



**NC MEDICAID
OMBUDSMAN**

AN UPDATE FROM THE NC MEDICAID OMBUDSMAN: YEAR IN REVIEW

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DATE: DECEMBER 15, 2021

TODAY'S AGENDA

- I. Review Managed Care Basics
- II. Getting Help From the NC Medicaid Ombudsman
- III. NC Medicaid Managed Care Issues Identified & Addressed
- IV. Tailored Plans & NC Medicaid Direct
- V. Questions and Feedback From You

MANAGED CARE BASICS



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NORTH CAROLINA'S TRANSITION TO MANAGED CARE

Changes

Health plans have a network of providers. Services must generally be obtained from providers in a beneficiary's health plan network.

Most people with Medicaid have been enrolled in a health plan. Coverage began July 1, 2021.

Individuals with significant behavioral health needs or intellectual/developmental disabilities still have a choice whether to enroll in a health plan until December 2022.

NC Medicaid Managed Care is intended to focus on "integrated care" and will address both medical and non-medical drivers of health.

For people enrolled in a health plan, Non-Emergency Medical Transportation is now managed by that health plan.

NORTH CAROLINA'S TRANSITION TO MANAGED CARE

What is Not Changing

Eligibility rules and the application process for NC Medicaid and NC Health Choice.

Covered services. Health plans may also offer added services.

How services are authorized and/or delivered for those not enrolled in a health plan.

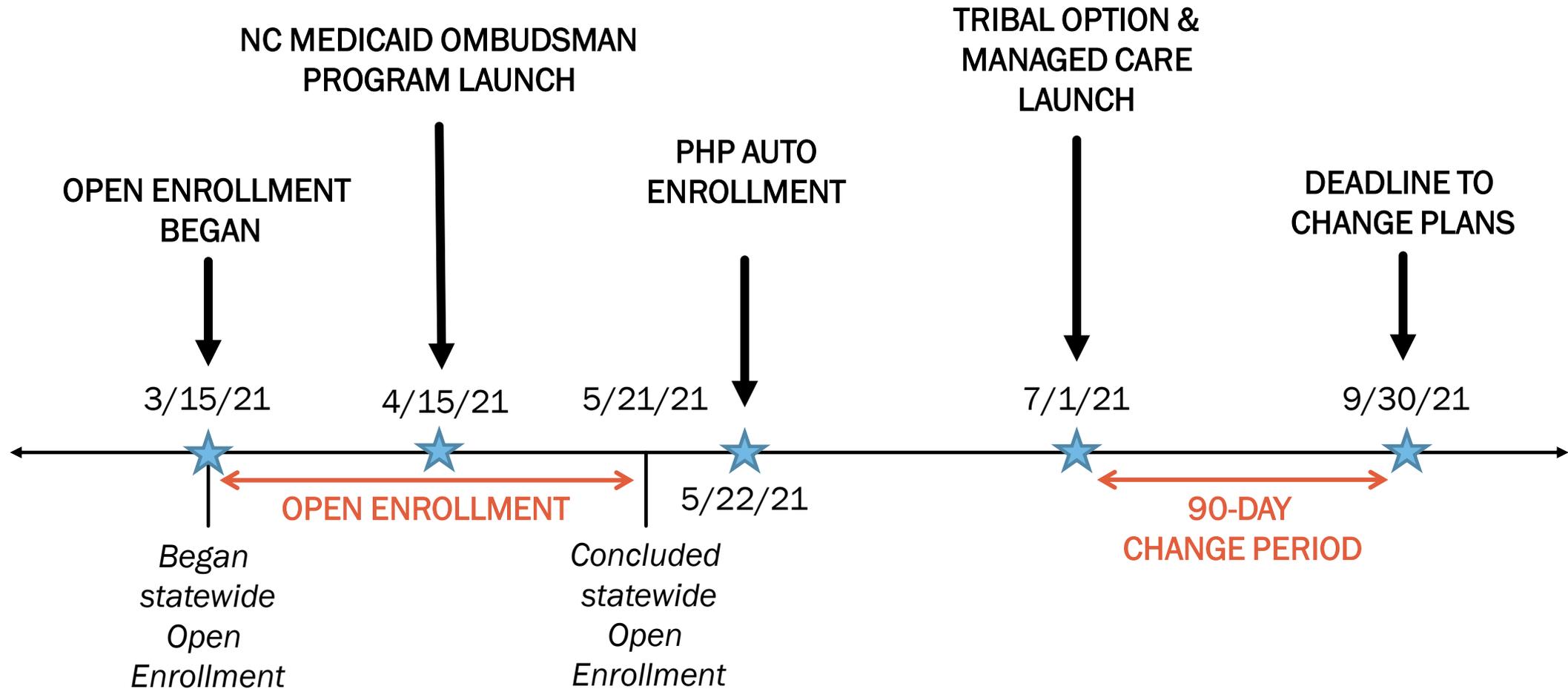
Waiver waitlists.

Clinical coverage policies.

NC MEDICAID MANAGED CARE ENROLLMENT GROUPS

Who must choose a health plan?	Who may choose a health plan?	Who cannot choose in a health plan?
<ul style="list-style-type: none"> • Most families and children • Children receiving NC Health Choice • Pregnant women • People receiving Breast & Cervical Cancer Medicaid • People who are blind or disabled and not receiving Medicare <p>Note: These groups must choose a health plan unless exempt or excluded for any reason.</p>	<ul style="list-style-type: none"> • Federally recognized tribal members and others eligible for services through Indian Health Service (IHS) • People with significant behavioral health needs, intellectual/developmental disability (I/DD), traumatic brain injury (TBI) and substance use disorders <p>Note: These groups may choose a health plan unless excluded for any reason.</p> <p>Note: Enhanced behavioral health services are only available through NC Medicaid Direct.</p>	<ul style="list-style-type: none"> • People receiving Family Planning Medicaid only • People who are medically needy • People participating in the Health Insurance Premium Payment (HIPP) program • People participating in the Program of All-Inclusive Care for the Elderly (PACE) • People receiving Refugee Medical Assistance • Children in foster care • Children receiving adoption assistance • Children receiving Community Alternatives Program for Children (CAP/C) services • People receiving Community Alternatives for Disabled Adults (CAP/DA) services • People receiving Medicaid AND Medicare • People receiving Innovations Waiver services • People receiving Traumatic Brain Injury (TBI) Waiver services

NC MEDICAID TRANSFORMATION TIMELINE



BENEFICIARY PROTECTIONS UNDER MANAGED CARE

Care Management

- Health plan members must have access to care management to address both medical care needs and social determinants of health. Care management can be provided by the health plan or locally by Advanced Medical Homes or local health departments.
- Health plans must employ a housing specialist, assist with food stamps applications, refer to medical legal partnerships, etc.

Transition of Care

- Transition of Care requirements are established to ensure beneficiary continuity of care upon the initial transition to NC Medicaid Managed Care and subsequently after beneficiaries transition among health plans and between health plans and NC Medicaid Direct or Local Management Entity/Managed Care Organizations (LME/MCO).

OTHER BENEFICIARY PROTECTIONS



- Health plans must provide language assistance services including interpretation and translation. Oral communication requires that translation services are made available. Written member materials must include taglines in the top 15 most common non-English languages in North Carolina.
- There are grievance, appeal and state fair hearing procedures that include timeliness standards.
 - Appeals are for any adverse benefit determination, such as denial of services or payments
 - Grievances are all other complaints against the health plan or providers
- Health plans must
 - have member advisory committees, including for Long-Term Services and Supports (LTSS).
 - facilitate transfers to different health plans or different providers, when appropriate.
- Health plans must operate a member services line, behavioral health crisis line and nurse line.

**NC MEDICAID
OMBUDSMAN
SERVICES**

YOUR ADVOCATE
FOR QUALITY CARE



**NC MEDICAID
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NC MEDICAID OMBUDSMAN: WHAT WE DO



- The NC Medicaid Ombudsman provides free, confidential support and education about the rights and responsibilities people have under NC Medicaid.
- We connect people to resources like legal aid, social services, housing resources, food assistance and other programs.
- We help Medicaid beneficiaries resolve issues so they can get the care they need.
- We are here to:
 - Educate
 - Advocate
 - Refer and connect
 - Conduct issue resolution
 - Track issues and monitor trends
 - Communicate with NC Medicaid

SERVICES PROVIDED BY THE NC MEDICAID OMBUDSMAN

Provide	Provide information to NC Medicaid beneficiaries about their rights under managed care or NC Medicaid Direct
Offer	Offer members guidance on filing appeals or grievances with their health plan
Investigate	Investigate issues reported by members and help them try to resolve issues informally
Monitor	Monitor the issues members experience with health plans and communicate with NC Medicaid to address problems
Refer	Refer members to community services to support health-related needs including legal aid, social services and other supports for a wide variety of issues

NO WRONG DOOR APPROACH

- The Ombudsman will also provide general information and referrals for many other issues.
- For example:
 - Medicaid and NC Health Choice eligibility
 - Private health insurance (including ACA coverage)
 - Referrals for other benefits such as food assistance, housing resources, Supplemental Security Income and veterans benefits



NC MEDICAID OMBUDSMAN'S INAUGURAL YEAR

- We have handled nearly 9,000 calls, including over 600 calls in Spanish.
- We have provided information and education or helped resolve issues in 6,807 cases.
- We have participated in over 200 outreach events, reaching nearly 20,000 people.

**NC MEDICAID MANAGED
CARE ISSUES IDENTIFIED
& ADDRESSED SINCE
LAUNCH**



**NC MEDICAID
OMBUDSMAN**

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

- Prepaid Health Plans (PHPs) have contracted with third-party NEMT brokers to provide this service to individuals enrolled in Standard Plans.
- Through calls to the NC Medicaid Ombudsman, we identified issues including missed appointments, scheduling issues and provider contracting issues.
- In response, NC Medicaid has set up additional daily standing meetings with Standard Plans and NEMT brokers to provide guidance and oversight, address issues and work through to resolution.
- Individuals with questions should contact their PHP or the NC Medicaid Ombudsman.

TAILORED PLAN-ELIGIBLE BENEFICIARY UPDATE

- Through June 1, approximately 7,000 Tailored Plan-eligible beneficiaries made an active selection to enroll in Standard Plans, which may have made them ineligible for services they were receiving, had recently received, or may benefit from receiving under NC Medicaid Direct.
- Given the potential for these individuals to experience loss of services, NC Medicaid stopped Standard Plan enrollments of these beneficiaries and all Tailored Plan-eligible beneficiaries who selected a Standard Plan remain in NC Medicaid Direct for now.
- NC Medicaid sent a notice in June 2021 informing these beneficiaries of the change back to NC Medicaid Direct.
- These Tailored Plan-eligible beneficiaries will still have the option to enroll in a Standard Plan, if they prefer.
- In August 2021, NC Medicaid notified beneficiaries of the specific enrollment process for these Tailored Plan-eligible individuals, which includes enhanced choice counseling to help verify that beneficiaries have all the information they need to understand the impact of their decisions. These beneficiaries will be required to attest to understanding their change in services before enrolled in a Standard Plan.



PCP REASSIGNMENT

- Individuals enrolled in Carolina Complete Health, AmeriHealth Caritas or WellCare may have received a welcome packet with the incorrect Primary Care Provider (PCP) listed.
- These PHPs were made aware of the issue and took steps to remedy the error. PHPs sent out new Medicaid ID cards with the correct PCP assignments and conducted outreach to providers impacted by this error.
- Individuals with questions should contact their PHP or the NC Medicaid Ombudsman.

MISINFORMATION

- NC Medicaid's transition to managed care is new to everyone, including providers, care managers and healthcare advocates. As a result, there inevitably has been a lot of confusion and misinformation floating around.
- The NC Medicaid Ombudsman has been working with NC Medicaid to get the correct information out to beneficiaries as well as health care staff and advocates.
- NC Medicaid has responded to this issue by creating helpful resources and fact sheets for providers and beneficiaries. You can access these resources on NC Medicaid's Transformation webpage: <https://medicaid.ncdhhs.gov/transformation>
- The Ombudsman hosts a monthly webinar series to provide helpful information and managed care updates. You can sign up for our email list to receive invitations to these webinars here: <https://ncmedicaidombudsman.org/>

TRANSITION OF CARE EXTENSION

- NC Medicaid and the PHPs agreed to extend the policy for out-of-network flexibilities to providers who have not yet contracted with a PHP through **Nov. 30, 2021**. These flexibilities were originally expected to sunset on Aug. 30, 2021, and the extension ended on Nov. 30, 2021.
- Under this policy, the PHPs agreed to:
 - permit uncontracted, out-of-network providers enrolled in NC Medicaid to follow in-network provider prior authorization (PA) rules and may continue to get a PA retroactively. This exception does not apply to concurrent reviews for inpatient hospitalizations which should still occur during this time period.
 - reimburse out-of-network providers at the in-network rate of 100% of the Medicaid fee schedule.
 - delay implementation of the 90% rate reduction following good faith contracting provision.
 - allow beneficiaries to change their PCP for any reason.
 - extend [flexibility for Non-Emergency Medical and Non-Emergency Ambulance Transportation providers](#) through November 2021.

For more information, see NC Medicaid bulletin [Extension of Out of Network Provisions](#).



TRANSITION OF CARE EXTENSION CONT.

- PHPs are no longer required to pay out-of-network providers at the in-network rate of 100%.
- PHPs can also now refuse to cover most out of network care, which could result in providers unwillingness to see patients enrolled in PHP they are not enrolled in.
- Transition of Care protections continue to be in effect for persons moving in or out of managed care.
- The following are the situations in which PHPs must cover out of network care after the transition of care period ends without prior approval:
 - emergency services and urgent care
 - care needed while traveling
 - family planning services
 - behavioral health services during pregnancy.

TAILORED PLANS & NC MEDICAID DIRECT



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Updated Launch for Tailored Plan

- NC Medicaid announced in November that Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plans will launch Dec. 1, 2022, instead of July 1, 2022.
- NC Medicaid's goal remains to ensure a seamless and successful experience for LME/MCO beneficiaries, their families and advocates, providers and other stakeholders committed to improving the health of North Carolinians.
- Beneficiaries who are enrolled in NC Medicaid Direct or the Eastern Band of Cherokee Indians (EBCI) Tribal Option and receive enhanced behavioral health, I/DD or traumatic brain injury services from a current LME/MCO will continue to receive care in the same way until the Tailored Plans launch on Dec. 1, 2022.

WHAT IS HAPPENING TO LME/MCOs?

(local management entities/managed care organizations)

Through December 2022: LME/MCO

- LME/MCOs continue managing care for those with significant behavioral health or I/DD needs (next slide).
- Physical health care for this population continues to be through NC Medicaid Direct (formerly known as fee-for-service).

WHAT IS HAPPENING TO LME/MCOs?

(local management entities/managed care organizations)

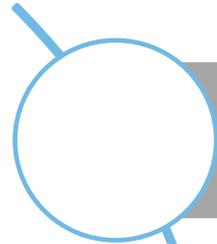
After December 2022: Tailored Plans

- For the first contract term (four years), LME/MCOs are the only entities that can become Tailored Plans.
- In July 2021, NCDHHS announced the following LME/MCOs selected as Tailored Plans:
 - Alliance Health
 - Eastpointe
 - Partners Health Management
 - Sandhills Center
 - Trillium Health Resources
 - Vaya Health
 - Cardinal Innovations Healthcare (has consolidated with Vaya) – Alliance took over Cardinal Innovations Healthcare as of Dec. 1, 2021
- Tailored Plans will manage both behavioral services and physical health care **only** for those with significant behavioral health, substance use, I/DD or TBI support needs.
- One Tailored Plan per region.

WHO TO CONTACT & WHEN?

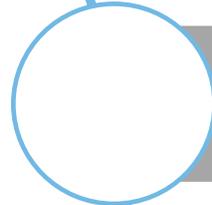
Department of Social Services (DSS)	Prepaid Health Plan (PHP)	NC Medicaid Enrollment Broker	NC Medicaid Ombudsman
Hours vary by county	Monday-Saturday 7 a.m. – 6 p.m.	Monday-Saturday 7 a.m. – 5 p.m.	Monday-Friday 8 a. m. - 5 p.m.
<ul style="list-style-type: none"> • To apply for Medicaid • Questions about Medicaid eligibility • Questions about type of Medicaid coverage • To update mailing address, phone number or language preference on file 	<ul style="list-style-type: none"> • Questions about covered services or health plan incentives • To change Primary Care Provider (PCP) • To request Non-Emergency Medical Transportation • To request a new Medicaid ID card (if lost or stolen) 	<ul style="list-style-type: none"> • To confirm enrollment in a health plan • To change health plans • If you were enrolled in a health plan but need to keep the services you currently receive through NC Medicaid Direct • Questions about a notice you've received 	<ul style="list-style-type: none"> • Questions about Medicaid transformation • If you are not receiving the care that you need • If you have contacted another entity about an issue and it remains unresolved • Questions about the complaint or appeal process • When you don't know where to start or who to call

CONTACTING NC MEDICAID OMBUDSMAN



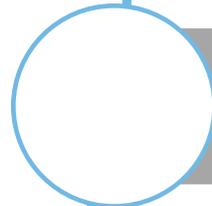
By phone

• 877-201-3750



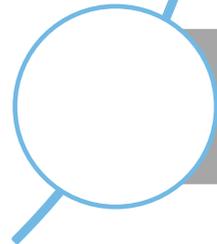
By email

• info@ncmedicaidombudsman.org



Online

• ncmedicaidombudsman.org



In person

• Coming soon!

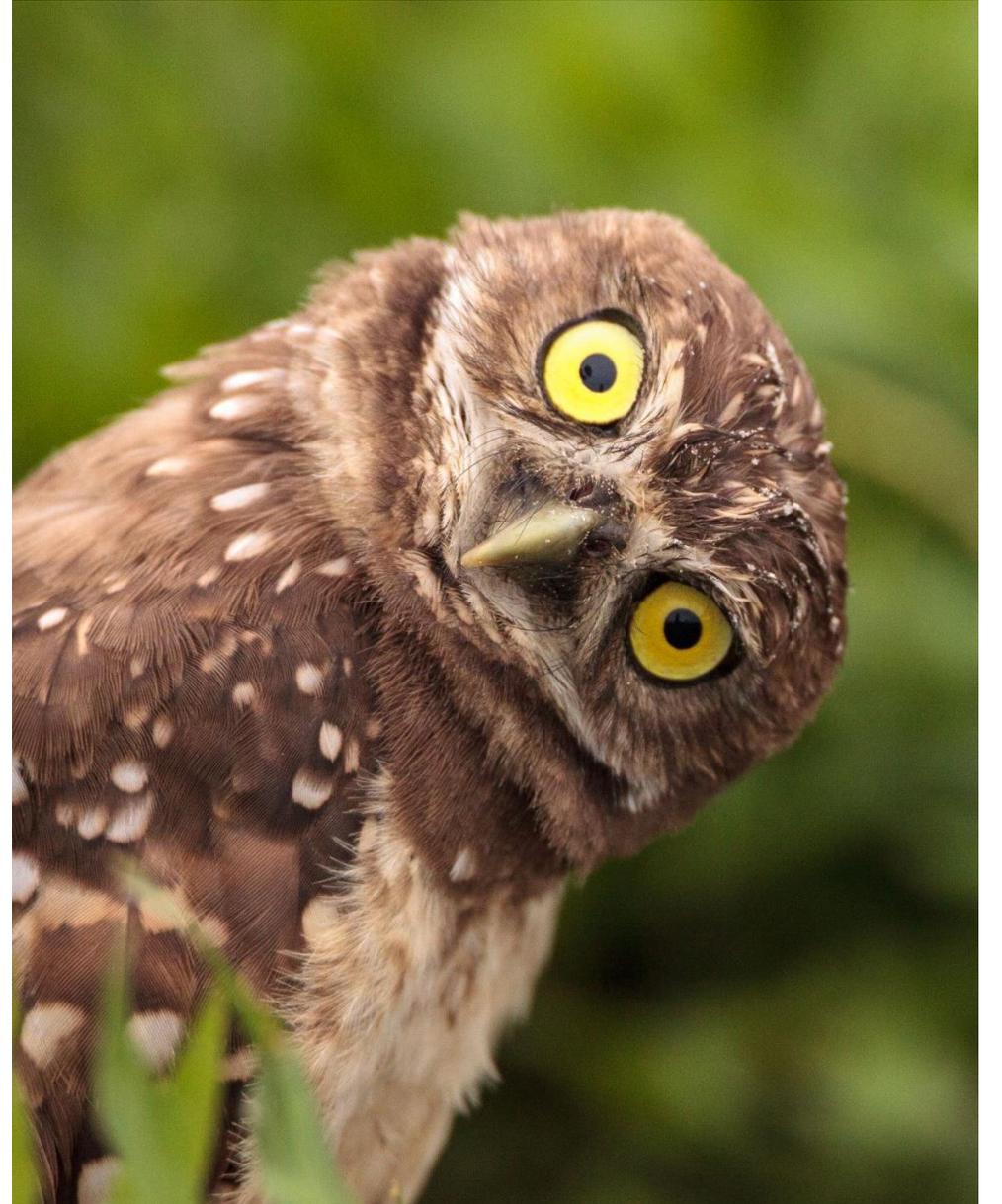
NC MEDICAID OMBUDSMAN OUTREACH

Digital versions of outreach materials (English and Spanish):
ncmedicaidombudsman.org/for-community-partners/

Request printed outreach materials (English and Spanish) be mailed to your organization by emailing info@ncmedicaidombudsman.org.

Presentations on NC Medicaid Managed Care & NC Medicaid Ombudsman available in English and Spanish. Submit your request here: ncmedicaidombudsman.org/for-community-partners/

**QUESTIONS?
FEEDBACK?
ISSUES TO REPORT?**



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