

North Carolina Medicaid Transformation: *Beneficiary Policies*

May 16, 2019

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Medicaid Transformation Vision

“ To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health. ”

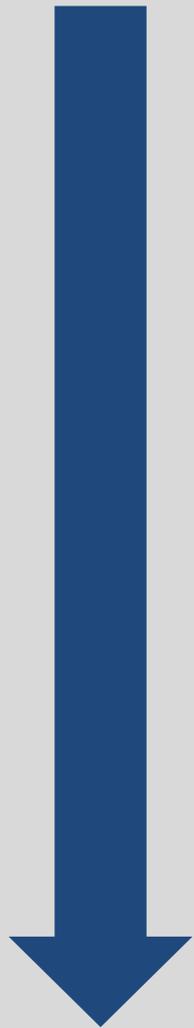
Context for Medicaid Transformation

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly **fee-for-service (FFS)** to **managed care**.

Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:

- Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden

Medicaid Transformation Timeline



| Timeline | Milestone |
|------------------------------|---|
| October 2018 | 1115 waiver approved |
| February 2019 | PHP contracts awarded |
| June - July 2019 | Enrollment Broker (EB) sends Phase 1 enrollment packages; open enrollment begins |
| Summer 2019 | PHPs contract with providers and meet network adequacy |
| November 2019 | Managed care Standard Plans launch in selected regions; Phase 2 open enrollment |
| February 2020 | Managed care Standard Plans launch in remaining regions |
| Tentatively July 2021 | Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans Launch |

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Beneficiary Eligibility and Enrollment Process

Beneficiary Eligibility for Managed Care

- Most Medicaid beneficiaries (e.g., parents and caretaker adults, children enrolled in Medicaid and NC Health Choice) will transition to Standard Plans beginning in November 2019
- Other Medicaid beneficiaries will transition to managed care at a later date or remain in fee for service
- DHHS will continue to determine Medicaid eligibility for all Medicaid beneficiaries following managed care implementation

Providers can review their patient populations to determine which patients are, and are not, transferring to managed care

Beneficiary Eligibility for Managed Care, cont.

Some Medicaid eligible populations will not transition to managed care until a later date or at all; others have the option to stay in fee for service

Excluded Populations

- Medically needy beneficiaries (i.e., spend down)
- Beneficiaries with limited Medicaid benefits (e.g., family planning)
- Community Alternatives Program for Disabled Adults (CAP/DA)
- Community Alternatives Program for Children (CAP/C)
- Program of All-Inclusive Care for the Elderly (PACE)

Delayed until BH I/DD Tailored Plan Launch

- Qualifying beneficiaries with a:
- Serious mental illness;
 - Serious emotional disturbance;
 - Severe substance use disorder;
 - Intellectual/developmental disability; or
 - Traumatic brain injury

Temporarily Excluded for up to 5 years

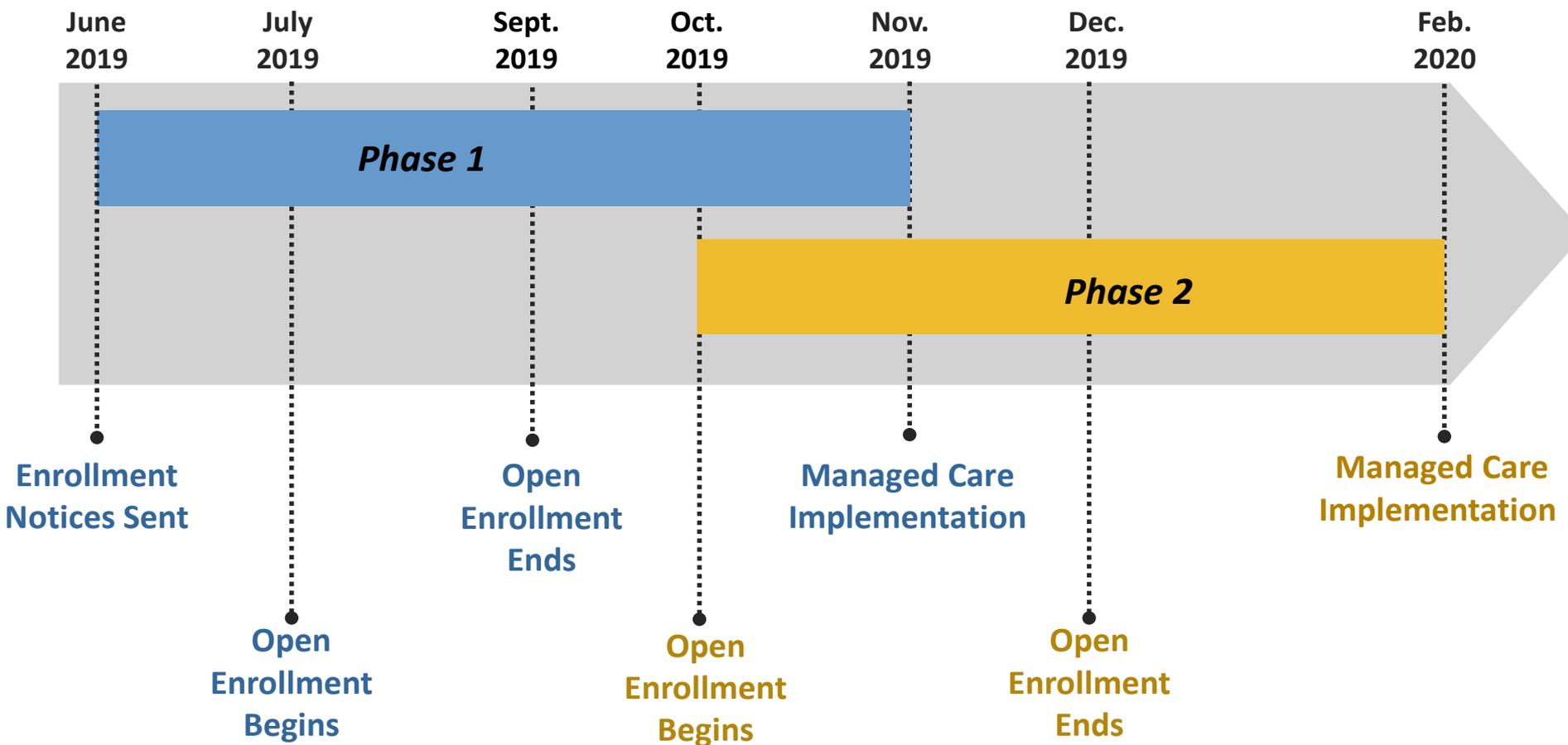
- Beneficiaries with long-term nursing facility stays
- Dual eligibles

Exempt (Optional Enrollment in MMC)

- Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians

Overview of Standard Plan Enrollment

Medicaid beneficiaries eligible for Standard Plans will enroll in two phases based on the region where they live*



*See Appendix for regions

Plan Selection for Current Medicaid Beneficiaries

- Beneficiaries will receive notification letters with instructions on enrolling in managed care
- Beneficiaries will have 60 days to select plans during open enrollment
- Beneficiaries can enroll in a plan via phone, online, paper or in-person
- Beneficiaries who do not select a plan during open enrollment will be auto-assigned to a plan based on an algorithm
- Beneficiaries have 90 days after plan enrollment to switch plans “without cause;” after that, they may switch only for certain reasons or annually

New Medicaid beneficiaries will be able to select a plan outside of open enrollment

DHHS’ enrollment broker is available to assist members during the plan selection process

PCP Selection

Advanced Medical Home/Primary Care Provider Selection

Under managed care, beneficiaries may choose their Advanced Medical Home (AMH)/primary care provider (PCP)

- The enrollment broker will provide beneficiaries with information and assistance in selecting their AMH/PCP at the time of PHP enrollment (e.g., answer beneficiary questions about which AMHs/PCPs are in-network for different PHPs)
- Subsequent changes to AMH/PCP assignment are managed by the beneficiary's PHP
- Beneficiaries can change their AMH/PCP **without cause** within 30 days of selection or notification of assignment, and up to one additional time every 12 months
- Beneficiaries may change their AMH/PCP **with cause** at any time

AMH/PCP Auto-Assignment

PHPs will assign beneficiaries to an AMH/PCP if they do not select an AMH/PCP

- Beneficiaries that do not select a AMH/PCP during the plan selection period will be assigned a AMH/PCP by the PHP in which they enroll
- AMH/PCP auto-assignment will consider:
 - Beneficiary claims history
 - Family member AMH/PCP assignment
 - Geography
 - Special medical needs
 - Language/cultural preference

If members want to change their PCP, providers should instruct them to call their PHP's member services department

These are the only items a PHP is allowed to consider for auto-assignment at this time but the State may add additional items in the future

Beneficiary Supports

Role of the Enrollment Broker

The enrollment broker will provide choice counseling, enrollment assistance and education to beneficiaries

Enrollment Broker Responsibilities

- Leading outreach and education efforts, including:
 - Developing and disseminating educational materials
 - Hosting outreach events during open enrollment period
- Providing enrollment assistance and choice counseling to support beneficiaries' plan and AMH/PCP selection by offering specific details about each plan, including:
 - Provider directory with information about whether beneficiaries' preferred providers are in network
 - Plan comparison chart for key quality or operational metrics
- Processing enrollments and disenrollments and transmitting to the state
- Maintaining a call center to assist beneficiaries with enrollment related requests

Role of the Member Ombudsman

Providers should be aware that there will be a member ombudsman responsible for helping patients navigate issues with managed care

Ombudsman's Responsibilities

- Provide information and education to assist beneficiaries with access to care
- Serve as a central resource to resolve issues within the Medicaid Managed Care delivery system
 - *Does not impede a beneficiary's right to file a grievance with a PHP, contractor or the state*
- Refer beneficiaries to external entities that assist Medicaid beneficiaries regardless of delivery system (e.g., PHPs, enrollment broker, local DSS agencies and other community-based organizations)
- Monitor trends related to access to care to support DHHS oversight of the Medicaid managed care program

PHP Member Services

PHPs must maintain a member services department; providers can also refer patients to their PHP's member services department to resolve issues

Member Services' Responsibilities:

- Assist members in selecting or changing PCP/AMH
- Educate and assist beneficiaries with obtaining services under Medicaid managed care, including out-of-network services
- Field and respond to beneficiaries questions and complaints
- Advise and assist beneficiaries with navigating the appeals, grievance and state fair hearing process
- Maintain:
 - Member facing service line
 - Website
 - Handbook

***Grievances, Appeals, and Other
Consumer Protections***

Appeals and Grievances

Beneficiaries will have rights to file grievances and appeals against their PHPs and must exhaust the internal appeals process before using the state fair hearing process

Grievances

- Beneficiaries will be able to file a grievance, or complaint, at any time, orally or in writing with their PHP
- PHPs must generally resolve the grievance within **30 calendar** days of receipt and within **5 days** if it relates to the denial of an expedited appeal request
- State will monitor grievances for trends

Appeals

- Beneficiaries must be able to appeal an adverse benefit determination with their PHP by phone, writing or in person within 60 days of notification
- PHPs must resolve appeals within **30 days** for standard requests and **72 hours** for expedited requests where a standard appeal could jeopardize the beneficiary's life, physical or mental health or ability to maintain or regain maximum function
- PHPs must continue to pay for benefits during the appeal under specified circumstances

Clinical policies webinar on 6/13 will cover appeals in more detail

Other Consumer Protections

DHHS has set certain marketing rules with which PHPs must comply to avoid unfairly steering beneficiaries to their plans; providers should be aware of these rules



PHPs may:

- Display marketing materials at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries
- Participate in community based events or activities
- Sponsor outreach activities and events
- Conduct media campaigns

DHHS will monitor all marketing activities for compliance; providers that have questions about a PHP's marketing activities can refer that question to DHHS



PHPs may not:

- Engage in door-to-door, telephone, email, texting or other cold-call marketing activities
- Misrepresent covered or available services, enrollment benefits, availability or skills of network providers
- Offer gifts or incentives to enroll except as allowed in the contract
- Display or conduct marketing activities in health care settings, except in common areas

Providers may display PHP marketing material in common areas and other approved places

Promoting Healthy Opportunities

Addressing Beneficiaries' Unmet Resource Needs

Providers that identify a patient with an unmet resource need can refer that patient to their PHP or AMH provider for help with non-medical services

- DHHS is committed to providing a well-coordinated system of care that addresses the medical and non-medical drivers of health—often referred to as the “social determinants of health.” DHHS has identified four priority domains: **Housing, Food, Transportation and Interpersonal Violence/Toxic Stress.**
- PHPs will be responsible for addressing non-medical and social factors that impact beneficiaries' health by:
 - Assessing for unmet resource needs as part of the Care Needs Screening
 - Have a housing specialist on staff
- PHPs must contract with local care management entities (e.g., Tier 3 AMHs and Local Health Departments) to:
 - Connect beneficiaries to needed social resources using NCCARE360, a statewide coordinated network and referral platform
 - Provide additional support for high-need cases, such as assisting with filling out a SNAP application or connecting the beneficiary to medical-legal partnership

Healthy Opportunities Pilots

Beneficiaries in select regions will have access to additional benefits aimed at addressing their social needs

- North Carolina received approval from CMS to implement “**Healthy Opportunities Pilots**”
- The Pilots will test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence (IPV) and toxic stress
- Pilot services include:
 - **Housing:** Tenancy support and sustaining services, securing housing payments, short-term post hospitalization services
 - **Food:** Food support and meal delivery services
 - **Transportation:** Non-emergency health-related transportation
 - **IPV/Toxic Stress:** Child-parent support and IPV and parenting support resources
- PHPs will play a central role in managing the Pilots—including by helping to identify eligible members, identifying which Pilot services they need and paying for the services

Additional details to be released later in 2019

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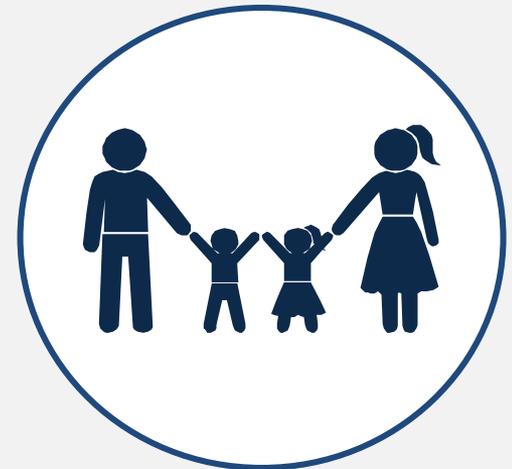
More Opportunities for Engagement

DHHS values input and feedback and is making sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website:
<https://www.ncdhhs.gov/assistance/medicaid-transformation>
- Comments, questions, and feedback are all very welcome at
Medicaid.Transformation@dhhs.nc.gov

Providers will receive education and support during and after the transition to managed care.



Upcoming Events

Upcoming Managed Care Webinar Topics

- **Behavioral Health Services: Standard Plans and Transition Period (5/23)**
- **AMH Contracting with PHPs (5/30)**
- **Clinical Policies (6/13)**
- **Healthy Opportunities in Medicaid Managed Care (6/27)**

Other Upcoming Events

- **Virtual Office Hours (VOH):** Running bi-weekly, as of April 26th
- **Provider/PHP Meet and Greets:** Regularly hosted around the State

Schedule for VOH and Meet & Greets available on the [Provider Transition to Managed Care Website](#)

Look out for more information on upcoming events and webinars distributed regularly through special provider bulletins

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Q&A

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Plan Selection and Auto-Assignment

DHHS will auto-assign those that do not choose a plan according to a transparent process

Plan Auto-Assignment

The State will auto-assign all beneficiaries who do not select a plan according to the following algorithm:

- 
- Beneficiary's geographic location
 - Beneficiary's membership in a special population (e.g., member of federally recognized tribes or BH I/DD Tailored Plan eligible)
 - PCP/AMH selection upon application and PCP/AMH historic relationship
 - Plan assignments for other family members
 - Previous PHP enrollment during previous 12 months (for those who have "churned" on/off Medicaid managed care)
 - Equitable plan distribution with enrollment subject to:
 - PHP enrollment ceilings and floors, per PHP, to be used as guides
 - Increases in a PHP's base formula based on their contributions to health-related resources
 - Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment