

NC Medicaid Managed Care Webinar
Community Partners: NC Medicaid's Transition to Managed Care
"Preparing for Launch"
June 3, 2021
Transcript

Thank you, today's webinar is focused on our community partners who support beneficiaries who will participate in the Medicaid Managed Care program. The purpose of today's webinar is to provide you information on where we are with managed care launch, to provide important details about the implementation and to ask you, as Community Partners, to help share critical information with Medicaid Beneficiaries who rely on the public system for their care.

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Because we are aware that sometimes providers join these webinars, and although most of our content will not be targeted to the provider audience, we did want to provide upfront information to you, as providers, that can help you in making the transition to Medicaid Managed Care. So what you see on the screen is a list of resources that are available to providers including details on our Medicaid Transformation website, as well as County and Provider Playbooks that are available. These contain a multitude of fact sheets about what providers need to know as they make the transition to Medicaid Managed Care. We also have available to you a link to the NC Medicaid Help Center and that's an online resource where providers can enter questions and search keywords to get information about this transformation that will help them make important decisions as we make the change. And then there are other informational supports available to you and training opportunities including the Back-Porch Chat Webinar series that's cohosted by the department and AHEC. As well as regular Medicaid bulletins that we distribute.

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With this transition to managed care, our Vision remains the same. We are committed to improving the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care. That system will address both medical and non-medical drivers of care. As you are aware, this is the most significant change that Medicaid has made in its 50-year history. We recognize that it's going to be a major change for Medicaid beneficiaries, and we want to make sure that everyone is aware of our commitment to making sure that beneficiaries can have improved health as we make this change.

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I'm going to turn it over at this time, after I address our day one priorities to Jay Ludlam, who will be providing more details. With this transition to Medicaid Managed Care, our priorities remain the same. That individuals get the care that they need, and providers get paid for the services they deliver. There are many other priorities that support this transition, but those two remain our key priorities. And with that I'll turn it over to Jay Ludlam.

Alright, thank you very much, Debra.

Good afternoon everybody. My name is Jay Ludlam. I'm the assistant secretary for Medicaid and very excited to walk you through many of the changes that we are in the process of implementing. To back up just a little bit and talk about something that happened last week. So last week as part of our effort to address the non-medical drivers of health we have awarded through a competitive procurement process, three regional Healthy Opportunity pilot entities. This is the first of its kind in the nation. A programmatic test of using evidence based non-medical interventions. We will evaluate the effectiveness of these non-medical interventions towards reducing costs and improving the health of Medicaid beneficiaries. This is part of our 1115 waiver authority, and we are very excited to welcome our three new partners: Access East, Community Care of the Lower Cape Fear and Dogwood Health Trust. There is more information at the link provided on the slide.

ncdhhs.gov/about/departments-initiatives/healthy-opportunities

Why don't we move to the next slide?

Alright, so another thing that we've been working on over the last couple of weeks is the conclusion of open enrollment and auto-enrollment. Open enrollment was where individuals were able to actively select their health plan. I will show some of the results of that effort in just a minute, but for those beneficiaries who did not choose a health plan. On or about the weekend of May 20, the department used an algorithm to auto-enroll those individuals into a health plan. There are certain criteria we used, and that criteria is below. One of the more important components was maintaining the existing primary care physician relationship with the beneficiary. We were able to complete that process and I'm happy to report, actually excited to report that 97% of our beneficiaries who are currently in the fee-for-service program and are transitioning into Medicaid Managed Care will be able to keep their current primary care provider in the new health plan they are assigned to. So this is a very exciting development.

Why don't we move to the next slide and get to the numbers? So this is the result. Of both the active selection as well as the auto-enrollment in the aggregated level across all the health plans and the tribal option. The couple of things to highlight, of course, and you're going to hear me highlight it a couple of times that 97% of maintenance for our PCPs is really it's a huge win I think for the Medicaid program, but there are a couple of details here that I want to draw your attention to.

We have been talking about 1.6 million individuals moving to Medicaid Managed Care and some of you out there may say your math doesn't add up... you're at 1.451. That is because we do have a number of beneficiaries who will be redetermined eligible during the month of June and were not included as part of our auto-enrollment process, those individuals, after they're redetermined eligible for Medicaid will be auto-enrolled just like everybody else and will be ready for July 1 go live.

We do anticipate that on July 1, we will be at approximately 1.6 million individuals who will transition into the health plans. Again, otherwise I think there's a really good distribution of beneficiaries across our health plans and we feel very comfortable and confident in the processes that we ran to succeed with auto-enrollment.

So why don't we move to the next slide about what happens next. So now we have kicked off a number of different steps internally and with our health plan partners. First of all we have sent our beneficiaries information from both the enrollment broker as well as from the health plans confirmation of their health plan enrollment. The health plans will start to send out information about the health plan itself and the services that they offer and provide beneficiaries with their ID card.

Those beneficiaries whose PCP may not have contracted with the health plan or those beneficiaries who might not have a primary care physician, the health plans will assign primary care providers based on who they, the standard plans, have contracted with. Beneficiaries will have 90 days after July 1 to change a health plan, although they can do that now. But the "clock" starts, that 90-day clock starts after we go live on July 1. So 90 days is really probably 120 days based on the work that we did earlier in May and in June. Of course, if individuals do want to change their health plans, they should call the enrollment broker at the number listed on the slide. (833-870-5500)

I'm going to move to some key milestones that are coming up. So again, a lot of our activity in June is bringing various systems and functionality and making it available both to beneficiaries and providers. So the first is that on June 1, a couple of days ago, the health plan and non-emergency transportation brokers began transitioning the calls to them so that they could schedule appointments for after we go live on July 1 and beyond. June 12 is the deadline in which our health plans are expected to send out enrollment packages that went through that May 22 auto-enrollment process. For those individuals that are redetermined, it will in the month of June, then it will be on rolling basis, but we expect the vast majority of our packages to be sent by the health plans on June 12.

Of course, on July 1 we go live. August 30 is the last day that the health plans will pay claims and authorize services for Medicaid enrolled out-of-network providers equal to that of an in-network provider. That's a lot of technical language, but what we have done is offer a transition period for our providers as they may need to work out certain contractual issues and to continue to negotiate with health plans. But by August 30, we do expect the program to start settling in to how we would long term expect it to run, and therefore that transition period begins to wind down at the end of August. At the end of September, which will be the last date that beneficiaries will be able to choose a different health plan for any reason. After that date, there are specific reasons that beneficiaries would need to describe or demonstrate in order to change a health plan. Up until they are again redetermined eligible for Medicaid and then they get another period of time, 90 days, to choose to choose a plan or to change their plan.

Why don't we move to the next slide?

Alright, so going back to Non-Emergency Transportation. Members now (beneficiaries who have transitioned to or expect to transition to managed care on July 1) may request transportation now for those appointments on or after July 1. So there's some details here that I won't read all of it, but I will read some of the key components. So the beneficiaries should be calling their health plans and coordinating through their health plans for those non-emergency transportation appointments. They should be making those requests at least two days in advance of that appointment. DSS offices will provide Non-Emergency Transportation for services those in NC Medicaid Direct, as well as the tribal option they will continue to do that. They are also continuing to provide services through June and up

to July 1, but after July 1 they will not be responsible for Non-Emergency Transportation for the health plan members. So again, we really need beneficiaries to be coordinating those appointments through the health plans themselves.

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So here are some key phone numbers, of course that beneficiaries can call if they want to schedule a Non-Emergency Transportation appointment. I won't read out those phone numbers you do see effectively really two main organizations ModivCare as well as One Call. But again, coordinate through your health plan, move to the next slide, please.

Also on June 1, not only did the non-emergency transportation broker phone line go up, but the health plans themselves. We brought their call centers online and so these call centers include pharmacy, the nursing hotline as well as the behavioral health crisis line. So that is available now for beneficiaries to call. And there are the phone numbers on the page.

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I began to describe it a little bit, but I do want to go into greater detail about transition of care. So transition of care is a really critical component of what we're trying to accomplish with this move to managed care. The thing that we are focused on is providing continuous or maintaining continuity of care for our beneficiaries and minimizing, as much as possible, the burden on providers during this transition. So what does this mean? Specifically, it is or for example, around prior authorizations. We have transferred those prior, open and active prior authorizations to the Standard Plan. So the Standard Plans are expected to honor open authorizations for 90 days or until the authorization expires, whichever comes first. If a member transitions between plans after July 1, the prior authorization, authorized by their original health plan, will also be honored for the life of the authorization by their new health plan. New authorization requests submitted after July 1 must be directed to the beneficiary's Standard Plan so this is for our providers out there who might be listening - you must request your new authorizations from the health plans on or after July 1.

For the first 60 days, and we talked about this a little bit, August 30, the health plans will pay claims and authorize services for Medicaid enrolled out-of-network providers equal to, and that means basically at the same rules and at the same rate as in-network providers, until the end of the episode of care, or for those 60 days August 30, whichever is less.

Thank you, next slide.

For newborns we do want to talk about that transition of care. Health plans will treat all out-of-network providers the same as an in-network provider for newborns for the purpose of prior authorizations. And they will pay out-of-network providers the NC Medicaid Direct fee-for-service rate for those services rendered through the earlier of: 90 days from the newborn's date of birth or the date that the health plan is engaged or has transmitted the child to an in-network primary care provider or other provider. There's an asterisk there which I will not read, but I think that this is an important slide for those of you who may be concerned about newborns and the transition to managed care. I am now

going to turn over the slides to Eric Rubin who will give a wrap up of the enrollment broker and the work they're doing. Thank you.

Thanks Jay. Hi, my name is Eric Rubin and I represent the enrollment broker. As Jay said, we've come out of open enrollment activities so a couple things have changed. One is we're still there but now we're there six days a week versus seven, but we still have our website up and running 24/7 so people can easily get to us. There's also a digital app out there and we'll talk a little bit about the use of these because it's been quite extensive as we've gone through the process, but again, Monday through Saturday we will be there 7 a.m. to 5 p.m. to answer questions. If people call in after hours, they can leave voicemail messages and we will call you back on the next day.

So if we can move to the next slide.

So as we said, we have gotten a lot of calls over the past maybe six weeks or so, we we've handled 137,000 live calls, but there's been a real embrace of the digital tools out there, so you'll see that we've got almost a quarter of a million web visits. This is where people can come find out a lot of information. I will talk a little bit more about what's on the website in a minute, but they can also enroll, we also have live chat sessions up and running and as we said there's a dedicated digital app so it's a perfect experience in the palm of your hand. And over 100,000 people have gone out and used the mobile app. We've had over 100 outreach events to date, held out in the community. Again due to the pandemic, these aren't live, but as we begin to see restrictions lifted, we will be moving out into the community as well.

So let's talk a little bit about how people can interact with us. You've seen that they are using a lot of these digital channels, so when we talk about chat, these are live chats. This is not a robot. As we said the website is out there. It is a great enrollment vehicle, but it is a great place to find information. It is constantly changing. As things continue to evolve in the program, people will find out the information does change out on both the web and mobile site. We're continuing with a very heavy phone presence as we've talked with the state, we know that Jay talked about the auto-assignment process that we've all gone through. It affected a lot of people, so we are staffed both in the month of June and July to answer phone calls of people cause what's important to remember is that people have gone in and enrolled and have selected no primary health care plan. They can still call us to change if they want to change the plan that they've enrolled into. But they'll find out if they call in and listen through the IVR (interactive voice response system) if they want to change their primary care provider, they'll have to do that with their health plan

We've made this easy. We auto-transfer people. You don't have to go and dial another number. So we've really tried to use our interactive voice response system to enable what people need to do. And it too is being very heavily used throughout the process, which we are excited about.

On the next slide we can see what the website looks like. For those of you have gone out and used the website, you will note it continues to change as the different phases of the rollout continue to change and we continue to add information throughout the website. Not only under the Learn tab but throughout the website as well. One of the things that we tried to do is make this a very user-friendly website. You can instantly, and you can see this on the next slide, just pick Spanish and the whole

website will convert right to Spanish. And then those Spanish speaking people can go through this site. Again as we update any part of the site, both the English and Spanish are kept in sync.

So if we go a little bit one more slide, we do use this metaphor of Learn. This is where people can really learn not only about what a health plan is, but what the benefits and services are we know people continue to have questions, so this is a key part. If you, again as a provider, have some of your patients come in and they have questions about the transformation, this is a great resource for them to use as well as your staff. It's user friendly and you'll see in the bottom of the right-hand corner on the chat function, chat is heavily used, and again it's something that we found when we deploy this, especially in settings with a lot of professional people that the offices really do like chat functions. It allows them to get online with someone while still talking to people at their desk or taking care of other activities.

So as we move on, I think the other place to keep checking the site and it's on the next page, is the meetings and events. As we've said, we've had over 100 meetings. These are webinars, these are Facebook events, and we will continue to have these events. You can contact us, and we'll talk about that in a minute, if you need an event in your area. We really want people to understand the great benefits that they can get. The plans that they can enroll in. And we know this is new for a lot of people.

So if we move a little bit one more slide, you'll see as you click in there. What kinds of engagements events we have, community outreach you can get, to marketing materials if you need them. If you want some fact sheets to post, flyers to give out again to patients. You can do that, and if you want to request a presentation you can literally email us, and we have a group that's solely focused on partner engagement and community outreach. We have people that are assigned virtually to every county and many counties have multiple people assigned to them. So we do have people ready, willing and able to come out and hold one of these events with a group in your area.

So, I think now we're going to cover the Medicaid Ombudsman, so let me turn over the presentation.

Thank you, Eric. So we just wanted you to be aware that the Medicaid Ombudsman program, which is a resource to beneficiaries to help them resolve issues that they may have, either with the provider or the health plan, is fully launched and able to engage individually and personally with Medicaid beneficiaries.

The program has four key functions. One of them is to educate individuals about their rights and the responsibilities for managed care and what it means for them as beneficiaries They're also there to advocate with issues and to advocate on behalf of beneficiaries. The third function that they perform is to refer and connect individuals to resources in the community. And finally part of their role is to conduct outreach and to communicate to individuals about Medicaid Managed Care to improve the beneficiary experience. You will see on the screen that the Ombudsman's website is available to you now, as well as a phone number where you can contact them Monday through Friday 8 a.m. to 5 p.m.

So this webinar is one of the ways that we are engaging with you as community partners and beneficiaries to make sure that individuals understand the change to Medicaid Managed Care. We

have spoken before about the beneficiary portal and our Medicaid Contact Center and other ways that we're using, including paid media to try to educate beneficiaries about this change. We do thank you for your partnership. You are a critical partner in this transition to Medicaid Managed Care. And we hope these webinars have been helpful to you in getting the most up-to-date information about this transition. We do intend to continue to have this webinar series where we'll provide you valuable information about the transition.

One of the things we're asking you to do to help share information about Medicaid Managed Care to ensure the key messages are consistent with what we've said in the past. We want you to make sure to help us to communicate to beneficiaries that Medicaid services will be administered and managed by health plans. The services that individuals receive will be reimbursed to providers by health plans, but the services that Medicaid has available will not change. Health plans in some cases will offer enhanced benefits to members. And also, we ask that you share with individuals that Medicaid eligibility rules remain the same. DSS will continue to determine eligibility and individuals can still qualify in the ways that they have in the past. Also, we want you to know that confirmation notices and health plan welcome packets, as well as member ID cards will be mailed to beneficiaries no later than June 12, so individuals may have already started receiving information in the mail. Those mailings will continue for the next week or so through June 12. And finally, individuals have until September 30, 2021, to change their health plan selection for any reason.

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Resources are available to you if you have additional questions. You can get information on our webpage (medicaid.ncdhhs.gov/transformation). The ncmedicaidplans.gov webpage, as well as send requests for engagements. We can have someone come out and provide information to your public meetings and other avenues that you have to help disseminate information to beneficiaries so you can use Medicaid.NCEngagement@dhhs.nc.gov to request an engagement from our Medicaid team. And I think that concludes our formal presentation.

We do have some time available for questions and answers. A copy of this webinar and our slide deck will be available on our webpage and I'll hand it over to Michael Leighs who will begin with our questions.

Debra, thanks so much. We do have several questions that have come in the chat and a few that we received before the webinar. So I'm going to start with the first one and believe Sonja on our team can help answer this, the first question is, will the Medicaid ID number change for folks that are moving to Medicaid Managed Care?

Hi everybody. No, the Medicaid ID number will stay the same. The plans are using that ID number on their cards also. The reason for that is if they receive some services outside managed care, they can still use the same card.

Thanks Sonja, and if I could keep you on for the next question as well. Question is if a woman is on pregnancy Medicaid will her baby automatically be enrolled in the same PHP or will they have a window to choose a separate PHP for the baby?

The baby will be auto-enrolled into the same plan the mom has, but then they have a choice period after the plan goes live that they will have time to change if they would like to.

Thank you great. I think I'll call on Eric for this one. Eric, are there translators available for Spanish speaking clients should they need to call the call center? If you could speak to that across the board for your channels if you don't mind.

Sure we do have bilingual agents on staff, so yes if people call in, they can talk to them. We also have the ability to tap into a language line service which really covers over 100 languages. And we'll get an interpreter on the line, our people will stay with both the interpreter and the beneficiary and then we'll walk them through the process and answer any questions that they have.

Great thanks Eric, appreciate that. Next question is, will we be able to check eligibility in NCTracks for the new plans or have to use individual websites? And I believe Melanie Bush is on the line. Melanie, could you take that?

Yes. So yes, we encourage all providers to confirm eligibility and NCTracks before any visit because expiration dates for eligibility are not included on your cards. You will be able to see the health plan in NCTracks that a member has either chosen or been assigned to. If an individual is remaining in NC Medicaid Direct, which is our current fee-for-service program, they will not have a health plan listed inside. So you should be able to see that starting June 1, so you should be able to see now if individuals will be assigned to a health plan starting July 1.

Thanks so much Melanie for that. Let's move to the next question. So Sonja, I think you might be able to help with this. What is the process for the opt out request form? There're a couple follow-ups, but maybe you could just take it from my records by mail or phone. I'll hand that off to you.

Okay, those forms are available through the enrollment broker. They can call or mail them in. They are processed by department. And yes, the folks are notified by mail. They will either receive a denial or they will receive a new letter saying what their new status is and what their choices are going forward. And those did not start being processed until about two weeks ago, so they're almost finished. We're trying to get everything completed well before July 1.

Yeah, thank you, Sonja. Moving to the next question. Will county DSS offices get a report of who is moved to managed care in their county and what plan they are enrolled in? So, Sonja or Melanie would one of you want to cover that.

I can start and then Melanie can join in if I don't cover it completely. The counties are receiving reports monthly of managed care status of their folks in their county and each caseworker can go into an individual's case to see exactly who they've been assigned to as far as PHP and PCP and what their managed care status is. So that is available to the counties now. Don't know Melanie if you have any other information than that.

Nope, OK, thank you for covering it.

OK, thank you Sonja for that. Appreciate it. Let me just move to the next question here. Next question might be something Jay or Melanie could cover. Question is as a provider; do we need to enroll in all of the offered health plans? Jay, maybe you could start if you're available.

Yes, alright, so to the question about whether or not a provider is required to enroll in all of the health plans or to contract with all the health plans. While that is not a requirement, of course the department encourages providers to contract with all the health plans as that provides the most access for our beneficiaries as possible. But they are not required to do that. There are pros and cons to making that decision. One con is that if a beneficiary came to your office you would have to follow the out-of-network prior authorization requirements for that health plan, which can be potentially administratively burdensome, but generally you are not required to contract with every health plan. Thank you.

Great, thank you, appreciate that. Let's see moving to the next question. How can a client choose an authorized representative so that we may assist him with following up with care bills? You have many clients have never lived in the US who receive Medicaid. Sonja, could you help us answer the authorized representative question?

Certainly. Someone can change or get a new authorized representative, but they have to go through their Department of Social Services. It is part of their eligibility process, so in that case there are forms that would have to be filled out by the Authorized Rep and by the beneficiary and then we could have those added into NCFast. Those are available from NCFast through to NCTracks and the enrollment broker.

Great, thank you so much, appreciate that. And moving to the next question, Sonja, you might be able to help us with this as well. Can beneficiaries change more than once within the 90 days? And I assume that means changing health plans.

During their 90-day choice period, they can change as many times as they would like to. They're not limited during that time.

Thanks and Sonja, we had received a previous question about the ability to change after September 30. I was wondering if you might be able to answer that as it's the same subject.

Yes. For mandatory recipients, they would have to have cause to change plans after the 90-day choice period. I can give you an example. If they have a family member who's receiving another plan they could ask to be put on the same plan, if they moved out of the area, they could ask to have another plan. There're several other reasons like health plans that don't cover services if they have some type of complex medical need. But they do have to have cause if they are mandatory during the lock in period.

Great, thank you appreciate that. So let me move to the next question here. So this is about the billing addresses for health plans. I wonder if perhaps Melanie or Jay could talk about some of the resources, we have in terms of contact information for the health plans. Melanie, did you want to start on that one?

Sure. I would highly recommend that all providers who have questions about Medicaid Managed Care reference our Provider Playbook. This is available on our Medicaid website under the provider link. It's a provider playbook on Medicaid Managed Care. There's a number of resources there that you'll find. We have trending topics. We have fact sheets that cover a number of topics, including some I've seen in the chat here. Some questions about how to find out how to submit claims, how to find out how to submit prior authorizations, what are the billing addresses, for example. All of that information we have in quick reference guides for every individual PHP, we also have a Day One Cheat Sheet. Everything you will need to know on day one, how to look up whether beneficiaries are enrolled in a health plan, how to request a prior authorization, how to schedule NEMT (non-emergency medical transportation); all of those are included in our fact sheets. We also have frequently asked questions. We have trainings. And trending topics that folks may be interested in. So that is again on our website (medicaid.ncdhhs.gov/transformation) and it's in our provider playbook.

Thank you, Melanie. This might be you or Sonja. We had a question about how you can check eligibility for NEMT clients since DSS is not a medical provider, they don't have access to NCTracks. Maybe we could talk about the NCFast options there and then, maybe just a little bit more about how that process works.

So I just mentioned in response to an earlier question that you should be able to go into an individual record and find out which PHP they have chosen or been assigned to and the PCP. If they did not have that, then they will remain in our Medicaid Direct program and the counties are still responsible for coordinating non-emergency medical transportation for those individuals so that information should be available on individual basis and in NCFast.

Thank you for that Melanie. Debra, could you help with the next question? I'm going to paraphrase here. We got a question about being told that many of the managed care organizations will still have a role moving forward. Assuming this, tell me the MCO role moving forward for providing services for the beneficiary. So I wonder if you could talk about that and our Tailored Plans. So I'll hand that one off to you.

Thanks Michael. So yes there are individuals who have severe or serious mental health conditions or behavioral health conditions who will continue to receive their services through the LME-MCOs until Tailored Plans are developed and launched. If an individual is determined to be exempt because they have a serious mental health, IDD, or substance abuse issue then they have the ability to remain in the current system or they can choose to enroll with the Standard Plan. Individuals should have received a notification from NC Medicaid about their choices and should have decided if they choose to select a plan. The LME-MCOs will continue to exist until Tailored Plans are awarded and go into operation in July of 2022. The LME-MCOs will continue to contract with providers, behavioral health providers, until Tailored Plans are launched in July 2022, so there should be no change in how individuals receive their care until Tailored Plans are launched in 2022. I hope that addressed the question, Mike anything else I could add?

I think that's great and very helpful. I appreciate that Debra. Let's see, so let me move to a couple others that we received beforehand and on these if I could call on Melanie. We had a question, if

patients are restricted to certain health plans and how they might be able to determine which plan is the best fit for them and a follow up is the options for choosing primary care physician.

So that's actually a very interesting question. It has a couple of different parts. We should stress that all of our Standard Plans are required to cover all of the same services across all five health plans and our EBCI tribal option so they will cover the same exact benefits of physical and behavioral health services that are included. What you can determine the differences through are their "in lieu of services". Services that they may provide that are not necessarily services that the Medicaid program provides but achieve the same effect or their value-added services and those are services that the health plan actually pays for that are above and beyond what Medicaid provides. And these are things like a car seat if you are a pregnant mom or a gym membership if it's something that you want to do to increase your health. Those types of things are called value-added services that the health plans pay. And those are available for comparison on our enrollment broker website (ncmedicaidplans.gov). Beneficiaries can go there and compare side-by-side plans and look at the options that they have. But the base services are the same.

As Debra just mentioned. There are going to be different plans for individuals who have significant behavioral health, substance abuse disorder needs and individuals with intellectual and developmental disabilities who may be receiving waiver services, but those health plans will not launch until next year. So that is not an option today.

And then in terms of what's the PCP question? Is it how will they choose a PCP? Exactly, the options in choosing a PCP. So for individuals who have selected a health plan, they had the opportunity to choose a PCP during our open enrollment period. Through auto-enrollment then for individuals who didn't make an active selection, we assigned them to a health plan. The health plans have actually started the process, and I believe it is complete, of auto-assigning beneficiaries who did not make an active selection of a primary care provider to a PCP in their network. All of this information will be conveyed to the beneficiary in an enrollment packet. It will include their health plan card with the name of their PCP included on that card. Beneficiaries have 90 days to change their PHP for any reason. For PCP changes, they need to call their health plans, not the enrollment broker. They need to call their health plans and make those changes.

Thanks very much Melanie, appreciate that. So we're going to move to the next question. Here's a question I think Sonja, or perhaps this might be you again, Melanie. It's about how health plans would be notified if a customer is no longer eligible, and so in other words, if the beneficiary is no longer eligible for Medicaid, how would a health plan be notified of that?

The health plans receive a nightly file that alerts them of any changes that happen in Member's case as far as their Medicaid eligibility. So it also alerts them of any address changes, phone number changes - anything like that, as well as if the eligibility is ending. So they do receive a nightly file that updates them with that information.

OK, thank you Sonja, I appreciate that. So moving to the next question. Melanie, if I could ask you to take this one or Sonja you might want to jump in as well. So we know we have some resources on this we might remind folks about. Could we go over the qualifications for those who are mandatory for

moving into a managed care plan, the question is around what who is qualified to move into managed care.

So we do have a fact sheet on this and I'm going pull it up really quick. (Do I need to choose a health plan files.nc.gov/ncdma/documents/Medicaid/NCMT-Fact-Sheet-ManagedCarePopulations-20210429.pdf) So there's always exceptions, but generally the individuals who have been told that they have to mandatorily enroll in managed care are most families and children unless they have some other reason that might exclude them. Children on NC Health Choice unless they have a health condition that might exclude them, pregnant women and then people who are blind or disabled but aren't dually eligible for Medicare and Medicaid. That is our mandatory population. And as Jay mentioned earlier it's about 1.6 million folks out of our 2.4 million Medicaid beneficiaries. Of course, any of these people may have a significant behavioral health or substance abuse disorder that may disqualify them or exempt them. They may be a federally recognized tribal member that also exempts them from enrolling in managed care. So there are exceptions, but generally it's families and children, Health Choice kids, pregnant women and adults who are not otherwise enrolled in the Medicare program.

Thanks Melanie, appreciate that. I'm moving to the next question. Melanie if you don't mind, we could keep you on for this one. Could you talk to us about auto-enrollment of a newborn? Again, I believe we have some resources on this issue available on our website as well.

As Sonja just said newborns that are born to women who are already enrolled in the Medicaid program will be auto-enrolled in the plan that their mother is in. We do have a fact sheet on this in our Provider Playbook and encourage folks to take a look at it. (Managed Care Eligibility for Newborns files.nc.gov/ncdma/NCMT-Provider-FactSheet-Eligibility-for-Newborns-20210521-v5.pdf)

For newborns born to women already enrolled in the Medicaid program, the newborn has to be determined eligible for Medicaid. That does take a bit of time, I think counties are required to complete that determination when they receive the information from the hospital within seven days. During that time of course, as we know, most of us who have had children, there are a couple of different doctor visits that have to happen in the meantime. There are usually the first week visit and maybe a second week visit and their shots. And then of course, the monthly visits within the first two months.

We have made the determination that once the newborn is enrolled, which again takes about seven to 10 days, and then they are auto-enrolled into a health plan, the health plan has to send the enrollment packet assign a PCP - all of that information. In that period of time the newborn will be seeing physicians and hopefully getting the shots and checkups they need in those first few important weeks. Our policy for newborns is that newborns, whomever they see will be paid 100% of the Medicaid fee-for-service rate for those services but they will be subject to any prior authorizations once they know the newborn is enrolled in a plan. It is our expectation that the health plans will then work to get that newborn into an in-network provider and when that newborn does finally have that first visit with an in-network provider then any other out-of-network visits will not be reimbursed the same that would probably be reimbursed at 90% of the Medicaid rate for out-of-network providers. So we do have a detailed fact sheet on this. We know that this is a critical time for folks to get care, and

we're trying to make it as easy as possible for infants to get the services they need and for providers to get paid.

Thanks very much Melanie. We've got a couple more questions and then we will wrap up, so I'm going to hand it over to Sonja. There's a question on how quickly NCFast is updated when a beneficiary changes their plan.

And this is a quick answer, it's updated that day, that evening and then it goes over to NCTracks that night so then NCTracks is updated and it is given out to all the plans in a report. So they know that next day. But it's not effective until the first day of the next month, when they make a change.

Thank you, Sonja, for that. We just have one more question here I'm going to tackle myself and then I'm going to hand it back to Debra to wrap up. We had a question about a fact sheet for beneficiaries explaining how to get transportation to appointments. I did want to flag that Kathy has added a fact sheet that's available on our website about NEMT ([medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/nemt](https://www.medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/nemt)) but also on that question. All of the health plans will be sending out Member welcome packets. There will be information specific to NEMT in our Member Handbook that will be shared out with each beneficiary, but there is also a separate insert, one pager, that has very clear instructions on how a member can make transportation arrangements for appointments coming up and the contact information to do so. So with that Debra, I'm going to hand it back to you.

Thank you, Michael, we appreciate you raising all the questions from our participants. And for Jay Melanie and Sonja answering all those questions. Just a reminder that we will host these webinars on a monthly basis. They are targeted to community partners and organizations that support beneficiaries, so we really appreciate you joining us in partnering with us to disseminate messages to beneficiaries about this change.

We have noticed today that we've gotten a significant number of questions from providers, and we certainly appreciate you joining as well, because you're a really important part of our service continuum. I would like to just highlight a couple of things that Melanie mentioned. We have a number of fact sheets that are available to you on our Medicaid transformation webpage ([medicaid.ncdhhs.gov/transformation](https://www.medicaid.ncdhhs.gov/transformation)) that will answer many, if not all, questions that you have. The fact sheets are there as well as the Help Center is there for you to research and search for questions in areas that you're concerned about. I'll draw your attention to our Medicaid webinar series, The Back-Porch Chat series that are being hosted by the department, and by DHB NC Medicaid. And that's another place for you to get some information about this transition.

Thank you again for joining and we'll look forward to talking to you next month. Thank you and have a great day.