North Carolina Medicaid Beneficiary Policies Webinar – Transcript

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MC Welcome everyone. Thank you for joining today's webinar. My name is Melissa Carlson. I'm a producer with Webex and I will be your organizer for today's webinar presentation on North Carolina Medicaid beneficiary policy. Today's presentation is the 5th in the series of nine provider education modules that are planned on Medicaid Transformation. Notification on additional provider education modules will be forthcoming and posted to the Medicaid Transformation website. We have a few housekeeping items before we get started. If you experience technical difficulties joining the Webex session, please dial 1-866-779-3239. Or your can message your Webex producer using the Q&A panel. During the presentation, all participants will remain in listen-only mode, and as a reminder, this event is being recorded. We will be holding a Q&A session at the conclusion of today's presentation. We encourage you to submit written questions at any time during the presentation using the Q&A panel at the bottom right of your screen. Please type your question into the text field and hit "send". Please remember to keep that dropdown as all ____. With that, we invite you to sit back, relax, and enjoy today's presentation.

I would now like to introduce your moderator for today, Mandy Ferguson, Consultant at Manatt Health. Mandy, you now have the floor.

MF Today's Beneficiary Policies Webinar is intended to help providers understand managed care requirements, expectations and implication specific to beneficiary eligibility, enrollment supports and protections. We have several team members from the Division of Health Benefits that will be on hand to present today's webinar and help answer questions that we receive today. These team members include Caroline McClanahan, the Associate Director of Eligibility Services, Lynne Testa, a Senior Program Analyst, and Lavette Young, the Associate Director of Appeals.

I would now like to introduce Lynne Testa, Senior Program Analyst at North Carolina Medicaid, who will provide the content overview for the presentation and briefly cover North Carolina's transformation to Medicaid Managed care. Lynne?

LT Thank you Mandy. And thanks to all of your for joining us today to better understand key beneficiary policies in Medicaid Managed Care. Next slide.

We will begin by the North Carolina Medicaid Managed Care Transformation Vision, followed by a deeper dive into the key beneficiary policies, and will end by discussing more opportunities for provider engagement in answering your questions. This is a vision for the Medicaid Managed Care that we as an organization continue to reiterate during our stakeholder event. We do this so that we will all remain focused on the vision for North Carolina Medicaid, which is to be innovative and whole person centered by integrating both

physical and behavioral health needs of the members as we transition into a well-coordinated system of care that addresses both medical and non-medical drivers of health. Next slide please.

So how did we get here and why are we making this change? In 2015 the General Assembly enacted a law that directed the transition of Medicaid in North Carolina health choice beneficiaries from a predominantly fee for service system to a managed care system. Since that time, we have been collaborating with _____, hospitals, beneficiaries, counties, other health plans, elected officials, advocates, and many other stakeholders, to help shape the program. The department is committed to ensuring that managed care plans deliver whole person care, that they address the full set of factors that impact health, that they perform local care management services and that plans maintain broad provider participation in the program by helping to mitigate provider administrative burden. Next slide please.

In February of this year, the Department awarded contracts to five pre-paid health plans. In alphabetical order, the 4 statewide plans are AmeriHealth Caritas of North Carolina, Blue Cross – Blue Shield of North Carolina, United Healthcare of North Carolina, and WellCare of North Carolina. A fifth _____ state health plan, Carolina Complete Health, is a regional provider-led entity operating in regions 3 and 5.

Coming in the next couple of months, the first beneficiary open enrollment period will begin as Maximus starts sending welcome packets to beneficiaries enrolling in managed care, effective November 1, 2019. Maximus is the enrollment program contracted by North Carolina Medicaid to ensure that Medicaid and NC health choice beneficiaries understand the benefits of managed care and receive choice counseling to select a prepaid health plan. By later this summer, the PHPs will be working to finalize contracts with providers so they can build their provider network to meet the network adequacy standards established by North Carolina Medicaid. You may have already been contacted by one or more of the health plans. But if you have not been contacted and you are interested in joining their network, you may proactively reach out to the health plan using the health plan's contact information sheet that is available on the North Carolina Medicaid provider webpage.

November will be a historic day for North Carolina Medicaid. Managed care will launch in regions 2 and 4. These regions span across the northern part of the state from Watauga County in the west to Nash and Wilson County in the east. Also in November the open enrollment period will begin for beneficiaries in the remaining managed care regions which span from Cherokee County at the far western tip of our state all the way along the southern border and up the coast of North Carolina. Managed care for these regions will launch in February of 2020. A map of the managed care regions is available on the North Carolina Medicaid Transformation website.

At this time I would like to introduce Caroline McClanahan, the Associate Director for Eligibility Services to cover the beneficiary enrollment process and beneficiary support.

CM Thank you, Lynne. Member Operations, which is the project team that has been responsible for implementing Medicaid Managed Care Transformation for our beneficiaries, and that also includes the County's Department of Social Services, have been working together for quite some time as ours __ was kinda the first out of the box as far as the actual steps toward

transformation. So, I'd like to go to the next slide.

We'll talk about several things, including the TPP selections. So beneficiaries are eligible for Managed Care. Next slide.

Includes most of our Medicaid beneficiaries and especially those who are in the family and children's Medicaid program, so those are the children under 21, caretakers of children, pregnant women, children on MC health choice for children. Those are the main individuals on family Medicaid. They will transition to _____ standard plans effective November 2019 in those regions that Lynne mentioned earlier, regions 2 and 4. Other Medicaid beneficiaries may be transitioning at a later date or may remain in fee for service. One of the other groups will be transitioning early will be non-Medicare adult Medicaid beneficiaries. So if there is a person who is disabled and not yet on Medicare, then they would also be part of managed care effective November 1st in those regions 2 and 4.

We will continue through the counties to determine Medicaid eligibility and North Carolina health choice eligibility as we always have. There is no change in that. They will just be involved very intensely because a lot of beneficiaries contact their county whenever anything happens, whenever they have questions, and when they get mail.

We'll talk a little bit about, here, you can see a bullet that says that you can still reveal your patient population in NC tracks, there will be no change in that. Providers can go into NC tracks to see the status of your, of the beneficiaries, whether they're enrolled in a plan, which plan, and all those kinds of things. Next slide.

So this is a little bit more in depth about who will be part of managed care, and especially who will not. So the excluded populations are those individuals who will not be going to managed care. And that includes individuals who are medically needy because they are subject to a spin down every six months. So they come on and off Medicaid. Beneficiaries who have limited benefits. So one of the main ones of those is our family planning Medicaid program. If they are only on family planning they will not be going to managed care because they get very limited benefits. Individuals who are on our waiver program are excluded. And then, Pace [?] individuals are excluded because they are already part of a managed care program. The ones who are delayed over on the right, Qualifying beneficiaries who have serious mental illness, emotional disturbance, severe substance abuse disorder, IDD and then traumatic brain injury individuals, will be moving at a later time. They will be exempt individuals, though, so even though they are delayed they are exempt and could choose to participate in a standard plan.

Temporarily excluded individuals include those who are in long-term care, for up to five years. So once they reach a certain point of 90 days being in a long-term care facility, they will move into excluded status. And those individuals who are due-eligible [?] then receive Medicare also.

Our exempt population ongoing are members of federally recognized tribes. Under federal regulations they are exempt from managed care, which means they get to choose to stay in Medicaid direct, or they can move to a plan, and change plans at any time. So the federally recognized tribe that we have in North Carolina is the Cherokee who are out on the ___ boundary within five counties in western North Carolina. However if I am in North Carolina and a member of any federally recognized tribe, we do capture that in our system and they are

also exempt. But it's not limited to the Cherokee.

I do want to point out that temporarily excluded also includes foster care and adoption. Children who are ___ saving that type of Medicaid, or in that type of care, until a tailored plan or a specialized foster care plan is implemented along with tailored plan. Next slide please.

So this is an overview of the enrollment process, and the open enrollment and the important dates that we need to keep in mind. Toward the end of June, around June 28th and shortly thereafter, enrollment packets will start going out to individuals who are in regions 2 and 4. And is they have a mandatory status, which means they're required to enroll. Or, they are exempt. They will get a packet. That means this is a point in time where we will start getting a lot of traffic at a lot of different levels. Including the DSS's, BHP. You may be hearing from individuals who are getting these packets as well. That enrollment will continue until mid-September, is our open enrollment period. If individuals who are required to enroll have not done so by September 13th, then we will auto-assign those individuals to a plan, and they will get their packets after that.

At the same time, or very close in overlap, are phase two open enrollment, which is regions 1, 3, 5 and 6 will begin in September. So the packets will be mailed out in September and open enrollment goes through the middle of December. Next slide.

So how will they be selecting a plan? They are going to get notification letters when those first packets are mailed out, they're called transition letters that lets the individuals know that we are moving to managed care in North Carolina, which of their family members are required to enroll, which ones have the option to enroll, and how to select a plan, and how to contact the individual who can help them do that.

Beneficiaries have 60 days, and they actually during the open enrollment period and moving into transition phase 1 and 2, they actually have longer, because they have, from the point that received their packet through the end of open enrollment. So actually, some of them will have up to 90 days or more to select a plan before open enrollment ends.

We do have an enrollment program, we're going to talk about that a little bit more in a couple of slides. Who will be responsible for enrolling beneficiaries, providing them the information that they need in order to make a decision that is best for them. And they will be able to enroll or get this consultation by phone, online, paper, in person, and they also have a mobile app that will be available for our beneficiaries if they like to use those kinds of electronic devices. Beneficiaries who don't select a plan by September 13th in the first phase or by December 13th in the second phase will be auto-assigned to a plan. And there is an algorithm that is in place to try to get down to the best plan to enroll these individuals. They will have 90 days after they are enrolled, or the effective date of their enrollment, to change the plan. And that is an ongoing process. When someone is approved for Medicaid, they will be assigned to a plan, and they have 90 days to change plans. After that point, they must have good cause or with-cause reason, unless they are exempt. Because exempt individuals will be able to change plans at any time. Next slide please.

So we've talked a little bit about enrolling in a plan. And now we're talking about PCP selection. Next slide.

So under managed care beneficiaries can still choose a primary care provider or advanced medical home. The enrollment broker will be giving information to beneficiaries about selecting their AMH or PCP while they are enrolling in a plan. And they will have all the provider directories from the different plans, as well as the directory for those who are still _____. As part of the enrollment, an individual will have the opportunity to choose a PCP, a plan, or both. If they are required to enroll in a managed care and they choose a provider, then we will use that provider as part of our algorithm in auto-assigning a plan that they did not select. And the enrollment broker will try to get individuals to select both a plan and a provider.

If the individual does not select a provider, it won't be auto-assigned by the enrollment broker. They will only assign the plan or enroll the person in a plan that they've selected, and then it will be up to plans to insure that they assign a best medical home or PCP as part of their responsibilities when they get the enrollment.

Now beneficiaries will be contacting their plan to change a provider. So the enrollment broker is the entity or the organization that will be enrolling or changing individuals then to help plan, but if someone is in a plan and you change their provider they will be doing that through the plan. So they have 30 days of their selection or notification of the assignment to their PCP or AMH to change that with the plan. And, again, they will have with cause reasons as well so the beneficiaries may change at other times. If not, if they're lock into the 30 days, then they will get another opportunity to change their provider at 12 months.

Next slide please.

So the auto-assignment will be done, again, by the PHP. If an individual does not select a provider when they enroll in a plan with the enrollment broker, again, the enrollment broker will not auto-assign them to a provider. That is the responsibility of the health plan. So, they also will have an algorithm much like we will use to auto-assign individuals to plans, and some of the things that they will consider are their claims to treat. Because all plans will be getting claims history for their enrollees.

Family Members. So if there are other family members they are assigned to a certain provider they may assign that individual. Geography is always a consideration so that their provider or their PCP or AMH is close to their home. If there are any special medical needs that need to be considered when the plan is assigning them, they will do that. And, of course, language and cultural preference will also be a consideration when individuals express a preference.

So these are the only items that a plan can take into consideration at this time to auto-assign a provider, and there is a note here that we may add additional items in the future. But these are the ones that are to use now to auto-assign a provider if an individual has not selected one.

Next slide.

Ok. During this process, I think you all are well aware it's going to be very important that the beneficiary has support so that they can address or go to in order to get through this process. It's going to be very confusing for a lot of our beneficiaries. They have had to select providers in the past who are _____, but now they also have to select a plan. And that's going to be new to the vast majority of our beneficiaries, and we're going to need to help them with

that process.

Next slide please.

So, we have engaged, as it was said earlier, in an enrollment broker, and Maximus is the enrollment broker. And they have a lot of responsibility in this area of counseling individuals, helping ensure that they have the right information they need to understand what managed care is and to make a choice. The enrollment broker provides choice counseling, and that is all those explanations about what plans offer. Looking at their providers that they prefer to see if they're enrolled, if they contracted with specific plans and doing the enrollment assistance and education. So, one of the big things that will be happening shortly is outreach and education efforts. So we are working with the enrollment broker now in scheduling events across Regions 2 and 4 to happen between now and at least the end of open enrollment. It will be ongoing, but we do need to focus on what will be happening through this time, and they are in the process of developing educational materials – the State is approving those. Hosting outreach events – they will be partnering in a lot of those with the PHPs, who also are required to do some outreach and education as well. So the main thing that the enrollment broker will be doing is this enrollment assistance and choice counseling to support beneficiaries in selecting the plan that is right for them and award the provider who best meets their needs. So the enrollment broker has a big responsibility in another area and that is to consolidate the provider directory that includes all of the plans and the providers that are enrolled with the plans as well as those providers to do fee-for-service. So when an individual is looking at a provider, they will be able to tell the plans that they participate in and that will help them in making their choice of plans. They also have a plan comparison chart that will be provided to individuals. It will be on their websites. And that chart, which shows all of the plans side-by-side, one of the main components of that chart will be any of the enhanced _____ [during lieu of services?] that a plan provides, in additional to the Medicaid services that are under the State plan that all plans are required to provide. That comparison chart will be important for an individual to see what the different plans may offer in addition to the standard Medicaid benefit. They will actually process enrollment and disenrollment and transmit it to the State through a connection to _____, which is our eligibility system. As part to their choice counseling they will also, of course, maintain a call center to help individuals with any enrollment questions. And, again, they also have a website, mobile app, chat feature, that provide a broad range of methods for beneficiaries to get the kind of help they need. Some individuals like going online and not having to talk to someone, and they will have that opportunity to do it, but they do have a call center that will assist those individuals who need to talk through something with the enrollment specialist that the enrollment broker has.

Next slide.

The ombudsman. We will have an ombudsman. We do not have one on board at this time, but an ombudsman will be a contact for beneficiaries and to help them through issues to help make sure they get directed to the right place to help resolve their issues. They're a resource for individuals so they will have a lot of information. They have to make sure that an individual can file a grievance if necessary. They refer a lot of beneficiaries. They will be referring beneficiaries to other entities that can assist them, and that will be an important thing for all of us who are involved in transformation. One of our main things that we'll need to concentrate

on is everything needs to understand who does what and so that we can get individuals to the right place. So, regardless of this delivery system, whether this person is managed care or whether they stay in ourf fee-for-service program, which will be called in See Medicaid Direct, I don't know if you've all seen that yet, the ombudsman is there to help. They will also assist the State by monitoring trends. What are they saying, what kind of complaints are they getting, are their complaints related to a specific plan or specific provider or whatever. So that will help us to address any issues at the State level and make that this process is as seamless as possible for our beneficiaries.

Next slide please.

All of the PHPs are required to have member service inspections. They have to have that and refer their patients to those members services to resolve issues. So one of the responsibilities, of course, was assisting members in selecting or changing their provider or AMH, as they are allowed to do so, and again it was always said that that was the responsibility of the plans and not the enrollment broker. They must educate the beneficiaries with the payment of services that they need and how to get out of network services and when that's appropriate. They must respond to questions and complaints. It's a very important part of the process. Navigating a field grievance and State fair hearing process. One of the important things they have to do is maintain a member services line. In addition they have to have a nurse line and a line for urgent behavioral health issues. The numbers for those must be on the member card, the Medicaid card, and we are reviewing those items now to make sure that they have the required information from the RFP. The handbook likewise has to have that information as well, and they will get their Medicaid health plan card and handbook in the mail when they are enrolled with the PHP.

Next slide please.

So grievances and appeals.

Next slide.

They will, the beneficiaries of course, have the right to appeal or to file grievances against the PHP if they do not agree with decisions that were made. One of the most important things is they do have to exhaust the internal appeals process before going on to the State fair hearing process. Still under grievances, that have to be able to file it at any time. They can do it orally, so that would be by phone or at a provider or at the plan, or in writing with the PHP. They should resolve most issues within 30 calendar days. There is a five day requirement if it happens to be an expedited appeal for a denial. And we will be monitoring the appeals and grievance process for trends to make sure that things are going smoothly and that the plans are meeting these requirements as set out in the contract. For appeals, this would be an appeal of a denial of a service or a benefit determination. They can do it by phone or in writing or in person within 60 days of notification that that service or benefit has been denied. They must resolve these appeals, again, within 30 days for standard requests and 72 hours if it happens to be an expedited request for appeal because that denial could affect the beneficiary's life, physical or mental health or ability to maintain or regain their function. So it has to be something that is really necessary within a short time. And the PHP must resolve that within 72 hours. One of the critical things is they must continue to pay for benefits during the

appeal under certain circumstances. And if you see then at the bottom the clinical policy, webinars and schedules for June 13th will cover appeals in a little more depth.

Next slide.

So protections. The SS is set in certain policies and procedures in place for which PHPs have to comply to avoid unfairly steering beneficiaries to their plans. So, we realized they are in competition and they can do marketing, but there are certain things that are allowed and certain things that are not. So, PHPs may display marketing materials, community centers, market providers, hospitals, schools, health fairs and public libraries. And as I said earlier, they will also be doing outreach events, so these kind of things may be out where you see them. We will be monitoring the marketing activities of these PHPs. We'll probably get some calls and those kind of things where people reporting something that they say may not be allowed. And so, we will be monitoring that.

What they cannot do is individual, door to door, telephone, email, texting or other marketing activities directly to individuals of cold marketing. They cannot misrepresent what they are allowed to cover and are covering enrollment benefits and what they have in their network. They cannot offer gifts or incentives to enroll, except as allowed in their contract. And I mentioned earlier that PHPs may offer enhanced services or in lieu of services. Those must be approved by the state and we are reviewing those now. So, those can be listed in their marketing materials. But they can't offer gifts for someone to enroll in their plan directly. They cannot conduct marketing activities in healthcare settings except in those common areas where they may be able to have things that display in the lobby of a hospital or whatever.

Next slide.

LT Mandy, we will now transition over to you to discuss promotion of healthy opportunities.

MF Great, thank you so much Lynn and Caroline. That was really a helpful overview. So, to talk a little bit about healthy opportunities, North Carolina is deeply committed to delivering a whole person care that goes beyond the four walls of the hospital to address the medical and non-medical drivers of health. So, promoting healthy opportunities, which is commonly referred to as addressing the social determinant of health is a core focus of North Carolina's Medicaid transformation.

The state has set forth four priority domains for addressing the social needs of beneficiaries in housing, transportation, food and interpersonal violence and toxic stress. So, PHPs and providers will work hand in hand and in close collaboration with one another to address the social factors that impact their beneficiaries health the most in those four core priority domains.

PHPs will be held accountable for doing the following and they will rely heavily on providers to help them with this. But it's to help them assess folks for unmet resource needs as part of the initial care needs screening. So, really identifying beneficiaries that have high resource needs in housing, food, transportation or interpersonal violence. And also to have a housing specialist on staff.

PHPs must also contract with local care management and to _____ tier 3 AMHs and local

health departments to connect beneficiaries to needed social resources using NC Care 360, which is a statewide coordinated network and referral platform. They also need to provide support for high needs cases such as assisting with filling out a SNAP application or connecting a beneficiary to medical legal partnerships. So as you can see, some of these requirements go above and beyond traditional medical care to really looking at the person as a whole and addressing their needs that are outside of the traditional healthcare delivery system.

In October, 2018, the federal centers for Medicare and Medicaid services approved an 1115 waiver from North Carolina for a five-year demonstration period. In addition to several other provisions, the waiver provides North Carolina DHHS important flexibility to implement a groundbreaking pilot program known as the healthy opportunities pilots in select regions of the state to cover evidence based non-medical interventions that are designed to improve health outcomes and lower costs.

The pilot services are going to be offered across the four domains that I just discussed to address housing instability, transportation insecurity, food insecurity and folks interpersonal violence and toxic stress. Pilot services are especially exciting because they go above and beyond what has traditionally been covered under the Medicaid program. So, for example, for someone who's identified to need housing services, they might be able to receive tenancy support and sustaining services. They might be able to receive help securing housing payments, or they might be able to receive payments to be housed for a short period of time after being hospitalized. And just to say again, this pilot program will be operating in just a couple regions of the state and will be for a select subset of beneficiaries that meet qualifying social and physical and behavioral risk factors. So, this will not be for everyone in the Medicaid program, but rather for a subset of beneficiaries.

So, PHPs will play a central role in managing the pilots, including by helping to identify _____ members, identifying which pilot services those members need and paying for those services. And the state is planning to release additional details on the program later in 2019 and in early 2020. We will also be hosting a webinar on the topic towards the end of June.

So now I'm going to turn it over to Lynn Testa to talk a little bit more about opportunities for provider engagement.

LT Thanks Mandy. Just so everyone knows, the department remains committed to ensuring that providers receive education and support during and beyond the transition to Medicaid managed care. We will look now at opportunities for further provider engagement. Next slide please.

Providers should know that we value their input and feedback and are making every effort to provide opportunities to connect through a multitude of activities. We are in the midst of a series of topic based webinars that offer education to providers on key topics to effectively serve Medicaid and NC health choice beneficiaries through the transition to managed care, and also offer fact sheets and FAQs to assist in the understanding of Medicaid changes.

The North Carolina Medicaid website serves as a central hub for providers to access resources about the transition to managed care. In addition to the Medicaid transformation link provided on this slide, the main Medicaid webpage www.medicaid.ncdhhs.gov offers links to additional engagement opportunities. From the main Medicaid webpage choose providers,

then providers transitioning to Medicaid managed care.

In addition to the presentations and recordings for this series of webinar training courses, there is information for PHP meet and greets currently being held across the state. PHP meet and greets are for providers and practice staff. The opportunity to meet with health plan representatives to ask questions about joining their provider networks. The department is also hosting virtual office hours, which is an opportunity for providers to ask questions regarding the transition to Medicaid managed care in a real time format. Please review these websites frequently to stay abreast of new information and opportunities for engagement. And because we value your feedback, we encourage you to continue submitting questions or concerns to the Medicaid transformation email address provided on this slide. Next slide please.

Here is a snapshot of the upcoming provider education opportunities. Five additional webinars are scheduled in the coming weeks that will cover topics on AMH contracting with PHPs, behavioral health services and the standard plans and during the transition period, clinical policies and healthy opportunities in Medicaid managed care. In addition, there is a link to the PHP meet and greets and virtual office hours scheduled on the right side of this slide. Providers are encouraged to visit the Medicaid websites often and to look for upcoming events and webinars advertised through special bulletins and NC track providers announcements.

Thank you for joining us today for the NC Medicaid managed care webinar on beneficiary policies in managed care. I will now transition to Mandy Ferguson for questions and answers.

MC Great, thanks Lynn and we've been getting a lot of really great, robust and tricky and exciting questions while we've been talking here. So excited to try to get through some here. Just to say that if we don't get to your question today, we will be putting together an FAQ document that will try to answer everyone's questions.

So before I start reaching out to folks to give answers to some of these good questions, I just wanna remind everyone that as Lynn said the slides will be available under the provider tab on the Medicaid website. So, you have to go to provider's transitioning to managed care, and then to the training courses. And we plan to post the slides from this presentation and all of the presentations that we do maybe a week or so after they occur. So take a look there on the website if you want to see the slides again, or if you want to listen to the recording again or send it to any of your colleagues.

So the first question that we had come up, I'm gonna kick it over to Caroline. And that's, how will I know which PHP a member is assigned to? Or, if that member is still in Fee for Service.

CM: Thank you Mandy. The . . . as I stated earlier, providers will still go into NCTracks to verify eligibility for individuals who are on Medicaid, to know whether or not those services will be covered. There will be information in there as you enquire once we're in managed care that shows whether or not they're enrolled with a plan, and which plan it is. Or whether they are still in NC Medicaid Direct, which is our Fee for Service program. So that information will be in NCTracks, and you will access it just like you do today. One of the most important things is, the plans will be issuing Medicaid cards to their individuals that will have their plan logo and information that's required to be on the card from the RSP. But one of the things that we did require is that they use the Medicaid ID number as the Member Number on their Medicaid card. So that regardless of what card they may present to you when they come to your office,

or if they provide you that Medicaid ID number, you will still be able to determine which plan they're with if they're enrolled in managed care or if that they are Medicaid Direct.

MF Great. Thanks Caroline. And I think the next question that we have, we've actually got two on grievances and appeals. So Livette, I'm going to turn over to you. The first is, can you give us an example, between a grievance and appeal, and which, what kind of falls in one bucket, versus what falls in another? What exactly is the difference?

LY Can you hear me? Thank you for the question. Can you hear me?

MF Yes. Yes we can. Thank you.

LY Well the difference between grievance and appeal? I'm sorry. Make sure I'm answering the correct question.

MF Between a grievance and an appeal.

LY OK. So, a grievance is any expression of dissatisfaction. It could be with the PHP, with the provider, with the ___ person. It could be anything that's other than a complaint about or a grievance about, like an adverse determination. For a service or ____ or whatever. So that's the key difference. One is – a grievance is more broad, cause it doesn't cover an adverse action or adverse benefit determination.

MF Great. Thank you so much. And also in the grievances and appeals kind of bucket of questions, we had one that says, "If a grievance is related to pharmacy coverage issues, is that going to be a 30-day resolution time as well?

LY As far as I know, I will double check on that, because I know there was some back and forth about pharmacy. But as far as I know, it should be treated the same as any other grievance. But if I find out __ I will report back.

MF Perfect. Thank you so much. And Caroline, I've got a couple other for you. The first is related to PCP selection. And it's, "What can I do if my patient is auto-assigned to another PCP?"

CM So, again, auto-assignment would be done by the plan. So if you have someone who has been auto-assigned a provider, and they wish to have you as their PCP, they would need to contact the plan to make that change in providers.

MF Got it. Thank you. And the second one is related to beneficiary supports. And it's, "How can I best assist patients that are having trouble with the transition to Medicaid managed care?"

CM I mentioned earlier that there are lot of beneficiary supports – that will be out there for their individuals who are transitioning. And it will be a difficult, or confusing time for a lot of our beneficiaries. Some will handle it better than others. So it depends on what they're having trouble with. And we be providing you, if you don't have already, along with everyone else that, all the other entities involved, DSS's, providers, the plans, the enrollment broker. And our contacts that are at Medicaid. Who do we get this person to as quickly as possible that can help them with their issue? And that's gonna be of the most important customer services that

we can provide to an individual.

So it will depend on what their issue is. If it is about enrolling, then that would be the enrollment broker, selecting or changing a plan. If it happens to be about services that they need, or something, questions about their services with the plan, then their member services line at the plan should be able to help them. If it is an issue about, that could be a complaint, maybe about a plan or something, they do have to contact the plan, or remember there will be the ombudsman as well. So if they're having some difficult issues that they can't get resolved at one of the contacts in the omsbudman will also be a resource to refer individuals to, if they are having difficulties.

We also wanna make sure that *you* have the information *you* need in order to help someone. So, as I said earlier, a lot of individuals would contact the DSS regardless of what a letter tells them to do. They may give them a number, but they go to the DSS because that's who they're familiar with. They just think they can help with any questions and I understand, the same thing happens with providers that a lot of these beneficiaries will bring things to you as a provider and ask you to help them understand what it means. So, we wanna make sure that you have the information. But some of the most important will be who do I get this person to as quickly as possible to help them with their issue?

MF Great, thanks Carolyn. Mandy? Yes, please.

LY I'm sorry, this is Livette, I apologize. I think I might have not articulated about a top _____ about the grievance, and I'm not sure that I articulated about what an appeal is, so I just wanted to clarify that if that's okay.

MF I would love – that would be great, thank you.

LY Great. So, I talked about what a _____, but an appeal would be that you can appeal an advert benefit determination. So, that would be an appeal. That's the issue that a member could appeal. So, I just wanted to clarify that because I think I've talked too much about grievance and didn't really clarify the appeals part of that question.

MF Thank you, that's great. Oh I've got a couple questions here related to healthy opportunities and addressing the social determinance of health, which I can take a stab at an answering, but would welcome others to jump in. The first is what should I do if I identify that my patient needs help applying for food assistance, so through SNAP or WIC? So really under managed care, PHP is either directly or through a contracted local care management entity that employs care managers such as a tier 3 advanced medical home provider or a local health department must help beneficiaries meet unmet non-medical needs. So, if there isn't a care manager in your practice, we'd recommend that you contact the PHP for help and having them kind of navigate the process. But at its core, we anticipate that PHPs and providers together will help beneficiaries navigate an application – filling out an application for SNAP, for example.

The other question that we received related to healthy opportunities is whether or not the regions for the healthy opportunities pilots have been selected. And at this time, they have not yet been selected and we're planning to competitively procure what we're calling the lead pilot entity, likely by the end of 2019 or early 2020. So, I would really encourage folks to look on the healthy opportunities section of the website for any information on timelines related to

that.

Let's see here, so I have a couple more questions that I think can be directed to Carolyn and then I think we'll be right at the top of the hour. So, Carolyn if you're up for it, I have got a couple more questions that I think you're in the best position to answer. The first of which is will providers be able to view all active enrollees and which plans they are enrolled in via NC tracks?

CM Okay, repeat that.

MF Yeah, it's will providers be able to view all active enrollees in which plan they're enrolled in via NC tracks?

CM Yes. You will verify that just like you do today, if you have a Medicaid ID or there are other ways that you can search for a beneficiary. You will be able to see them, their eligibility and if they are enrolled in a plan and which plan that would be.

MF Great, thank you. And can you tell us a little bit more about what happens for folks that are likely going to be tailored plan enrollees? Will they be receiving letters in June as well or what exactly is the process for those folks?

CM So, we do have a process for identifying through information we have today, individuals who appear to be potentially going to a tailored plan once they are implemented. So, we are identifying those individuals with a managed care status of temporarily exempt tailored plans. What that means is they are exempt. So, yes letters in June and then in September for the other phase of implementation. We'll be going out to anyone who is mandatory or exempt, and that includes those individuals who have been identified as tailored plans, potentially eligible in 2021. So, they will receive letters, yes.

MF Great. Okay, perfect. And then Lynn I think the last question I'm gonna send to you, but we can bat it around. And it's asking will Medicaid managed care plans be available in all regions and how do we know which plans are in our regions? And I can flip back up to the slide on the health plans if that's helpful.

LY Yeah, that would be great. So Mandy, yes, there will be health plans that are available in all regions of the state. As I mentioned in my opening remarks, we have awarded four contracts. If you go out to our website, we have a listing of who those health plans are that were awarded Medicaid managed care contracts. There are four statewide plans which I mentioned earlier, and there is also one regional PLE that will be operating in regions 3 and 5. So, all of that information is available on our website, and we do have contact information also available in case providers want to be proactive in reaching out to those health plans to become participating network providers.

CM So, anywhere in the state, a Medicaid beneficiary has the choice of at least four plans, the four statewide plans.

LY And in regions 3 and 5, they have five choices.

MF Great. Okay, well I think that's a pretty good round up summary of the questions that we've received as part of this webinar, so I'm inclined to give folks five minutes back in their day, but we really thank you all for continuing to be so engaged in this webinar series and we look forward to seeing you next week to talk about the behavioral health services during the transition period. Thank you so much.