.

Please see the provider manual for more information about credentialing and contracting.

# Provider Roles and Responsibilities

The behavioral healthcare benefit is fully integrated with the rest of the healthcare programs and inclusive of our fee-for-service Medicaid members requiring behavioral health services only. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Adhere to all terms and conditions within the PHP/provider contract.
- Participate in the care management and coordination process for each Healthy Blue member under your care.
- Seek prior authorization for all services that require it.
- Attempt to obtain appropriate consent for the disclosure of substance use treatment information to the member's primary care provider for all members treated for behavioral health conditions, document attempts and report information to Blue Cross NC upon request.

# Provider Roles and Responsibilities (cont.)

- Provide Blue Cross NC and the member's PCP with a summary of the member's initial assessment, primary and secondary diagnosis and prescribed medications if the member is at risk for hospitalization; this information must be provided within 24 hours after the initial treatment session.
- Provide, at a minimum, a summary of the findings from the member's initial visit to the PCP — this must be provided within five calendar days of the visit for members not at risk for hospitalization and must include the behavioral health provider's contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.
- Notify Blue Cross NC and the member's PCP of any significant changes in the member's status and/or change in the level of care.

# Provider Roles and Responsibilities (cont.)

- Ensure that members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge with a qualified mental health professional — this treatment must be provided within seven calendar days from the date of the member's discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.
- Encourage members to consent to the sharing of substance use treatment information.
- Comply with mainstreaming requirements.
- Refrain from excluding treatment or placement of members for authorized behavioral health services solely on the basis of state agency involvement or referral.
- Monitor and report on preventable conditions.
- Keeping enrollment with state of North Carolina current.

# Coordination of Behavioral Health and Physical Health Treatment

Screening and identification of behavioral health conditions begin in the primary care provider's (PCP) office.

- No referrals are required for routine outpatient behavioral health services when provided by an in-network provider.
- As a network provider, you are required to notify a member's primary care provider when a member first enters behavioral health care and anytime there is a significant change in care, treatment, medications or need for medical services.

Providers must secure the necessary release of information from each members or the member's legal guardian for the release of treatment information.

For code-specific requirements for all services, visit our provider self-service website and select **Precertification Lookup** from our *Quick Tools* menu. https://provider.healthybluenc.com

# Care Management

Healthy Blue Integrated Care Management Design:

- Improve member health outcomes
- Integrating physical and behavioral health care
- Identification and use of Best Practices

Care Management continuum of services and supports:

- Matched on individualized basis to meet the needs of the member
- Identified at-risk members offered care management
- Inpatient admissions due to behavioral health or substances use disorders

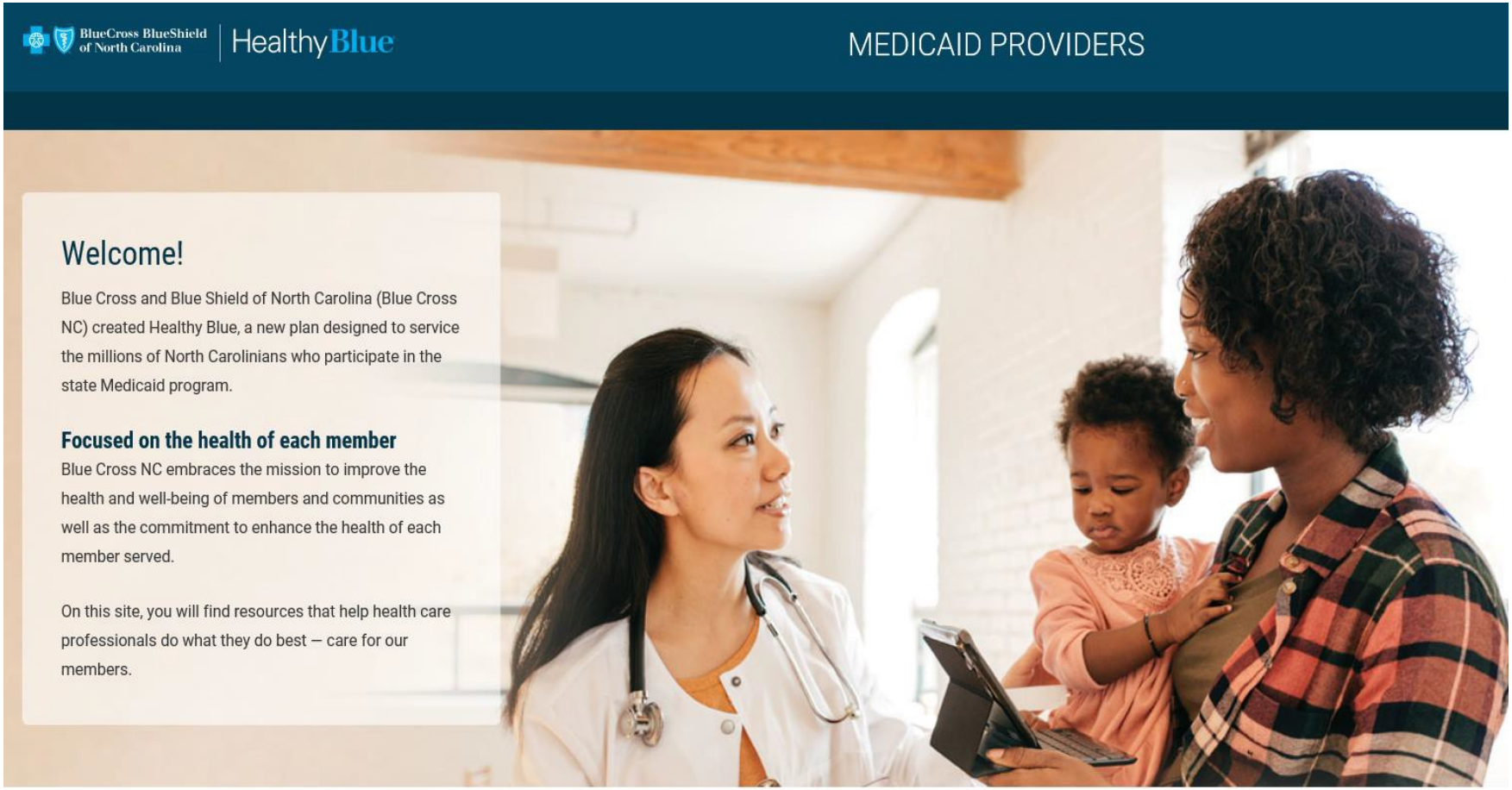
# Care Management (cont)

- Care Managers can help with coordinating services, ensuring services are in place post discharge, access to SDOH and community resources, connecting to value added benefits, and many other resources.
- Care management services are available to Healthy Blue members by contacting us via phone at **1-844-594-5072**, fax at **1-844-451-2792**.
- AMH1 and AMH2 providers have the opportunity to make referrals to Care Management by calling our Member Services.

## Tools and Resources

- Public Provider Portal
- Availity Portal
- Interpreter Services
- Nurse Line

# Public Provider Website

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# Availity Portal

- Availity (https://www.availity.com) is a web portal that is used by providers to securely access patient information such as eligibility, benefits, claim status, authorizations, and other proprietary information.
- Healthcare providers can use a single login to access multiple health plan providers at no cost. The registration process is easy. Multiple resources and trainings about site navigation are available.

# Healthy Blue Provider Website vs. Availity Portal Comparison

| Provider website | Availity Portal |
|---|---|
| • Accessible to all providers, regardless of participation status<br>• Open access without registration/login<br>• Claim forms<br>• Precertification Look Up Tool — Prior Authorization Requirements Look-Up Tool<br>• Provider Manual<br>• Clinical Practice Guidelines<br>• News and announcements<br>• Provider Directory<br>• Fraud, waste and abuse resources<br>• Preferred Drug List (PDL)<br>• Medical Policies<br>• Elsevier Performance Manager | • Precertification Look Up Tool<br>• Patient360 (provider facing)<br>• Multiple eligibility and benefits inquiry<br>• Provider Online Reporting<br>• Interactive Care Reviewer for medical prior authorizations requests<br>• Pharmacy authorizations and benefits<br>• Claims dispute submission<br>• Claims dispute inquiry<br>• Medical appeal prior authorization submission<br>• Maternity identification<br>• HEDIS® attestation<br>• Remittance inquiry<br>• Reimbursement tool |
| https://provider.healthybluenc.com | https://www.availity.com |

# Interpreter Services

Use an interpreter, when necessary, to ensure your patient understands all his or her options and can make an informed decision. Free interpreter services are available to Healthy Blue members 24/7 with over 170 languages.

Call Healthy Blue Provider Services at **1-844-594-5072** (TTY number) for:

- Interpreter services for provider services
- Telephonic interpreter services
- In-person interpreter services for care management

# 24/7 NurseLine

- Members can call the 24/7 NurseLine for health advice 7 days a week, 365 days a year at **1-844-545-1427**.
- Registered nurses answer members' questions and help them decide how to take care of health problems.
- If medical care is needed, the nurses can help a member decide where to go.

## Billing

- Prior Authorizations
- Claims – Start to Finish
- Reimbursement Policies
- Electronic Payment Services
- Appeals and Grievances

# Prior Authorization

Some of the services that require prior authorization (PA):

- Cardiac rehabilitation
- Chemotherapy
- Diagnostic testing
- Hearing aids
- Home health care and home IV infusion
- Elective inpatient admissions
- Hospice
- Hospital admission
- Long-term care
- Nonemergent outpatient and ancillary services
- Inpatient admission elective admissions

PAs approved prior to go-live will be honored for 90 days.

Please see the provider manual for a complete list of services that require PA.

# Prior Authorization Requirements

- Requirements for outpatient services can be viewed via the Prior Authorization Lookup Tool at https://provider.healthybluenc.com.
  - Search by market, member product and CPT® code.
- Services may be listed as requiring prior authorization that may not be covered benefits for a particular member. Please verify benefit coverage prior to rendering services.
- To determine coverage of a particular service or procedure for a specific member:
  - Access eligibility and benefits information on Availity.
  - Use the Precertification Lookup Tool, located under *Payer Spaces Applications* on Availity at https://www.availity.com.

# Request Prior Authorization and Notification

The preferred way to submit and manage prior authorization (PA) requests is by using the Interactive Care Reviewer (ICR) on Availity. ICR allows you to review status or submit a clinical appeal online. Log in to https://www.availity.com using your Availity credentials. Then:

- From the Availity Portal homepage, select **Patient Registration** from the top navigation bar
- Select **Authorizations & Referrals**
- Select **Authorizations**
- Select the payer and organization
- Select **Submit**
  - The Interactive Care Reviewer application, our online authorization tool, will open
  - Use ICR to submit and manage your medical PAs
- Use the PA fax (**1-855-817-5788)** number if you would like to fax a paper request

# Request Prior Authorization and Notification (cont.)

Failure to obtain PA for Healthy Blue members and failure to notify us of a member's admission or transfer within established time frames will result in your claims being administratively denied, and providers will not receive payment for the service(s). **PAs approved prior to go-live will be honored for 90 days**.

Providers can also call Healthy Blue Provider Services at **1-844-594-5072, prompt 2** to start a PA request including an **urgent** authorization request.

# Prior Authorization for Inpatient Admissions

All inpatient admissions and elective surgery will require a PA. Failure to comply with notification rules will result in an administrative denial. PA with supporting documentation is required for:

- Planned/elective admission
- Inpatient surgery
- Skilled nursing facilities
- Long-term acute care
- Acute rehabilitation

Blue Cross NC must be notified of all member admissions or transfers within one business day of admission. Ideally, notification should occur on the day of admission; however, you have one business day to notify us without penalty. A business day is considered Monday through Friday and does not include weekends and/or weekdays that fall on federal holidays.

# Prior Authorization for Inpatient Admissions (cont.)

Notification is required for the following services.

- **Observation:** Notification review is only needed for nonparticipating facilities.
- **Obstetric deliveries:** Medical necessity review is required for anything over a 48-hour stay for vaginal delivery and anything over a 96-hour stay for a cesarean section delivery.
- Failure to comply with notification rules will result in an administrative denial. All medical emergent inpatient hospital admissions will be reviewed within 72 hours or three calendar days of the facility notification to Blue Cross NC. Emergent inpatient admissions require notification within one business day following the admission. Authorizations can be requested through Interactive Care Reviewer (ICR), the Availity Portal, by fax or by phone.

Physical health (fax) — **1-855-817-5788**

Behavioral health (fax) — **1-844-439-3574**

Provider Services (phone) — **1-844-594-5072**

# Prior Authorization for Inpatient Admissions (cont.)

Clinical information for the initial admission review will be requested at the time of the admission notification.

For emergent admissions, the facilities are required to provide the requested clinical information within 24 hours of the request.

If the information **is not received** within 24 hours, a lack of information adverse determination (in other words, a denial) may be issued.

If the clinical information **is received**, a medical necessity review will be conducted using applicable *NC Clinical Coverage Policies*.

Decisions are communicated verbally or via fax within 24 hours of the determination.

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# Planned/Elective Admissions

Providers must receive prior approval at least 72 hours prior to the admission or scheduled procedure in order to ensure the proposed care is a covered benefit, medically necessary and performed at the appropriate level of care. Authorizations can be submitted via:

- Availity: https://www.availity.com Select Patient Registration > Authorizations & Referrals to navigate to Interactive Care Reviewer
- Inpatient (fax): **1-855-817-5788**
- Inpatient behavioral health (fax): **1-844-439-3574**
- Provider Services (phone): **1-844-594-5072**

Failure to comply with notification rules will result in an administrative denial. A medical necessity review will be conducted using applicable *NC Clinical Coverage Policies.* Additional supporting documentation may be requested to determine if the request is medically necessary.

# Authorization Review Time Frames

Determinations will be communicated to the facility.

| PA request | Time frame for decision |
|---|---|
| Standard authorization request | As expeditiously as required by the enrollee's/member's condition, **not to exceed 14 calendar days** |
| Expedited authorization request* | As expeditiously as required by the enrollee's/member's condition, **not to exceed 72 hours** |

Note:
* Expedited requests will be completed when "...following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function." (*Code of Federal Regulations Title 42 §438.210*)

# Inpatient Concurrent Review

Inpatient concurrent review is the process of obtaining clinical information to establish medical necessity for a continued inpatient stay including review for extending a previously approved admission.

- Facilities are required to supply the requested clinical information within 24 hours of the request to support continued stay.
- During each concurrent review interval, the clinician will assess member progress and needs to help coordinate such needs prior to discharge. This is done to help facilitate a smooth transition for the member between levels of care or home and to avoid delays in discharge due to unanticipated care needs.
- In addition, the attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

# Clean Claims

- A clean claim is a claim submitted for reimbursement that contains the required data elements and any attachments we request.
- To qualify as a clean claim, we require the following attachments:
  - A Medicare remittance notice if the claim involves Medicare as a primary payer and Healthy Blue provides evidence it does not have a crossover agreement to accept an electronic remittance notice.
  - Description of the procedure or service, which may include the medical record if a procedure or service rendered has no corresponding CPT® or HCPCS code.
  - Documents referenced as contractual requirements in a global contract (if applicable).
  - Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute.
- Find more information on the required data elements and attachments in the provider manual.

# Claims Submissions

We accept both *CMS-1500* and *UB-04* claims. You can submit paper claims, but we encourage you to submit single claims through direct data entry through the secure Availity portal or batch / multiple claims by electronic submission through Availity's EDI gateway. *(Please note we do not accept faxed claims.)*

Using our digital tools or EDI reduces claims/payment processing expenses and offers:

- Faster processing than paper
- Enhanced claims tracking
- Real-time submissions directly to our payment system
- *HIPAA*-compliant submissions
- Reduced claim rejections and adjudication turnaround time

There is a filing limit of 180 days from the date of service. It is the responsibility of the provider's office to ensure electronic claims are completed and submitted without rejection.

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Note: Use your existing clearinghouse vendor with Payer ID **00602** via EDI.

# Claim Status Inquiries

You can research the status of claim status using the Availity Portal's Claims Status feature or by calling Provider Services.

To access Claims Status through Availity, you must be assigned the Claims Status role by your Availity Administrator.

Once you have the role assignment follow these steps:

- From Availity's home page, select **Claims & Payments** | **Claim Status.** In the *Organization* field, select the organization and in the *Payer* field, select **Healthy Blue**.
- You can also access the status of a claim from eligibility and benefits response on Availity. Select the **Go To** button located in the top right-hand corner of the patient eligibility information screen.

Register for the *Availity New User Webinar* to learn more about Claims Status Inquiry.

# Rejected Versus Denied Claims

- There are two types of notices you may get in response to your claim submission, rejected or denied.

**Rejected claims** do not enter the adjudication system because they have missing or incorrect information.

**Denied claims** go through the adjudication process but are denied for payment.

- You can find claims status information on Availity Portal at https://www.availity.com or by calling Provider Services at **1-844-594-5072.**
- If you need to appeal a claim decision, submit a copy of the *Explanation of Payment* (*EOP*), letter of explanation and supporting documentation.
- If your claim is administratively denied, you may file an appeal. As part of the appeal, you must demonstrate that you notified or attempted to notify us within the established time frame and that the services are medically necessary.

# Claim Correspondence

Correspondence is when Blue Cross NC requests more information to finalize a claim.

- Correspondence is **not** considered a provider claim payment dispute.
- Typically, Blue Cross NC makes the request for information through the *EOP.*
  - Examples: Submit medical record, submit itemized bill, submit other health information.
- The claim or part of the claim will appear as denied on the *EOP*.
  - However, this is only because more information is required to finalize the claim.
  - Once the information is received, Blue Cross NC will use it to finalize the claim.

# Claim Correspondence

You may submit correspondence:

- Online — **This is the most efficient way to submit correspondence.** You can submit through Availity. You can access the online tool at https://www.availity.com.
- In writing — Mail all required documentation to:

Blue Cross NC | Healthy Blue
Correspondence Unit
P.O. Box 61010
Virginia Beach, VA 23466

# Provider Claim Payment Disputes

If you disagree with a claim payment, you may begin the claim payment dispute process.

- The simplest way to define a claim payment dispute is when the claim is *finalized,* but you disagree with the outcome.
- Examples include (but are not limited to):
  - Contractual payment issues
  - Claim code editing
  - Retro-eligibility
  - Claim data
  - Timely filing

# Provider Claim Payment Disputes (cont.)

The claim payment dispute process consists of two steps:

- **Reconsideration:** The initial request to investigate the outcome of a finalized claim.
- **Claim payment appeal:** If you disagree with the outcome of the reconsideration, a formal claim payment appeal may be requested.

# Provider Claim Payment Disputes (cont.)

Claim payment disputes **do not** include:

**Medical necessity/ authorization denials**

A claim may deny for a *denied authorization*, *not medically necessary* or something similar. In these instances, the claim payment was denied due to a denial of the authorization/service. These should be managed through the grievance and appeals process.

**No authorization denials**

When a service requires an authorization, but authorization was not requested, a claim will deny for *no authorization*. If you would like have the service considered, submit the medical record for review through the correspondence process.

# Submitting Claim Payment Disputes

You have several options to file a claim payment dispute:

- **Online** (reconsiderations and claim payment appeals): This is the most efficient way to submit a claim payment dispute. You can submit a dispute with attachments, get status and receive documentation through the secure portal Claims Management Tool. You can access the online tool at https://www.availity.com > Select Claims Status & Payments > Appeals
- **By mail** (reconsiderations and claim payment appeals): Reconsideration form is located at https://provider.healthybluenc.com. Mail all required documentation to:

  Blue Cross NC | Healthy Blue
  Payment Disputes
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

- **Over the phone** (reconsiderations only): Call Provider Services at **1-844-594-5072, follow prompt 3.**

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# *Reimbursement Policies*

- *Reimbursement Policies* serve as a guide to assist in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan.
- Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions.
- The billed code(s) should be fully supported in the medical record and/or office notes.

**Upon go-live, *Reimbursement Policies* will become effective and are located on the Healthy Blue provider website https://provider.healthybluenc.com and the Availity Portal https://www.availity.com.**

# Balance Billing

Billing the member:

- Providers cannot request or accept payments from Medicaid recipients, their families or others on behalf of the recipient for any of the following:
  - Base rate changes
  - Missed appointments
  - The difference between insurance allowed amounts and usual/customary charges (provider contract reductions)
- If health services are determined to be experimental, investigative or not medically necessary, providers may **not** bill the member unless the provider gives the subscriber written notification of noncoverage immediately before the health services are performed and the subscriber agrees in writing to be financially responsible for the health services.

# Code and Clinical Editing

- Blue Cross NC applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits.
- Blue Cross NC uses sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices.
- Editing sources include but are not limited to CMS National Correct Coding Initiative, *Medical Policies* and *Clinical Utilization Management Guidelines*.
- We are committed to working with you to ensure timely processing and payment of claims.
- For additional information, refer to the provider manual and/or your *Provider Agreement* as a guide for reimbursement criteria. You can also contact Provider Services at **1-844-594-5072** for more information.

# Claims overpayment recovery and refund procedure

- Refund notifications may be identified by two entities: Blue Cross NC and its contracted vendors or the providers. Blue Cross NC researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check or authorize setup of a claims adjustment to reconcile the overpayment amount.
- *Refund Notification Form*: To submit a refund, a *completed Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at https://provider.healthybluenc.com > Forms.
- The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, call Provider Services at **1-844-594-5072** and select the appropriate prompt.

# Encounter Data

Blue Cross NC relies on accurate, complete and timely claims data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with Medicaid managed care.

Encounter data is created from the claims data submissions from our providers and will be edited according to the standards set by NCDHHS. Categories of editing include: HIPAA compliance level 1-5, provider data validation against NCTracks enrollment, procedure and diagnosis validation against age and gender standards, and drug data validation against CMS standards for rebates.

**We are obligated to submit encounter data to NCDHHS. Accurate data will translate to complete and timely data to NCDHHS.**

# Encounter Data (cont.)

- Qualified directed payments
- Services verification
- Medicaid managed care quality improvement activity
- Fraud/waste/abuse monitoring
- Measurement of utilization patterns
- Access to care
- Hospital assessment updates
- Research studies

**We will continue to support improvement in provider claim data quality that leads to encounter submission quality.**

# Electronic Payment Services

We encourage providers to manage payments electronically and offer electronic funds transfer and electronic remittance advice.

**Enrolling in electronic funds transfer (EFT) provides the following benefits:**

- Claims payments are deposited to your account faster.
- EFT payments don't get delayed or lost in the mail.
- EFT payments are more protected from fraud.
- You save time with fewer trips to the bank.
- You save money by reducing your associated labor and case security costs.

**Registering for electronic remittance advice (ERA) provider the following benefits:**

- Easy access to online remittance advice.
- Transactions can be uploaded and posted to your system automatically.

# Electronic payment services (cont.)

To receive electronic funds transfer (EFT) payments, register and enroll with the CAQH© Solutions EnrollHub™ tool at https://www.caqh.org/solutions/enrollhub and select the payer name:
**Blue Cross NC — Healthy Blue**.

Even if you are registered with CAQH and enrolled with another payer, you will need to enroll with us to receive payments via EFT.

For registration-related questions, contact EnrollHub Help Desk at efthelp@EnrollHub.CAQH.org or by phone:
**1-844-815-9763**
7 a.m. to 9 p.m. ET Monday to Thursday,
7 a.m. to 7 p.m. ET Friday.

For more convenience, you can also enroll for online Electronic Remittance Advice (ERA).

If you wish to enroll for ERA (835), use Availity to register and manage account changes.

If you have a relationship with a clearinghouse, work with them to ensure connectivity to the Availity EDI Gateway.

If you have any questions, contact Availity Client Services at
**1-800-AVAILITY**
**(1-800-282-4548)** Monday to Friday,
8 a.m. to 8 p.m. ET.

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# Remittance Information

- You can view your remittance information on Availity using the Remittance Inquiry tool accessed through Healthy Blue Payer Spaces.
- To use Remittance Viewer (835), you must be signed up for 835 either through your own EDI software or clearinghouse.
- Training on these tools is available through Availity live webinar sessions beginning in June.

# Provider Grievances

Grievance is defined as any verbal or written complaint or dispute by a provider, where remedial action is requested, over any aspects of the operations, activities, or behavior of Blue Cross NC, except for any dispute about which the Healthy Blue provider has appeal rights.

| | |
|---|---|
| Online | Use the Availity Portal secure provider Payment Appeal Tool at https://www.availity.com > Select Claims & Payments > Appeals. Through Availity, providers can upload supporting documentation and will receive immediate acknowledgement of their submission. |
| Verbally | Call Provider Services at **1-844-594-5072.** |
| Written | Mail all required documentation, including the *Claim Payment Appeal Form* or the *Reconsideration Form* to:<br>Blue Cross NC \| Healthy Blue<br>Provider Grievance and Appeals<br>P.O. Box 61599<br>Virginia Beach, VA 23466-1599 |

# Provider Appeal

Provider appeal is defined as a review of an adverse determination. A provider can submit a written appeal within 30 days of data of disposition. The following are the reasons a network provider may appeal an adverse decision:

- Program integrity related findings or activities
- Finding of fraud, waste or abuse
- Finding of or recovery of an overpayment
- Withholding or suspension of a payment related to fraud, waste or abuse concerns
- Termination of or determination not to renew an existing contract based solely on objective quality reasons
- Termination of or determination not to renew an existing contract for Local Health Department (LHD) care management services
- Determination to lower a provider's tier status
- Violation of terms between Blue Cross NC and the Healthy Blue provider

## Vendor Service Partners

- Pharmacy
- Transportation
- Vision

# Pharmacy

- Pharmacy Member Services is available 24/7.
- Healthy Blue pharmacy benefits are aligned with the state pharmacy benefits.
- See the provider manual for more information regarding monthly limits, covered drugs, carve-outs and exclusions.
- The *Preferred Drug List* (*PDL*) aligns with the state and is available on the provider website at https://provider.healthybluenc.com.
- A pharmacy look up tool is available on the member website (www.healthybluenc.com) to assist members in finding an in-network pharmacy.

# Pharmacy (cont.)

Providers are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If for medical reasons a member cannot use a preferred product, providers are required to contact Healthy Blue pharmacy services to obtain PA:

- Visit https://provider.healthybluenc.com for details on our coverage policies and preferred products.
- For formulary drugs requiring PA, criteria for review is aligned with the state policies.
- A decision will be provided in a timely manner so as not to adversely affect the member's health. Decisions are made within 24 hours of receipt of the request to comply with federal regulations. If Blue Cross NC is missing necessary clinical information that is critical to the review, the service will be denied.
- PA services are available 24 hours a day.
- See the provider manual for more information regarding monthly limits and covered drugs.

# Pharmacy (cont.)

- Blue Cross NC encourages the use of electronic PA. Within the electronic PA submission, you will find prompts for all necessary information to complete the review. If the service is denied, Blue Cross NC will notify the prescriber and the member in writing of the denial.
- Providers can submit requests online, through phone or fax.
  - Online submission via Interactive Care Reviewer which is accessed through Availity. https://www.availity.com (Select Patient Registration > Authorizations & Referrals) is preferred and ensures that all necessary clinical information is submitted for the review. This will lower the volume of responses the prescriber will get back from the plan requiring more information.
  - To request by phone, call Provider Services at **1-844-594-5072** Monday through Saturday from 7 a.m. to 6 p.m. Eastern time.
  - Fax all information required, along with a *Prior Authorization Form*, to **1-844-376-2318** for general pharmacy requests. The form is located on the provider website at https://provider.healthybluenc.com.

# Vendor Services

**Transportation** is available through ModivCare™.

- Phone: **1-855-397-3602,** TTY **1-866-288-3133**
- https://modivcare.com

**Vision services** are available through EyeMed®.

- Phone: **1-855-422-6733**
- Hearing/speech impaired members may contact EyeMed using a TTY machine to engage an operator at 711 and asking the operator to call **1-855-422-6733**.
- UM PA requests fax number: **1-513-492-6739**
- https://eyemed.com/en-us/provider

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## Compliance

- Fraud, Waste and Abuse
- Marketing Guidelines
- Person-Centered Practices

# Fraud, Waste and Abuse

CMS defines fraud, waste and abuse as:

**Fraud**

Intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit

**Waste**

Overusing services, or other practices that directly or indirectly result in unnecessary costs; generally not considered driven by intentional actions, but from misusing resources

**Abuse**

When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary

# Fraud, Waste and Abuse (cont.)

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it.

No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting the Healthy Blue provider website at https://provider.healthybluenc.com and completing the *Report Waste, Fraud and Abuse* form.
- Calling our Special Investigations Unit fraud hotline at **1-866-847-8247.**

# Marketing Guidelines

- Blue Cross NC and subcontractors, including healthcare providers, are prohibited from engaging in the following, which are considered member-marketing activities:
  - Marketing directly to potential enrollees or prospective enrollees, including persons currently enrolled in Medicaid or other Healthy Blue programs (includes direct-mail advertising, spam, door-to-door visits, phone or other cold-call marketing techniques).
  - Distributing plans and materials or making any statement (written or verbal) that NCDHHS determines to be inaccurate, false, confusing, misleading or intended to defraud members or the NCDHHS; this includes statements that mislead or falsely describe covered services, membership, availability of providers, qualifications and skills of providers, or assertions the recipient of the communication must enroll in a specific health plan in order to obtain or not lose benefits.

# Person-Centered Practices

## The Learning Community

The Learning Community utilizes its vast network of expertise to develop and continue to refine concrete skills and tools that really put into practice a world where all people have positive control over the lives they have chosen for themselves. Their efforts focus on people who have lost or may lose positive control because of society's response to the presence of a disability. They foster a global learning community that shares knowledge for that purpose.

# Person-Centered Practices (cont.)

## What is Person-Centered Thinking?

Person-centered thinking:

- Underlies and guides respectful listening, which leads to respectful action.
- Supports people in having positive control over the life they desire and find satisfying. People are:
  - Recognized and valued for their contributions (current and potential) to their communities.
  - Supported in a web of relationships, both natural and paid, within their communities.

**Why Person-Centered Thinking?**

It's the right thing to do, and it is the foundation for meeting CMS requirements for residential settings and service planning.

Also fulfills the CMS requirement that person-centered service plans must be developed through a person-centered planning process.

# Quality Management

- Quality of Care
- Critical Incident Reporting

# Quality Management

- Our Clinical Quality Management Department ensures Blue Cross NC is providing Healthy Blue members access to quality healthcare and services. Clinical quality management staff continually analyze provider performance and member outcomes for improvement opportunities.
- Our solutions are focused on:
  - Improving the quality of clinical care.
  - Increasing clinical performance.
  - Offering effective member and provider education.
  - Ensuring the highest member and provider satisfaction possible.

# Inpatient Level of Care Review Guidelines

- MCG Care Guidelines are evidence-based guidelines used for clinical decisions and care planning. There are separate guidelines covering specific areas of care. MCG Care Guidelines for inpatient level of care will be used upon go-live.
- Blue Cross NC has the right to customize MCG Care Guidelines based on determinations by its medical policy and technology assessment committee.

# Inpatient Level of Care Review Guidelines (cont.)

| Inpatient and surgical care | General recovery care | Recovery facility care |
| --- | --- | --- |
| • Manage, review and assess people facing hospitalization or surgery proactively with nearly 400 condition-specific guidelines, goals, optimal care pathways and other decision-support tools. | • Effectively manage complex cases where a single *Inpatient & Surgical Care Guideline* or set of guidelines is insufficient — including the treatment of people with diagnostic uncertainty or multiple diagnoses. | • Coordinate an effective plan for transitioning people to skilled nursing facilities and inpatient rehabilitation facilities. |

# Quality of Care Issues and Referral Process

A **quality of care issue** is: A medical, social, environmental or economical event that has the potential to have an adverse affect on the health and welfare of our internal and external customers, members, or the organization.

The web-based *Quality of Care/Critical Incident Referral Form* can be found on the Healthy Blue provider website at https://provider.healthybluenc.com in the *Forms* section. The form can be submitted via the website or via https://www.availity.com. The Quality Management Team will initiate an investigation once the form is submitted.

**Our purpose**

- To ensure quality and appropriateness of care and services rendered by monitoring for potential quality of care issues on an ongoing basis on behalf of our members
- To systematically identify, investigate, and resolve quality of care issues as well as track and trend issues for reporting and recredentialing purposes

# Quality of Care Issues and Referral Process (cont.)

- A **never event**: an occurrence that should never happen in a hospital that is usually preventable.
- Examples include:
  - Surgery on the wrong body part, wrong patient or the unintended retention of a foreign object in a patient after surgery.
  - Death associated with the use of contaminated drugs or devices/products.
  - Infant discharged to the wrong person, patient suicide or attempted suicide, patient disappearance, or other occurrences related to patient protection.
  - Patient death/disability associated with medication error, stage three/four pressure ulcers acquired after admission to a healthcare facility or other occurrences related to care management.
  - Death/disability from burns, falls, electric shock or other environmental occurrences.
  - Patient abduction, sexual/physical assault or other criminal occurrences.

# All Adverse Events  Referral Process

Quality of care event categories include, but are not limited to:

- A **sentinel event**: an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Such events are called **sentinel** because they signal the need for immediate investigation and response.
- Examples include:
  - Inpatient death unrelated to the natural course of patient's illness or underlying condition.
  - Inpatient major permanent loss of function unrelated to the natural course of patient's illness or underlying condition.
  - Delayed or missed diagnosis or treatment.
  - Unplanned admission to hospital after an outpatient procedure.
  - Unplanned subsequent return to surgery for the same procedure.

# Critical Incident Reporting for Behavioral Health

For behavioral health related critical incidents relevant to the *North Carolina General Status 122C*, providers of publicly funded services licensed under *North Carolina General Statutes 122C* must report critical incidents in the existing state Incident Response and Reporting System (IRIS) within **24 hours** at https://iris.dhhs.state.nc.us.

# Thank You

We appreciate you taking the time to attend our training and hope the information covered today answered any of your questions.

In a world of escalating healthcare costs, we work to educate our members about the appropriate access to care and their involvement in all aspects of their healthcare.

**We look forward to working with you to continue this education and provide valuable healthcare to our members — your patients.**

Provider website:
https://provider.healthybluenc.com

Provider Services phone:
**1-844-594-5072**

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# Appendix

# Population Profile by Region

| Race/ethnicity by region[1, 2, 3] | | | |
|---|---|---|---|
| **Region 1** | • White 87%<br>• African American 3%<br>• Hispanic 5%<br>• Other 5%<br>Average food insecurity rate: 14.5% | **Region 2** | • White 80.4%<br>• African American 9.1%<br>• Hispanic 7.7%<br>• Other 2.8%<br>Average food insecurity rate: 14.8% |
| **Region 3** | • White 71.4%<br>• African American 17%<br>• Hispanic 7.5%<br>• Other 4.1%<br>Average food insecurity rate: 15.3% (Anson Co. Rate 22.5%) | **Region 4** | • White 57.4%<br>• African American 29.5%<br>• Hispanic 8.7%<br>• Other 4.4%<br>Average food insecurity rate: 17.3% (Vance Co: 23.5% and Warren Co: 23.3%) |
| **Region 5** | • White 58.1%<br>• African American 24.2%<br>• Hispanic 9.6%<br>• Other 8.1%<br>Average food insecurity rate: 18.2% (Scotland Co: 25.5%) | **Region 6** | • White 58.3%<br>• African American 32.3%<br>• Hispanic 6.3%<br>• Other 3.1%<br>Average food insecurity rate: 18.9%; (Edgecombe Co., Halifax Co., Hertford Co. and Northampton Co.: ≥ 25.0%) |

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Footnotes:
1 CountyHealthRankings.org
2 FeedingAmerica.org
3 Wilmingonnc.gov

# Region-Specific Needs and Opportunities

To address members' needs related to behavioral health, obesity, chronic disease prevention, partner violence, tobacco use and opioid use disorder (OUD), we have identified tools, technologies, key relationships and made investments described below:

| Identified needs per region[1, 2, 3] | | Identified tools, technologies, and relationship to address needs[1, 2, 3] |
|---|---|---|
| **Region 1** | • Behavioral health (substance use/addiction)<br>• Obesity (physical activity and nutrition)<br>• Chronic diseases<br>• Partner violence<br>• Smoking<br>• Uninsured<br>• OUD | • Telemedicine: Project ECHO medication assisted treatment (MAT) training for OUD; RPM; eConsult<br>• Behavioral health facilities: Monarch healthcare; Mountain Area Health Education Center (MAHEC); RHA Health Services for Disabilities, Behavioral health, and substance use<br>• Tammy Lynn Center (services and supports for children and adults with I/DD)<br>• Youth Villages (supports for children with Adverse Childhood Experiences and their families) |
| **Region 2** | • Behavioral health<br>• Obesity (physical activity and nutrition)<br>• Chronic diseases<br>• Infant mortality | • Behavioral health facilities: Monarch Health Care; DayMark Recovery Services; RHA Health services for disabilities, Behavioral health, and substance use<br>• Telemedicine: Project ECHO MAT training for OUD; RPM; eConsult<br>• Workforce Development partnership funding five Nursing Schools in NC MMC Regions 2, 4 and 5 |

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Footnotes:
1 CountyHealthRankings.org
2 FeedingAmerica.org
3 Wilmingonnc.gov

# Region-Specific Needs and Opportunities (cont.)

| Identified needs per region | | Identified tools, technologies, and relationship to address needs |
|---|---|---|
| **Region 3** | • Behavioral health<br>• Obesity (physical activity and nutrition)<br>• Chronic diseases<br>• Infant mortality | • Behavioral health facility: Monarch Health Care<br>• Telemedicine: Project ECHO MAT training for OUD; RPM; eConsul |
| **Region 4** | • Behavioral health<br>• Obesity (physical activity and nutrition)<br>• Economic issues: housing and education<br>• 1 of 3 regions with food insecurities | • Behavioral health facilities: Monarch Health Care; DayMark Recovery Services; Carolina Outreach<br>• Telemedicine: Project ECHO MAT training for OUD; RPM; eConsult<br>• Workforce development partnership funding five Nursing Schools in regions 2, 4 and 5 |

| Identified needs per region | | Identified tools, technologies, and relationship to address needs |
|---|---|---|
| **Region 5** | • Behavioral health<br>• Obesity (Physical activity and nutrition)<br>• Chronic diseases<br>• 1 of 3 regions with food insecurities<br>• OUD | • Telemedicine: Project ECHO MAT training for OUD; Project ECHO; RPM; eConsult<br>• Behavioral health facilities: DayMark Recovery Services; Carolina Outreach<br>• Workforce Development partnership funding five Nursing Schools in regions 2, 4 and 5 |
| **Region 6** | • Behavioral health<br>• Obesity (Physical activity and nutrition)<br>• Chronic Diseases<br>• Only region with pneumonia/influenza as leading cause of death<br>• 1 of 3 regions with food insecurities<br>• OUD | • Telemedicine: Project ECHO MAT training for OUD; RPM; eConsult<br>• Workforce Development partnership with UNC Pembroke Health Sciences<br>• Child Health Support: Center for Child and Family Health; SAFEChild Advocacy Center in Wake County |



Footnotes:
1 CountyHealthRankings.org
2 FeedingAmerica.org
3 Wilmingonnc.gov

# Community Impact

## How are we creating positive change in our communities?

We have invested $50 million dollars in our communities to address:

- Early childhood development
- Opioid epidemic
- Expanded access to primary care
- Other healthy opportunities

# Community Impact — Investments in Early Childhood Programs

| **Prevent Child Abuse North Carolina** | **SAFEchild's *Funny Tummy Feelings*** |
| --- | --- |
| Creating safe, stable, nurturing relationships and environments | Helped expand to 175 additional elementary schools (tripling the number of students learning how to address feelings of discomfort in harmful situations) |

# Community Impact — Investments in Early Childhood Programs (cont.)

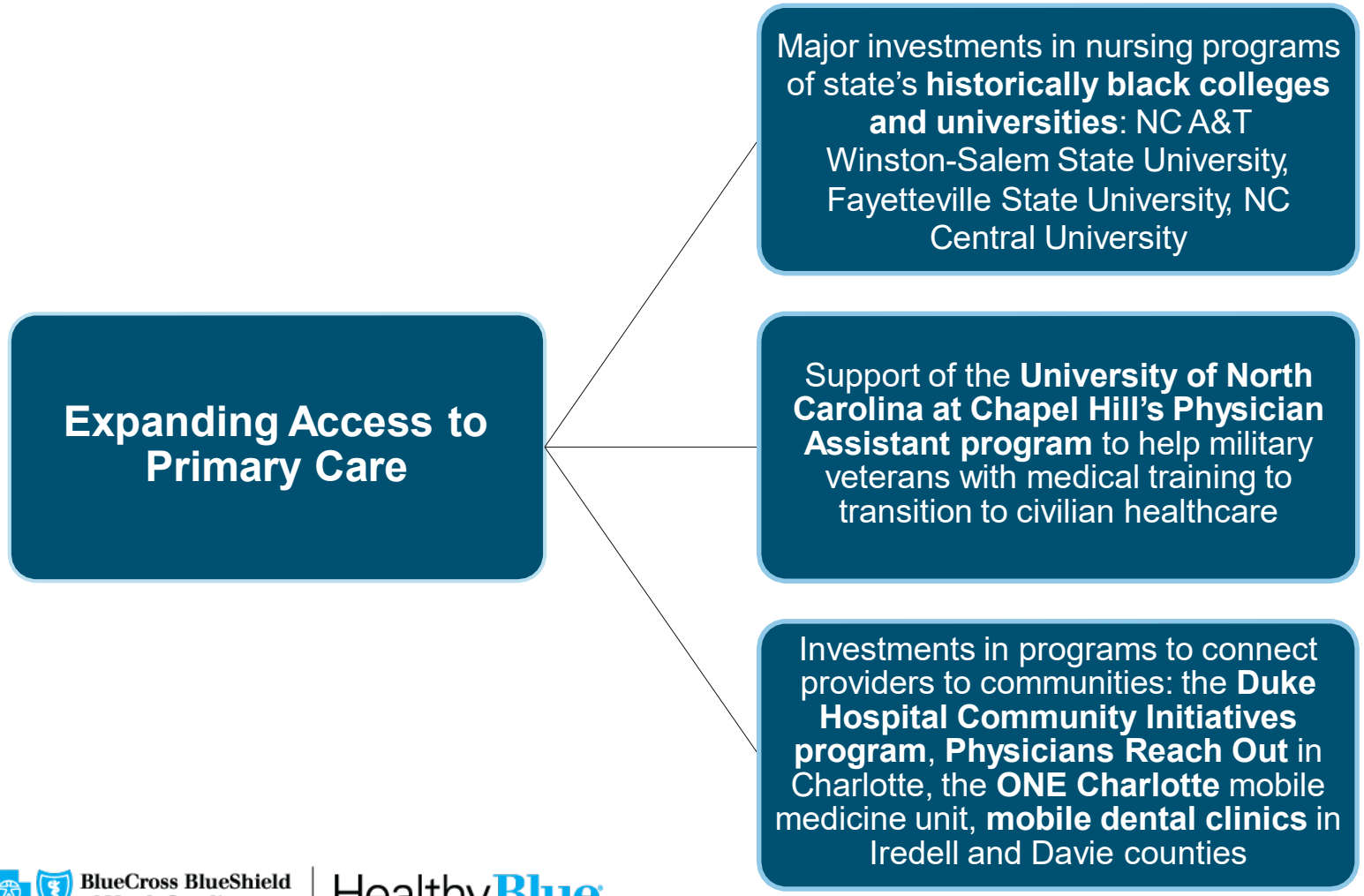
## Carolina Global Breastfeeding Institute at University of North Carolina, Chapel Hill

- Educates and nurtures first-time mothers
- Provides wellness services for young families and
- Promotes baby-friendly designation status of local hospitals

## Family Connects International®

- Offers its evidence-based nurse home visiting model offered at no cost to families with newborns in Durham, Forsyth and Guilford counties
- Reduced the need for infant emergency medical care in other regions and improving maternal and infant health outcomes

# Community Impact — Expanding Access to Primary Care

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# Community Impact — Addressing Healthy Opportunities Initiatives

## Addressing Healthy Opportunities

- Thrive NC raised awareness of food insecurity in a two-day festival that brought the Triangle community together with food from more than 50 local restaurants and chefs
- Blue Cross NC gave more than $470,000 to nonprofits dedicated to addressing food insecurity:
  - Investments made and increased access to healthy foods in nearly 70 North Carolina counties, supporting Meals on Wheels of North Carolina, the Food Bank of Central & Eastern NC, and MANNA FoodBank
  - Worked with the North Carolina Coalition Against Domestic Violence to expand program to rural communities, supported expansion of the Red Cross's Sound the Alarm to install 36,000 smoke alarms and funded North Carolina Community Action Association's to make repairs to 700 homes.

# Community Impact — Working to End the Opioid Epidemic

- Began limiting opioid prescriptions and expanded coverage of treatments for dependency to include a new drug, Sublocade
- Contributed to TROSA, a program that provides comprehensive treatment, work-based vocational training, education and continuing care
  - Investment will create new capacity in the Triad serving the entire state and improve access to its services in Western NC.
- Investing in the University of North Carolina School of Government to develop community-based solutions in up to 10 communities over the next two years

# Community Impact — Working to End the Opioid Epidemic (cont.)

- Partnership with Mutual Drug member pharmacies and Inmar® distribution services to place 85 new drop-off sites for safe disposal of unused/unwanted prescription medications and funded a new educational initiative at the Alice Aycock Poe Center for Health Education for substance abuse prevention.
- Issued requests for proposal to invest in five additional organizations to prevent addiction, treat opioid dependency and transform communities at a local level.

# Member Rights and Responsibilities

## Members Have the Right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity.
- Be told where, when and how to get the services they need.
- Be told by their PCP what health issues they may have, what can be done for them and what will likely be the result, in language they understand.
- Get a second opinion about their care.
- Give their approval of any treatment.
- Give their approval of any plan for their care after that plan has been fully explained to them.
- Refuse care and be told what they may risk if they do.
- Get a copy of their medical record and talk about it with their PCP.

# Member Rights and Responsibilities (cont.)

## Members Have the Right to:

- Ask, if needed, that their medical record be amended or corrected.
- Be sure that their medical record is private and will not be shared with anyone except as required by law, contract or with their approval.
- Use the Healthy Blue complaint process to settle complaints.
- Use the State Fair Hearing system.
- Appoint someone they trust (relative, friend or lawyer) to speak for them if they are unable to speak for themselves about their care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

# Member Rights and Responsibilities (cont.)

## Members Agree to:

- Work with their PCP to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their PCP's advice and ask questions.
- Call or go back to their PCP if they do not get better or ask for a second opinion.
- Treat healthcare staff with the respect.
- Tell us if they have problems with any healthcare staff by calling Healthy Blue Member Services at **1-844-594-5070.**
- Keep their appointments. If they must cancel, call as soon as they can.
- Use the Emergency Department only for emergencies.
- Call their PCP when they need medical care, even if it is after hours.

# Advanced Medical Homes (AMH) Program Overview

The Carolina ACCESS care management program under fee-for-service is changing to AMH managed care program. This new program model will have advanced focus on the following:

- Connecting members to the services and supports they need through comprehensive assessment and needs identification.
- Local care management and care coordination.
- Connection to community programs and resources.

**Vision for AMH**

Build on the Carolina ACCESS program to preserve broad access to primary care services for Medicaid enrollees and strengthen the role of primary care in care management, care coordination, and quality improving as the state transitions to managed care.

# AMH Program Overview (cont.)

AMH is defined as an initiative under which PHPs delegate care management responsibilities and functions to state-designated AMH practices to provide local care management services.

Key goals of the AMH Program include:

- To deliver a system of healthcare services for Medicaid members
- To preserve broad access to primary care services for Medicaid enrollees
- To strengthen the role of primary care in care management, care coordination and quality improvement

Note: AMH Definition from *NC Medicaid RFP 2018 Combined_All PDF*

# What is an AMH?

An AMH Practice is defined by the designated NPI and service location. PHPs and practices have options as part of the AMH transition:

- Current Carolina ACCESS practices may continue to provide the same services as they do today in the future as AMH
- Eligibility for additional payments for practices ready for advanced care management functions
- Leverage in-house care management capacity or contract with Clinically Integrated Network (CIN) or other partner of their choice
- No longer required to contract with Community Care of North Carolina (CCNC) to participate

# AMH Program: Eligibility and Services

Eligibility as an AMH Practice:

1. Provide primary care services
2. Enrolled in the North Carolina Medicaid Program

Examples of eligible practices are single-specialty and multispecialty groups led by allopathic and osteopathic physicians in the following specialties:

- General practice
- Family medicine
- Internal medicine
- OB/GYN
- Pediatrics
- Psychiatry and neurology
- For a full list of permitted subspecialties, refer to NCTracks.

# AMH: Enrollment

Attestation and certification:

- **Practices not currently enrolled** will need to complete enrollment application via NCTracks in advance of attestation
- **Medicaid-enrolled practices not currently enrolled in Carolina ACCESS** will be required to enroll through NCTracks; this will automatically certify practices for Tier 2
- Practices already participating in Carolina ACCESS are automatically grandfathered into AMH
- Practices currently enrolled in CAI will need enroll in Tier 2 via NCTracks

**AMH-certified practices can contract up to their highest certification level with one or more PHPs.**

Notes:

1. More information on the attestation tool and training is available https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/provider-training.html. > AMH 101, Introduction to the AMH Program.

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# AMH Tiers

## Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- Providers will need to coordinate across multiple plans; practices will need to interface with multiple PHPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

AMH Payments (paid by PHP to practice)

- Per member per month (PMPM) Medical Home payments
  - Same as Carolina ACCESS
  - Non-negotiable

## Tier 3

- PHP delegates primary responsibility for delivering care management to the practice level
- Practice requirements: meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities
- Single, consistent care management platform: Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 PHP contracts

AMH Payments (paid by PHP to practice)

- PMPM Medical Home Payments
  - Same as Carolina ACCESS
  - Non-negotiable
- Additional Care Management Payments
  - Negotiated between PHP and practice

## Tier 4

- To launch later

# AMH Practice Requirements: Tiers 1 and 2

**Practice requirements for Tiers 1 and 2:**

1. Perform primary care services that include certain preventive and ancillary services.
2. Create and maintain a patient-clinical relationship.
3. Provide direct patient care a minimum of 30 office hours per week.
4. Provide access to medical advice and services 24 hours per day, seven days per week.
5. Refer to other providers when service cannot be provided by PCP.
6. Provide oral interpretation for all non-English proficient beneficiaries and sign language at no cost.

Note: Practice requirements for Tier 1 and 2 are the same as requirements for Carolina ACCESS practices.

# AMH Practice Requirements: Tier 3

**Practice requirements for Tier 3:**

- Practice requirements for Tier 3 include all Tier 2 requirements plus additional care management responsibilities.
- AMH must attest that they or their contracted CIN/other partners are capable of fulfilling these requirements.

Note: More details on data requirements to follow in webinar on IT Needs and Data Sharing Capabilities.

# AMH Practice Requirements: Tier 3 (cont.)

**Additional requirements for AMH Tier 3:**

- Risk stratify all empaneled patients.
- Provide care management to high-need patients.
- Develop a care plan for all patients receiving care management.
- Provide short-term, transitional care management along with medication management to all empaneled patients who have an emergency department visit or hospital admission/discharge/transfer and who are at high risk of readmissions and other poor outcomes.
- Receive claims data feeds (directly or via a CIN/other partner) and meet state-designated security standards for their storage and use.

# AMH: CINs

**What is a CIN?**

- CINs are entities with which AMH provider practices can voluntarily choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH.
  - Examples of these specific functions and capabilities include data aggregation, risk stratification and care management.
- A CIN could be part of:
  - A hospital or health system to which a practice already belongs or is otherwise affiliated
  - A group of practices

# AMH: Data Requirements

AMH practices will use multiple types of data from PHPs and other sources to carry out care management functions and assume responsibility for population health. Under managed care, PHPs will each track and maintain their own population health data and be responsible for sharing that data with AMH Practices.

Required data flows **from PHPs to all AMH**:

- Beneficiary assignment information
- Initial care needs screening information
- Risk scoring data
- Common quality measure performance information

# AMH: Data Requirements (cont.)

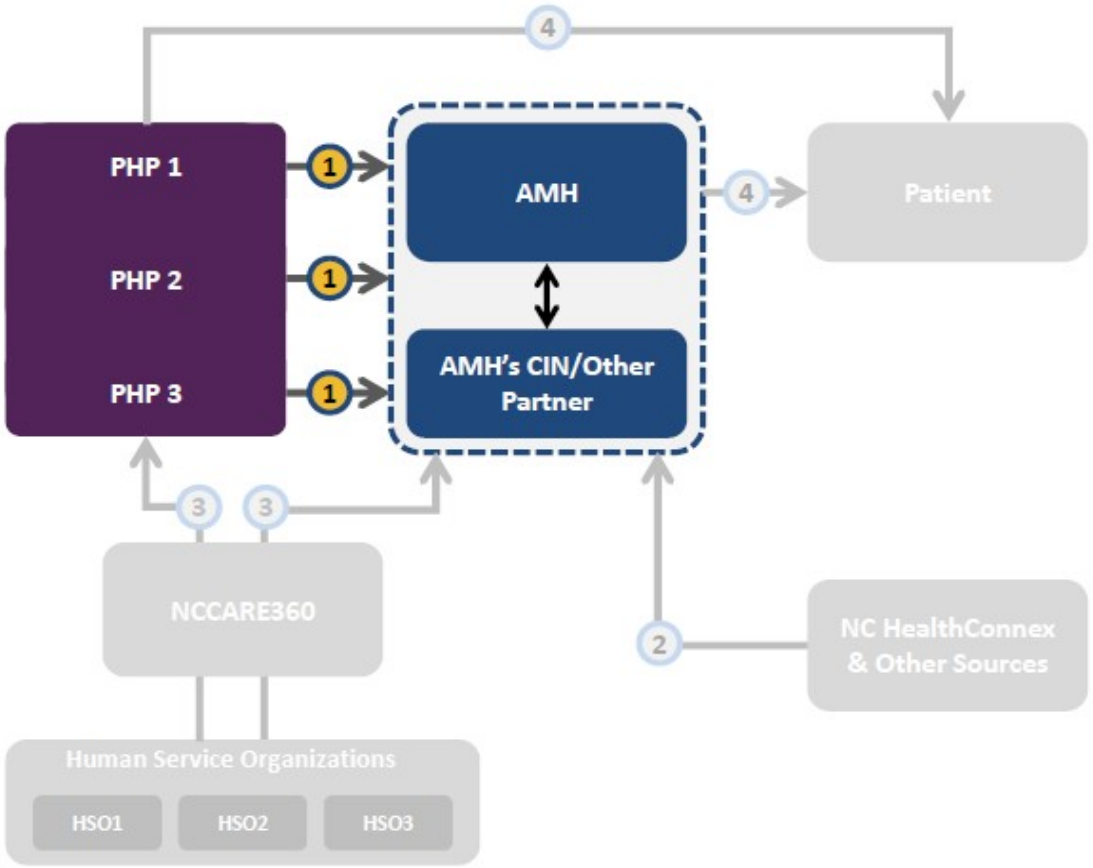
Required data flows **to Tier 3 AMH**:

- Encounter data from PHPs
- Admission, discharge and transfer information from NC HealthConnex or other source

Additional data all AMH are encouraged to access:

- Clinical information for population health/care management processes from NC HealthConnex or other source
- Data about available local human services via NCCARE360

# Introduction to AMH, IT and Data Sharing




**Data Flows**

1. Beneficiary assignment information
   - PHP risk scores
   - PHP Care Needs Screening information
   - Quality measure performance information
   - Encounter data to Tier 3 AMHs
2. ADT data (available through multiple options)
   - Other clinical data (available through multiple options)
3. Connect beneficiaries with unmet resource needs to human service organizations (HSOs) using NCCARE360
4. Beneficiary data sharing

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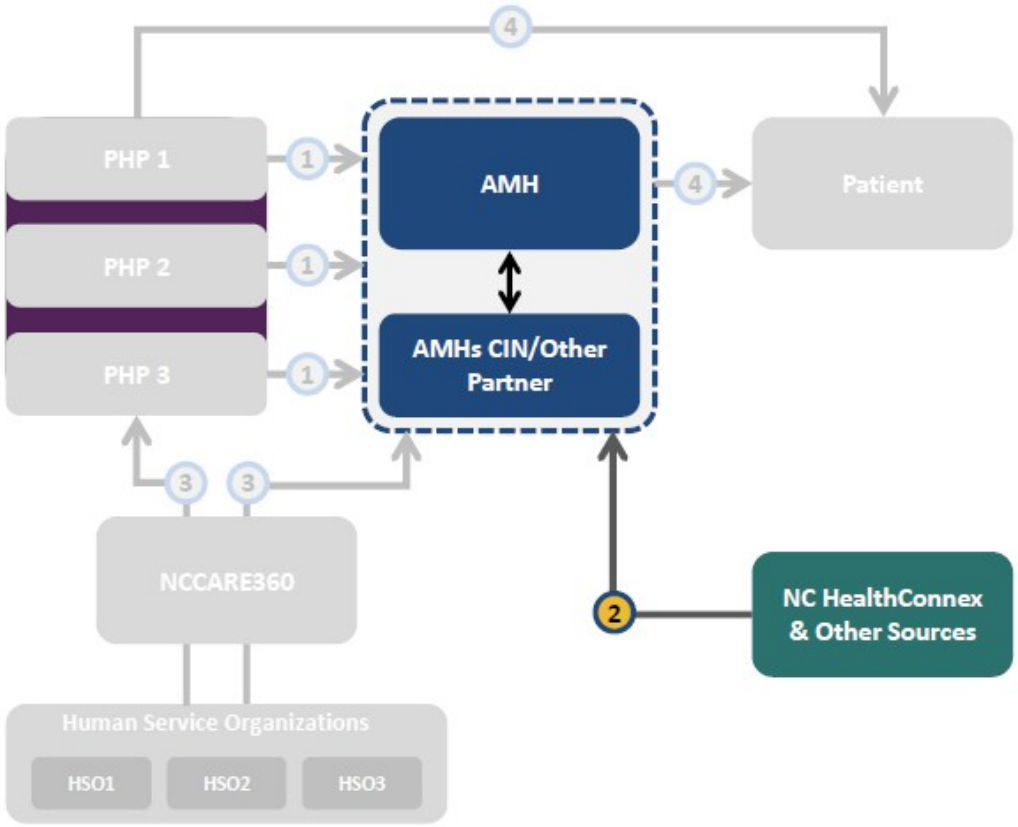
# Introduction to the AMH, IT and Data Sharing (cont.)

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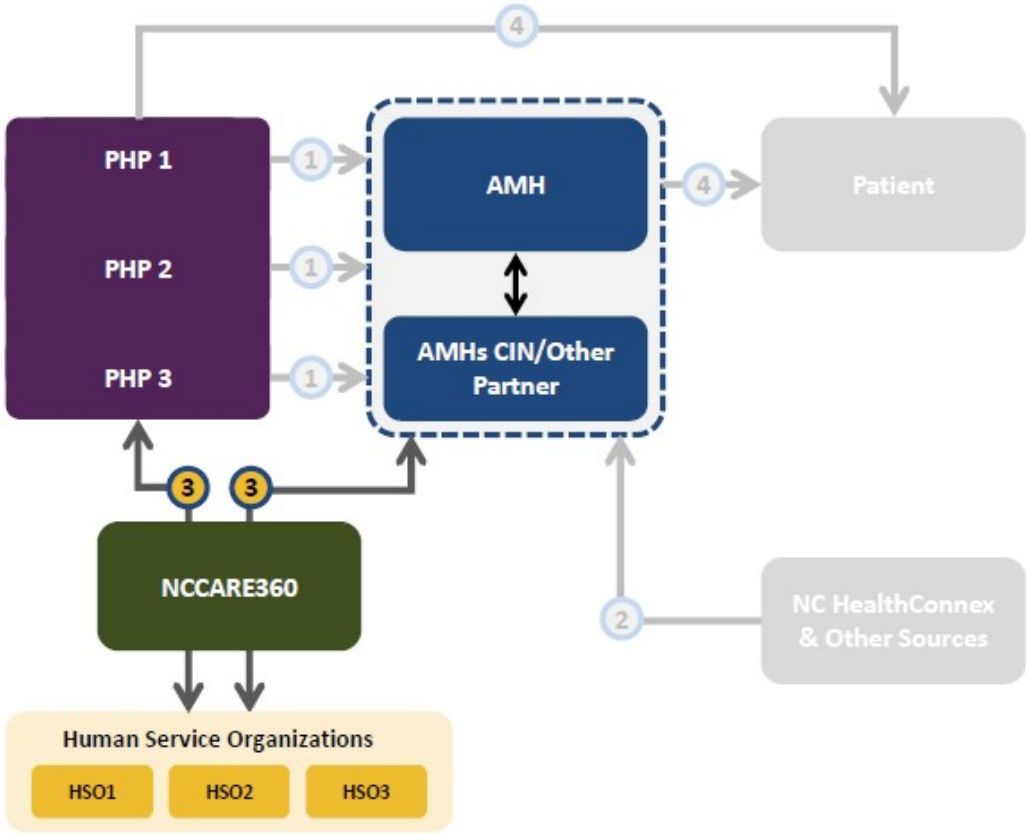


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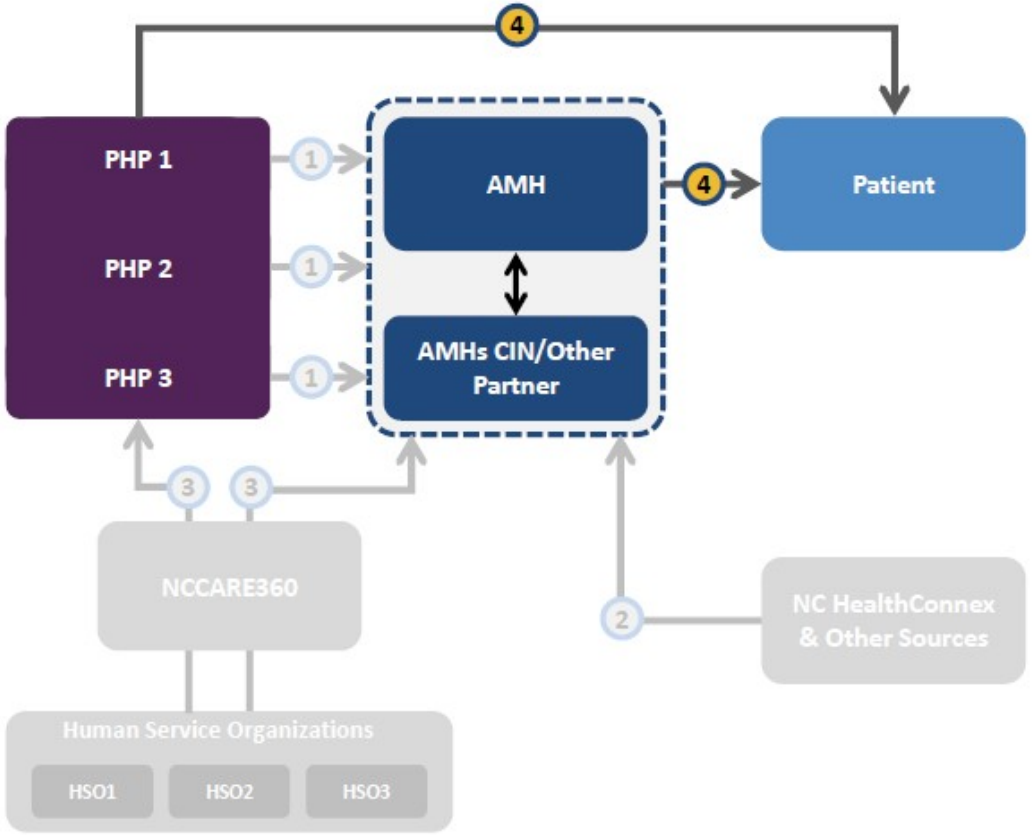


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# AMH Quality Measures

The AMH Program provides clear financial alignment for practices to be able to focus more on cost and quality outcomes over time by gradually aligning incentive payments for practices to specified quality and outcome measures.

**There are five categories of quality measures for AMH:**

1. Measures tied to quality strategy objectives
2. Total cost of care
3. Key performance indicators
4. Gaps in care: Compliance with age-appropriate mandatory preventive care screenings
5. Other — To be developed in collaboration with NCDHHS and key stakeholders

# AMH: Claims, Billing and Information

Items to consider

- How to bill for AMH per member, per month:
  - NPI versus TIN
  - Group level or provider level
  - What codes/modifiers are needed
- Per member, per month versus care management fee:
  - Tier 3 can receive both

For more information on AMH visit:

- NCDHHS AMH site — https://medicaid.ncdhhs.gov/ advanced-medical-home
- AMH training — https://medicaid.ncdhhs.gov/ amh-training#amh-108,-amh-it-and-data-sharing

For questions regarding AMH, reach out to: AMH@healthybluenc.com.

# Blue Premier Value-Based Programs Overview

Value-Based Programs offer financial incentives for higher levels of quality care and improved health outcomes.

- Sixty percent or more of all medical expenditures will be in qualified Blue Premier Value-Based Programs by the end of contract year two.
- North Carolina's rural providers and hospitals will participate in Blue Premier Value-Based Programs to sustain their rural practices and reward them for high-quality, person-centered care.
- Blue Premier Value-Based Programs will potentially kick off in 2022.
- Blue Premier PQIP Essentials will be the initial value-based program.
- Value-based programs will include programs for both physicians and nonphysicians:
  - PCPs, OBs and psychiatrists
  - Behavioral health professionals, hospitals and organizational provider entities (nonphysicians)

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