



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Health Benefits

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MANDY COHEN, MD, MPH • Secretary

DAVE RICHARD • Deputy Secretary, NC Medicaid

**Transcript of
Your Medicaid Health Care: Understanding the Changes and Available Support**

Janie Shivar

Thank you so much and welcome, everybody, to our latest installment on our Tailored Plan transformation for Medicaid transformation. Today's presentation is specifically geared for consumers, families, providers, all stakeholders, really. But we really wanted to have an opportunity to present some very simplified, basic information about Medicaid transformation that's very easily digestible really for everyone. So, thank you all for making the time to join us today. We really appreciate that. This webinar is being recorded so you'll be able to listen to it again. Also, the slides in the actual presentation will be available for everyone after today's webinar. It will be posted on the Department's website probably within the next 10 to 12 days. We're very excited today to have the Deputy Secretary of Medicaid, Dave Richard, with us, as well as Kathy Nichols, one of the assistant directors at a DMHDDSAS, as our presenters today. We also have several subject matter experts in the room with us today who are going to be fielding some of your questions at the end of our presentation. Dr. Keith McCoy, Kelsie Knick and Deb Goda with the Department are with us, as well as Susan Thompson and me, who will be doing the technical support for this webinar. So, you are able to put questions into your chat box, but we do have all of our lines muted so that everyone will be able to hear our presenters today. And with that I will turn it over to our first presenter, Dave Richard.

Dave Richard

Thank you, Janie, I really appreciate everybody joining us. I know your time is valuable and these are important topics and we want to make sure that as we are working through transformation and continued work both on Standard and Tailored Plans that we have an opportunity to have these kinds of conversations on a regular basis. So, again, we want to thank you for joining us. The slide that's on now shows how we plan to walk through this webinar. I'll do some high-level parts of this conversation and turn it over to Kathy for a lot more of the detail work that we'll go through in detail information. So hopefully this will be a very valuable webinar and again, your questions are very important.

So, let's skip to the next slide. This one's pretty easy. We'll go to the next one. So, one of the things that we want to make sure that as we talk about what's happening inside of Medicaid transformation that we remind folks that what we really care about most is making sure that individuals who are Medicaid beneficiaries—in this case, people who have mental health, substance use, or intellectual disability needs, as well as traumatic brain injury. But we recognize what we are trying to do is to make sure that we are putting the individual at the center of the services that we provide. I think you all know that's been a value for the Department throughout our efforts. But as we are changing, we do want to make sure that we really think about whole-person care and how do we think about that it's very broad. So, we talk a lot about behavioral health people use that so when it says behavioral health, I/DD, and physical health integration, that's really a key component of this that's happening as we start with Standard Plans now and go live on November 1st. But it's beyond just physical health and into specialty services. We also want to make sure that we are talking about pharmacy, which is part of physical health that we don't want to leave that out as we think about this. But also, the unmet needs, the social needs that people may have. So, when we talk about whole person care, it's really about the entire need that an individual has that as a Medicaid beneficiary or someone who receives state-funded services as we move into the

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Tailored Plan as part of this effort. So, we continue to mine data and look forward to you continue comments to help us stay on track with that focus.

And then, what I'm sure all of you that are on the webinar hear lots of stuff and I think one of the most difficult things that we all have is trying to decide what's accurate and what's not accurate in what you hear. And I want to be clear, I know when people talk about what's going on in these plans and talk about how we do a transformation, everyone wants to get it accurate. But sometimes, like that old kindergarten game, as you go two or three things that people say, you might find that the information is a little bit less accurate as you go down. So, the goal of these webinars is really to give you the most up-to-date information about what is happening today, in North Carolina Medicaid, as we make this transformation. So that you can use these slides. You can use this information to make sure you're checking as you hear different information in the field about what's actually happening. So, listed a lot of things in these boxes around here, but you know, again, the important part of this is to make sure that we're giving accurate information. And that's what we'll do as we go through the slides today. And that you'll have that detailed information about what's actually happening on the ground.

Now, the thing I just want to remind people of is that the biggest change that's happening inside of Medicaid is that we are moving from a system in which we had run primarily fee-for-service on a physical health side – almost all fee-for-service on a physical health side – with little managed care. We did have managed care and will continue to do so for behavioral health, I/DD and substance use and traumatic brain injury carve out, but our goal is to integrate all of those services inside of managed care. But there will be two ways to get Medicaid for a while (and probably forever in some scenarios). One of them is through Medicaid Managed Care. That includes the Standard Plans that are going live November 1st in two regions. And those are—we call them health plans—we'll talk about them that way. We'll also include the LME/MCO's operating Tailored Plans in 2021. So, we'll have a significant—from almost all of the Medicaid population will be served through managed care by the time we get through 2021. But there is a transition period that we'll mention. But there is also the Medicaid—what we call fee-for-service, traditionally—which we are now rebranding as Medicaid Direct. So, you'll hear us say that, Medicaid Direct. For people who are not in managed care. And it's really important to think about that because the same services will be available in managed care as they are in Medicaid Direct. What's important right now in this transition to know is that as we go live with standard plans, those individuals that still receive services through LME/MCOs for them carve out, behavioral health, I/DD specialty services, will continue to receive physical health services through Medicaid Direct just as you do today. So, between now and 2021, that doesn't change in terms of receiving those for those individuals that will stay inside of the LME/MCOs as we transition to Standard Plans. And as Kathy goes into slides we'll talk a lot more detail about who those people are and what it looks like. Here is the most important thing to remember, every person who is eligible to get Medicaid will still receive Medicaid services. Moving to Managed Care does not affect the eligibility of a person, what it does affect is how you get those services authorized and paid for. So, everyone that is currently eligible for Medicaid will continue to receive Medicaid services and new people that become eligible will continue to receive those. So that's the most important part of this slide.

And so now we are going to transition to Kathy to talk about a lot more detail on this and Kathy as Janie mentioned, is assistant director at our Division of Mental Health, Developmental Disabilities and Substance Abuse Services. It is also important to note that she has a wide range of expertise. She was a key staff member at Medicaid prior to that so she has experience in both the stated funded and the Medicaid services. So, Kathy, why don't you go ahead and start?

Kathy Nichols

Thanks, Dave. So, this next slide talks about the Enrollment Broker and this is a different function that does not exist in Medicaid today. Well I guess it exists in Medicaid today, but it will be available to help people as they enroll for the November rollout of regions 2 and 4 of our Standard Plan. The enrollment brokers are being trained to help people make the correct decisions about which plan is right for them – whether that be Medicaid Direct, working with the Tailored Plans, transitioning to one of the Standard Plans. There's a person to help talk through all of these confusing choices to figure out the right choice for the right person at the right time. And being mindful of technology, there will also be the availability to use mobile apps for people that prefer maybe texting or emailing instead of talking with someone. But also, for

people that prefer paper, they will also accept mail and fax for some of their communications. So, we want to make sure that there is no wrong door as far as media goes to engage with the Enrollment Broker to help decide about which plan to choose.

The next slide talks about what we are going to talk about now, which is specific changes for how Medicaid may impact somebody. There may be—there probably are folks out there that have received a letter from Medicaid. In July, I believe, letters were sent to people who are receiving Medicaid health care to let them know about upcoming changes to Medicaid Managed Care and the letters were sent with specific information to these recipients to talk about what changes that particular recipient could expect to see in the coming months as we move towards the November start date. Other people in the family or other Medicaid recipients may have gotten different letters and that is okay because everyone's situation is going to be different and these were individually tailored to a specific person and their specific health care needs. Depending on the letter, a person that has received a letter may not need to do anything. Folks that would probably be put into a Tailored Plan in 2021 should receive a letter that says you don't have to do anything unless you want to go into a standard plan. So, the letter basically would have an enrollment, an option to enroll and in a mixed household, maybe a couple of different letters might have gone to folks in the household depending on the needs of the Medicaid members. So, the slide that's up now has a letter—an example of a letter—for someone that would need to enroll into a Standard Plan. So, there are a couple of decision points that would be required to be made when that letter is delivered. One is to choose a primary care provider. If you are already engaged with a primary care provider that might be your choice or you might need to choose one. And then a secondary decision would be choosing a health plan. Each of our Standard Plans will provide the same types of services but not all doctors may choose to enroll into all of the plans. That would be a provider decision as to which plans they want to work with. So, if you have a doctor that you are engaged with, that's one of the things that you will probably want to check to see which plan they are enrolled with. If you have questions about either of those items, then the enrollment broker would be the best place to go next for or contacting someone to talk through those choices. And the contact information for the enrollment broker is in that package of materials that was sent with the letter.

So, the regions that are displayed here are the ones that will be going into a Standard Plan, Medicaid Managed Care system on November 1, 2019. So, folks living in these yellow counties, in regions 2 and 4, should have already received these letters to be making decisions about their primary care provider, their health plan, if they want to move to a standard plan or if they need to stay engaged with the LME/MCO for the behavioral health needs and Medicaid fee-for-service for physical health until 2021. These are the counties that are going to be impacted first. If you live in one of these counties and you haven't received a letter if you are a Medicaid recipient, then it would, it would be, we would like, it would be good to contact Medicaid immediately, so we can understand what, where we've missed, and get you connected to the right plan.

The next slide is just a listing of the counties in Region 2 and in Region 4. So, enrollment has already started for these plans, and it's scheduled to end – open enrollment's scheduled to end on September 13th of 2019. And then the plan would start delivering services on November 1st. There, there will be an ongoing open enrollment period, so if you need to change your PCP in the future during open enrollment of the following year, you would be able to do that. And in the interim, if somebody's needs change and they are in a Standard Plan but require a higher level of behavioral health care, for whatever reason, they will be able to put in a request to transition to the LME/MCO to receive those enhanced behavioral health services there.

If you have a mandatory letter and you live in one of the three counties on the next slide, those health plans' selection processes should begin in October. So, the – and all of those other regions, 1, 3, 5 and 6 – will be billing under Medicaid managed care in February. So, there will be a delayed rollout for those additional counties.

Slide 15 is another breakdown of the counties in the regions that were listed for 1, 3, 5 and 6. This website, this webinar will be available on our website, to go back and check. You don't have to worry about going too fast to fully absorb all of these counties. But the enrollment period for these counties will start on October the 14th, and then enrollment will end December 13th of 2019, with a go-live date for them

of February 1st. If somebody does not choose a health plan, and they're in one of these regions, a plan will be auto-assigned by Medicaid by the deadline for the enrollment date for each of the regions. So, phase – for regions 2 and 4, Phase 1, by September 13th, and for the other regions, by December 13th. So, these people will still be able to continue to get services and they will still be covered, but the plan will be chosen by Medicaid if the recipient has not done so.

So, if you get this letter, which is the letter on slide 17, this is being sent to folks that don't need to do anything, because they will continue – if they want to continue getting their Medicaid services delivered the same way as it is today. So, they would remain with the LME/MCO for their behavioral health services and receive their physical health services fee-for-service. And nothing will change until July of 2021 is the proposed date for that transition. So, if this letter, if folks receive this letter, they do not have to make any decisions or choices today, unless they want to move to a Standard Plan. However, there are some services that will only be available in the LME/MCOs and the Tailored Plans in 2021, including Innovations Waiver slots and enhanced services for behavioral health, such as our assertive community treatment teams. So, if someone isn't sure about whether they want to stay where they are or move to a Standard Plan, again, the best contact would be the enrollment broker, who would be, who had been trained to help folks make the right decision for them. If you do not choose a health plan and you're not required to, nothing will happen. So, again, if you received previous, the letter on the previous slide, saying that you were, you were exempt, nothing will happen about, with your current services until July of 2021.

On slide 19, this is an example of a letter that might come, and some folks in the home may have been flagged to choose a plan and some may not have. So, if the family wants to keep their current doctor, their primary care provider, they should check and see if their doctor is working with the plan they want to enroll in. That would, again, would be something to discuss with the enrollment broker, if there's any questions about choice. And not all doctors will work with every plan. So, it's very important if you have a doctor that you have a good relationship with to check and make sure that you're getting in to the plan that covers your physician. And, if you have other members of the household that maybe have higher behavioral health needs that get a letter that says that you don't have to make a choice, only the person that does not have those higher behavioral health needs to make that choice. So, different people in the house, in the household may be in Medicaid Direct, while others may be in a managed care plan, based on where the best fit is for that person for their needs. So, if you do not choose a health plan, and you are optional, then nothing will happen, and you will continue to receive services the way you do now, and if you're required to choose a health plan, then you, again, should talk to the enrollment broker if you have questions, but ensure that you choose a plan that covers your PCP, so that you can ensure that those really important relationships remain intact. And if a plan is not chosen by the end of enrollment for both phases, the person will be auto assigned by Medicaid.

So, on slide 21, this is a very important slide – the next one, please – because this contains the information that folks will need if they want to call the enrollment broker, if they have questions, if they think they got the wrong letter. This number was the enrollment broker, 833-870-5500, is a really important number for folks that they can call and contact somebody who can take the time to make sure they're making an informed choice and getting the best care for their situation. The other thing that can be done is, if somebody wants to request to stay in Medicaid Direct, if, if they got a form asking them to choose one of the Standard Plans, they can call the enrollment broker and this would be the way of starting the process of flagging that you need Enhanced Behavioral Health Services, so you'd want to stay with the LME/MCOs. So, very important number.

On slide 22, this addresses the question of if you do not get a letter, some people will not have an option to choose because they are either in a special group or need services only provided by NC Medicaid Direct and through the LME/MCOs. So, for example, someone who has Medicaid and Medicare cannot choose a health plan or PCP and will not receive a letter. If, again, if you did not get a letter, and you are in Regions 2 and 4, at the moment, then you can call the enrollment broker immediately to discuss options and why you may not have received a letter. The rest of the regions will be getting letters in the coming months, but this would still be the same number that everyone would call to talk to somebody for some of the counseling about the right choices of plans or providers.

So, next we get into a couple of questions about some special eligibility categories. So, if – for the folks in these categories that are listed here, if they – if these folks receive a letter saying that they're required to enroll in this health plan, then they, then they or their guardians should contact the enrollment broker, as they should not be receiving a letter for choice. So, if somebody has Medicaid and Medicare, or the nursing facility or has acceptable or is in foster care, or in our Cap DA or Cap C or Pace programs or on the TBI or Innovations Waiver, or is a TCLI recipient for the Transitions to Community Living Initiative, or living in a state facility for intellectual and developmental disabilities or an ICF, or if they're getting enhanced services from the LME/MCO, all of these folks might not be required to enroll in a plan. They would have the choice to go into a Standard Plan, but they might not be required to make that choice.

So, or if you have Medicaid and Medicare, for example, you should stay in the Medicaid Direct, and you should have no changes in your access to care. And if you are in this situation and have received a mandatory letter then you, which should alert the enrollment broker immediately, as you, as they need to adjust your, your, they need to adjust to make sure that you're not going into a plan that, that you should not be in. The same is true per a nurse for folks that have lived in a nursing home for more than 90 days. They should not have to make any choices, as they will probably be staying in a Medicaid Direct. If they do not have Medicare and have lived in a nursing home for less than 90 days, perhaps for rehab or something like they, they will, they, these folks will probably get a letter that asks them to choose a health plan. And, again, if there's questions, they should contact the enrollment broker to discuss choices.

If somebody has a deductible or a spend-down, they should be staying in Medicaid Direct and have no changes in healthcare. Again, though, if you are an individual that does have a deductible or spend-down and received a letter about making a choice, please contact the enrollment broker. If somebody is in foster care, youth in foster care, and former foster youth in adoptive placement, and former foster youth up to age 26, these individuals, again, should be staying in Medicaid Direct and not have any changes made to their Medicaid healthcare, and they should not be receiving a mandatory choice letter, and if they do, then, again, contact the enrollment broker. I hope that everyone's hearing the them, but, but the, the enrollment broker is the one spot, one-stop shopping spot for really being able to make informed decisions and making sure that folks are in the right place.

So, if somebody is on the, the Cap DA, Cap C or Pace services, so they could be home and community-based waivers for individuals, for children, and for disabled adults, and our Pace program is for our, is for the elderly. These are all capitated, special kinds of programs and Medicaid services that would stay in Medicaid Direct. Innovations and TBI waivers are also home and community-based service waivers, and the folks that are, that are on these waivers should not be receiving a letter to choose a standard plan. If they are, then they should contact the enrollment broker, and if somebody was, is, has any questions about what would happen if they choose to move to a standard plan, they should also, they should also contact the enrollment broker, but they would lose their Innovations waiver slot. If someone is on the wait list for the Innovations waiver, however, and wants to be in a Standard Plan until a waiver slot is available, they will not lose their place on the Innovations wait list.

And then, individuals who are in our Transitions to Community Living Initiative (TCLI), folks, those are folks with severe and persistent mental illness that are at risk of being in, being in an adult care home but are receiving services to enable them to remain in the community, or if somebody has an intellectual and developmental disability and is in an intermediate care facility, these folks or other individuals that have special, that have special prioritization and would be remaining in Medicaid Direct, and should not be making a choice to move plans.

On slide 32, this is the, the final of the specialty populations that we have flagged for special scenarios. These are people that are receiving services through their LME/MCOs. Some individuals may want to choose a health plan, a Standard Plan, that are receiving services from the LME/MCOs. Some may not. People who are in Assertive Community Treatment team, ACT, or ACT and CST and psychosocial rehab, or one of our child behavioral health residential services, or individuals that are, that need intensive outpatient for substance use or comprehensive outpatient treatment for substance use issues, and those with recurrent behavioral health crises should be remaining in Medicaid Direct and not choosing a Standard Plan as those Enhanced Behavioral Health Services will remain with the LME/MCOs and Medicaid Direct until Tailored Plans go live in 2021. In addition, if someone is receiving any state-funded

services along with their Medicaid services, those individuals should also be staying with Medicaid Direct and the LME/MCOs, as there will not be any state-funded services available in the Standard Plans. Again, if you did not get the correct letter or if you did not get a letter, and you want to make sure that you are in the right place, please contact the enrollment broker for assistance and counseling.

So, the next set of slides is just what to do next, and as I feel like I've said a lot of times, if there's any questions at all and you need any assistance at all with your enrollment, and choosing a plan, and making sure that you're in the right place, please do contact the enrollment broker at, again, 833-870-5500. There is also a website link here for information and contact and contact assistance. And then there are ongoing opportunities to engage with the State to ensure that we have heard everybody's voice and that we have gotten everybody's feedback who tries to make this incredibly complex process go as smoothly as possible so that people are disrupted to the minimal amount possible. We do have regular webinars, conference calls, meetings, and regular updates on the website noted there, and that's a great place to get information and to leave feedback for us. Other has schedules of meetings, such as the Medicaid Advisory Committee and other venues where, if you want to come in person and listen and give some feedback that we would love to hear from you and see you. And that is the end of the slides for this presentation. The appendix slide's just for the benefit of folks, if they want to look something up just to make sure they're in the right place. The services listed on slide 38 are the services that will only be available in Medicaid Direct in the LME/MCOs. I had referenced ACT and CST and PSR, but this will show every single service that would only be in the Tailored Plan, and therefore folks that need these services should make triple sure that, that their current coverage will remain with the LME/MCOs in Medicaid Direct until 2021. So that concludes the, the slides, the slideshow part of the, of the presentation. I think that we have some questions.

Janie Shivar

Yeah, we do. And we've had multiple questions, Dave, about how the budget stalemate's going to impact the November 1st start date.

Dave Richard

Thank you, and, before I answer that, I want to just reemphasize what Kathy said about engagement and the importance of that is that these webinars are really an opportunity to do that, but there are also multiple other places, and as we continue to design the Tailored Plans, we do want that continued engagement from people across, across the state. As you know, the governor has vetoed he budget because of it not containing multiple things that he felt were critical for moving the state forward. One of them was Medicaid expansion. But there are other items he has talked about extensively, about needing. We have said consistently to members of the general assembly and to every, every group that we speak to is that, if we don't have a budget by a certain date, that we would, we would not be able to go forward with the November 1st deadline – go live date. And what we have said is that, we believe that timeframe is end of August or 1st of September. It should be really clear about the reasons for that, is that, inside of the budget, there are multiple places where it either authorizes the ability for the State to access certain funds, or to do certain events that have to take place to go live. For instance, hospital assessments, which help us in the Medicaid program and allow us to pay hospitals the rates they receive for services are included inside the budget – not only the money, but the ability for us to make the transition to managed care. Access to our transformation fund is required in that budget to be able to continue to move forward with certain items. A premium tax, this is on all health plans, including that budget that is part of the financing for the managed care. And several other items inside of that. We also have – the reason why we've said that August / September timeframe is that, although technically you would not need those things until the first day you go live, there are multiple things that are going to happen in September into October that we believe we don't want to subject people to uncertainty around, including the beginning of auto assignment for beneficiaries during that period. So, so, that is what we have said to the members of the General Assembly. That's what we have said to every constituent group that we know of that, that we've talked to just to, to make sure that we're not misleading folks. It is that August and September timeline. We've been reluctant to give an exact date, because we don't want this to be highly politicized or the other side of that. But we will obviously in the coming weeks have to decide if the budget is not finalized during that period of time.

Suzanne Thompson

Thanks, Dave. The other question that we've seen several times is, where are the safeguards to ensure that people don't lose services during the transition?

Dave Richard

So, so, the best safeguard, and Kathy and others may want to step in on that is, we have done everything we can in terms of how we are, we've put in our contract with Standard Plans, the work we're doing with LME/MCOs in transition of care. What we know is, is that, during this timeframe, when people are, for instance, if folks have received service of LME/MCO now will receive formatting Standard Plan. That is really important that that information is shared about the kind of service array that was available and what people were receiving. So, that information between LME/MCOs and those Standard Plans, we are working to make sure that that is provided through our transition of care effort.

We have said consistently that the priorities for the Department day one of going live with managed care start with the beneficiary. We have a lot of really incredible, I think, goals and objectives that as we move toward whole person care critical to the effort social determinative health effort, high standards around the following and changing that effort. But really, the most important thing on day one in the very beginning of managed care is that if a beneficiary was planned to be seen by a physician or by other service provider prior to go live on November 1st that they continue to be able to be seen by that provider after going live. And that includes even if we made a mistake. So, if there is a problem with a person who has the wrong health plan on their card and the doctors not engaged in that, they show up at that physician's office, they should still be seen, and we are working to make sure that those physicians will be paid for that.

Because that's the second part of that is that we can't afford to have providers provide services and not receive payment for those. So that's another commitment that was made. So, I think what I would say is that our best efforts have been around making sure that we have this really robust effort around transition of care, a commitment to providers that if they see somebody, if they're Medicaid enrolled and they see someone, even if they don't have the right card when they come in, they'll still get paid for those services and as the transition takes place.

To be clear, we know that a transition is complex, there will be things that go wrong. And as they go wrong, we have an approach in which people will notify us rapidly, we'll address those issues in real-time with providers and with our health plans to make sure that we avoid the kind of things that will cause someone to miss a service if they need.

Suzanne Thompson

Thanks Dave. So, we've had several questions about peer support and how this change is going to be if that's peer support. Kathy?

Kathy Nichols

So, the managed care process is not – peer support is currently – was available as a state-funded definition as of August 1st of this year. And a Medicaid definition is in the process of going through the policy process. The goals for that definition would be to have it available in October of 2019, but ultimately the switch to managed care should not impact our offering of peer support as a service to anyone and it should be available in both the Standard and the Tailored Plans when the Medicaid definition becomes effective. We believe this is an important service in the continuum and an important service for folks to be able to maintain their stability in the community. So, we have no intention of reducing access to peer support specialists as part of the transformation process. Do you want to add anything to that? Nope, he shook his head, so that's a no.

Janie Shivar

Thank you. So, we have a couple questions for people wanting to know how beneficiaries will know which services are carved out.

Kathy Nichols

So, the services that are only available in Tailored Plans are the services that are listed in the appendix on that last page. And again, is it before these are posted on the website?

Janie Shivar

We usually post our slides within about 10-12 business days.

Kathy Nichols

So, within the next two weeks this should be available and posted. There are other documents on the Medicaid managed care transformation site that also list the services that are carved out only for Tailored Plans, but if somebody is just joining now and is having trouble – and you can always contact the folks on the Medicaid transformation web page as well and that question will get routed and answered for folks. So, you won't necessarily have to wait for the webinar, but this will be available and posted so that you can go back and look at this slide, as well as the ones of the counties for each of the regions and the planned implementation dates.

Dave Richard

Let me add one other thing is that so as the services were determined, it's important to note that this is still a legislative process by which it was a pretty significant amount of negotiation on there and I think all of us would say there are places that you may see that you wonder why this was in that array there. And I think over time, we may see changes as we go forward, but this is how the current legislation tells us that we must proceed with managed care.

Janie Shivar

So also, for those people who registered before about noon yesterday, I sent the slide deck and the FAQ last night. So, if you registered afternoon yesterday, sorry I didn't have your email information to send it, but it will be posted. The other question is if people have carved out services will there be a second Medicaid card for that?

Kathy Nichols

And it's not that it's carved out of managed care plan, it's the fact that if it's a service that is only available in Medicaid direct and the LME/MCO and in the future in a Tailored Plan, then the person's going to be staying in Medicaid direct if they are getting that service. So, it's not that they're enrolled in two plans with two separate Medicaid cards.

Janie Shivar

Thank you. So, we have another question and people are wanting to know if somebody is receiving their behavior health services through the LME/MCO right now where will they get their physical health services starting in November if they're in one of the 27 counties?

Kathy Nichols

If they are receiving enhanced behavioral health services, the services are 538, they will continue to receive their physical health services the same way that they do today, assuming their provider is still an

active enrolled provider in Medicaid direct. They shouldn't have to have any changes made to their service delivery system.

Dave Richard

Kathy, we might add too is that so if an individual currently who received services from LME/MCO but is moved to a Standard Plan, in terms of receiving the physical health services, it should not change actually. The only thing that makes sure that you're paying attention to is that your physician is enrolled in the health plan, the physician you want to be able to see enrolled in the health plan that you sign up for, or if someone doesn't sign up and they're auto assigned to make sure they check that. Because inside of behavioral health and I/DD specialty services there is a closed network in which the network with services to those providers cannot have everybody. Inside of Medicaid, it is any willing provider. So, that provider will continue to be Medicaid eligible, but they may not be enrolled in each plan. So, that's the important component. You should still be able to go to your position, but make sure that they are enrolled in the health plan that you're enrolled in.

Keith McCoy

One additional thing, this is Keith McCoy, many people who have mild to moderate behavioral health disorders, mental health disorders, substance disorders, may be getting what we call basic services. So, just outpatient services at a clinic or medication management through a psychiatrist or a physician extender. And they, because they're not demonstrating a need for more intensive services or demonstrating evidence of having a more significant functional impairment would be switching to a Standard Plan. So, in addition to making sure that your primary care doctor is associated with that Standard Plan, you also would want to ask and make sure that your behavioral health provider, who's providing those outpatient services through therapy or medication management are in that plan. So, you'd want to do your best to try to pick a plan that has those key providers to you if you're wanting to keep those providers.

Kathy Nichols

But if your providers have chosen not to enroll in a Standard Plan, there will be providers available, it will be a new provider, but the services would still be available in the Standard Plan.

Keith McCoy

Right, the Standard Plans will provide many of the crisis services for behavioral health as well as those outpatient therapy and medication management services.

Kathy Nichols

Right and just one more thing. You'll be auto assigned a primary care physician in the Standard Plan if you don't choose one and it will be based on an algorithm of past history with certain physicians, family history if you have people in your family using a certain doctor. But you will not be auto assigned a behavior health provider. So, that would be something that you choose yourself, like Keith said if you're getting outpatient therapy or med management, that would be something that you would choose yourself and the Department would not auto assign you into a behavior health provider.

Janie Shivar

Thanks Kathy. We've had a lot of questions about people on the Innovations waiting list and how this affects them.

Kathy Nichols

So, maybe we didn't spend enough time on it, but if somebody is on the Innovations waiting list, some of the same choices would apply. So, if they're on that waiting list and they have Medicaid and are receiving one of the enhanced services on slide 38, they would want to remain with the LME/MCO and receiving their physical health services through Medicaid direct. If they do not have Medicaid but they're on the waiting list and they're receiving state funded services, they would not be getting a letter because they don't have Medicaid, but they would continue to be able to get state services and keep their spot on the list. If an Innovations recipient chooses to go to a Standard Plan for whatever reason and they're on that waiting list, they will not lose their spot on the list, but they will be moved back to the Tailored Plan if a slot becomes available.

Janie Shivar

Thanks Kathy. We also have had a lot of questions about people who are on the Standard Plan and they have life changing events. Do they have to wait for a new enrollment period or can they use the process for requesting changes?

Kathy Nichols

A change can be requested not during open enrolled periods. If there is a life changing event – a birth, a death, a first episode psychosis – some of the same things that would apply to other private plans.

Keith McCoy

And that includes if you need one of these services that are only available through the LME/MCOs right now. You would be able to, or your provider would be able to help you make your request to get switched over. And those switches, if you need that service, then those switches, you wouldn't even have to wait until the first of the next month. That's just what happens immediately so that you could begin receiving that service. Or if the service had to be prior authorized so that the LME/MCO could immediately review that service and make a medical necessity decision.

Janie Shivar

And the other question that's popped up a couple times is if somebody is in an enhanced service and they get sent down to a lower service, do they have to change their insurance plan?

Kathy Nichols

No, the enhanced services would only be available in the Tailored Plans, but the other services would be available in both plans. So, the Tailored Plans should have peer supports, out-patient services, so both of those services that folks got down to, but still need to do it if they continue to stabilize the community.

Keith McCoy

And then to add to that, say you recently stepped down from Intensive in-home to basic outpatient services. I would look back period for determining eligibility to remain in the LME/MCO and fee for service systems based on behavioral health service cues goes back to 24 months. And so, even if you're not actively using that service, you'd still be eligible to remain in the fee for service or NC Medicaid direct LME/MCO system.

Janie Shivar

I think we've answered all of the groupings of questions. Thank you, Susanne, and thank you to our presenters. I'm going to turn it back over to Dave Richard for a few final comments. And while I do that I'm going go back to a slide that has our website and also in the lower right-hand corner, you will see an

email address that is for any questions that you may have on Medicaid transformation. You can send those in and they will get routed to the appropriate person for a response.

Dave Richard

Thank you, Janie. I just wanted to close out by thanking everybody again for being on the call. And also, just to make sure that we just remind folks is that if there are questions like as Janie mentioned that we have these ways in which people can participate. What we don't want to have happen is that individuals are worried about or thinking about this transition and aren't getting those questions answered, because we do know it is different, it is a change for North Carolina. We believe that as we make this transition in change, do you move to a whole person care is one of the most important things that we are doing in North Carolina because we have talked about it for years in our state. And the opportunity is to really go live with this is really exciting. But also, we know that it can cause some anxiety for folks throughout the system. So, we want to make sure that people feel comfortable asking those questions for these areas. But you also have other – I know many of you have other informal ways in which you ask questions, so please don't feel that you have to avoid using those as you move through it. So, again thank you so much for being on the call and we look forward to the next webinars that we can go down a road and seeing other benefits as we talk about this. Thank you.