MCAC MANAGED CARE SUBCOMMITTEE

Beneficiary Engagement

April 9, 2018

Welcome

Marilyn Pearson, MCAC Representative
Jenny Hobbs, MCAC Representative
Debra Farrington, DHHS Program Lead

Agenda

- Subcommittee Member Introductions

- Subcommittee Charter

- Meeting Schedule and Work Plan

- Logistics and Member Participation

BREAK

- Managed Care Overview

- Beneficiary Engagement

- Public Comment

- Next Steps

Charter

- Review Beneficiaries in Managed Care concept paper and comments received

- Review recommendations for operations of Beneficiary Support System; i.e., PHP member services, Enrollment Broker, Ombudsman

- Address strategy and methods for engaging beneficiaries

  - Identify new engagement methods

  - Evaluate and make recommendations for leveraging existing bodies; i.e., Consumer Family Advisory Committee

- Discuss strategy for communicating with beneficiaries

- Review marketing and member materials

Meeting Schedule and Work Plan

Schedule	MEETING #1	MEETING #2
DATE	Monday, April 9, 2018	Monday, May 7, 2018
TIME	9:00 am – 10:30 am	10:30 am – 12:30 pm
PLACE	Dorothea Dix Campus **McBryde Building, Room #444 820 South Boylan Ave.** Raleigh, NC	Dorothea Dix Campus **Kirby Building, Room #297 1985 Umstead Drive** Raleigh, NC

Work Plan	MEETING #1	MEETING #2
TOPICS	Subcommittee Charter	Beneficiary Support Systems (PHP marketing and member services)
	Expectations, Logistics, Meeting Frequency	Beneficiary Support Systems (Ombudsman)
	High Level Review of Beneficiaries in Managed Care concept paper	Engagement Strategy and Methods
	Comments on Beneficiaries in Managed Care Concept Paper	

Logistics and Member Participation

- Meetings will be available in-person and by webcast/teleconference

- Meetings are open to the public

- Public will have time at the end of each meeting to comment

- Direct written comment to Medicaid.Transformation@dhhs.nc.gov

MEMBERS:

Active participation during meetings will be key to informed input

Offer suggestions, information and perspective

Engage with other members

Ask questions

Beneficiaries in Managed Care

- **Eligibility and Enrollment**
  - Medicaid Eligibility Determination/Interface with DSS/EBCI Public Health and Human Services
  - Enrollment Broker
  - Enrollment in Managed Care
  - Auto-Assignment Factors
  - Disenrollment

- Beneficiary Supports in Managed Care
  - PHP Marketing
  - PHP Member Services
  - Beneficiary Outreach and Education
  - Health Promotion, Wellness and Disease Prevention
  - Beneficiary Feedback to PHPs and the Department

Beneficiaries in Managed Care

- **Appeals and Grievances**
  - Beneficiary Appeals
  - Beneficiary Grievances
  - Ombudsman Program

Comments received

Discussion

Public Comment

Next Steps

Next Meeting
Monday, May 7, 2018
10:30 am – 12:30 pm
Kirby Building, Room 297

Next Topics
Beneficiary Support Systems (PHP member services and Ombudsman program)

Appendix

Medicaid Managed Care

Vision

- High-quality care
- Population health improvement
- Provider engagement and support
- Sustainable program with predictable cost

Goals

- Focus on integration of services for primary care, behavioral health, intellectual and developmental disorders, and substance use disorders

SL 2015-245, as amended, directed transition from fee-for-service to managed care for Medicaid and NC Health Choice programs

- Address social determinants of health (unmet social needs, such as employment, housing and food, and their effect on health)

- Support beneficiaries and providers during transition

Medicaid Managed Care Background

- Timing: Go live within 18 months of CMS approval

- Prepaid health plans (PHPs)
  - 3 statewide contracts
  - Up to 12 regional contracts to PLEs in 6 regions
  - Beneficiary chooses plan that best fits situation, or will be auto-assigned according to assignment algorithm
  - At managed care launch, PHPs will offer standard plans with integrated physical, behavioral and pharmacy services (requires enabling legislation)

- PHPs must accept any willing and able provider, including all essential providers (as defined in legislation); exceptions: quality, refusal to accept rates

- Rate floors for physicians