Transforming Lives

Trillium HEALTH RESOURCES

Network Communication Bulletin #050

To: **All Providers**

From: **Khristine Brewington, VP of Network Management, MS, LPC, LCAS, CCS, CCJP**

Date: **October 7, 2019**

Subject: ECHO Survey Feedback and Opportunities for Improvement, Innovations Waiver Registry of Unmet Needs, North Carolina Department of Health and Human Services Provider Contracting Deadline, North Carolina Department of Health and Human Services Provider Training Opportunities, 835 Transaction File Changes, New Process and Website for First Commitment Waiver Exam, New Mission and Vision Statements

TRILLIUM EXPERIENCE OF CARE AND HEALTH OUTCOMES (ECHO®) SURVEY FEEDBACK AND OPPORTUNITIES FOR IMPROVEMENT

Every year Trillium Health Resources and other LME/MCOs across the state participate in the Experience of Care and Health Outcome (ECHO®) Surveys. These surveys are administered to assess performance of the health plans and member perception of care they received through the North Carolina LME/MCOs and to assist in the development of quality improvement strategies. The survey is administered to a random sample of members from each LME/MCO who received at least one Medicaid funded behavioral health service through the LME/MCO within the preceding fiscal year.

This satisfaction survey for child and adult Medicaid members provides a comprehensive tool for assessing health care experiences. DataStat, Inc. conducted the 2016-2017 survey on behalf of The State of North Carolina Division of Health Benefits (DHB) and The Carolinas Center for Medical Excellence (CCME). Each survey has over 50 questions each that provide specific details and insight into the counseling and treatment members receive as well as the quality of health care services provided by their health plan. The majority of questions focus on the health care experience such as getting treatment quickly, how well clinicians communicate, getting treatment and information from the plan, perceived improvement, and overall satisfaction with counseling and treatment.

Trillium received the state's 2016-2017 analysis and also completed our own review of the results. In an effort to improve lower scoring areas, the "Opportunities for Improvement" section was discussed and reviewed in detail.

Due to the correlation between performance in particular areas of member experience and overall satisfaction with counseling or treatment, it was determined that the focus should be on specific performance-related items connected to Question 28 and Question 29.

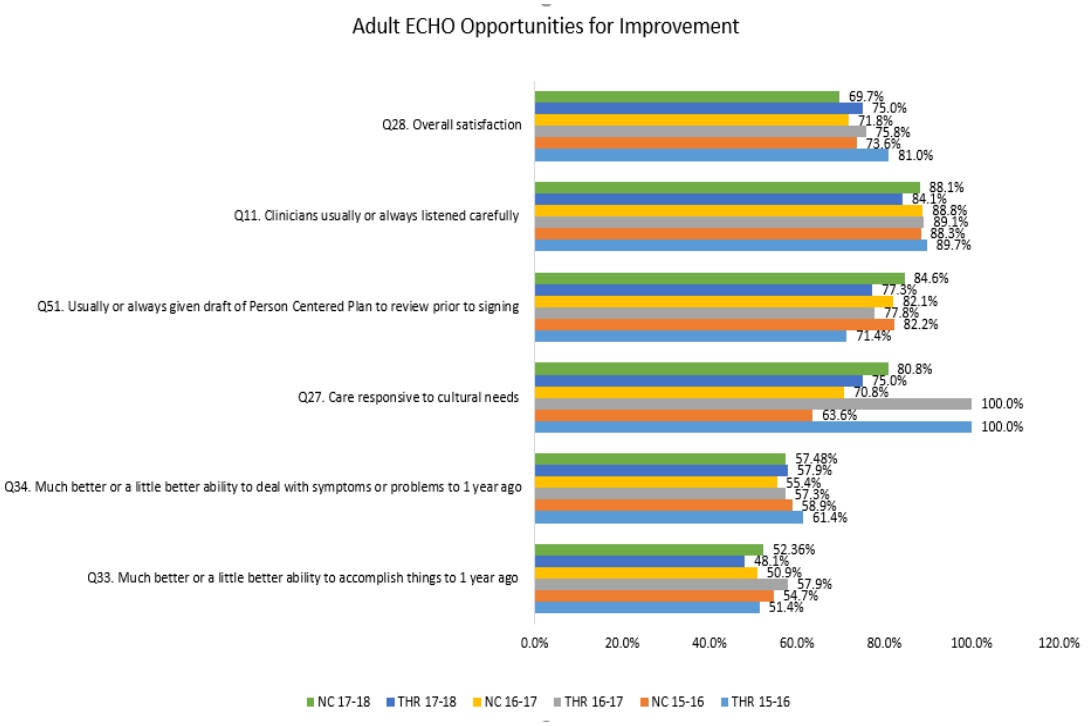
> *Q28-Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your counseling or treatment in the last 12 months?*
>
> *Q29-Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all of your child's counseling or treatment in the last 12 months?*

These questions measure overall satisfaction with counseling or treatment. In addition, the following questions contained in "Opportunities for Improvement" were identified as areas that MAY BE able to be influenced.

ADULT-ECHO

Q27. Care responsive to cultural needs

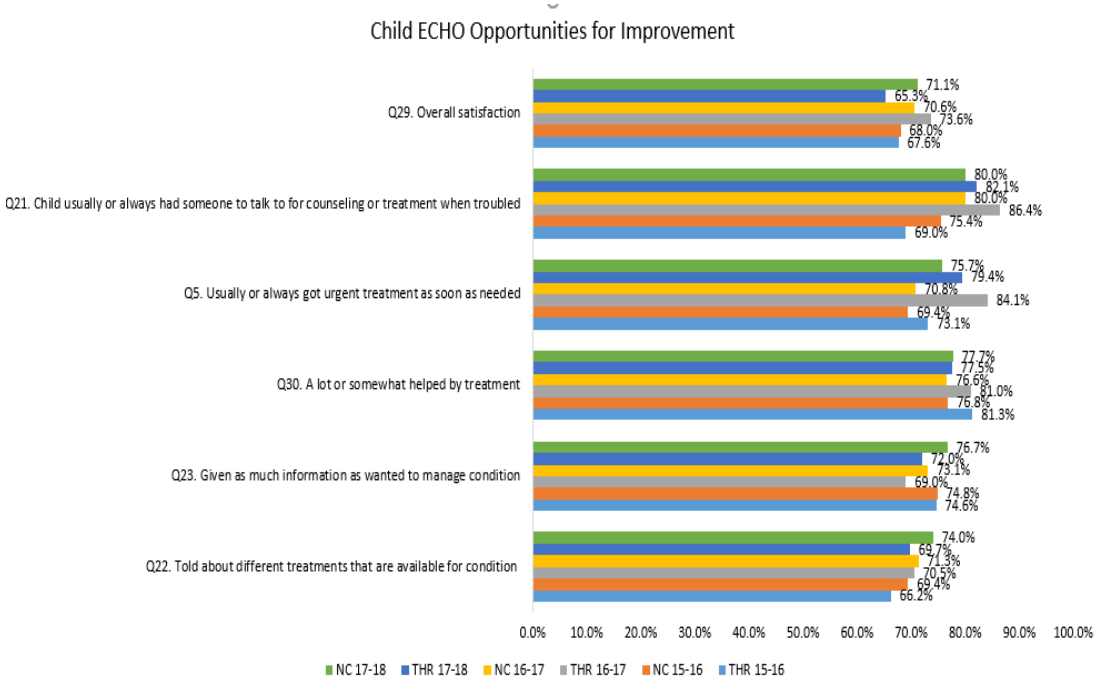
Q51. Usually or always given draft of Person Centered Plan to review prior to signing



CHILD-ECHO

Q22. Told about different treatments that are available for condition

Q23. Given as much information as wanted to manage condition



This information is being shared to make you aware and to encourage you to evaluate any and all internal business practices that may have an impact on these items within your organization. Trillium intends to re-assess these areas upon receipt of the 2017-2018 survey results and determine if progress has been achieved towards an increased level of satisfaction.

A complete report of the ECHO survey analysis can be found on Trillium's website at www.trilliumhealthresources.org under Strategic Planning and Outcomes.

For feedback or questions please contact the Trillium QM staff at QMinfo@trilliumnc.org

Innovations Waiver Registry of Unmet Needs Information

NC Innovations Waiver is a Home and Community Based benefit plan to support persons with Intellectual and/or Developmental Disabilities (IDD) to maximize their potential in their natural community settings as an alternative to institutional settings. At the current time, there is no additional Waiver funding available. This application can be completed in order to be considered for the Registry of Unmet Needs (waitlist) for Innovations Waiver services.

To be considered for the Registry of Unmet needs for Innovations Waiver Funding the following information must be submitted:

- Completed Application for Innovations Waiver Registry of Unmet Needs (for Spanish Version)
- Most recent psychological evaluation (must include the following)
  - Intellectual/Cognitive Testing such as IQ assessment
  - Adaptive behavior assessment
  - Diagnosis
- If member is over the age of 18, documentation supporting the diagnosis prior to the age of 18

If it is determined that the individual is not an appropriate referral- (because the information provided indicates that the person likely does not meet criteria for participation in the Innovations Waiver) - he/she will not be added to the Registry of Unmet needs. You will receive written notification about the decision.

If you have questions about the application process please call Trillium Health Resources at 1-866-998-2597.

Division of Health Benefits | NC Medicaid Provider Contracting Deadline: November 15, 2019

Questions and Answers

1. **What is changing?**

   For inclusion in auto-enrollment, provider contracts must be signed and mailed to the health plan no later than November 15, 2019.

2. **Why are these changes happening?**

   It takes health plans at least two to three weeks to process provider contracts and ensure that providers can be paid. Additional time is then needed to transmit information to the Department for inclusion in the auto-enrollment process.

3. **Who is impacted?**

   All Medicaid providers who want beneficiaries assigned to them as a primary care provider (PCP) during auto-enrollment and to be reimbursed appropriately on day one.

4. **Why is it important to contract with health plans in advance of November 15, 2019?**
   - PCPs who do not contract with health plans by November 15, 2019, risk losing patients, as health plans will assign beneficiaries to in-network providers.
   - Providers who do not contract with health plans in a timely fashion may also miss out on the ability to earn Per Member Per Month (PMPM) payments through the Advanced Medicaid Home (AMH) program.
   - If a contract is not in place by Feb. 1, 2020, and the provider has not engaged in good faith negotiations, the provider is at risk for being reimbursed at 90% and subject to additional prior authorizations.
5. **Are providers required to contract with all health plans?**

   No. Providers may contract with as few or as many health plans as they prefer. However, patients will be enrolled with an in-network provider for the health plan that they choose.
6. **What are health plans' responsibilities with respect to contracting with Medicaid PCPs?**
   - The Department of Health and Human Services (DHHS) acknowledges that contracts between providers and health systems are long-term agreements with many components, and recognizes that health systems have to exercise due diligence in getting to a contract that is right for both the health system and the health plan.
   - DHHS expects health plans to negotiate with any willing provider in good faith.
   - North Carolina is an "any willing provider" state. Health plans may only exclude eligible providers from their networks under the following circumstances:
     - Provider fails to meet Objective Quality Standards, which can be found in the PHP Provider Manuals; or
     - Provider refuses to accept network rates
7. **What are health plan responsibilities with respect to contracting with Medicaid PCPs that are Tier 3 AMHSs?**

   Health plans are required to contract with all AMH Tier 3 practices located in each health plan region.
8. **What are required payments for PCPs and AMHs?**
   - Health plans must reimburse in-network providers no less than 100% of Medicaid Fee-for-service (FFS) rates unless they have mutually agreed to an alternative arrangement.
   - In addition to FFS payments, health plans must also make care management payments to AMHs.
9. **What is the timeline for auto-enrollment?**
   - Beneficiaries in all managed care regions will have the option to choose a health plan and PCP during open enrollment. Open enrollment is currently live in regions 2 and 4, and will open statewide on October 14, 2019.
   - Beneficiaries may keep their current provider by signing up for a health plan that contracts with that specific provider and selecting the provider as their PCP
   - Open enrollment closes on December 13, 2019.
   - After open enrollment closes, beneficiaries who have not chosen a health plan will be automatically enrolled in one by the DHHS. The majority of beneficiaries will likely be auto-enrolled in a health plan.
   - Health plans will then be responsible for auto-enrolling beneficiaries who have not already selected a PCP with an in-network PCP. DHHS has prescribed certain elements of the PCP auto-enrollment algorithm in the health plan contract.

- PCP auto-enrollment must be completed before the health plans mail Medicaid ID cards, which must be shared with auto-enrolled members by January 9, 2020. After auto-enrollment, any new members must be assigned within seven days.

10. **How soon after finalizing a contract with a health plan will I show up in the Enrollment Broker Provider Directory as in-network with that health plan?**
    - Once the contracting process is complete and the health plan has all the required demographic information from the provider, it typically takes **at least** 2-3 weeks to load a provider into the health plan's system and begin showing the provider as in-network. A provider can help expedite this process by beginning to share physician roster information with the health plans in advance of finalizing their contract. This allows the health plans to begin processing this information and be prepared to enroll a provider most quickly.
    - It is important to DHHS that a provider not show up as in-network with a health plan until such point that the health plan can make payments to that provider. This ensures that both the beneficiary and provider have the most accurate information about where to seek care and ensure timely payment for services.
    - Please ensure that NCTracks provider data are accurate. To make changes to your NCTracks provider record, a provider must submit a Manage Change Request from the Status and Management page of the NCTracks Secure Provider Portal. Providers should review each page and confirm that all service locations (address/phone number), taxonomies, patient restrictions, and office hours are correct. There is a minimum of five business days after the Managed Change Request is approved before the updates will appear on the Enrollment Broker Provider Directory.

11. **If I am unable to finalize my health plan contract(s) by November 15, 2019, should I still pursue contracting with a Medicaid Managed Care Health Plan?**
    - Yes. Providers are encouraged to continue contract negotiations with health plans and finalize the contract as soon as possible after November 15, 2019. It is important for contracts to be in place prior to Feb. 1, 2020, to ensure that you will be able to continue to serve Medicaid beneficiaries and be reimbursed appropriately on day one.
    - At the point at which health systems or providers successfully execute contracts with a health plan, they become in-network providers with that health plan.

12. **If I am unable to finalize my health plan contract(s) by November 15, 2019, but I do finalize my health plan contracts before February 1, 2020, will my patients be able to select me as their PCP? How?**
    - After coverage begins on February 1, 2020, beneficiaries have a 30-day choice period during which they are able to change PCPs. In addition, beneficiaries can change their PCP twice a year without a special reason. Beneficiaries will be able to call their health plan and select a PCP different from the one they received during auto-enrollment.
    - At the point at which health systems or providers can finalize negotiations with a health plan, they become in-network providers with that health plan. For more information on contracting with a health plan, contact them directly. Contact information is located on the Medicaid website at https://medicaid.ncdhhs.gov/health-plan-contact-information.

North Carolina Department of Health and Human Services Provider Training Opportunities

- Tuesday October 22, 2019 9am-12pm
  https://www.eventbrite.com/e/mental-healthsubstance-use-101-tickets-74282132859
  MH/SU 101 (9am-12pm)
- Tuesday October 22, 2019 1pm-4pm
  https://www.eventbrite.com/e/crisis-response-training-tickets-74282550107
  Crisis Response (1pm-4pm)
- Wednesday and Thursday October 23-24, 2019 9am-4pm
  https://www.eventbrite.com/e/critical-time-intervention-tickets-74283240171
  Critical Time Intervention (9am-4pm)

835 Transaction File Changes

Effective November 21, 2019, in compliance with 5010 HIPAA compliance regulations, Trillium Health Resources will be updating the outgoing 835 transaction files to all Providers.

Currently, Trillium is sending a 1 in the 2100 loop, segment CLP02 identifying Trillium as a primary payer. This will change to include a 2 or 3 to identify Trillium as secondary or tertiary payer as applicable. If Trillium is the primary payer, 1 will still continue to be sent.

This change will assist providers in correctly applying payments received from Trillium if Trillium is not the only payer of the claim.

If you have any questions or concerns about this upcoming change please contact Trillium's IT Department at PDSupport@TrilliumNC.org or a Trillium Claims Specialist by calling 866-998-2597 or by e-mail Claims2@TrilliumNC.org.

New Process and Website for First Commitment Waiver Exam

Effective October 1, 2019, North Carolina Department of Health and Human Services (DHHS) has a new website (https://www.ncdhhs.gov/ivc) with all of the Involuntary Commitment (IVC) forms; IVC forms fact sheet, a short video on how to complete the health screening, and other resources such as information on Senate Bill (SB)630 and commitment examiner training. If you have questions about any of the changes and/or forms, you may contact DHHS at IVCCommunication@dhhs.nc.gov.

New Mission and Vision Statements

We would like to introduce Trillium's new mission and vision statements. We are dedicated to carrying out our mission by investing in the health and well-being of the communities we serve, and empowering individuals with access to services, tools, and resources to live a fulfilling life. We are consistently adapting, innovating, and strengthening our approach to caring for those we serve. We look forward to continuing to serve our members through the changes in the years to come.

MISSION: Transforming lives and building community well-being through partnership and proven solutions.

VISION: For every community and individual we serve to reach their fullest potential.

Any questions about this Communication Bulletin 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 here.

Trillium offers trainings for providers and also shares about educational events across the region. To learn more, visit our Upcoming Events page. Trillium occasionally announces open enrollment and RFPs for new and existing providers. Visit the RFP | RFA | RFI | Opportunities page for listings.