OVERVIEW OF THE BENEFICIARY ENROLLMENT EXPERIENCE IN NC MEDICAID MANAGED CARE FOR MEDICAID PROVIDERS

Beneficiary Experience

North Carolina's transition to managed care will change how most beneficiaries access NC Medicaid services. As a health provider serving Medicaid beneficiaries, you may be one of the support systems that beneficiaries turn to with questions. This paper provides an overview of what beneficiaries will experience in the coming months. It is one of several resources to help providers support beneficiaries as they have questions. It addresses the following topics:

- Timeline for Moving to Managed Care
- Goals for Day 1
- Managed Care Populations
- Enrollment
- Notices from the Enrollment Broker
- Open Enrollment
- Auto-Enrollment
- After Enrollment
- Choice Period
- Recertification
- Member Support Processes
- Appeals
- Grievances
- Tailored Plans
- Transition of Care
- Phase 2: Beneficiary Transition

Introduction

In 2015, the NC General Assembly enacted Session Law 2015-245, which directed DHHS of Health and Human Services (DHHS or the Department) to transition Medicaid and NC Health Choice from fee-for-service to managed care. **NC Medicaid Managed Care** (Medicaid Managed Care) refers to the new program in which the State pays prepaid health plans (PHP) a monthly rate for all services provided by contracted Medicaid Providers. **NC Medicaid Direct** (Medicaid Direct) refers to the traditional fee-for-service Medicaid delivery model in which the State pays a set rate for each service that a beneficiary receives from State Medicaid Providers.

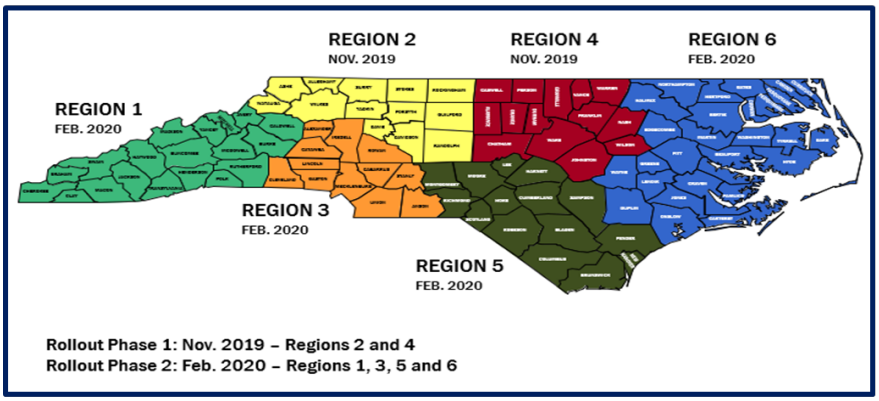
The transition to managed care requires that most Medicaid beneficiaries enroll in a Medicaid Managed Care health plan. DHHS has designed the Medicaid Managed Care enrollment process to assure beneficiaries and their families have the tools and resources to experience a smooth transition while selecting a health plan and primary care provider (PCP) and resolving potential grievances and appeals, including:

- ✓ Ensure their local Department of Social Services has their most current address
- ✓ Choose a Primary Care Provider (PCP)
- ✓ Choose a health plan
- ✓ Enroll in a health plan

Timeline for Moving to Managed Care

DHHS will transition most beneficiaries to Medicaid Managed Care in two phases based on geographic region. Phase 1 will run from June 28, 2019 to November 1, 2019 and will impact approximately 500,000 beneficiaries. Phase 2 will run from September 2, 2019 to February 1, 2020 and impact approximately 1.1million beneficiaries. In total, approximately 1.6 million Medicaid beneficiaries will be impacted by this change. Counties in Regions 2 and 4 will transition first, followed by counties in Regions 1, 3, 5 and 6. The graphic below shows the counties in each region and includes dates for key milestones.

Medicaid Managed Care Regions Graphic (Picture 1.1)



Managed Care Phase 1 (Regions 2 and 4)

- Call Center and Website Live: 6/28/2019
- Enrollment Packets Mailed: 7/8/2019
- Open Enrollment: 7/15/19 – 9/13/19
- Reminder Postcard: 8/13/19
- Auto-Enrollment: 9/16/19
- Health Plan Coverage Starts: 11/1/19

Managed Care Phase 2 (Regions 1, 3, 5, 6)

- Enrollment Packets Mailed: 10/1/2019
- Open Enrollment: 10/14/19 – 12/13/19
- Reminder Postcard: 11/13/19
- Auto-Enrollment: 12/16/19
- Health Plan Coverage Starts: 2/1/20

Goals for Day 1 of Managed Care

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' goals 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.

Managed Care Populations

While most existing Medicaid beneficiaries will transition to Medicaid Managed Care, there are limited exceptions to mandatory enrollment for certain populations. Based on criteria established by the North Carolina General Assembly, Medicaid beneficiaries are divided into three groups relative to their status during the transition to Medicaid Managed Care: those who must enroll in a health plan; those who may enroll in a health plan; and those who cannot enroll in a health plan. These groups are defined as follows:

- **Must Enroll (Mandatory) –**Most beneficiaries must enroll in a health plan, including most current Medicaid beneficiaries in Family & Children's Medicaid, Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled (includes Supplemental Security Income (SSI) and Special Assistance (SA) recipients).
- **May Enroll (Exempt)** – Beneficiaries in this group have the option to remain in Medicaid Direct or choose a health plan in Medicaid Managed Care. This group includes members of federally recognized tribes and beneficiaries who will be eligible for Behavioral Health and Intellectual / Developmental Disability Tailored Plans tailored plans. The latter group will move to tailored plans when those launch in mid-2021.
- **Cannot Enroll (Excluded)** – A small number of people with complex or unique health care needs will remain in Medicaid Direct because of the type of medical services they need. This group cannot enroll in a health plan through Medicaid Managed Care, including those who receive benefits as part of the following programs: Emergency Services Only, Medicaid Be Smart Family Planning Program, Health Insurance Premium Payment (HIPP), Incarcerated individuals, Medically Needy (spend down), Program of all-inclusive care for the elderly (PACE), Partial dual-eligible Medicaid/Medicare, Presumptive Eligibility, children in foster care, and Refugee Medicaid. Beneficiaries on the Innovations and Traumatic Brain Injury waivers cannot enroll in a health plan until Tailored Plans go live. When Tailored Plans go live, they must enroll.

The Beneficiary Experience Begins with Enrollment

For most of North Carolina's Medicaid beneficiaries, the journey to Medicaid Managed Care will begin when they receive their enrollment packets. A third-party enrollment broker will assist beneficiaries with enrollment activities. The enrollment broker will provide accurate, unbiased, personalized customer service through a program staffed by knowledgeable specialists who will provide information to beneficiaries as they navigate the Medicaid Managed Care transformation. The enrollment broker will:

Real time support from an enrollment specialist will be available at 1-833-870-5500 (TTY Toll-free: 1-833-870-5588) for beneficiaries as they transition to Medicaid Managed Care.

- Educate Medicaid beneficiaries about their health plan selection options
- Help Medicaid beneficiaries make informed decisions on selecting a health plan that best meets their needs
- Enroll Medicaid beneficiaries in a health plan with their preferred primary care provider (PCP)

Notices from The Enrollment Broker

Beginning July 8, 2019, the enrollment broker will mail enrollment packets to beneficiary families. The enrollment packets address the Medicaid population holistically. Notices do not distinguish the NC Health Choice populations. The transition to managed care impact both NC Medicaid and NC Health Choice populations. Those in NC Health Choice will receive the same notices based on the conditions described in the previous section. status as described below.

A beneficiary's Managed Care status determines which group he or she is in and therefore which notice he or she will receive from the enrollment broker. Members of the excluded population who cannot enroll in a health plan will not receive any notice. 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. Providers and their staff will likely be asked questions as well. Appendix A describes all notices that will be sent to beneficiaries.

The enrollment packet will include information on the many ways beneficiaries can get support during enrollment, including:

- Call the Call Center

  For Real-Time Support, members can call 1-833-870-5500 (TTY Toll-free: 1-833-870-5588)

- Mail or fax in the Enrollment Form provided in the Enrollment Packet

- By visiting the website ncmedicaidplans.gov

  The NC Medicaid Managed Care website (available in English and Spanish) provides an integrated experience for beneficiaries to manage their enrollment needs. This is a great resource to direct beneficiaries to for questions about enrollment. The website includes the following tools and information:

  - Health plan comparison charts and lists of benefits for phase 1. Will be updated for phase 2.
  - Provider network directory and search capability
  - Program information, brochures and enrollment forms (as downloadable PDFs)
  - Questions and answers
  - List of events in their county

  Any website visitor can browse for information and search for a PCP. By creating an account and logging in, beneficiaries can access additional functions. Beneficiaries can create an account with a valid NCID login to access a secure web portal. The North Carolina Identity Management Service (NCID) is a web-based application that provides a secure environment for state agency, local government, business and individual users to log in and gain access to real-time resources, such as Medicaid and other State provided assistance programs. More information on the NCID can be found online. Once beneficiaries have an NCID, on the NC Medicaid Managed Care website beneficiaries can do more, including:

  - Access case-specific information
  - Manage their online account
  - Complete choice counseling
  - Enroll in their selected health plan
  - Choose a PCP
  - Access a Chat Tool which accesses enrollment specialists to answer questions (via Chat with Us! Button; compatible with iOS and Android operating systems for mobile users)

- Via a smart phone app

  To get the NC Medicaid Managed Care app, members should search for NC Medicaid on Google Play or the App Store.

  The Medicaid Managed Care Mobile App is multilingual (English and Spanish) with real-time data presenting information and options specifically matched to each beneficiary. On it, beneficiaries can view their enrollment status, compare health plans and enroll.

Throughout the mailing and open enrollment timeframe, beneficiaries may see public service announcements (PSAs), social media or DHHS Website announcements, but the enrollment packet is a targeted touchpoint directly to individual beneficiaries.

Open Enrollment

The official Medicaid Managed Care Open Enrollment period for Phase 1 begins on July 15, 2019, and runs through September 13, 2019. It is anticipated that by July 15, 2019, most beneficiaries will have received the appropriate enrollment packet in the mail. During open enrollment, beneficiaries will be able to select the health plan and PCP of their choice. During the open enrollment period, beneficiaries will also receive a reminder postcard. Reminder postcards will be mailed on August 13, 2019. Beneficiaries who wish to keep their current PCP must enroll in a health plan their PCP works with.

Beneficiaries can change their plan selection as many times as they request during open enrollment and the choice period described below using any of the methods mentioned above (e.g. calling the enrollment broker, returning the enrollment form via the mail, using the app, etc.). After that, unless a beneficiary has a special reason, he or she cannot change their health plan until their Medicaid recertification date.

Auto-Enrollment

Beneficiaries in the mandatory population who have not selected a health plan by September 13, 2019, will be assigned one by DHHS. DHHS has developed an auto-enrollment process that aims to match the beneficiary with the best health plan based on information available to DHHS. The auto-enrollment process will use the following criteria:

- Beneficiary's geographic location
- Historic provider-beneficiary relationship for primary care providers
- Plan enrollments for other family members will be considered to minimize the number of health plans for each family
- Equitable plan distribution across the available health plans

Auto-enrollment will start on or about September 16, 2019, which is the first business day after Open Enrollment closes.

Beneficiaries who are part of the exempt population will remain in Medicaid Direct and will not be auto-enrolled in a health plan.

After Enrollment, Health Plans Will Welcome Beneficiaries

Around August 15, 2019, health plans will begin to mail Welcome Packets to beneficiaries who have enrolled in their plan. The Welcome Packets will contain the Medicaid ID card specific to each plan. Beneficiaries will use their Medicaid ID card for all Medicaid covered services. This includes all services provided by their health plan as well as any services which are carved out of Medicaid Managed Care and which are still provided by Medicaid Direct. Carved out services are those services which are covered by Medicaid but excluded from Medicaid Managed Care. These services include dental, eyeglasses, local educations agencies (LEA) and Children's Developmental Services Agency (CDSA). These services will continue to be provided to the beneficiary through Medicaid Direct. More information on carved out services can be found online. Beneficiaries will have only one Medicaid ID number and one Medicaid ID card which is used for services received by both Medicaid Managed Care and Medicaid Direct. The Medicaid ID card will include carved out services listed on

the back. Once a beneficiary is enrolled in Medicaid Managed Care, they will only need this Medicaid card to receive all Medicaid services regardless of if the services are part of the health plan or are a carved out service. Beneficiaries can call their health plan for replacement cards, at no cost.

Health Plan Coverage Begins for Managed Care Beneficiaries

For members of the Phase 1 transition population, Medicaid Managed Care coverage begins November 1, 2019. When coverage begins, members must use their new health plan. Managed Care beneficiaries will have the same cost sharing responsibilities as beneficiaries in Medicaid Direct. This is a familiar experience for beneficiaries and is the same as in the fee-for-service experience.

Choice Period

All Managed Care members—whether they selected a health plan or were auto-enrolled—have a 90-Day Choice Period following the health plan effective coverage date. During this period beneficiaries may switch health plans without cause. After the 90-Day Choice Period most beneficiaries must remain enrolled in their health plan for the remainder of their eligibility period, unless they can demonstrate cause for switching (e.g., moving out of health plan service area, or a complex medical condition better served in a different health plan).

Certain special populations, such as members of federally recognized tribes and individuals receiving long term services and supports in institutional and community-based settings will be able to switch health plans at any time. Those in the exempt population who may enroll if they choose can move between health plans and between Medicaid Direct and Medicaid Managed Care at any time without cause. Changes are typically effective the next month.

Recertification

Medicaid eligibility is redetermined for each beneficiary every twelve months. Therefore, beneficiaries with recertification dates after auto-assignment (or September 13, 2019 for phase 1 or December 16, 2019 for phase 2), will be sent an enrollment packet that tells them the deadline for selecting a plan. The enrollment packet will also inform beneficiaries of the 90-day choice period during which they may change plans. Beneficiaries who are redetermined eligible after auto-enrollment will receive the Mandatory notice (meaning that they must enroll in a health plan), giving them the 90-day choice period beginning Nov. 1, 2019 to change the plan in which they are enrolled as described above. If a beneficiary is redetermined to be eligible after Nov. 1, 2019 the 90-day choice period specified in the enrollment packet notice will be dynamically calculated based on their recertification date.

Member Support Processes

DHHS is committed to ensuring that beneficiaries experience a seamless transition to Medicaid Managed Care and can enroll in health plans that best meet their needs. When issues arise, DHHS has established policies and procedures to resolve problems quickly with minimal burden. Depending on the situation, members will have access to real-time phone support to help resolve issues they may encounter. Members may call the enrollment broker for complaints about the enrollment broker. The enrollment broker's phone number is provided with all enrollment packet materials. Members may call their Health Plans for assistance with non-emergent medical transportation (NEMT) services for plan members, complaints about a provider or health plan and for a behavioral health crisis. The appropriate phone numbers for a member's health plan are provided on the back of the Medicaid ID card.

Appeals – Adverse Benefit Determination

As required by federal law, beneficiaries enrolled in Medicaid Managed Care will first seek to resolve appeals related to their health plan's coverage of services with their health plan. They will have 60 days from the date of the notice of an adverse benefit determination to file a request for an appeal with the health plan. Health plans will be required to send written acknowledgement of the request within five calendar days for a standard appeal and within 24 hours for an expedited appeal request. To ensure access to services, beneficiaries may request that their benefits be continued or reinstated while the appeal is pending. Health plans must provide written notice of resolution as expeditiously as the beneficiary's health condition requires and within 30 calendar days of receipt of a standard appeal request. For an expedited appeal request, health plans must provide written notice of resolution, and make "reasonable effort" to provide oral notice within 72 hours of receipt of an appeal.

If the health plan upholds the change or termination of a benefit, the beneficiary may seek a State Fair Hearing at the Office of Administrative Hearings (OAH) after receiving the notice of resolution; the request must be made no later than 120 calendar days from the date of the notice. Mediation opportunities will be available to beneficiaries. Beneficiaries will also have the right to request a continuation of benefits while an appeal is pending. OAH will also conduct disenrollment-related State Fair Hearings and issue final decisions.

Grievances

Beneficiaries will be provided the opportunity to file a grievance with their health plan, the enrollment broker or with DHHS to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or health plan employee). A beneficiary may file a grievance with a health plan, DHHS, or the enrollment broker at any time. The health plan and enrollment broker must acknowledge receipt of each grievance in writing within five calendar days and must resolve the grievance within 30 calendar days from the date the grievance is received. If a grievance relates to the denial of an expedited appeal request, health plans must resolve the grievance and provide notice to all affected parties within five calendar days from the date the health plan receives the grievance.

Transition of Care at the Implementation of Managed Care ("Crossover")

As beneficiaries transition from Medicaid Direct into Medicaid Managed Care, DHHS intends to maintain continuity of care for each beneficiary and minimize the burden on providers. To accomplish this, DHHS is focused on:

- Ensuring the beneficiary data are effectively and securely transferred to the beneficiary's selected health plan.
- Offering Beneficiary and Provider education to ensure that all partners are as prepared for the transition as possible
- Developing clear communication channels and processes between involved partners
- Implementing additional safeguards for high-need populations

Ensuring Continuity of Care: Data Transfer

To ensure smooth transition of care, data regarding beneficiary claims and encounter history will be provided to health plans. The first Claims and Encounter History data will be sent to health plans after open enrollment ends and auto-enrollment has occurred. Data will include 24 months of paid claims history for all services (carved in and out, including pharmacy) and will also include LME/MCO encounter history for applicable beneficiaries.

To ensure continuity of care, data transfers will also include approved prior authorization data for transitioning members. This will ensure that health plans have the data necessary to honor the beneficiary's current services. In addition, data will be provided on prior authorizations that have closed within 60 calendar days of the start of Medicaid Managed Care coverage. Data transfers for both Medical and Pharmacy Prior Authorizations will be sent starting 30 days prior to Managed Care Launch continuing daily after Managed Care Launch.

Ensuring Continuity of Care: Beneficiary and Provider Education

DHHS has developed communication requirements for external vendors to support beneficiary and provider preparation prior to Managed Care Launch. This includes direct outreach to beneficiaries and providers along with call center requirements to address Transition of Care questions during Managed Care Launch.

Ensuring Continuity of Care: Safeguards for High Need Members

DHHS has identified specific subgroups of "high need" members within the Medicaid population who may benefit from targeted follow up by the health plan to ensure services have continued without disruption. Health plans are required to provide beneficiary-specific follow up on these identified high-need members and report back to DHHS on disposition. In addition, health plans will be required to participate in "warm handoff" knowledge transfer sessions for particularly vulnerable Members identified by Community Care of North Carolina (CCNC), LME-MCOs or DHHS.

Phase 2 Beneficiary Transition

After the conclusion of Phase 1, DHHS will begin the transition for beneficiaries in regions 1, 3, 5 and 6 in Phase 2. Phase 2 counties will experience the same process, outcomes and next steps as did counties in Phase 1, but with later dates for key milestones.

Major dates for Phase 2 are as follows:

- Enrollment Packet Mailings will start October 2019
- Open Enrollment Period will be October 14, 2019, to December 13, 2019
- Beneficiaries will receive a Reminder Postcard on November 13, 2019
- Auto-enrollment will take place December 16, 2019
- Health Plan Coverage starts February 1, 2020
- 90-Day Choice Period is from February 1, 2020, to April 30, 2020
- For most populations, no more plan changes starting May 1, 2020, unless with cause

Tailored Plans Launch in 2021

Within Medicaid Managed Care, there are Standard Plans (which provide integrated physical and behavioral health services for most beneficiaries in Medicaid Managed Care) and Tailored Plans (specialized plans which provide integrated physical and behavioral health services for members with significant behavioral health needs and intellectual/developmental disabilities (I/DD) and Traumatic Brain Injury). Most Medicaid beneficiaries will have to choose a health plan and will be enrolled in a Standard Plan in 2019/2020. Any Medicaid beneficiary who meets the Behavioral Health I/DD Tailored Plan eligibility criteria will have access to a Behavioral Health I/DD Tailored Plan when they become available in 2021. Prior to the launch of the Tailored Plans, beneficiaries who are identified as meeting the eligibility criteria for Behavioral Health I/DD Tailored Plans will not choose a health plan in Medicaid Managed Care unless they choose to opt in. These beneficiaries will remain in Medicaid Direct (traditional fee-for-service). They will continue to receive care from their current

delivery system, generally Medicaid Direct and Local Management Entity-Managed Care Organizations (LME-MCOs) until the Behavioral Health I/DD Tailored Plans are launched. Beneficiaries enrolled in the Innovations or Traumatic Brain Injury waiver will not have the option to enroll in Medicaid Managed Care at this time.

Medicaid will regularly review encounter, claims and other relevant and available data to identify beneficiaries enrolled in Standard Plans and new Medicaid beneficiaries who meet Behavioral Health I/DD Tailored Plan eligibility criteria. Beneficiaries identified as meeting the eligibility criteria for Behavioral Health I/DD Tailored Plans after they are enrolled in a Standard Plan will have the option to move to Medicaid Direct and BH I/DD Tailored Plans. Additionally, new Medicaid beneficiaries and Standard Plan beneficiaries who are not identified as eligible for Behavioral Health I/DD Tailored Plans will be able to request a review to determine whether they are eligible to enroll in a Behavioral Health I/DD Tailored Plan.

For more information on the Tailored Plans, please see the Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment Final Policy Guidance.

Appendix A

Enrollment Packets

Reviewing the primary enrollment related sample notices linked in the table below will help address questions providers may receive from beneficiaries about the notice they have received regarding the transition to Medicaid Managed Care. The table provides a description of each notice and when it will be sent.

Additional notices related to enrollment, as well as other sample notices can be found online.

Please note that all notice text is valid as of the date of this paper 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).

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 7/08/2019* • Phase 2: beginning 10/1/2019*
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 7/08/2019* • Phase 2: beginning 10/1/2019*
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 7/08/2019* • Phase 2: beginning 10/1/2019*
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 7/08/2019* • Phase 2: beginning 10/1/2019*