Back Porch Chat: NC Medicaid Managed Care Hot Topics

June 3, 2021

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AGENDA

01 Key Updates

02 Transitions of Care

03 What-Ifs of Managed Care

04 Bottom Line for Transitions Affecting Providers

05 Other Hot Topics

06 Q&A

North Carolina's Vision Remains the Same

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

Three Regions for Medicaid Healthy Opportunities Pilots

- Following a competitive selection process, the North Carolina Department of Health and Human Services has selected three organizations to serve three regions of the state, marking a major milestone towards launching the nation's first comprehensive program to test evidence-based, non-medical interventions designed to reduce costs and improve the health of Medicaid beneficiaries. The groundbreaking program will create a systematic approach to integrating and financing non-medical services that address housing stability, transportation access, food security, and interpersonal safety into the delivery of healthcare.
- The three organizations will reach two regions in eastern North Carolina and one in western North Carolina.
  - **Access East, Inc.**: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
  - **Community Care of the Lower Cape Fear**: Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
  - **Dogwood Health Trust**: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
- **To be eligible for and receive Pilot services, NC Medicaid Managed Care members must live in one of the three selected regions, have at least one qualifying physical or behavioral health condition, and have one qualifying social risk factor.**

Read more detail about the LPEs and the Pilot program in this press release.

NC Medicaid Managed Care Health Plan Assignments Completed for Beneficiaries

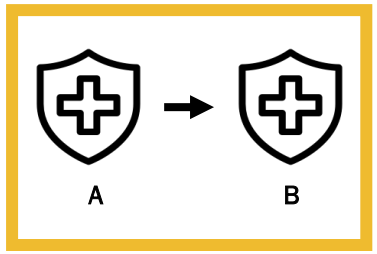
- **All Medicaid beneficiaries currently eligible to transition to managed care have selected or been assigned a health plan with 97% enrolled in a plan that includes their current primary care provider (PCP) in network.**
- As a result, nearly all current beneficiaries will keep the same health care provider that they have today when managed care launches on July 1. That means more families can continue to visit the practices and doctors who know them best and are familiar with their specific health care needs.
- Beneficiaries who did not select a health plan during open enrollment, which ended on May 21, were auto-enrolled in a plan. NCDHHS' auto-enrollment process prioritized existing relationships between beneficiaries and their primary care provider and, where possible, a plan that has contracted with that provider was selected for the beneficiary. A summary of NC Medicaid Managed Care enrollment by plans and regions can be found here. Confirmation notices and health plan welcome packets will be mailed to beneficiaries through June 12. Beneficiaries have until Sept. 30, 2021 to change plans for any reason.

For more information, please see the press release here.

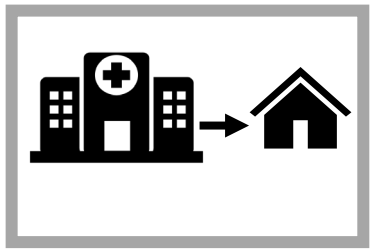
A Note on Terminology

“Transition of Care” and “Care Transitions” have distinct meanings.

Today’s Focus



“Transition of Care” refers to the time-specific processes and safeguards established to support continuity of care when a beneficiary transitions to a new health plan or to a different healthcare delivery system (e.g., Medicaid Direct to managed care).



“Care transitions” refers to changes in a beneficiary’s care setting (e.g., inpatient to community-based setting).

See AMH Provider Manual 2.0 . See also the AMH Training Page for more information on Transitional Care Management in AMH Tier 3.

Overall Vision for Transition of Care Design

As beneficiaries move between delivery systems, the Department of Health and Human Services (Department or DHHS) intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

July 1, 2021: The Transition of Care Crossover "Bridge"

- On July 1, 2021: 1.6M of 2.5M will transition to NC Medicaid Managed Care.
- 5 "Standard Plan" Health Plans will then be responsible for providing services within the Standard Plan scope.
- Crossover Protections align with Transitions of Care (TOC) design principles and tailored to reflect the "mass transition" crossover dynamic.

Ongoing Transition of Care: The NC Transition of Care "Tridge"

Health Plan 1

Health Plan 2

NC Medicaid Direct/Tribal/Local Management Entities – Managed Care Organizations (LME-MCO)

- Enrolling
- Disenrolling
- Tailored Plan eligible

"Tridge" in Midland, Michigan: https://www.kuriositas.com/2012/01/tridge-michigans-three-way-bridge.html

Transition of Care Design: Regardless of Phase

Driving Design Priorities	Resulting In
Facilitating Uninterrupted Service Coverage	Continuity of care protections related to service authorizations and provider continuity.
Supporting Continuity of Care through Data Transfer	Automated data transfer of prior authorizations, claims/encounter data and pharmacy lock-in data.
Clear and Organized Communication Between Entities	Communication protocols between health plans and with Local Management Entities – Managed Care Organizations (LME-MCOs), CCNC and other entities engaged with the transition.
Establishing Additional Safeguards for High Need Members	Rapid follow up at Launch, warm handoffs between entities and transfer of additional Member information.
Member and Provider Education	Transition of care-specific educational materials, webinars and call center scripting.

Crossover: Managing NEMT

Facilitating Uninterrupted Service Coverage

- After July 1, 2021, Health Plans will assume responsibility for Non-Emergency Medical Transportation (NEMT) for enrolled members.
- To support continuity of care, NEMT data will transfer from NC Tracks.
- Department of Social Services (DSS) will supplement data transfer for high engagement beneficiaries.
- ***Now Available!*** Starting in June 1, 2021, beneficiaries can call the Health Plan directly to schedule transportation for appointments occurring after July 1, 2021.
- Beneficiaries requiring NEMT before July 1, 2021 should continue to reserve appointments as they currently do.

Managing Prior Authorizations

Facilitating Uninterrupted Service Coverage

Crossover

- Open medical, pharmacy and behavioral health* prior authorizations ("PA") will transfer from NC Medicaid Direct to the member's Health Plan.
- Health Plan are required to honor medical PAs minimally for the first 90 days or until the authorization expires, whichever occurs first.
- Health Plan required to honor pharmacy PAs for life of the authorization.

Ongoing

- If a beneficiary transfers between Health Plans after July 1, 2021, PAs authorized under Health Plan A will transfer to Health Plan B.
- Health Plan B is required to honor the PA for the remainder of the PA.

** Subject to 42 CFR Part 2 limitations*

“What if a Patient Needs to See a Provider Out of Network?”

Facilitating Uninterrupted Service Coverage

Generally: Health Plans will seek to build their networks and seek to contract with providers.
Health Plans have the authority to extend out of network provider transitional periods beyond what is required by contract and statute.

Crossover

- Health Plans will treat out of network providers on par with in-network providers minimally for the first 60 days after Launch or until the episode of care, whichever is sooner. Health plans may extend this timeframe and are required to do so in some cases.*

- **Newborn policy**: Health plans will treat all out-of-network providers the same as in-network providers for purposes of prior authorization and will pay out-of-network providers the Medicaid fee-for-service rate for services rendered through the earlier of:

  90 days from the newborn’s birth date

  OR

  The date the health plan is engaged and has transitioned the child to an in-network primary care provider (PCP) or other provider.

*When a Beneficiary experiences an *ongoing special condition* or is undergoing an *ongoing course of treatment* as reflected in the NC DHHS Transition of Care Policy.

Ongoing

- Health Plans are required by contract to adhere to statutory transitional periods for out of network providers serving transitioning members who meet the criteria for an ongoing course of treatment, or an ongoing special condition as defined in the NC DHHS Transition of Care Policy.

- If a provider is terminated from the Health Plan’s network, and the beneficiary has received services within the previous 6 months, the health plan must issue letter to beneficiary and assist in securing new provider, as necessary.

- The Newborn policy established also applies.

Safeguarding Members Transitions after July 1

Establishing Additional Safeguards for High Need Members

If a member transitions between Health Plans:

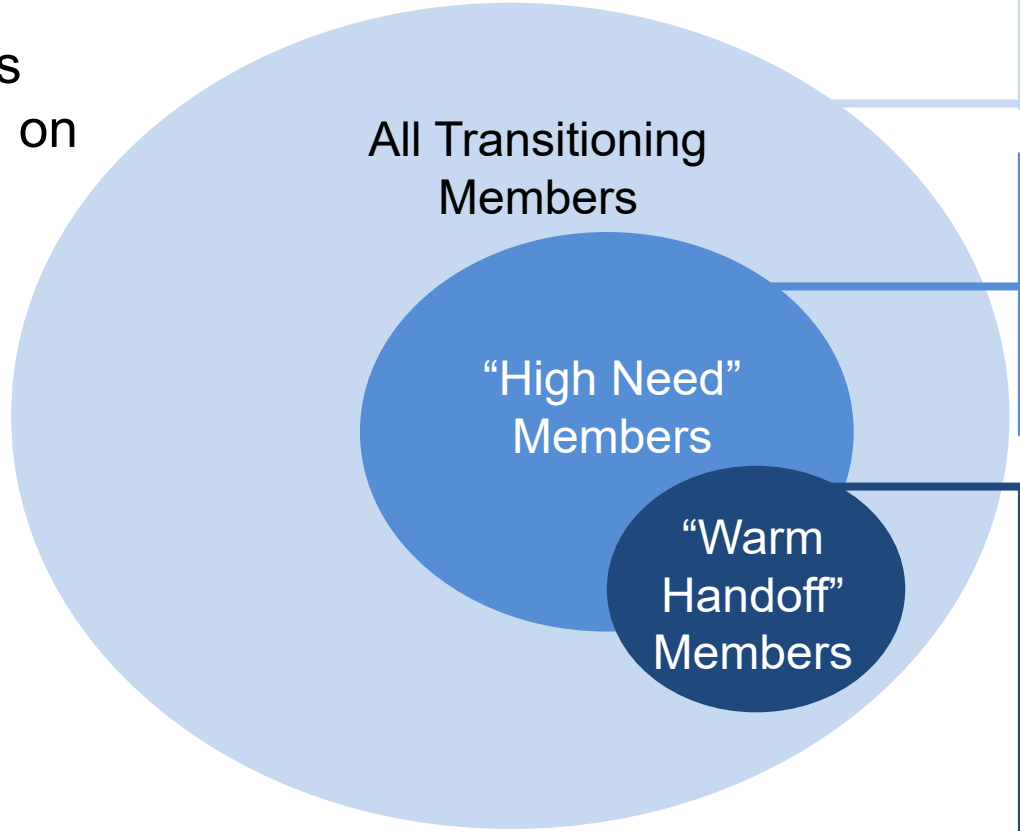
- Health Plan A will transfer Claims, PA Data, Pharmacy Lock In Data to Health Plan B.
- Health Plan A will transfer a “transition file” to Health Plan B:
  - Care needs screening.
  - Care plan (if applicable)
  - Information about open appeals (if applicable).
  - Transition summary page including current socio-clinical information for all members identified for a warm hand off and all members disenrolling from Medicaid Managed Care and returning to Medicaid Direct.

- Either Health Plan may initiate a warm handoff clinical briefing for transitioning members, with a particular priority on transitioning care managed members.

Safeguarding Beneficiaries Through Crossover

Establishing Additional Safeguards for High Need Members

Crossover Activities Customized Based on Service History, Vulnerability



All Transitioning Members:

Data Transfer:

- Claims
- Prior Authorization
- Pharmacy Lock In Data
- Care Plans Community Care of North Carolina (CCNC) (for beneficiaries in active care management)

"High Need" Members:

- High Need Members are transitioning Members whose service history indicates vulnerability to service disruption
- **This group is identified on DHHS "High Need Member List"**

"Warm Handoff" Members (<2000 Members):

- High Need Members who have been identified by NC Medicaid Direct "transition entities" (CCNC/LME-MCOs) or by the Health Plan as warranting a verbal briefing between transition entity and Health Plan
- This group is identified on the DHHS "High Need Member List" and through a specific warm handoff/summary sheet process.

Supporting High Need Members at Crossover

Meet Jo

Jo is a 45-year-old Medicaid Beneficiary who has been determined to have a disability but does not yet qualify for Medicare. Jo has been auto assigned to Health Plan A but hasn't opened her mail in weeks. Jo receives over 91 hours of personal care services a month, depending on aides to assist with many Activities of Daily Living (ADLs).

Jo has also been recently hospitalized for COVID-19, though she is back home now. CCNC currently provides care management to Jo and has been closely engaged with her after the discharge. She is considered clinically stable.

Prior to MC Launch

- Because of Jo's specific Long-Term Services & Supports (LTSS) service use, DHHS identifies her as "High Need" and sends her name/information to her health plan on a "high need beneficiary" list.
- Because Jo is clinically stable, CCNC has **not** identified her for a "warm handoff" though her health plan could still request one.

At MC Launch

- Jo's Health Plan (or Advanced Medical Home [AMH] Tier 3) will conduct a High-Need follow up at Crossover.
- The Health Plan/AMH contacts Jo to ensure Personal Care Services and other key services have remained in place upon transition, troubleshooting, as necessary.
- Health Plan reports when Jo has been successfully contacted.

Ongoing Support for Members Disenrolling to NC Medicaid Direct

Establishing Additional Safeguards for High Need Members

Members who will be required to Disenroll Reflect Some of our Most Vulnerable Populations

- Children disenrolling due to Foster Care eligibility
- Members disenrolling due to Dual eligibility
- Transition due to Tailored Plan Eligibility

Transition Principles in Effect Regardless of Disenrollment Population

Pre-Transition

- Activate communication with NC Medicaid Direct Receiving Entity
- Prepare Member
- Support Provider
- Population-Specific protocols.

Transition

- Coordination with Receiving Entity.
- Transition File Transfer
- Warm Handoff
- If applicable, Submission of LTSS Disenrollment form
- Population-specific protocols

Post Transition

- Health Plan follows up with Receiving Entity
- Population specific protocols.
- Open Prior Authorizations from Health Plan Transfer to NC Tracks/LME/MCOs and will remain in effect*

*Providers may be required to submit PA directly in certain circumstances (e.g., due to 42 CFR Part 2, LTC PA.)
*PAs for services only available through Standard Plan Option will not carry over in Medicaid Direct.

Supports for Beneficiaries Disenrolling to NC Medicaid Direct: A Foster Care Scenario

Sam is 7 years old and served by a Standard Plan Health Plan. Sam is removed from his family home due to confirmed physical abuse. Sam ‘s DSS worker doesn’t have much information on Sam, as he was removed from his home under urgent circumstances. Sam is placed with relative three counties away. Once the DSS Income Maintenance Worker enters the foster care evidence into NC Fast, Sam will disenroll from his Health Plan and return to NC Medicaid Direct.

Scenario Specific Protections in Place for Children Disenrolling Due to Foster Care Enrollment.
Health Plans will assist DSS child welfare workers access after hours information about the child, assist in securing urgent clinical needs, including finding providers available to see the child in the child’s region.
Child will be identified for care management if not previously identified.
Health Plans and CCNC work in partnership to support the effective transition of the child from NC Medicaid Managed Care to ensure continuity of care.

What if, after July 1, 2021, a Member Needs a Behavioral Health Service That is not Covered by Standard Plans?

A provider can request a transfer to NC Medicaid Direct and LME-MCO if a member needs a behavioral health or Intellectual or developmental disabilities (I/DD) service that is *not* covered by Standard Plans.

Provider Works with Member to Complete the Request

Member and provider discuss which services member needs that are not available in current plan.

Member or Legal Guardian Signs the Request

Member or guardian confirm the member wants to immediately disenroll from the Standard Plan.

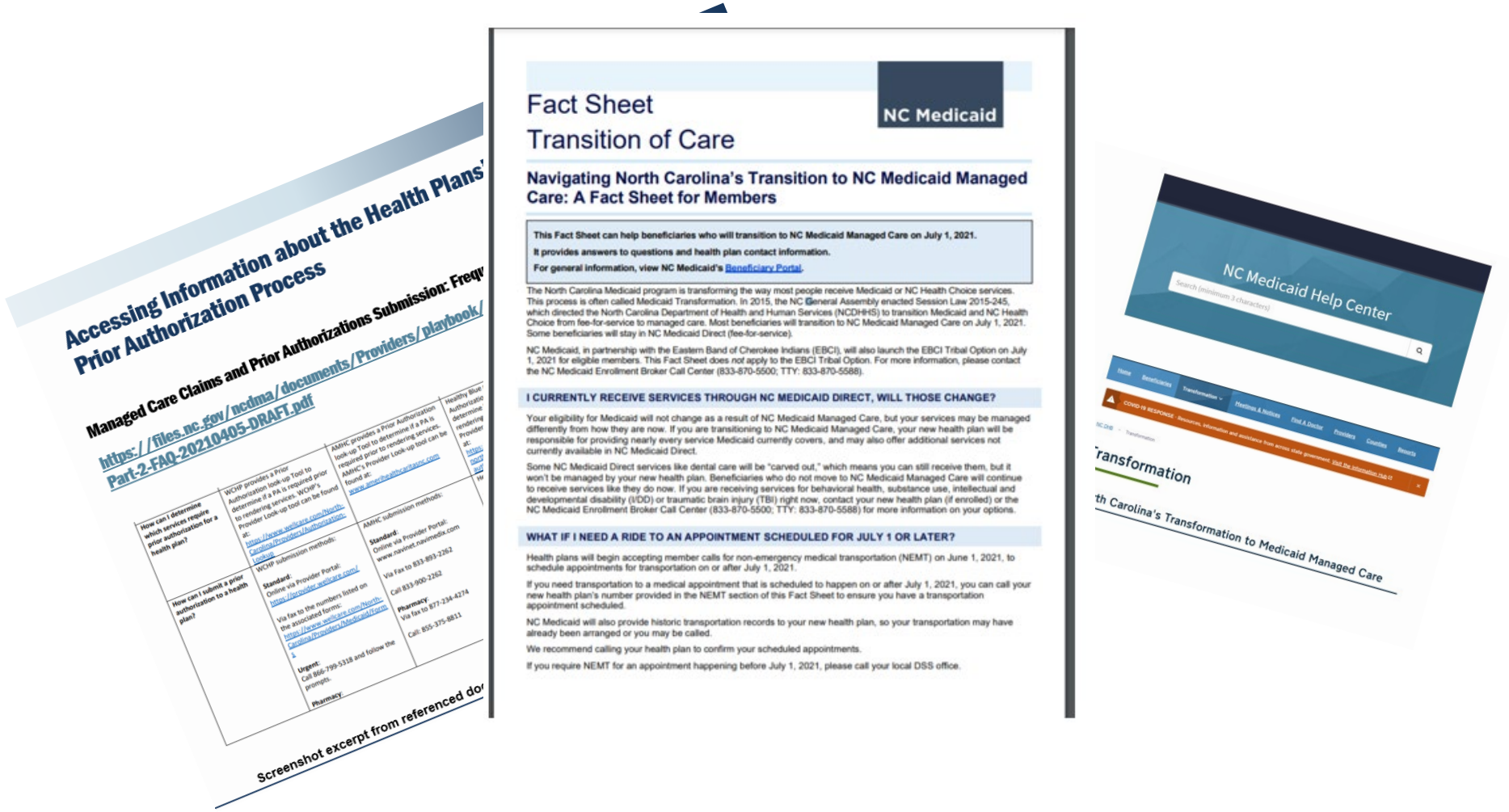
Provider Submits the Request

Provider submits the provider form and a service authorization form to the Enrollment Broker, which will send to appropriate Vendor within 24 hours.

NC Medicaid Reviews the Request and Transfers Member

NC Medicaid reviews the request and, if approved, transfers member to new plan within 1 business day.

Important Educational Resources Included in the Appendix of this Presentation



Transition of Care What Ifs

Where can providers find out which health plans their hospital or organization is contracted with?

What if a patient signed up for the wrong plan during the enrollment period?

What if a patient comes to the office for services at managed care launch and that provider is not in network with their plan?

If I am an AMH3, how do I get information on the behavioral health services my patients are receiving?

What if a patient chooses a Standard Plan, but because of their behavioral health needs should be in the LME-MCO/Tailored Plan?

Transitions for Children What Ifs

What if a child with complex medical needs that is obtaining care from multiple academic centers, is not able to get care from one specialist or center that is not in network with all their other specialists?

How do parents manage children in different plans (one child has Medicaid and the sibling has HealthChoice, or one child is in Standard Plan and the other is in Tailored Plan or Medicaid Direct)?

What if a child needs specialized care that they can only get outside of the state, such as from the Children's Hospital of Philadelphia (CHOP)? Will the process for covering these services be the same for all the plans?

When a child is referred to the Child Medical Examiner (CME) by the DSS social worker, does the CME have to be the child's primary care provider? If the CME is not enrolled in the same health plan as the child, is prior approval required? What if the exam is requested by another provider or law enforcement?

What if a foster care child needs to switch plans, will coverage under the new plan be retroactive to the beginning of the diagnosis/event that allows them to switch plans?

Bottom Line for Transitions Affecting Providers

- The **health plan will honor existing and active prior authorizations** on file with the North Carolina Medicaid or NC Health Choice program for services covered by the health plan **for the first 90 days after launch (Sept. 29, 2021) or until the end of the authorization period**, whichever occurs first.

- **For the first 60 days after Launch** (Aug. 30, 2021), **the health plan will pay claims and authorize services for Medicaid enrolled out-of-network providers equal to that of in-network providers until end of episode of care or for 60 days, whichever is less** (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).).

- **If a member transitions between health plans** after July 1, 2021, a **prior authorization authorized by their original health plan will be honored for the life of the authorization** by their new health plan

Additional transition of care-specific guidance can be found at https://medicaid.ncdhhs.gov/transformation/care-management/transition-care.

NC Medicaid Managed Care Enrollment Summary (As of 5/22/2021)

Total Members by Health Plan by Enrollment Method

All Regions	Active Selection	Auto-Enrollment	Total		Existing PCP in-network
Plan	Total Members	Total Members**	Members	% of Members	% of Members
AmeriHealth Caritas	12,120	264,048	276,168	19%	97%
HealthyBlue	104,870	251,578	356,448	25%	98%
Carolina Complete Health*	23,943	166,816	190,759	13%	98%
United Healthcare	37,824	283,815	321,639	22%	97%
WellCare	33,854	268,525	302,379	21%	97%
Tribal Option	76	3,630	3,706	0.3%	100%***
Total	212,687	1,238,412	1,451,099	100%	97%

*Carolina Complete Health is only available to members in Regions 3, 4 and 5.

**Totals include members temporarily living out of state that were auto-enrolled into plans.

***Members who have an existing PCP that is not in the Tribal Option network will remain in NC Medicaid Direct

Note: Total Members do not include the approximately 166,000 Medicaid beneficiaries who are due for Medicaid recertification between May 22 and July 1, 2021. After completing recertification, these members will be auto-enrolled into a health plan and will have a 90-day choice period to change plans like all other beneficiaries in Medicaid Managed Care.

Prompt Payment of Providers

- Health plans are responsible for **claims processing and timely payments to providers** for claims submitted **within 180 days of the date of service**.
- Health plans must, **within 18 calendar days of receiving the Medical claim**, **notify the provider whether the claim is clean** or request all additional information needed to timely process the claim.
- If the claim is clean**,** the health plan **must pay or deny within 30 days** of receipt.
- Health plans will be required to act on additional information that is submitted by a provider within the required timeframe.
- **Health plans that do not pay claims within the required timeframe** according to prompt pay requirements w**ill bear interest at the annual rate of 18 percent** beginning on the date following the day on which the claim should have been paid or was underpaid. In addition to interest, a health plan **shall pay the provider a penalty equal to one percent of the claim** per day.
- Providers do not have to make separate requests to the health plan for interest or penalty payments and are not required to submit another claim to collect the interest and penalty.
- The **health plan shall within 14 calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim** or pend the claim and request from the provider all additional information needed to timely process the claim.
- A **pharmacy pended claim shall be paid or denied within 14 calendar days of receipt of the requested additional information.**

For more information, see: https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Playbook-Provider-Payment-20200331.pdf

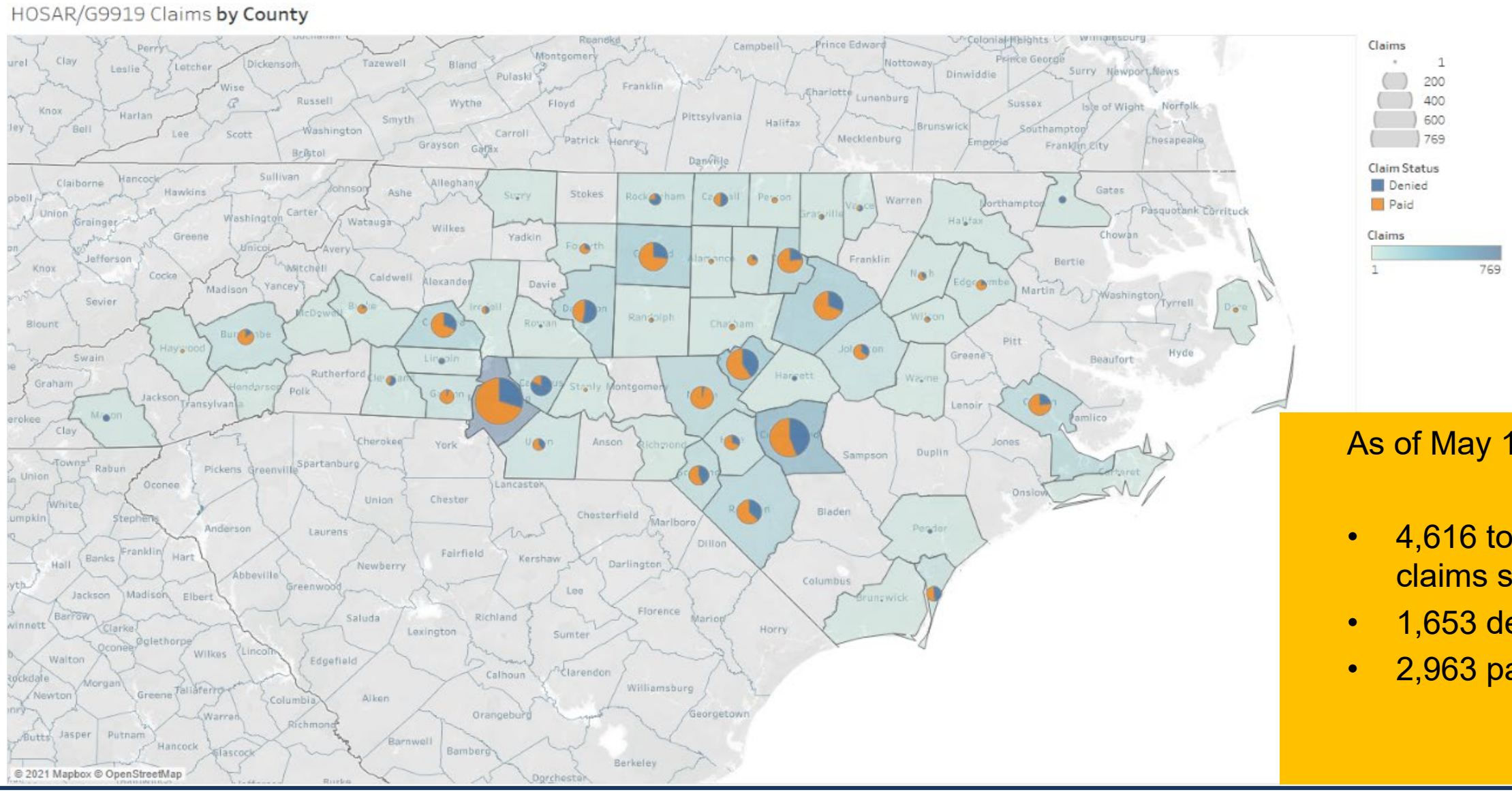
AMH Tier 3 Glidepath

Total # AMH Tier 3s Paid

- April: 1098
- May: 1186
- June: 1238

- Total Paid (for all 3 months) - **$31.8m**
  - **75%** of all AMH Tier 3s in final June payment
  - **80%** of Standard Plan members attached to the AMH Tier 3s

Healthy Opportunities Screening, Assessment & Referral (HOSAR)



As of May 13, 2021

- 4,616 total HOSAR claims submitted
- 1,653 denied claims
- 2,963 paid claims


QUESTIONS?

APPENDIX

Transition of Care Quick Reference

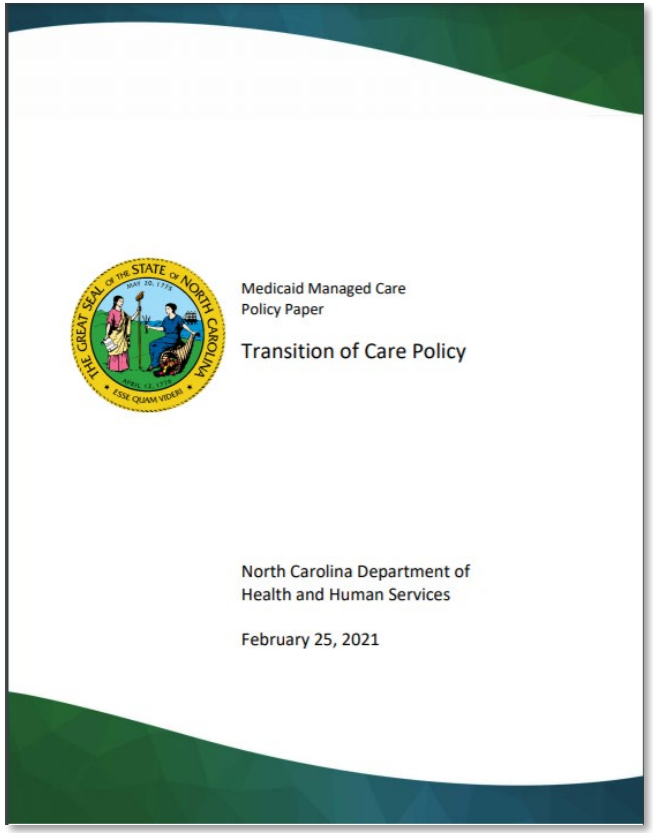
Safeguard	**Crossover** **In effect for members transitioning on July 1, 2021**	**Ongoing TOC** **If a member transitions between Standard Plan Health Plans (or between Medicaid Direct and standard Plan Health Plans) after July 1, 2021**
Ensuring continuity through data transfer	Standard Plan Health Plans are required to intake PA data from NCTracks and LME/MCOs. Standard Plan will also intake claims and pharmacy lock in data. All will help ensure member continuity of care and inform care management engagement.	Standard Plan Health Plans are required to transfer a member's claim history, pharmacy lock-in and open and recently closed PA data to the member's new Health Plan. Standard Plan Health Plan will also transfer a socio-clinical summary of information, health needs screening and care plan if applicable for all transitioning members.
Prior Authorization (PA) Continuity:	Standard Health Plans will honor Medical and Behavioral Health PAs active upon MCL for the first 90 days or until the expiration, whichever occurs sooner. If the health plan reassess and reduces, it must issue appeal rights. Pharmacy PAs will be honored for the life of the PA.	Standard Plan Health Plans must honor full term of all active prior authorizations for transitioning members.
Out of Network (OON) Provider Status	Standard Plan Health Plans must treat OON provider in parity with in-network providers for at least 60 days (or until the end of the episode of care) and longer in some circumstances.*	Standard Plan Health Plans must adhere to a 90-day transitional period (and longer in some circumstances) for transitioning members who experience an ongoing special condition or under an ongoing course of treatment.*
High Need Member Protections	LME/MCOs and CCNC will identify high risk transitioning members requiring a warm handoff with the Standard Plan Health Plan at launch. Standard Plan Health Plans will also be required to conduct expedited follow up for a broader identified High Need transitioning population.	Standard Plan Health Plans are required to expedite the care needs screening process for all newly enrolled ABD members. The Standard Plan Health Plan will coordinate a warm handoff for identified transitioning care managed members and all members disenrolling back to Medicaid Direct .
	*The health plan shall, in instances in which a Member transitions into a health plan from Medicaid Fee-for-Service, another health plan, or another type of health insurance coverage and the Member is in Ongoing Course of Treatment or has an Ongoing Special Condition permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g).	

For More Information

As beneficiaries move between delivery systems, including between health plans, the Department intends to maintain continuity of care for each Member and minimize the burden on providers during the transition.

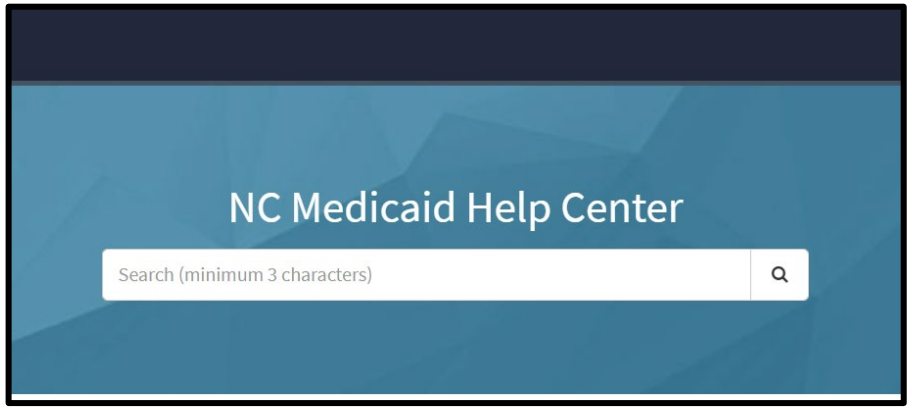
On February 25th, the Department published its finalized **Transition of Care Policy,** which includes:

- Data that health plans must share when a Member transitions into or out of a health plan
- Timelines for sharing required data
- Additional requirement for the transition of care-managed Members, or members transitioning to NC Medicaid Direct or Tribal Option
- Requirements for transitions that entail a change of providers (e.g. provider is no longer part of health plan network)



The Policy is available here

Reminder: Key Provider Information Resources



- NC Medicaid Help Center
- NCDHHS Transformation website (Including County & Provider Playbooks)
- **Health Plan websites**

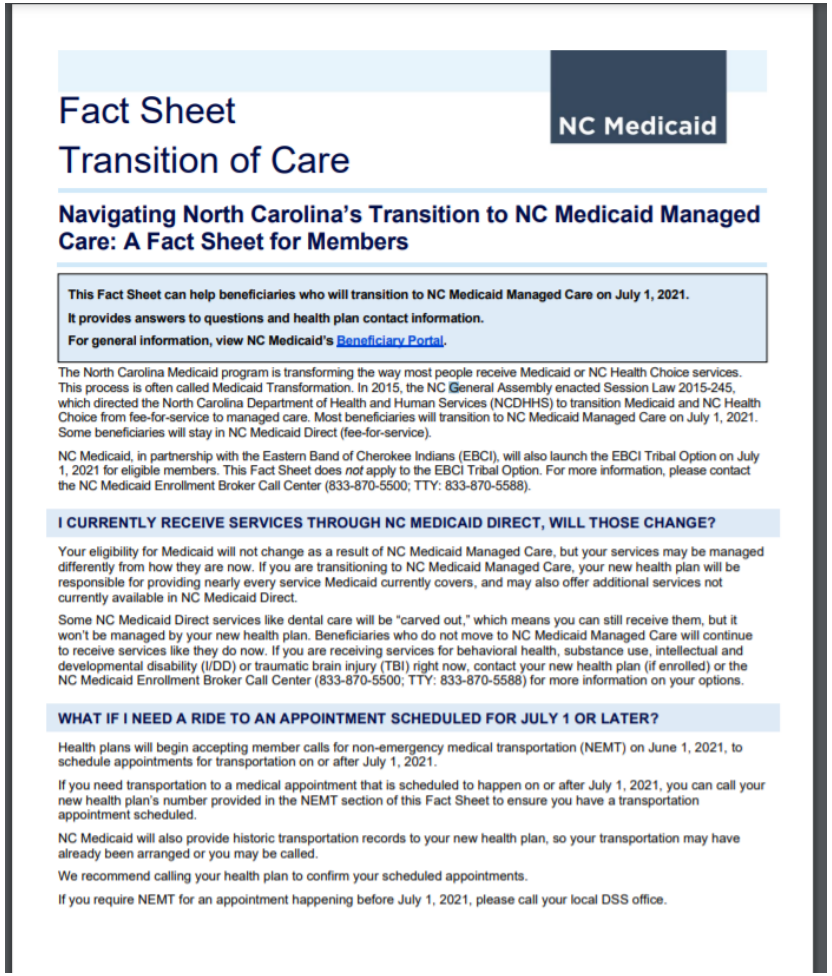
Accessing Information about the Health Plans' Prior Authorization Process

Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2

How can I determine which services require prior authorization for a health plan?	WCHP provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. WCHP's Provider Look-up tool can be found at: https://www.wellcare.com/North-Carolina/Providers/Authorization-Lookup	AMHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. AMHC's Provider Look-up tool can be found at: www.amerihealthcaritasnc.com	Healthy Blue provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. Healthy Blue's Provider Look-up tool can be found at: https://provider.healthybluenc.com/north-carolina-provider/prior-authorization-lookup	CCH provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. This tool will go live later this summer, before the launch of NC Medicaid Managed Care.	UNHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. UNHC's Provider Look-up tool can be found at: https://UHCprovider.com/priorauth
How can I submit a prior authorization to a health plan?	WCHP submission methods: **Standard**: Online via Provider Portal: https://provider.wellcare.com/ Via fax to the numbers listed on the associated forms: https://www.wellcare.com/North-Carolina/Providers/Medicaid/Forms **Urgent**: Call 866-799-5318 and follow the prompts. **Pharmacy**:	AMHC submission methods: **Standard**: Online via Provider Portal: www.navinet.navimedix.com Via Fax to 833-893-2262 Call 833-900-2262 **Pharmacy**: Via fax to 877-234-4274 Call: 855-375-8811	Healthy Blue submission methods: **Standard**: Online via Provider Portal: https://provider.healthybluenc.com/north-carolina-provider/prior-authorization Via Fax to: 800-964-3627 (Inpatient) 844-445-6649 (Outpatient) **Urgent**: Call 844-594-5072	CCH submission methods: **Standard**: Online via Secure Provider Portal: http://carolinacompletehealth.com/ Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization. This tool will go live later this summer, before the launch of NC Medicaid Managed care. Call 833-552-3876 Via Fax to 919-670-4948	UNHC submission methods: **Standard**: Online via Prior Authorization and Notification Tool on Link: https://UHCprovider.com/priorauth If you're unable to use Link, call Provider Services at 877-842-3210. **Urgent**: Call Provider Services at 877-842-3210 and follow the prompts. **Pharmacy**:

Screenshot excerpt from referenced document to provide example. Links not active.

Resources to Support Beneficiaries



Fact Sheet
Transition of Care

NC Medicaid

Navigating North Carolina's Transition to NC Medicaid Managed Care: A Fact Sheet for Members

This Fact Sheet can help beneficiaries who will transition to NC Medicaid Managed Care on July 1, 2021.

It provides answers to questions and health plan contact information.

For general information, view NC Medicaid's Beneficiary Portal.

The North Carolina Medicaid program is transforming the way most people receive Medicaid or NC Health Choice services. This process is often called Medicaid Transformation. In 2015, the NC General Assembly enacted Session Law 2015-245, which directed the North Carolina Department of Health and Human Services (NCDHHS) to transition Medicaid and NC Health Choice from fee-for-service to managed care. Most beneficiaries will transition to NC Medicaid Managed Care on July 1, 2021. Some beneficiaries will stay in NC Medicaid Direct (fee-for-service).

NC Medicaid, in partnership with the Eastern Band of Cherokee Indians (EBCI), will also launch the EBCI Tribal Option on July 1, 2021 for eligible members. This Fact Sheet does *not* apply to the EBCI Tribal Option. For more information, please contact the NC Medicaid Enrollment Broker Call Center (833-870-5500; TTY: 833-870-5588).

I CURRENTLY RECEIVE SERVICES THROUGH NC MEDICAID DIRECT, WILL THOSE CHANGE?

Your eligibility for Medicaid will not change as a result of NC Medicaid Managed Care, but your services may be managed differently from how they are now. If you are transitioning to NC Medicaid Managed Care, your new health plan will be responsible for providing nearly every service Medicaid currently covers, and may also offer additional services not currently available in NC Medicaid Direct.

Some NC Medicaid Direct services like dental care will be "carved out," which means you can still receive them, but it won't be managed by your new health plan. Beneficiaries who do not move to NC Medicaid Managed Care will continue to receive services like they do now. If you are receiving services for behavioral health, substance use, intellectual and developmental disability (I/DD) or traumatic brain injury (TBI) right now, contact your new health plan (if enrolled) or the NC Medicaid Enrollment Broker Call Center (833-870-5500; TTY: 833-870-5588) for more information on your options.

WHAT IF I NEED A RIDE TO AN APPOINTMENT SCHEDULED FOR JULY 1 OR LATER?

Health plans will begin accepting member calls for non-emergency medical transportation (NEMT) on June 1, 2021, to schedule appointments for transportation on or after July 1, 2021.

If you need transportation to a medical appointment that is scheduled to happen on or after July 1, 2021, you can call your new health plan's number provided in the NEMT section of this Fact Sheet to ensure you have a transportation appointment scheduled.

NC Medicaid will also provide historic transportation records to your new health plan, so your transportation may have already been arranged or you may be called.

We recommend calling your health plan to confirm your scheduled appointments.

If you require NEMT for an appointment happening before July 1, 2021, please call your local DSS office.

Available on the NC Medicaid Transition of Care webpage

Managing Open Appeals

Facilitating Uninterrupted Service Coverage

Crossover

- If an initial service request is denied in NC Medicaid Direct for dates of service after July 1, provider may resubmit new service request to member's Health Plan for review.
- If a Health Plan reassesses authorized service on a Crossover PA and limits or terminates authorization at 90 days, it must issue appeal rights.
- If a Health Plan is supporting a transitioning member under Maintenance of Service, it is responsible for maintaining service until reassessment.

Ongoing

- If a member transitions between Health Plans is under Continuation of Benefit, the receiving Health Plan must maintain services until reassessment.
- Health plans will upload all adverse determination to Clearinghouse and the member's originating Health Plan will transfer appeals status information, as applicable, to the member's new Health Plan.

Managed Care Populations

While most Medicaid beneficiaries will enroll in NC Medicaid Managed Care, some people will not. The table below outlines who must enroll, who may enroll, and who cannot enroll.

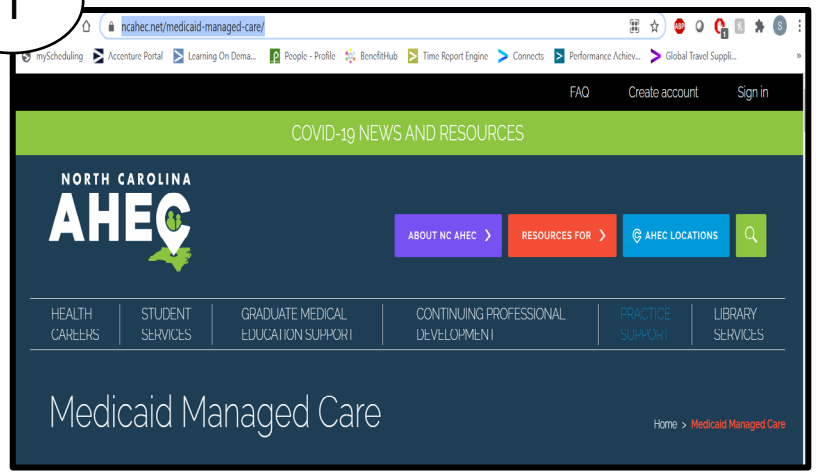
MANDATORY	EXEMPT	EXCLUDED[1,2]
Must enroll in a health plan	**May enroll** in a health plan or stay in NC Medicaid Direct	**Cannot enroll** in a health plan; stay in NC Medicaid Direct
Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled	Federally recognized tribal members/IHS eligible beneficiaries, beneficiaries eligible for behavioral health Tailored Plans	Family Planning Program, Medically Needy, Health Insurance Premium Payment (HIPP), Program of All-Inclusive Care for the Elderly (PACE), Refugee Medicaid

[1]Some individuals are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, Community Alternatives Program for Children (CAP-C), and Community Alternatives Program for Disabled Adults (CAP-DA).

[2]Some federally recognized tribal members/IHS eligible beneficiaries are excluded and may enroll in the EBCI Tribal Option.

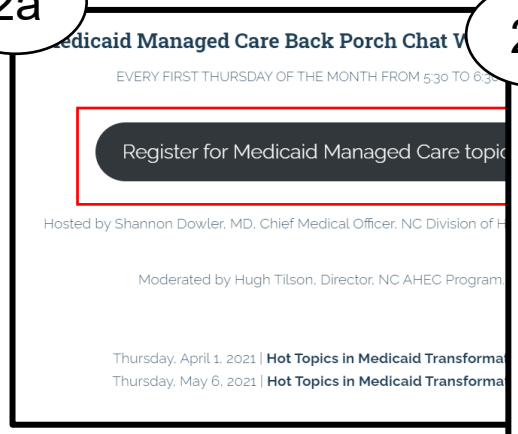
How To Sign up for the Back Porch Chat Webinar Series

1

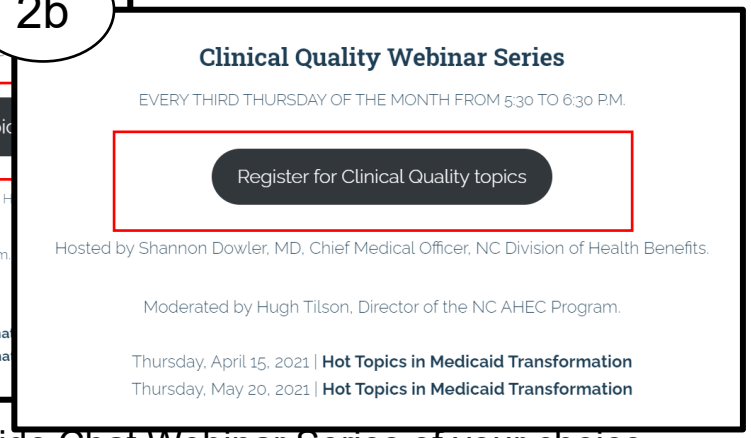


1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



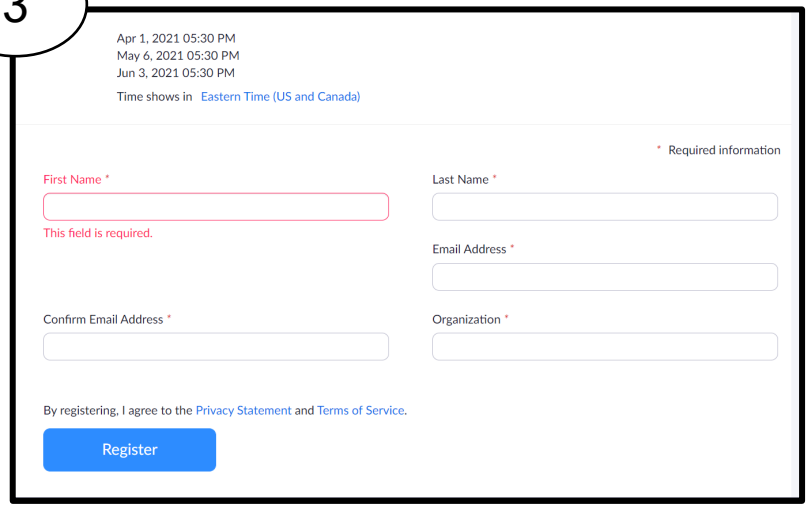
2b



2. Scroll down to the Fireside Chat Webinar Series of your choice

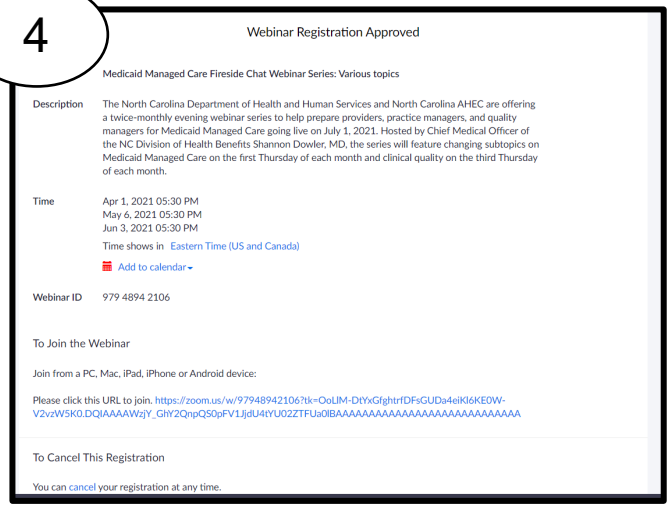
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.