

Fact Sheet

Introduction to Medicaid Transformation: Part 1 – Overview

What is Medicaid Transformation?

Medicaid Transformation is changing the way most people receive Medicaid services. In 2015, the NC General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services (DHHS) to transition Medicaid and NC Health Choice from fee-for-service to Managed Care.

Under the fee-for-service model, DHHS reimbursed physicians and health care providers based on the number of services provided or the number of procedures ordered. This model will now be known as **NC Medicaid Direct**. Only a small number of people will stay in Medicaid Direct.

Under Managed Care, the State is contracting with insurance companies, called Health Plans. These insurance companies will be paid a capitated rate, which is a pre-determined set rate per person to provide health care services. This model is known as **NC Medicaid Managed Care**. Approximately 1.6 million of the current 2.3 million Medicaid beneficiaries will transition to NC Medicaid Managed Care.

In addition, DHHS is contracting with the Cherokee Indian Hospital Authority (CIHA) to support the Eastern Band of Cherokee Indians (EBCI) in addressing the health needs of American Indian/Alaskan Native Medicaid beneficiaries. This new delivery system, the **EBCI Tribal Option**, will manage the health care for North Carolina's approximate 4,000 Tribal Medicaid beneficiaries primarily in Cherokee, Graham, Haywood, Jackson and Swain counties.

CHANGES FOR MEDICAID BENEFICIARIES

NC Medicaid Managed Care will bring changes for most Medicaid beneficiaries.

- Medicaid services will be administered and reimbursed by Health Plans.
- Beneficiaries will be able to choose a Health Plan and primary care provider (PCP). The Enrollment Broker will be available to help beneficiaries make a choice.

- Medicaid services will not change, but Health Plans (including the EBCI Tribal Option) may offer enhanced services to plan members.
- Medicaid eligibility rules **will not** change because of Medicaid Transformation.

Local Departments of Social Services (DSS) will have materials to share with beneficiaries about the changes. Current beneficiaries will receive information by mail that outlines actions to be taken, when to take those actions, and who they can contact for assistance.

KEY TERMS YOU SHOULD KNOW

ELIGIBILITY refers to whether a person qualifies for Medicaid or NC Health Choice.

BENEFICIARY ENROLLMENT is the process of joining a Health Plan that is responsible for that person’s Medicaid health coverage.

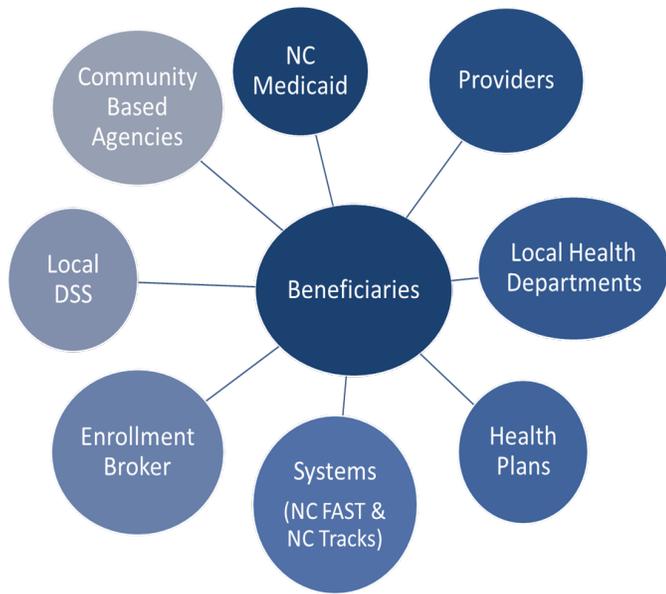
BENEFICIARY refers to a person who is eligible for Medicaid or NC Health Choice. Once a beneficiary enrolls in a Health Plan, he or she becomes a **MEMBER** of that Health Plan.

Within Medicaid Managed Care, there are **STANDARD PLANS** (members will benefit from integrated physical and behavioral health services) and **TAILORED PLANS** (specialized plans that offer integrated services for members with significant behavioral health needs and intellectual/developmental disabilities). Tailored Plans are expected to launch July 1, 2022.

EBCI TRIBAL OPTION is the Health Plan that will be available to federally-recognized tribal members and others eligible for Indian Health Services (IHS).

NC Medicaid determines the populations in Managed Care who will enroll in a Health Plan.

KEY PARTNERS AND THEIR ROLES



Beneficiaries are at the center of the transition to managed care. Partners need to work together to support beneficiaries during and after the transition to Managed Care.

MUST ENROLL	CANNOT ENROLL	MAY ENROLL
Required to enroll in a Health Plan.	Stays in NC Medicaid Direct.	May enroll in a Health Plan or stay in NC Medicaid Direct.
Most Family & Children’s Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled. (MANDATORY)	Family Planning Program, Medically Needy, Health insurance premium payment (HIPP), Program of all-inclusive care for the elderly (PACE), Refugee Medicaid (EXCLUDED*)	Federally recognized tribal members, beneficiaries who would be eligible for behavioral health tailored plans (until they become available)** (EXEMPT)

*Some beneficiaries are temporarily excluded and become Mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, & Community Alternatives Program for Children (CAP-C).
 **Target launch date for Tailored Plans is July 1, 2022.

- **NC Medicaid:** Provides NC Medicaid Direct supervision and oversight of Health Plans and other partners.
- **Providers:** Contract with Health Plans; must continue to enroll as a Medicaid and/or NC Health Choice provider.
- **Local DSS:** determine Medicaid eligibility, update beneficiary information, and Medicaid case management.
- **NC FAST & NCTracks:** Systems used to transmit beneficiary and provider information, NC FAST remains the system of record for beneficiary information; NCTracks remains the system of record for provider information.
- **Enrollment Broker:** Acts as an unbiased, third-party entity to provide enrollment assistance and help in choosing a Health Plan and PCP; provides outreach & education to beneficiaries.
- **Health Plans:** Provide health care and ensure related services are available to their members; inclusive of the EBCI Tribal Option.
- **Local Health Departments:** Provide services under NC Medicaid Direct and may contract with Health Plans for some services.
- **Community-based Agencies:** Disseminate information to help educate the public on changes to Medicaid and provide feedback to DHHS from clients they serve.

We will also partner with a **Member Ombudsman**, someone who is appointed to help resolve beneficiary complaints. More information will be forthcoming.

NC Medicaid has also created a **Provider Ombudsman** who is available to help resolve Health Plan complaints from providers. Inquiries may be submitted via the Medicaid.ProviderOmbudsman@dhhs.nc.gov email distribution listserv or the Medicaid Manage Care Provider Ombudsmen phone line at 919-527-6666.

WHAT DOES MEDICAID TRANSFORMATION MEAN FOR YOU?

Providers will be impacted by Medicaid Transformation. As with beneficiaries, many things will stay the same, but some things will change. This playbook is one tool to help you understand what is changing. DHHS offers and coordinates support to providers through direct listserv communications, web-based resources on the Medicaid website, webinars, FAQs and Virtual Office Hours. Training and hands-on technical assistance are also provided for targeted providers (e.g., Rural/Essential/Smaller Providers). DHHS is also collaborating with provider associations to share information, gather feedback, and provide needed support.

Under NC Medicaid Managed Care, providers will submit claims to the Health Plan with whom the beneficiary is enrolled. The Health Plan will then pay providers. Providers are encouraged to explore contracting options with each Health Plan. Provider office staff must know which Health Plans the provider has contracted with, share that information with beneficiaries, and encourage beneficiaries to respond to their enrollment notification to self-select a Health Plan and PCP.

Participating NC Medicaid and NC Health Choice providers should contact Health Plans directly regarding contracting options. Please see the [Health Plan Contact Information](#) for more information. Health Plans are required to contract with “any willing qualified provider,” unless the provider fails to meet the Department’s applicable Objective Quality Standards for participation as a Medicaid Enrolled provider; or when a provider refuses to accept network rates (which shall not be less than any applicable rate floors). There are specific requirements for Health Plans to include all essential providers (i.e., federally qualified health centers, local health departments, veteran’s homes and rural health centers) in their provider networks.

Providers should be aware of timelines associated with Medicaid Transformation and ensure that related information and communications (like these fact sheets) are shared with office staff. All who interact with beneficiaries should be aware of Medicaid Transformation and the changes it brings. Providers can contribute to the success of this transition by ensuring office staff participate in upcoming trainings. More information for providers transitioning to Medicaid Managed Care is available [online](#).

WHAT ADMINISTRATIVE CHANGES SHOULD YOU EXPECT?

NC Medicaid has worked to mitigate the administrative burden for providers.

Health Plans are also required to ease provider administrative burden by:

- Standardizing and simplifying processes across Health Plans whenever appropriate
- Using standard prior authorization forms
- Covering services due to “medical necessity,” setting fee-for-service benefit limits as a floor in managed care, and requiring coverage of the same services as NC Medicaid Direct

In addition, DHHS is:

- Utilizing a centralized, streamlined enrollment and credentialing process
- Ensuring transparent payments for Health Plans and fair contracting and payments for clinicians
- Standardizing quality measures across Health Plans
- Establishing a single statewide preferred drug list that all Health Plans are required to use

More information on key dates and milestones within Medicaid Transformation are provided in the **Introduction to Medicaid Transformation: Part 2 – Enrollment & Timelines** Fact Sheet.

GOALS FOR DAY 1 OF MANAGED CARE

DHHS’s highest priority is the health and well-being of the people it serves. DHHS is committed to improving the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health.

From the first day of NC Medicaid Managed Care, the main focus of DHHS is to ensure that:

- A member with a scheduled appointment will be seen by their provider.
- A member’s prescription will be filled by the pharmacist.
- Calls made to call centers are answered promptly.
- Members know their chosen or assigned Health Plan.
- Members have timely access to information and are directed to the right resource.
- Health Plans have sufficient networks to ensure member choice.
- A provider enrolled in Medicaid prior to the launch of NC Medicaid Managed Care will still be enrolled.
- A provider is paid for care delivered to members through evidence-based interventions designed to address non-medical factors that drive health outcomes and costs.

