Division of Health Benefits
NC Medicaid Managed Care Update

Jay Ludlam, Assistant Secretary
NC Medicaid Transformation

March 8, 2019
Vision for NC Medicaid Managed Care

“Improving the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health.”
# Prepaid Health Plans

Create single point of accountability for care and outcomes for Medicaid beneficiaries through two types of Plans

<table>
<thead>
<tr>
<th>Standard Plans</th>
<th>Tailored Plans</th>
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<tr>
<td>✓ Beneficiaries benefit from integrated physical &amp; behavioral health services</td>
<td>✓ Specialized managed care plans targeted toward populations with significant BH and I/DD needs</td>
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<tr>
<td>✓ “Primary care” behavioral health spend included in PHP capitation rate</td>
<td>✓ Access to expanded service array</td>
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<td>✓ Phased implementation – Nov. 2019 &amp; Feb. 2020</td>
<td>✓ Behavioral Health Homes</td>
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<td>✓ Projected for July 2021</td>
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PHPs for NC Medicaid Managed Care

Statewide contracts

- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina, Inc.
- UnitedHealthcare of North Carolina, Inc.
- WellCare of North Carolina, Inc.

Regional contract – Regions 3 & 5

- Carolina Complete Health, Inc.
Managed Care Regions and Rollout Dates

Rollout Phase 1: Nov. 2019 – Regions 2 and 4
Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6
With the transition to managed care, DHHS will ensure

- A person with a scheduled appointment will be seen by their provider
- A person’s prescription will be filled by the pharmacist
- Calls made to call centers are answered promptly
- Individuals know their chosen or assigned PHP
- Individuals have timely access to information and are directed to the right resource
- A provider enrolled in Medicaid prior to Nov 1, will still be enrolled
- A provider is paid for care delivered to members
- PHPs have sufficient networks to ensure member choice
What beneficiaries can expect
Understanding MC Impacts to Beneficiaries

What’s New
1. Beneficiaries will be able to choose their own health care plan
2. Most, but not all, people will be in Medicaid Managed Care
3. An enrollment broker will assist with choice

What’s Staying the Same
1. Eligibility rules will stay the same
2. Same health services/treatments/supplies will be covered
3. The beneficiary Medicaid Co-Pays, if any, will stay the same
4. Beneficiaries report changes to local DSS
Beneficiary Experience – Auto Assignment

Beneficiaries who don’t choose a health plan will be assigned one automatically, consistent with the following components in this order:

1. Where the beneficiary lives.

2. Whether the beneficiary is a member of a special population (e.g. member of federally recognized tribes or BH I/DD Tailored Plan eligible).

3. If the beneficiary has a historic relationship with a particular PCP/AMH.

4. Plan assignments of other family members.

5. If the beneficiary has a historic relationship with a particular PHP in the previous twelve (12) months (e.g., “churned” off/into Medicaid Managed Care).
Member Timeline – Phase 1

2019

Feb

- Initial letter sent to beneficiaries in 2 counties
- Address verification letter sent to remaining counties

March

- Flyers posted at DSS
- Address corrections to DSS

April

- 2nd letter to members
- Member Outreach activities

May

- Public Service Announcements
- PHP marketing materials

June 3rd

- EB Call Center Open
- Welcome Packets mailed

July

- Open Enrollment Begins - July 15th

Aug

- Open Enrollment Ends - Sept 13th

Sept

- Members auto assigned to PHPs based on algorithm

Oct

- Member ID cards
- Member Handbooks

Nov 1st

Managed Care Launch - Phase 1

Dec

- Member feedback
- Evaluation of materials, process
Member Timeline – Phase 2

2019

June 3rd

• EB Call Center Open
• Outreach Activities

July

• Flyers posted at DSS
• Address corrections to DSS

Aug

• Letters to members
• Member Outreach activities

Sept 2nd

Enrollment Welcome Packets

Oct

• Open Enrollment Begins- Oct 14th

Nov

Dec

• Open Enrollment Ends- Dec 13th

2020

Jan

• Member ID cards
• Member Handbooks

Feb 1st

Managed Care Launch- Phase 2

March

• Member feedback
• Evaluation of materials, process
What counties can expect
Managed Care and DSS Workers

County DSS will CONTINUE:
• Processing Medicaid applications, changes of circumstance, and redeterminations.
• NEMT for FFS Beneficiaries
• Updating PCP for FFS Beneficiaries

County DSS will not be responsible for:
• Choice Counseling
• Enrolling Members in Plans
• NEMT for Managed Care Members (unless contracted with PHP)
• Updating PHP/PCP for Managed Care Beneficiaries

County DSS will START:
• Referring beneficiaries to the enrollment broker for PHP counseling & assignments.
• Referring beneficiaries to their Plan for PCP selection or changes
# Managed Care Impacts on DSS

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<th>Staff Time</th>
<th>Operational</th>
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<tr>
<td>• Increased in-person/walk-in contacts</td>
<td>• Non-Emergency Medical Transportation (NEMT) changes</td>
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<td>• Increased telephone calls</td>
<td>• Potential changes in agency layout/traffic flow</td>
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<td>• Training time for all staff</td>
<td>• Potential fiscal impacts re: staff, NEMT vehicles, contracts</td>
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<td>• Maintenance of scripts, information, updates</td>
<td>• Potential additional phones/interview areas to connect beneficiaries to the EB</td>
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<td>• Participation in outreach events</td>
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County Managers and County Commissioners

County Leadership:
• DHHS and Associations are engaged in joint planning
• Joint messaging, ongoing meetings
• Specific Training for Commissioners, Finance Officers, Managers

DHHS assist with evaluating financial impacts on:
• NEMT for Managed Care and FFS Members
• County Transportation system impacts
• Staff Time
• Additional Utilization Based Payments

County Involvement in policy recommendations:
• Tailored Plans Design (regions, governance)
• DSS Eligibility Processing
• Public Health Case Management programs
What providers can expect
Provider Experience In Managed Care

Addressing Administrative Burden:

• a centralized and streamlined provider enrollment and credentialing process;

• transparent, timely and fair payments for providers;

• a single statewide drug formulary that all PHPs will be required to utilize;

• same services covered in Medicaid managed care and fee-for-service (with exception of services carved out of Medicaid Managed Care)

• Department’s definition of “medical necessity” used by PHPs when making coverage decisions; and

• providers offered some contracting “guardrails”, standard PHP contract language
## Managed Care Impacts on Providers

### Contract/Payment

- Potential contract with multiple PHPs, CINs
- Opportunity to negotiate rates*  
- Understanding contract terms, conditions, payment and reimbursement methodologies
- Network adequacy and out of networks standards
- AMH program/tiered payments

### Information/Problem Solving

- Build relationships with health plans
- PHP provider assistance line
- Provider appeals procedures specified in PHP provider manual
- DHHS provider ombudsman to assist with problem solving
- Opportunities to provide feedback i.e. AMH TAG

* rate floors apply
Questions