

NC Medicaid Managed Care Webinar
Community Partners: NC Medicaid Managed Care Standard Plan & Tailored Plan Updates
Sept. 9, 2021
Transcript

Welcome to our webinar on NC Medicaid Managed Care. We thank you for joining. This afternoon's webinar is targeted to community partners and we intend to provide updated information on Standard Plans as well as Tailored Plans.

Good afternoon, I'm Debra Farrington, chief of staff of North Carolina Medicaid and just a few points that I want to note. To view this slide deck and to participate in this presentation via closed captions. We ask that you click the three dots at the top right of your window and scroll down to select "turn on live captions". Live captions are also available in Spanish. All cameras and microphones will remain muted throughout the training. Please use the question-and-answer feature to ask any questions or provide any comments. We will address questions towards the end of the presentation.

Managed Care has launched, and we do as I mentioned before, want to provide information to you which will enable you as community partners to address questions that you received from individuals who you serve or support. We ask you, our Community Partners, to help share the information that you will hear today, and we appreciate your joining and relying on us as a trusted messenger. We certainly view you as a trusted partner.

The agenda today we're going to cover includes update on standard plans, will provide some key information on updates set or key dates that have changed. We will also address Behavioral Health, I/DD Tailored Plans talk about the contracts that have been awarded and some milestones we will be planning for Members and address key messages. We will also share resources and information with you. And as I mentioned before, have a question-and-answer period towards the end.

We appreciate the questions that some of you submit it prior to the webinar.

Due to the highly contagious to Delta variant of COVID-19, North Carolina is experiencing the fastest acceleration in cases since the pandemic began. Last week, we had our single highest day jump in ICU admissions since the beginning of the pandemic. If cases continue to rise at the current rate, we will surpass our previous peak, which occurred in January before vaccines were widely available. We will exceed that in a matter of weeks.

The Delta variance high rate of transmission leaves unvaccinated people very vulnerable. Testing is widely available. Anyone who has symptoms or who has been exposed to COVID 19 should get tested as soon as possible. To find a testing location in your community go to ncdhhs.gov/GetTested. Early testing is essential to accessing treatment.

People who are not experiencing serious symptoms should not go to the emergency department for routine COVID-19 testing. People should seek medical attention immediately for serious symptoms such

as trouble breathing, persistent pain, or pressure in the chest, new confusion or inability to arouse or bluish lips or face.

As I mentioned, early testing is essential to accessing treatment. While vaccines are the best protection against serious illness, hospitalization and death, Monoclonal antibody therapy can reduce the severity of COVID-19 symptoms and decrease the likelihood of hospitalization, especially in high-risk patients. If you test positive for COVID-19, Monoclonal antibody therapy must be administered within 10 days of your first COVID-19 symptoms, so it is crucial to get tested early.

Vaccines are protecting individuals against hospitalization and death. The CDC recently shared new data this week showing that vaccines continued to be remarkably effective in reducing risk of severe disease hospitalization and death. Even against this widely circulating Delta variant. North Carolina hospital leaders have shared that almost everyone in the ICU and on a ventilator is unvaccinated. Vaccines save lives, please visit [MySpot.nc.gov](https://www.nc.gov/MySpot) for accurate information about the COVID-19 vaccine. We need to layer up our protection to fight this contagious Delta variant and weather the storm: Vax up, Mask up and urge others to do the same.

At this point, we're going to go into details about Medicaid managed care, and with that I'll turn it over to Dave Richard, Dave.

Debra, thank you so much and thanks for the vaccine message. I just want to reiterate how important it is. I know there's a lot of information out there by about vaccines. If you are talking to people that are hesitant, please make sure they get the best information. It really is. And when you think about the work that we do and that we're concerned about, people that have significant needs. Both medical and behavioral health and development disabilities. It is so important that we really, really encourage people to get vaccinations to protect not only ourselves, but make sure we're protecting those individuals. So again, thanks for that really strong reminder, Debra.

I'm going to talk to you for a few minutes and then turn it over to Jay to go through a lot of operations in terms of where we are with our Standard Plan launch and where we are going with our Tailored Plan launch. But I want to say a few things. I want to remind people of this slide because this is the this is the sort of Holy Grail of where we're trying to get to, right. To improve the health of North Carolinians through innovative whole-person, centered and well-coordinated system of care that addresses both medical and non-medical drivers of health.

We've been talking about this slide ever since we talked about launching a managed care but what I'm so excited about is that we are only two months in, and I think we can begin to see how this will work right? And we're not there yet, right where these things are happening across our continuum of services, managed care, but the feeling I get is that over the next couple of months we're going to smooth out some of the bumps that we know.

What happened is we make this transition and then our health plans along with the state and long as you with you will be able to begin moving toward really this vision that we have to really wrap people around whole-person care, which includes those social determinants of health. To help you out Healthy Opportunity pilots will be launching in February. They've already started the local areas.

Care management work is starting with Standard Plans but really as I think like to think about it when we get to diversity, year will be moving rapidly to what we're going to begin to see, and some of these benefits here. And frankly, when we move to Tailored Plans, we have even more of that opportunity because of the individuals that get served there. So to me, it's an exciting time, but let me just say this right, we knew you knew all of us do is when we started in such a big transition in North Carolina there would be bumps. And there have been. There are issues we know around payments. There are issues sometimes about prior authorizations. There have been some issues around non-emergency medical transportation and we hear them, and you guys are doing a great job and making sure that our team and the health plans hear when those issues are there.

What I want to say is that our team at North Carolina Medicaid and our friends over at Division of Health of Mental Health, I/DD and Substance Use and Mental Health Services, we're working jointly to make sure we correct those as rapidly as possible. Our health plans I will I say, have been really good partners in this. Obviously we hold them accountable. We hold them accountable pretty tightly on these things, but they are responding and on most issues rapidly to try to correct those and then some. We've got to push a little bit harder and make sure that people move there, but we are pleased with the partnership that we've started and we're only to a little bit over two months in, and although again, we've had some bumps in the road. They're being corrected pretty rapidly, and that's exciting, I think for the future of this program.

Last thing I want to say and as Jay gets ready to talk about this, is that we also know that you on the front lines are having to deal with COVID. You're having to deal with a massive transition that we have here and that you're frankly I suspect most of you are just tired and we recognize that. So we want to make sure that we're all paying attention to each other in this very difficult time. Our goal is to relieve as much stress as we can on our provider and beneficiary community as we move forward. We believe the health plans are with us in that in that journey, so please continue to tell us when you see things that aren't going well. Would also love to hear stories when things are going well so that we know how to how we can make sure that people hear about those as well but work with us and make sure that you're keeping in contact. You'll see the contact places at the end of Jay's presentation, but you on the ground or eyes and ears about how we make this system better and our goal, our most important goal, here is that the individuals that we serve get the right services and that our provider community gets paid for providing those services.

Ultimately, this system will wind up smoothing out and things will work really well, but again we thank you for all the work that you're doing today to help us understand when things aren't going well and helping us correct. So I'm going to turn it over to Jay to walk through a series of slides and then I know we all will be available for questions as we get through with those. So thank you very much for joining us today. Jay.

Thank you Dave, I appreciate that and a good afternoon everyone. I hope you are safe and well. I'm going to provide an overview of our Standard Plan rollout where we are around 70 days in as well as begin talking about our next phase and the work we're doing with the Tailored Plans and helping them get ready for go live next July.

So first of all, just a couple of level setting stats here. I think you are all aware of the five health plans that are operating in the Standard Plan program. We currently have approximately 1.6 million individuals. It's been relatively stable, about 1.6 million individuals who are enrolled in one of those five health plans across the state. We have a very good uptake on our primary care network and approximately 98% of our beneficiaries on any given day are assigned to a PCP. And then of course, we work to be sure that those individuals find a PCP that may not have one.

I do want to draw people's attention to an important date that's coming up. The important date is September 30, 2021. That's just what 21 days away. This is the deadline for most beneficiaries who transitioned to managed care on July 1 that they will have to change a health plan for any reason. We call that reason, or we call that "without cause", and I apologize. It's a little bit of bureaucracy tease but without cause refers to a regulation that we are obligated to follow as part of the managed care rule and that allows beneficiaries to change health plans for any reason. And so most of our beneficiaries that "without cause", that for any reason period of time ends on September 30.

What that means is that we will then be moving into a "with cause" reason, and I'll talk about those in just a minute. What happens afterwards but I do want to draw people's attention to this end of September deadline that's coming up.

So as I mentioned there are "with cause" reasons. So "with cause" means that according to the Code of Federal Regulations (CFR) that what we are obligated to follow outlines a number of different provisions that would allow a beneficiary to change health plans outside of that period of time that that we have that 90-day period of time and it's actually important enough for me to read these reasons. So that you are familiar with them. Of course, if you have any questions, feel free to give the enrollment broker a call or send an email. We will have some email links in just a minute for where you can send your questions or issues around this.

Some "with cause reasons" to switch a health plan.

- If you move out of the health plan's service area.
Obviously if you're a beneficiary and with Carolina Complete CCH, you're moving to a different region, then that would be a good reason to change plans.
- If you have a family member who's in a different health plan.
- If you can't find all the related services, all the services you need from providers in your health plan and there is a risk of a risk of you getting those services separately, that's a reason to change plans.
- A different health plan may be better able to serve your complex medical conditions. That's a reason.
- Your LTSS provider is not in your health plan.
- Your health plan does not cover a service you need for either moral or religious reasons.

Then there are a number of kind of catch-all other reasons, and they're not specifically or necessarily defined in the regulations, but they are for example, poor quality of care or lack of access to a covered

service, lack of access to providers experienced in dealing with your health care needs, so those are a number of different reasons why a beneficiary or beneficiary should use as an explanation when they're calling the enrollment broker, if they're seeking to change health plans after that 90-day window. The enrollment broker is the tool to use to change health plans calling. Calling your existing health plan, they would not be able to help you. Calling the state, we would not be able to help you.

As we've talked about throughout the spring and earlier this summer, the enrollment broker is the choice counselor who will assist beneficiaries in changing plans.

What I'm going to talk about a little bit here are, and Dave touched on a couple of these things, with any rollout this large affecting 1.6 million individuals we anticipated bumps. There are nearly over 990 thousand providers. We expect bumps in this, and I don't want to minimize the fact that when I say bumps that these issues we're talking about affect individuals and we take very seriously. So it is something that we have developed a number of resources, and want to highlight, that can support both providers as well as beneficiaries not only during this transition but ongoing.

Dave highlighted a couple of them, so I'm not going to talk about them a lot. I think the big area that we were especially focused on in July and early August and we continue to monitor closely is non-emergency transportation. We treated non-emergency transportation issues as risks of potential member harm. We work very closely with the chief medical officers at each of the health plans. We routed those issues very quickly and looked to wrap around the beneficiary so that we could be sure that they were getting the services and the care that they needed and for the most part in most cases I think the system is starting to stabilize and we're able to work through and assist beneficiaries on non-emergency transportation issues, but that's definitely an area that we were very focused on.

Another area we're focused on is related to provider payment. We continue to meet with the health plans on a daily basis, working through various issues to be sure that they are paying our providers correctly for the services that they provided in good faith. A number of resources that we focus on to support both beneficiaries and providers. The North Carolina Medicaid Ombudsman, the Provider Ombudsman. We have a Help Center that includes an external-facing website where you can type in issues. You can send issues, or you can call our Member Contact Center. Those all come into the Help Center. Those are routed either to state staff and/or to health plans. Staff for resolution and comment. We take those answers, and we create knowledge articles so that other people can learn from the issues that you have drawn and brought to our attention or to the health plans. We also use those if necessary to hold the health plans accountable. Health plan oversight is really a prime primary role that we'll be playing going forward, especially in the managed care world.

We are doing a lot of engagement and communication with stakeholders, so if you get bulletins from North Carolina Medicaid, you are getting a lot of bulletins right now describing adjustments that the health plans are making or that providers should make in order to get those claims paid. A lot of work on the part of both the state staff as well as the health plan staff to get these issues resolved.

We have received a number of questions related to do the health plans have an adequate provider network to serve our beneficiaries. And there are a couple of talking points that I want to share with you related to network adequacy. So one is that network adequacy is an idea that the health plans should

have sufficient providers that they have contracted with to serve the beneficiaries that have enrolled with those health plans. We track that in a number of different ways, and we tracked that definitely before we went live, and we focused on five key provider areas and an OB GYNs in network systems and network outpatient behavioral health to name a few. Areas that we tracked before we went live. We will be publishing those where we found ourselves on July 1 with those metrics will and so you'll get to see where each of the health plans were and by region, so you'll be able to compare each of the health plans in that way.

Another network adequacy analysis that we are doing is a more rigorous. Contract requirement to meet a regulation that CMS imposes on us as a Medicaid program, and so we are in the process right now of reviewing that very formal network adequacy filing that each of the health plans had to make. It is acceptable for the health plans to raise their hand and admit that they have a missing or a gap in their network and to ask and seek an exception. Doesn't mean we're going to grant an exception, but the health plans can ask for exceptions, oftentimes in other states, those exceptions may be tied to a corrective action plan or a more robust "What are you going to do about this?". For the long run we may approve an exception for a short period of time, and then expect the health plans to get contracting. Find those providers even develop access that may not have had access in the past, so we are in the process of working through that analysis.

Right now I believe our target date for that analysis to be complete is October. It's based on mid-July data, so it's really a great view for us on where the health plans were and then as part of that exception process, the health plans will update us as to where they are. So that is something that will be doing.

Some things that we have done that you may have missed. We enacted a couple of policy flexibilities at the end of August that we felt were necessary, in part because of the increasing caseload with the Delta variant as Debra pointed out, this is a huge concern. For the department and to our provider community as well as we felt that it was there was some system changes that we are doing to support providers and health plans that we found needed to be done. But what we did is we have extended certain flexibilities for providers who have not contracted with a health plan, so sometimes those are referred to as out-of-network providers. We have provided a series of out-of-network flexibilities. We took the policies that we had in place for the first 60 days of managed care, after managed care go live and we have extended those through the end of November and we we've highlighted some of those here.

I won't read all the words on this slide, but it really is designed to ensure the optimal access of care for our Medicaid beneficiaries and to support our providers. So if there are specific questions happy to go through those. These flexibilities did apply to our non-emergency transportation vendors and will unlikely be extended after November 30. I don't want everybody to think that we've done it once, we'll do it again. Obviously we'll be adaptive and to conditions on the ground, but we do not anticipate extending these again.

We're going to move to the other work that we're doing with our DMH partners or Division of Mental Health partners and that is the creation and preparations for launching Tailored Plans in July 2022. A couple of highlights on the Tailored Plans. I think many of you are aware, but you're going to start to become more aware because we will be building this into more and more of our presentations throughout

the coming year and getting you prepared as well as getting the Tailored Plan Partners prepared for launch.

So to remind you Tailored Plans offer the same services as Standard Plans in addition to specialized services for individuals with significant mental health and substance use disorders, intellectual and developmental disabilities and traumatic brain injuries, as well as people using state-funded and waiver services. We estimate currently based on our current enrollment, approximately 175,000 individuals will be enrolled in Tailored Plans. I do want to emphasize there are there are a lot of similarities. There are some fundamental differences, but one thing that I do want to emphasize is that our CFAC advisory committees will continue to retain their role in advising Tailored Plans and the Department in our progress with them. We are also making sure that the CFAC has a role in the Standard Plan, but I want to really underscore that there is no intention of changing the CFAC role as we move to Tailored Plans.

So I'm going to go back in time now, I was in July 2022. I'm gonna go back to July 2021 when we awarded plans to seven organizations as Tailored Plans. And so if you see in recent guidance the state will often talk about six Tailored Plans. But just to remind folks the Tailored Plan RFA, the request for application, was open to all the existing LME/MCOs that existed as of November 1, 2020 and at that time there were seven. I think many of you are aware that Cardinal Innovations is in the process of consolidating its membership with other MCOs right now, so we do not anticipate that Cardinal will be a Tailored Plan when we go live, but we did award to seven health plans.

And I've already stated that other work, but there are some next steps that will be focused on obviously it is around that consolidation sometimes you hear it referred to as disengagement, or transition. But we are working with each of the LME/MCOs and their county partners as we transition those county disengagements. We will be communicating a lot more over the coming weeks and months around that process, as well as the Tailored Plan launch.

So here's the cool, colorful picture and in fact, if I was really technically savvy, I would change my current – let's see if I can do it. I will change to my Tailored Plan map so that I'm being sure that I'm focused on the right thing, but we have this map is our current understanding of where we anticipate each of those counties that are disengaging or transitioning from Cardinal which of the Tailored Plans that they will be serving.

So a couple of things that I want to highlight here. Potential Tailored Plan members will be auto-enrolled in the Tailored p\Plan based on their administrative county. That is the county that manages the beneficiary's Medicaid case. And depending on their managed care status, potential members may be able to select a standard plan or Medicaid Direct or the Eastern Band Cherokee Indian Tribal Option. So the next slide will highlight some key member milestones that we'll be focused on and then I'll be transitioning to Debra in just a second, but I will take this slide, Debra, if that's all right.

So a couple of key things here. One is there are there are similarities, but differences between Standard Plans and the Tailored Plans, and so some of these things are going to be what we're really focused on in communicating, helping you understand. I'm sure you're going to have questions about it. You're going to raise issues, and this is exactly why we're having these discussions and presentations with you so that you really understand what's the same and what's different between the Standard Plans and the Tailored

Plans. There will be no open enrollment. We will auto-enroll members into the Tailored Plans. There are some individuals as I said before, that may have a choice. It's a limited number of individuals and again they are going to have that ability not to choose which Tailored Plan that they want to be in, but if they are eligible for it, whether or not they would best be served by a Standard Plan or by the Eastern Band of Cherokee Indians and that Tribal Option so again, it's not a choice between Tailored Plans, it's a choice between Standard Plan and Tailored Plan programs and the choice period is where beneficiaries will be able to choose a PCP. Again, this is our projected Timeline and that will get us to July 1st. This is going to be an area that we will talk a lot about over the next couple of weeks and months and I look forward to those conversations, so I'm going to pass it back to you Debra to go over some other key points. Thank you.

Thanks Jay. So the next slide includes some key messages around Tailored Plans that we wanted to share with you today. We have been intentional in our communication and engagement with beneficiaries and with you as Community Partners. We want to make sure that our messaging is clear and consistent. We've shared these key messages with LME/MCOs, and we want to share them with you as we accelerate our implementation of the Tailored Plans. Looking towards July 1, 2022, and so I won't read all of the messages but just will highlight a few things.

First, looking at the messages on the left side. And that column we want to make sure our prior priority remains that beneficiaries get the services that they need and the right amount and in the right place that they need them. The Tailored Plans are set to go live on July 1, 2022, and they will provide a comprehensive array of physical, behavioral, health, pharmacy care management services for people who have mental health conditions. And traumatic brain injury and those who need substance use services. The Tailored Plans will offer certain services that are unique. For people who have mental health conditions, substance use disorders I/DD, traumatic brain injury some services that are not available in the Standard Plans. Some individuals will be enrolled in a Tailored Plan and based on their managed care status as Jay mentioned before, will have an option to change at any time.

A person's choice will be driven by their managed care status. Beneficiaries who need certain services that are available in the Tailored Plan will be enrolled with the Tailored Plan in their county beginning on April 1, 2022.

There's only one Tailored Plan available in each county, so members cannot choose a different Tailored Plan. Once a member has been enrolled in a Tailored Plan, they will need to choose a primary care provider with that Tailored Plan. And if a person doesn't choose a primary care provider by May 31, 2022, the Tailored Plan will choose a primary care provider for them. These dates align with what Jay just reviewed. So we just want to emphasize certain key messages for you to receive and for you to share.

And the last point I'll make on this slide is that Tailored Plans will offer services for mental health disorders, substance use disorders, I/DD or TBI, that are funded by state, or federal government sources outside of NC Medicaid and these are what we have often referred to as state-funded services. Members will not have access to state-funded services if they leave a Tailored Plan. We'll make sure that you get a copy of the slide deck from today and can leverage these messages in presentations that you do going forward.

So today's webinar was targeted to community partners, but we do know that there are a number of providers who participate in these webinars, so we want to redirect your attention to the resources that are available to you on our webpage at [medicaid.ncdhhs.gov](https://www.medicaid.ncdhhs.gov). There are various playbooks available for you, as well as fact sheets and quick reference guides

Jay also referenced our Medicaid Help Center ([medicaid.ncdhhs.gov/helpcenter](https://www.medicaid.ncdhhs.gov/helpcenter)) where we have knowledge articles available for you to research and hopefully get your question answered that way, but we also have staff available to support questions and answers that come in through our Provider Ombudsman or through our staff.

And we'd like to promote the AHEC webinar series that is happening with Dr. Dowler and other members of our team every first and third Thursday of the month.

And then I will direct you to our Medicaid Bulletins that occur are published on a regular basis, so that you can access those and reference the bulletins for any questions or information.
[medicaid.ncdhhs.gov/providers/medicaid-bulletin](https://www.medicaid.ncdhhs.gov/providers/medicaid-bulletin)

With that, it concludes the formal part of our presentation today, and I'm going to hand it over to Michael Leighs who will facilitate our question and answers. Just highlight for you that you can enter a question through the Q&A box that's at the top right corner of your screen and we will get to as many questions as we can with the time remaining, Michael.

Debra, thanks so much and I want to double check that there isn't one more slide there. Yeah, and this was a something we had previously had up in the top, so apologies for shifting around, but I just did want to pause on this slide. Deborah, if you would like to cover, happy to hand it back to you or I'm happy to run through.

Feel free to keep going, Michael.

So just a reminder to folks we have kind of laid this out before you've seen this in other presentations, but it never hurts to share. As a reminder, there's really kind of three steps that we've laid out. We know folks will continue to have questions as a number of our presentation presenters have said this is a big change. There's a lot going on it impacts a lot of our beneficiaries, so there's really three steps that we're encouraging folks to use when they have questions.

So, first off is to just check to see what health plan you are enrolled in. Beneficiaries should have received a welcome kit from the health plan that would include their Medicaid ID card, but if you are still unsure about what health plan you're enrolled then you can call the Enrollment Broker and they can clear that up quickly (**833-870-5500**).

The next step is if you have a particular question about benefits or coverage you would call that plan. As I said, the Enrollment Broker can provide that information, but we also have a list of health plans and the contacts on our website [medicaid.ncdhhs.gov/transformation](https://www.medicaid.ncdhhs.gov/transformation) as well.

And then finally if you have another question that can't be answered with those two steps, we encourage you to call our NC Medicaid Ombudsman. This is a new program that began this year in conjunction with NC Medicaid Managed Care Standard Plan & Tailored Plan Updates

managed care that we're very excited about and they have served as a significant resource in helping beneficiaries navigate this transition to managed care. So we're grateful for the work that they've done. Their information is there below. There's a 1- 800 number (**877-201-3750**), or you can visit their website, which is ncmedicaidombudsman.org. And they can field a variety of questions that folks may have around managed care.

So with that, let me move to some of the questions that we've received. We received a few in the chat, as well as some that you sent in before the webinar started, so let me start first with those that we got today. There were a couple that I'm going to just sort of pull together, and I'm going to ask Deb Goda on our team if she can answer. We have some questions about the switch from a Standard Plan back to NC Medicaid Direct, and so there's a few different questions that asked about the process and the timeline for that. So Deb, would you mind sharing with folks how that process works and what timeline they can expect?

Certainly, and I think the first question was about paperwork for consumers taking so long to occur and another was the process is taking a long time, over a week.

So if an individual requests to move, using the Medicaid Request to Move to Medicaid Direct form for the beneficiary, it's an eight-day day turnaround time. The reason for the eight-day turnaround time is because the vendor that is processing those requests has to reach out to the provider to get additional information. We made the form as simple as we could for beneficiaries so that they didn't have to provide assessments and attachments and things of that nature. There have been some issues where the vendor is contacting the provider and the provider doesn't respond when the beneficiary has submitted the form because the beneficiary didn't tell the provider. That can cause a delay.

For the provider form. That's a five-day turnaround time, and that's because the provider is submitting the form. They're aware they can submit documentation. The form itself is a little more complex. If the request is submitted with the service authorization request for an enhanced service, a B3 service, a state-funded service, something that's only available to individuals under the Tailored Plan, then that request is processed within one business day, but that service authorization request needs to be submitted with the form to the enrollment broker.

I know there's been some confusion when people have tried to submit a service authorization request to the LME/MCO but the LME/MCO doesn't have that person enrolled so they can't issue an authorization. So we are going to be adding some information to the enrollment broker website. The enrollment broker is going to be doing a video tool for us. It will explain in depth how it is that the provider can submit this form and how it should be submitted.

But if you have a person who needs an enhanced service and they need it now, fill out the service authorization request (SAR) the provider form for return to Medicaid Direct and submit both of them to the enrollment broker. The enrollment broker will notify Medicaid eligibility section of the change and they will submit that SAR to the LME/MCO or Beacon for health choice zero to three illegal aliens. So we don't want to delay anybody getting a service that they need.

Thanks Deb for that, appreciate that just want to continue to the next question here. I'm going to call on Melanie to see if you could help on this one. I think there was just some clarification that was asked about the August 19 extension of out-of-network provisions and sort of how that applies to the ability to change PCPs as well as the ability to change health plans and how that is interrelated. I think that Jay spent a lot of time earlier talking about the September 30 date, but if you could just provide a little bit clarification on the PCP change period.

Yes, so I think it really is just so many acronyms in our August 19 Bulletin we did outline that individuals can change their PCP until November 30. That is true. Your PCP, of course, is your primary care physician. And to make that change you would contact the health plan with which you are enrolled. And so that has been extended until November 30.

What Jay was referring to earlier is the ability to change your prepaid health plan, your PHP for any reason and that time period ends on September 30. After September 30 you can still change your PHP, but you do need to meet one of the "with cause" reasons that he walked through. So those two dates are still in effect and not contradictory. We're just talking about PHP changes ending on September 30 and then PCP change is ending on November 30. I hope that clarifies.

Thanks Melanie, and I wonder if we could talk a little bit more about the process to change PCP. I did see a question that came in after that regarding sharing a question a member could ask. So the process to change a PCP is that you would contact the health plan with which you are enrolled and make that change either through your beneficiary portal or via the customer service line. To change a PHP selection for "with cause" you would contact our enrollment broker or go to NC Medicaid plans Gov and work through that beneficiary portal or contact them through their customer service call center and they can help you make that PHP change for any reason through September 30 and then "with cause" reason after September 30.

Great thanks Melanie. I want to go to the next question here. Will the choice period be the same time frame as open enrollment for the standard plan in 2022? So I wonder if we could maybe go back to the slide where we had the time frame for the Tailored Plan and maybe we could revisit that. I wonder if Deb you might be able to jump in here and then talk a little bit more about this period, which is going to be April 1 to May 31, 2022, and I think that would answer the question that was published here in the chat.

OK, so once a month if we're looking at the choice period that between April 1 and May 31. This is the time where the individual who's Tailored Plan eligible can choose to go into the Tailored Plan to which they would be geographically assigned based on where their Medicaid eligibility comes from. But they could also choose if they wanted to move into a Standard Plan at that time as well. So if an individual is Tailored Plan eligible they can move from the Tailored Plan to the Standard Plan now.

There are a few caveats where individuals on the innovations or TBI waiver can't move until they disenroll from the waiver or someone who's living in an ICF facility or getting state-funded residential has to notify the Tailored Plan that they're planning on leaving before they do so. Because we don't want people losing services and losing their homes when they choose a plan. But for the most part, if someone in the Tailored Plan decides they want to move into a managed care plan, they can move. And then if they

decide they want to move back, as long as they are still eligible, they can move back without having to do a new request to move form.

So the exception would be if an individual moves into the managed care plan and after a year or two decides that they want to move. It may be that they have not received a service and that's Tailored Plan only and that's why they were eligible in the first place. So but for the most part there is going to be able to be movement from the managed care plan to the Tailored Plan for those individuals who are qualified for the Tailored Plan.

Yep, thanks so much. I'm going to move to the next question and Melanie, I was hoping you could help us with this. The question is can you speak to the provision of NEMT under Tailored Plans?

Tailored Plans are also going to be using transportation brokers just like our Standard Plans do. We have received information that there are four plans that are going to be using the ModivCare broker and two plans that are going to use OneCall. Alliance Health, Trillium Health Resources, Partners Health Management and Sandhills Center have all contacted with ModivCare to coordinate any NEMT. Eastpointe and Vaya Health have contracted with OneCall, so the transportation brokers will replace the counties and they will coordinate, schedule and pay for all of the non-emergency transportation that Tailored Plan individuals may need.

There will be a just so you're aware we will have a transition of care period. So once we go through the timeline that Deb just walked us through and once the end of open enrollment happens and there is a period of time where it began. The transition of care period starting on June 1. Transition of care information, including health information and any NEMT information that we have captured from the counties, will be transferred to those brokers so that existing appointments or ongoing standing appointments can be scheduled and that will happen from June 1 until July 1 before launch and then on an ongoing basis going forward.

Thank you Melanie. Appreciate that we did receive another question in the chat about network adequacy and specifically focused on children's behavioral health needs in the southeastern part of the state, and I wonder if Jay you could talk a little bit more about the process around network adequacy assessment.

Thank you for that so there are a couple of different ways that we are approaching this, so when we before there and I think there are a couple of questions about network adequacy in the chat also, but generally again before we went live we looked at those primary but five important categories of service - primary care, hospitals, pharmacy, OBGYN and outpatient behavioral health. We used those five criteria before we went live, and we evaluated each of the health plans, either as percent of beneficiaries covered or by the percent of counties in a region covered by sufficient contracting, and we found that all of the health plans were able to meet that standard before we went live.

And, as I said, we'll be publishing that data, very soon as part of our analysis, we will be looking closely at behavioral part of our analysis coming up. We will be looking very closely at behavioral health I don't know if we will be looking at psychological assessments specifically as a service or provider type. I will have to go back to my data on network adequacy I think there's a couple of ways that we're looking at this one. Did we have sufficient providers in our network before we went into managed care. I mean there

are some areas of the state that they don't have sufficient provider resources in all of the different provider types, so there's that one aspect. There is the other aspect of network adequacy really measures the contracting. There's also other analysis that we will be performing which is the contracting realized access our beneficiary is able to actually get the care that they need. There's physical access. Are they able to literally get into the clinic or the facility or the providers office? Physically able to and then really the key measures that will be looking at or around quality. Are we improving the quality based on the various metrics that we have outlined in our quality strategy?

So it's a multi-tiered analysis, but I think what we will find is that at least on paper, most of the health plans in most of the regions and most of the counties actually have adequate networks or have exceptions and processes that they will be offering beneficiaries that will support the beneficiaries and be sure that they get that care, but I think that it is something that we will be watching very closely, it's something that we will be holding the health plans accountable for and we will be. As I said, publishing that analysis likely in mid-October, late October, early November, around that time frame, I don't have an exact date yet. Hope that addresses the question, Mike.

Yeah, Jay, thanks so much. I appreciate that. I have a 1 one that I think is pretty quick. When were the welcome kits mailed and I think this was referring to the update that I shared about the health plan? Welcome kits that went out at the end of June leading up to the launch of managed care on July 1, folks should have received those at the end of June.

They would get additional packets if they're coming into plans after the launch of managed care. But those were sent out at the end of June. I would remind you if we could also go back on the slide to the beneficiary options for resolving issues. Thank you so much. If folks didn't receive the materials, if they misplaced them, you could always call the enrollment broker and they can clear up what plan that you enrolled in. So let me move to the next question.

We did receive a couple of questions on this and looking for some clarification about dual enrolled Medicare and Medicaid-eligible individuals and Tailored Plans and in how they fold in. So I wanted to call on Julia Lerche to see if she could help us with clarification.

Thank you so much for that question. So beneficiaries who are dually eligible for both Medicare and Medicaid and are also enrolled in the innovations or TBI waiver will be covered through the Behavioral Health I/DD Tailored Plans when they launch in July 2022. So duals, who are not on the innovations or TBI waiver will generally continue to be covered like they are today through NC Medicaid Direct fee-for-service system. Thanks, Mike.

Great, thanks so much, appreciate that. Debra, we probably have time for one or two more questions, so let me go to a couple that we received before.

I was wondering then if we could talk a little bit Deb, maybe you could help on this about the innovations waiver individuals will they interact with the Tailored Plans once those are launched? Let me hand that off to you to see if you could share a little bit more information.

No problem. So the question was around innovations and whether or not innovations would be available once Tailored Plans go live and yes, innovations and TBI will both be under the Tailored Plans just as they are now with the LME/MCOs. There was also a question about the B3 services. We are looking to move the B3 to an I option because B3 is the authority that we use and the Tailored Plans are under the 1115. So we will be moving to a different way of providing those services and stakeholder engagement will begin soon on those on those services.

Great, thanks so much Deb. I do want to be mindful of our time here. We have two minutes left and Debra, I wanted to hand it back to you to see if you would be able to wrap it up. And I know you had mentioned that we will be routing some of the questions that we received to the Help Center for more clarification on some of the technical questions that we received in particular from some of our provider partners. So that will be a follow up item but let me hand it back to you to wrap it up.

Thanks Michael, we appreciate everyone joining today's webinar and for your questions. They're very helpful because I think when you raise questions it helps us to answer things that may be confusing to a number of our partners and constituents. So thank you for your questions we do have an ability to download all the questions and to forward them to our Help Center.

If you sent in a question anonymously then we just want to make sure that you have access to our webpage where you can go out and get access to our transformation email address. If you want a direct response to a question, feel free to send us an email through our transformation email address (Medicaid.Transformation@dhhs.nc.gov). Otherwise, we will use the questions submitted today to help develop of additional knowledge articles.

A copy of today's presentation will be made available on our website and you see on your screen that will be at medicaid.ncdhhs.gov/transformation/more-information

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