

NC Medicaid Managed Care Update

Transcript

>>: Good morning, everyone. My name is Chris Mackey, and I'm the Director of Communications here for the Department of Health and Human Services. I just wanted to let you know that the Medicaid Managed Care update webcast will begin in 5 minutes. In the meantime, please make sure you're using a computer or smart phone with audio connected to the Internet and that the audio function is on and the volume is turned up. There is no dial-in for this type of webcast. If you have technical, if you have any technical issues now or during the presentation, send a message using the ask a question box on your screen, and just so everyone knows, participants who are deaf or hard of hearing, this presentation is going to be closed captioned. If you did not sign up for the captioning when you registered, you may do so now by clicking on the link located in the footer at the bottom of your screen. So, thank you very much. We'll get started here in another 3 or 4 minutes.

>>: Good morning, everybody. I'm Chris Mackey. I'm the Director of Communications here at the Department of Health and Human Services. This is a stakeholder call. We held a separate call for members of the media. If you're a credentialed member of the press, you're welcome to join this call, but this call is not for attribution. We are about to get started with our Medicaid Managed Care update, but before we get started, here are a few reminders about the webcast technology. Please remember that you need to use a computer with audio or smart phone connected to the Internet to hear the presenters. Make sure your audio is turned up. If you have a technical issue now or during the presentation, send a

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>>: Great. Good morning, everyone. Thanks for taking time to join us today. As you likely have heard, we announced our Medicaid Managed Care transition earlier this week and wanted to have the opportunity to talk directly to you, to, um, update you on where we are and to talk about next steps. Before I dive into the presentation, I wanted to thank my team, most of whom are sitting around the table here with me, for their hard work in getting to this point. It is an enormous amount of work, as you can imagine, to move, um, the Medicaid program to managed care. It has been many years in, um, the works, and, um, this announcement really kicks off all of the operational work that we're going to be doing across the state. So, one, I want to thank Dave Richard, who is sitting next to me, who's our Medicaid Director, I wanted to thank Jay Ludlam, the assistant secretary for Medicaid transformation, and then, of course, we're going to be talking about the selection of our PHP partners, so I want to, right up front, thank the evaluation committee that did a ton of work over the last number of months, um,

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going through, in detail, each one of those proposals, comparing those to our RFP and then coming out with their recommendations. So, I really appreciate the work of our team. Those were all members of the NCE Medicaid team, and they devoted a lot of their time over the last number of months to that, so appreciative of all their hard work.

So, let's dive in here to the slides. As you remember, just stepping back here about where have we been, um, over the last number of years, so since 2015, folks have been, um, working towards this effort, um, when the general assembly passed the legislation directing us here at the department to transition to managed care. As a reminder, not all those folks in Medicaid are going to be transitioning in at once. What we are going to be talking about today is really the first part of this managed care transition, which is, um, the standard plan. It does move 1.6 million beneficiaries into managed care, starting, um, later this year, but we are just going to exclusively be talking about that transition. Over the last number of years, we've had extensive collaboration with you, um, in getting feedback, we put out many, many policy papers that led up to, um, the release of the RFP that happened in August, all of those policy papers, we really appreciated the extensive feedback that we got, and we refined our thinking as we went into that RFP. Then we had, um, the RFP released, and then, um, folks, um, put together their applications, and we had eight offerors that submitted offers that we considered. At the same time, we also got approval of our 1115 waiver, and we had called to talk about that waiver and the important aspects of it, but essentially, it allows us to move forward with all of the things we've been talking about and planning, and then this week, a very important milestone in the program, which is choosing those PHP partners that are

going to be coming along with us on this journey.

Moving to the next slide, just to remind us all, sort of north star of where we're headed in this Medicaid Managed Care work, it's really so we can work to improve the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both the medical and non-medical drivers of health. That is essentially the charge that we are asking those, um, who are going to be our partners with to join us on, and we're looking forward to continuing to do the policy and operational work to execute on this vision. So, let's get to the meat of the announcement, which was who the, our partners are going to be in Medicaid Managed Care for our standard plans. So, the four state-wide contracts that we awarded are for these, um, entities here, AmeriHealth Caritas of North Carolina, Blue Cross Blue Shield of North Carolina, UnitedHealthcare of North Carolina, and WellCare of North Carolina, and in addition, Carolina Complete Health was awarded contracts in regions 3 and 5, and Carolina Complete Health is a provider-led entity.

As folks may recall from the legislation, um, it was altered and moved from three state-wide contracts to four state-wide contracts, which is why you see four PHP contracts here. In addition, we have some static on the phone, apologies. In addition, when our evaluation committee did their work, these were the four top point scorers in that evaluation process, and they made the recommendation for these four state-wide contracts to move forward. Um, in those four, you will notice that there are no provider-led entities in those four state-wide contracts, and, so, when Dave Richard and myself, you know, looked at that result, um, and knowing the intent of the general assembly to really try to include provider-led entities in the

program, we went ahead and awarded Carolina Complete Health, a provider-led entity, in regions 3 and 5, to make sure that we were, um, living up to the spirit of that legislation, but also to, um, allow for innovation in the governance space of these entities and, um, allow for some additional beneficiary choice in those regions. Um, so, we're excited about these five partners who, um, worked very hard, putting together very, um, complete plans that we are going to be working with them on over the next number of years. As a reminder, these are contracts that last for three years, with two, um, option years, so somewhere between three and five years, so these will be our partners for three to five years, but let me go to the next slide here, because there's a few more details. There's a lot of work still to do to get to actually going live.

So, we know we have our pre-paid health plan contracts, and as I mentioned, it's going to be managing care for about 1.6 million Medicaid beneficiaries across the state. Again, they're just contracts for standard plans, the behavioral health tailored plans are going to be procured later, so those with more, um, serious behavior health needs, IDD needs, um, are going to continue to be in fee for service, run by the state, as well as having their, um, their behavioral health services authorized by our partners. I want to remind folks that our PHPs, um, you know, as they are going to be given a lot of, um, the operational responsibility for running the Medicaid program in terms of paying the bills and collecting data, we, at the state, still retain strong, rigorous oversight of these entities to make sure that everyone is living up to the, um, to the standards that we have put together for this program. We want to make sure that there are strong networks, for example, that will be one of the first pieces that we'll be looking at as they start to contract with

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doctors and hospitals, we want to be sure that there are adequate networks to serve our Medicaid beneficiaries. PHPs are going to be required to provide the full range of benefits. They're going to be accountable for quality and outcome. They're going to make, need to be responsible for positive beneficiary experiences, timely payment to providers, and many other aspects of the program that we will be, um, overseeing here at the department.

On slide six, one of the other things we announced this week was how we are going to phase in this first part of the managed care work. I've learned a lot of lessons, working at the federal level, about hard IT projects and the need to make sure that we work out all the operational and technology details, because there are a lot here as we move into this work, and so we are going to be launching in two of the six regions to begin with, starting November of 2019. So, on this slide, you see a nice picture of the six regions, and in regions two and four, that's the yellow and the red regions here, we're going to be starting that in November of 2019. In regions one, three, five, and six, we will be starting in February of 2020. Again, folks, um, had asked us over the course of the last couple days, well, why did you choose regions two and four, and just want to share that, really, it was around a bunch of operational practicalities. One, we recognize that the eastern part of our state has been impacted by hurricanes the last number of years, and looking at a November date, we didn't want weather to be an issue, so we looked at regions more in the western and central parts of the state.

Um, and then the majority of our state staff is here in the Wake County area, in region four, so wanted to have the most, um, operational flexibility to have our staff as close to the work as possible, as we do this first phase of things. So, that's

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how we have regions two and four to go first. Regions one, three, five, and six, again, in February of 2020. So, let's talk about some of the next steps here. As I mentioned, there's a lot of work to be done, and we are starting that work as of Monday. We know in any big procurement like this, it is a \$6 billion a year procurement, and that you have folks who are, were awarded contracts and those that weren't. Um, we expect there may be folks who want to, um, revisit what the evaluation committee did or submit a protest, and that is fully within their right to do. We have a protest protocol here at the department, and we'll work through that very quickly, but in the meantime, for getting started, work starts, started on Monday to get ready. The next step is we're going to be preparing for that launch, including operational readiness and overall compliance with contract provisions. Any of you who are, work in doctor's offices and hospitals will also be receiving information regarding contracting with PHP entities to build networks, so that will start, frankly, they started before this award and will likely continue in earnest over the next number of months.

In terms of our Medicaid members, they will begin receiving information about enrolling in managed care over the next few months, including how to select one of these new PHPs, as well as select their primary care provider. Um, so, all of that will start, and I'll show you a timeline on the next slide, and in addition, the department's going to be conducting, as I mentioned, thorough readiness reviews. Folks will, our PHP partners have put together great applications, now we need to make those, um, those offers and applications a reality, but they still need to meet those gates of readiness reviews in order to launch and go live for the program, so still work to do before we actually, um, go live here. So, on slide eight, we capture

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some of what our Medicaid beneficiaries can expect next in terms of timeline. As I mentioned, regions two and four are going to be going live first, so if you look at the top here, in the yellow, this is where beneficiaries who are in regions two and four can expect an open enrollment period during the summertime, July, August, September. That is when they will be asked to select one of the PHPs in their regions, and regions two and four will have those four choices of state-wide plans to select from.

Um, and then, again, starting November 1st, beneficiaries in regions two and four will start to receive services through those PHPs. In the second phase here of roll-out, you'll see that beneficiaries will be in open enrollment in more of the fall and into the start of the winter, so October, November, December, beneficiaries will be selecting PHPs, if they're in regions one, three, five, and six, with services through the PHP starting February of 2020. So, we'll be doing a lot of work to stand up our enrollment broker functionality and assistance, so that by the time open enrollment comes, that folks can know how to, um, get help and independent information about how to make good selection of those PHPs for them and their family. We very much want everyone, um, all of our beneficiaries in the Medicaid program to do this homework for themselves and their families, to make sure they're making the best choices. If they don't select a plan during that open enrollment time, we, at the department, will put them into a plan, and we will use an algorithm based on sort of where they live, what doctors they've seen before, to put them in the best plan that we can surmise, but, of course, we always want folks to make that selection, um, for themselves, if they are interested in doing so. So, we'll be working through that through this first open enrollment period.

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So, on slide nine, um, for those of our Medicaid beneficiaries who may be on the call or those of you who work closely with our Medicaid beneficiaries, some of the key things that they should know is that the only thing they really need to do today, right now, is make sure their information is up-to-date, their address, phone number, contact information, so that as we move through this process, we know how to reach out to them, give them information, um, about what is happening in terms of the timelines and such, so that's the really important thing, is making sure their information is up-to-date. And then they should also know that help is going to be available, as I mentioned, for beneficiaries to select a plan based on what makes most sense to them. So, they shouldn't have to feel like they have to go out and learn about these four or five, um, new entities in their areas right now, that there's going to be help available to help them make that selection, and they should know that we are very much thinking about their rights and making sure that beneficiary rights are going to be protected through this process. We very much have them at the center of our thinking through all of this work, and it's good to remind, while many things are changing, there are a bunch of things that are staying the same.

So, our eligibility for the Medicaid program is staying the same, the way someone becomes eligible for the program is still going to happen through the same process through our counties. Um, they're going to still have the same services and treatment and supplies covered that is required by law in this transition, and the cost-sharing pieces of our Medicaid program are not changing as well. So, the real new step here for our beneficiaries is that they are going to be selecting an insurance company to enroll with as we move forward into the next phase, but eligibility will be the same, the coverage will be the same, and the cost-sharing will

be the same. So, with that, I think, um, ends the bulk of what we wanted to share with folks, but I know that there's going to be questions. We're happy to answer questions now, but if you have questions after this, you can see some of the, um, contact information here for our team or overall transformation feedback, and make sure that you're continuing to check-in with us. There's still policy development going on as we work through this next operational phase, we're going to be talking more about data and data flows and how all those pieces work together to make our program run, and, of course, we will still be doing a lot of work to build to the next phase of this work, which is the tailored plan work, so a lot more policy work to do, so do continue to check back with, um, our Medicaid transformation website for additional documents. So, with that, I'm going to turn it back over to Chris and to work through some of your questions. Thank you.

>>: Terrific. Um, we are now going to take questions, and the team is here to help answer those questions. We'll start with a question from Cheryl, who wants to know what specific groups will be held back from the standardized plan.

>>: Great. Hi, Cheryl. Mandy Cohen. Thanks for that question. So, I'm going to turn it over to Dave Richards to talk about that, but at the highest level, the 1.6 million beneficiaries that are moving into the standard plans generally are moms and kids. That's not exclusively, and the folks that are going to be in tailored are those with more, um, serious behavioral health needs, intellectual and developmental disabilities, TBI, but there are other populations, like our dual-eligible, our foster kids and others who are not going forward in this phase, and, so, it's a probably very detailed question where we can direct you to some additional resources, but I'll turn it over to Dave Richards for some additional detail.

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>>: I think you got the highlights of that, and just to reiterate, those folks that will be in tailored plans will stay in fee for service for their physical health services until tailored plans are launched. Our CAP programs will not go live, dual-eligibles will not go live at this period of time. Obviously, the innovations waivers is part of the tailored plan. There are folks that have spent-down and limited benefits that will not go live, and a reminder that dental services are not included in managed care at any point at this time. So, that's the high-level list of it, and again, on the website, you'll be able to see all the specific details of those that go live initially and those that are delayed.

>>: Terrific. Tracy from Venture Rehab Group has a couple of questions. Have reimbursement guidelines been established to identify acceptable turn-around times for payments to providers, such as one month, two months, three months? And when will providers know what to expect regarding payment timeframe?

>>: Great. Thanks for that question. I'm going to turn it over to Jay Ludlam, our assistant secretary for transformation.

>>: Good morning. Thank you for the question. Um, so, provider reimbursement, of course, is dictated by state law, so the health plans will be expected to follow state law. In the contract, um, there are, um, there are timeframes that are defined as well, but, um, generally, it's, I would say it's 30 days for the health plans to reimburse providers for coverage services.

>>: Thanks, Jay. Um, William would like to know what were the key factors that distinguished the selection of state-wide versus regional partners for administration of Medicaid Managed Care?

>>: Hi, William. Thanks for the question. So, all eight offerors were, um,

evaluated on the same criteria, and that was intentional. We, um, believe all folks, no matter their governance structure, um, are being asked to do, um, the work of a PHP, and thus we had the same criteria, um, for everyone, regardless of their governance structure, and those had many, um, different facets to them, everything from financial management to how they did care management and how they manage services and their beneficiaries, and, so, there were a number of, um, ways in which folks were scored. Our evaluation committee gave points across all of those, um, and then folks with the highest point scores were awarded state-wide contracts. The provider-led entities, by state law, essentially had a few different options in the way that they could participate in the program. Provider-led entities, these are, again, providers that, these are entities that have providers as part of their governance structure. They had the opportunity to either be considered for state-wide or for regional contracts or for both, and we actually had three provider-led entities that, um, were competing as part of this process, and actually all three chose a different path.

One of our provider-led entities only wanted to be considered for state-wide, one was open to be considered either for state-wide or for regional, and then one only wanted to be considered for a few regions, which was, um, you know, again, they had the opportunity, the options to do. Um, so, our evaluation committee, again, awarded the top, um, top point-getters the four state-wide contracts, for those who wanted to be considered state-wide, either traditional, commercial insurance, or, um, PLE.

>>: Great. A question from Diane. She wants to know, so, the four state-wide will also be in regions three and five, with the addition of the provider-led

entity?

>>: Hi, Diane. That's exactly correct. So, the four state-wide will be in all six regions. In addition, um, Carolina Complete will be in regions three and five, so folks from regions three and five will have five entities, the rest of the regions will have four.

>>: Um, Louis wants to know will current behavioral health providers be able to take Medicaid, if not currently a provider for united health or other companies mentioned?

>>: Hi, Louis. So, as mentioned, we, starting now, our folks are going to be, these PHPs that were newly selected are going to be starting their contracting process and building their networks, so that process will start now. Some may have relationships with some of these plans already, others will need to build them, um, starting new over the course of this year, but that will start now, and so there is opportunity. Um, again, the Medicaid program does have a provision of any willing provider who wants to contract and be part of the Medicaid program.

>>: From McKenzie, is there money allocated under the session law for social service departments to hire additional workers to handle the increased workload of helping Medicaid beneficiaries pick plans?

>>: So, hi, McKenzie. So, I'll start. As mentioned, the counties will still have responsibility on the eligibility side. The enrollment side, at least at first, is going to be a hand-off to what we're calling our enrollment broker, so it won't be the county staff that will be doing the enrollment counseling. In an ideal world, it would be one person that can lead you through that whole process, but just the nature and timing of the way we need to start the program, it will be the counties will still be in

charge of the eligibility, and, obviously, will need to be helpful in handing off to the enrollment broker, to make sure there's a smooth transition there, but we will have other folks, both sometimes embedded right there within the county, other times on the phone, to help folks through that second phase of the enrollment process here, but let me see if my team wants to add anything.

>>: This is Jay Ludlam. All I would add is the enrollment broker is an independent third-party, so the enrollment broker does not hire state staff and wouldn't need to.

>>: Great. Bob wants to know, we are wondering what mechanisms will ensure that one is truly coordinated with the compliance decisions guiding the course? And how will we ensure best clinical care while honoring the non-clinical and social support of the functions needed to promote the recovery of a more valuable, healthy life?

>>: Thanks, Bob. It's a really important point and one that we have been spending a lot of time, um, making sure that we get the policies right to foster exactly what you're talking about, which is recognition that we're all trying to drive towards health, and sometimes, that means healthcare services, and other times, that means things like housing and food and transportation, and, so, we are embedding, um, a number of ways in which we're trying to, um, have those be part of this program. One, we are asking all of our PHP partners to screen folks for things like, um, housing insecurity, food insecurity, transportation issues, so that they can better help direct them to services that they need, but we also have spent a very large amount of time thinking about our care coordination and care management work within the Medicaid program. We have, um, created what we

have called an advanced medical home program, which I think builds on a lot of the good work of the Carolina Access Program and sort of takes it now to the next level and into the future, where we really are focused on local practice-based care coordination and hoping to see as many practices out there taking on the responsibility of care coordination directly within their practices, um, and using data to help our Medicaid beneficiaries get the best care they can, in the right settings, at the right time, making sure that they're getting their medicines and taking their medicines, but also, to your point, um, recognizing that care is beyond those four walls of the hospital and the clinic and making sure folks are getting what they truly need, um, to be healthy. It's a big, um, a tall order and a lot of work, and so we have a lot of work to do to get prepared for, um, for folks to be able to be supported in that work, and we look forward to that, to building that implementation over the next number of months.

>>: Um, Louis had a follow-up question. Will Medicaid recipients have deductible as most current Blue Cross Blue Shield clients?

>>: Hi, Louis. So, I'm going to turn it over to my team for more specifics, but essentially, the cost-sharing that exists in the Medicaid program will stay the same, so our PHPs can't introduce new cost-sharing requirements on top of what already exists in the Medicaid program, and those are based on someone's income level as of right now. Thank you.

>>: Thank you. Can PHPs start now on building networks, um, contracting professionals, or do they have to wait until the protest period is done?

>>: Thanks for that question. No, the work starts today, and frankly, probably started before Monday in terms of folks having, likely having contract

negotiations, so we continue to do all of our work, fully recognizing that protests are part of this process, and we will work through them, but that does not stop the work that we know needs to happen to get ready for November 1st. That's right around the corner, so a lot of work needs to be done to hit those, that deadline.

>>: From Sharnice, when will a beneficiary have the opportunity to change PHPs?

>>: Great question. I'm going to turn that over to Jay Ludlam.

>>: Thank you very much. So, um, an individual beneficiary with a health plan, um, will have 90 days after they initially select the health plan. Um, it is, um, that is the first period. They are also, um, able, if the health plan is not working out for them, they are able to do a, what's called a with-cause change, they are allowed one, um, beneficiaries are allowed one change, um, in addition to that 90-day period per year, but I think that, um, we would expect some flexibility around that, if the health plan is really not working for you.

>>: Mike from Partners has a question. In regions one, three, five, and six, will all benefits be managed as they currently are until February of 2020? Will the LMECOs manage all of behavioral health for everyone until February of 2020 in those regions?

>>: This is Dave Richards. You are correct, that they will manage until, um, February 2020, and the, um, and once that transition happens, then, obviously, the standard plans will manage those folks that are in the standard plans at that point, but, um, up until that point, the LMECOs will have the responsibility for all, what they're doing today and will continue to manage the behavior health services of those people that will stay in tailored plans.

>>: Thanks, Dave. Tom from Leading Age North Carolina wants to know as you looked at other state experiences with transitions to managed care, what's the number one observation you would emphasize with providers?

>>: Oh, Tom, really good question. How do I prioritize? You know, I think at the beginning of this transition, um, we want to make sure our beneficiaries who are getting care on October 31st are getting that care on November 1st, that if they had prescriptions that needed to be filled on October 31st, they're getting them on November 1st. We want to make sure that, um, our providers who are getting paid by the state on October 31st then get paid by the health plans in the timely way in which they're supposed to in the November timeframe, right? So, I think, at first, it's really focusing on some of just the core fundamentals, making sure that the program is up and running, that we don't see disruption in anyone's care, so that's what we'll be highly focused on. Then, obviously, we have some high expectations of where we want to move the Medicaid program to overall related to that care coordination and the care management and the recognition of the, um, drivers of health beyond the, um, healthcare system, and so those are the kinds of things that we'll build to over time, but again, I think this first period of time, what we're really aiming for is that continuity of care and that smooth transition for our beneficiaries, so that they get the needed care that they need, and then we would build from there.

>>: Thank you. From Kim from Macon County Transit, how will transportation services for beneficiaries change? Will the PHP broker those services?

>>: Hi, Kim. Let me probably answer that in two parts. First, I'm going to

turn it over to Dave or someone on our team to talk about non-emergency medical transportation within the program and sort of the traditional part of the Medicaid program, and then we'll turn back to talking about some of the additional pieces we're trying to build in around transportation.

>>: So, Kim, as you know, I'll ask Jay to add to this, obviously, we continue to provide that service to folks in fee for service, that those folks that stay in fee for service will continue to use the, um, systems that are in place, mostly county transit programs. As we move into managed care, there will be the opportunity for changes, and I'll ask Jay to talk a little bit about that.

>>: Yes, each of the health plans will be expected to provide the non-emergency transportation benefit. Whether or not they choose to hire a third-party broker to manage those services and coordinate the contracting that's necessary to bring up a robust non-emergency transportation network, that really is, um, up to the health plan and their determination of what the best way to provide those services are, but it is our expectation that they will, um, provide them.

>>: And then if I could, um, loop back. One of the other ways in which we are thinking about transportation is part of this package of things, that we very much know transportation allows you to both get to your appointments, maybe get to pick up your medicines from the pharmacy, etc. Um, we know that's a key, important piece here, so as we think about our healthy opportunities pilot that we will be launching, um, within our Medicaid program, um, that we know transportation will be an important factor there, and again, we, that is a pilot where we have been given authority from the federal government to think about using our Medicaid dollars, um, a bit differently and to pay for some of these kinds of services beyond what the

program has paid for in the past, but that will be in a pilot setting, it'll be in about two to three regions here, across the state, and stay tuned for more details on that.

That is something that we'll not be launching in the next year.

>>: Thank you. From Dana from Clark Family Medicine, will providers be required to sign a contract with all four PHPs that have been chosen?

>>: Hi, Dana. Thanks for the question. Um, the short answer is no, providers are not required to sign with all four. They can sign with all four, if they, I'm sorry, or five, if they want to, but they are not required to do so. Um, we expect that there will be a lot of, um, interactions between those five entities and, um, and various practices and hospitals over the next number of months to establish their network in different ways but let me see if my team wants to add to that.

>>: No, that's perfect.

>>: Okay, thank you.

>>: From Henry, how do providers enroll to be an advanced medical home?

>>: Henry, great question. Um, we are having folks enroll to be medical homes right now. We've seen some really good participation so far, but, certainly, by no means a closed opportunity, so we are still looking for folks to do that. I'm going to turn it over to Jay to tell you more details.

>>: Yeah, um, it's a great question. If you are interested, um, to, um, as a provider, to be an advanced medical home, an AMH, there is a website that is, um, linkable from the North Carolina, I would search for North Carolina Medicaid Transformation, there is a link to the AMH, um, attestation website, and from there, there are instructions on how to, um, enroll and complete the process. It's a relatively, um, simple attestation process, and, um, just need to be ready by

November 1st of 2019.

>>: Thanks, Jay. Meredith from the Burke County DSS would like to know who will enter the PHP and NC fast? And what will the Medicaid cards look like and where will they be sent from?

>>: All right, now we're getting into the details. I like the way you're thinking, Meredith, wanting to really figure out all the operational things. Um, I think that is, these are great questions. I think those are some of the details that we're still working out with our county partners and exactly what those, the cards will look like and such. So, I'm going to say stay tuned on that question there, and those are the kinds of things that within the next couple months, we will definitely be talking with each of the counties about, so that everyone, um, gets up-to-speed well before the open enrollment period this summer in the regions two and four.

>>: And on the second part of the question, what will the Medicaid cards look like, so, um, each of the health plans will have their own cards. There are standards to that card that, um, that are required for all of them, but, um, each of the health plans will issue their own cards based on, um, the health plan that the beneficiary, um, chooses or is assigned to.

>>: Thank you, and I will apologize if I mispronounce this. Marisio, does DSS have direct contact with PHPs for changes for clients?

>>: Also, a really good question, um, related to changes, and I think, again, another piece of the operational work that we're trying to figure out. We know that different folks are going to be interacting with beneficiaries at different times and want to always figure out how do we get the best information about our beneficiaries into our system so that we can all be sharing that data, so stay tuned, again, on that

issue. It is very much on my mind personally, and I'm seeing a lot of nodding heads around the table here of our team, so thank you for highlighting that. It's an important question that we'll be sharing more on soon.

>>: Jane from Cardinal Innovations Healthcare would like to know will standard plan members have a similar opportunity for input to PHPs as they do now through state and local consumer and family advisory committees?

>>: Jane, this is Dave. Thank you for that question, and as we said, I think continually clear terms at the state, it will continue in its role as an advisory to the state about all things around behavioral health services, and we want to hear, um, continue to hear from you related to standard plans and to, um, our tailored plans. Um, we are asking that the PHPs will have a member advisory committee, which we're hoping for, the standard plans will include those who are really concerned about behavior health issues, but I think you hear clearly from the department the commitment to have the consumer and family voice, um, highly present in all that we do, both standard plans and tailored plans.

>>: Thanks, Dave. Um, Julie from Northern Hospital of Suri county would like to know will each payer have the same standard fee schedule to pay providers, or will there be different rates, depending on contracts between payer and providers?

>>: Hi, Julie. Thanks for that question. We have, um, said that there will be a rate floor for our providers, both hospitals and doctors and other clinicians within the program, so there will be a rate floor. Now, that means, though, that there will still be negotiations beyond that, but we know at least that there is a minimum that PHPs will need to hit in terms of rates. I do want to say that we hope that folks are

going to take this opportunity, with a brand new program, new contracting opportunity, to think about, you know, where is all of healthcare going in terms of contracting and, um, relationships between insurance companies and doctors and hospitals, and is this an opportunity to think differently about contracting instead of the same standard sort of, you know, rates and fee for service, is there an opportunity to think about alternative contracts, um, that can allow for a focus on, um, driving towards health and really driving towards outcomes as you think about those contracts. So, we do have that rate floor in there, but, again, I'm encouraging everyone to really think about this opportunity in a new way, think about where, um, healthcare is going overall, what are the kinds of goals that you have for your own practices or hospitals, and think about can we use this as an opportunity to really drive towards that future for our Medicaid program.

>>: Thank you. Um, Dennis from Morganton Eye Physicians would like to know will providers be required to credential with each PHP, or will credentialing remain centralized with NC tracks?

>>: Yes. Hi. This is Jay Ludlam, and the department is committed to using a centralized credentialing process that does not require providers to credential separately with each health plan. I want to be sure to emphasize the difference between credentialing and contracting. You would have to contract with health plans that you are interested in participating with, but you are not, um, there is no credentialing requirement from the health plans. The state will continue to operate, um, its provider enrollment process, so you have to be a North Carolina enrolled Medicaid provider in order to participate in either fee for service or managed care. Initially, our credentialing requirements, um, on providers are very low, we will utilize

existing information that we've already received from providers through that enrollment process, as well as try to, um, add, um, additional information that might be available to, um, a third-party that we've hired to help manage this process during the transition. Sometime in the future, we will have, likely migrate the state, um, from a, um, from this process to a more robust centralized credentialing vendor option, but that is, um, in the future and not for something to worry about today.

>>: Thank you, Jay. Christina from CCWNC would like to know will beneficiaries be auto-assigned to an AMH or PCP, or how will that process work?

>>: Excellent. Thank you for that question. So, there are, um, two aspects to this. The first is during the, um, the enrollment process, um, an individual, a beneficiary may request a, um, a PCP or an AMH at the time of enrolling with the health plan. So, the beneficiary would, um, look for an AMH or PCP that they are interested in continuing to, um, receive their care from and ask the enrollment broker for any health plans that that AMH or PCP might be working with. So, there's that aspect, where the member can choose during the enrollment process. If the member does not have a particular, um, preference, um, or, so, they don't indicate, um, whether or not they have a choice on PCP or AMH, um, the health plan will assign the PCP or AMH based on some of that, um, that historical relationship with the member or based on a transition of care information that is provided to the health plan. Again, if the member does not, um, like the choice that, um, was made for them by the health plan, they will have an opportunity to, um, change their AMH/PCP assignment so that they can get it right. Um, so, there are many moments or, um, milestones in time where the member can, um, choose an AMH or PCP or, um, choose one or change one.

>>: Thank you. Hang on one second. Is, um, Katherine would like to know is routine vision going to be fee for service, or will it be under managed care?

>>: This is Dave. In our current design for managed care, um, yeah, excuse me, sorry. I apologize. We're having a little bit of a continued, um, discussion to make sure we get the answer right here. So, the answer is that, um, exams will be in a PHP, and glasses will continue to be in a fee for service system, and part of that's the way we've designed the system for, um, how we get those eye glasses delivered to people.

>>: Great. Thank you. I think we're closing in on some of our last questions here. Hang on one second. Could you repeat how often beneficiaries are allowed to change plans or PHPs?

>>: So, this is Jay Ludlam again. There is a 90-day without, um, cause period, after you've, um, you've chosen your health plan, and there is, um, literally any reason you want to choose a different health plan, you can do so during that 90 days. After that 90-day period closes, there are, um, federal requirements and reasons why a person, um, can change a health plan, and those are called with-cause reasons, and, um, aside from that, and during that, um, with-cause period, um, you would have one formal change period, but I think that, um, from a department perspective, um, you know, I think it's important that people find one time per year, so, I think it's important for members and health plans to develop that relationship, and so if the health plan is not working for the beneficiary, um, we will work with them to try to get them in a health plan that best serves their needs.

>>: Um, great. One last question here. Why were regions three and four selected for the PLE?

>>: Great. Well, first, let me correct, it was actually regions three and five that were selected for, um, the provider-led entity, Carolina Complete. The reason three and five were selected is that we wanted to make sure that folks had as much lead time before we started, um, into managed care with that entity as possible. As mentioned earlier, we're going to be going live first with regions two and four, and so we wanted to make sure that the regions selected for that provider-led entity were from sort of the second wave, and then we also wanted to make sure that the regions we selected, um, were regions that have more of our beneficiaries and, again, could have sustainable amount of enrollment that we could see for the plan and thus, um, regions three and five were selected. Thanks for that clarification.

>>: Thank you for answering those questions. I would like to turn it over for some closing comments, and I'll remind you now that, um, this presentation will be posted on the Medicaid Transformation website.

>>: Great. Well, thank you again for your time this morning. I thought the questions were excellent and, again, keep them coming beyond this presentation, if you have more. It really does help us understand what are the ways in which we're not being as clear as we need to be and can help, um, all of you, um, understand all the changes that are happening in the system. Stay tuned for a lot more from our department on that front, both whether it's related to advanced medical homes or overall contracting. Again, you're going to see a lot more around data and data flows, but also, we're going to obviously be starting to talk to our Medicaid beneficiaries, and we know many of you talk to our Medicaid beneficiaries, um, day in and day out, and, so, we'll really look forward to partnership and making sure we have, um, good communication and good messages for them, because this will be,

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you know, anytime there's a change, it can be confusing for folks, and so we want this to be as smooth as possible, so we're going to be doing all we can to continue to communicate a lot, and so I just thank you for tuning in and, um, asking very thoughtful questions today. Thank you so much for the time.



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