

NC Medicaid Managed Care Webinar
Community Partners: NC Medicaid's Transition to Managed Care
"After Launch"
July 8, 2021
Transcript

Good afternoon. Thank you for joining NC Medicaid Managed Care Webinar for Community Partners: NC Medicaid's Transition to Managed Care "After Launch".

Just a few couple of announcements to note. To view with closed captions, click the three dots at the top right of the window and scroll down to select turn on the live captions. All cameras and microphones will remain muted throughout the training.

Please use the chat feature to ask a question or provide any comments that the presenters will be able to see.

Managed Care has launched, and we want to take this opportunity to provide information to you, to enable Community Partners, to address questions and concerns that may be raised by individuals you serve and those who need support. We ask you, our Community partners, to help us share information because we rely on you as trusted partners to help dissemination information about Medicaid Managed Care.

Today, Dave Richard will review our vision and Medicaid's commitment to our day one priorities. Jay Ludlam will talk about after launch, what we're experiencing. They'll talk about enrollment issues that have been identified, and how the department has resolved those issues. We will provide information for our Members on how to change their PHP or their PCP and will cover some resources that are available to you as community partners, resources available to providers and beneficiaries

And finally, we'll talk a little bit about the role of the Ombudsman and how you can access the Ombudsman. We're also excited to have as part of the presentation today, members from the PHP who will talk about how individuals who are enrolled with PHP can access member services and other critical information.

We will allow time at the end of this presentation for question and answers and we ask for you to stay on. Come to hear those later. We also want to let you know that there is a webinar scheduled this afternoon for providers. That's a joint webinar that's being sponsored by Behavioral Health and Medicaid, so we will drop in the Q&A the link to that webinar. We will also provide a link to the Back Porch Chat that is occurring next Thursday where providers can get information about the launch of Medicaid Managed Care.

And with that, I'd like to introduce Dave Richard, the deputy secretary for NC Medicaid, and turn it over to him now, thank you.

Thanks so much. Debra, appreciate that. And thanks everybody for joining us today. I know this is the 4th of July week and a lot of things going on, but I really appreciate you coming in today. Let me just start out by saying how excited we are that we launched managed care. I, for one, have been so tired of saying that we will be launching managed care on July 1. We've been doing this for almost five and a half years, working on this effort and it's very exciting that we've had that. And I want to want to just start out by saying, is that without the incredible work of our team at Medicaid, with our health plans, with our providers and with our beneficiaries and advocates, this would not have happened. We recognize this as a partnership across so many folks to make this launch possible, and again, we're very excited about it.

Jay is going to talk about a lot of details, but we just want to remind folks about what our real goals are in managed care as we go forward. And I haven't read it in a while, aloud, but I'm going to do it again. To improve the health of North Carolinians through an innovative, whole-person, centered, well-coordinated system of care that addresses both the medical and non-medical drivers of health.

I received the email from a former colleague at another Medicaid agency, congratulating us on going live and I sent something back to him, and his response was essentially you did it right. You listened to what other people across the country have been doing. You worked closely with stakeholders to get there and you put forth one of the most aggressive and innovative programs in the country. And now you have a chance to prove it. So we are all in this together and we look forward to this work as we move forward and seeing these things really play out in North Carolina.

And as I just mentioned what these innovations is what it's all about. So we want to have a payment structure by using managed care because it's a leverage that we have that really begins the reward. Better health outcomes you've heard Secretary Cohen say it often and I think it's what our mantra is. We want to buy health. We don't want to just buy health care in North Carolina and that's really what we have tried to put together in this plan. The integration of physical and behavioral health. It's something we've talked about forever and we now are in that place.

Right, so our health plans that you hear from later, for most people that have mental health or substance use needs will be authorizing those services and integrating those with the physical health that people need. And we know a year from now, we launch our Tailored Plans with people with more significant needs. Behavioral health needs will go forward. And then a hallmark of this really has been the investment in non-medical interventions that are so important. Social determinants of health as people like to use.

Our pilot projects. We've awarded those projects our health plans are committed to the working with them and doing things inside their health plans today to drive that. We all know that it is so important that we think about the social side of work as we're improving health for our beneficiaries across the state. So really integration is about three things right? Physical health, behavioral health and these social determinants of health as well.

And all the great things that we're going to do in this managed care with you as our providers and beneficiaries and advocates and our health plans are so important. But we know the first several days, the first 60 days, 90 days, the most important thing is that we make this transition work. So what we want to just remind you what our day one priorities were right. If you had a prescription; it would be filled by pharmacist. It was going to get filled the next day when we launched managed care. We know that Members would know their plan or if they were assigned to plan, would know that plan itself. Members

have timely access to information directed to the right resource. Part of the reason we're doing that today is to make sure that we can help people. Think about that, and that the health plans have the significant sufficient networks to ensure member choice. Those are in place.

But that a provider enrolled in Medicaid prior to the launch of Medicaid will still be enrolled, hopefully they have contracted with as many of the health plans as possible, and that calls made to call centers are promptly answered. And then I'll hit the most important ones right? Is that beneficiaries will get seen and providers will get paid. And we'll talk a little bit more about some of those issues as Jay goes forward, but I want to again, thank our team. Thank all of you I have worked with this over the course of these six years, our health plans, our providers our advocates and our beneficiaries. We look forward to seeing the great benefits of this transition to managed care as we move forward. So I'm going to turn it over Jay Ludlam, who has been leading the transformation efforts so Jay.

All right, good afternoon everybody. I hope you can hear me. I want to take a minute. Dave does a really good job of thanking everybody on at the Medicaid team and he works very hard with stakeholders and legislators who make sure that the Medicaid program has the resources it needs and the vision and goals that we need, and it is through Dave's leadership over the last six years that we have gotten ourselves to this point and have been able to successfully launch managed care. We are all pleased as staff that worked with Dave to take that burden off him, and he can now say that we have officially launched something that he has worked six years on, which is an incredible amount of time. And a testament to his dedication to not only North Carolina Medicaid, but North Carolina itself. So thank you Dave for your leadership and guidance.

Alright, I'm going to talk a little bit about where we are now and just in case people weren't paying attention on July 1, we did launch our Standard Plan transformation project and moved to managed care for 1.6 million beneficiaries. These are primarily children and pregnant women, who have been who have moved into managed care. I'm not going to read out the names of the five health plans, these are the five health plans that we competitively procured. Carolina Complete Health, though, is a regional health plan. The other four health plans are statewide. We also had an important initiative that also launched. This is our tribal option that we worked with the Eastern Band of Cherokee Indians to help realize their goals and their path towards their goals and were able to successfully launch the tribal option also on July 1.

So a couple of things. One thing that we have said all along is that while we felt prepared, while we had validated that the health plans were prepared and that their partners were all prepared, that we expected some bumps and we have experienced those bumps.

And while things have been relatively quiet, these are some of the things that we have been working on. So after auto-enrollment occurred and we worked with the health plans and transitioning information to the health plans related to member enrollment records, transition of care records, and this also included primary care assignments. So it's important that beneficiaries to a certain extent retain that relationship with their existing primary care providers and we have worked with the five health plans to be sure that information is in their system correctly and that beneficiaries were able to retain those relationships where appropriate. It's not always appropriate, but where it's appropriate were able to retain those relationships, so that was a very large body of work that we continue to work through launch and to stabilize that aspect of the program.

There were some early issues as well. One of the health plans did hardcode Health Choice on the ID card, so it appeared as if all their members were a part of the Health Choice program. That was not correct, and it affected a large number of individuals. If you haven't heard about it, it's in part large part because the leadership at the health plan really dug in on the issue. We worked with our provider associations and county partners to get the message out and we are in the process right now of, I'm sorry, the health plan is in the process right now of sending out updated cards with correct information. We do encourage beneficiaries to continue to go to their appointments and for providers to look in the system for whether or not the individual is eligible for Medicaid on the date of service, which is something that all providers should be doing, but also what health plan that they are enrolled in and which programs also. So that program issue should be generally resolved by the end of this week.

We also have heard and seen reports of some providers canceling appointment because of issues around prior authorization. A little bit of confusion even though we have been emphasizing those day one goals, since for the last I don't know eight to nine months that beneficiaries receive the same services that they received prior to managed care and that providers would get paid. There has been a little bit of confusion related to prior authorizations and honoring those prior authorizations. We published updated guidance last night. We hope that quiets some of those issues down. We have a link here that you'll need to type in and that does provide you a direct access to that bulletin and that guidance. (medicaid.ncdhhs.gov/blog/2021/07/07/updated-hospital-procedure-continuity-nc-medicaid-managed-care)

But again, generally, we expect providers to provide services if PA/prior authorization is needed providers can submit that prior authorization retroactively to ensure payment. It is important for the health plans to get that prior authorization. It helps their care managers have the information necessary to support care management. So it is important. But providers, you have additional time to get that PA in order to get paid fully.

Couple of reminders. Now that we are live members can change their health plans for any reason for the for 90 days after July 1. So through September 30 beneficiaries could call the enrollment broker if they want to change health plans. If they find that they were auto-enrolled in a health plan that they didn't want or that they are now through experience discovering that perhaps their provider is not contracted or does not intend to contract with the health plan, those beneficiaries can change. The enrollment broker is a fully staffed right now waiting for those phone calls they and so please feel free, at least for the next 90 days, to call for absolutely any reason and get your health plan changed if that's something that's important to you. Members, this is a reminder of a rule within managed care and that is members can change their primary care provider within 30 days of that PCP assignment. So for the month of July, effectively. After that 30-day period beneficiaries can change their PCP once a year, annually, and you should be contacting your health plan directly if you want to change your primary care provider.

All right, non-emergency medical transportation. There's been some questions about Non-Emergency Medical Transportation. How do I schedule a visit? Each of the five health plans have different phone lines that you can call to reach the non-emergency transportation broker. We have listed those phone numbers. For your sanity I'm not going to read it all out to you, but this is a resource for you. Of course, if you are a beneficiary who's remaining in Medicaid Direct, or if you're with the EBCI tribal option, you should be contacting your local DSS offices to schedule non-emergency transportation.

Some of you may say I'm in managed care, but I didn't receive information about which health plan or about managed care. We would ask that you call the enrollment broker and they will be able to answer any questions as well as provide you additional information through the mail. Obviously if you're a beneficiary and you have moved to managed care; you'll now receive your care through the health plan. You should receive a health plan card. These are going to be in addition to the NC Medicaid ID card so that you will now have two cards. And like I just said, you can change your health plan for any reason through September 30.

And just to emphasize that Medicaid eligibility, we've been talking about enrollment which It's a word that starts with the letter E. It is similar. It's a little confusing sometimes, but one thing that I do want to emphasize is that Medicaid eligibility rules, those have not changed simply because we've moved to managed care.

So if I'm a beneficiary and I'm having problems with my health plan or I've questions or confusion. A health plan should have mailed everyone enrolled with them a welcome kit that includes that member ID card. It also would include a Member Manual that outlines various services that the managed care organization provides. It will have key phone numbers; it may also have additional information about value-added services that the health plan offers as well. You can receive more information through the enrollment broker, as I said. You can call the enrollment broker but since the health plans are up and running, their call centers are up. We've been monitoring call center volume. It does not look overwhelming based on the reporting were getting so we do recommend that you contact your health plan to get an ID card if you have not received one.

If you still have questions, we have an independent third party, Medicaid Ombudsman, who can take your calls, help direct you to the resources and answer questions, connect with your health plan if you're having difficulties with that. And that information is on that slide as well. This is more about the Ombudsman resources. They have resources available for beneficiaries. You can use them as your first point of contact. If, after you've contacted your health plan and you don't understand what they've tried to explain to you or your question it, you can contact the Medicaid Ombudsman and they will assist you with those kinds of questions. The staff are trained, they are there to help. A part of their role is to help the managed care organization understand the impact of the information that they're providing beneficiaries and help those managed care organizations make adjustments to their programs or to the way that they their call centers and their scripting. So we really encourage beneficiaries who have potential issues to reach out to the Ombudsman here is their website (ncmedicaidombudsman.org). There is the phone number (877-201-3750), and this is when they're available to answer questions. Of course the website is up 24/7.

I would like to introduce Brenda and Francheska from AmeriHealth Caritas, who will provide more information about services AmeriHealth Caritas is offering. I'm going to ask that they come off mute and come on camera. Let's see if this works. Hi Francheska, Brenda.

Good afternoon I'm Brenda Radford. I'm the director of member engagement for AmeriHealth Caritas North Carolina and Francesca Elliot, who you probably can see on screen is our manager for community outreach. Our plan is proud to be serving more than 305,000 beneficiaries, AmeriHealth Caritas has been serving Medicaid beneficiaries since 1980. Our company began as a partnership with the Sisters of Mercy in Philadelphia, PA and that foundation drives our mission to help people get care to stay well and to build healthy communities. North Carolina is the newest addition to the family of companies which

operates in 13 states as well as the District of Columbia. With the total membership of more than 4.5 million Medicaid, Medicare and CHIP members. We have more than 300 associates that are based here in North Carolina supporting our community-focused approach to care, and our team includes community educators, care managers, community health navigators and provider account executives. They're already living and working in the communities across our great state.

I'm especially excited about the wellness and community centers that we will be opening in each of our six Medicaid regions in the state. Community centers are going to offer a variety of programs and services to our members and to the community from cooking and exercise classes to job search assistance, we're going to be looking forward to partnering with community-based organizations on many of these activities, and the centers are equipped to offer on-demand video interpretation services so we can support all of our Members no matter what their language needs are. And you go to the next slide, please.

We have a North Carolina based contact center which is operational 24 hours a day, seven days a week. Our number is listed on the slide that you see in its **855-375-8811** and it's included in our member welcome kit and on our website (amerihealthcaritasnc.com). Our contact center folks can help with many of the needs of our Members from updating their address information to ordering a new ID card or finding a primary care or other health care provider. In addition, our Members have 24/7 access to a behavioral health crisis line as well as a nurse line and all our telephone lines have TTY access and interpreter capability.

So in addition to the information that's on our website, members are encouraged to register for access to our Member portal which they can access from our website, and we also have a mobile app available for downloading on Google Play or the Apple App Store by looking for the AHC mobile. AmeriHealth Caritas is proud to be a part of NC Care 360 Network and will be using that resource through our contact center and with our care managers and our wellness centers to connect members to the community resources that they need. Thank you.

Why don't we go to the next team? I think it's Carolina Complete Health.

Hi, I am Julie Ghurtskaia, I am the vice president of population health with Carolina Complete Health. And as Jay mentioned, we are a regional health plan in Regions three, four and five. We are a provider-lead entity and that means we consist of providers who practice within the communities of North Carolina. Carolina Complete Health is a partnership between the North Carolina Medical Society, the North Carolina Community Health Care Association and Centene. Our board consists of practicing providers and that brings in actual local information on how to care for the Members in North Carolina.

We have a member services line that is available and supports our Members and providers **833-552-3876**. Some other important numbers to know as we also have a 24/7 Behavioral Health/Crisis Line, and that's **855-798-7093** and also a nurse advice line for support during and after hours, weekends, holidays, 24/7, that's **833-552-3876** as well.

And some important links to have are listed here and similar to AmeriHealth we have support throughout the communities at this point. Community health workers, care managers and all of this can be accessed through our Member services line. But then we also have individuals on the ground as well to support.

And we are here to truly transform the health of the community one person at a time. So thank you for having us today, and many thanks from Carolina Complete Health.

Thank you Julie. And Healthy Blue.

Good afternoon everyone. I hope you are staying dry as tropical storm Elsa moves past us here in North Carolina. My name is Kristy Kent. I am a manager with Healthy Blue overseeing our community and engagements investments and our DSS liaison. I'm going to start things off and then hand it off to my colleague Jessica Hubbell.

Healthy Blue is the Blue Cross and Blue Shield of North Carolina plan for Medicaid. We've been in North Carolina since 1933 and serve all 100 counties with our new Medicaid beneficiaries. We're excited to say that we're serving more than 4 million North Carolinians. Our mission to improve the health and wellbeing of our customers and communities, and we won't stop until health care is better for all. We're pleased to be here with you today, we're pleased to serve our new Medicaid members and to continue working with communities across the state. Before I hand it over to Jessica, I would really just like to put in a plug if we could support you, if we could support your community-facing staff, we'd love to do that, so please don't hesitate to reach out to us. Jessica, I'll hand it to you.

Hi good afternoon it is very nice to see everyone here today. I'm Jessica Hubbell and I oversee marketing and community relations for Healthy Blue. Similar to the other plans, our member service line (**844-594-5070**) is really a great resource for members. We have our times that it's open listed on here, but we also have a voicemail that is available outside of those times for Members. Leave a message and we do make returning these calls our priority. Additionally, on our website which is listed at the bottom (healthybluenc.com), we have a lot of great resources, including a live chat option which I have personally tested a couple times and it's a phenomenal resource. So we have somebody there who can answer questions if Members have technology available to be able to do that. And a lot of times that eliminates the wait times on the phones, which is great. Our website also has a lot of really great information on it, like how to change a PCP, we've got a member portal where Members can look up and find a doctor and they can look up specialists that are within the network. They can request an ID card which is a great resource. They can download an ID card. All these great things are there. So again, for Members that do have the ability to go on technology and get those resources, it's a really great place.

We've also listed here for you our Behavioral Health Line (**844-594-5076**), our Nurse Line (**844-545-1427**) and our Transportation line (**855-397-3602**) and that there's a lot of phone numbers listed here. If nothing else, if you can get to the Member Services line they can help direct you. So if there's any number that that's the one number to have and Members have that on their ID card as well. So just any questions feel free to reach out to Kristy and as she said, we're here to help and partner anyway we can.

And now we're going to hand it off to United Healthcare and Corinna.

Thank you Kristy and Jessica. So greetings, I'm Corinna Miller. I'm the community development director with United Healthcare. I'd like to thank you for allowing us the opportunity to participate today. We at United Healthcare applaud the continued great work all of you are doing in our local community. At United Healthcare, we've been proudly serving more than 1.4 million North Carolinians for the last 35 years. And it's an honor to help more North Carolinians live healthier lives through North Carolina

Medicaid Managed Care. We're finally here. We are committed to helping keep Medicaid beneficiaries in the center of all that we do at United Healthcare.

Our Members have numerous ways to access and receive the assistance they need. So do you want to take a look at our screen? We've got our Member Services line (**800-349-1855**) and all of these have the TTY lines, as well some very important other numbers. We've got our Provider Service line (**800-638-3302**), Behavioral Health, Crisis line (**877-334-1141**) and our NurseLine (**855-202-0992**). Both the Behavioral Health Crisis line and the NurseLine are available 24 hours a day, seven days a week. Last, but not least, we have our Pharmacy Service line (**855-258-1593**) and some other important sites and links for you to take a look at is our website (UHCCP.com/NC) as well as a link to our [Member Handbook](#).

All members with not only United Healthcare but the other PHPs, in addition to their ID card and their welcome letter will be receiving or have received a Member Handbook. So in addition, in North Carolina to the six brick and mortar regional locations United Healthcare has, and we affectionately call them Community Health Hubs, we also have two mobile units. Recognizing that 80 of the 100 counties in North Carolina are rural and we use those so that we can begin to meet not only you our Community Partners, but our Members where they live and go on a daily basis.

So I would love to offer and reach out to us, we did recently have three open houses in our newest community health hub locations, and we want those to serve as truly a community health hub. So whether you have education training, whatever it may be, we want to make sure that you're maximizing the use of our space at no additional cost to you. I'd really like to just end with not only a huge thank you. But just to echo what Dave Richard said earlier is that we're all in this together. Thank you for your time today.

Now I'm going to turn it over to Shaune Lancit with WellCare.

Thanks so much, Corinna. I hope everybody can hear me okay. I'm so glad to be here today, so excited that we have finally arrived at Go Live and excited to be here with everybody to serve some of North Carolina's most vulnerable with the WellCare brand. I'm Shaune Lancit and I'm the director of community engagement for WellCare of North Carolina. The WellCare brand has been around since 1985 and we have always focused exclusively on government-sponsored health care. So we have a good understanding of the unique needs of folks who are on Medicaid. We are also part of the Centene family, and we take a community approach to health care in a local approach to health care. So we have two teams on the ground who some of you may have met already is my hope. We have a team of community relations specialists who focus on connecting with our Members on the ground and meeting them where they are at local events in the community. At organizations like the YMCA, the Boys and Girls Club, local supermarkets, health fairs and we also host events in the community that we invite our Members and the community to attend.

We also have a team of community advocates whose focus is really on building relationships with community-based organizations to help strengthen and improve and support the social safety net in the communities where we operate. Because we feel like social determinants of health are such an important piece to the overall health and well-being of our Members and we know that starts with our community partners who are addressing the social determinants of health. So our community advocates focus on building and strengthening those relationships and seeing how we can support and partner.

As far as resources for our Members that are newly enrolled in WellCare and trying to navigate their benefits. We have an array of different resources. We have welcome rooms which are in all six regions across the state. These are brick and mortar sites where members can walk in and talk to someone from their health plan. We have an array of offerings and classes. We have things like nutrition education classes, parenting classes, game days and baby showers that we offer at our sites, SNAP enrollment and then local offerings by region and again just a place where someone can walk in and meet and talk to somebody from their health plan.

We also offer new member orientations twice a month where our community relations specialists host a webinar that's out of our welcome room so they can attend in person or via webinar just to learn the basics about how to navigate their health plan, how to download the app, what the important numbers are, how to read their card, how to find their primary care physician. And that brings me to our mobile app, which is something that our Members can download to very easily to access copies of their card and request documents and get support that they might need.

I'm going to turn it over to Kara Taff who's also another member of the WellCare Leadership team who's going to talk a little bit about the member services line and the other numbers and resources we have directly for Members who are trying to learn more, get questions answered and access their benefits.

Thanks Shaune. I'm Kara Taff, senior director of business operations for WellCare, North Carolina. Thanks for having us today and appreciate all you do in the community.

We do have our Member Services number that's listed on the slide (**866-799-5318**). It's open like the others, 7 a.m. to 6 p.m., Monday through Saturday and on all state holidays. And then 24 hours a day, we have our Behavioral Health Crisis line (**833-207-4240**) and our Nurse Advice line (**800-919-8807**). In addition, after hours, members can either leave a message on the Member Services line and the call will be returned or can access the Nurse Advice line as well. We also have our health plan website (wellcare.com/NC) which has a lot of great resources on it. Our public site information on value-added benefits and transportation and our Member Handbook. Our secure web portal has many of the tools that Shaune just listed there as well. ID cards and chat and care plans and all kinds of great information. So we want Members to use all the services that are available to them to get the best care they can in North Carolina. Thank you for your time today.

Thanks Kara, and just want to say thank you again. To echo Corinna and everybody, thank you so much for the amazing important work in the partnership in serving North Carolinians. Really glad to be here today and really excited to partner with all of you in our joint mission. So thanks so much.

Thank you, Shaune. I want to give a special thank you to our health plan partners for joining this afternoon's call and providing information on how Members can access various services and supports that are available through the health plans. I also want to thank you; our audience and I want to thank our health plan partners for bearing with our technical difficulties. We do know there were few incidences where you were able to hear speakers but not able to see them, and we apologize to the plans and to you as participants for those technical difficulties.

At this point, I just want to go through a few additional resources that are available to our beneficiaries. You will see on the screen and we will provide for you on our Medicaid Transformation website after this

webinar is complete a copy of these slides where you can access the information that's listed here, which includes our enrollment broker website ncmedicaidplans.gov where you can access information about managed care, about how to change a health plan. And you as community partners can share that with beneficiaries as well. Also we have the NC Medicaid website (medicaid.ncdhhs.gov/beneficiaries) that's available for beneficiaries as well as a [Day One Quick Reference Guide](#) and the link to the [Beneficiary Portal](#) so feel free to check out all those resources that are available to help Medicaid recipients, Medicaid beneficiaries get access to information.

On the next slide, we want to provide information to providers. We recognize that of the 500 individuals who are on this afternoon's call, some of you are providers. Although this webinar is not targeted to providers specifically, we do want you to have access to some resources that are available to you, including our Medicaid website (medicaid.ncdhhs.gov) that has a number of supports including fact sheets about how you submit claims, on our website you can also get access to quick reference guides that the health plans have developed and made available for you. There is practice support available through AHEC (ncahec.net/medicaid-managed-care) we also have a number of Medicaid Bulletins (medicaid.ncdhhs.gov/providers/medicaid-bulletin).

And let me just go back for a second to call out our NC Medicaid Help Center (medicaid.ncdhhs.gov/helpcenter). That is a resource that's available to you as providers where you can type in a question and get answers to those questions. We have hundreds and hundreds of what we call knowledge articles that are available to you to address the questions that you have. We do note that some of you as providers have put questions in the chat today and some of those we will respond to privately, but just because we want to keep this focused on beneficiary-related information, we won't address many of the provider-specific questions via this webinar but we will make sure that all of your questions get passed on to our Help Center and you will get a response to questions that you have raised today.

So what should you do as a provider if you have an issue? First, we're encouraging you to check in NCTracks for any information about beneficiary enrollments. If you still have questions after checking in NCTracks, you can call the NCTracks Call Center that number is published here as **800-688-6696**. You can also connect with the health plans if you have questions about coverage, benefits or payments. You can find a list of the health plan contact information at the link here ([health-plan-contacts-and-resources](#)), which is the health plan contacts and resources on the Medicaid website. Finally, if you've contacted the health plan and you've checked NCTracks, you can't find the information you needed or seeking, we have a Provider Ombudsman that's available to help you solve problems and address concerns. The Provider Ombudsman number is listed as well on the screen. That number is **866-304-7062** or you can email the Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov. You can call the Ombudsman, or you can reach them via email.

So at this point we are going to have an opportunity to address some of the questions that were entered through our Q&A chat box and I'll turn this over to Michael Leighs who will read some questions and call on our SMEs, our Subject Matter Experts, to provide you answers.

Debra, thanks so much. We had several questions that I published in the Q&A, but we did receive one beforehand. We had an opportunity to receive some questions for folks who registered for the webinar before the webinar started, and I did want to touch on one of those to start. We've got a question, **could you go into detail about care management, what it means in practice, and what services are**

available for plan members who don't meet the plans risk stratification criteria? And I'm going to call on Kelly Crosbie to share a bit more about care management.

Hi everyone, this is Kelly Crosbie from North Carolina Medicaid and I want to talk a bit about care management. Care management is an important service that is available to anyone in a Standard Plan. Folks in the question mentioned risk stratification and that's true. Plans will use data to try to identify and be proactive about the people that, based on their data might most benefit from care management, and they'll do proactive outreach to those members, but everyone is eligible for care management. It is important to know, too, that the Care Management model in Standard Plans is very local and community-based.

The vast majority of care management will be provided by primary care practices. They're called Advanced Medical Homes and they will provide care management for their members. They can use data to identify people as well, but they can just know their patients and know who would benefit from care management. They can also take referrals from the community. Health plans can take referrals for the community and local health departments will provide care management. They take referrals from the community; from providers and they specifically provide care management to at-risk children birth to five and pregnant women. But those services are often initiated from community referrals from providers or other members so please know that care management is readily available. It should be local and in the community and no matter what the data says beneficiaries can request care management or providers or community members can refer individuals for care management. The care management should be comprehensive it should help address medical needs but also unmet resource needs. So if the person needs help with food, housing, transportation, electricity, whatever it is. It should be a whole-person care management.

Kelly, thanks so much for that, appreciate that response. I'm going into the published questions that you'll see in the Q&A. I'm going to start with the first one, **what is the process for having Medicaid return to the MCO if they are receiving enhanced services. So I'll just rephrase this. It sounds like what is the process for having Medicaid beneficiaries returned to the LME-MCO if they are receiving enhanced services.** I'm going to call on Melanie Bush to answer this question.

Hi thanks Mike. My name is Melanie Bush for North Carolina Medicaid. We do we have implemented a process called a Request to Move to NC Medicaid Direct or LME-MCO form this is available on our enrollment broker website. That's ncmedicaidplans.gov. There are two forms there, you can submit them online or you can download a paper form and fax it to the enrollment broker. The first form is the beneficiary form. If you feel like you want to remain with your LME-MCO because you are receiving those enhanced services. You can fill out that form and submit it online or via fax and it will be reviewed, and you will receive notification of whether it is approved or denied.

The second form is for providers. Say that an individual is in a Standard Plan but something about their health changes and they now need a service that is only available in an LME-MCO. Then the provider would need to submit a Request to Move form that includes service authorization information. We are telling providers to include as much information as possible so that we do not have to reach back out and gather more information and delay the care. And those will be approved based on the situation, the crisis that is happening within 72 hours, so those are treated a little differently than just the general beneficiary form. But again, both of those forms are available on our ncmedicaidplans.gov website and available to submit online or via fax.

Thanks so much Melanie. Appreciate that response. I'm going to move to the next question. **Why are people being turned away from their scheduled medical procedures because they have a particular managed care plan that they were auto-enrolled in. It is happening and the managed care providers are telling clients to call their local DSS. We have no control over this. Why are clients being told to call the DSS.** And I'm going to hand this to Jay Ludlam. He had talked about some guidance previously that I think he may touch on again, but Jay can you take this question.

Yes, good afternoon. Again my name is Jay Ludlam. So the question was why are people being turned away and what can we do. First I think that there's a little bit of confusion, it's a transition, but I think that confusion results in those cancelled appointments. We really want to encourage providers to see beneficiaries and deliver those services that are necessary. And that's in part that guidance that I referred to earlier that I said that we published last night. I'm going to read just a portion of it, I think that it would be too much to really read it all right now, "between July 1 and August 30 of 2021, medically necessary services that normally require prior authorization will still be reimbursed a 100% of the Medicaid fee schedule for out-of-network providers. In-network providers will get the contract rate." To ensure that providers fully understand the health plans prior authorization requirements during the transition, the health plans will still process and pay for those services. There's a couple of conditions and we tried to make those as light as possible. But effectively the provider could submit a retroactive prior authorization after the services are provided. So really, our goal is for providers to deliver those services and beneficiaries receive them.

If you do have a potential cancelled appointment, I encourage you to first of course, call your health plan. The health plan should help you get those services, realize they should be able to connect with the provider and be able to explain that process and try to straighten out that confusion. If that confusion continues, the beneficiary can call the Member Ombudsman who can do the same or the provider Ombudsman and that number was read out by Debra earlier, but I'll just read it out for folks. It's **866-304-7062**. That is the Provider Ombudsman. These are really important cases. We do want to see our beneficiaries get the care that they need. You can contact the Provider Ombudsman or the Member Ombudsman in worst-case scenarios. The health plans and should be able to assist you through this process. I would not refer them to the DSS offices. If you do, we encourage the DSS office to reach out to their state partners so that we can work with the health plans to get those services delivered. Thanks, Mike.

Thanks so much Jay, I did want to just continue going down the items that we have listed here, and I want to be mindful of time. I'm going to jump ahead there is a question about NEMT and a couple have come in and I just wanted to hand it over to Melanie if I could just to reiterate the process. The concern here is that folks weren't picked up in a specific scenario and if you could reiterate real quick, Melanie the process and what folks would do in that scenario if there is a challenge.

So our health plans are using transportation brokers. Four of the health plans, except WellCare. All four health plans are using Modivcare as their broker, and WellCare is using OneCall as their transportation broker. We are encouraging folks to call their respective transportation brokers, depending on which plan they're in, to arrange their NEMT. I understand in this case that we have had a couple of scenarios that have happened where individuals were promised a ride and then it was not available at that time that they needed it. In that case, I would certainly have individuals call their health plan. It is their responsibility to resolve any issues and make sure that you get to the appointment that you need to.

However, if you need services that day that would impact your health or missing that appointment would adversely affect your health, we are encouraging folks to reach out to the Medicaid team. Contact us, either through the Provider Ombudsman (**866-304-7062**), if you're a provider, that this beneficiary didn't come in, that would be the appropriate thing. We have instructed the counties to escalate through their OST representatives to get into North Carolina Medicaid. If it is an emergent issue, then of course please go to the hospital. But generally the NEMT process is supposed to be coordinated by the health plans and their brokers if you do have issues, however, reach out to the Member Ombudsman (**877-201-3750**), if you're a beneficiary or the Provider Ombudsman if you are having those issues.

Thanks Melanie, thanks so much for that and I do want to be mindful of the time we have reached 2:50 p.m. so I just want to reiterate what you see on the screen recording of the webinar and the slide deck will be available on our Medicaid transformation page at the link that you see on your screen (medicaid.ncdhhs.gov/transformation/more-information) and then also just reiterate that there are a variety of additional resources that we continue to add to an update on our Medicaid Transformation website and so I encourage you to visit that website (ncdhhs.gov/medicaid-transformation) and encourage you to bookmark it. As I said, we use that for a variety of updates and continually add information there in regular basis. We will also continue to host these webinars and we really appreciate the wonderful attendance that we've gotten and the great questions this afternoon. So with that I will wrap up and thank you all for joining us this afternoon.

Thank you.