Fact Sheet #1
Introduction to Medicaid Transformation: Part 1 – Overview

NC Medicaid

NC Medicaid 2019 County Playbook

What is Medicaid Transformation?

Medicaid Transformation is changing the way most people receive Medicaid services. In 2015, the NC General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services (DHHS) to transition Medicaid and NC Health Choice from fee-for-service to managed care.

Under the fee-for-service model, DHHS reimbursed physicians and healthcare providers based on the number of services they provide or the number of procedures they order. This model will now be known as **NC Medicaid Direct**. Only a small number of people will stay in Medicaid Direct.

Under Managed Care, instead of contracting directly with providers, the State will contract with insurance companies, called Prepaid Health Plans or PHPs. These insurance companies will be paid a pre-determined set rate per person to provide all services, known as a capitated rate. This model is known as **NC Medicaid Managed Care**. Approximately 1.6 million of the current 2.1 million Medicaid beneficiaries will transition to Medicaid Managed Care.

CHANGES FOR MEDICAID BENEFICIARIES

Medicaid Managed Care will bring changes for most Medicaid beneficiaries.

- Medicaid services under Managed Care will now be administered by health plans.
- Beneficiaries will be able to choose their health plan and primary care provider (PCP). They will have new support systems available to help them make that choice.
- Medicaid services will not change, but the health plans may offer enhanced services to their plan members, such as smoking cessation programs.
- Medicaid eligibility rules will not change because of Medicaid Transformation.

Local Departments of Social Services (DSS) will have materials to share with beneficiaries about the changes. Current beneficiaries will receive information by mail that outlines actions to be taken, when to take those actions, and who they can contact for assistance.

KEY TERMS YOU SHOULD KNOW

ELIGIBILITY refers to whether a person qualifies for Medicaid or NC Health Choice. Eligible individuals may need to enroll in a health plan.

ENROLLMENT is the process of joining a health plan that is responsible for that person's Medicaid health coverage.

BENEFICIARY refers to a person who is eligible for Medicaid or NCHC. Once a beneficiary enrolls in a health plan, he or she becomes a **MEMBER** of that health plan.

Within Medicaid Managed Care, there are **STANDARD PLANS** (members will benefit from integrated physical & behavioral health services) and **TAILORED PLANS** (specialized plans that offer integrated services for members with significant behavioral health needs and intellectual/developmental disabilities).

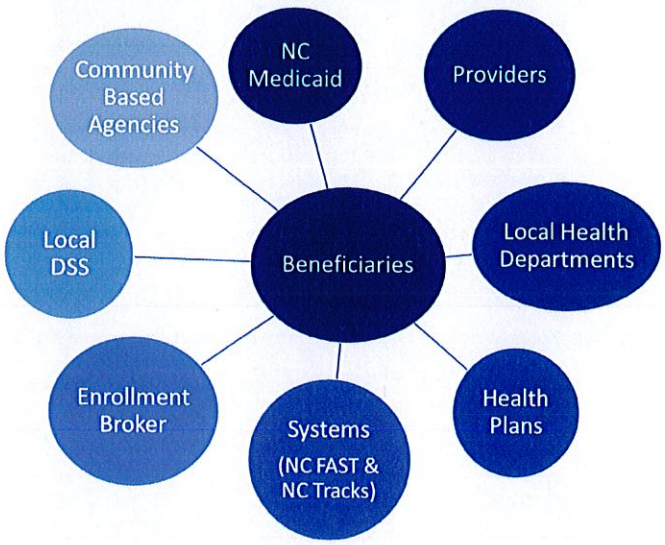
NC Medicaid determines the populations in Managed Care who will enroll in a health plan:

MUST ENROLL	CANNOT ENROLL	MAY ENROLL
Required to enroll in a health plan.	Stays in Medicaid Direct.	May enroll in a health plan or stay in Medicaid Direct.
Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled. (MANDATORY)	Family Planning Program, Medically Needy, Health insurance premium payment (HIPP), Program of all-inclusive care for the elderly (PACE), Refugee Medicaid (EXCLUDED*)	Federally recognized tribal members, beneficiaries who would be eligible for behavioral health tailored plans (until they become available)** (EXEMPT)

*Some beneficiaries are temporarily excluded and become Mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, & Community Alternatives Program for Children (CAP-C).

**Target launch date for Tailored Plans is mid-2021.

KEY PARTNERS AND THEIR ROLES



Beneficiaries are at the center of this process. Partners need to work together to support beneficiaries through this transformation and ongoing.

- **NC Medicaid**: provide Medicaid supervision, oversight of health plans and other partners
- **Local DSS**: determine Medicaid eligibility, update beneficiary information, Medicaid case management
- **NC FAST & NC Tracks**: these systems will continue to transmit beneficiary information; NC FAST will remain the system of record.
- **Enrollment Broker**: unbiased, third party entity to provide enrollment assistance and help choosing a plan; outreach & education to beneficiaries.
- **Health Plans**: provide health care and related services to their members
- **Providers**: will contract with the health plans; must continue to enroll as an NC Medicaid or NC Health Choice provider
- **Local Health Departments**: continue to provide services under Medicaid Direct; may contract with health plans for some services
- **Community based-agencies**: disseminate information to help educate the public on changes to Medicaid; provide feedback to DHHS from clients they serve

We will also partner with an **Ombudsman**, someone who is appointed to help resolve complaints. More information will be forthcoming.

WHAT DOES MEDICAID TRANSFORMATION MEAN FOR YOU?

The local DSS will be impacted by Medicaid Transformation. As with beneficiaries, many things will stay the same, but some things will change. This playbook is one tool to help you understand what is changing. NC Medicaid will continue to provide in-person training for each local DSS to help you stay informed and learn how to help beneficiaries.

DSS Directors should be aware of timelines associated with Medicaid Transformation and ensure that related information and communications (like these Fact Sheets) are shared with county partners and with staff. All staff who interact with beneficiaries should be aware of Medicaid Transformation and the changes it brings. Directors can contribute to the success of this initiative by ensuring staff participate in upcoming DSS Medicaid Transformation training, interacting and collaborating with DSS liaisons from the Enrollment Broker and the health plans, and by championing this change. Be on the lookout for "**BUDGET CONSIDERATIONS**" in other Fact Sheets to help facilitate conversations about budgeting.

DSS Program Managers and Supervisors have a similar role. We encourage you to provide staff with opportunities to participate in training. Discuss upcoming changes with your teams and work to understand the role of the Enrollment Broker and health plans. Share information and materials with your staff as it becomes available and participate in Medicaid Transformation training.

DSS Direct Line Staff should actively participate in training and be prepared to answer beneficiary questions related to Medicaid Transformation. You will not know all the answers – the best customer service you can provide is to direct beneficiaries and members to the right place. A goal of NC Medicaid is to support you with the information you need.

Please make a point to update contact information at **every interaction** with beneficiaries! NC FAST will remain the system of record. Keeping addresses up-to-date is very important.

Please see below for a summary of how the role of the local DSS will change.

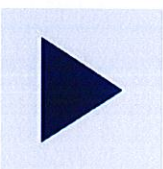
More information on key dates and milestones within Medicaid Transformation are provided in the **Introduction to Medicaid Transformation: Part 2 – Enrollment Fact Sheet.**

County DSS will CONTINUE:

- Processing Medicaid applications, changes and redeterminations.
- Generating replacement Medicaid cards for NC Medicaid Direct.
- Non-Emergency Medical Transportation (NEMT) for NC Medicaid Direct.
- Updating Primary Care Provider (PCP) for NC Medicaid Direct.

County DSS will not be responsible for:

- Choice counseling to help beneficiaries choose a health plan.
- Enrolling beneficiaries in health plans.
- NEMT for health plan members.
- Updating health plan or PCP for health plan members.
- Generating replacement health plan ID cards.



County DSS will START:

- Referring beneficiaries to the Enrollment Broker for health plan choice counseling & enrollment assistance.
- Referring beneficiaries to their health plan for PCP updates, NEMT, and other requests related to their health plan.

GOALS FOR DAY 1 OF MANAGED CARE

The Department of Health and Human Services' (DHHS) highest priority is the health and well-being of the people it serves. DHHS is committed to 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. DHHS' main focus for Medicaid Transformation is that on Day 1:

- 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 health plan;
- Individuals have timely access to information and are directed to the right resource;
- Health plans have sufficient networks to ensure member choice;
- A provider enrolled in Medicaid prior to the launch of Medicaid health plans will still be enrolled; and
- A provider is paid for care delivered to members through evidence-based interventions designed to address non-medical factors that drive health outcomes and costs.

Fact Sheets will be updated periodically with new information. Created 5/16/2019.
For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation

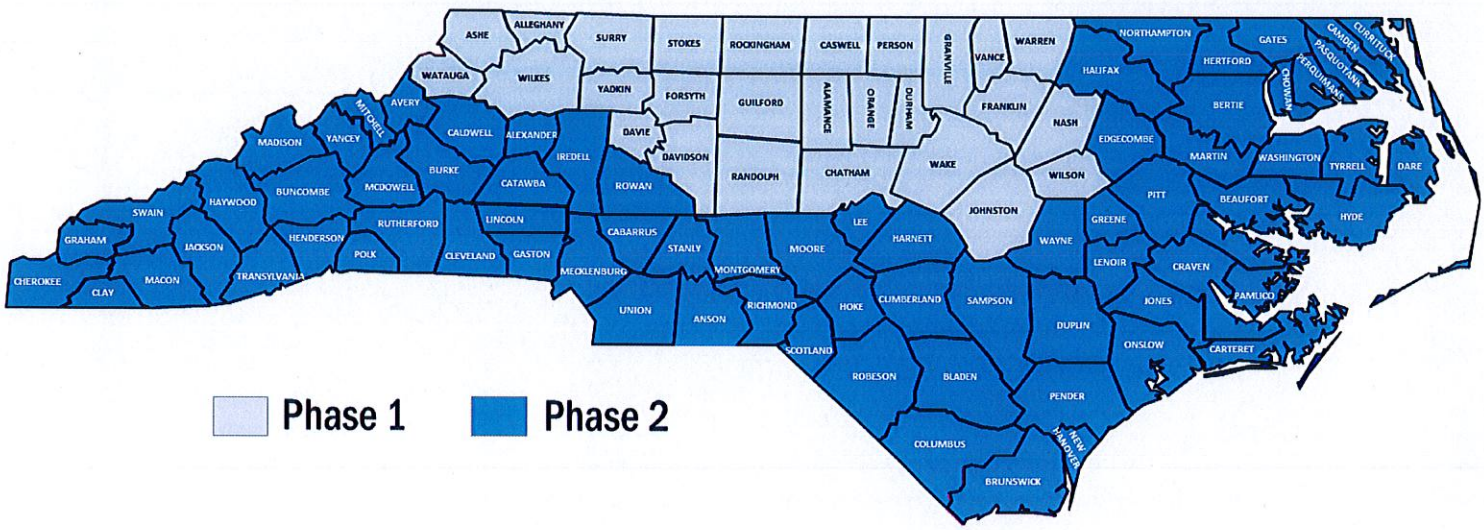
NC Medicaid

Fact Sheet #2
Introduction to Medicaid Transformation: Part 2 – Enrollment & Timelines

NC Medicaid 2019 County Playbook

Medicaid Managed Care is Rolling Out in Two Phases

The Department of Health and Human Services (DHHS) will transition most beneficiaries to NC Medicaid Managed Care in two phases based on region. A small number of beneficiaries will stay in NC Medicaid Direct. This Fact Sheet provides details on how and when these transitions will occur. Phase 1 will run from June 28, 2019, to November 1, 2019 and Phase 2 will run from September 2, 2019, to February 1, 2020.



*For a list of counties by region, please see the Appendix attached to this Fact Sheet.

State of North Carolina • Department of Health and Human Services • Division of Health Benefits (NC Medicaid)
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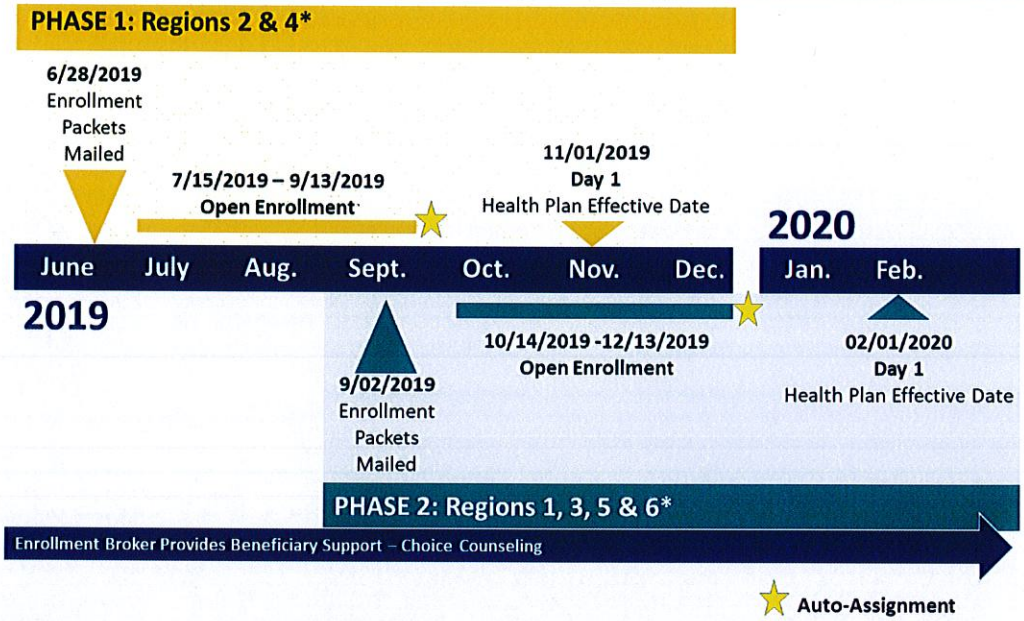
NC MEDICAID MANAGED CARE TRANSITION TIMELINE



*Dates are approximate and subject to change

MILESTONE	IMPORTANCE	PHASE 1 DATE(S)	PHASE 2 DATE(S)	WHO CAN HELP?
Enrollment Packets mailed from Enrollment Broker	Current beneficiaries will receive details by mail on who in their household can enroll in a health plan, what plans they have to choose from, and how they can enroll. Beneficiaries may select a primary care provider (PCP) & enroll in health plans.	Begins 6/28/2019*; packets mailed to beneficiaries who must enroll or may choose to enroll in a health plan.	Begins 9/2/2019*; packets mailed to beneficiaries who must enroll or may choose to enroll in a health plan.	Beneficiaries can contact the Enrollment Broker for assistance.
Open Enrollment	Beneficiaries may select a PCP & enroll in health plans. Postcard reminders will be sent to crossover population who has not yet enrolled.	7/15/2019 – 9/13/2019*	10/14/2019 – 12/13/2019*	Beneficiaries can contact the Enrollment Broker for assistance.
Auto-Assignment	Beneficiaries who have not selected a health plan or PCP will be assigned one systematically.	9/16/2019*	12/16/2019*	Beneficiaries can contact the Enrollment Broker for assistance.
Day 1 – Health Plan Effective Date	Beneficiaries in NC Medicaid Managed Care will now receive Medicaid services from their assigned health plan.	11/1/2019*	2/1/2020*	Beneficiaries can contact their health plan and/or the Enrollment Broker for assistance.

*Dates are approximate and subject to change

HOW ENROLLMENT OCCURS

Beneficiaries can enroll in plans in various ways. They can:

- select a Primary Care Provider (PCP) and health plan through the Enrollment Broker.
  - By calling 1-833-870-5500 (toll free)
  - Online at ncmedicaidplans.gov
  - By completing and returning a paper enrollment form by fax or mail
  - Using the NC Medicaid Managed Care mobile app
- be Auto-Assigned to a health plan and PCP if they do not choose one by the deadline.

Auto-assignment is based on 1) where the beneficiary lives, 2) whether he or she is a member of a special population, 3) historical provider-beneficiary relationship, 4) health plan assignments of other family members, and 5) previous health plan enrollment within the past 12 months.

Beneficiaries may also indicate PCP and health plan preference in NC FAST (via ePASS application or caseworker entry).

WHEN ENROLLMENT OCCURS

During the transition/rollout period, as noted above. (Note: Beneficiaries may change health plans at any time during Open Enrollment).

After Day 1 (when health plans begin coverage for members):

- New Applicants –
  - Enrollment is effective the month the application is dispositioned. (This may mean a portion of their eligibility period will be NC Medicaid Direct.)
- Beneficiaries with Change of Circumstance Impacting Enrollment -
  - Enrolled or disenrolled effective the month following the change.
- At Redetermination:
  - Beneficiaries may choose to remain with current health plan or make a change.

Beneficiaries have a 90-DAY CHOICE PERIOD in which to change health plans for any reason. The 90-days starts as of the effective date of enrollment.

CHOICES FOR ENROLLMENT

Beneficiaries will have 4 to 5 health plans to choose from when they enroll, based on the region in which they live:

- WellCare
- UnitedHealthcare Community Plan
- Healthy Blue
- AmeriHealth Caritas
- Carolina Complete Health*

The Enrollment Broker can assist beneficiaries in choosing a health plan and a PCP.

*Carolina Complete Health, Inc. is only available to beneficiaries in Regions 3 & 5 (For a list of counties by region, please see the Appendix attached to this Fact Sheet.)

BUDGET CONSIDERATIONS:

Milestones in Medicaid Transformation described above may result in additional foot traffic and phone calls to the agency. Please reference "Fact Sheet #3: Increase in Beneficiary Contact."

Fact Sheets will be updated periodically with new information. Created 5/16/2019.
For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation

APPENDIX: Full list of counties by region.

Region 1

Avery
Buncombe
Burke
Caldwell
Cherokee
Clay
Graham
Haywood
Henderson
Jackson
Macon
Madison
McDowell
Mitchell
Polk
Rutherford
Swain
Transylvania
Yancey

Region 2

Alleghany
Ashe
Davidson
Davie
Forsyth
Guilford
Randolph
Rockingham
Stokes
Surry
Watauga
Wilkes
Yadkin

Region 3

Alexander
Anson
Cabarrus
Catawba
Cleveland
Gaston
Iredell
Lincoln
Mecklenburg
Rowan
Stanly
Union

Region 4

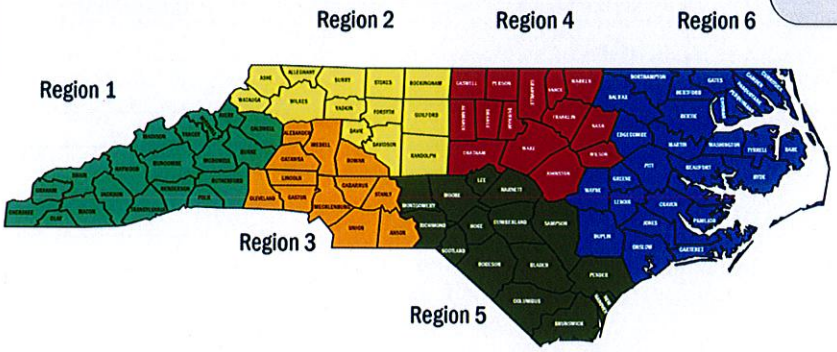
Alamance
Caswell
Chatham
Durham
Franklin
Granville
Johnston
Nash
Orange
Person
Vance
Wake
Warren
Wilson

Region 5

Bladen
Brunswick
Columbus
Cumberland
Harnett
Hoke
Lee
Montgomery
Moore
New Hanover
Pender
Richmond
Robeson
Sampson
Scotland

Region 6

Beaufort
Bertie
Camden
Carteret
Chowan
Craven
Currituck
Dare
Duplin
Edgecombe
Gates
Greene
Halifax
Hertford
Hyde
Jones
Lenoir
Martin
Northampton
Onslow
Pamlico
Pasquotank
Perquimans
Pitt
Tyrrell
Washington
Wayne



Fact Sheet #3
Increase in Beneficiary Contact

NC Medicaid 2019 County Playbook

Potential for Higher Call Volumes & Foot Traffic at the DSS

Change almost always prompts questions. Many Medicaid beneficiaries will turn to their local Department of Social Services (DSS) to get answers. As a result, the local DSS will likely experience higher call volumes and foot traffic. You can anticipate when increased volumes are likely based upon the Medicaid Transformation timelines associated with your county.

The Introduction to Medicaid Transformation – Part 2: Enrollment & Timelines Fact Sheet outlined some of the key milestones most of our beneficiaries will experience in the transition to Medicaid Managed Care. We recommend that the local DSS prepare for an increase in calls and visits around the time that these milestones occur. Please reference the table below for approximate dates we anticipate will result in increased contact. We have also included examples of scenarios to demonstrate why a beneficiary may contact the DSS (or other community partners) during this time. NC Medicaid will provide the local DSS with additional training to help counties prepare for transformation.

Milestone	Phase 1 Timeframe to expect increased contact	Phase 2 Timeframe to expect increased contact	Example Scenario
Enrollment Packets mailed to beneficiaries	Starting 6/28/2019* (all should be mailed within 10 Business days)	Starting 9/2/2019* (all should be mailed within 10 Business days)	Joe receives a letter from NC Medicaid explaining that he and his family need to enroll in a health plan. Instead of calling the toll-free number on the form, he calls his caseworker to make sure this is really something he has to do.
Reminder Postcards mailed to beneficiaries	Starting 8/13/2019*	Starting 11/13/2019*	Angie receives a postcard from NC Medicaid reminding her about Open Enrollment. She remembers seeing something about that a few weeks ago, but misplaced her paperwork. She calls the main number for her local DSS to see if they can help.
Auto-Assignment	Starting 9/16/2019* Health Plans will mail Welcome Packets to their members within 7 Business days of plan assignment.	Starting 12/16/2019* Health Plans will mail Welcome Packets to their members within 7 Business days of plan assignment.	Lola received mail from NC Medicaid about enrolling in a health plan, but she ignored it. She is auto-assigned to a health plan after Open Enrollment ends. She then receives mail from one of the health plans containing a handbook and an insurance card. She calls her Medicaid caseworker to ask if she still has Medicaid.

***Dates are approximate and subject to change**

BUDGET CONSIDERATIONS:

Periodic increases in call volume and foot traffic may impact your staffing needs. Please consider the following to determine possible implications for your budget.

- Do we have the resources to hire temp staff to support the increase in foot traffic and phone calls? (NC Medicaid is reviewing the possibility of 75% reimbursement for temp staff who are updating addresses in NC FAST. More information will be shared in the coming weeks.)
- Do we have the resources to upgrade staff (ex. clerical staff to Income Maintenance Caseworker/IMC-1) to allow for additional responsibilities to support beneficiaries?
- What is the current volume of calls our office receives on a daily basis? How would a call volume increase of 15%, 20%, or 50% impact the number of reception and triage staff we need?
- What were our call volumes during Open Enrollment for the Federal Marketplace? (This may provide a basis upon which we can estimate call volume during Managed Care Open Enrollment.)

RETURNED MAIL

Most beneficiaries will receive information by mail from the Enrollment Broker and from their Health Plan. The DSS will not see an increase in returned mail due to Medicaid Transformation.

- Mail from the Enrollment Broker will be branded as "NC Medicaid" but will have the return address for the Enrollment Broker. This includes:
  - Welcome Packets/enrollment forms
  - Reminder postcards about enrollment
  - Notices related to Managed Care status changes and disenrollment
- Mail from the Health Plans will be branded with the Health Plan's name and logo and will have the return address for that plan. This includes:
  - Health Plan handbooks and health plan ID cards for members
  - Provider Directory
  - How to access Care Management Services

Returned mail will be compiled by the Enrollment Broker and the Health Plans and shared with NC Medicaid. More information will be coming soon about how out-of-date addresses will be shared with the local DSS.

Fact Sheets will be updated periodically with new information. Created 5/16/2019.
For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation

NC Medicaid

Fact Sheet #4
Non-Emergency Medical Transportation (NEMT)
NC Medicaid 2019 County Playbook

Who is responsible for NEMT under Medicaid Managed Care?

Medicaid is required to provide transportation to medical appointments for all eligible individuals who need and request assistance with transportation.

For beneficiaries enrolled in Medicaid Managed Care, health plans are required to provide non-emergency medical transportation (NEMT) services. Health plans may use transportation brokers to arrange and provide transportation, or contract directly with transportation providers.

For beneficiaries in NC Medicaid Direct, county DSS agencies will continue to arrange NEMT. Counties will continue to follow North Carolina NEMT policies, and providers will continue to bill NC Tracks for reimbursement.

For all beneficiaries – NC Medicaid Managed Care and NC Medicaid Direct – transportation will be available if the beneficiary receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid and NC Health Choice provider). Medicaid only pays for the least expensive means suitable to the beneficiary's needs.

WILL OUR BENEFICIARIES RECEIVE THE SAME SERVICE FROM THE HEALTH PLANS THAT THEY ARE USED TO RECEIVING FROM THE DSS?

Yes. The amount, duration, and scope of the NEMT service is NOT changing. NEMT will be provided by the health plan in which the beneficiary is enrolled for Medicaid. Health plans will be contracting with statewide and regional NEMT brokers to arrange and provide NEMT to enrolled members.

Health plans are required to:

- Provide NEMT appropriate for the member to the nearest appropriate medical provider;
- Provide NEMT to a Medicaid-covered service provider, including services carved out* of Medicaid Managed Care, provided by a NC-enrolled Medicaid provider;
- Provide travel-related expenses, including:
  - Lodging,
  - Food,
  - Parking fees/tolls,
  - Transportation vouchers (i.e. taxis, ride sharing services, public transit), and
  - Mileage; and
- Develop a network of NEMT providers.

*Carved out services are services that are not covered by the health plan and will remain fee-for-service.

Health plans are also required to:

- Provide training to NEMT providers,
- Address behavioral issues during transportation events;
- Establish rates for reimbursement,
- Adhere to DHHS network adequacy standards; and
- Have contractual requirements for quality of care, vehicles, drivers, timeliness, and no shows.

Members will:

- Be informed that there is no cost for NEMT services;
- Be informed of who may accompany them without cost and that any member under the age of eighteen (18) does not have to ride alone;
- Have the health plans NEMT Policy explained including:
  - How to request or cancel a trip,
  - Limitations on transportation,
  - Advanced notice requirements, and
  - Expected Member conduct and procedures for no-shows;
- Be able to arrive at provider in time for the scheduled appointment but no sooner than one hour before the appointment;
- Not have to wait more than one (1) hour after the conclusion of the treatment for transportation home;
- Not be picked up prior to the completion of treatment; and
- Can request an appeal if the request for transportation assistance is denied.

HOW AND WHEN CAN HEALTH PLAN MEMBERS SCHEDULE NEMT?

Health plans will send Welcome Packets to enrolled members that include information on how to access NEMT services. Health plans will begin accepting member calls on October 1, to schedule appointments for transportation occurring November 1 or later.

Health plans must ensure that:

- Members are NOT required to make transportation requests more than two (2) days in advance;
- Members are not required to make transportation requests in person; and
- Urgent transportation services are exempt from any advance-notice requirement.

Fact Sheets will be updated periodically with new information.
Created: 5/17/2019
For more information, please visit
https://www.ncdhhs.gov/assistance/medicaid-transformation

CAN THE DSS CONTRACT WITH THE HEALTH PLANS FOR NEMT SERVICES?

Health plans should be contacting counties and may contract with them to use existing NEMT providers, including county-owned transportation services or fleets. DHHS does not need to participate in these discussions. If there are issues or questions related to NEMT, the health plans or the DSS offices should bring them to NC Medicaid for discussion and resolution.

WHO ARE THE NEMT BROKERS FOR EACH HEALTH PLAN?

PHP	NEMT Broker	Contact information
WellCare	OneCall	Adam Beam Phone: (502) 724-3410 Email: AdamBeam@onecallcm.com Website:www.onecallcm.com
UnitedHealthcare Community Plan	National MedTrans	Patrick Sullenger Email: psullenger@natmedtrans.com OR netdev@natmedtrans.com Phone: 844-885-2696 ext. 3 Website: https://nationalmedtrans.com/providers/
HealthyBlue	LogistiCare	Email: network@logisticare.com Phone: (866)-431-4635 Website: https://www.logisticare.com/drive-with-logisticare/
AmeriHealth Caritas	LogistiCare	John Bryer Email: jbryer@amerihealthcaritas.com Phone: 484-496-7663
Carolina Complete Health	LogistiCare	Website: https://www.circulation.com/network/signup

BUDGET CONSIDERATIONS

- With health plans taking on NEMT services for their members, do we need to find new responsibilities for any of our NEMT staff (e.g. assist fielding questions, reach out to beneficiaries to get updated address information, update addresses in NC FAST)?
- Do we want to contract with health plans for NEMT services?
- Do we have NEMT vehicles we no longer need?

NC Medicaid

Fact Sheet #5
Warm Transfers & Referrals

NC Medicaid 2019 County Playbook

What is a warm transfer?

"Warm transfer" is one way to support beneficiaries through the changes associated with Medicaid Transformation. Throughout the transition, many organizations – from the Enrollment Broker to the Health Plans to the County Departments of Social Services (DSS) – will work together on behalf of beneficiaries. With warm transfers beneficiaries get connected to the right person, regardless of who they start with. Here is a description of a warm transfer related to other types of referrals:

Referral	Provide contact information for appropriate support entity.
Cold Transfer	Transfer beneficiary to appropriate support entity and provide contact information.
Warm Transfer	Transfer beneficiary to appropriate contact and stay on the line with him or her until a live agent answers; explain the situation to ensure the agent clearly understands before leaving the call.

ROLES BY ORGANIZATION UNDER MEDICAID TRANSFORMATION

Local DSS

- Determine Medicaid eligibility.
- Enter Plan Preference in NC FAST for beneficiaries who already know which health plan they want.
- Assist beneficiaries in understanding who to contact to get questions answered.
- Ensure that address and contact information is up-to-date in NC FAST.
- Ensure that changes in circumstance are recorded in NC FAST and evaluated.
- Provide general assistance with questions about Medicaid eligibility.

Enrollment Broker

- Send notices to beneficiaries about enrolling in health plans.
- Provide choice counseling to help beneficiaries choose the right health plan and primary care provider to meet their needs.
- Enroll beneficiaries in health plans.
- Provide general assistance with questions about Medicaid Transformation.
- Perform outreach to beneficiaries (provide informative materials, participate in community events) and be accessible by phone, mail, internet, and in-person.

Health Plans

- Send health plan information and insurance cards to beneficiaries.
- Provide Medicaid services, care coordination, and NEMT for their members.
- Assign a primary care provider if not selected by the member (and handle changes to primary care providers, as needed).
- Conduct screening to assess overall wellness of their members (e.g. do you have access to food & shelter, are you experiencing violence at home?)

TRANSFERS & REFERRALS TO THE DSS

The Enrollment Broker, Health Plans, and Medicaid Contact Center will all make referrals to the local DSS, and in some situations, this will be a cold or warm transfer.

TO WHOM IS THE DSS SUGGESTED TO MAKE WARM TRANSFERS (WHEN POSSIBLE)? AND WHEN?

Enrollment Broker:

- Complaints about the Enrollment Broker.

Health Plans:

- Assistance with NEMT services for plan members.
- Complaints about a provider or health plan.
- Behavioral Health Crisis.

Ombudsman:

- Help resolving a problem.

DISCUSSION TOPICS FOR WARM TRANSFERS

The following questions and topics are intended to assist the local DSS in evaluating how current operations may need to change in preparation for Managed Care implementation.

Incoming Warm Transfers

1) Supporting incoming calls:
   - Are we already "dropping" calls that come in to the agency (not all incoming calls are getting answered)? What can we do to mitigate this?
   - Can we secure a dedicated line to be used for the Enrollment Broker and health plans to transfer individuals with questions?
2) Prepare call center/triage/reception staff to receive these incoming calls:
   - Provide general information about the Enrollment Broker and health plans to ALL staff (not just Medicaid).
   - Determine if you need more staff enabled with the capability to update information in NC FAST (e.g. change of address).

Outgoing Warm Transfers

1) Technology/resources to support a warm transfer over the phone:
   - Do our phones have the capability to transfer to another line?
   - Time constraints for staff – consideration that a true warm transfer will add time to the phone call.
2) Technology/resources to support a warm transfer in person:
   - Do we have phones in the lobby or other areas in the agency that could be used to support this?
   - Will there be someone available to walk the person to the phone and initiate the phone call?
   - Are there any privacy concerns related to the location of these phones?
   - Do we have office space in our agency to allow for in-person assistance from the Enrollment Broker? (when available)
   - Do we have a kiosk/computer room for individuals to use? Will there be someone available to walk the person to the computer and guide them to the website for their health plan or the Enrollment Broker?
   - If we do not have the technology/resources to accept and/or receive warm transfers, how can we support our beneficiaries for whom a simple referral (e.g. provide phone number for the Enrollment Broker) is not enough?

Potential Scenarios:

- You receive a call from a beneficiary, Sue Jones, asking about a letter she received in the mail. She says there is information about health plans, and she has heard from her neighbors that they chose WellCare as their plan. She asks you if she should choose WellCare or if there is a better plan for her. You have known Sue for a few years and understand that she is not tech savvy. What do you do? **ACTION** for a true warm transfer:
    - Let Sue know that you cannot help her choose the health plan that is best for her, but you know who can.
    - Ask her to hold for a moment while you connect her with a counselor to help her make a decision.
    - Transfer the call to the toll-free number for the enrollment broker and wait for someone to answer.
    - When a person answers, explain who you are and that you have Sue on the phone who needs help choosing a plan.
    - Confirm that the purpose of the call is understood before hanging up.

BUDGET CONSIDERATIONS:

Please consider the following to determine possible implications for your budget.

- Do we have the resources to add another phone line in the agency to be dedicated for transfers from the Enrollment Broker and health plans?
- Can we secure phones and/or computers in areas within our agency for beneficiaries & members to contact the enrollment broker or their health plan?
- Should we consider adding temp staff to support incoming and/or outgoing warm transfers?

Fact Sheets will be updated periodically with new information. Created: 5/16/2019
For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation

NC Medicaid

Fact Sheet #6
Managed Care Populations and Enrollment Notices

NC Medicaid 2019 County Playbook

While most Medicaid beneficiaries will enroll in NC Medicaid Managed Care and choose a health plan, that is not the case for everyone. This Fact Sheet outlines who must enroll, who cannot enroll, and who has a choice; and it shares the notices that each group will receive. These groups, or populations, will be further defined for DSS employees in NC FAST in the field labeled Managed Care Status. The table below shows which beneficiaries will be included in each Managed Care Status. DSS employees should reference NC FAST Project 14 4.0 training for more information.

Group	Beneficiaries included in this group	Managed Care Status in NC FAST
MUST ENROLL (Mandatory)	Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled (includes SSI and SA recipients).	Mandatory Standard Plan
CANNOT ENROLL (Excluded)	Emergency Services Only	Excluded – Emergency Services Only
	Medicaid Be Smart Family Planning Program	Excluded – Family Planning
	Health Insurance Premium Payment	Excluded – HIPP
	Incarcerated individuals	Excluded – Incarcerated
	Medically Needy (spend down)	Excluded – Medically Needy
	Program of all-inclusive care for the elderly	Excluded – PACE
	Partial dually-eligible Medicaid/Medicare	Excluded – Partial Dual Eligible
	Presumptive Eligibility	Excluded – Presumptive Eligibility
	Refugee Medicaid	Excluded – Refugee
MAY ENROLL (Exempt)	Federally recognized tribal members	Exempt - Tribal

Group	Beneficiaries included in this group	Managed Care Status in NC FAST
BECOME MANDATORY LATER (Temporarily Excluded or Temporarily Exempt)	Community Alternatives Program for Children (CAP-C)	Temporarily Excluded – CAP-C
	Community Alternatives Program for Disabled Adults (CAP-DA)	Temporarily Excluded – CAP-DA
	Resident of a Division of State Operated Healthcare Facilities (DSOHF)/Veterans (VA) Home	Temporarily Excluded – DSOHF/VA Home
	Dually-eligible Medicaid/Medicare	Temporarily Excluded – Dual Eligible
	Those who have lived in a nursing facility for over 90 days	Temporarily Excluded – Facility
	Foster Care/Adoption Medicaid	Temporarily Excluded – Foster Care/Adoption
	Foster Care/Adoption Medicaid and receives Medicare	Temporarily Excluded – Foster Care/Adoption – Dual Eligible
	Foster Care/Adoption Medicaid and would qualify for a tailored plan*	Temporarily Excluded – Foster Care/Adoption – Tailored Plan
	Dually-eligible Medicaid/Medicare and would qualify for tailored plan*	Temporarily Excluded – Tailored Plan – Dual Eligible
	Receiving the Innovations/Traumatic Brain Injury (TBI) waiver and would qualify for a tailored plan*	Temporarily Excluded – Tailored Plan – TBI (Traumatic Brain Injury)/Innovation
	Receiving the Innovations/Traumatic Brain Injury (TBI) waiver, would qualify for a tailored plan,* and is dually-eligible Medicaid/Medicare	Temporarily Excluded – Tailored Plan – TBI/Innovation Dual Eligible
	Would qualify for a tailored plan*	Temporarily Exempt – Tailored Plan

*Tailored Plans are specialized plans that offer integrated services for members with significant behavioral health needs and intellectual/developmental disabilities. The target date for these types of plans to be available is mid-2021. Until then, beneficiaries who fall into this category will be Exempt or Excluded.

Auto-Assignment Reminder: Beneficiaries in the Mandatory population who do not choose a health plan will be auto-assigned to one. In some states, only about 10% of beneficiaries choose their own plan. Please encourage beneficiaries in your interactions with them to make an informed choice by contacting the enrollment broker and choosing their own plan.

NOTICES FROM THE ENROLLMENT BROKER

A beneficiary's Managed Care status determines which notice he or she will receive from the Enrollment Broker. Notices include details on enrollment status, steps that need to be taken, and guidance on how to complete those steps. All notices will be labeled with "NC Medicaid" and will instruct recipients to contact the Enrollment Broker with questions. DSS staff will still likely be asked questions as well. Reviewing the sample notices linked in page 3 of this Fact Sheet will help address these questions. The table provides a description of each notice and when it will be sent. In addition to notices related to enrollment, we have included two samples of grievance notices beneficiaries will receive from the Enrollment Broker in the event they file a complaint against the Enrollment Broker.

Please note that all notice text is valid as of the date of this Fact Sheet and is subject to change. The format in the samples provided may also differ from the actual notices that are mailed to beneficiaries, and titles have been added for your reference (titles will not appear on the actual notices).

Enrollment Packet Notices

Notice	Description	When is it sent?
1. Enrollment Packet: Mandatory Notice	Sent to households with beneficiaries in the Mandatory population (people who must choose a health plan). Provides information based on each beneficiary's status on how to choose a health plan and how to choose a primary care provider.	• Phase 1: beginning 6/28/2019* • Phase 2: beginning 9/2/2019*
2. Enrollment Packet: Exempt Notice	Sent to households with beneficiaries in the Exempt population (people who have the option to choose a health plan but are not required to do so). Provides information on how to choose a health plan, how to choose a primary care provider, and how to stay in NC Medicaid Direct.	• Phase 1: beginning 6/28/2019* • Phase 2: beginning 9/2/2019*
3. Enrollment Packet: Mandatory and Exempt in same household	Sent to households with at least one beneficiary in the Mandatory population (people who must choose a health plan) and at least one in the Exempt population (people who have the option to choose a health plan but are not required to do so). Provides information based on each beneficiary's status on how to choose a health plan, how to choose a primary care provider, and when appropriate, how to stay in NC Medicaid Direct.	• Phase 1: beginning 6/28/2019* • Phase 2: beginning 9/2/2019*
4. Enrollment Packet: a) Information Sheet b) Enrollment Form c) Health Plan Comparison Chart	Sent along with the notice in the Enrollment Packet to guide beneficiaries on how to choose a primary care provider and health plan.	• Phase 1: beginning 6/28/2019* • Phase 2: beginning 9/2/2019*

Other Notices

Notice	Description	When is it sent?
5. Managed Care Mandatory	Sent to a beneficiary in the Mandatory population (people who must choose a health plan) after he or she has chosen a health plan or been auto-assigned to a health plan. It lets the beneficiary know which health plan he or she is in.	• After the beneficiary has selected a plan through the Enrollment Broker, or • After the beneficiary has been auto assigned to a health plan. (Auto assignment begins 9/13/2019* for Phase 1 and 12/13/2019* for Phase 2).
6. Managed Care Exempt - Newly Exempt Health Plan Member	Sent to a beneficiary who is currently enrolled in a health plan when his or her Managed Care Status has changed to Exempt (people who have the option to choose a health plan but are not required to do so) Displays the health plan in which the beneficiary is currently enrolled and provides information on how to change health plans, keep the one they have, or switch from a health plan to NC Medicaid Direct.	• After a beneficiary who is currently enrolled in a health plan has a change in Managed Care status to from Mandatory to Exempt.
7. Managed Care Exempt – Assigned to NC Medicaid Direct	Sent to a beneficiary in the Exempt population (people who have the option to choose a health plan but are not required to do so) who is currently assigned to NC Medicaid Direct. Provides information on how to switch from NC Medicaid Direct to a plan.	• After the beneficiary has chosen or been assigned to NC Medicaid Direct (beneficiaries in the exempt population who do not choose a health plan will be in NC Medicaid Direct).
8. Managed Care Exempt – Chose a Health Plan	Sent to a beneficiary in the Exempt population (people who have the option to choose a health plan but are not required to do so) who has chosen a health plan through the Enrollment Broker. Displays the health plan the beneficiary has chosen and provides information on how to change health plans, keep the one they have, or switch from a plan to NC Medicaid Direct.	• After the beneficiary has chosen a plan through the Enrollment Broker.

Other Notices (cont.)

Notice	Description	When is it sent?
9. Managed Care Excluded – Health Plan to NC Medicaid Direct	Sent to a beneficiary who has a change in status from Mandatory (people who must choose a health plan) or Exempt (people who have the option to choose a health plan but are not required to do so), while being enrolled in a health plan to Excluded (people who cannot enroll in a health plan, and who must be in NC Medicaid Direct). Provides the reason of the change.	• Shortly after the change is reported that caused the beneficiary's status to change to Excluded.
10. Managed Care Excluded – Exempt (NC Medicaid Direct) to Excluded	Sent to a beneficiary who has a change in status from Exempt (have an option to choose but not required to do so) and is enrolled in NC Medicaid Direct to Excluded (people who cannot enroll in a health plan), and no longer has the option to select a health plan. Provides the reason for the change.	• Shortly after the change is reported that caused the beneficiary's status to change to Excluded.
11. Reminder Notice - Transition	Sent to Mandatory beneficiaries (people who must choose a health plan) who have not already chosen a plan. Reminds them that they have 30 days remaining to select a plan.	• Phase 1: beginning 8/13/2019* • Phase 2: beginning 11/13/2019*
12. Grievance Acknowledgement	Written acknowledgement of a grievance the beneficiary has submitted to the Enrollment Broker.	• Shortly after the Enrollment Broker has received a complaint from a beneficiary about the Enrollment Broker.
13. Grievance Resolution	Written notice of resolution of a grievance the beneficiary has submitted to the Enrollment Broker.	• No later than 30 calendar days after the Enrollment Broker has received a complaint from a beneficiary about the Enrollment Broker.

Fact Sheets will be updated periodically with new information. Created 6/3/2019.
For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation